ORIGINAL ARTICLE

Experiences of an ongoing preceptorship programme for newly employed nurses in medical departments – A qualitative study

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Received: December 17, 2024 **Accepted:** February 14, 2025 **Online Published:** February 20, 2025

ABSTRACT

Objective: To explore the experiences of head nurses, preceptors, and newly employed nurses in five Danish medical departments on an ongoing preceptorship programme.
Methods: The Rigorous and Accelerated Data Reduction (RADaR) technique was used to design this study and guide the data collection and analysis. In December 2023, 21 participants (head nurses, preceptors, and newly employed nurses) were interviewed in qualitative semi-structured interviews.
Results: The findings show an overall need for a structure of the content, planning, and execution of the preceptorship programme and a specific focus on the newly employed nurses' personalities and individual needs throughout the introduction. Three themes were unveiled after the RADaR analysis: "Aiming for overall structure and individuality," "Preceptoring – Advantages and disadvantages of cutting corners," and "Clarifications of expectations and progress."
Conclusions: A more structured preceptorship programme that considers individual needs and focuses on social interactions could strengthen the future introduction of newly employed nurses in medical departments. Even though the head nurses and preceptors considered the preceptorship programme too lengthy and time-consuming, it could be time and money well spent as it may increase retention and reduce turnover of newly employed nurses.

Key Words: Individual needs, Medical departments, Newly employed nurses, RADaR technique, Retention, Social introduction, Qualitative

1. INTRODUCTION

High nurse turnover and nursing shortage in hospitals is a global problem,[1,2] often related to nurse dissatisfaction with their current positions,[3,4] with their manager,[5] or with the extensive workload and a stressful environment.[6] While a nursing shortage can result in lower mental health status and lower job satisfaction in the remaining nursing staff,[7] nursing shortage also has consequences on the quality of

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patient care and outcomes.[7, 8]

Numerous recruitment and retention strategies have been tested internationally to prevent an increasing turnover and to overcome the nursing shortage.[9] Most studies of effective nursing shortage management strategies focus on offering a high-quality working environment[10] and specific introductory programs for newly employed nurses.[11, 12] Interventions with the highest benefit involve internships, residencies, or transition programmes that provide formal teaching, preceptorship, and ongoing support for newly employed nurses.[12, 13] In an integrative review, to identify best practices of formal new graduate nurse transition programs, Rush and colleagues[12] found that all-around preceptorship of the new graduate nurse transition to a new hospital job was an important emphasis of all programmes. The all-around preceptorship was found to increase competencies and confidence over time for the newly graduated nurses through a structured and supportive period of transition from learning to applying complex skills[12] The fixed preceptor role during the introduction process of preceptorship programmes has been shown to have a positive impact on the retention of newly educated nurses,[14, 15] on the work-readiness of young nurses,[15, 16] as well as on increased competencies,[14, 17] professional socialization,[14, 17, 18] and job satisfaction.[18]

In the five regions in Denmark, the highest nursing shortage is found in the Zealand region, where recruiting and retaining nurses is urgently needed due to the many vacant nursing positions across hospitals and departments.[19] Recruiting and retaining nurses for the medical departments is especially difficult which is also a known international problem.[20] It is therefore important to retain the nurses in the medical departments as effectively as possible. Over the past few years, there has been a concentrated national focus on specific initiatives for introducing newly employed nurses, through preceptorship programmes, to ensure a safe and satisfactory entry into the new workplace for newly employed nurses.[19] At Zealand University Hospital, a preceptorship model was introduced in 2020[21] focusing on a safe transition to practice for newly employed nurses, based on six comprehensive dimensions of culture, guidelines, network, collaboration, competencies, and results.[22] However, it can be difficult to see the success and effect of the overall preceptorship model when the turnover of nurses is continuously high at the hospital. The nursing turnover in Zealand University hospital has been 30% on average over the past four years, hence a new effort must be made to modify and improve the ongoing preceptorship programme. A qualitative approach will therefore be used to explore the experiences of head nurses, preceptors, and newly employed nurses in five Danish medical departments on an ongoing preceptorship programme.

