The Influence of Nurses' Confidence on Practice Breakdown

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Abstract

Background: New graduate nurses are tasked to provide complex clinical care in hospitals. As they transition into professional practice, they may lack confidence leading to practice breakdown.

Objective: Determine the relationship between nurses' confidence level and practice breakdown in a community hospital.

Methods: An electronic cross-sectional survey was conducted among nurses at Mountainside Medical Center. Data were collected from 100 registered nurses using the Casey-Fink Graduate Nurse Experience Survey, the Nurse Practice Breakdown Checklist, and a demographic questionnaire. Descriptive statistics were utilized to summarize the characteristics of the respondents, including mean scores for role confidence and practice breakdown. The chi-square test for equal proportions was used to examine the distribution of responses across nurse characteristics. Mean scores were compared using an independent t-test. One-way ANOVA was conducted to examine the relationship between the demographic variables, confidence, and practice breakdown. Statistical analyses were conducted using SAS 9.4. Approvals to conduct the study were obtained from the Western Copernicus Group Institutional Review Board and William Paterson University' s Institutional Review Board.

Results: A total of 100 nurses responded to the survey, yielding a response rate of 20.4%. Respondents were likely to have five years or more of experience (60, 60%) or have a history of being a charge nurse (n=69, 69%)**.** Overall mean scores for role confidence and practice breakdown were 3.42, (SD=0.67), and 0.95(SD=1.37), respectively. Older nurses had higher role confidence, $p<0.05$. Those with a specialty certification demonstrated higher role confidence

(mean = 3.63, SD = 0.60) and lower levels of practice breakdown (mean = 2.96, SD = 1.30). There was no relationship between confidence level and practice breakdown.

Implications for nursing practice: Practice breakdown is most likely a multifactorial phenomenon, and additional research is recommended.

Keywords: confidence, newly graduated nurses, practice breakdown

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Chapter 1: Background

Identification of the Problem

Registered Nurses (RNs) are a critical component of the healthcare delivery system and compose the largest workforce sector in healthcare (Haddad et al., 2023). Opportunities for employment are expected to increase at a much faster rate than all other occupations. To fill the projected gap, newly graduated nurses (NGNs) are in demand to prevent the consequences of a nursing shortage. However, their limited experience makes them susceptible to causing medical errors (Haddad et al., 2023).

Newly Graduated Nurses (NGNs), Newly Licensed Graduated Nurses (NLGN), and novice nurses are terms used to define any nurse with less than one year of experience (Haddad et al., 2023; Tyndall et al., 2018). However, for this paper's purpose, the term NGN will be used. The acute care environment is demanding and fast-paced, accompanied by high levels of stress and results in nurses leaving their jobs prematurely. In the United States, the turnover rate for NGNs is much higher than for experienced nurses, 31.7% and 27.65%, respectively (American Hospital Association [AHA], 2023; Bae, 2023). In fact, approximately 17% of NGNs leave the nursing profession within their first year, and up to 30% within the first three years (Sutor & Painter, 2020).

Novice nurses often report self-doubt as they manage the influx of emotions that comes with professional integration into a new profession (Anderson & Edberg, 2010; Jewell, 2013). A novice nurse’s confidence, or their self-perceived feeling about how they view themselves as a professional, is a crucial component of nursing practice and the care they provide (Najafi & Nasiri, 2023; Kim et al., 2016). Low levels of confidence cause NGNs to feel unprepared for clinical work and are known to influence their ability to think, communicate, and practice (Najafi

& Nasiri, 2023; Urban & Barnes, 2020). In addition, patients feel uneasy when they receive care from a nurse with low levels of confidence (Perry, 2011). Conversely, increased levels of confidence are associated with the ability to recognize changes in patient conditions and respond appropriately, which leads to fewer adverse outcomes or events that threaten patient safety (Davila, 2019; Ortiz, 2014).

More than 50% of events that result in patient harm are preventable, and account for 251,000 deaths annually in the United States [US] (Anderson & Abrahamson, 2017; World Health Organization [WHO], 2023). Patient safety is a framework of organized activities that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make errors less likely to occur, and lessen the impact of injury by reducing the risk of unnecessary harm to an acceptable minimum (WHO, 2023). While one cannot assume that all events that threaten patient safety originate from nursing errors, one can surmise that as the largest sector of the healthcare profession, nurses are highly likely to contribute to events that threaten patient safety (Haddad et al., 2023). With an increasing number of NGNs reporting incidents that result in unsafe practices, it is important to explore the relationship of role confidence with breakdowns in healthcare delivery (Tyndall et al., 2018).

Problem Statement/ Research Questions

This study examined the influence of role confidence on practice breakdown. This paper sought to answer the following question:

What is the relationship between role confidence and practice breakdown among nurses at a northern community hospital in New Jersey?

Significance

Safety events are a threat to a patient's life and cost the American healthcare system approximately $19 billion a year, due to hospital overstays, unnecessary time off from work, and legal action (Azyabi et al., 2022). In addition to the impact that practice breakdown has on patients and the healthcare system, the healthcare worker is often traumatized by the event, experiencing an array of emotional and psychological trauma (Zangaro et al., 2023). While patients are the first victim, the second victim is the healthcare worker who may have created, caused, or contributed to the event (Wands, 2021). The trauma that originates from the event can lead healthcare workers to second guess their clinical skills and knowledge, voluntarily leave/quit the profession entirely or have a higher absenteeism rate when compared to their peers (Sahay & McKenna, 2023; Wands, 2021).

DNP Project Essentials

The Doctor of Nursing Practice [DNP] degree emphasizes integrated practical experiences and application to professional practice (American Association of Colleges of Nursing [AACN], 2006). Exploring the influence of confidence on practice breakdown may validate the health system's investment in interventions that increase a nurses' role confidence and decrease practice breakdown.

The DNP essentials utilized in this study include *Essential I,* the scientific underpinnings for practice, *and Essential II,* organizational and systems leadership for quality improvement and systems thinking (AACN, 2006). These essentials provide the foundation whereby the DNP graduate can transform the current health delivery system and improve both quality and outcomes of patient care.

Summary

The transitional period of NGNs into the world of professional practice is a challenging period, exacerbated by feelings of doubt, confusion, disorientation, and loss (Murray et al., 2019). In addition, this transitional period into practice highlights gaps in knowledge, and the inability of novice nurses to tailor their academic knowledge to independent clinical situations (Ozdemir, 2019). Feelings of inadequacy can lead novice nurses not only to leave the profession but may also cause events that threaten patient safety. Although there is research on the influence confidence has on NGNs, there is limited literature available on the impact that role confidence has on practice breakdown (Najafi & Nasiri, 2023; Tyndall et al., 2018). This study aims to contribute to the growing body of literature on understanding the effect of NGNs' confidence on patient outcomes.

