BUILDING AN EVIDENCE-BASED
TRANSITION TO NURSING PRACTICE
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Welcome and Opening Remarks

POLLY JOHNSON: I'm Polly Johnson and I am the Chair of the Foundation for Nursing Excellence. I'm also the Executive Director of the NC Board of Nursing. There are three organizations in North Carolina that have been working on today's program and on our grant to fund this conference. We've got the NC Center for Nursing and the NC AHEC Programs of the state. I'd like to ask Gail Mazzocco from NC AHEC Programs to give us a few words and then Billy Bevill representing the NC Center For Nursing.

GAIL MAZZOCCO: Good morning. As the Director of the AHEC nursing office at the School of Nursing at UNC-Chapel Hill, one of the things, and perhaps the primary thing, I do is to coordinate the school's efforts to help the North Carolina AHEC programs to meet its mission. That mission is to meet the state's health and health work force needs by providing educational programs in partnerships with others. And this is one of those endeavors, a collaborative effort to do exactly what the AHEC is about. While I'll say a bit more about the AHEC role in facilitating the transition to nursing practice a bit later, I do, on behalf of the AHEC, want to welcome you to the conference and to thank you for coming, because we know that each of you will provide a unique contribution to being here. This is really an active conference, not a listening conference. So we know that you
and we will get our money's worth. Thank you.

**BILLY BEVILL:** I'm Billy Bevill. I'm the Associate Director for Recruitment and Retention at the North Carolina Center for Nursing. This particular project is extremely important to the mission of the North Carolina Center for Nursing, because it is a major work force issue. At the Center of Nursing, our mission is to ensure there are adequate nursing resources to meet the health care needs of the people in North Carolina. And we look at this as both a quantity and quality issue, to make sure that nurses are adequately prepared to practice, but also this is a major retention area and a patient safety issue, as well. So we are extremely excited that you are here. We look forward to the results at the end of the day. Thank you.

**POLLY JOHNSON:** Thanks to both of you. I'd like to tell you just briefly a little bit about the Foundation for Nursing Excellence. We were formed by the NC Board of Nursing in 2002 and our mission is to improve health outcomes of the citizens of North Carolina through enhancing the practice of nursing. We have considered this one of our major issues, as well, is how do we transition new graduates into the workplace in a manner in which they enhance their competencies and can further develop, build on their education and increase the strength of our work force in the future. We have been very fortunate to receive a grant from
the Agency of Health Care Research and Quality. In fact, we were thrilled to do that so it allowed us to create this as an invitational conference. We carefully selected invitees, representing various areas of the State of North Carolina, as well as some of our national leaders in the area of competency development in nursing. It will be an intense day, as you can see from our agenda. I will introduce our keynote speaker who, by the way, will be on phone. He got stuck in the airport last night in Chicago, and after three hours of sitting on the tarmac, they finally decided that the flight needed to be canceled and he could not get on another flight, so I will be helping to advance the slides and he will be talking with you in a few minutes.

I would like to move on to the program and introduce to you David Leach. David is the Executive Director of the Accreditation Council for Graduate Medical Education ("ACGME"), and I had the wonderful opportunity of meeting him when he and I both served on the Institute of Medicine's Health Professions Education Committee. We also have another member of that committee here in our audience, David Swankin. From that opportunity of meeting him and recognizing all the work that the Accreditation Council for Graduate Medical Education has done, it was very clear that as we looked at transition to practice that we needed to hear from our colleagues about the rich work that has been done in
terms of medical education and basic competencies for medicine. So without further ado, I will turn it over to David. So please welcome David Leach, even though he's as disappointed as I am that he can't be here in person, but we thank you for being available to us anyway, David.
Keynote Address

David Leach, MD, Executive Director
Accreditation Council for Graduate Medical Education

“10 Years of Research: Critical Issues in the Transition of New Health Care Professionals into the Work Force”

DAVID LEACH: Thank you so much, Polly. I'm so sorry I can't be with you. Jackie and I have a place in Asheville and we were really looking forward to visiting North Carolina again. And when you say that your goal is to improve the health care outcomes for citizens of North Carolina, that's great. But mostly I'm sorry because of the importance of this topic. I think for way too long the formal education of nurses has been attenuated and getting this transition into the workplace right is one of the most important things that all of the health care professions can focus on and apply energy to. So I'm very happy to be with you, at least long distance, but I wish I could be there in person.

The objective, quite simple, is to clarify something that you have thought about, really all of your life. I think most of us from the time we learned to tie our shoes thought about competence and then as we became professionals we thought about it more deeply. But it's very important to be clear. We have done a number of things to strengthen the transition of physicians into the work force. We aren't through, by no means perfect. There's a lot of
work to be done, but we can share our lessons, mistakes we made, things that worked that might be helpful to you. And also, I think there is a frame way of thinking about this that might be useful. *(The next slide)*

I think it's important whenever there's a time of great change to sort of get grounded in our values and our experiences that are more enduring. It frees us up so that we can make change more readily. Dee Hock says that "Substance is enduring; form is ephemeral; preserve substance; modify form; and know the difference." And so I think we should begin, first of all, with a moment of gratitude. I never -- I've been a physician for 30 years and I have never anticipated that it would be this satisfying a career. A lot of things have changed and yet there have been some enduring things. So the next slide is a poem by William Stafford, a poet from Kansas who died, and he wrote this a few months before he died. I think that many health care professionals find it attractive; it speaks to them because they hunger for their thread. So think about this thread. The poem is called "The Way It Is." "There's a thread you follow. It goes among things that change. But it doesn't change. People wonder about what you are pursuing. You have to explain about the threat. But it's hard for others to see. While you hold it, you can't get lost. Tragedies happen; people get hurt or die; and you suffer and get old.
Nothing you do can stop time's unfolding. You don't ever let go of the thread."

I've read that poem probably a hundred times, and I always get something additional out of it when I read it again. And I think it is important to think, both at a very personal level and also at a professional level, about things that we're doing that -- they're so good that we want to drag them into the new world and to be fair about that and to hang onto that, and then to modify other things. And it becomes easier to modify other things if you know they're not part of your thread. *(The next slide)*

I think in the case of medicine the context of our work and your work are similar, but also different. And so some of the particulars in the case of medicine -- each year there's about 16,000 graduates from medical school. They are joined by another 9,000 foreign medical graduates, so that every year about 25,000 graduates enter postgraduate, or what we call graduate training, in the United States. These are formal training programs. Three to seven years duration. The ACGME sets the standards for these programs and accredits about 8,000 residency programs that may have 100,000 residents. We do have leverage, which helps. And the leverage is that while we don't report to the federal government, we're not -- we don't report to the Department of Education, for example, but we -- the federal
government does recognize our work in that they give about $6 billion a year towards graduate medical education and that money is contingent on being accredited by the ACGME. So if a major academic center were to lose ACGME accreditation, they'd probably lose about $100 million a year, so that's very heavy leverage. We are cognizant of that.

There are two other heavy levers. One is licensure, and you must be -- spend at least one, and usually two, years in a ACGME program to become a licensed physician. And board certification. And virtually all physicians would like to be board certified and that is contingent on completing a ACGME accredited program. That's an advantage that we have that, as near as I can tell, you don't. It is not -- You could go down the path of trying to get more leverage. I think that it's actually in the -- in professional self regulation it's important but it's not absolutely essential. There's also whole hospital credentialing activity that actually usually recommends it but we have no formal relationships with the Credentialing Committee.

In our work there's a great debate going on, and I think this is sort of at the heart of your debates, as well. Our residents, our post-graduate nursing students are employed and we have learned in the midst of a major anti-trust lawsuit that we appear to be winning. We've won and
it's now on appeal, but if we were to lose that, it would be
a clear statement that residents are employees and they're
not. The National Labor Relations Board has already ruled
that residents are employees. Yet, everybody knows the
difference between a graduated medical student and the chief
resident is so profound that something very meaningful has
happened in those intervening years. And they could call it
education or not, but it is a learning curve that is much
steeper than it is at any other time in an employee's life.
And there are a lot of recognition that residents are, in
fact, students, that they're not capable of functioning
without supervision when they graduate from medical school.
If we were to lose this lawsuit, we also would probably -- it
would bankrupt the ACGME and other organizations in medicine,
and we would revert to corporate standards, which is sort of
what you have now. ACGME sets national standards. The
standards are the same for all residents in a given
discipline no matter where you are in the country. A
corporate standard might be one in which a hospital would
train you to do something that it needs done, and our grads
would be well trained in that, but you would not become a
complete physician or a complete nurse. And if you wanted to
move to another hospital, they may or may not have that need.
There would not be the sort of uniform recognition that
you've been trained in a standardized way. One of the
insights that occurs in the formal residency program is that really a program is an illusion that the only things real in a program are the people and the relationships they have, one with the other. And those sense of relationships either facilitate or inhibit learning, and that's very interesting to think about.

Another is the purpose of graduate medical education and it's easy to get off on an educational tangent and realize that it is good to develop people, but the real purpose of graduate clinical education is to improve patient care, and I think that would be the real purpose of any formal transitional educational programs for nurses. And if you keep your eye on that and gather data about that and demonstrate that teaching hospitals get better outcomes than non-teaching hospitals, the public gets that concept, and they're willing to support it to some extent. It's very clear that one's individual formation is related to the context that they're working in, that if you're working in a sleazy environment, your formation is impaired. You know, if you're working in a highly ethical, competent environment, your formation is enhanced.

Now the other thing that we're all dealing with, nursing and medicine, is the so-called 38/53 problem. I had dinner with Paul O'Neal and he said he knew of no other industry, except health care, that accepted a 38 percent
reimbursement on amount of skills. And I told him I thought that was about the right number, since only 53 percent of the time did we get it right, and that's where Glen's work shows that about 53 percent of the time we are actually delivering care that everybody agrees and that there's abundant evidence for is the right care. So that problem is a big problem, and it's going to require that we merge again. It is no one profession can fix that problem.

Now this is the one time I'm actually glad I'm not there because I think I may be way off on my assumptions about nursing, and you could start throwing things. But I would ask you to think about the national context of your work. From my perspective and my limited knowledge, I think that nurses have variable skills at entry. They're trained, some of them, in extensive programs, some with abbreviated programs and then they show up for work. There are multiple accrediting bodies. My experience with multiple accrediting bodies is that that's a recipe to diminish the effectiveness of either accrediting body. Accrediting bodies, to some extent, are interested in something as crude as market share, and if one accrediting body has a certain set of standards, another could lower its standards to attract more business. It sounds very crass, but I think that this ability to stand a firm line and speak authoritatively requires that the profession have one accrediting body. As near as I can tell,
there is no standardized post-graduate curriculum for owners. There may be curricula that are out for different types of specialist nurses but, in general, it's catch as catch can for graduated nurses.