2. METHODS

2.1 Design

The qualitative research methodology called the Rigorous and Accelerated Data Reduction (RADaR) technique[23] was used to design this study. The RADaR technique determines the data collection and analysis to secure a quick and evidence-based process. No philosophical paradigm is described by Watkins[23] to guide the RADaR technique. Even though epistemological underpinnings may be beneficial within a qualitative study[24] it is not a methodological requirement.[25] The reporting of this study complies with the consolidated criteria for reporting qualitative research (COREQ) recommendations.[26]

2.2 Settings

The medical department settings consisted of three in-hospital departments (A, B, and C) and two outpatient departments (D and E). The two outpatient departments have approximately 35,000 patient contacts a year, and 25,000 contacts have a physical presence in the department. The three in-hospital departments have 70 beds and a yearly intake of 3,800 patients. As of April 2024, 56 registered nurses were employed in the three in-hospital departments. Additionally, nine licensed practical nurses were employed as substitutes for nurses. There were 17 vacant nursing positions in the three in-hospital departments but none in the two outpatient departments.

2.3 The preceptorship programme

The preceptorship programme in the medical departments was inspired by the overall preceptorship model of the hospital.[21] To adapt the model to the culture and context of the medical departments, two elements were chosen as focus points constituting the content of the programme:

• Evaluation meetings: The evaluation meetings were conducted by the head nurse and the preceptor after 4, 8, 12 weeks and 6 and 9 months following specific schedules with discussion points from the overall hospital model.

• The preceptor role: The nurses with a key function as preceptors were clinical nurses from the department, who had been selected by the management to engage in the preceptorship programme. These nurses had no extra skills but were highly motivated to introduce the new graduate nurses to their nursing tasks in clinical practice. The preceptors were responsible for executing the evaluation meetings and for the daily introduction of the newly employed nurses. The elements of the introduction consisted of a specific list of nursing tasks that all newly employed nurses must learn

within the first month.

2.4 Participants

To evaluate the preceptorship programme from different perspectives, participants consisted of facilitators and recipients of the preceptorship programme. Head nurses and preceptors were considered facilitators as they were responsible for the content and execution of the programme within the five departments. The recipients constituted nurses who were newly employed within the past year before data collection.

All participants were recruited by the first author following convenience sampling.[27] The total amount of head nurses ($n = 6$) and preceptors ($n = 6$) of the five medical departments were invited and agreed to participate. The recruitment and sampling process of the newly employed nurses was performed concurrently by the first author, who sat in each department for a week, to provide the nurses with the opportunity to be interviewed when they had available time during their working day. Ten newly employed nurses were invited – nine agreed to participate and one declined due to vacation. A summary of the characteristics of the 21 participating nurses is displayed in Table 1.

Table 1. Summary of participant characteristics ($n = 21$)

Participant	Age, years	Sex	Graduation year as a nurse	Position	Time employed in the position	Department	Interview duration (Minutes)
#1-#6	35-54 (mean 47)	F	1993-2013	Head nurse	1½-15 years	A-E	31-71 (mean 50)
#7-#12	31-62 (mean 46)	F	1984-2016	Preceptor	1½ years	A-E	22-58 (mean 41)
#13-#21	24-54 (mean 34)	F/M	2009-2022	Newly employed nurses	2 weeks-10 months	A-E	19-72 (mean 44)

Of the 21 participants, 20 were women. The participants were 41 years old on average (median 46 years), ranging from 24 to 62 years, and had on average been educated as nurses for 13 years (median 11 years). The head nurses had been employed in their positions for an average of six years. The preceptors had all been in this position since it was introduced in the hospital $1\frac{1}{2}$ years before data collection.

2.5 Data collection and analysis

The Rigorous and Accelerated Data Reduction (RADaR) technique[23] was applied for data collection and analysis through four phases: 1) Data collection with rapid interview tables; 2) Placing data into three coding tables and creating codes; 3) Reducing data; and 4) Identification of main themes. The RADaR technique has proven to deliver valid and timely findings, with an acceptable agreement with results from thematic analyses.[23]

2.5.1 *Phase 1: Data collection with rapid interview tables*

Data were collected in December 2023 by the first author through semi-structured individual interviews with the 21 participants. The interviews were conducted in the five medical departments in secluded rooms made available by the department management. Qualitative interviews were chosen according to the appropriateness of the RADaR methodology technique[23] and to gain a broad description of the participants' perspectives.[27]

To explore and evaluate the different perspectives on planning, executing, and receiving the preceptorship programme, interview guides were developed specifically for each of the three participant groups, coherent with their state of involvement in the programme:

- The questions for the head nurses and preceptors were directed towards their experiences of the overall programme for the newly employed nurses (Can you tell me about your Preceptorship programme (what works and what doesn't)
- The questions for the preceptors covered their experiences of the operational execution of the programme elements (What are your main tasks? What should be a part of the programme? How much time do you use on the execution of the programme?)
- The questions for the newly employed nurses were directed towards their experiences of receiving and participating in the preceptorship programme (Can you describe your introduction here? What are your experiences on the evaluation meetings? On the Preceptorship? Your positive and negative experiences and suggestions for improvements?)

