Readiness to Practice Indicators: Accelerating New Graduate Nurses Toward Independent Practice

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Academic institutions and hospitals want the same outcomes: safe, practice-ready nurses, but each use different tools to evaluate practice-readiness. Successful transition-to-practice programs aimed at closing the academic gap require thoughtful and actionable collaboration between academic and practice settings with consideration of using mutual evaluation tools. Readiness to Practice Indicators (RPIs) are an evidence-based tool intended as a determinant for independent practice that synthesizes the scope and standards of nursing practice with a focus on how to manage a patient assignment. RPIs have been used with new graduate nurses since 2016 and now are being used as the performance evaluation tool shared by academic and hospital organizations in a new Student Readiness to Practice Program. Participating academic institutions, hospitals, and community organizations have agreed to use the RPI evaluation tool across settings. Future research will evaluate whether early exposure to RPIs in the senior practicum accelerates the transition of new graduate nurses into productive staffing and increases retention and satisfaction among new nurses and preceptors.

New nurses are not practice ready, specifically, when it comes to managing a full patient assignment independently. Compounding the problem, hospitals validate clinical competence via cumbersome evaluation processes that add unnecessary time to the initial competency assessment, subsequently delaying the new nurses' movement into productive staffing.

Kavanagh and Sharpnack[1] report new data suggesting that we continue to lose ground in the preparedness of transitioning nurses into independent clinical practice at a time when it is needed most. The COVID pandemic shined a light on nursing working conditions and lack of resources, and exposed lengthy nurse on-boarding processes that hindered the ability to quickly move new nurses into independent clinical practice.[2] This calls for a renewed urgency in making meaningful change in the way we assess readiness to practice among new nurses.

Nurse Development Resources® (NDR) Benchmarks were implemented in 2016 as an evidence-based, predictable, and measurable tool that aids preceptors in determining when a new nurse is ready to practice independently.[3] This article reports on the evolution of the NDR Benchmarks to the Readiness to Practice Indicators.

BACKGROUND

Setting the Academic Standards

The American Association of Colleges of Nursing (AACN) *The Essentials: Core Competencies for Professional Nursing Education* is the framework proposed to supersede the current Essentials documents and is informed

KEY POINTS

- **Mutual clinical performance evaluations are necessary to close the academic to practice gap.**
- **New graduate nurses are less prepared to practice safely post-COVID.**
- **Actionable partnerships between academic institutions and hospitals are necessary to move new nurses safely into productive staffing.**

by the lived experiences of nursing practice where there is a fusion of knowledge and action.[4]

> Active learning involves making an action out of knowledge—using knowledge to reflect, analyze, judge, resolve, discover, interact, and create. Active learning requires clear information regarding what is to be learned, including guided practice in using that information to achieve a competency. It also requires regular assessment of progress towards mastery of the competency and frequent feedback on successes and areas needing development. Additionally, students must learn how to assess their own performances to develop the skill of continual self-reflection in their own practice.[4]

The Quality Safety Education for Nursing (QSEN) adapted the Institutes of Medicine (IOM) competencies for nursing and proposed definitions that describes essential features of what it means to be a competent and respected nurse. Using the competency definitions, QSEN proposed statements of knowledge, skills, and attitudes (KSAs) that should be developed for each competency during prelicensure nursing education.

The safety and competency frameworks proposed by AACN and QSEN are guidelines for prelicensure nursing education. Unfortunately, the frameworks were interpreted by hospitals as a call to show proof of KSA competence for every situation and skill a new nurse may encounter. The result was an all-inclusive documentation-focused onboarding process.

Academic-to-Practice Gap

Leading health care organizations agree on the core competencies for health care providers, which include patient-centered care, evidence-based practice, quality improvement, safety, teamwork, and information technology: American Nurses Association (ANA), American Association of Colleges of Nursing (AACN), IOM, National Council of State Boards of Nursing (NCSBN), World Health Organization (WHO), National Institute of Health (NIH), Quality Safety and Education for Nursing (QSEN), and the American Association of Critical Care Nurses.[5] Although there is agreement on core competencies, wide variation exists within nursing about processes that are intended to assess, evaluate, and document competence among new nurses.[6] However, consensus has been reached regarding 2 distinct competency sets that need to be addressed: initial competency assessment and ongoing competency assessment.[3,7]

Initial competency assessment is intended to begin at hire and culminate with independent practice. Initial competency assessment focuses on job KSAs necessary for independent practice during the first 6 months to a year in the assigned clinical setting.[3] However, initial competency assessment has become part of a behemoth process of confirming what we already know.