You do have, and I may be wrong in all these assumptions, but you do have corporate, rather than national, standards, and that puts you at the will of particular hospitals who are under tremendous financial pressure, or have a fiduciary obligation to respond to that pressure in ways that help the corporations but may not help the health profession as a whole. As near as I can tell, and I understand that Nancy Spector, who's a great friend and who works across the street from me in her office -- as near as I can tell, licensure is required and that's a very important potential towards the leverage. And I think, in general, graduated nurses are treated as employees rather than as students. *(The next slide)*

A really relevant question to anybody is how -- how do they think about management or leadership or work, and that the sort of fallback position is using people to get work done, but in fact, there's a slightly different way of framing it that just brings so much more energy to the table. And that is using work to form professionals. And the work that we do, as doctors and nurses, is noble work. It's very noble to help people when they're vulnerable. That is good
work. And it does shape you, whether you call it education or not. And using the work that we do in a way that is designed to form professionals, rather than just using people to get work done, brings the whole person to the -- to the arena. When you are using people, you get a little bit of them, but you don't get all of their goodness. When they are, and you are, aware of the fact that this is shaping them, shaping their character, shaping their competence, more energy and more wholeness is present. *(The next slide)*

The competence business is tricky. G. K. Chesterton, who was a noted author, was once asked by someone, You know, you have a lot of books. What one book would you like to have with you if you were stranded on a desert island? And *(the next slide)* his answer is, *A Practical Guide to Shipbuilding*. We need a practical guide to competence, a practical guide to physician competence, a practical guide to nursing competence, and sort of isn't there a book we can read on this and sort of do it. And there isn't, in the case of either profession. I think we are doing things and learning by doing, but you're writing that book. You're writing that book today and in your other meetings. It is not written yet. *(Next slide)*

I think there are trends in place that could help your efforts and our efforts and can help us partner. One is, in general, there's been a shift from process
measures to outcome measures or accrediting bodies. Process measures have always been important, and process measures, the things that say you must have so many months of this, so many months of that, and so many library books, and this is your faculty to student ratio and so on. That tends to express ideal values of whichever profession you're talking about, and it actually ends up separating and fragmenting the various professions. But outcome measures, can the graduated nurse or undergraduate resident demonstrate this particular skill, actually tend to bring us together, especially around the patient's bedside. So that shift from process to outcome may be a unifying force.

Another trend that's helpful is the focus on microsystems. Paul Batalgen has done the most work with this and looking at the unit, the coronary care unit, the labor and delivery unit, the ambulatory pediatric clinic, the operating room, whatever that particular unit is, that's where health care is actually delivered. That is where it happens, and if you look there, there's usually nurses and doctors working together and potentially, learning together. But in fact, right now that's only potential. It is not actual. But the more we focus on microsystems, the more we're forced to relate to one another in ways that are helpful to the formation of both parties. And so I think that's something that could help.
We are shifting -- We're not abandoning individual competence as an interest, but we realize that context is so important that we have started an initiative on institutional competence. What does it take for an institution to demonstrate good stewardship over the formation of its resident physicians? There's also, because of the IOM and lots of other good reasons, interprofessional learning, and like most of you, I reserve interdisciplinary learning to distinguish gastroenterologists and psychiatrists and interprofessional learning to distinguish doctors, nurses, pharmacists, and so on. And I think that society is getting impatient with the results that we're delivering and they're insisting that we talk to one another and learn together. That's a trend that's helpful.

Evidence-based practice is now a requirement, and that also requires that we work together. Learning portfolios, we adjust. We're in the planning stages of a learning portfolio that's organized around educational objectives for individual learners. That's a dataset that's owned by the individual, not the program, not the institutions, and that they carry with them for the rest of their life. That kind of database also attracts further learning after graduation and building your portfolio, and it also focuses on -- could focus on interprofessional learning.

The fact that there are shortages of virtually
every health professional, especially nurses, makes that sort of a burning platform and people, I think, may be more willing to consider alternative ways of doing business.

So I think these are all trends in place that could help you in your efforts and could help all of us in our efforts. (The next slide)

In medicine we, some years ago, identified six general competencies that we expect all physicians to know, independent of their specialty. And the way we did this was through a two-year period of extensive conversations with all the various specialties. And it was really a hoot, and it's extremely important. We accredit 119 different specialties, which were all very fragmented, and they needed to be fragmented. The knowledge base for a retinal surgeon is different than it is for a urologist or a psychiatrist. But we needed some unifying force that could draw all of us together and that had to be real. And we identified -- we started out with 84 competencies and we asked the entire community to rank order them in terms of importance and feasibility of measuring them, and these are the top six. Patient care and medical knowledge sort of, people assumed, would be there, are there. The other four were sort of interesting. Every physician should be able to analyze their practice and know how to improve it. A deep focus on interpersonal and communication skills was needed. There was
a hunger for a return to professionalism and being clear about values in our profession. And systems-based practice. When we first started this systems-based practice, one physician said to me, “What if you're not working in an HMO?” And that showed just how blind we all are to the system that we work in. And, of course, in fact, everybody works on a system and the system has profound influence upon your work. An analogy that helps, in the case of physicians, and I think would help in nursing, as well, is you can be a perfectly functioning kidney but if the heart fails, you're gonna fail. And once we had the six, we allowed the various specialties to speciate them so that under patient care/medical knowledge, that would be different for the different specialties, but they all had to respond to patient care and medical knowledge. We randomly learned that the other four were basically the same. Those skill sets are basically the same across all specialties, which was helpful. And (the next slide)

To reiterate that this brought together 119 different specialties, which should give you courage as you bring together your different communities. And again, a focus on process tends to divide and a focus on outcomes tends to unify. (The next slide)

So what we learned that might be helpful to you, one of the things we learned is that whatever we measure, we
tend to improve, and that very quickly residents want to know what's on the test, and that suddenly becomes the source of learning. And on *(the next slide)* we found that you need different types of measures done over time to really get your arms around it. We've always had cognitive exams. To that we've added 360 degree evaluations, so now patients contribute to the evaluation of residents. Nurses contribute to the evaluation of residents, and medical students and peer residents and supervising residents and faculty. And it really broadens the perspective so that the resident who looks good on rounds but is actually pretty unreliable is detected. They can't get away with that as much any more.

An almost essential evaluation tool is direct observation and evaluation. And this occurs -- medicine has its many -- at the bedside where this is done. Surgeons in the operating room. Psychiatrists use one-way mirrors. But there are -- There's a need to have someone actually observe the learner doing what they're supposed to be learning and judging whether they have learned it or not. And then these learning portfolios, really a collection of assessment techniques, a collection of experiences, that the learner has that may serve particular education objectives. *(The next slide)*

So some of the lessons we've learned is that competence is a habit. It's not happening at the time of
exam. That may be essential, but it's not adequate. You really want to know, not just can I do something, or do I know something, but actually do I do it, I have it in my performance on a regular basis. Can you count on me, that's what competence is. It develops along a continuum. The alternative to competence is not necessarily incompetence. It could be someone who's a novice, an advanced beginner, a proficient, an expert or master. There's a depth to competence, as well. It's not an on/off switch. It's more than just knowledge and skill, and it's not enough to know the rules. So (the next slide)

If we look at competence as a habit, we realize that assessment of habits require relationship over time and really relationships over time to make a judgment of an individual's performance. It's not simply passing a test. On (the next slide) It also exposes an assumption that we've lost track of in modern times, that being that our work is a cooperative rather than a productive art. And we've allowed the language of productivity to slip in and be honored in a way that diminishes the fundamental truth of the fact that our work is cooperative work. The quality of health care is dependent on the quality of the relationships. The relationship with the patient, the relationships with other colleagues. In the next slide, if you probe this a little bit more, it's obvious that in healthcare we are, in fact,
cooperating with the body's natural tendency to heal. The outcome isn't totally dependent on us. Likewise, in teaching we're cooperating with the mind's natural tendency to ascend to the truth. The outcome, if that natural tendency is impaired, ain't gonna happen. With management, we're cooperating with people's natural tendency to form communities. And if we don't get that right, and the communities use scapegoating, for example, as a cohesive force, rather than striving for common purpose, it gets pretty ugly. And I think we've lost this message in the modern world where productivity has ascended.

So in the next slide there's an underlying assumption that comes from this. That the quality of life for our patients and ourselves is directly related to the quality of the conversations in our lives. And if you sort of want to know how that's going, just reflect on the quality of the conversations over the last day, two days. What is it like in a hospital now? Are these happy conversations? Are these conversations that are quality conversations, because it affects our patients and it affects ourselves in the formation of all our professions. (The next slide)

Another lesson is that the important things are hard to measure, and the next slide, Dee Hock who founded the DEFAC Corporation, has listed the criteria for hiring people in this order; integrity, motivation, capacity,
understanding, knowledge, and experience. And he said it has to be in this order because if you lack integrity and are highly motivated, you can get the organization in big trouble. If you lack motivation and yet are brilliant, nothing is going to happen. If you lack capacity, your understanding is limited. Your knowledge is limited, and your experience may be blind. Two people can have the same experience. One of them gets it, one of them doesn't. And yet, in fact, there's an inverse relationship between the ease of measuring and the importance of criteria. It's always pretty easy to measure experience and very hard to measure integrity. So we tend to get lots of measures about experience and knowledge and not pay attention to the really important ones which, I think, are integrity, motivation, and capacity. If you're thinking about a young nurse coming out of school and going into the experience and having no attention paid to the other domain, you can -- it's sort of a black and white world without the technicolor offering that could be there. *(The next slide)*

Knowing the rules is not enough. And we know that learners need to prepare for the unknown. How they think is as important as what they think, and I think will actually be more important over time. Bushsia Fatesia, Syracuse University, has done these cognitive simulations, using computers and scenarios. It doesn't require any
medical or nursing knowledge. You're put in charge of running a big city and then all kinds of things happen that -- the nuclear powerplant melts down and there's a flood, but how you manage these various crises and how you make decisions about what to do is studied in the simulation. And she's used psychiatric residents, surgical residents, and emergency medicine residents and studied them over time. And as much as a surgical resident learns from the first year of training to the fifth year of training, and it's profound how much they learn, they do not change how they think. On her graph they are all red and the psychiatrists are all green and they don't change how they think, relative to their training. And they do think differently. And in her view, CEOs, where she did this original work, are best if they have multiple ways of thinking, if they can think in different ways rather than just one particular way. And I think that's a whole part of education that, in medicine, is ignored and I think it's worth paying attention to again, primarily by measuring it. The residents who she measures over time and teaches actually different ways of thinking seem to end up stronger.

The next slide is a Stacey diagram, which she doesn't like, rather it's Ralph Stacey, but I still find immensely useful. And you'll see on the vertical axis that positive sign is at the bottom and that means that there's
widespread agreement. Everybody who's an expert agrees this is the right thing to do versus the top of the vertical axis is negative where virtually nobody agrees that a particular action is the right one. On the horizontal axis, the positive sign is to the left, and that means there is a deep understanding of the cause and effect relationships. If I do this, this will happen. Whereas, on the right there's no understanding of the cause and effect relation. We teach in what Stacey would call a control zone. And that's a very real zone in medicine. It's the world of clinical guidelines. There is abundant evidence. We know that it's the right thing to do and there's widespread agreement this is the right thing to do. But under-emphasized is the fact that a lot of medicine and a lot of nursing is -- lacks that agreement and there is not that degree of certainty about the phenomenon. You may not know what the patient has or if you do know what the patient has, there may not be adequate evidence or adequate agreement about what to do, and residents and nursing graduates and all of us need to know how to function in this complexity and even in the zone of chaos to understand where -- which of these zones we're in and how we can intervene most effectively, not just the sort of control zone where we tend to pay most of our attention to.  *(The next slide)*

Competence proceeds along a continuum from
novice, advanced beginner, competent, proficient, expert, and master. This according to Dreyfus, Betolin added the master category. And basically, on the next slide you'll see this moves from rules and if you ask a medical student or an intern What do you do if you have a patient with a fever, and they will reach in their pocket and pull out a Washington Manual, and they'll say I do the following five things. It's rule-based behavior. If you ask a master What do you do if you have a patient with a fever, they will say I couldn't possibly answer that without seeing the patient. Their behavior is totally context driven.

And it's very interesting how you get from that rule-based behavior to context-based behavior. And in the case of residents, it's our hope, we think of medical students as novices and the graduated student as an advanced beginner. And we hope by the time they finish residency, they're competent. And then proficient is the first few years of independent practice in which you actually develop the intuitive capacity where you immediately see what's going on. Nurses do this extremely well. They can tell whether patients are sick or not, whether they're crashing or not when they see these patterns emerge. Experts not only see that but they see how -- what they need to do now, in this particular occasion. And then Betolin has distinguished experts from masters by saying experts hate surprise and
masters love surprise. As an endocrinologist, if I declare someone has Graves Disease and am proven wrong and I get pouty-wouty, then I'm an expert. If I run around saying that I was wrong about the case; look at this case, isn't this an interesting case, I may be a master. The reason that this transition to the work force is so important is that that moves you from advanced beginner to competent and that opens up a whole new set of your faculties, as you mature as a professional.