Chapter 2: Review of Literature

Theoretical Framework

Patricia Benner's Novice to Expert model (Benner, 1982) describes the professional journey as nurses become competent, independent clinicians. She adapted the Dreyfus Model of Skill Acquisition to the nursing profession and noted that a novice nurse has no practical experience, minimal information on the application of their learned theoretical knowledge and uses context-free rules to guide their performance. In their journey to become experts, novice nurses transition through various stages, from novice, advanced beginner, to the competent stage, which could take 1 to 2 years to achieve (Benner, 1982; Ozdemir, 2019). Throughout the first two stages, nurses are anxious and stressed when the needs of their patients change (Benner et al., 2009). However, through trial and error, NGNs improve their cognitive, psychomotor, and emotional skills to implement safe individualized nursing care (Benner et al., 2009; Ozdemir, 2019). This is congruent with Duchscher's transition phases, which suggest that NGNs require approximately one year to become confident independent clinical practitioners (Duchscher, 2008).

Kramer (1974) coined the term 'reality shock' to describe the experience of NGNs' as they transition into a professional setting. The phases described by Kramer (1974) and expanded by Duchscher (2008), include three transitional periods during the first 12 months of professional practice. The first two phases of transition encompass periods of learning, adjusting, questioning, and doubt (Duchscher, 2008; Montgomery et al., 2021; Wakefield, 2018). In the final phase the NGN can either transition to become an independent, confident clinical practitioner or experience burnout, leading to an increase of practice breakdown.

Related Research

An understanding of the potential for mistakes by NGNs must be evaluated as they are at a greater risk of causing errors and threatening patient safety than their experienced counterparts (Berkow & Virstis, 2008; Murray et al., 2019). Novice nurses were 49% to 53% more likely to be involved in errors compared to those who were more experienced; while nurses with less than two years of experience were responsible for 80.5% of practice errors (Smith & Crawford, 2003; Kenward & Zhong, 2006; Kim et al., 2016). Unlike experienced nurses, NGNs tend to have low levels of confidence, which may result in poor performance, delayed, or missed care, and an increased risk for errors, putting both patients and nurses at risk (Hayes, 2018). With an estimated 600,000 baby boomer nurses leaving the workforce by 2030, and NGNs expected to fill in the gap, it is possible that the number of incidents may increase (National Academies of Sciences, 2021).

The development of a nurse's clinical knowledge is refined through various aspects of their environment, including the expertise of their co-workers, team functioning, and social climate (Ebright et al., 2004). While the available research demonstrates the existence of numerous factors contributing to breakdown in nursing practice, low levels of confidence continue to be a principal factor for errors made by novice nurses (Najafi & Nasiri, 2023; Saintsing et al., 2011; Wang et al., 2023).

Confidence

Confidence in professional practice is an important characteristic, as it encourages nurses to ask questions, consider alternatives in patient care, and implement interventions (Nibbelink & Brewer, 2018). Increases in self-confidence provide nurses with the ability to manage the daily requirements of clinical practice, identify appropriate interventions for individual patient scenarios, and manage emergencies (Nibeelink & Brewer, 2018). In fact, increased self-

confidence is aligned with improved communication, positive attitudes towards the profession, and positive feelings about themselves as professionals, which can significantly influence critical thinking and clinical practice (Najafi & Nasiri, 2023). While increased confidence in one's role is not the only requirement to be competent, it plays a factor in ensuring that patients receive appropriate care. As acute care hospitals become increasingly specialized and complex, it is essential that nursing meets the demands of the dynamic interactions of patient care (Willman et al., 2022). Confidence in one's role is not fully acquired in the academic environment, but gradually through experiences of patient care and continuous interaction with other healthcare professionals (Benner, 1982; Duchscher, 2008; Jewell, 2013; Dyess & Sherman, 2009; Newton & Mckenna, 2007; Spiva et al., 2013; Wangsteen et al., 2008).

Jamieson et al., (2023), conducted a longitudinal study with 530 nurses in their first year of practice, using the Casey-Fink Graduate Nurse Experience Survey (CFGNES). NGNs reported an increase in their self-perceived preparedness to complete their professional responsibilities, increasing from 86% at baseline to 91% at the 6-month mark, and 98% at the 12-month mark. In addition, there was a decrease in concern about harming a patient due to lack of knowledge and experience, from 20% at baseline, to 12% at the 6-month mark, and 7% at the 12-month mark.

Fink et al. (2008) conducted a longitudinal survey of 434 NGNs engaged in a nurse residency program and collected data at the beginning of the program, the 6-month mark, and the 12-month mark. Their findings revealed that at baseline, none of the respondents felt comfortable performing any clinical skills independently. At six months, 10% of NGNs reported improved comfort, however, only 7% felt comfortable in their clinical skills at the 12-month mark. This was attributed to an increase in NGNs' independence and management of more complex patient

care situations. Furthermore, there was an increase from 8% at baseline to 28% at the 6-month mark, to 58% at the 12-month mark in how comfortable NGNs felt in their professional role. For those who reported transitional challenges adjusting to their professional role, low levels of confidence were contributing factors.

Pfaff et al. (2014) conducted a study exploring the confidence of NGNs in acute care, community, and the longer-term care/complex continuing care sectors. NGNs working in the acute care sector reported higher confidence levels in interprofessional collaboration (mean rank =264.02), as compared to those in the community care setting (mean rank = 250.34) and long-term care/continuing sector (mean rank = 250.34 and mean rank= 201.88, respectively), $p < 0.05$. Among 16 NGNs who expanded on the quantitative findings, participants disclosed that accessibility and proximity to an educator or manager, and working in different disciplines, influenced their confidence in collaboration. According to Dyess and Sherman (2009), low levels of confidence can lead NGNs to deliberately avoid interactions with other healthcare professionals and hinder the opportunity for creating innovative solutions to the challenges that arise in achieving quality outcomes in clinical practice (Samuriwo, 2022).

Confidence in one's professional role, including collaborating with other professionals, appears to be due to several factors. Koh et al. (2023) conducted a retrospective, 24-month longitudinal study using the CFGNES to assess practice confidence in 124 NGNs. The study revealed a statistically significant increase in confidence over time from baseline to 24 months ($p< 0.001$). However, while there was an increase over the 24-month period, the largest increase in mean scores was seen from baseline to 6-months, 67.57 and 72.44, respectively. After the 6-month mark, mean scores continued to increase at 12 and 24 months, 73.63 and 74.65, respectively. Ortiz (2014) reported that 72 NGNs completed the CFGNES at 3 different time

points, and the most significant increase in confidence occurred between the 6-month and the 12-month mark. The aggregate mean confidence level reported was 3.83 at 2 months, 3.91 at 6 months, and 4.19 at 12 months.