NCLEX is a standardized national exam that tests safe and competent nursing care, and success on the NCLEX is considered evidence that licensure candidates are prepared to provide safe, quality nursing care.[8,9] To continue educating nurses, nursing colleges must teach to NCLEX standards and meet expected state board pass rates. Registered nurses (RNs) who have passed the NCLEX understand how to apply the nursing process to health promotion, disease prevention, and management. We must, however, be reminded that practice is evolving at a faster rate than education can respond, increasing the academic-to-practice gap.[1]

During hospital onboarding programs, redundant courses are given to ensure new nurses know what has already been demonstrated by successful completion of the NCLEX exam. New nurses who passed the NCLEX do not require additional courses on heart failure, diabetes, and hemodynamic monitoring. They need experience. Second, fragmented resources with extensive competency checklists ranging from nursing skills to equipment training to self-paced computer-based learning are expected to be navigated and absorbed. Finally, competing priorities with unreasonable timeframes exacerbate confusion among preceptors and new nurses in determining how to achieve independent safe practice.

The onus for safe practice of newly graduated registered nurses is on both academic and practice settings working in partnership with a renewed commitment to bridge the academic-to-practice gap.[4] Collectively, all we want is to have a nurse who has successfully passed NCLEX apply their KSAs in clinical practice. The best way for this to occur is through repeated clinical experiences with the patient population they serve in tandem with a preceptor.

Current Situation

Hospitals' interpretations of AACN and QSEN recommendations require rethinking as to how preceptorships are conceptualized. The preceptors' role is to model KSAs in practice and act as teachers, mentors, and evaluators for new nurses, but we have moved from this traditional preceptor model to clinical experiences that focus primarily on lengthy documentation processes. Still, preceptors are laden with checklists and competency documentation, which distracts preceptors from performing their role efficiently and with confidence. Active learning necessitates using knowledge in the clinical setting with real patients who have real problems. Using active learning and a framework that describes the essential features of what it means to be a competent clinical nurse informs the role of the preceptor.

The Performance Based Development System (PBDS) is a reliable and valid tool used to measure performance of new graduate registered nurses (NGRN).[10] From 2016 to 2020, del Bueno's PBDS results showed that only 14% of NGRN perform in the acceptable safe range for practice, and 29% of new nurses fail to recognize urgency or a change in patient's status.[1] Active learning is how this early recognition is achieved—through repeated exposure to subtle changes in patients' conditions.

PBDS identified 57% of new nurses needed opportunities for growth in managing patient problems and selecting proper nursing interventions, both best met through clinical experiences alongside a preceptor.[1] Preceptors are best positioned to facilitate the translation of the new nurse's knowledge into clinical practice. As frontline care providers, they can emphasize the integration of evidence-based rationale to their decision-making process, helping the new nurse manage patient problems and select the proper nursing interventions.

Finally, communication failures have been cited as the most common root cause of sentinel events and a significant threat to patient safety.[11] PBDS data show new nurses need opportunities to better communicate relevant data and convey their rationale for nursing actions.[1] What better way to actively learn communication skills than by consistently interacting with the health care team with a preceptor guiding the way?

Post-pandemic, hospitals continue to struggle with high turnover and an even higher than average influx of new nurses. Lengthy on-boarding processes impede timely transition to independent clinical practice. To expedite transition to practice, on-boarding programs have abbreviated in-person clinical experiences yet continue to use precious time to re-teach and validate prior assessed knowledge. The result is an alarming decline in the initial assessment of new nurses' competence where the latest 2020 PBDS aggregate showed less than 10% assessing in the acceptable safe practice range with further reductions subdivided by limited clinical experiences where only 7% were assessed as in the acceptable range for a novice nurse.[1,12,13]

AACN's Essentials raises awareness of the need for clear information, regular assessment of progress, frequent feedback, and a time for reflection, which essentially describes the role of the preceptor. The unintended consequence of existing lengthy processes was that preceptors were left to determine when a nurse in transition is ready to practice independently by their sense of readiness rather than evidence of competence.