On the next slide, Hubert Dreyfus says, "To become competent, you have to feel bad." So imagine that you are a medical student and you've got all day to examine one patient, and all you have to do is get all the data that there is. You don't have to distinguish chicken pox from chest pain. You just have to get all the data. Now imagine that you're a first-year graduate and you've got ten admissions and you're a bit overwhelmed. You don't have time to get all the data on all ten of those patients. You have got to take a point of view from which to see the case and you have to say this detail is relevant, that detail is less relevant. And you formulate a little hypothesis. You say, The patient's short of breath. I think this is due to pneumonia, and you begin to ask questions that might reinforce that concept that the patient has pneumonia. And maybe you're wrong. Maybe it's a tension pneumothorax and
the patient suffers because you're wrong, and you feel that. And Dreyfus says at that point you can take one of two paths. You can go back to rule-based behavior and say On Tuesday night shortness of breath from a pneumothorax and add that to your already thick rule book, or you can go to context-based behavior. But that requires that you actually talk again with the patient about what you overlooked that could have helped you figure out this was tension pneumothorax.

Somehow or other, in that act of feeling bad, more of your capacities are opened up and it allows you, because your emotions are opened up, it's more than just your intellect -- it allows you to develop these intuitive capacities to see patterns of disease. And so there's a time when the graduated nurse and the graduated resident that they make a mistake and they feel bad, and that's a very important time in their development. It's absolutely a good mentor. And if, for example, I'm a resident who makes a mistake and I don't feel bad, I should probably get a little help so I can feel bad. If I am one, which is more typical, a resident who makes a mistake and then I feel so bad that I think I should abandon medicine and go do something else for a living, I need a little help in putting this into perspective in my own formation. It's a very important vulnerable time and it's almost immoral to have a graduated nurse encounter that
without having proper mentorship to get over that and to actually aid in her formation or his formation so that they can become better nurses. *(The next slide)*

Another reason why this is important is that, while knowledge and skills are a prerequisite, our real value to society comes from our capacity to make good clinical judgments. Learners seek practical wisdom. They know this. And that's why this is not a new concept. Aristotle, whose father was a physician, categorized the versions of learning as episteme, which is a cognitive knowledge; techne, a craft or art; and phronesis, that's practical wisdom. That is what is learned in this post-graduated period. You can learn cognitive knowledge. You can even learn techne. But practical wisdom takes time and experience. *(The next slide)*

I asked John Kostis, who's the Chair of Medicine in New Jersey what this word "phronesis" means. And he said it was "knowing exactly which rule to break and exactly how far to break it to accommodate the reality before you." Absolutely elegant definition. And that is so crucial to our values to society. We have to teach people how to do that and it's a formal act of prudence. You're not breaking all the rules. You're just breaking this rule, and you're not breaking this rule all the way. You're just breaking it as far as you need to accommodate the reality before you. But the important thing is you have a mental model of the disease
and there's a real patient before you and you always are biased toward reality, towards the real patient, rather than towards your mental model. It's an act of humility and prudence and it's not to be recklessly done, but it has to be done almost every time. And so this is very rich and has been in the formation of a health professional. And to ignore that and just have young nurses on the work force without paying attention to that is serving neither society nor them, nor all of us, very well. *(The next one)*

In a sense we're talking about improvisation and people don't like to talk in public about how much of health care is improvisation, that, in fact, that it is, and improvisation engages both rules and values. And health professional formation must pay attention to both of those, and we have paid attention to rules, but not to values.

And the next slide, which will date me, because I did bring Robert Pirsig's book, *Zen and the Art of Motorcycle Maintenance*. He says, and I think when you're talking about competencies, it's important to remember this, that "quality isn't something you lay on top of subjects and objects like tinsel on a Christmas tree...it comes from the cone from which the tree must start." It comes from the inside out. Competence is -- in one sense it is like merit badges that you put on your arm, but in fact, it's much deeper than that. *(The next slide)* Which is why it's so
important to have communities that support character
development, to paraphrase Aristotle, character is determined
by community, and community is determined by character. So
my character is determined by my childhood community, family,
school, community, and then, in turn, as an adult, I
contribute to the communities that I'm in and the quality of
that community is affected by the character of all of it.
So there's this reciprocal relationship that makes this work
important. *(The next slide)*

In Gardner and Csikszentmihalyi and Damon's
book, *Good Work*, they say something that's relevant to our
work, and that is "Why is it that experts primarily teach
techniques to young professionals, while ignoring the values
that have sustained the quests of so many creative geniuses?"
We've got to pay attention to our values. *(The next slide)*
This is translated into how can we prepare the next
generation of health professionals to have values as well as
knowledge and skill. And *(the next slide)*

A series of matryoshka dolls. So I'm a human
and then I decided to become a nurse. Then I bring my human
values into the community of nursing and I am working in a
particular institution that has its values, that are shaping
me, and I it. And I suddenly have professional societies
that I go on to. They have values that are shaping me, and
me it, and I live in a society that has particular values
that govern and influence all of us. So there's this dynamic going on that can either support human self or crush it, and I think it's important to pay attention to that. *(The next slide)*

I think that this idea of thinking of education as formation, as a shaping, shaped by both internal and external variables, is important. This is a journey to authenticity and it comes from the inside out. Somewhere deep in each of us there's what Jaspers calls "unconditional imperative," which is a command of my authentic self to my mere empirical self that defines who I am. It's timeless. We join a profession and there are shared assumptions in the profession that provides some foundation for action. That's important. But if you want me, all of me, it has to be compatible with my individual values. And first of all, I have to know what my individual values are and how they play out in the field. And we have to pay attention to that and support that in the formation work we do. *(The next slide)*

The first thing you encounter is that it's very easy and, in fact, normal for me to put on a false self. You see this in adolescents all the time. It's like wearing a set of clothes. Today I'm going to be this way. Tomorrow I'm going to be that way. And I sort of try that out. And there's a variety of reasons why I don't expose my true self, mostly fear. And I get fluent in dealing with this false
self. To get to have the whole nurse or the whole doctor show up for work, you have to be in touch with and aligned with your true self, which is part of the work of formation and it's hard to do that.

*The next slide* shows that it's very possible, and usually the case, that only part of me shows up. My intellect will show up. My ego will certainly show up, but to get all of me, it is a much trickier business, and there is some sort of inner teacher that can facilitate that. Parker Palmer refers to that as life on the Mobius strip, and *the next slide* shows a Mobius strip with this remarkable ability to, without crossing a boundary, go from the outside surface to the inside surface and back again. So if you sort of imagine that your finger is riding along the outside of the surface on the left-hand side, and you just follow the lines around, the next thing you know you're on the inside and there's this fluidity that is used as a metaphor for living the undivided life. There's another representation on the next slide. And that actually is what health care professional formation is all about. *(The next slide)*

If we answered what kind of community might invite the whole person to show up. Frenzy doesn't help. And, of course, frenzy is pervasive. *The next slide* is a section from one of Robert Thomas Merton's journals. "There is a pervasive form of modern violence to which the
idealist...most easily succumbs; activism and overwork. The rush and pressure of modern life are a form, perhaps the most common form of its innate violence."  (Next slide) "To allow oneself to be carried away by a multitude of conflicting concerns, to surrender to too many demands, to commit oneself to too many projects, to want to help everyone in everything is to succumb to violence." Sounds like a health care system to me. The next slide concludes the segment. "The frenzy of the activist neutralizes his or her work...It destroys the fruitfulness of his or her work, because it kills the root of inner wisdom which makes the work fruitful." That's part of the problem. We've created an environment laden with frenzy that make it very hard for us to get in touch with our inner wisdom, let alone teach others how to do it. And that's what we have to overcome. (The next slide)

If you're foolish to do this work, it's best to work with nature, and I think all humans have three faculties that are helpful. They all have intellect, which merely has as its object the truth. They have a will, which seeks goodness. And they have an imagination, which seeks beauty. (The next slide) This one translates into the work of health care. The empath or the intellect is to discern the truth, what's going here. The will is to make good clinical judgments, and the imagination does so with harmony and creativity and beauty. (The next slide)
These values that we could reinforce in health care derive from this in a very natural way. The value of integrity, discerning and telling the truth. The value of altruism, putting what is good for the patient before what is good for the doctor or nurse. The value of practical wisdom or prudence. That is beauty in clinical judgment. And the fourth virtue, arete, which is integrate all of these virtues to excellence.

So the next slide, I think, at the nub of this is the fact that the quality of patient care and the quality of professional formation are inextricably linked. If I am 200 miles away from an academic health center, it's just me and the patient, and I give shabby care to that patient, my formation is made shabby by that encounter. And if I give excellent care, my formation is made excellent by that encounter. You cannot separate those two things. And that is very important principle as you go about your work today and beyond.

I'm gonna flip through this because I think I'm over time and we're going to take the next slide, the model, and I'm just going to cover it lightly. This is from Sholom Glouberman and Brenda Zimmerman on complicated and complex systems. And the next slide which is a table with three things. I think it's actually a very useful frame. I think the formation of health professionals is a lot more like
raising a child than it is like sending a rocket to the moon. And Zimmerman has categorized these phenomena into simple phenonemas; recipes, where you can use a simple recipe and a standardized product results. A rocket to the moon, which is complicated and requires rules, requires experts, and it does exist in health care. There are complicated phenomena in health care. And then the third analogy is raising a child. Now if you sent one rocket to the moon, it actually enhances your chances of sending a second rocket to the moon. But if you raise one child successfully, it does not ensure ... because every child is unique. Every patient is unique. Every nursing student is unique. Every resident is unique. And so your values form this work, so if you're sending a rocket to the moon and the engine overheats, your values are not very helpful. You need a technical manual to know what to do. If you're raising a child, a child-rearing book is not that helpful. Your values will allow you to adapt to the child's response, and so you need both rules and values.

(The next slide)

I'm gonna skip over this in the interest of time. It was two of our initiatives, competence and reform of duty hours, to demonstrate these two phenomena, but I think that I'm going to go over them, so we'll go to the next slide after that. Conversations, we'll skip that. The next conversations we'll skip that. Duty hours versus
competencies, we'll skip that. I do want to get this one slide that's entitled Particularly important at this time: rules versus values. And we're in an era of performance measures, which is good, but inadequate. Performance measures are based on science. They are rules. They're easy to measure. They're evidence based; did you do it or did you not do it? They assume the Stacey control zone. Competence is much deeper and it involves both art and science. It involves values, as well as rules. It's hard to measure. It's context and evidence based. It proceeds along a continuum and allows you to function in all three zones.

(The next slide)

We're moving in our world from a world that's qualified to a world that's competent. In other words, I graduated from an institute in an accredited program. I'm board certified. My training largely emphasized medical knowledge. There's no warrants to anybody that I'm competent, but I am qualified to practice medicine. This is a scheme that's very useful to doctors. It's not very helpful to patients. We're moving to a world of competence where I will be declared competent based on my habits, my actual performance, based on a balanced set of measures and attributes. There is an implied warrant there. There is a kind of a statement that says you can trust me to behave in this way, my habitual behavior. That's very useful to
patients and troublesome to doctors. I think that that model could work for nursing, as well. *(The next slide)*

Community leads to clarity, and clarity leads to courage, and we need courage. And we need clarity, and we need conversations like you're having today to sort of get this right, and to have the courage to do it. *(The next slide)*

I talked a little bit about postmodernism. I'm going to skip it so it will be there if you want it, but let's move on. And the particularly important slide we're gonna skip, too. We're gonna go back to Dee Hock's quote, "Substance is enduring; form is ephemeral; preserve substance; modify form; and know the difference." The next slide, and I would argue that values are enduring; rules are ephemeral; preserve values; modify rules, and know the difference. And realize that we don't receive wisdom, that we discover it. We discover it after a journey that no one can take for us or spare us. And yet, the next slide, community can help and good conversations about professional values helps. That health care professional formation is never complete. We are all pilgrims, on the way and oriented toward fulfillment.