Practice Breakdown

Expert nursing practice may appear fluid when compared to inexperienced nurses, however, practice breakdown due to human error is still possible (Moores, 2018). Whether intentional or accidental, practice breakdown has the potential to cause harm, resulting in negative patient outcomes (Wolf, 2012). Practice breakdown can be caused by many factors, including an education-professional gap, which result in an inability to anticipate projected care needs, perform safe patient care, and independently recognize changes in a patient's condition using a balance of critical thinking, reasoning, and skill (Hart & Wludyka, 2022; Thomas et al., 2020; Tyndall et al., 2018;).

A multi-site study in six hospitals in the Philippines revealed that the most common nursing tasks not completed were changing a patient's position, skincare, and oral care (Labrague et al., 2019). Frequent repositioning of patients can prevent skin breakdown and has an associated cost of $26.8 billion in the United States (Padula & Delarmente, 2019). Among 5,000 NGNs at a large midwestern academic health system, 23% were unable to recognize a change in patient condition, while 54% were able to recognize a change in their patient's clinical condition but unable to manage the problem (Kavanagh & Szweda, 2017). Furthermore, a multi-phase study completed in North Carolina with 188 NGNs, revealed that more than 75% reported at least three "risk-for-errors" events in the first six months of practice (Roth & Johnson, 2011).

Summary

The transitional period faced by novice nurses can produce unintended actions that impact patient safety. Duchscher's transitional shock theory and Benner's novice-to-expert theory provide frameworks that describe the emotional turmoil and knowledge development of novice nurses (Benner, 1982; Duchscher, 2008; Duchscher & Windey, 2018; Ozdemir, 2019). These frameworks are congruent with the time it takes for an NGN to become an independent, confident, competent practitioner. The literature supports the influence confidence has on clinical skills and how increased levels may mitigate events that threaten patient safety (Roth & Johnson, 2011; Spector et al., 2015; Tyndall et al., 2018). However, there is a dearth of literature on the concept of practice breakdown, and even less on the relationship between confidence and practice breakdown, highlighting the importance of this study.

Chapter 3: Methods

Design

This was a descriptive, cross-sectional study, utilizing the Casey-Fink Graduate Nurse Experience Survey (CFGNES) (Appendix A) and the Nurse Practice Breakdown Checklist (NPBC) (Appendix B).

Setting

Hackensack Meridian Mountainside Medical Center (MMC) is an acute care community hospital with a 365-bed capacity. It serves an urban community in New Jersey and provides diverse services including bariatric, cardiac, dialysis, emergency, gynecologic, maternity, neurology and neurosurgery, and orthopedics.

Sample

Registered Nurses (RNs) working at MMC were included in this study. The inclusion criteria required participants to be a graduate from an accredited diploma, associate, baccalaureate, or master's nursing program. Those excluded from the study were nurses with administrative titles (nurse managers, assistant nurse managers, and supervisors). Travel and per-diem nurses were also excluded from participating in the study. At the time of data collection, MMC had approximately 489 RNs, with 35 NGNs hired over the past 12 months.

Definitions

Confidence

Confidence is one's perception about how one views oneself as a professional and is aligned with the ability to think, communicate, have a positive attitude towards one's job, and function in clinical practice (Najifi & Nasiri, 2023).

Practice Breakdown

Practice Breakdown is the disruption or absence of any of the aspects of good nursing practice (Benbow et al., 2017).

Instruments

The CFGNES developed by Casey & Fink in 2023 (Appendix A), was used to measure RNs' role confidence levels. The survey was revised several times to reflect current healthcare trends, with the latest revision occurring in 2023 (Casey, 2021). Content validity for the survey was established by 20 content experts using a Delphi Content Validity Index (CVI) scoring (Casey-Fink Surveys, n.d.). The internal reliability of the role confidence scale was a Cronbach alpha score of 0.88 (Casey-Fink Surveys, n.d.).

Role confidence is composed of eight questions and scored on a 4-point Likert scale where 1= strongly disagree, 2 =disagree, 3 =agree, and 4= strongly agree. Responses were summed and a mean score was calculated, resulting in a single continuous variable representing the overall level of confidence. Higher mean scores indicated higher levels of confidence, and lower mean scores indicated lower levels of confidence.

The NPBC (Appendix C) was created by the principal investigator, using elements generated by the National Councils of State Boards of Nursing [NCSBN] (2008), their taxonomy of error, root cause analysis and practice-responsibility [TERCAP] data collection tool, and the Practice Breakdown Research Advisory Panel (PBARP) (Woods & Doan-Johnson, 2002). The TERCAP is a national nursing adverse event database created by the NCSBN to collect data on nursing practice breakdown and provides a multi-focal approach to categorizing breakdown behaviors (Texas Board of Nursing, 2013). The PBARP analyzed data from nine state boards of nursing that utilized the TERCAP instrument and categorized twenty-one case studies into eight

categories of nursing errors: lack of attentiveness, lack of agency/fiduciary concern, inappropriate judgement, medication errors, lack of intervention on the patient's behalf, lack of prevention, missed or mistaken physician or health care provider orders, and documentation orders (Woods & Doan-Johnson, 2002).

The NPBC (Appendix C) has five distinct categories: medication errors, documentation errors, inappropriate judgement, lack of agency/fiduciary concern, and lack of attentiveness. Respondents reviewed each item and indicated whether specific events had occurred and categorized their severity using a Likert scale ranging from 1 to 4, with 1 =no harm, 2 = harm, 3 = serious injury, to 4 = death. A non-applicable column was added to ensure all data was captured. Items were summed, and a mean score was calculated, with higher mean scores indicating a higher frequency of PB.

Eight nursing experts with experience in the acute-care environment established content validity. They included the Chief Nursing Officer (CNO), the Director of Quality, and two clinical educators at MMC. In addition, the director of the clinical education department from an acute care facility, and three nursing professors with current acute care experience and expertise in research validated the content in the checklist.

Lastly, a demographic questionnaire created by the principal investigator was used to obtain the characteristics of the nurses and workplace (Appendix D). In the demographic section of the survey, the race/ethnicity categories of American Indian, Native Pacific Islander, or unknown were collapsed into 'other.' The following clinical units were collapsed into Obstetrics/Newborn: labor and delivery (L&D), peripartum, and neonatal intensive care unit (NICU), and Surgical Services: pre-operative, surgical, and post-anesthesia care (PACU).

Procedure for Data Collection

An invitation to participate in the survey was sent by email (Appendix E), monthly, for three months, to RNs at MMC. A flier with a QR code (Appendix F) linked to the survey in Qualtrics, was distributed by the principal investigator and placed in all hospital units.