According to the RADaR technique,[23] the interview guides were formatted into rapid interview tables to ensure similarity in the data transcripts. The qualitative interviews were subsequently conducted, and notes on the most important quotes of the interviews were written in the rapid interview table during the interviews. To supplement and elaborate the quotes in the rapid interview tables, the authors digitally recorded and reviewed the interviews. The interviews lasted from 21:39 minutes to 71:46 minutes (mean average of 45 minutes per interview), depending on the time available from

the participant.

2.5.2 *Phase 2: Placing data into three coding tables and creating codes*

Three coding tables were developed – one for each of the participant groups. In the three coding tables, answers from each question in the rapid interview tables were organized to get an overview of what all the participants of the individual groups replied to the specific questions (see Table 2).

Each reply and note were read, reduced, and provided with a code. A total of 201 codes were created from the responses of the head nurses (n = 50), the preceptors (n = 51), and the newly employed nurses (n = 109).

2.5.3 *Phase 3: Reducing data*

In Phase 3, data were reduced to focus on the 201 collected codes and their belonging notes for replies from the three participating groups (see Table 3).

Sections in the Phase 3 table were divided into the main areas of the rapid interview table (planning, executing, and receiving) for a complete overview. Eliminating large paragraphs of text and data in the Phase 3 table provided the research group with only the text relevant to the study aim.[23]

2.5.4 *Phase 4: Identification of main themes*

The 201 codes from Step 3 were further reduced into themes concerning responses from each of the three participant groups. Three themes were developed, based on Phase 4 thematic analysis of the 201 codes: Aiming for overall structure and individuality, Preceptoring – Advantages and disadvantages of cutting corners, and Clarifications of expectations and progress. Table 4 presents an example of the thematic analysis.

Table 2. Example of the coding table for the head nurses' responses

Question: Please tell me how you experienced the overall Preceptorship programme			
Participant	**Replies**	**Notes**	**Code**
#4	*The programme is very regulated and structured, and there was not so much we could do for the individual new nurses.*	The programme is very structured, and we miss the individuality.	Structure and individuality
#5	*We have performed a specific introduction for years. Also, before it was called preceptorship (…). We use many of the elements in the programme but not that structured.*	Using the preceptorship elements but not structured	
#6	*We try to be structured about the evaluation meetings, but they are not always on time. So we often follow them to the point of what makes sense.*	We sometimes let go of the structure.	

Table 3. Example of a condensed data table for all participants with a focus on the collected codes

Question: Please tell me how you experience the overall preceptorship programme		
Participant	**Code**	**Notes (From Phase 2)**
Head nurse		
#4	Structure and individuality	The programme is very structured, and we miss the individuality
#5	Structure and individuality	Using the preceptorship elements but not structured
#6	Structure and individuality	We sometimes let go of the structure
Preceptor		
#8	Structure and individuality	Structure, in the beginning, emanating to individuality
#11	Individual introduction	Individual introduction and peer teaching
#12	Individual introduction	Individual introduction and peer teaching
Newly employed nurse		
#16	The picture is painted too pretty	Making promises that are not kept
#18	Not protected during the introduction	The introduction was too short and unprotected
#19	Lack of completed preceptorship programme	Too many newly employed nurses at the same time

Table 4. Example of identification of the theme "Aiming for overall structure and individuality"

Code	Notes (from Phase 2)	Theme	Participant(s)
Structure and individuality	The programme is very structured, and we miss the individuality.	Aiming for overall structure and individuality	Head nurses #4, #5, #6
	Using the preceptorship elements but not structured.		
	We sometimes let go of the structure.		Preceptor #8
	Structure, in the beginning, emanates from individuality.		
Individual introduction	Individual introduction and peer teaching.		Preceptor #11, #12
The picture is painted too pretty	Making promises that are not kept.		Newly employed nurses #16, #18, #19
Not protected during the intro	The introduction was too short and unprotected.		
Lack of completed preceptorship programme	Too many newly employed nurses at the same time.		

