Nurse Residency Program Builder

Tools for a Successful New Graduate Program

JIM HANSEN, MSN, RN-BC
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Contents

About the Author ........................................................................................................................................ vii

About the Contributing Authors ........................................................................................................... viii

Foreword .......................................................................................................................................................... x

Chapter 1: Nurse Residency Programs and the Preparation-Practice Gap ................................................. 1
  The Preparation-Practice Gap .................................................................................................................. 2
  Spanning the Preparation-Practice Gap ................................................................................................. 5

Chapter 2: Making a Financial Case for Nurse Residency Programs: Learning the Language of the C-Suite ............................................................................................................................. 11
  Making an Organization More Financially Profitable ........................................................................... 12
  New Graduate Nurse Turnover: The Key Metric ................................................................................... 13
  Deriving Your New Graduate Turnover ............................................................................................... 15
  The Cost of Turnover ............................................................................................................................ 18
  Estimating the Cost of Designing a Program ......................................................................................... 21
  Offsetting the Cost: Projecting Return on Investment (ROI) ............................................................... 26
  Designing a Proposal .............................................................................................................................. 28

Chapter 3: Concepts and Competencies: Foundation of the Nurse Residency Program ........ 31
  The New Graduate Experience .............................................................................................................. 32
  Conceptual Frameworks: Novice-to-Expert Theory, Reality Shock, and Transition Stages ............... 35
  Competency Frameworks ....................................................................................................................... 41
# CONTENTS

## Chapter 4: Curriculum Design: The Road Map to Competency

- Three Types of Learning .................................................................54
- Three Domains of Learning ..........................................................58
- Passive and Active Learning .........................................................59
- Blocked and Threaded Content ......................................................61
- Principles for Designing Learning ..................................................63
- Teaching Activities .........................................................................63
- Summary .......................................................................................69

## Chapter 5: Setting the Stage

- Structuring the NRP Sessions .........................................................72
- Three Categories of Offerings .........................................................75
- How Adults Learn ..........................................................................77
- Andragogy and the Adult Learner ...................................................77
- Engaging New Nurses in the Classroom ...........................................84
- Summary .......................................................................................88

## Chapter 6: Presenting Content: Transitional Topics

- Organization ..................................................................................92
- Prioritization ................................................................................95
- Critical Thinking ............................................................................97
- Transition Shock—Part 1 ...............................................................100
- Transition Shock—Part 2 ...............................................................104

## Chapter 7: Presenting Content: Professional and Clinical Topics

- The Profession of Nursing ............................................................115
- Novice to Expert ..........................................................................118
- Professional Development .............................................................121
- Medication Safety .......................................................................124
- Evidence-Based Practice .............................................................126
# CONTENTS

## Chapter 8: Program Evaluation

- Presentation .............................................................................................................. 134
- Content .................................................................................................................. 136
- Outcomes .............................................................................................................. 140
- Return on Investment (ROI) .............................................................................. 144
- Evaluation Frequency ......................................................................................... 146
- Summary ............................................................................................................... 148

## Chapter 9: Evaluation of Graduate Nurses

- The Challenges of Individual Evaluation .......................................................... 149
- Defining Competency ........................................................................................ 150
- Levels of Evaluation ......................................................................................... 150
- Evaluation Strategies ....................................................................................... 151
- Evaluation of Errors ........................................................................................ 152
- Developing a Learning Plan .......................................................................... 153
- Summary ............................................................................................................ 158

## Chapter 10: The Future of Nurse Residency Programs

- A “Protomodel” for a National NRP ................................................................ 161
- Potential Funding for NRPs ............................................................................ 163
- Summary ............................................................................................................ 165

## Bibliography

- .............................................................................................................................................. 167

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About the Author

Jim Hansen, MSN, RN-BC

Jim Hansen, MSN, RN-BC, oversees the department of new graduate and student services at Kootenai Health in Coeur d’Alene, ID.

With a clinical foundation in emergency and critical care nursing, Hansen’s interest in orientation models led him into nursing staff development years ago, where he has focused on designing and implementing new graduate transition to practice programs in the acute care hospital environment ever since.

He holds associate’s and bachelor’s degrees from Brigham Young University, has a master’s degree in nursing education from the University of Wyoming, and is American Nurses Credentialing Center (ANCC) board certified in nursing staff development. Kootenai Health is an ANCC Magnet Recognition Program® designated facility.