Passive informed consent (Appendix H) from the participants was obtained after they read an explanation of the study. Participants were presented with two options: one box to indicate consent and another to signify refusal. If they opted not to participate, they were not able to proceed with the survey questions. The consent reiterated that their participation was voluntary, they could stop at any time, and there was minimal potential for duress or physical, psychological, social, legal, and economic risks to any nurse.

After completing the anonymous survey, participants were asked if they wished to receive an electronic $10 Amazon gift card as a token of appreciation for their time. The funding letter is attached to Appendix G. If they wished to receive the gift card, they submitted their email address via a separate electronic form, ensuring that the participants' survey responses were not linked to their email addresses.

Data Analysis

Data were kept on a password-protected computer, available to the researcher only. Results were reported in aggregate, and cell sizes under ten percent were suppressed. Observations with incomplete demographic responses but completed responses, in the CFGNES and NPBC surveys, were coded as unknown. Cronbach's alpha was used to assess the internal consistency of role confidence in CFGNES and practice breakdown in the NPBC.

Descriptive statistics including frequency, percentages, means, and standard deviations were used to summarize the respondents' demographic characteristics, confidence level, and

practice breakdown. A chi-square test for equal proportions was employed to assess differences in the distribution of responses across nurse demographic and workplace characteristics. Means of role confidence and practice breakdown were evaluated using an independent t-test. One-way analysis of variance (ANOVA) was used to examine the relationship between demographic variables, nurses' confidence level, occurrence of practice breakdown. Statistical significance was set to $p < 0.05$. For all statistical analysis, SAS 9.41 was used.

Protection of Human Subjects

Approvals of this study were obtained from the Western-Copernicus Group (WCG) # 202443381, and William Paterson University Institutional Review Boards, # 2025-314 (Appendix I).

Summary

This study sought to garner responses from clinically practicing nurses at MMC to determine the relationship between role confidence and practice breakdown. Data were analyzed utilizing SAS 9.4. While safeguarding the identity of participants and maintaining confidentiality, descriptive statistics were utilized to summarize the characteristics of the respondents. A chi-square test for equal proportions was employed to assess differences in the distribution of responses across nurse characteristics and an independent t-test was conducted to evaluate the means. Lastly, ANOVA was used to examine the relationship between nurses' confidence level, practice breakdown, and demographic and workplace characteristics.

Chapter 4: Results

A total of 100 RNs responded to the questionnaire, yielding a response rate of 20.4% (Table 1A). The scales of role confidence (n=100) and practice breakdown [PB] (n=84) demonstrated excellent internal consistency, with Cronbach's alpha values of 0.943 and 0.851, respectively.

Participant Demographics

Respondents were likely to be between 20-29 years old (27,27%), female, (78, 78%) white, (27, 27%), worked straight days (49, 49%), or have five years or more of clinical experience (60, 60%) (Table 1A).

In addition, respondents had three months or less of unit orientation (76, 76%), worked in the obstetrics/newborn department (21, 21%), had experience working as a charge nurse (69, 69%), lacked specialty certifications (62, 62%), or did not participate in a residency program (58, 58%) (Table 1B).

Table 1A

Demographic Characteristics of Nurses, N=100

Variables	N (%)
Age	*
20-29 years	**27 (27)**
30-39 years	**18 (18)**
40-49 years	**14 (14)**
50-59 years	**23 (23)**
≥ 60-64 years	**9 (9)**
Unknown	**9 (9)**
Gender	*
Female	**78 (78)**
Male	**13 (13)**
Unknown	**9 (9)**
Race/Ethnicity	
White	**27 (27)**
Asian	**17 (17)**
Black of African American	**15 (15)**
Hispanic or Latino	**18 (18)**
Other	**23 (23)**
Education	*
Diploma/Associate	**19 (19)**
Bachelors	**62 (62)**
Master's	**10 (10)**
Unknown	**9 (9)**
Professional Experience	*
<1year	**7 (7)**
1-3 years	**13 (13)**
3-4 years	**11 (11)**
≥ 5 years	**60 (60)**
Unknown	**9 (9)**

*$p<0.05$

Table 1B

Workplace Characteristics of Nurses, N=100

Variables	N (%)
Work Pattern	*
Straight days	**49 (49)**
Straight nights	**32 (32)**
Other	**10 (10)**
Unknown	**9 (9)**
Duration of Unit Orientation	*
< 3 months	**76 (76)**
≥ 3 months	**13 (13)**
Unknown	**11 (11)**
Clinical area of practice	*
Medical-Surgical	**14 (14)**
Adult Behavioral Health	**2 (2)**
Emergency Department	**16 (16)**
Intermediate Care	**9 (9)**
Adult Intensive Care	**13 (13)**
Obstetrics/Newborn	**21 (21)**
Surgical Services	**16 (16)**
Unknown	**9 (9)**
Charge Nurse History	*
Yes	**69 (69)**
No	**22 (22)**
Unknown	**9 (9)**
Certification	*
Yes	**29 (29)**
No	**62 (62)**
Unknown	**9**
Residency Participation	*
Yes	**33 (33)**
No	**58 (58)**
Unknown	**9 (9)**

*$p<0.05$

Role Confidence and Practice Breakdown Mean Scores

The overall mean confidence score was 3.42 (Standard Deviation (SD)= 0.67) (Table 2A). Higher mean confidence scores were noted among nurses who were Asians (mean= 3.60, SD= 0.34), females (mean= 3.49, SD 0.54), those who held a bachelor's degree (mean= 3.36, SD= 0.76), worked in the adult intensive care unit (mean= 3.45 SD= 0.33), had five or more years of experience (mean =3.57, SD=0.59) or participated in a nursing residency (mean= 3.82 SD=0.73).

Table 2A

Mean Confidence and Practice Breakdown Scores, by Nurses' Characteristics

Variables	Mean Confidence Score (SD) (n=100)	Mean Practice Breakdown (SD) (n=84)
Age		
20-29 years	3.27 (0.75)	2.82 (1.40)
30-39 years	3.56 (0.36)	3.00 (1.68)
40-49 years	3.17 (0.97)	2.40 (1.35)
50-59 years	3.68 (0.31)	3.38 (1.21)
≥ 60-64 years	3.67 (0.36)	2.94 (0.77)
Unknown	3.17 (0.90)	-
Gender		
Female	3.49 (0.54)	3.06 (1.33)
Male	3.12 (1.02)	2.27 (1.50)
Unknown	3.17 (0.90)	-
Race/Ethnicity		
White	3.51 (0.40)	2.41 (1.23)
Asian	3.60 (0.34)	3.33 (1.52)
Black of African American	3.43 (0.78)	3.15 (1.47)
Hispanic or Latino	3.17 (0.85)	3.06 (1.39)
Other	3.35 (0.83)	3.17 (1.26)
Education		
Diploma/Associate	3.51 (0.33)	2.76 (1.37)
Bachelors	3.36 (0.76)	3.08 (1.37)
Master's	3.84 (0.26)	2.56 (1.39)
Unknown	3.17 (0.90)	-

The overall mean score for PB was 2.95 (SD=1.37) (Table 2B).