Now practical things that can be done, my own bias, and I'm not well informed, but I would say that every new nurse needs mentorship for at least three years, and we
have to avoid abandoning our young people. I think faculty, which, of course, with all the health care shortages, you have shortages of faculty. So do all the other professions. But we could pull together in pharmacy, physical therapy, respiratory therapy, medicine. All of these could serve the faculty if we got this right. Using data is something that can be very helpful in persuading hospitals and others about the importance of this work. (Next slide). My favorite mantra is "To teach is to create a space in which obedience to truth is practiced." And the last slide, "To teach or to learn is to create a space or community in which obedience to truth is practiced." And that's what you're doing today.

I'm so sorry I can't be with you, but for all I know, by now you've all left and I'm just ... I enjoyed talking with all of you, or just myself.
Q&A

POLLY JOHNSON: Thank you, David. We have time for maybe two questions, if someone has a question that they want to ask.

POLLY BEDNASH: David, this is Polly Bednash. I have one question for you. Early in your conversation you talked about the general competencies and testing for the general competencies. And one of the areas you focused on is the issue of patient care. Can you talk with me about how you approach that, given the wide array of specialties that you have, and how you address that array of specialties in a form that allows you to test patient care issues in a general way. For nursing that happens to be a burning issue right now at a number of levels, so you might be helpful for us here. Thank you for your answer.

DAVID LEACH: Thanks for the question, Polly, but for patient care we considered that the skill set you need to take of patients. So it did vary across the specialties. But it was basically what to do with your hands, what you do -- can you conduct a proper interview? Can you gather the data adequately? Can you perform a given procedure? And it is really the bedside skills of patient care and if you are a cardiologist, that may mean can you do an echocardiogram. If you're a psychiatrist, it may mean can you manage a particular crisis. But whenever you deconstruct
competence, it's artificial, and we chose to deconstruct it into six competencies, because you have to deconstruct it to measure it. So this is sort of a skill set, and the kind of measures we would use are direct observation of the person to see them performing a procedure or interviewing a patient. Feedback from others who see them in their daily work. There's less of this on the cognitive exam which is more apt to test knowledge, but it can be part of a learning portfolio.

POLLY BEDNASH: Thank you, David, just again, to clarify this. So you really don't have one generalized assessment of competencies for all those. It varies according to the specialty and what you see are the general competencies for that specialty.

DAVID LEACH: That's true. We do have six competencies and, in general, four categories of assessment tools. And it turns out that there are not 119 different. For example, all surgical specialties, the directly observed behavior will include things like proper handling; can you name the instrument? Can you use the instrument correctly? So that assessment tends to be a unifying force that balances the deconstruction of competence from the (inaudible) competence.

POLLY JOHNSON: Patricia, you had a question?

PATRICIA BENNER: Yes. This is Patricia Benner
and I work a lot with Dreyfus'

DAVID LEACH: Oh, it's such an honor to meet you. Of course, you did. You did the whole thing from novice to expert --

PATRICIA BENNER: Right, and so I just love your seat on the implications for medical education and I do think it is a real ground for agreement. I'm participating in the Carnegie Foundation study of medical education and nursing education just now, which I know that your group is also involved in, as is AACN. Currently, what the medical group is finding out is that in that three to seven years duration of residency in medicine, there were a lot of really discontented residents who feel like they are used as, let's see, how can I put this nicely? Scutwork is one word that comes out in the very research oriented interviews, but that they get bogged down with a lot of clinic assignments and work that don't meet their educational needs.

DAVID LEACH: Right.

PATRICIA BENNER: And, of course, nursing has been there first, in our apprenticeship programs, but how to create institutional responsibility for formation, because we really will have only as good a professionals as the institutional space allows over time. So I really think that this is a place where we could really work together to create institutions that are more fit for both the values and the
professionalism of the practice and not just formed on the corporate model. But I would like your thoughts on how we build into -- how do we keep out of the production mode in that vision for residency, because I agree, nurses need mentorship after graduation. So any thoughts on that will be most appreciated.

DAVID LEACH: Well, thank you for your question and I've read your stuff and I've been so impressed with it, And you're quite right, the resident -- I think residents and nurses share in common the Holly (inaudible) quote that the health care system is broken and residents and nurses live in the cracks of a broken system. They're the glue that holds it together, that they get things done when nobody else can get them done, when the system doesn't automatically get it done. And the problem with that system is that it's a vigilance- based system with people who are tired, and when we reform duty hours for residents we -- we now survey over the internet a third of the residents every year for two years and we've surveyed 60,000 residents with an 85 percent return rate. And we know our perception of how much non-educational work they're doing just because nobody else is doing it, and in doing the duty hours pays some attention to that, but it still is a huge problem. And I think that you're absolutely right, we could partner on this and sort of define what the essentials are for good patient care and not
have us be a vigilance-based system, but rather get systems in place that support patient care and do that not counting on exhausted residents and nurses to pick up the slack when things break down. And so I see a lot of forces in play like this great interest in the Toyota production things that Pittsburgh has demonstrated and others that really are paying attention to the process of health care and trying to improve it. I think on a given microsystem if we could partner, we could say this is the way we're gonna take care of patients, period, the end. And nobody could trump us. But if we don't partner, then we can play against each other in a way that weakens both of us. And so I agree with you. I think defining the coherent programs that pays attention to the formation of health professionals of whatever age and whatever experience level, on a given microsystem, and just insisting that's the way we're gonna deliver health care. The production types have had it their way for the last, you know, few decades, and this is the result. They're gonna try it a different way and I don't think anybody would stop us. The financial issues are daunting, but when you're -- when you're taking the lives of 100,000 people a year, because of medical error, we've got the attention of the policymakers and the public. And I think there is -- it's a right time for change. I don't know exactly how to do that, but I would be very open with working with any of your groups.
POLLY JOHNSON: Well, I thank you very much, David. It's been a wonderful challenge that you've set in front of us and extremely thoughtful information and for the audience, we will get copies of the PowerPoint for all of you.
Nancy Spector, RN, MSN, DNSc, Director of Education
National Council of State Boards of Nursing

“Identifying and Measuring Critical Competencies among New Nurses”

POLLY JOHNSON: Nancy Spector, is an education consultant with the National Council of State Boards of Nursing, is going to be talking to us about the information and some of the evidence that we've been gleaning at the National Council level related to this transition.

NANCY SPECTOR: Thank you very much and it's so exciting to be here, and it's really exciting to hear Dr. Leach. The background of the National Council in working with transition to practice really starts -- everything of our major initiatives really starts from our board. And our board decided as a strategic initiative that seeking excellence in regulation was really important. Along the same lines, they saw as an unintended consequence of the CAT or the computer adapted testing that we have now that was started in the mid-90s, one unintended consequence was that nurses were graduating and in some states got the results back within 24 hours and were starting as a registered licensed nurse. In the past we had that time period where there was a provisional or conditional license, so the board recognized this and along the same time we had a committee called PERC, which was Practice Education and Regulation Congruence, and they recommended that we look at transition so that our transition of education to practice, so that
there were really about three major things involved in the background of our working on this transition.

One of the first areas of study, and at this time, the previous people from our research services have left and we have new people, so it kind of started with the previous people and is carried on now by our new people, one of which is Suling Li, who is with us today, our new Associate Director of Research, and we're very excited to have her and Dr. Kevin Kimler. But Dr. June Smith and Linda Crawford in 2002 did a large stratified random sample of 1,000 RNs and they did a three-stage mailing, coming up with 633 useable surveys. They did a color analysis on this and it provided proportional estimates. The surveys involved self-reports for new graduates and the questions surrounded the work environment. Education and transition, we really hadn't done anything before in this, so we really didn't know what we were going to come out with. They looked at involvement and errors and difficulty of assignments and then the demographics of the new nurses.

So we looked then at those two outcomes, the first being involvement and errors. Thirty-nine percent of the new nurses were involved in errors and currently another study along those lines, we have found about 50 percent of the RNs. Now you can see our definition of being involved in errors. It's not only occurrences that resulted in harm or
the potential of harm to patients, but having been involved in making an error or supervising others and making an error, discovering errors made by others. Now you're probably wondering why it was made so broad. Some of the experts had given us this advice because they said otherwise we may not get real reliable results. The 49% is concurrent with what literature says is out there, but one of the things we are looking at now is really making this more reliable way of looking at being involved in errors, seeing if we can validate it with some actual error kinds of research.

You can see of the types of errors that were made by nurses, the top three were medication errors. I think that would be expected, falls, and then delays in care/treatment. The other ones were much smaller percentage, but those were the three major, and I think medication errors and medication administration comes out loud and clear throughout all this presentation that we do.

Interesting to look at some of the causes of errors. Again, probably not something that is shocking but inadequate staffing way out in front. Then lack of adequate communication. If you look back at what David's research shows, that their competencies, communication, also IOM, definitely are very important area of competence. And across disciplines. Lack of support from other departments. I think not only do we need to look at communication and
interdisciplinary work through other professions, but within the nursing profession, itself, some of this mentoring that David was talking about over the three years. Poorly understood policies, and then up there are inadequate orientations. And you'll see as we go through this what the new nurses say they have in terms of orientation versus what the employer say that they're offering, and it really is quite different.

Some of the other factors involved in errors, again, not a surprise, problems with understanding English and non-English speaking clients and also problems in understanding medical orders. If the person had been a nurse aide, they were more likely to be involved in an error, but if they had worked as a practical nurse, they were less likely to be involved with an error. Over time, more likely, and again, I thought the age one was interesting. The younger new nurses were more likely, and I guess that's probably related to the maturity.

The second outcome we looked at was the difficulty of the current assignment, and we thought this related to how well they were being able to use their competencies. Twenty percent of the new nurses felt that they were too difficult, their new assignment. But the second was just amazing to me. Very different from what we heard from employers. The average days to their first assignment was eight days. Now
we don't hear that from the employers, but I think all of us who have been out there working know that you have this set kind of orientation, but sometimes it has to be scrapped because there's work to be done, and I have a feeling that that might translate into that. Even 13% said that their very first assignment was too challenging.

Now with every study there are limitations, and we're trying to work on some of these. Self report of your perceptions can sometimes certainly skew how a thing is interpreted and I do think that if a nurse has had more of a broad education, perhaps they would tend to see their limitations more and report them more than if somebody had more of a limited orientation. And I do think we need to recognize that when we're interpreting these results.

The definition of error, as I said, it was the advice of experts to use that definition, but that does need to be validated that that, in fact, that is true error and I think it's a little troubling that it's involved with others' errors. So I think that is something that Suling definitely is working on now.

These were some of the different models for the transition programs that the students reported, and I thought some of them were a little surprising. For example, paid tuition in a program. This is not a part of an academic program. They got out of their academic program and they
paid money to be a part of an orientation program. But as you can see, some of them were before graduation and some of them were after graduation. That was really very good because we found some good results related to those that were after education.

For a successful transition, we found that the knowledge type, general versus specific, general meaning a core education; specific meaning specialty organization. If they're in cardiology, they learned those kinds of techniques. And there really was mixed results with this. However, they might be interpreted so that you use both in a transition program. For those that had specific knowledge only in their program, they had fewer errors and perhaps that makes sense because they were given specific knowledge for what they were prepared to do. And they also were better prepared for their current assignment. In other words, they had less difficulty. And again, that went specifically to their assignment. Yet the core knowledge was valuable, too, because it helped them to function better as a team. We did find functioning as a team to be significantly related to those making fewer errors and being more comfortable with their current assignment. That's a very big key competence, and that's provided by the core knowledge. They were also more prepared to teach their clients with core knowledge. So what we have recommended as a best practice from that bit of
knowledge is that a transition program is probably best with core knowledge, but also with some specific knowledge.

