Susan Boyer, RN, Med., Project Director
Vermont Nursing Internship Project

"Measuring Outcomes in Existing Transition Programs to Improve New Nurse Competency"

SUSAN BOYER: The Vermont Nursing Internship Project -- I was asked to come and speak for this and it's really hard to tell you in half an hour what we've been doing. So I focused on just the topic area that was on the agenda, which was that improving new nurse competency and it spoke specifically to the outcomes and data and this is a little -- it's fairly hard data. It's not a service, so it's a little easier to talk about it without thinking about validity and reliability. The other thing to keep in mind is our project is an implementation project, not research. And I do have a evaluation consultant now that we are federally funded, and she takes care of those research questions and IRB and things like that and when I'm perplexed, I just call her and leave it there. And I don't talk that language very easily. But I get to be the one to present to CEOs and other administrative groups when a hospital wants to adopt it or wants to consider adopting the internship, and it's been really powerful to have data. You know, data is a four-letter word, but it is really powerful. And I am preaching that particular sermon to preceptors and clinical nurses. They don't like doing all that documentation but I say, it gives us power; it gives us something to be able to talk to the CEOs about and convince them to spend the money.

So we took a look when we were starting the project, we figured out, okay, what do we want to measure? What do we want to have for outcomes? And one of those things was well, can we recruit more nurses, because we're looking at recruitment and retention. And found that 48 percent of the interns in that first year were recruited from out of state schools and/or residents. That was a powerful piece of data to be able to use, subsequently. The other thing that we looked at is do we make a difference? Does offering this internship -- yes, we're gonna ask agencies to spend money and have these people not in the staffing mix for ten weeks, in our case, and is there any kind of results that can convince the CEFO to spend that money? So we looked at surveying the current staff, managers, educators, and preceptors, and asking them, you know, what they thought of the current process for transition to practice. No, we did not find a tool that was valid and reliable. I should skip over this slide completely, possibly, but this is the data we got back on satisfaction from that same group of managers and etc., and they looked at -- We surveyed prior to offering the internship and then a year later and asked that same group, you know, what did they think about the satisfaction with the process. So this, we felt, gave us some evidence that we had made a difference.

This is the most powerful evidence. We have one participating agency that prior to offering the

internship, prior to our first pilot year, they had no education department. They had downsized that right out of existence. And the nurse manager on the med-surg unit was just suffering terribly from this 20 percent vacancy ongoing, constant, 20 percent vacancy. Last year when I talked with them early in the year, they has a zero percent vacancy. They still have a zero percent vacancy for the whole of the nursing department for that agency. An agency about 30-40 miles from them in that same part of Vermont, when I went and talked with group, they told me, Geez, we're spending 2 to $4,000 per week just in advertising, so that's where you can take a look and find the dollars to back up spending the money on the internship. They went from that 20 percent to a zero percent. Now they have no recruitment or advertising costs and the nursing students that go to that site are going to that med-surg manager and saying, Are you gonna have a position for me; we want to come here. In fact, that med-surg manager, she sees her unit as being the jumping off ground. People come into med-surg, then they go to the ER, ICU, etc. She's now seeing them come back. They went to the ICU and now they're coming back to med-surg because of the workplace culture that they have established. We also got qualitative feedback from preceptors and from interns, many, many comments, appreciating the process that we've changed and the support that we have been able to provide.

We're learned a great deal out of this process.

We learned about what preceptors want and need. The fact that the preceptor development is the most important thing we can invest in, and it shouldn't be -- well, what we had been traditionally doing, I've been in staff development agency based for many years and what I had traditionally done and the rest of us was what I call just-enough-just-in-time kind of training. You know, geez, I can condense that to four hours, I'm sure. Maybe I can get it done in two hours, to teach them how to do this. Well, when we remodeled -- after we offered the first pilot of the internship, we were blessed to have some grant money to then revise our preceptor development and we got the chairpersons of all the nursing schools in the state involved in this, and thanks to that academic influence, really looked at offering preceptor development that was research and theory based. Really looking at having it be a complete process instead of that just-enough-just-in-time. We now offer two day courses and that's not enough. The preceptors finish that two days, saying things like, Geez, I didn't realize it was so intense, it was such a big job. I want more. And they give me a list of the other topics and we offer advanced preceptor development also.