Although he spends most of his time in the hospital environment, he remains an active faculty member of several area nursing schools. He is an accreditation site visitor for the National League of Nursing Accreditation Commission, a member of the National Nurses in Staff Development Organization and the American Society for Trainers and Developers, an American Heart Association instructor, and an editorial board member for the Journal for Nurses in Staff Development.
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Kendra Varner, MSN, RN, is a nurse residency program coordinator for the Kettering Health Network in Dayton, OH. Varner facilitates graduate nurse transition into professional practice through a yearlong educational support program.

Varner joined Kettering Health Network in 2009 as a nurse residency program coordinator, where she assists with recruitment, provides didactic instruction, rounds on the residents in the clinical setting, and gives significant psychosocial support and career guidance. She collaborates with nurse leaders to promote, develop, and manage the program and evaluate outcomes. She provides support to new graduates in the community through public speaking and professional writing.

Varner received her baccalaureate degree from Wright State University in Dayton, and obtained a master of science in nursing with a focus on education from the University of Memphis.

Varner notes that her journey to become a nurse educator began through a difficult senior preceptor experience that almost ended her career in nursing before it even started. An ICU manager and a group of experienced nurses “found and raised” her, providing the support so essential for a newly graduated nurse’s success. In 2000, Varner was first introduced to the concept of transition while preparing to serve two years in east Africa as a missionary nurse educator, and later revisited the topic as a clinical instructor for students struggling with the shock of going from general studies into the nursing program. She is a passionate advocate for all nurses in transition, particularly new graduates.

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Ashley F. English, BSN, RN, is a professional development specialist at Kootenai Medical Center in Coeur d’Alene, ID. She began her nursing career in 2007 as a part of Kootenai Health’s nursing resource team (float pool staff). She has cultivated a passion for nursing education and staff development since graduating with her bachelor of science in nursing degree from Northwest Nazarene University in Nampa, ID.
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She intends to continue her growth in nursing education and staff development by obtaining a master of science in nursing within the next four years.
The socialization of new nursing professionals into the dynamic climate of healthcare continues to challenge institutions of higher education, healthcare administrators, and policymakers across North America. Compounding this are reports of alarming numbers of new RN professionals, the majority of whom are initially employed in hospitals, changing their places of employment or leaving the nursing profession altogether within their first several years of practice. Equally informative are claims that less than half of the current nursing workforce would recommend nursing as a career option. If it is our intent to not only recruit new nurses, but to motivate and inspire future generations of professionals, we must create support strategies that reflect, address, and continually monitor the challenges novice practitioners face when being formally introduced into their practice community.

As someone familiar with this provocative topic, I started my program of study and work with newly graduated nurses quite by accident in 1997. With plans to study the thinking process of the novice professional as part of my master of nursing degree, I stumbled upon a much more significant and encompassing experience. As I have discovered, the initial role transition for a new nurse is not simply a cognitive exercise; rather, it is a physical, emotional, socio-cultural, political, developmental, intellectual, and in some cases, spiritually charged process that culminates in nothing less than personal and professional transformation for the individuals involved.

For the past 12 years I have researched, studied, and worked extensively with newly graduated nurses and those who seek to support them. I have been motivated primarily by a curiosity about my early findings that suggested new nurses are relatively unprepared for what the role transition to practice will entail, subtly encouraged to accept the embedded traditions of their workplaces rather than advocate for improvements, programmed to complete their required tasks on time without questioning the rationale behind them, and socially restrained in their attempts to challenge the status quo; all the while feeling varying degrees of moral conflict about their inability to advance and enhance quality care for their patients. This experience has revealed itself as having the potential to breed disconnect, discontent, disillusionment, and disappointment in those newest members of our profession on whom we depend for the very future of our healthcare system.
FOREWORD

In 2007, I completed my doctoral (PhD) work, using my familiarity with the topic and my long-standing relationship with new nurses across North America as a platform to build a strong base of knowledge on how nurses make their initial transition into the professional world after being students. I was able to generate two theoretical models (Stages of Transition© and Transition Shock©), which the authors have outlined in Chapters 3 and 6. These constructs build on Patricia Benner’s resilient skill acquisition model of nursing expertise development and Marlene Kramer’s groundbreaking work in reality shock for new nurses. It is by virtue of the combined application of many authors’ work that we will reach that abundant middle ground where most solutions to life’s challenging issues lie.

I believe that it is not possible, nor desirable, to expect that the process of moving from school to professional work for the new nurse will be uneventful; this period encompasses tremendous growth, and with growth necessarily comes pain. Our task as supporters is to minimize the untoward outcomes of this experience, take away the obstacles to successful professional integration, and provide these future nursing leaders with the support they need to get through the rough spots that everyone experiences when going through a major change in their lives.