2.6 Ethical considerations

All participants received written information concerning the study essentials, author credentials, judicial rights, and the amount of participation when they were invited to participate. The participants received the information verbally on the day of the interviews and were asked to complete a written consent form. The study was approved by the Danish Data Protection Agency (J. nr. REG-141-2022). It was carried out following the Code of Ethics of the World Medical Association (Declaration of Helsinki) for experiments involving humans.

3. RESULTS

The findings show an overall need for a structure of the content, planning, and execution of the preceptorship programme and a specific focus on the newly employed nurses' personalities and individual needs for the introduction. All three participant groups highlighted the preceptor role and the evaluation meetings of the preceptorship programme as important throughout the introduction. However, lack of time and resources to execute the programme as planned often entailed consequences for the newly employed nurses' introduction period. In the following, the three themes of Aiming for overall structure and individuality, Preceptoring – Advantages and disadvantages of cutting corners, and Clarifications of expectations and progress will be presented as they were found during the RADaR analysis of the 21 qualitative interviews with the head nurses, preceptors, and newly employed nurses.

3.1 Aiming for overall structure and individuality

Overall, the head nurses and preceptors evaluated the preceptorship programme to be positive and stated that it works. The head nurses and preceptors explained how the preceptorship programme at the medical departments originated in the overall preceptorship model for the University hospital. In this model, the head nurses and preceptors selected the elements of preceptorship and evaluation and implemented them to fit each department separately.

The head nurses and preceptors all agreed that the preceptorship programme should have a practical and structural plan. They recommended the development of a structured checklist for what the newly employed nurses must go through during their time of introduction, including specific and general nursing tasks and activities. It was important for the head nurses and preceptors to clarify what the preceptorship programme should contain, how long it should last, what the newly employed nurse could expect, and which goals they should achieve. A head nurse was already working on the structured checklist:

"We currently use a learning instrument which is kind of a competency table, where you mark every time you learn something new (. . .). I like that everybody gets the same introduction. I made the instrument so the preceptor can see every little thing the newly employed nurses must learn" (Head nurse, department B)

The head nurses and preceptors also realised how the preceptorship programme should contain individual activities alongside the structured checklist. This was due to the differences in personality, experience and competencies of the newly employed nurses, who needed introduction on different levels and on different subject.

Although the head nurses and preceptors had positive considerations about the preceptorship programme, most of them experienced the program as too extensive with a lack of time and resources to execute it as planned.

"We need an overall structure for the preceptorship programme in the entire medical department, but we don't have

the time to do it. It is messy, and everybody has different ways of doing the introduction without knowing why (. . .). It is a massive work and the preceptors should be provided time for it" (Preceptor, department C)

The head nurses and preceptors all struggled with aligning the ideal planning with the execution of the preceptorship programme in daily clinical practice, concerning the preceptor trajectory and executing evaluation meetings.

3.2 Preceptoring – Advantages and disadvantages of cutting corners

The preceptor role was described by all participant groups, as an essential aspect of the introduction of the newly educated nurses. However, the head nurses and preceptors explained how the content and flow of the preceptor role were too sparsely described and varied between the five departments. The head nurses and preceptors further stated how they considered the preceptor trajectory to run for too long and how problems arose when many new nurses were employed simultaneously. The preceptors explained how they lacked time to provide a thorough introduction for all.

"Once, we had three new nurses starting the same day, which was very problematic. They differ a lot from each other and it wasn't easy. One wanted to get started doing rounds and another was very insecure. She kept her COVID mask on during the nursing rounds meeting to hide" (Preceptor, department C)

The newly employed nurses described the head nurses' explanations of how the lack of introduction was caused by a lack of time and staff. The newly employed nurses considered it a major problem that the preceptorship programme was canceled due to sick leaves and operational issues, and they had a feeling that more was promised than could be kept.

"The idea of preceptorship is great, as well as having a Buddy. However, the picture was painted too pretty according to what was promised and what was kept" (Newly employed nurse, department B)

The majority of the newly employed nurses experienced, that the minimum of time with their preceptor, resulted in a rapid provision of responsibilities without a safety net, which contributed to frustrations and anxiety about being unable to handle the situation. Some newly employed nurses described how they were the nurses in charge of patients and students six weeks after employment. Especially if they were former students in the department:

"Then, when I was introduced by nurses who knew I was a former student in the department, they thought: "Oh well, she can take care of eight patients". And I was like, Wow... I could have said something, but that just isn't me" (Newly employed nurse, department B)

The newly graduated nurses were very particular about the fact, that there was a big difference between being a student and a nurse. A thorough introduction to clinical practice and to the "transition shock" that can occur, was a specific necessity for them.