To make all of this work, you really do need to be willing to invest in various resources. One of those pieces is having management support. The way we've made it work in Vermont is I would present to those CEO groups at each agency to get buy-in for the process, because one of

the most important factors is preceptors having time to teach. We have traditionally expected that clinical nurse to carry this full patient assignment and, oh, by the way, we have a new grad starting tomorrow; can you precept her? Well, when I first started on (inaudible) three, 30 years ago, when I started on that unit, that full patient assignment would have two or three patients with IVs in and then the gallbladder that was there for, let's see, 7 to 14 day stay. Now it's more like 7 to 14 hours. And with that increased technology, in fact, the last time I worked on that same unit, I was -- out of my four or five patient assignment, three or four of them had TPN or PPN running and no IV pumps because, you know, the budget wouldn't allow for more than two on the unit. So we really need to make sure that we factor in the time to teach. Also, that we have those clearly defined expectations. When I look at the agenda for this conference, it sounds like that is what we're focusing on, for the most part, today, those competency assessment pieces. What are the clearly defined expectations for the new hire?

The other piece, though, that needs to be in place and can help the preceptors immensely is having clinical coaching plan. That's the teaching plan. We write standardized care plans for patients for all sorts of DRGs and all sorts of care problems. Let's have standardized teaching plans for new hires. And so then the preceptors, who generally do not have any kind of a degree in education,

let's give them the tool that gives them a guideline for what they need to do and how to do it.

That process can greatly improve new nurse competency, but only if we have all the tools and parts and pieces in place. We need to have those clearly defined expectations. We're very blessed in our project. We did our initial literature research in the fall of '99. That's also in the *Online Journal of Issues in Nursing*, published a whole issue about competency assessment. We found Dr. Lenburg's model there and said, Wow, this is the role of the nurse. This is the role of the nurse and all the parts and pieces. And started right from the beginning basing our competency checklist on that. That's where we started. One of our first things was to create that competency expectations, but the reality of the process showed us that what really needs to happen for that checklist to be effective, for it to do anything that we want it to do, is to have a system change within the agency. So that management really supports the process we're trying to implement, supports having time for preceptors to teach, and investment in that process, supports sending preceptors to really detailed development and also them to provide those preceptors with that clinical coaching plan, which is a tool for them.

Last night several of us went out to dinner and we had a little side discussion about what we're talking about today, and I added some more slides last evening based

on that. One of the questions that came up is, is it that we're just falling into more and more traineeships? You know, more and more apprentice-based kind of teaching? And that is true if we focus just on technical skills. But the reality of that competency development piece is what we really need to be focusing on developing, is critical thinking in the novices. And now we're asking clinical nurses that haven't necessarily even had critical thinking instruction in their own education to then turn around and teach it. So one of the resources I love using is Ros Alfaro-LeFevre's work on critical thinking because she has very specific measurable criteria, and she talks about the various components of critical thinking and that it includes not just the technical skills, not just the knowledge base, but also interpersonal skills and communication skills. So then we also incorporate the COPA model because the COPA model is inclusive of the total professional role. Again, not just the technical skills, but it looks at the full eight essential competencies that include critical thinking, leadership, management, human caring relationships, knowledge integration, and teaching, as well as the -- well, communication, I think, we always have addressed, at least to some extent. And technical skills, we're exhausted about. Now our list is actually a page and a half, maybe, that focuses on what we do in a technical aspect, but then the rest of it really looks at the other aspects of what we do as nurses.