I believe that the Nurse Residency Program Builder is one of the most comprehensive resources I have seen that speaks to the whole of the transition experience for the newly graduated nurse. It is foundationally evidence-based but pragmatically focused; a start-to-finish support for the supporters. I applaud Jim Hansen and his team for producing this comprehensive, and what I believe will be seminal, support resource for the nursing community. As we ponder the challenges facing new nurses entering the real world, it is worth remembering that while the initial professional role transition of graduate nurses is itself a unique stage in their professional journey, it is also a magnified reflection of the realities many nurses face on a daily basis. As such, resources that support the evolving transition experience of new nurses have the potential to inform, support, unite, and advance the entire profession by making visible the contemporary challenges and triumphs of the whole nursing discipline.

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There is what has been described as a ‘continental divide’ between nursing education and nursing practice …
– The Joint Commission, 2005

In recent years, the nursing profession has embraced a new idea that attempts to solve a decades-old issue—that of helping new graduate nurses make a smooth and confident leap from the world of nursing academics to the world of nursing practice. The timing could not be more opportune. The nursing shortage that has been steadily growing for years has now reached crisis proportions, and it appears that it will only get worse as the bulk of the nursing workforce prepares to retire in the next decade (Buerhaus et al., 2007). A key to the future stability of the nursing workforce lies in the ability to attract and retain new minds and hearts into the profession of nursing. A recent and remarkably effective way of doing so is through a nurse residency program (NRP).

The concept of the NRP represents the healthcare industry’s efforts to complete the goals of the nursing education world—to fully prepare new graduate nurses to provide safe and effective care in the 21st century acute care environment. NRPs are one type of new graduate “transition to practice” program, which also include other programs such as internships, preceptorships, structured orientations, and extended orientations (Park & Jones, 2010).
What makes the NRP stand apart from its peers, however, is its scope. Other transition programs are usually limited to the specific department or unit for which they are created. For example, a neonatal intensive care unit (NICU) might be interested in hiring and training a new graduate nurse to competently care for patients. NICUs normally do not hire new graduates, but require a nurse to have prior experience before applying. So, in order to accommodate the special needs of a new graduate RN with little or no experience, the NICU designs an atypical orientation for the new nurse so that, in time, he or she can care for patients in a competent and professional manner. This particular type of program would most commonly be referred to as an “internship” in nursing literature; it is primarily designed to serve the needs of that particular NICU and the specific new graduate nurse hired into it. NRPs, on the other hand, are housewide programs that are designed to serve the special needs of all new graduate nurses hired into the facility. They are generally not unit specific; instead, they tailor their efforts to the specific needs and desires of new graduates, regardless of how or where they may be employed.

In order to get a better understanding of why NRPs came into being, what its purposes are, and how it benefits hospitals, it is necessary to look back in time to better understand how nursing arrived in the situation it is in today that necessitates the need for an NRP. It is attributable to a phenomenon called the preparation-practice gap.

The Preparation-Practice Gap

In the first half of the 20th century, nursing education was completely different than it is today. At that time, the majority of nursing education was accomplished at the bedside in a hospital unit. Nursing students would work with patients in apprentice-like positions during the day doing remedial tasks and basic patient care while observing and learning from the RNs. Classroom lectures and activities occurred in the evenings and were also frequently done in the hospital, often with nursing professors who worked as bedside nurses in addition to their teaching positions.

The system had many pros and cons. One significant weakness was that nursing education had a very practical, technical focus instead of a professional, collaborative one. It not only lacked significant grounding in the liberal arts and sciences, but also had very little in the way of nursing science, theory, or education in what we think of as the profession of nursing today. It was not their fault—nursing was still in its infancy and there was very little true nursing science to teach students. The major benefit of the education model, however, was that when nursing students finished their nursing program, received their diploma, and took their nursing board examinations, they had spent literally thousands of hours in the hospital wards caring for patients. They knew what working as a nurse was like. They also had the benefit of being educated by
industry experts, career bedside nurses who possessed superior clinical skills. The hospitals also benefited greatly from these “grow your own” programs, because nurses were taught according to their policies and cultural norms, and often already had a strong commitment to the hospital that employed them.