Table 2B

Mean Confidence and Practice Breakdown Scores by Workplace Characteristics

Variables	Mean Confidence Score (SD) (n=100)	Mean Practice Breakdown Score (SD) (n=84)
Overall Mean Score	3.42 (0.67)	2.95 (1.37)
Work Pattern		
Straight days	3.52 (0.62)	3.08 (1.35)
Straight nights	3.32 (0.71)	2.84 (1.41)
Other	3.43 (0.47)	2.56 (1.38)
Unknown	3.16 (0.90)	-
Professional Experience		
<1vear	3.14 (0.22)	2.43 (1.64)
1-3 years	3.10 (0.82)	2.58 (1.46)
3-4 years	3.30 (0.74)	2.9 (1.42)
≥ 5 years	3.57 (0.59)	3.08 (1.33)
Unknown	3.16 (0.90)	-
Duration of Unit Orientation		
< 3 months	3.48 (0.54)	2.98 (1.39)
≥ 3 months	3.20 (1.05)	2.66 (1.33)
Unknown	3.23 (0.85)	-
Clinical area of practice		
Medical-Surgical	3.30 (0.77)	2.46 (1.47)
Adult Behavioral Health	3.50 (0.70)	3.00 (0.57)
Emergency Department	3.37 (0.72)	2.99 (1.56)
Intermediate	3.26 (0.93)	3.29 (1.18)
Adult Intensive Care Unit	3.45 (0.33)	3.23 (1.13)
Obstetrics/Newborn	3.59 (0.38)	2.92 (1.40)
Surgical Services	3.52 (0.75)	3.01 (1.46)
Unknown	3.17 (0.90)	-
Charge Nurse History		
Yes	3.46 (0.63)	2.96 (1.30)
No	3.39 (0.67)	2.91 (1.59)
Unknown	3.16 (0.90)	-
Certification		
Yes	3.63 (0.60)	2.97 (1.30)
No	3.35 (0.64)	2.93 (1.42)
Unknown	3.17 (0.90)	-
Residency Participation		
Yes	3.82 (0.73)	3.19 (1.30)
No	3.48 (0.59)	2.80 (1.41)
Unknown	3.17 (0.90)	-

Nurses with higher PB scores were noted to be 50 to 59 years old (mean =3.38, SD=1.21), worked straight days (mean=3.08, SD=1.35), or had 5 years or more of experience (mean=3.08, SD=1.33) (Table 2A, 2B). On the other hand, those with lower PB scores were noted to be male (mean = 2.27, SD=1.50), between the ages of 20 to 29 (mean =2.95, SD=1.37), White (mean = 2.41, SD=1.23), or had one year or less of clinical experience (mean = 2.43 SD=1.64) (Table 2A, 2B).

Factors Affecting Nurse's Confidence and Practice Breakdown

Age was positively associated with role confidence (F =2.37, $p<0.045$) (Table 3). As nurses' age increased, so does their confidence level. Additionally, professional experience, gender, and specialty certification were borderline significance with confidence (F= 2.13, $p< 0.083$; $F = 02.73$, $p<0.070$; F=2.53, $p<0.085$, *respectively*).

Notably, there were no relationships between practice breakdown and confidence, or practice breakdown and the demographic variables. Nurses were asked to identify the likelihood that they would file an incident report if they observed a fellow nurse involved in the disruption of standard nursing practice. As reflected in Figure 1, 81% of nurses reported that they were likely to report a nurse involved in PB, while only 1% of the respondents who answered the question reported they would not.

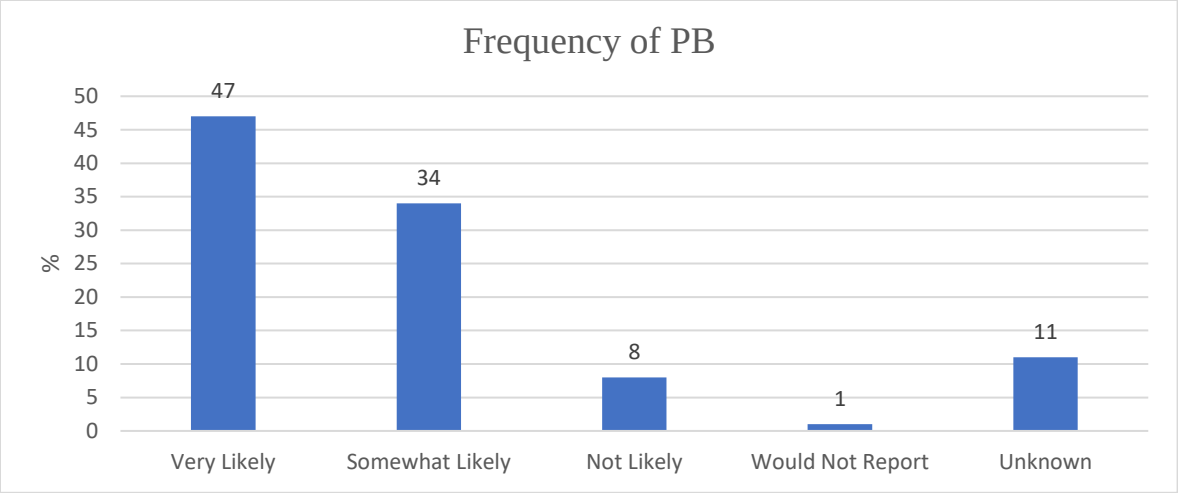
Table 3

Relationship between Nurses' Characteristics, Role Confidence, and Practice Breakdown

	Role Confidence Unadjusted (n=100)			Practice Breakdown Unadjusted (n=84)			Adjusted Model (n=84)		
	R-Square	F-Value	p-Value	R-Square	F-Value	p-Value	R-Square	F-Value	p-Value
Variables	-	-	-	-	-	-	**0.48**	-	-
Age	0.11	2.37	0.045	0.05	1.14	0.343	-	1.19	0.329
Gender	0.05	2.73	0.070	0.04	3.53	0.063	-	3.59	0.065
Race/Ethnicity	0.05	1.12	0.351	0.07	1.48	0.215	-	1.52	0.213
Education	0.06	2.12	0.103	0.02	0.81	0.447	-	0.86	0.432
Work Pattern	0.03	1.08	0.360	0.20	0.67	0.517	-	0.70	0.501
Professional Experience	0.08	2.13	0.083	0.03	0.69	0.561	-	0.73	0.539
Duration of Unit Orientation	0.03	1.50	0.229	0.01	0.59	0.555	-	0.63	0.538
Clinical area	0.04	0.58	0.767	0.03	0.44	0.849	-	0.48	0.818
Charge Nurse	0.02	0.80	0.452	0.00	0.02	0.887	-	0.02	0.884
Certification	0.05	2.53	0.085	0.00	0.02	0.896	-	0.02	0.893
Residency Participation	0.02	0.91	0.407	0.02	1.62	0.206	-	1.69	0.200
Role Confidence	-	-	-	0.19	1.52	0.144	-	1.49	0.170
Practice Breakdown	0.216	1.25	0.258	-	-	-	-	-	-

Figure 1.