We looked at those eight essential competencies that Dr. Lenburg has put together and then said, Okay, what are the specific behaviors, specific criteria that show us that this person has the assessment and intervention skills, that this person is showing the critical thinking skills? Also had to look at it from both the new grad point of view and what do you expect of the nurse as a whole, because if we're gonna have this fit accurately, in staff development it's really core that your job description should be your clearly defined expectations. And then your orientation checklist should flow out of that and just maybe be a little more detail, and your performance appraisal should be evaluating the same thing. But we don't in reality expect a new grad at the end of orientation to be functioning at the same level as an experienced nurse a year or two years down the road. So how do we make that fit? We did it by identifying within those critical behaviors what are the essential core things that the person has to identify, has to demonstrate to get off orientation.

And then the other component of that is in evaluating those behaviors, we looked for the person to, number one, be willing and able to identify the limits of their own ability and to seek assistance appropriately. Because the reality in nursing is we're always gonna be faced with things that we're not ready for, that we haven't experienced, that we haven't done before. If you can acknowledge your own limits and seek resources, then you're

a safe practitioner, and it's those that don't meet those criteria that are not gonna be safe.

So we are actually able to define and detail a competency assessment tool that addresses both new grads and travelers, using the same tool and the same process. And the same competency expectations. And it does fit with performance appraisal. I have some agencies in Vermont that are using those same criteria right straight through. They use the job description, the orientation checklist, and the same criteria for performance appraisal. Can't say that's universal. All of the acute care agencies in Vermont are using some form of it. There's only two hospitals that are not directly involved in data collection for the internship, and actually, now we have home care, extended care, and public health using the COPA model and our -- and basing their expectations on the same model that we use in acute care. What a concept! Multiple hospitals using the same checklist? Is our practice that different from one place to another?

And the core of what we need to be doing here is changing that workplace culture. Instead of having nurses eating their own in any form or fashion, to provide an environment, a workplace environment of support and nurture. An environment that values learning, values the individual, and is willing to invest in time for questions, for learning, for teaching, instead of what we were doing prior to this, is that definition of insanity, doing the

same thing over and over and over again and expecting different results. I believe that's what we've done in health care, especially in nursing, for a long time, and we need to break out of that particular rut.

So our preceptor education includes all of these components. I've highlighted some of them with the orange because they are different than the traditional preceptor education that has been done. We base that role and responsibilities on Joanna Grif-alseach's work, wonderful foundation, but I feel we need to take it beyond there now, because that competency development and validator is vitally important. And let's detail that and make it a very specific part of the role. Thus, we need to be teaching our clinical staff, all of our preceptors, what's involved in that, as well as that whole protector, the safety assurance. It's been sort of the foundation of what we do, but you know how to spell assume, so let's not assume any more. Let's be very specific about the safety protection role and detail what it means, that the preceptor is protecting the safety for the patients, also protecting safety for the novice. So this is an expanded view of what we see as the role and responsibilities of that preceptor.

We also speak very much -- I want to say, you know, actually stop and talk with Patricia Benner. I've been teaching about her model forever and when I saw she was gonna be here, I thought, Oh, my Lord, I'm gonna meet her. But it's amazing when I talk with preceptors how their

understanding of that process is so limited, until you get very specific and start talking about it and then they can share, Oh, yeah, I remember going through that. And it can help them immensely in working with the novices they work with.

Competency assessment is something we need to specifically teach preceptors about and give them an opportunity to practice with the tools. That's what they asked for. We've had way over a thousand Vermont participants in our workshops and then I've taught outside the state extensively, probably at least that many. And what I hear repeatedly from these participants is they want practice with the tools. They want to sit down and talk about the real life experience that they're gonna face, how to deal with them. And they want more. They keep saying they want more, so you cannot offer too much education along this line.