The newly employed nurses considered getting to know their new clinical practice and patients equally important to fitting in well with the staff group of new colleagues. Due to a lack of resources, the preceptor role was often passed on to the clinical nurses in the department. The newly employed nurses were pleased with this decision as they considered it an excellent way to get to know their new colleagues.

"I liked following (name of nurse blinded) during my introduction to the department. She introduced me to social events and drew me into conversations, making me feel like a part of the group. She opened the team for me, and I felt very included" (Newly employed nurse, department C)

The clinical nurses often let the newly employed nurses work at their own pace, which suited them much better. It also meant that the newly employed nurses, who had previously been in the department as students, had the opportunity to be involved in how to be a nurse, rather than continuing in their role as a student.

3.3 Clarifications of expectations and progress

The head nurses and preceptors described, how the evaluation meetings were planned to be held with the newly employed nurses and themselves 4, 8, 12 weeks, and 6 and 9 months after their first day. For these meetings, the head nurses and preceptors used specific schedules with discussion points, developed by the overall preceptorship model for the University hospital. The preceptors explained that the evaluation meetings were too many, too redundant, and rarely held as planned, due to operational issues and lack of time. The preceptors also assessed the questions in the evaluation meeting schedules as imprecise and incompatible with the adaptation of individual concerns:

"The questions in the evaluation meeting schedules are strange. Our nurses differ a lot from each other, so I conduct the meetings according to their personalities. The questions are not redundant but too broad" (Preceptor, department D)

The preceptors described, that the evaluation meetings should be concretized and structured so that they suited all five medical departments and simultaneously make room for the individuality of the newly employed nurses. Although the preceptors were critical of the evaluation meetings, they also

deemed them useful because they could keep track of the newly employed nurses' well-being and progress in the department.

The newly employed nurses were very pleased with the evaluation meetings, which they experienced as important for their introduction and progress. Here the newly employed nurses felt that they were cared for and heard. The newly employed nurses also considered the evaluation meetings as a way to follow up on what they had learned, what they were missing, and whether there were things that needed to be changed:

"They (the evaluation meetings) make you feel welcome and taken care of (. . .) Changes are made if you need it" (Newly employed nurse, department E)

In some departments, interviews of the newly employed nurses' expectations were held during the first week with the head nurses and preceptors. These interviews were very important for the newly employed nurses, as they could communicate their needs for introduction and the parties' mutual expectations.

"During the expectations interview, we talked about who I am, how we succeeded in introducing me to the busy practice work, and how to keep calm so the patients don't pick up on the stress" (Newly employed nurse, department C)

The interviews of expectations were requested in the other medical departments, to clarify the newly employed nurses' individual needs for introduction, and avoid a misdirected introduction.

4. DISCUSSION

Through 21 qualitative interviews, head nurses, preceptors, and newly employed nurses in five Danish medical departments provided their experiences and perspectives on the content, execution, and receipt of a preceptorship programme. Although the three participant groups differed in their roles within the preceptorship programme, they all agreed that the preceptor role and the evaluation meetings were important throughout the introduction. However, the head nurses and preceptors additionally stated that they considered the preceptor trajectory to run too long and that the number of evaluation meetings was superfluous and unfeasible in a busy daily practice, mainly when many new nurses were employed simultaneously. The lack of time for introducing newly employed nurses as intended by hospital departments is a well-known predicament.[28,29] Where the newly employed nurses need emotional and professional support and encouragement, the limited time and resources in practice often leave the newly employed nurses with a lack of direction[28] and can affect the success of the introduction.[29] In our present study, the head nurses and preceptors' lack of time and resources to execute the preceptorship programme as planned, also entailed consequences for the newly employed nurses who experienced a compromised preceptorship programme due to sick leaves and operational issues in focus. The newly employed nurses felt provided with too much responsibility too fast, which contributed to frustrations and anxiety about being unable to handle the situation.