Now placement of the transition program. It could be before or after graduation, pre-hire or post-hire, pre-licensure or post-licensure. When the transition program was given after graduation, or pre- -- no, just after graduation, they had significantly fewer errors and they were better prepared for their current assignment. Now that's not to say that you shouldn't have a transition program in the education program, but it is something to look at that after graduation there should be some transition post-hire program, and I do believe there are some people here from Kentucky, so they do have in their law now a required post-graduation, before they can get their nursing license, transition program that will be started as of January 1, 2006. All of the new graduates will have to have 120 clock hours of direct supervision with a licensed nurse before they can become licensed. And along with this, within six months they have to pass the NCLEX and have certified that they have these 120 hours. They also, in Kentucky, in their education program, have to have a transition program of also 120 hours before they graduate. And that has been in place since 2004. But this new post-graduation, pre-licensure program is the first of its kind in the nation and may be something that boards in the future will be looking at. Now to my knowledge, and
maybe we can talk about this afterwards with questions, I don't think there are any specific criteria for this program, except that it has to be 120 hours and that they would work with an RN, and in the future, you know, maybe we could develop some -- some specific criteria also.

Another one of the models that came out, and this was a mandatory versus a voluntary program. There were mixed results with these, with people who were in mandatory programs. There were more errors that were made. However, with the voluntary program, the new nurses felt that they were less prepared to administer medications. It very well could be that with the mandatory program, they had more experiences than they did with the voluntary program; therefore, they didn't, in the voluntary program, even have the chance to have an error because they didn't have as many experiences. But for the time being, we don't -- we aren't recommending anything for that.

However, probably the highest recommendation that we have is using the same mentor with the same schedule in the transition program. And we looked at this by looking at a sum score of all of the competencies. I believe there are eleven that they reported feeling prepared to do; feeling prepared to work within a team, to supervise people under them. Many different areas. And the sum score was very highly significant with when they had the same mentor with
the same schedule, so we definitely would recommend that. And we translated that as to feeling more competent because if the nurses felt so prepared for all of these different areas they felt more competent. And one of the things we found in the literature when we wrote a white paper recently on pre-licensure requirements of clinical, is that competence comes out very strongly when students receive good clinical experiences. So again, we highly recommend that your program use the same mentor with the same schedule.

Now for regulators, one of the things that we're looking at at the National Council is aspects to include in educational programs. As all of you know, the regulators approve the education programs and of what they approve, they have asked us to look at the data or the evidence behind some of the areas that they recommend. So for this point in time, and we are still looking at this and some ongoing research, we have found these to come out as being important to include in programs: Making decisions, that the new nurse, or that the nurses in programs provide direct care to two clients; knowing when and how to call the physician and working effectively within the health care team. Both of those came out very strongly, and they are also part of the IOM recommendations and as you saw, part of ACGME's recommendations. And then supervising care. Many of our studies or other studies have shown that new nurses are not
educated to know how to delegate or supervise care with either a nursing assistant personnel or LPNs. So at this point in time, these five come out loud and clear. However, as I said, we are continuing to look at this and we're hoping by the end of next year in about June to come out with something even more definitive than this.

Now Drs. Crawford and Smith also looked at some employer research and I think it's kind of interesting to see the difference of what employers say to what the new graduates say. And as you can see, there were 1,100 employer responses and only 41.9% said that the new nurses provide safe and effective care. And again, this study was done in 2003. They said that their programs lasted 6.7 weeks in length, their orientation programs. Remember, the new grad said it was eight days. So I have a feeling some of this comes from being there and therefore, they needed to use them to work.

The long-term care transition seemed to offer the least, both in terms of length and in terms of quality, and the quality is translated as customizing the program to the new nurses' individual needs and you saw that. Some of that is very important when we looked at some of the specialties. The employers rated these as the highest competencies that they would like to see in nurses, and critical thinking or clinical decision-making comes out on
top, and I think that we can all agree with that. And therapeutic relationships. It sounds like a very reasonable list. And it's interesting to compare that -- later on we'll compare that to what the new graduates say, and you can see the difference between the employers and the new graduates.

In Spring 2003, Drs. Crawford and Smith specifically addressed transition, and they looked at the different kinds of transition programs that were offered, both in terms of type and design. We have now about 62% of the educational programs doing preceptorships with their transition programs and you can see over 50% have a standardized transition, which is very good.

Now you can see in that study they ask the same question that they asked the employers: What are the most important competencies that you use in your clinical setting? And you can see that critical thinking and clinical decision-making, and I'm so glad to see that students see that on top. However, it's interesting then to go down the list. Remember, the employer said therapeutic relationships second, which again, goes across all that communication, interdisciplinary communication, which we know to be so important. And they say medication administration. And they see psychomotor as number three, whereas, if you remember, the employers had that way down as number five. So I think that that probably makes sense when a new nurse comes out,
they're nervous about getting things done. And we, as their supervisors or educators, really need to be sure that they have those mentor programs in place to be able to be precepted.

Now the future, now that we have Dr. Li and Dr. Kenward with us, we had kind of a layover time where we didn't have anybody and our research kind of languished for a bit but now we're getting up and started again. We are continuing to collaborate with the Vermont Nursing Internship Program ("VNIP") and I do believe Susan Boyer is here. And she will be talking about that later today. And this is a wonderful program that I would like to see some other states starting. It is talking about transition across practice, education, and regulation. And we so much need to do this. As David said, we need to collaborate between professions. We so need to collaborate within professions. And I see that as a program there. Dr. June Smith, who left the National Council and went to the University of Nebraska and she had done a lot of work on transition and they in Nebraska now are thinking of starting a program similar to Susan Boyer's. So I see some of these programs maybe beginning in the rest of the nation.

In the winter Drs. Kenward and Li will be doing an outcome study, working with the VNIP doing -- looking at outcomes. They're looking at nurse retention so we'll be
looking at some of the outcomes, and I know your first question is, what are the outcomes you're going to be looking at? We haven't quite got that down yet, but we will. That really is the hardest part, I think.

There is some HRSA work going on that Susan Boyer is probably more familiar with than I am. Looking at outcomes of all of the residency programs in the nation. I'm familiar with AACN’s but there are some other nurse residency programs and those are very interesting to us, because certainly, the research is very strong that those programs need to exist.

Besides the outcomes in Vermont, we are going to be doing a pre and post study before the application of the implementation of the Kentucky law and then post and see again, looking at outcomes, to see if we can find any differences and we certainly, you know, are anticipating those results.

We will be studying or developing a model on transition programs and I see this as being an evolving model as we get more and more data, but that should be coming out next August at our annual meeting.

Kind of hand in hand with this transition research, we are also looking at quality indicators of nursing education programs and we're looking at that so that, again, the boards can have some evidence to base some of
their approval criteria on. For that we are looking at some of these nurse competencies and again we're trying to validate what the best ones are and then we will relate that back to the nursing program where those nurses graduated and those who are the better prepared to see how the nursing program teaches those kinds of competencies for the nurses. So I think that should be really exciting. We are getting the results in now. Suling has just gotten through looking at the nurses. We have to get through the program. We're doing this work with our Practice Regulation Education Committee. They're coming in this week. Barbara Knopp is going to be joining us from North Carolina, and then in January we'll have the results all ready. We're going to be calling a roundtable of the nursing education experts from around the nation, certainly AACN, NLN, Nuadin, the organization, as well as other nursing experts. A roundtable of about 16 or so, plus our committee. And we're going to put these on the table and we're going to have reactions to them, and also maybe some insight into how we can interpret some of these results, because we are just really highly motivated that we have to collaborate within nursing better. And then these results will be available for our delegate assembly meeting next year. And again, this is going to be something that will be evolving.

The art of progress is to preserve order amid
change and to preserve change amid order. And when David talked about that thread, I thought about that. As we're changing, we still have to maintain the order, but then, we can't forget to change. Thank you very much.

POLLY JOHNSON: Are there any questions that you might have?

BERNADETTE SUTHERLAND: Bernadette Sutherland. I'm Bernie Sutherland from the Kentucky Board of Nursing and I just let you know that the resource -- we've recently added to the Board of Nursing website the model of information for our clinical internship, the 120 hour program. We've put on there a lot of questions and answers to help guide individuals in their understanding of that, and it's really a work in progress, as well. But it's currently there for your availability.

PATRICIA BENNER: Can I give us just a little on the definition. It's Patricia Benner. I do think it's really important to separate out discovery because the front line defense of the patient is the nurse who discovers the error. I don't know how you can tease out others being involved because others will always be involved. But I think you can tease that out, and I think that the separation is really about discovery and prevention of errors, which is the front line central nursing role.

NANCY SPECTOR: Right, right. Thank you.
Mary Lynn, RN, PhD, Associate Professor
UNC-Chapel Hill

"Measuring the Impact of a Multi-State Transition Program for New RNs"

GAIL MAZZOCCO: We'll start by introducing Mary Lynn. Dr. Lynn is an associate professor at the School of Nursing at UNC-Chapel Hill. She attended the University of Florida, which she tells us about a great deal, where she earned a BSN and a Master of Nursing degree and she earned a PhD in psychometrics from the College of Education, also at Florida.

The reason that Mary is here, and certainly some of the data she is going to talk about, is built upon the fact that she is interested in the development of measurement tools around a variety of things having to do with patient care. She is the evaluation and analysis consultant for the University Health Consortium AACN Nurse Residency Program. I can also attest to the fact that Mary is a wonderful mentor.

When I first came to Chapel Hill, it was Mary who said to me, "Okay, now what do you need to know to get through the day?" And I can assure you there wasn't another soul that asked me that question. And she was most helpful in that regard. We are delighted to have Mary with us today to share her perspectives on measuring the outcomes on transition programs for new nurses.

MARY LYNN: A caveat that I have to say at the
very beginning and it is certainly a misnomer from the title, which was given to me, is that while I'm involved with the program I cannot specifically talk about the program and as you'll see, that's basically the nature of contracts. But I can certainly point out to you the two principles involved in the program. Polly Bednash, who is the Executive Director of the American Association of Colleges of Nursing, ("AACN"), and Kathy Krsek, who is the manager for this project at the University Health System Consortium and she's involved in other things there. I remember her talking about early on, this was a very small part of her actual job responsibilities, but a major amount of her time. It has grown in the amount of both of those things over the time because the project now has 28 hospitals involved in it and is growing by several institutions each year. So if you don't have a chance to hear anything from them, please, if you have any questions about their residency programs, try to collar either one of them during one of the breaks or at some other point in time. I'm not really here to talk about the nuts and bolts of all of this, although, truthfully, I'm gonna talk about a lot of nuts and bolts. But I am here principally to talk about issues related to measuring the impact of a multi-site program.

These issues are gonna fall in four areas; implementation, data collection, selecting measures, and
analysis. If I talk only about measurement issues, I would really be precluding a lot of very important pieces that fit in it and that would be a shame. I should say at the very beginning I'm assuming a more quantitative approach to looking at this -- a residency program than a qualitative approach, so for those of you, and at this moment Pat Benner doesn't appear to be here which is a really mighty good thing. Oh, she's moved! She'll tell you the other side at some later point.