Okay, clinical coaching plan is the other piece that I can show you after I'm done with the slides, 'cause I did copy it onto the hard drive here. But it's vitally important that we offer the preceptors that tool to help them through the process. And I'm telling you about these things. I know it's not exactly the transition to new practice that you've come here. It's not exactly the competency assessment piece, but it's like that checklist. The competency checklist that we use is vitally important, but it needs to be built on the foundation of having the

other pieces in place, having the preceptor development and the tools for them to work with.

Team building is an important part so that the colleagues of those preceptors, instead of saying, Oh, there's two of them, they can take the extra preop and the two admissions today. instead of that approach, we need to have those colleagues offering to pick up one of their patients so that the preceptor has time to teach. And the novice has time to explore the learning that they need.

Delegation and liability is a huge issue and Neta Restald, the Executive Director of our Board of Nursing comes and presents that piece for us in preceptor workshops. And the preceptors still often come to those workshops with the expectation that, oh, that patient's assigned to a student, the faculty person is responsible for their care. They still think that nurses that they delegate to work under their license. Other misconceptions that we need to correct and they need to understand what appropriate delegation is an appropriate assignment, so that we're protecting the safety of the novices and of the patients we're working with. You can't give them enough on communication and conflict management, and you need to teach them, not only about what critical thinking is, but how to then turn around and teach it to others.

This sums it up. You do have this slide, and this really sums up what we need to provide strong transition to practice, because you need those clearly

defined expectations. Need to change our systems when we haven't done that already. We need to make sure that it supports and nurtures both the educator but the preceptor and the novice, provides time for that preceptor to teach, and then that we provide all the tools that are needed. And that clinical coaching plan is one of those vital tools. I'll show you what -- Well, this is -- this is Ros' model. You can find this on the web. You saw that other web address. Anybody that has questions and can't find something, send me an e-mail and ask me for it. I can send it to you. We also, for the internship, have a web page that is **www.vnip.org,** and there's a resource page on that web page that links with all of these things. But this really shows with Ros' point of view how that not only do they need to have the knowledge base, the school learning, the foundation work, they need to develop the critical thinking skills and attitudes and behaviors, along with the technical skills and the interpersonal skills. And if you don't have all four aspects of this, then you're not gonna have critical thinking.

This is the tool that we use. Every unit uses socialization as a serious component, so it gives the preceptor an opportunity to stop and think, have we gone through all of these things? Too often they're really busy. They get assigned a novice, whether it's a new hire or a new grad or a student, and they're into Ms. So and So needs this and socialization, if we want to stay, is vitally important.

So we need to actually earmark that and target it.

But the other reason that we very specifically use these is as that tool for critical thinking development, to get the preceptor focused on actually asking these questions, What went well? What did not go well? These are all very familiar things to you, but they're not familiar to those clinical nurses that are -- we are relying on to develop critical thinking skills in the novices. And we've really seen a difference. It's hard to measure. Measuring competence is extremely difficult, and in some ways it's not even the most important question that comes out of this. It's their confidence and their continued development along the continuum. Because confidence by, you know, some definitions, may take two to four or even more years to get there. What we're looking for is safe and effective practice and a transition to practice process that causes people to stay, to feel good, to continue their professional development.

I can show you the rest of this document, but it's easier if I show you on my computer. But here's an example, and it's identified as goals, not weeks, because it takes different time periods to move through these. These can be used for even new grad or even an experienced person that needs a teaching plan and then they transition on through. Same as with the standardized care plans, using the ones that apply for the particular person in a situation and their needs. I'm trying to think if there's anything

else. What's most important is what you're looking for and what your questions are. So let's open it up to questions.

UNIDENTIFIED SPEAKER: Are the new nurses, either the new grads or the new hires, are they assigned to the same preceptor for an extended period of time?