Proportion of Nurses who would report if they observed PB, N=100



Chapter 5: Discussion

This study sought to explore the relationship between role confidence and practice breakdown among nurses at a northern NJ hospital. Findings revealed insufficient evidence to support a significant association between the two variables. Nurses who reported higher levels of confidence also reported higher levels of practice breakdown. This may be due to not clearly understanding the Likert scale responses. Previous studies have demonstrated that nurses with higher levels of confidence are associated with improved communication skills, completion of the daily requirements of clinical practice, and managing difficult patient situations, which are associated with better patient care delivery (Najafi & Nasiri, 2023; Nibeelink & Brewer, 2018; Ying et al., 2025). Future studies using this scale may consider using reverse scoring for the practice breakdown scale.

Specialty certifications have been shown to validate professional knowledge, enhance personal achievement, improve clinical competence, and support the delivery of higher quality care (Accreditation Board for Specialty Nursing Certification [ABSNC], 2022; Alsadah et al., 2025). Certifications demonstrate the knowledge, skills, and ability of practicing nurses in their respective specialty, verifying their adherence to the standards of nursing practice (Myers et al., 2024). Sixty percent of respondents reported lacking a professional certification. This gap could explain respondents' higher rates of practice breakdown.

Nurses over the age of 60 reported higher levels of role confidence (mean = 3.67, SD = 0.36) and lower levels of practice breakdown (mean = 2.94, SD = 0.77). These findings suggest that age may serve as a protective factor against low levels of confidence. Prior research has similarly identified age as a contributor to greater competency, resilience, and professional preparedness (Loke & Fung, 2014; Shin et al., 2022; Oksuz et al., 2018). With increased age

often comes greater professional experience, which has been associated with higher confidence levels (Jackson et al., 2019; Roth & Johnson, 2011). The result from the study aligns with the literature, that as clinical experience accumulates, confidence levels tend to increase (Fink et al., 2008; Jamieson et. al., 2023; Koh et al., 2023; Ortiz, 2014).

The result of this study suggests that practice breakdown could be a multifactorial phenomenon influenced by organizational and systemic influences. One factor not examined in this study is the nurse's perception of their work environment. A nurse's work environment has been shown to impact healthcare delivery. When perceived positively, supportive work environments have been associated with higher quality of care, more confidence, and fewer adverse events (Liu et al., 2019; Wong, 2024;). Unfavorable working conditions, such as inadequate staffing, unexpected rise in patient acuity, and unavailable supplies or equipment, can interfere with a nurse's effort to provide high quality nursing care (Gong et al., 2015; Gong et al., 2025; Mousazadeh et al., 2019). Although our findings did not establish a relationship between confidence and practice breakdown, it emphasizes the need for further investigation. Practice breakdowns are likely to persist, with patients negatively impacted and nurses becoming second victims of these adverse events.

Limitations

While steps were taken to ensure the rigor of this study, there are a few limitations that must be acknowledged. First, healthcare's current nursing turnover rate of 16.4% could have impacted the response rate at this community hospital (Nursing Solutions, 2025). The actual sample size was smaller than anticipated, with an uneven distribution among nurses and workplace characteristics. Secondly, the study sought to evaluate the experience of NGNs, however, their low participation may have been impacted by the perceived effort to complete the

survey. Thirdly, the findings of this study were based on self-report, relying on nurses' subjective responses, particularly regarding their understanding of practice breakdown. Finally, this study has limited generalizability as the respondents were sampled from a specific clinical site and not representative of the broader nursing workforce. Therefore, these results should be interpreted with caution and considered relevant to similar practice settings and populations. Future efforts to evaluate practice breakdown will require the inclusion of other factors, including job satisfaction and work environment.

Conclusion

The purpose of this study was to explore the relationship between a nurse's confidence and practice breakdown. Utilizing a descriptive, cross-sectional design, this study did not demonstrate a significant relationship between confidence and practice breakdown. However, the results revealed that nurse's age is a significant predictor for their level of confidence. The outcomes of this study are still valuable as it suggests that confidence alone may not be a reliable predictor when it comes to nurses not upholding the standards of nursing practice. Further research considering the multiple factors that may influence practice breakdown is recommended.

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Appendices

Appendix A: Casey-Fink Graduate Nurse Experience Survey (Revised 2023)

Casey-Fink Graduate Nurse Experience Survey© (revised 2023)
Kathy Casey, PhD, RN, NPD-BC and Regina Fink, PhD, APRN, AOCN, CHPN, FAAN

Section I – Role Transition Experience

The following are questions about your experience as you transition into the professional nursing role. All responses are anonymous and will be kept confidential. Please select the response that best describes your recent clinical experience.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. I am confident prioritizing patient care needs.				
2. I feel confident delegating tasks to others.				
3. I am comfortable making suggestions to the physician/provider on changes to the plan of care.				
4. I feel confident communicating with physicians and other providers.				
5. I feel confident using best evidence when making clinical decisions.				
6. I feel confident communicating a plan of care with patients, families, and caregivers.				
7. I have confidence in my clinical decision-making skills.				
8. I can accurately recognize changes in my patient's condition.				
9. I can complete my patient care assignment on time.				
10. I feel confident managing my patient workload.				
11. I can organize my time effectively to complete my patient care tasks.				
12. I can prioritize competing tasks during my shift.				
13. I feel supported by my peers.				
14. I feel comfortable asking for help from other nurses on my team.				
15. Co-workers are available to help me during new situations and procedures.				
16. I feel supported by the nurses in my clinical practice area.				
17. My team works well together during stressful shifts.				
18. I feel safe asking my co-workers questions.				
19. I am satisfied with the clinical practice area I am working in currently.				
20. I feel valued for the work I do.				
21. My team debriefs after difficult clinical situations.				
22. I have resources at my work to help me manage my stress.				
23. I am satisfied with my current role in nursing.				
24. I feel that I am a valued member of the health care team.				

