Transitioning Nurses: *How Do We Know They Know?*

Anne McNamara, PhD, RN, Ronda LaVigne, MHA, BSN, RN, NE-BC, and Bobbi Martin, MSN, RN, CNE

Knowing when newly hired nurses are ready for inclusion in productive staffing is a challenge for nurse leaders in all practice settings. Health care organizations dedicate extensive resources to prepare new graduate nurses, nurses transferring from one specialty to another and experienced nurses joining an existing workforce in a new setting. However, the duration of "orientation programs" varies greatly across the country. Some are as short as 4 weeks, and others may be as long as a year. It is critical that organizations create or purchase an evidenced-based tool to understand and guide decisions relative to the relationship between length of orientation time and the nurse's readiness to practice independently.

The purpose of this article is to share strategies for success when bringing new nurses into your organization. The combination of evidence-based tools and resources along with enthusiastic, engaged health care partners is how you can *know* when your new nurse employee is ready to provide safe, competent patient care and be counted as fully productive staff.

BACKGROUND

Hospitals have an ever-present need for competent staff, but evidence-based tools that direct the length of clinical precepted time are scarce. Currently, transition-to-practice programs use predetermined timeframes, competency set completion, and subjective opinions to finalize the changeover process. Focus is on completing onboarding tasks and documentation within a specified timeframe as opposed to nurturing the principles necessary to independently manage a full patient assignment and become engaged in the organizational culture.

The Institute of Medicine (IOM) report *Future of Nursing: Leading Change, Advancing Health*[1] recommended the implementation of transition into practice programs for new graduates and transitioning nurses. Recommendation #3 states: "State boards of nursing, accrediting bodies, the federal government, and health care organizations should take actions to support nurses' completion of a transition-to-practice program (nurse residency) after they have completed a pre-licensure or advanced practice degree program or when they are transitioning into new clinical practice areas." This recommendation was and is the driver for many organizations to create solutions aimed at meeting the needs of transitioning nurses.

The literature points to a gap between knowledge acquired during basic nursing training and the application of knowledge into practice that influences the delivery of quality care. National discussion and the development of evidence-based practice standards for nurse sensitive topics have focused the nursing profession's attention on improving the critical indicators nurses are able to impact during the delivery of care.

However, a lag occurs between research discoveries to improve those indicators and the point-of care nurse's knowledge and application of evidence-based practices. The health care industry recognizes evidence based practice as an effective strategy for reducing mortality, morbidity, and medical errors. Equally noteworthy is the recognition that evidence-based practices are not consistently implemented by nurses, clinicians, and health care systems across the United States. Emphasis is often on the process of new research rather than the clinical application of validated research. Common barriers to implementation of research findings include ease of access to evidence based practice information, nurses' lack of time to access evidence based practices, and absence of an organizational culture that supports the use of evidence-based practices.[2]

Nurse scientists have identified effective strategies that accelerate discoveries in basic research and transform them into clinical tools, processes and applications. The IOM report *Crossing the Quality Chasm* highlights that the lack of success with translation of early research findings into generalized and effective interventions causes drag in movement toward integration of evidence-based interventions into clinical practice.[3] Additionally, IOM recommends that 90% of health care decisions be evidence-based by 2020, an unlikely goal without a paradigm shift in organizational cultures that aggressively support the implementation of evidence-based practices.

There is agreement among leading health care organizations as to essential core competencies for nurses practicing in acute care settings (American Nurses Association, American College of Nurses, Institute of Medicine, National Council of State Boards of Nursing, World Health Organization, National Institute of Health, Quality Safety and Education for Nursing, and the American Association of Critical Care Nurses). The essential categories across organizations include competency in patient-centered care, evidenced-based practice, teamwork and collaboration, safety, informatics, quality improvement, and education.

However, ambiguity exists about best practice when evaluating competency. If one thinks of competency assessment in a dynamic and ever changing environment, it is like sailing where one needs to know the direction of the current and adjust the sail to stay on the desired course. Without clarity and validity of competency evaluation, your nursing staff will become distressed and see the demands of competencies as daunting and without relevance.

The literature has diverse definitions of competency. As early as 1981, Pollock[4] defined competency as "whatever is required to do something adequately." In 1982, Benner[5] refined the definition to be "the ability to perform a task with desirable outcomes under the varied circumstances of the real world." del Bueno et al.[6] shared their definition as "the effective application of knowledge and skill in the work setting." The American Nurses Association[7] published a position paper distinguishing between the definition of competence and competency. Competence is the *demonstration* of knowledge, skills, and attributes, whereas competency is the *expected* criteria for *performance* of knowledge, skills, and attributes. Wright[8,9] created a competency assessment model that breaks competencies into initial and ongoing categories. She defines initial competencies as "knowledge, skills, and abilities required in the first 6 months to a year of employment." Ongoing competencies are not to be a repeat of the initial competencies or a static list of skills that are checked off year after year. Her model contends that you do not lose knowledge of skills, but you may become less proficient. Validation of ongoing competencies should include new, changing, high risk, and problematic aspects of the job.