The preceptor is the 1 person who is side by side with the new nurse as the navigator of complicated schedules and innumerable resources, and sets priorities for the patient care assignment, unit, and health care team. The preceptor is the role model for real practice and the new nurse's safety net toward achievement of safe independent practice. How are preceptors equipped with the tools and resources to navigate the outcomes we all envision? Unfortunately, the response has been to fragment clinical experiences with excessive documentation that interrupts the focus of learning how to safely manage a full patient assignment.

IMPLICATIONS

The implications of newly graduate nurses not being practice-ready are vast and costly and affect new graduate and experienced nurses alike as well as patients and hospital organizations. New nurses are keenly aware they are not practice-ready upon graduation. This coupled with evaluation methods that do not clearly describe how to manage the complexity of a full patient assignment increases nurse anxiety, dissatisfaction, and turnover.[14,15] Implications of an underprepared and less experienced nursing workforce impact patient outcomes. Evidence shows nurses who are under stress make more mistakes, which leads to poorer patient outcomes.[16,17] A meta-analysis quantitatively evaluated the association of the nurse's work environment with job and health outcomes.[18] The largest effects were observed for nurse job outcomes and nurse-assessed quality and safety. Nurses in supportive work environments had 28% to 32% lower odds of leaving, 23% to 51% lower odds of rating nursing unit quality and safety as fair or poor, and 22% lower odds of reporting they were not confident that patients could manage care after discharge. Patients had 16% higher odds of satisfaction and were 8% less likely to experience an adverse event or death.

Finally, hospitals with a shortage of nurses experience significant financial consequences. In 2020, the average cost of turnover for a bedside nurse was $40K. Each percent change in RN turnover costs or saves the average hospital $270,800 to $328,400 per year.[19,20] The turnover rate for staff RNs was at 18.7% in 2021, a 2.8 percentage point increase from 2019.[19,21] These figures emphasize the need to expedite new nurses' transition into practice.

Response to the Academic-to-Practice Gap

Nurse residency programs were developed over the past 20 years in response to elevated concerns regarding newly licensed registered nurses' ability to provide safe and quality care with the increased complexity of the patient population.[22] Shortly after nurse residencies were created, the Institute of Medicine and the Joint Commission recommended that organizations provide nurse residency programs for newly licensed nurses.[23] Currently, nurse residencies are in nearly half of all national hospitals.

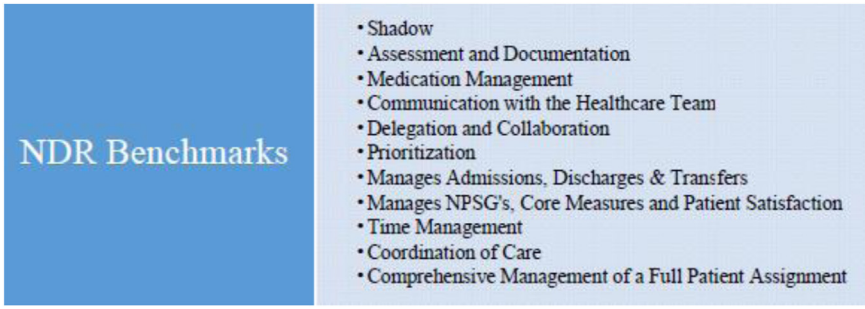

Figure 1. NDR Benchmarks

In 2013 to 2014, at the initial stages of beta-testing NDR, nurses were observed to be hyper-focused on complicated competency packets without specific criteria that concisely described how to manage a full patient assignment. As a result, preceptors could not confidently assert if their new nurse could practice independently. Moreover, new nurses could not operationalize introductory principles necessary to manage patient care such as delegation, prioritization, and time management.[3] This discovery served as a catalyst for further research and resulted in the development of NDR Benchmarks, a meaningful tool with specific and measurable criteria that provides guidance for the preceptor and new nurse. More importantly, benchmarks were intended to function as a *determinant* for readiness-to-practice.