When you have multi-site programs and multi-site can literally be even within the same system, but across institution are truthfully, within the same hospital and across units, because as you know, units have different personalities, different staff, and different methods of implementing certain things. It offers the possibility of great discrepancies across sites. There's a constant and consistent need for people to be checking in, so I've got a little Southern "Hey, what 'ya doing?" but truthfully, it is very important that somebody has the responsibility for checking in with all individuals involved in the program on a very regular basis specifically to say, "Hey, what 'ya doing?" 'cause sometimes you'll find out what they do and it's not what you thought they were doing. And when you involve people in these kind of programs from the institutional level, you generally get people who are the
most enthusiastic or the most assigned to do this. And the most enthusiastic comes to this assignment where some want to actually do things on their own. And that's not a bad thing, but it's a thing that needs to be controlled, because truthfully, when you're implementing multi-site program, you want all sites to be getting the same program, as opposed to sites differing in program. Obviously, the people who are implementing the program need a tremendous amount of resources, because they're in uncharted waters. We don't know what a residency program is in nursing, really. Everybody who is doing this is making this up from ground zero, trying to figure out what's needed. And you'll hear residency programs that range from two weeks to two years, and there's a big gap, but most of them are on the two-week end, as opposed to on the two-year end.

When you look at data collection issues, the one issue about data collection that's probably gonna get you first is, is it research? And this is Why do you ask that question? because one of these will be involved with you. If you're at an institution that receives any form of federal money, and most institutions in this country receive some form of federal money, then you have to assure that an IRB reviews anything that is considered research.

Now when it's considered research, there are two essential ingredients. I speak on this time from my hat as
an IRB chair, in that there are two essential ingredients. There must be human subjects. We consider most residents to be human. And second piece is that it must be intended to develop generalizable knowledge. Now what does that mean? That's always the hard test to try to figure out what that means. We can say sometimes, Does that mean you intend to publish it? But the truth is that do you think that you're adding to knowledge in the area, whether you publish it or not? And if so, and IRB must review the research. Immediately, that means all the people who are your residents are voluntary participants in your study. They do not have to do -- They have to do the residency program because they enrolled in it, but they don't have to take any of the data collection tools. And they can drop out of the residency program, which they could do anyhow. Contracts aside, they can leave the program if they choose to do so. It obviously creates tremendous possibilities for missing data. And that is a problem in evaluating any residency program is you have a lot of problems with missing data. Because you must tell them that you have the right to withdraw at any time or choose not to answer any question you don't choose to answer.

Now there are ways to mitigate that by, if you do it online, is to not allow them to submit their instrument without answering every question. But you can't be assured that the ones that they didn't want to answer, they answered
honestly. And so that's a real question. Obviously, if it is not research, you don't have an IRB, and in fact, what you can do is insist that they participate in the data collection as a portion of being in the residency, but that needs to be an agreement up front and can't be implied later. I have noticed that some programs, even in this state, will tell students who are in a certain program that all of a sudden some data collection comes up there. They've come from the university down there, so they're saying, I don't have to do this; this is voluntary. But the truth is it's not voluntary if it's a condition of employment. So that's different.

There is still a possibility of missing data, even if it's not research. You can mitigate it in the same ways. But truthfully, you might encounter problems if you ever want to publish something that doesn't have IRB review. Now I'm not saying that all journal editors are right in doing this but they more or less now insist on everything as having had IRB review, whether it was warranted or not. So it is an issue that most every editor will insist that you have, IRB review of a study, whether or not it was actually required in your particular circumstance.

How often do you collect data? This is always an issue, because at a minimum you are obviously gonna collect it before and after. I mean, this is certainly your minimum, but the graduate is in turmoil for potentially
years. And so you don't really know a) how long your program is gonna run, but b) how long do you collect data, because you might try to collect data beyond the length of your program. But at a minimum, you at least need to consider pre and post and maybe some interim measurement. Now if your program is a month long, don't bother the interim measurement, because your person hasn't even gotten through knowing where the restrooms are and how to get to the cafeteria, so I would suggest no interim measures. But one of the -- one of the problems that you must remember is that the more you measure them, the more likely they are to drop out. Not only the length of the measurement but the more often you measure them, the more likely you are to actually lose them. That doesn't mean you can't build in rewards. You can. You can build in rewards for people participating. Now that needs to be part of your IRB application, if it's an IRB study, or it needs to be a modification of some of the IRB, but you can do anything that is reasonable. The IRB will require you to -- will allow you to pay them differentials if you want to do so for their participation. To give them some form of other incentive, to give them -- people are actually motivated at times by small little token treats. They'll say, If you do this, you're gonna get this small thing, and this week is a squeeze ball and next week it's a first-aid kit or whatever. I call this the K-Mart
method of data collection, and I've used this in many of my studies.

When actually you're looking at selecting measures to be used, one of your first questions has got to be, Has it ever been used with this level nurse? There are virtually no tools that have been designed to be used for new graduates. There are a few, but not very many. It's kind of like the old psychology problem where most of the tools were developed, basically, using undergraduate psychology majors and then they tried to apply them to real adults, and they found that they didn't always work. But some other questions we're gonna have to talk about is What do you know about its quality? What does it really measure? And what is it that you want to measure? When you talk about has it been used with this level nurse, again, few scales have been used with new graduates. But the other issue is that a lot of the items and factors on scales to be used with practicing nurses have items or factors that do not relate to new graduates. As you siphon the list of what new graduates are wanting to learn, psychomotor skills, where is that on the job satisfaction measure? Where is my ability to manipulate an IV on my competence scale? It's not there. And the kind of things that they're principally concerned with are not the things that we're often measuring.

The other thing is that new graduates, when
encountering scales that have little or no relevance to their particular position, don't -- aren't inclined to fill them out. I learned this lesson kind of backwards in many cases of my life, and I'll make a short story, knowing that we only have so much time. In my previous life, before being here -- Well, I've actually had lots of previous lives before being here. In all of them I was alive and awake through. I'm not really talking about, you know, the life I was a cockroach and in the next one as a ... When I was teaching at the University of Mississippi, I sat in my office and helped many a masters student design a thesis study. They didn't have a doctoral program at the time and they would do their study and they would get results they expected or didn't, and I didn't think much about it because, you know, you always said oh, a small sample or homogeneous sample or something. And the next life I went to the University of Arizona to do a post-doc and I was in a class on theory and I misheard the assignment that the students were to do and they were to deductively do something. And I thought they said inductively do something, and so I went out to inductively do something. My background was as a pediatric nurse and I had an observation that I had made many times over that families of children with catastrophic or chronic illnesses handled the diseases so differently and it was actually unrelated to the diagnosis or the seriousness of the diagnosis. And I
wanted to see if I couldn't figure that out. So I went and interviewed children and their parents in the oncology clinic. And without belaboring all the details of that story, I kind of went into that interview experience, not being a qualitative researcher, with a whole list of questions that I -- actually, a whole model that I thought explained it. I was pretty sure it was the child's developmental stage and the family structure and that the economic -- you know, this is the kind of thing I did in my office with the master students. And the truth is that didn't have anything to do with what was going on. What had to do with what was going on was how much -- to what extent the family normalized the situation. The children -- The two contrasting situations are, a mother in her arms with about a three-year-old who, in my nursing observation, was going to die within the next few days, was certainly in a horrible situation and that mother couldn't have been more telling about how each time she came to the hospital, the role-playing they did before they came and how the things that they did with spinal taps and they would do it on the doll and they would say why it's important that the doll hold still. And they would have a pin and when the doll moved it would make marks all over the pin so they would understand -- the child would begin to understand that moving was gonna be a problem. And there were rewards the child would get.
Fast forward a few days to interviewing a woman who had about an 11-year-old son who had had leukemia and he'd been in remission for five or six years and I started off the interview with, Can you tell me what was your experiences when you first found out that Bobby had leukemia? And she said, Oh, just excuse me. And then, Bobby, could you go get me...whatever, and (whispering) We never mention leukemia in front of Bobby. And I'm thinking, My God, what lack of normalization did they make, 'cause he's fine. I mean, he was absolutely fine and she can't talk about it and they can't talk about it with him. Yet this other mother could talk about anything and they handled the situations so well, yet her child would die very soon. And, in fact, did die.

Normalization of the process of the illness is what made a difference. Child developmental stage didn't matter. Family dynamics didn't matter. Socioeconomic status didn't matter. It was a very telling experience to me that you really have to know what you're measuring and know how it fits with what you're doing, because you can design -- you can design a million studies and they're gonna miss the mark and you're never gonna know why. And you're never gonna know why 'cause you didn't measure the things that really mattered in the situation.

What do you know about an instrument's quality?
Here is our -- I am an academic; here's the sermon. You're gonna get this piece. Now we're gonna get to my next slide. You know, sooner or later you always discover in a presentation the misspelled word that it didn't pick up, so there is no "Te-rest" reliability. I just thought I'd -- I just thought I'd point that out, in case you had a question.

On the other hand, the way you get to write a new statistics book is invent some new terminology. So I might have a new book on measurement with te-rest reliability, which is a new form of dinosaur. You know, the te-rest? Anyhow, this is a brief overview, but I'm gonna hopefully tell you something in the next few minutes that you actually don't know, and -- or maybe two things you don't know. These are the standard forms of reliability and validity, internal consistency, te-rest, or better known as test-retest. The validity is content, criterion-related, and construct. When we look at reliability, at a minimum -- you still have te-rest here -- you should know at one of the other of these about every instrument you use to know about its quality. You should know about internal consistency, if it's a tool, it's amenable to that. Or test-retest, if that's appropriate, and if you're doing longitudinal research, you must know about test-retest, because the whole issue is how does this scale ferry over time.

When you look at validity, you really need to
know two things; content validity and construct validity. Now let me just back out to say, content validity is that the items on whatever measure that you're using, in fact, can be judged by experts to belonging to the domain and being comprehensive of the domain that you want to measure. But construct validity is the case in which the instrument has been tested, to say does it work like it's supposed to work? Does it co-vary with things it's supposed to relate to? Does it not relate to things it's not supposed to relate to? I've published more than one article in Nursing Research and Heart and Lung and a few others over time about the extent to which people do any of these in the new instruments they publish in the literature. And I can tell you it's less than a third of the instruments that you're using that have any of this information available or even with the assessments done on them.

So if you only had to know one parameter, which one would you really want to know? Would you really want to know about reliability or validity? Now this is -- You can just answer it to yourself. Don't raise your hand. Don't tell me what you want to know. But I'll tell you that my answer is validity. And your answer could be either one, and I will say to you and stand here and contend that you cannot prove me wrong, that any instrument that is truly valid will always be reliable. But it is not true that an instrument
that's reliable has anything to do with its validity. Again, the example that I use in teaching this course is Polly, would you please go out and find out how satisfied the workers are at the main desk? And she comes back and says, Five foot six inches. I say, Polly, let me just ask you again. Could you go out and find out how satisfied the workers are at the front desk, and she goes back and says, Five foot six inches. She's 100 percent reliable. But she's bonkers! She doesn't have a clue what she's measuring. Now I am making my case, and then I say to you which one do you see all the time in the literature, or which is the one you even focus on when you look for an instrument to decide if it's a good instrument? Reliability. And you're off the mark. Reliability is what you do. Why do you focus on that? Because it's available. It's easy to do. It's easy to find. There's the number, and you read the validity part and you don't even know what they're talking about. So do you see now the error of your ways? If you only had to know one thing, focus on validity, and if they don't tell you about the validity of a tool, don't use it. Because you truthfully know nothing about it.

The statement that you see, you should never trust, is "The reliability and validity have been well established." This infers that if you are up on things, you would already know about it. Or you should trust me, the
author, because I know about it, and most of the time it doesn't refer to anything meaningful. And I teach a course in a doctoral program at UNC Chapel Hill and one of the assignments that the students have is to take an instrument they care about, find its original development work, and then follow it through published uses in the literature. And they have to find out about its original reliability and validity and lots of other things. And you'd be amazed, that I would say in any class of ten to fourteen students, maybe one has an instrument that has any validity work done on it. And they're using commonly used, well publicized and well used instruments. Gold standards in many of the fields. This sermon has ended. But you are a new person.