As nurse leaders are creating or purchasing transition to practice tools, a critical aspect to consider is the validation method of competency. Skilled preceptors are critical in determining the readiness of a transitioning nurse to move into productive staffing. Most residency or orientation programs use checklists, but based on Wright's model, the valida-

tion methods must include additional activities such as return demonstration, case studies, peer review, self-assessment, presentations, mock surveys, discussion groups, direct observation, and evidence of daily work. These activities have a strong foundation in adult learning principles that include giving the transitioning nurse choices, building on the nurse's experiences, encouraging sharing of experiences, using task-oriented problem solving approaches, and direct observation either in a simulated or actual patient situation.

Using skilled preceptors, health care organizations need to accurately determine the length of "precepted" or "orientation" time a new nurse needs before moving into productive staffing. Organizations need to create or purchase systems that are consistent, measurable, and predictable. Using evidenced-based approaches, along with the "married state preceptor model"[10] allows the preceptor to evaluate the new nurse graduate and act as a role model in how to manage a patient assignment. As a point-of-care nurse, precepting adds an additional role with more responsibilities to an already full workload. Because a nurse delivering care has multiple and diverse obligations, clear, comprehensive, and easy to access competency assessment tools are needed.

In a recent article, Martin and LaVigne[11] added to the body of literature an additional consideration for creating high performing new graduate nurses. Core competencies should be interwoven into the following Nurse Development Resources (NDR) Benchmarks℠ as described by Martin and LaVigne. They contend that NDR Benchmarks illustrate and encompass the knowledge, skills, and behaviors necessary to manage a full patient assignment. The NDR Benchmarks provide foundational concepts that assist organizations with the determination of a nurse's readiness for safe, competent, and independent practice. These benchmarks include shadowing, assessment and documentation, medication management, communication with the healthcare team, delegation and collaboration, prioritization, admissions, discharges and transfers, core measures and nurse sensitive indicators, time management, coordination of care, and competent management of a full patient assignment. NDR Benchmarks eliminate reliance on complex competency evaluation packets or checkoff lists that fragment the transition, and distract preceptors and transition nurses from focusing on management and coordination of the patient assignment. Instead, the benchmark strategy focuses on individualizing immersion timeframes, determining readiness for independent management of a full patient assignment, and improving the delivery of quality care during the nurse transition process. NDR Benchmarks are an example of translating research evidence into a practical implementation tool. Although NDR Benchmarks provide clear criteria and are theoretically and logically ordered, they remain flexible and can be achieved either concurrently or consecutively. Overachievers do not want to be held back. By contrast, fearful and insecure novice nurses with appropriate support can become excellent practitioners. The key is, once all NDR Benchmarks have been mastered, the transitioning nurse is ready for a comprehensive review of preparedness.

This idea of matching NDR Benchmarks with core competencies has advanced the science in program development for nurse residency programs. For preceptors to have an evidenced-based tool to evaluate the transitioning nurse while managing a patient assignment allows for an objective versus subjective way of knowing when a new graduate nurse is ready to move into productive staffing.

HOW DO YOU KNOW THEY KNOW?

Nursing is complex, and our goal as health care leaders is to create a workforce focused on quality care and patient outcomes. We are tasked with creating innovative approaches designed to provide a road map to accurately determine the length of "precepted" or "orientation" time a nurse needs that is consistent, predictable, and measurable, and provides the evidence necessary for managers and educators to deem a nurse ready for independent practice. Most organizations are creating or purchasing web-based electronic data management platforms that serve as a repository to track timeframes of completion of all competencies for each transitioning nurses. The data help nurse leaders to better understand how immersion periods may vary among individuals. The nurse leaders need tools to track each transitioning nurse's progress and determine when mastery has occurred so that the all-important meeting with preceptor and transition nurse can be scheduled to discuss next steps to independent management of a full patient assignment.

SUMMARY

A review of the literature indicates that resources, home grown or purchased, should address the need to improve communication channels, re-educate nurse leaders and preceptors, provide regular surveillance of transition nurse progress and preceptor documentation, offer technology enhancements that alert nurse leaders of milestone markers (100% benchmark validation), and develop a real-time dashboard for quick assessment of transition nurse progress. Health care organizations know that evidence-based knowledge and resources are tools that support delivery of care to the highest possible standard. No matter how small or large the implementation or how seemingly usable the tool, the takeaway is time, attention, and accountability are essential for transferring evidence-based innovations into quality nursing practice. Through this process, nurse leaders will have confidence in knowing that their workforce is focused on quality care and improved patient outcomes essential to the health of the organization. NL

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Anne McNamara, PhD, RN, is executive vice president for Isleworth Partners, the holding company for Galen College of Nursing and Galen Center for Professional Development in Louisville, Kentucky. She can be reached at amcnamara@isleworthpartners.com. *Ronda LaVigne, MHA, BSN, RN, NE-BC, is a nurse development resource specialist for Galen Center for Professional Development. Bobbi Martin, MSN, RN, CNE, is executive director for Galen Center for Professional Development.*

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