NDR BENCHMARKS

NDR Benchmark Development

The initial goal of Benchmarks was to eliminate reliance on complex competency evaluation packets and focus the preceptor and new nurse on how to safely manage a patient assignment. NDR Benchmarks are an evidence-based alternative approach to determine readiness to practice based on foundational competency criteria identified through research of national healthcare organization's position statements (ANA, AAAC, IOM, NCSBN, WHO, NIH, QSEN, and ACCN).[1-8] Each organization's position statement identified foundational competencies for all health care providers that included patient-centered care, evidence-based practice, quality improvement, safety, teamwork, and information technology.[3]

These identified core competencies were interwoven into 11 benchmark categories that gave the preceptor and new nurse a 10,000-foot view of their mutual end goal: manage a full patient assignment safely and independently (Benchmark Categories, *Figure 1*). The criterion within each category concisely encompasses the KSAs necessary to independently manage a full patient assignment and provide the language preceptors need to clearly communicate what observable behaviors the new nurse is expected to perform in daily practice.[3]

NDR Benchmarks

The Benchmark model was designed to show the new nurses' individual progression toward competent independent management of the full patient assignment. By virtue of the complexity of providing care to a full patient assignment, the preceptor role models all Benchmark criteria behaviors with every patient, family, and health care team member. The new nurse can observe the preceptor integrate all Benchmark criteria in delivering care and begin to assimilate criteria into their developing clinical practice using a collaborative planned approach.

Illustration of Use

The collaborative planned approach allows for the preceptor and new nurse to select which Benchmark categories to focus on during their initial and subsequent clinical shifts. In this illustration, the new nurse has completed the Shadow Benchmark and the preceptor and new nurse choose to focus on Assessment & Documentation and Communication with the Health Care Team Benchmark categories (Benchmark criteria in *Figure 2*). Note the Assessment & Documentation criteria are not simply a head-to-toe assessment checklist. Validation requires the orientee consistently incorporate the plan of care, treatment decisions, and safety into their assessment and communicate it to the health care team.

Assessment & Documentation and Communication With the Health Care Team Benchmark Categories

As the new nurse gradually assumes the responsibility of the Assessment & Documentation Benchmark criteria, multiple opportunities naturally occur that allow the new nurse to demonstrate performance under the Communication Benchmark. For example, frequent assessment findings such as a change in a patient's condition, a critical lab value, or a request for referral require the new nurse communicate with the healthcare team. The criteria within the Communication Benchmark also requires the new nurse to adhere to national patient safety goals, coordinate consults, and advocate for patients, not merely perform an

NDR BENCHMARK ASSESSMENT & DOCUMENTATION
Uses at least two patient identifiers when providing care, treatment, and services
Conducts and documents accurate full patient assessments on entire patient assignment
Documents focused reassessments
Demonstrates respect for the patient and engages patient in plan of care and treatment decisions
Updates plan of care for entire patient assignment
Demonstrates culturally sensitive patient and family care
NDR BENCHMARK COMMUNICATION WITH THE HEALTHCARE TEAM
Advocates for patient within the healthcare team
Demonstrates professional interactions and communication with patients and families
Conducts thorough handoff between shifts and care delivery locations
Demonstrates SBAR communication with primary patient care providers
Reports critical results of tests and diagnostic procedures on a timely basis
Coordinates consults as necessary for patients (e.g., OT/PT/RT/Dietary/etc.)
Demonstrates ability to resolve conflict within the healthcare team including the patient, family, and interdisciplinary team

Figure 2. Assessment & Documentation, and Communication With the Health Care Team

SBAR (situation, background, assessment, and recommendation), a common communication tool frequently used as the sole method for evaluating communication.

The advantage of using Benchmarks is their gestalt nature. While focusing on 2 or 3 Benchmark categories, the new nurse naturally performs criteria within other Benchmark categories. In this example, while the orientee is coordinating the consults necessary for patient care under the Communication Benchmark, they are gaining experience with progressively complex criteria under the Coordination of Care and Time Management Benchmarks (*Figure 3*).

The American Nurses Credentialing Center (ANCC) and the Commission on Collegiate Nursing Education (CCNE) accredits nurse residencies and recommend curricula be individualized to progressively build knowledge and skill (core competencies) based on management and delivery of high-quality patient care and development in their professional role as nurses.[24,25] Using Benchmarks, the management and delivery of high-quality patient care is reflected with successful validation of the most complex Benchmark category, Management of a Full Patient Assignment.