The limited support and time for introduction are often seen to cause a high turnover of newly employed nurses,[29] which contradicts the reasons and considerations for running preceptorship programmes. Can we afford not to provide time and resources for a thorough introduction period for newly employed nurses? The nursing shortage is global, and the difficulties of recruiting nurses are overwhelming,[28,30] hence focus must be placed on retaining the nurses already employed within the hospital departments.[11] A large variety of introduction-to-practice programmes, focusing on mentorship,[31] preceptorship,[13] and internship,[32] have been developed and evaluated. The significant results of these interventions show that a structured and intensive introduction programme for nurses, can increase retention and reduce turnover of nurses.[13,31,32]

Even though the limited time can be a barrier to the successful introduction of newly employed nurses,[28,29] our present study shows, how a compromised situation turned out for the better. The preceptors explained how they occasionally left the introduction responsibility to the clinical nurses in the department when their time was short. Even though the preceptors felt reluctant to do this, the newly employed nurses were very pleased with this arrangement. The newly employed nurses described it as a breath of fresh air during their introduction. Because they needed to be introduced to practice as well as to their new colleagues, it was a perfect situation for them. The process is also connected with the literature that describes onboarding as a generic term for the "socialization" process that helps new employees learn the knowledge, skills, and behaviours needed to succeed in a new organization.[13] The socialisation process is thereby associated with developing a sense of competence and control as well as social belonging,[33,34] which essentially provides the newly employed nurses with a sense of security.[29]

It is in many ways important to have an exclusive preceptorship programme for newly employed nurses that is structured and aim to work with the individual needs for the introduction of the newly employed nurses. Many of the newly employed nurses in our present study felt they were being provided with too many responsibilities too soon and were treated as every other nurse in the department. Studies show, that

involving newly employed nurses in a structured way and clearly distinguishing them from other employees, is associated with higher levels of adjustments to clinical practice.[33] The unique distinction also counts for individual attention, as our present study showed concerning the evaluation meetings and interviews of expectations. Preceptorship practices are related to greater adjustments and encouraging newly employed nurses to be who they are, which is associated with higher levels of adjustment indicators.[33]

4.1 Limitations

The study was conducted during a rapidly increasing nursing shortage, why the Rigorous and Accelerated Data Reduction (RADaR) technique[23] was used. The limitations of the RADaR method include the inability to achieve the same in-depth level of interpretation as the conventional qualitative data analysis method.[35] However, the reduction in time between data collection and analysis and the ability to collect more data and include more research participants in a short period was preferred. Rigour in qualitative research has been associated with the length of time regarding immersion with data; however, the development of rapid qualitative research indicates that rigorous findings can also be developed rapidly.[36,37] Another limitation could be leaving out philosophy and theoretical perceptions as a part of the qualitative design. When a qualitative researcher uses a philosophical perspective, it represents their worldview and influences how data are collected and analyzed. The implications of the results of this study could indicate yet again a loss of depth in the findings.[23]

5. Conclusions

Head nurses, preceptors, and newly employed nurses agreed, that a thorough introduction was necessary through a preceptorship programme consisting of partnership with the preceptor and concurrent evaluation meetings. The study showed, how preceptorship programmes must be structured according to nursing practice as well as consider the individual needs of the newly employed nurses. The head nurses and preceptors described the execution of the introduction trajectory and the evaluation meetings as too long and too time-consuming, however, sufficient time for proper introduction was needed by the recipient newly employed nurses. Delegating the practical tasks for introduction to the clinical nurses of the department was seen as a promising way to save resources for introduction but was also considered fruitful by the newly employed nurses as they valued acquaintance with their new colleagues and learning about their new practice and patient population as equally important.

To strengthen the future introduction of newly employed nurses in clinical hospital practice, preceptorship programmes must be structured and consider the individual needs of the newly employed nurses and focus on social interactions with new colleagues. Even though the head nurses and preceptor nurses of this study consider the introduction trajectory as too long and too time-consuming, providing the time and resources for the introduction process could be money well spent as it may increase retention and reduce turnover of nurses.

Acknowledgements

We would like to thank all the participating nurses, for taking time out of their busy work schedule to be interviewed for our study.

Authors contributions

CB and KMK contributed to the study design. Data collection was performed by CB. CB and KMK performed the data analysis with inputs from CAH, CB drafted the manuscript. All authors performed critical reviews and approved the final version.

Funding

This research received no specific grant from funding agencies in the public, commercial or not-for-profit sectors. The project was, however, financed by the Head management of the Medical Department, Zealand University Hospital, Koege.

Conflicts of Interest Disclosure

The authors declare that there are no potential conflicts of interest.

Informed consent

Obtained.

Ethics approval

The Publication Ethics Committee of the Sciedu Press. The journal's policies adhere to the Core Practices established by the Committee on Publication Ethics (COPE).

Provenance and peer review

Not commissioned; externally double-blind peer reviewed.

Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Data sharing statement

No additional data are available.

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