Over the next several decades, as nursing education moved out of the hospital and into the collegiate classroom, the pros and cons of doing so continued but essentially switched polarity. Nursing gained tremendous ground in providing a liberal arts foundation and helping students gain a professional identity as nurses. They did this, however, at the cost of spending time at the bedside, and students entered the workforce after passing their boards with only a few hundred bedside clinical hours instead of the thousands of hours their older colleagues had possessed when they started nursing years earlier. This fundamental shift in how nurses were educated gradually allowed the nursing preparation world (school) and the nursing practice world (hospital) to drift apart like two diverging continents, creating a fissure between them that nursing students had to jump across as they left the classroom to head to the hospital for clinical experience.

Over time, the fissure widened into a significant cleft. Nursing researchers noticed and raised an initial alarm. As early as 1974, Marlene Kramer published a now famous work titled *Reality Shock: Why Nurses Leave Nursing* that described the phenomenon that new nurses experienced when they got their first job after finishing nursing school. They realized that when they started working, the idealistic and theoretical education they received did not fully prepare them for the realities of nursing in the acute care environment. By that time, healthcare in America was changing dramatically. Advances in technology and medical science had pushed healthcare into the specialty areas—people were living longer and often managing multiple comorbidities as they aged, and hospitals were seeing more and sicker patients than ever before. The role of the acute care nurse shifted from that of a generalist to that of a specialist, and nurses were pressured to assume care for older, sicker, and more complex patients than ever before.

Again, it was not entirely the schools’ fault. Nursing programs diligently worked to revise their curricula to meet new industry practices, but industry was changing even faster. As hospitals began to struggle to keep abreast of a rapidly shifting healthcare industry, the schools struggled even more and began to lag further behind. The resulting effect upon new graduates was that the preparation-practice fissure widened to a large gap, and most new graduates had difficulty making the leap. Some of them—as many as 12% in Kramer’s work—essentially fell into the gap and left nursing altogether without completing their first year of practice.

As the healthcare industry has continued to aggressively shift to embrace new trends, policy reforms, technology, and practice standards, the preparation-practice gap has continued to widen. In a 2002
white paper entitled *Healthcare at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis*, The Joint Commission flatly states:

> There is what has been described as a “continental divide” between nursing education and nursing practice. In the academic setting, nurses, like other health professional disciplines, are educated in a silo. This problem is compounded by the lack of awareness of nursing faculty about actual nursing practice today; the virtual absence of clinical experience from the nursing school curriculum; and the lack of involvement of nurse clinicians in the education process. (The Joint Commission, 2002, p. 30)

Here, The Joint Commission attributes the preparation-practice gap to essentially two factors:

- Nursing faculty are not clinical experts anymore, and clinicians’ involvement in nursing education is lacking
- Nursing students are not getting enough quantity and quality time at the bedside working with actual patients

In 2007, the Advisory Board Company also illustrated how wide the gap actually was when it asked hundreds of nursing school leaders and hospital nurse executives across the nation their level of agreement with the statement, “Overall, new graduate nurses are fully prepared to provide safe and effective care in an hospital setting.” As shown in Figure 1.1, their responses could not be more divergent.
With a consensus of only about 10%, these academic and industry nurse leaders are clearly not on the same page with regard to what “fully prepared to practice” means.

The affect of the preparation-practice gap on American healthcare is profound. New nurses universally report feelings of stress, anxiety, and reality shock throughout their first year of practice, and hospitals feel a cultural and financial strain in high rates of new graduate turnover, short-staffed hospital units, and poorer patient outcomes. Unfortunately, this comes at a time when baby boomer generation nurses—the bulk of the current nursing workforce—are nearing retirement, others of their generation are living longer with poorer health and placing greater demands on hospitals, and nursing school enrollments are only recently beginning to rise after a years-long period of stagnant growth.

**Spanning the Preparation-Practice Gap**

The good news is that in the last few years, academic and industry nurse leaders have worked from both sides of the preparation-practice gap to build bridges. On the academic side, there has been a recent call to completely rethink the structure of nursing education in America. The 2009 report from the Carnegie Foundation, titled *Educating Nurses: A Call for Radical Transformation*, presents the findings of the first
large-scale national nursing education study in more than 40 years. They present the data within the context that nursing has undergone profound changes in the areas of nursing science, technology, and patient advocacy. They also observe that nursing education has not evolved to the same degree that nursing practice has in adapting to a shifting market-driven healthcare industry and the resulting changes in the acute care nursing environment.

The research team conducted site visits, surveys, and interviews of hundreds of nursing school faculty and leaders, and they identified three key outcomes:

1. Nursing programs today do well helping students develop nursing ethics and values, and in assisting student with identifying with the profession of nursing.