Coordination of Care and Time Management Benchmarks

A key concept of Benchmark validation is the preceptor only validates criteria when a new nurse consistently demonstrates the criteria in their daily clinical practice. Once the new nurse consistently demonstrates all criteria within a Benchmark, the preceptor can validate the Benchmark category. The significance of validating a category is that once a category is validated, the responsibility of the expected behaviors shifts from the preceptor to the new nurse until the new nurse assumes complete responsibility for all 11 Benchmarks. When a new nurse performs all 11 Benchmarks consistently in clinical practice and is observed and validated by a preceptor, it indicates the new nurse is ready to practice independently. Although Benchmark completion signals placement of the nurse into the staffing mix, validation of assigned initial competency sets continue up to 1 year, allowing for the natural occurrence of specific and repetitive learning opportunities. This constitutes a paradigm shift from current practice that delays movement into productive staffing where 100% completion of competency sets serve as the primary indicator of independent practice.

NDR BENCHMARK COORDINATION OF CARE
Coordinates appropriate referrals for timely interventions (e.g., consults, discharge planning, social work, etc.)
Coordinates care to ensure efficient use of time (e.g., patient preparation for tests, procedures, etc.)
Demonstrates coordination of care among healthcare team for full patient assignment
Manages human and material resource allocation and utilization
Provides holistic care to the patient and family for a full patient assignment
NDR BENCHMARK TIME MANGEMENT
Demonstrates time management skill (takes breaks consistently, charts in a timely manner, and provides routine care)
Consistently arrives to work at expected time
Completes patient care for patient assignment within timeframe of designated shift
Demonstrates ability to meet the time constraints and needs of other providers and departments
Consistently leaves work at expected time

Figure 3. Coordination of Care and Time Management

Figure 4. NDR RPIs

TRANSITION FROM BENCHMARKS[SM] TO READINESS TO PRACTICE INDICATORS[SM]

Since 2016, NDR Benchmarks have been used in practice with varied sized hospitals ranging from multihospital Magnet® accredited organizations to small rural hospitals across the nation. Five years later, we wanted to know whether Benchmarks had the intended impact as a determinant for independent practice. We conducted a review of current core competency statements from the original 8 national leading healthcare organizations including QSEN, AACN, NCSBN, National Academy of Medicine (NAN-formerly IOM), AACN, WHO, ANCC, and the ANA, and cross-walked them with our initial findings that supported Benchmarks. Themes that emerged from updated competency statements had all been previously included in original NDR Benchmarks categories. These included leadership, professionalism/ethics, lifelong learning/education, resource utilization, and population health.

Next, we wanted to hear the lived experience of nurse residency coordinators; nurse educators who interact daily with nursing leadership, unit managers, directors, preceptors, and new nurses to hear the challenges they faced onboarding nurses. Specifically, we wanted to know if Benchmarks were valuable, did they reduce unnecessary onboarding time, were preceptors better prepared, and were new nurses practice ready. In the fall of 2021, we invited partners who have used Benchmarks in practice for 5 years to a 2-day retreat to share their experiences and provide recommendations for future use. We requested they complete a process map of how Benchmarks are used at their organization prior to attending the retreat. We asked them to share their thoughts, feelings, ideas, and frustrations on sticky notes related to Benchmark categories, criteria, and their process of using Benchmarks during our initial reception.

Participants reported they are continually asked to reduce the length of onboarding time for new nurses. However, the group stated Benchmarks were merely 1 component of a process that remains 100% tied to completion of all assigned materials before moving new nurses into productive staffing—the very barrier we intended to overcome. Client partners explained that although they recognize Benchmarks could be used as the *determinant* of independent practice, and many of the skill-based competencies and supportive courses could be dispersed throughout the first 6 months to 1 year, their health care systems have embedded processes that make change difficult. A few of the sticky note comments on process barriers included: "inconsistent use across departments and managers," "buy in," "uncommitted preceptors," "not utilized how it should be," and "preceptor competence."

Participants unanimously affirmed Benchmarks are valuable, describe the role of the nurse, and provide language that clearly articulates expected behaviors to determine readiness to practice. Specific sticky note comments on value included: "overarching role as a nurse," "all encompassing," "like that it is a guide," "transparent x 3," and "worked well with surveyors." During our discussion of specific Benchmark categories and criteria, we learned that the criteria align with the role of the registered nurse, but there was some redundancy and need for clarification. The group worked collaboratively to refine the criteria for clarity and eliminate redundancy.