SUSAN BOYER: We try to. That's not always feasible. We also do not want to not use part-time people. They may be some of your best preceptors. So what I focus on when teaching preceptors in workshop is that every new hire, new grad, is entitled to have a primary preceptor. The primary preceptor is the one that lays out the plan. The plans for the days when they're not gonna be there, when they're taking vacation. What we have from feedback from interns is that they would rather work evenings, nights, and weekends than change preceptors. And so some agencies do that. They assign them to be paired with the preceptor. Other agencies -- what we've found works best is to have the new grads, interns within the funded part of our project, our new graduates, new to specialty or reentry nurses. And so those, in most agencies, are hired to start, no matter what their -- their expected job is gonna be, they will start eight hour days five days a week and day shift, because that's when the agency can provide the best quality experiences and the most diversity and the most staffing to cover that. Other questions?

CARRIE LENBURG: I'm Carrie Lenburg, and I'm very, very pleased to be working with Susan in the VNIP

project for, what, about three years now?

SUSAN BOYER: Yes.

CARRIE LENBURG: One of the things I would like to say is I'm also working with a number of colleges and universities, as well as other organizations and projects that are incorporating COPA model and just the key point I want to make is there has to be a framework, a structure that is a composite that balances out the many dimensions of nursing, which, as we know, is terribly complicated. It's very complex, and forever we have focused on a few of the key things that are critical to nursing rather than looking at the whole balancing of these eight core competencies. And by the way, COPA does stand for the emphasis on competency outcomes and performance assessment. Those two bookends of what are the outcomes, what are the expectations, in clear, unequivocal language; and then what are the measures that we can use for validating the achievement of those competencies. So that COPA model is, I think, for me it's very gratifying to see that after three decades of working on trying to identify competencies and how to measure them, getting some clarification on what it means, we're finally beginning to see some organizations, agencies, nursing education programs at all levels, beginning to use the model. So I'm extremely gratified to be working with Susan, and thank you very much for inviting me, Brenda and company, to this conference. I'm looking forward to participating this afternoon. Thank you.

SUSAN BOYER: That brings to mind a couple of things that I missed in my notes, and for one, our preceptor workshops are open to all direct care providers. We address mixed audience, because all of the topics, you relook at them. It's all about teaching and learning, communication skills and interpersonal relationship. We all use those. I taught a workshop last Friday, will do the second day this coming Friday, and in that group I have many RNs and at least half a dozen licensed nurse aides. And we have checklists that address their role because they are -- they are working with other nurse aides to teach them.

UNIDENTIFIED SPEAKER: You referenced the fact that most of your new hires that are in this program work eight hours, five days a week? Is that the normal working schedule for your staff, 'cause most of our nurses are working three twelves.

SUSAN BOYER: Most of the staff in most agencies are working three twelves. And at the tertiary care hospital, they have the new grads go right to the shift they're gonna work and they do go right to twelves. The problem with twelves is we find that you don't get more than two or three days in a row and when you have those repeated breaks, you lose the continuity. So we -- we have found anecdotally and, you know, the feedback we get from interns is they make better progress and feel better about it when they're doing five days a week. But then some of them don't want to work that many days a week either. And the reality

is, in the workplace, you do what the person is willing to hire to, because although we do draw the line at taking part-time people, that doesn't work. Less than -- It's three or less days a week it is very difficult to get through the competency development part -- process, because they don't have the continuity. Other questions?

UNIDENTIFIED SPEAKER: You talked some about costs but I wonder if there was any comparative data available in terms of the hospital costs to support recruitment and retention versus the cost of supporting the preceptor approach?

SUSAN BOYER: I have one hospital in the state talking about looking for other alternatives, as well as an internship, because they're spending over a million dollars a year on travelers. The hospital that has gone to a zero percent vacancy, they have calculated and feel they spend about an average of 50,000 a year in additional staffing costs to provide the educational support for the new interns. But then there's that hospital close to them that's spending 50-100,000 a year just in advertising, and they still have the vacancies. So we don't have hard figures. Each hospital actually does it a little bit differently, so, you know, I can't give you a straight answer.

Okay. Thank you.