2. Students’ clinical experiences at the bedside are powerful learning experiences, and students use these opportunities to learn to work and think like a nurse. Learning is accelerated when clinical experiences are discussed within the context of classroom lectures and textbook knowledge; it seems that the best learning is accomplished as students see and apply in real life what they learned in the classroom.

3. Nursing programs today are often ineffective at teaching nursing and social sciences and technology. Nursing faculty often teach decontextualized knowledge with a dependence on slide presentations, and make the assumption that students will naturally apply that information as they practice at the bedside. (Benner, Sutphen, Leonard, & Day, 2010, pp. 11–14)

The third finding lies at the very heart of the preparation-practice gap. The report goes on to affirm that nursing education must commit to some important structural changes that will allow the time in nursing school to be more efficient and efficacious.

Essentially, there needs to be a fundamental shift for nursing faculty from a nonclinical “sage on the stage” to a clinician “guide at your side” to connect what the students see and experience in the hospital with real nursing science and practice thinking in the classroom. The report recommends restructuring nursing education in four specific ways:

- Shift from a focus on covering abstract knowledge to an emphasis on teaching for a sense of salience, situated cognition, and action in particular situations

- Shift from a sharp separation of clinical and classroom teaching to integration of classroom and clinical teaching
• Shift from an emphasis on critical thinking to an emphasis on clinical reasoning and multiple ways of thinking that include critical thinking

• Shift from an emphasis on socialization and role taking to an emphasis on formation (Benner et al., 2010, pp. 82–89)

The Carnegie report is a tremendous step to spanning the preparation-practice gap and producing new nurses who are fully prepared to assume care for patients in the 21st century acute care environment. However, accomplishing these deep structural changes will take significant amounts of time (i.e., years) and funding to accomplish. In the meantime, the gap remains.

If *Educating Nurses: A Call for Radical Transformation* represents the academic response to spanning the preparation-practice gap, then the nurse residency program is the industry response.

An NRP predominantly takes the form of a series of classroom sessions or workshops that allow new graduates to step away from their individual nursing units, meet together, and participate in learning experiences that allow them to do what they may not have fully done in nursing school—integrate the clinical bedside experiences they have in their units with the steadily growing base of nursing knowledge that they gained in their nursing programs. In this way, the NRP capitalizes on the second finding in the Carnegie report—that clinical experience is most powerful when it can be combined with classroom knowledge. The NRP is designed to merge the clinical with the classroom and the patient with the professional nurse.

Because the NRP does its job so effectively in shrinking the gap that new nurses must leap in order to transition successfully into practice, hospitals that use NRPs report that they are doing a better job at retaining new graduate nurses. They also find that their new graduates are more comfortable in their transition as opposed to before the hospital developed an NRP. The list of citations in the nursing literature that support these claims is too lengthy to include here, but a representative list of articles that discuss these benefits is presented at the end of the chapter. Obviously, as time progresses, there will continue to be research and inquiry into the greatest benefits of NRPs, but initial reports are quite positive.
Basically, hospitals that have NRPs report:

- Easier recruitment of new graduate nurses in the hospital
- Lower rates of new graduate turnover
- Accelerated practice readiness of the new graduates
- Higher populations of younger nurses
- A positive return on investment for the cost of the NRP
- Greater commitment of nurses to their own professional development.
- Nurses who align themselves more fully with the tenets of the ANCC Magnet Recognition Program®

The NRP has been so initially beneficial that it has quickly garnered a lot of support and backing from industry researchers and policymakers. In short, The Robert Wood Johnson Foundation recommends them, the Carnegie foundation advocates for them, the American Association of Colleges of Nursing can accredit them, the Advisory Board exemplifies them, hospitals need them, nursing schools teach their students about them, and new nurses shop for them.

This book is intended to help you design and build your own NRP. The chapters that follow give you the resources you need to understand how an NRP can benefit your organization, as well as provide you with the tools necessary to get you started and truly make it your own. The major sections of the book are arrayed similar to the nursing process as it applies to nursing staff development. It begins with assessment in the next chapter, and follows up with sections on planning and implementation, which are then followed by evaluation. The book concludes with a short discussion on the future of the NRP and where current industry trends are taking it.

No one knows for sure what the future may hold, but odds are that as long as the preparation-practice gap exists, there will be a role for the NRP to assist you and your organization with preparing the nursing workforce of the future. So, read on, and enjoy the journey.
Recommended reading