	Strongly Disagree	Disagree	Agree	Strongly Agree
25. I feel included in my clinical practice area.				
26. I would recommend nursing as a career to a friend.				
27. I consistently feel overwhelmed by my workload.				
28. I consistently feel high levels of stress while at work.				
29. I feel exhausted at the end of my shift.				
30. I am experiencing stress in my personal life that is affecting my work.				
31. I feel overwhelmed by the patient acuity in my clinical practice area.				
32. I feel stressed because of my workload.				
33. I feel comfortable if I need to handle bullying from others.				
34. I feel comfortable managing incivility from co-workers if/when it occurs.				
35. I feel confident handling stressful situations on my own.				
36. I tend to bounce back quickly after difficult clinical situations.				
37. When faced with difficult tasks, I am certain that I will accomplish them.				
38. Even when things are tough, I believe that I can perform my role quite well.				
39. I feel a strong commitment to stay at this organization.				
40. This organization's values align with my professional values.				
41. I am likely to be working at this organization in one year.				

Preceptorship (Unit Orientation)

If you are no longer on orientation, please select not applicable.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable
42. My preceptor provides feedback about my work performance.					
43. My preceptor helps me to develop confidence in my practice.					
44. My preceptor guides my ability to make clinical decisions.					
45. My preceptor helps me learn from my mistakes.					
46. My preceptor helps me become familiar with my clinical practice area routines/policies.					
47. My preceptor helps me integrate into my clinical practice area.					
48. My preceptor engages me in critical thinking opportunities.					

Section II – Learning Needs Assessment of Skills

*Please rate your confidence in doing these **skills** using the following scale:*

	Not Confident	Somewhat Confident	Highly Confident	Not relevant to my practice area
1. IV starts				
2. Phlebotomy				
3. Blood product administration				
4. Central line care				
5. PCA pump management				
6. Nasogastric tube care				
7. Tracheostomy care				
8. Giving handoff report				
9. Chest tube care				
10. EKG/telemetry rhythm interpretation				
11. Calling a Rapid Response				
12. Participating in a Code Blue				
13. Reporting abnormal lab values				
14. Caring for a dying patient				
15. Urinary catheter insertion				
16. Wound care				
17. Documenting a plan of care				
18. Patient discharge process				
19. Suicide screening				
20. De-escalating a violent patient/family				
21. Managing ethical dilemmas				
22. Reporting errors in care				
23. Managing patients with substance use withdrawal				
24. Assessing patients for pressure injury				
25. Reporting bias/discrimination in the workplace				

Section III - Demographics

Please complete the response that represents the most accurate description of your individual professional profile.

1. Age:

a. 20-24 years
b. 25-29 years
c. 30-34 years
d. 35-39 years
e. 40-44 years
f. 45-49 years
g. 50-54 years
h. 55-59 years
i. 60-64 years
j. ≥ 65 years

2. Gender:

a. Female
b. Male
c. Non-binary, transgender, or gender fluid
d. Other (please specify) _____

Casey-Fink Graduate Nurse Experience Survey (revised 2023)
© Kathy Casey, PhD, RN, NPD-BC and Regina Fink, PhD, APRN, AOCN, CHPN, FAAN

Appendix B: Casey-Fink Instrument Approval

April 30, 2024

Dear PhD Adviser,

Raymond J Reynoso-Polanco has our permission to use the Casey-Fink Graduate Nurse Experience Survey© (2023) for their PhD dissertation at William Paterson University.

We Raymond give permission to modify the wording in the demographic section to match the healthcare organization and needs of the study population.

Please feel free to reach Kathy Casey at 303.905.4507 if you have any questions.

Sincerely,

Kathy Casey PhD RN NPD-BC FAAN
Professional Development Specialist
kathy@caseyfinksurveys.com

Regina M. Fink, PhD, APRN, AOCN, CHPN, FAAN
Professor Emerita | School of Medicine and College of Nursing
Interprofessional MSPC & Palliative Care Certificate Programs
University of Colorado Anschutz Medical Campus
12631 E. 17th Avenue, AO1 - Room 8410, Box B-180
Aurora, CO 80045
regina.fink@cuanschutz.edu

Appendix C: Nurse Practice Breakdown Checklist

Nurse Practice Breakdown Checklist

Directions: Please review and check any event that occurred within the past calendar year. If the event has occurred, please identify what was the impact on the patient (i.e., no harm, harm, serious injury, or death). Each category has an example, but please feel free to write in the row labeled "other" if the example is not applicable to you. If there has been an event that you are not sure if it fits into any of the categories provided, please describe the event in the space provided at the end of the checklist.

No Harm: error occurred but with no harm to the patient.
Harm: error occurred that contributed to a. minor negative change in the patient's condition.
Serious Injury: error occurred that contributed to significant harm produce physical or psychological injury.
Death: error occurred that may have contributed to or resulted in the death of a patient.

Practice Breakdown Categories	**No Harm** (1)	**Harm** (2)	**Serious Injury** (3)	**Death** (4)	**Not applicable**
Lack of Attentiveness: *paying attention to patients' clinical condition and responses to therapies, as well as potential hazards or errors in treatment.*					
Other:					
Lack of Agency/Fiduciary Concern: *failing to act in the best interest of the patient/family.*					
Questioning an inappropriate physician order					
Failing to call a physician for critical labs					
Other:					
Inappropriate judgement: *failing to identify the nature of the clinical situation.*					

Inadequate assessment (missing or misinterpreting relevant vital signs and symptoms)					
Failing to prioritize patient care appropriately					
Other:					
Documentation errors					
Lack of documenting an assessment despite a providers' order (i.e., neurological checks).					
Other:					
Medication Errors					
Missed doses of medication					
Wrong time of administration of medication, either more frequently or less frequently than ordered					
Other					

If there was an event that did not fit any of the categories above, please describe the event below and whether it resulted in no harm, harm, serious injury, or death.

Appendix D: Demographic Questionnaire

1. Age
    a. 20-24 years
    b. 25-29 years
    c. 30-34 years
    d. 35-39 years
    e. 40-44 years
    f. 45-49 years
    g. 50-54 years
    h. 55-59 years
    i. 60-64 years
    j. ≥ 65 years
2. Gender
    a. Female
    b. Male
    c. Non-binary
    d. Transgender
    e. Gender fluid
    f. Other (please specify) _____
3. Race/Ethnicity (Select all that you identify with)
    a. American Indian or Alaskan Native
    b. Asian
    c. Black of African American
    d. Hispanic or Latino
    e. Native Hawaiian or other Pacific Islander
    f. Other (Please specify) _____
4. Pre-Licensure Nursing Degree obtained (What you currently have)
    a. Diploma
    b. Associate
    c. Bachelors
    d. Master's in nursing
5. What is your scheduled work pattern?
    a. Straight days
    b. Straight nights
    c. Rotating days & nights
    d. Other (please specify): _____
6. How long have you been practicing as a Registered Nurse?
    a. ≤6 months
    b. 7-12 months
    c. 13 -23 months
    d. 2-3 years
    e. 3-4 years
    f. ≥5 years
7. How many weeks was your unit orientation?
    a. I am currently in my unit orientation.