When you select a measure, when you talk about the measure, you need to ask what does it really measure? The labels on instruments are provided by mere mortals. You pick up a tool that's a measure of satisfaction, it could be a measure of compliance and could be a measure of docility. It could be a measure of hostility. It could be a measure of anything. Some labels are applied by the match of the items to some theory, and some are the best thoughts at the moment, which would be the truth in terms of the labels.

The situation worsens when we talk about subscales or factors with an instrument. You'll find most instruments have been either somebody sat down on an
armchair, called it armchair factor analysis, and they determined that these items belong on this factor and these items belong on this factor and these items belong on this factor, and the truth is that there's no empirical support to that. But again, once they've determined whether they got the items through armchair factor analysis or real factor analysis, they stick labels on each of the factors. And then the question is what does this factor really measure? In a second I'll answer the question of why should you avoid the tendency to use a subscale out of an instrument.

So here's an instrument, bunch of items, the blue on the right. Excuse me, blue on the left is a collection of items. This magic box, the factor analysis, which is a magic box made up of matrix algebra and people in Switzerland who have nothing better to do than to invent the formulas. This is my theory of where all statistical formulas came from was Switzerland, because it's really cold there in the winter and they have nothing to do, so they sat there and made up formulas. But anyhow. Your subject your items to this black box of factor analysis and out of it comes three factors. You come along and you say, By God, I think I have a competence factor, a satisfaction factor, and a giver of quality care, which is the only name I could come up with at that moment. And the truth is that this is a mere mortal who has a vested interest in how they name those
factors and they put the names on the factors and then you come along and say, Oh, my God, here is the perfect tool; I'm doing this study where I need to know about competence, satisfaction, and givers of quality care. And you suck up that tool and use it. Now those labels have no more meaning than my middle name, which many people thought for years was Rasputin, because I told them it was. But it's not! My mother, who is now dead, will tell you it's not Rasputin. But I didn't like my middle name and it was an "R" and I said it was Rasputin. Those labels are no more meaningful than my middle name having been Rasputin, because an instrument in its development has content validity done on the whole set of items. These items hang together as a set of X. Factor analysis redivides them into factors that a mortal sticks a label on. Those items were never validated as items of competence. Those items were never validated as items of satisfaction. Those items were never validated as this giver of quality care. Those are mortal labels stuck on those factors for convenience of the person who needed to do something. And just to give you an idea, some of them are theory. One time I was doing factor analysis on an instrument and someone said -- a psych-tech person, I love talking to psych-tech people to help you think up names for things, because my statement is they never listen to what you're really saying anyhow. They're trying to figure out
what the undercurrent of it is. So I might say, Well, here are the items on this factor, and she says, Well, it sounds like Rogers to me. And I said, Oh, my God, don't tell me I have a Martha Rogers factor in my scale. She said, Carl Rogers, positive regard here. So anyhow. The reason that you don't come along and snatch those satisfaction items out as a satisfaction measure is who knows if they are a satisfaction measure or not? It's a label somebody stuck on there. It's never been tested to be a measure of satisfaction.

Now if somebody takes the next step, takes each of those factors and tries to validate what they work with that they're supposed to work with and what they don't work with they're supposed to work with, then fine. But it happens all the time. You'll see major large nationally funded studies, million bucks or more, where people do this all the time. So I'm not saying it's not done. I'm just saying I've made you a new person now on two counts, this being the second of them.

Okay. You need to be informed, therefore, and have compelling information about content validity, construct validity. But the second pieces are the intended participants of the instrument. An instrument's validity is a property that carries with it as long as it's used for the purpose and with the participants it was intended to be used
with. So you develop a scale on retiring nurses and you use it with new graduates, it's an inappropriate use. The validity doesn't carry. You -- It's a scale that measures satisfaction, but you think well, you think it works with institutional commitment so you'll use it. It doesn't work. The validity doesn't carry with it -- so you need to have, and obviously, the purpose for which it was developed. You need to have compelling evidence for #1 and #2 and then you need to be consistent with #3 and #4 in your use of an instrument.

What do you want it to measure? What is the match of this instrument with the objectives of your particular program? Why was your program created? Was your program created to impact on competence, satisfaction, and whatever, or were you just trying to hang onto the graduates that are employed at your institution? If the purpose of your residency program is to hang onto the graduates, your outcome is hanging on or not hanging on. That's all. That you have retention or turnover. It is not anything else. And the more you add into it, the more complications you create for yourself. So what is the purpose of your actual program? What do you hope to have an impact upon, and who's paying? 'Cause it's a real consideration. If you want to do a complicated study with multiple measures and complicated methods of data collection, you need somebody with a deep
pocket to be putting money into that, and most single institutions don't have an opportunity, and when you bring in multiple institutions, it does require some form of funding.

Selecting the actual measures. The more you measure, the more scale that you look at, the more participants you will need to have. So you decide we want to use these five scales that have, each of them, three subscales. So that's 15 measures. Then you got a bunch of demographic data and a few other things and you're already looking at a minimum of two or three hundred individuals that you need to do this. Now you can find a quotation for any subject variable to subject number of ratio you want. I can find you one for one to three, one to five, one to ten, and one to twenty. So tell me what you want and I can find them, but what the world agree is that for every variable you have in your study, you should have at least ten participants. Now it doesn't mean -- I've been asked this question before: So if I have gender in there and it says male and female, do I have to have ten males? No. That's not what it means. What it means is that if you have five scales, that each have three subscales, that's 15 variables. And let's say you have ten demographic variables. So you have 25 variables. You need to have at least 250 people in your data to be looking at that analysis. And most institutions aren't gonna have nearly that. Even with two institutions aren't gonna have
250 residents to look at your data, so pare back on what you're measuring because the truth is that you definitely can and we almost always over-measure. We rarely under-measure.

The truth when looking at actual measurements is there are very few good measures. Now my students will always say to me, Did you say it was okay for me to do this scale because you knew it was really bad? And I say, No, most scales are really bad. The question is What's the best bad one you can get, because that's the one you need. Every scale is missing in some regard, and there's no perfect scale. But the question is you need to know the weaknesses of the scale before you enter the study.

Don't get so frustrated you just pick one, or worse than that, select it because it's the only one somebody sitting at the table knows about. Because that is a bad idea. You may need to resort to developing your own or having someone do it for you. And now that your eyes are just rolling to the back of your head, let me suggest that in the absence of a really good measure, you're truthfully better off asking a single question, with bipolar answers, something like this, Rate your competence on the following scale from totally incompetent to totally competent. You're, truthfully, better off asking a single question like that than using a lousy scale to measure variable competence.

When you look at analysis considerations, I
mentioned earlier that site can be a variable that needs to be, quote, controlled for, in terms of differences of implementation. There are many things contained within site. The enthusiasm and knowledge of the program or faculty coordinators. If you have, let's say, five sites involved, I can guarantee one of those people doesn't want to be doing their job related to that particular issue. And one of them is so over-zealous you can just hardly keep them down on the ground to keep them doing their work, and the other three are average people. But in any size group, you're gonna have every range of the type of individuals putting it in. You're obviously gonna have different degrees of implementation. Some people will do everything you tell them to do, and some will say, I like A and C and L, and those are the things we're gonna do here. I don't think, since these are not in priority order, I probably shouldn't have put this third. It probably should be first, if it was priority order. The priority that the institution places on this program is probably one of the principal issues that relate to site. Obviously, the resources of the institution and finally, the diversity of the new graduates, because depending on the institutions you have involved in a program, some institutions have nothing but blond 22-year-olds, male or female, who are being hired into the institution and some people have a tremendous amount of second-degree individuals,
older individuals, ethnically diverse individuals, etc. It depends on where you are. And site is a variable that contains all of that information.

You need good participation in any evaluation. There's no way that you can possibly do data analysis without good participation. Those who participate need to provide complete data. Reward the heck out of them. I'm just telling you, if you want complete data, do everything you can to do it. You must look at the reliability of any instruments used in your particular application. And I didn't mention it earlier. I did mention it about validity. Reliability and validity do not behave the same in uses of instruments. The validity of an instrument carries with it, as long as it's used for the participants it was designed to be used for and for the purpose, but the reliability tool is not a property of the tool and varies highly from one application to another application. Had an experience with a student at Mississippi again, who had a scale that had been used nationally, six factors. I insisted she do the reliability. Three of them not only had poor reliabilities, but they were down in like the .2s and .3s. We could have navel-gazed for a millennium trying to figure out why those were so low, but the truth is that those data could not be used because the scale was not reliable. Reliability has to be assessed every time it's used because it is -- it varies
based on -- this is the -- it's a mini-lecture, basis on the homogenative sample to be used. It doesn't make sense to you, but the more homogeneous a sample is, the lower the reliability will be. And that goes back into its genuine definition. And in Mississippi they are homogeneous, I must say, to you. Fifty percent of the incoming nursing class came into nursing to marry doctors. Okay. And you just want to say, Marry the janitor. Please don't marry a doctor. The quality and inferences of the results that you have can never exceed the quality of the measurements that you've used. Period.

The more complicated the analysis, again, the more participants you need. And the issues with new graduates, retention, satisfaction, competence, and other issues are extraordinarily complex. Measuring any of these is -- I would consider a life work for any of you. Want a dissertation idea? There's one for you.

That's my sermon as I intended to present it. I think I've gotten us back on time. So we have two minutes for questions, if there are any. Or just sarcasm, which I'm full of. That will be your alternative. Are there any questions? Did you want to ask Polly or Kathy any questions?

POLLY BEDNASH: You understand why we hired Mary Lynn. She's very competent and also she's a delightful person to work with. And Kathy and I do have the privilege
of working as part of the leadership team on this project, which began five years ago. Does have 28 sites. It's a very complex program, a year-long formal curriculum, which has had an ongoing evaluation program imbedded in it all along the way. Our accreditation arm, the Commission on Collegiate Nursing Education, is in the process of working with people from the University Health System Consortium and our member education institutions to develop an accreditation process and we expect that's going to be done within the next six months, don't you expect, Kathy? That will be in place and so these will be formally accredited. There's a great deal of investment on the part of the clinical partners here. They are paying these individuals full salary and they are seeing some spectacular outcomes, which are very different than the outcomes we saw reported earlier today. So I'll be interested and delighted in the conversation and the exchange about these internships. We also are pleased that Mary Lynn did work also with Kathy with the Division of Nursing on a model for evaluation of the (inaudible) funded regimen, the internship program. They believe that what we've done sets the model and those conversations continue. We are looking to try and focus on some of the more complex issues. I understand sometimes that it's difficult to find where you want to land about looking for the right measure, but we are interested in thinking in a more complex way about the
quality of the outcomes and rather than focus on some of the simpler, either cognitive or psychomotor kinds of outcomes, we're trying to think about creating a learned professional who can continue that learning process and be incorporated into an array of professional values and we think we're getting there.

CATHLEEN KRSEK: Well, Polly really said it all. We're very proud of our program. As she said, we have been 28 academic medical centers across the country and I'm happy to talk to any of you about it throughout the day.
POLLY JOHNSON: Thank you, Mary Lynn, you did a great job. The next group of presenters is presenting different models of transition to practice programs. The first presenter is Anne Coghlan, who is my counterpart at the Ontario College of Nursing. She's going to be talking about a voluntary transition program, a bridge to practice, which just basically created because of the huge number of foreign educated nurses moving into the province and how do we do that, which is a global issue that all of us across this country and worldwide are struggling with. Susan Boyer will be talking about the Vermont Nursing Internship Program that you've heard referenced this morning. And Dianne Marshburn will be talking about the program that's here in North Carolina, at Pitt County. So, Anne, thank you for coming.
ANNE COGHLAN: Thanks very much, Polly. I'm very relieved with the introduction that Polly gave because I am not an expert in competence, but certainly, it is an issue that, as a regulatory body, we deal with every day. And many of the topics that you're discussing today are ones that are near and dear to discussions that we've been having in our jurisdiction.