After a thorough day-long review of Benchmark categories, only 2 changes were made. The Shadow Benchmark was replaced by Professional Accountability, and criteria were amended to reflect an active, collaborative role of the new nurse versus a passive observational role. Second, participants reported documentation is a crucial part of the role of a nurse and needed to be a separate category from the Assessment Benchmark. Lastly, the title of Core Measures and Nursing Sensitive Indicators was changed to Quality Measures and Sensitive Indicators (*Figure 4*).

Quality Measures and Sensitive Indicators

Minor changes were made to criteria under the remaining categories to clarify statements or reduce redundancy, but no major significant changes were warranted. Many discussions centered around preceptors and how concise guidelines and training are

crucial for successful implementation. During the wrap-up session, the group insisted the most significant change required to Benchmarks was a name change. Benchmarks did not reflect the intended use of the tool and held too many other associations in the health care field. After the retreat and based on partner feedback, we determined Readiness to Practice Indicators or (RPIs) better reflected the intent of the tool.

We created RPI guidelines per recommendations from the retreat and conducted a focus group with academic and clinical practice national nurse leaders. The primary goal of the focus group was to test RPI guidelines with a new audience for their clarity of instruction and relevance as a tool used to determine independent clinical practice. Feedback was overwhelmingly positive in support of using RPIs as a tool to indicate readiness for independent practice of newly hired nurses. In addition, participants saw value in using RPIs with senior clinical nursing students as a tool to introduce them to expected behaviors as a professional nurse and a possible solution to close the academic to practice gap. The common theme reported by the group was the simple but comprehensive aspects of the tool. Participants reported criteria was clear, concise, and exposed new nurses and student nurses to the salient considerations for managing a patient assignment.

As a result of the focus group, we were invited to participate in a pilot program with Maricopa County, Arizona, funded through the American Rescue Act Plan to increase the practice readiness of NGNs. The pilot partnered 3 nursing schools and 6 health care organizations to train preceptors who work with senior nursing students (SNS). The pilot was intended as a model for how communities can close the academic–practice gap with a seamless transition of NGNs into practice.[26] The goal of using RPIs in the pilot was to introduce and expose student nurses to the knowledge and skills necessary for independent practice during their senior nurse clinical practicum. With the opportunity to validate several of the RPI categories during their senior nurse practicum, student nurses experience early on what is required to manage a full patient assignment. The assumption is early exposure to RPIs provides the foundational framework of expected behaviors that can expedite the new graduate nurse into independent clinical practice.

RESULTS

Qualitative data from the Maricopa Pilot suggest the RPIs were beneficial to student learning. Students surveyed at the end of a transition to practice experience reported the RPIs provided structure and guidance for goal setting and communicating with their preceptor, and focuses the student on clinical judgment as opposed to nursing skills. In addition, 90% of students reported feeling prepared to care for a full patient assignment, and 95% of students reported feeling competent to deliver safe patient care as a new graduate nurse after their experience working with the RPIs.

Maricopa pilot preceptors and faculty report RPIs provide structure and organization to the senior practicum experience. Specifically, RPIs have a level of detail that outlines and integrates KSAs necessary to manage a full patient assignment. Finally, relationships were built between all participant roles increasing engagement and lending itself to a more robust senior practicum experience. Repeated measures analysis of variance showed significance (0.003) from baseline to final (average 71.65-75.00) that preceptors had an increase in self-efficacy in performing their role.

The success of the Maricopa Pilot yielded additional funding for a 4-year student readiness to practice program. Participating academic institutions, hospitals, and community organizations have agreed to use the RPI evaluation tool across settings. Future research will evaluate whether early exposure to RPIs in the senior practicum accelerates the transition of NGNs into productive staffing and increases retention and satisfaction among new nurses and preceptors.

CONCLUSION

Now is the time to redesign nurse onboarding processes and rethink how we assess readiness to practice. A paradigm shift must occur in our understanding of what documentation of competence is necessary, relevant, and practical for new nurses to safely move into productive staffing. The use of evidence-based tools that synthesize scope and standards of nursing practice with a focus on how to manage a patient assignment is critical to accelerate independent safe practice.

Academia and hospitals want the same outcomes: safe, practice-ready nurses, but each use different tools to evaluate practice-readiness. Academically validated performance evaluations are not recognized by or transferable to hospitals. Closing the gap and successful transition to practice programs require thoughtful and actionable collaboration between academic and practice settings with consideration of using mutual evaluation tools.

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