   b. ≤5 weeks
   c. 6-8 weeks
   d. 9-12 weeks
   e. 4-5 months
   f. ≥6 months
8. Select your clinical practice area:
   a. Oncology
   b. Geriatrics
   c. Bariatrics
   d. Orthopedics
   e. Adult Behavioral Health
   f. Emergency Department
   g. Adult Telemetry
   h. Adult Step-down
   i. Adult ICU
   j. Float Pool
   k. Labor & Delivery
   l. Mother/Baby (ante-postpartum care)
   m. NICU/Newborn nursery
   n. Perioperative
   o. PACU
   p. OR
9. Have you functioned as a charge nurse?
   a. Yes
   b. No
10. Have you obtained your current specialty's' certification?
   a. Yes
   b. No
11. How likely are you to file an incident report if you observe practice breakdown (disruption of standard nursing practice) by another nurse?
   a. Very likely
   b. Somewhat likely
   c. Not likely
   d. Would not file a report.
   e. Other (please specify): _____
12. Did you participate in a nurse residency program?
   a. Yes
   b. No

Appendix E: Email sent for Recruitment.

Hello,

You are being asked to participate in a research Study because you are a Registered nurse (RN) currently employed at MMC working as a full-time or part-time staff member.

The purpose of this study is to explore the relationship between a nurse's confidence level and practice breakdown (the absence or disruption of any aspects of standard nursing practice).

Please Scan or Click the link below:

QR CODE

William Paterson University & Western IRB

After completing survey, you may be eligible to receive a $10.00 gift card as a token of appreciation

If you are interested and have questions, please contact:

Raymond Reynoso, MSN, RN
Principal Investigator
reynosor@wpunj.edu

Thank you for your contribution to the nursing literature!

Appendix F: Recruitment Flyer

Nursing Research Study:

Nursing Confidence & Practice Breakdown

Approval by Western & William Paterson University Pending

Purpose:

The purpose of this study is to explore the influence self-confidence has on nursing practice breakdown (*the disruption of standard nursing practice*).

Participants:

Licensed Registered Nurses at Hackensack Meridian Mountainside Medical Center.

Time Commitment:

Approximately 10 minutes of your time will be required to complete survey.
Can be completed on a computer or smartphone device by scanning the QR code below.

QR CODE

After completing survey, you may be eligible to receive a $10.00 gift card as a token of appreciation

If you are interested and have questions, please contact:

Raymond Reynoso, MSN, RN
Principal Investigator
reynosor@wpunj.edu

Thank you for your contribution to the nursing literature!

Appendix G: Funding Letter

WILLIAM PATERSON UNIVERSITY
School of Nursing • University Hall, Room 345
300 Pompton Road • Wayne, New Jersey 07470
973.720.2253 • wpunj.edu/cosh/departments/nursing/

BUDGET LETTER

This letter serves as evidence that the William Paterson University, School of Nursing, will fund $2,500 towards the study titled:

The influence of confidence on practice breakdown among nurses at Mountainside Medical Center, New Jersey

A $10.00 gift card will be given as a token of appreciation to 250 voluntary participants of this study.

Signature:

Debbie Y Mohammed, DrPH, MS, MPH, AACRN, APN

Associate Professor

School of Nursing

William Paterson University

Appendix H: Informed Consent

The purpose of this study is to examine the relationship between newly graduated nurses (NGNs) confidence and practice breakdown. Your participation in the project is completely voluntary and your consent will be needed to complete the survey.

You are being asked to participate in this research because you are a licensed registered professional nurse (RN) in the state of NJ. There is no risk associated with you participating in this project and there is no threat to your employment if you choose to participate. The benefits of your participation and involvement will add to the minimal body of literature investigating the influence of confidence and practice breakdown. Results will allow acute care facilities to better design pathways that increase nurses' self-confidence, which has ultimately been shown in the literature to improve nursing care. In addition, you can claim a $10.00 electronic gift card as a token of appreciation for your time and input.

Any data collected as part of this project will be stored in a safe and secure location. Your participation will be anonymous, your name is not required to be signed on this document or survey, and no one, including the investigator, will be able to identify you if you choose to participate. There is minimal potential of physical, psychological, social, legal, and economic risks to you as the way the data is collected, managed, stored, and reported, will ensure not include any identifiable characteristics.

You can agree or disagree to participate by clicking **yes** or **no** at the end of this form. If you choose to participate, your participation is voluntary and without coercion. In addition, you may revoke your consent to participate in the survey at any time. Understand that there will be no form of retaliation if you choose not to participate or refuse to participate in this study.

If you feel that you have not been treated according to the descriptions in this form as a project participant, you may contact the Institutional Review Board (IRB) at William Paterson University of New Jersey at 973-720-2852 or WCG IRB at 609-945-0101.

I understand that by providing consent for this project, I am also providing consent for my anonymized responses to be included in datasets that may be used in the future by the investigator of this project or other investigators for research related to the purpose of this research project.

Consent:
___ Yes. I give my consent to participate in Research.
___ No. I do not want to participate.

Appendix I: IRB Approval

THE WILLIAM PATERSON UNIVERSITY OF NEW JERSEY

INSTITUTIONAL REVIEW BOARD FOR HUMAN SUBJECT RESEARCH

c/o Office of Sponsored Programs
1800 Valley Road, Room 222
973-720-2852 (Phone)
973-720-3573 (Fax)
http://www.wpunj.edu/osp/

Chair: Professor Michelle Gonzalez (GonzalezM77@wpunj.edu)
College of Education
Contact: Kate Boschert (irbadministrator@wpunj.edu)
Office of Sponsored Programs

To: Raymond Reynoso-Polanco
Doctoral Candidate of Nursing

From: Michelle Gonzalez

Subject: IRB Approval: Expedited Review

Study: Protocol # 2025-314: The Influence of New Graduate Nurses Confidence on Practice Breakdown.

Date: December 6, 2024

The IRB has APPROVED the above study involving humans as research subjects. This study was approved as Category: Expedited Category 7; special class of subjects: None.

IRB Number: 2025-314 This number is WPU's IRB identification that must be used on all consent forms and correspondence.

Approval Date: 12/06/2024
Expiration Date: 12/05/2025

This approval is for one year. It is your responsibility to ensure that an application for annual continuing review has been submitted before the expiration date noted above. If you do not receive approval before the expiration date, all study activities must stop until you receive a new approval letter. There will be no exceptions. In addition, you are required to submit a Final Report at the conclusion of the project. The IRB Continuing Review, Annual Update, and Final Report Request are to be submitted through InfoReady at https://wpunj.infoready4.com/.