Certainly, transition to nursing practice is a concern for those who have just completed their basic nursing education and are entering into the practice of their chosen professions for the very first time. But it's also very much a concern for those who are transitioning from the practice of nursing in another country and eager to practice their chosen profession in North America. As Polly indicated, my presentation will highlight the developments, key features, and outcome of a transition program for internationally educated nurses. From the view of a regulatory body, this program, which we affectionately refer to as CARE, Creating Access to Regulated Employment for nurses, is an example of a successful approach to assuring the competency of nurses new to practice in Ontario. And as I was reviewing my notes this morning, I had indicated that this was an example of a
successful approach to improving the competency of nurses, but that's really not the case. It really is ensuring that nurses who are competent to practice and have demonstrated all that already in their original country of practice, can transfer those competencies to new practice.

So to set the context a little bit, the College of Nurses of Ontario is a regulatory body for 140,000 registered nurses and registered practical nurses and that is the title we use that would be synonymous with licensed practical nurses. We set the standards and identify competencies upon which educational programs in Ontario are based. And you'll see on the slides some of the registration requirements.

The issue for internationally educated nurses is that they generally meet all but one requirement and are what we call exam eligible, but find it very difficult to be successful on the exam. In 1999 31.9% of internationally educated nurses who wrote the national exam in an effort to become registered in our province actually passed the exam. It was an issue of concern for a number of stakeholders, including the College of Nurses as the regulator. And at that time there were very limited options available to refer applicants for assistance. A group of dedicated stakeholders came together in the late '90s to explore options for assisting these internationally educated nurses to
successfully secure nursing employment in Ontario. And there was a recognition that a combination of factors contributed to difficulties experienced by these nurses.

First of all, the context of practice. Understanding legal and regulatory issues is all about the public trust. And what is the public trust in the jurisdiction of Ontario? Certainly, success on the exam, but also the need for Canadian work experience and opportunities for on-site exposure to the health care system. It will be no surprise to you that sector language -- sector specific language training was identified as an important need, as well as consistent, easily accessible information, support, which I'll talk about more in a moment, time, and of course, money.

The CARE project creating access to regulated employment for nurses began in 2001 and was designed to address the specific needs of internationally educated nurses. The College of Nurses was a founding member of the advisory group. The key outcomes of the program included the hope that CARE nurses would increase their chances of success on the national nurse registration exam, that they would become registered to practice in Ontario, and that they be well prepared to join and excel in health care organizations in Ontario. Over and over again participants in this program report that the major benefits of the program is increased
confidence. So they come to Ontario thinking, I'm a registered nurse and I can easily secure employment, look after my family, perhaps send money back home, and then discover that their chosen profession is not as easy to access as they had hoped. Through the program confidence is developed, as well as competence.

Another key benefit that has been identified is the opportunity to develop insight into strength and areas for development, and we all know that many of those are context specific. I had the experience of attending the graduation, the first graduation from this program, and it was a very moving experience. Nurses from all over the world with their families, including children, grandparents, nieces, nephews, and adopted family members who had been supportive through their experience, talked about the benefits of the program. And one nurse who I particularly remember who'd been successful, had written the exam after completing the program and had become registered in Ontario, told me that she wasn't yet going into practice. And when I asked her, what she said, I am very confident in my skills as a nurse, but I need a little more work on my English. She seemed quite competent to me in speaking English. The key message for me there was that she would be ready when she had the confidence to be successful.

The program components include both required
elements and option elements. Nursing in Ontario provides the participants with an overview of professional issues, such as legal, ethical, and professional standards of nursing practice in Ontario. The clinical skills assessment, as you can imagine, provides an assessment of skills and competencies in basic nursing practice, including an overview of current technology used in health care settings and I, for one, would certainly need that if I were to go back to practice. Health assessment addresses the development of skills in making physical and psychosocial assessments across the patient life span and focuses particularly on interviewing skills, history taking, and assessment technique. Again, all things that have some context specific application.

The optional components of the program includes a five-day orientation which helps prepare -- helps students prepare a Canadian style resume and cover letter, helps them to learn job search strategies, and opportunities to meet potential employers, and practical assistance with preparing for a job interview.

The exam preparation review includes an intensive overview of nursing in Ontario. The psychosocial aspects of nursing and the nurse client relationship, again, which is very different in North American culture as compared to cultures in other parts of the world. Practice questions
and practical strategies for writing a multiple choice and short answer exam are also included in that optional component. The CPR and first-aid really is the same program that any other student would receive, but through CARE the opportunity to take that program with other internationally educated nurses at a reduced cost, is an example of an optional component that's offered.

I'm not going to go through all of these because of time, but for example, the technology optional component provides hands-on instruction, practice with IV pumps, and other common equipment. And the English communication for nurses teaches words, expressions, and provides an opportunity for nurses to practice listening, speaking, and writing, using real nursing situations. The program also includes a variety of support services. When a participant first joins CARE, the individual meets with a counselor and sets up what's known as an individualized CARE plan for success. That plan is tailored to meet different needs. The individual also has an opportunity to write a nursing readiness assessment to find any gaps in clinical knowledge. The individual receives assistance in selecting the CARE services and courses that match the gaps identified in their readiness assessment. They have an opportunity to review career goals. And very significantly, they chose a date to take the nursing registration exam. Those who offer the
program have found that setting that goal at the very beginning is a critical element.

Those who participated either in attending and graduating from the program or in offering the program are able to identify consistently the success factors that you see on the screen. First of all, the holistic approach is identified over and over again. It's not enough to focus on exam writing. The circumstances that each internationally educated nurse brings to the program is very different than what a new graduate from an Ontario program might be experiencing. As I said, they are often coming with families or have left families at home. They're in a new country. Many are working long hours to support a family. Some are dealing with very significant social issues, including domestic abuse and severe financial hardship. So the holistic approach to the program ensures that there is support for the individual as they journey through the process of becoming ready to write the exam and become registered.

The other very key success factor is the multi-partner approach. The next slides will show you who the partners are, but one that I really want to highlight is the contribution that graduates of the CARE program make. They want to give something back, and so we now have a cadre of graduates from the program who are involved as volunteers.
So the key partners include a variety of educational institutions, both university and community college. Health care organizations, both acute care and long-term care. Professional associations and the major nursing union in the province. We've had support from provincial, federal, and municipal governments. Private foundations, settlement agencies have been very interested in supporting the program and were a key founding partner and continue in a very significant way to make a contribution.

And then, of course, last, but not least, the regulatory body.

In terms of all partnership with the CARE program, the college is a major source of referral to CARE and that has really been a major boon to the staff in our organization who work in a registration area. They're delighted to be able to say with confidence, Here's where you can go for assistance. And they didn't have that option just five years ago. We are a joint participant on the advisory committees. We regularly share information around issues and barrier for internationally educated nurses, trends in the migration of nurses to Ontario, and policy development. As well as, we are beginning to partner in research development and proposal collaboration, including a recently funded study that has been funded by the Ontario government.

So in terms of key results, almost 600
internationally educated nurses have received the direct benefits of CARE since its inception in 2001. Over 80% of those participants passed the exam, and 90% of those who passed secured jobs as nurses in Ontario. Hospitals report significant rewards of this innovative partnership, and through the opportunity of a clinical placement with an employer, lifelong relationship is established and we heard from the keynote speaker this morning the importance of relationship.

Government funding was secured. It has been sustained. We now have long-term funding and that funding has also recently been enhanced with the program being replicated in another urban center in our province, and interest in several other provinces.

Certainly the -- the mentorship component of the program cannot be under-estimated. These participants, when they join CARE, establish a relationship that supports them throughout the program and what we're finding now is that that relationship supports them in practice for quite some time once they become registered and gain employment. They continue to come back because that's their support network.

From the regulator's perspective and after the previous presentation from Mary, I'm going to be very cautious in reporting statistics. While we don't track CARE participants, what we have noted is since the inception of
the program, the overall success on the registration exam has increased. So not all internationally educated nurses go through the CARE program. It is voluntary. The number of exam writes represent both first and repeat exam writes. And you'll see on this slide that there was an increase in the number of exam writes in each year, from 1999 to 2004. So 1999 we had 1,305 internationally educated nurses write the exam. In 2004, 6,081. I need to caution you that 2004 is a strange year, and the reason is that our entry to practice requirements changed, so we had a lot of second, third writes who were in a flurry to try to be successful before the educational requirement changed. So 2003 saw a small decrease in the pass rate over 2002. The -- 2004 should be treated as an anomalous year, as it's not representative of the other years under consideration, but certainly, since the inception of the program, if you look at between '99 and 2002/2003, the overall pass rate has gone up.

Another huge benefit of the program is what we find in CARE participants. They are dedicated life-long learners. And that -- that competence is critical to ongoing success in meeting accountability as a self-regulated professional and accountability for ongoing competence is something that these nurses take very seriously. And if you'd like more information, the CARE website is included in the handout. Thank you very much. We have a few minutes for
UNIDENTIFIED SPEAKER: I just want to make a comment. As an international nurse, I'm from South Africa originally, and I was recruited for a company to come and work in the United States and I'm really thankful for a program like this, because that didn't exist when I came to the United States, and I was at the pinnacle of my career in South Africa and I transitioned to the United States and I had to start from scratch. The thing that I like the most is the fact that you have a holistic approach because what happened to us as we were recruited, we received the materials to study for the entrance exam and then we were flown out here to start the entrance exam, went back home and then they work on the paperwork for the board of nursing once we were successful. Then we -- I arrived back here. I had to do a CPR class. I had to do ACLS and within two weeks I was on the job and I had to work and function as any other nurse.

So I just want to congratulate you on a wonderful program, and I hope, I'm not sure that something like this exists in this country, but I think that I know a lot of South African nurses recruited to come to work in this country and we are all across this country and I think that it would be wonderful to have a program like that that help our nurses and people who are transitioning to the United States. Thank you.
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 a 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.
Dianne Marshburn, RN, MSN, CNA, Administrator, Nursing Research and Special Projects
Pitt County Memorial Hospital
Greenville, NC

“Measuring Outcomes in Existing Transition Programs to Improve New Nurse Competency”

DIANNE MARSHBURN: My name is Dianne Marshburn, and I'm Administrator at Pitt County Memorial Hospital, which is a constituent of University Health Systems of Eastern Carolina. I certainly have had an interest (in this topic) over the years as I've worked with new graduates through their transition.

First of all, to give you a little insight about us, we are a 745-bed teaching hospital. We have a strong commitment towards education, both from organizational perspective, as well as with our nursing vision. We became a Magnet facility about a year and a half ago. We have about 1,200 nurses on staff and hire anywhere between 120 to 150 new graduates a year, so certainly, we have a strong interest and an investment in how they transition to practice. With that, I like the quote by Yogi Berra saying, "You've got to be very careful if you don't know where you're going, because you might not get there." So our transition program is designed around staff development activities. We do use the preceptor model. We call it the clinical coach model, where we take them through an extensive training as far as around teaching learning principles, and working with adult learners
and looking at using a clinical coach plan and the competency based orientation plan, which I'll get into a little bit more shortly.

Our whole framework that we use around our transition program is built around some of the work with Dorothy del Bueno and her performance based development model. We use sort of the concept of three circles and a square, where we're really looking at critical thinking skills, where we're looking at problem recognition. We're looking at risk management, differentiation of urgency and the rationale of why they're doing what they're doing.

Interpersonal skills, we feel very strong about that collaborative team building, working with others, how to work through conflict and resolving issues. And then, of course, the technical skill. Again, looking at patient safety, looking at how efficient and effectively to move forward.

The tools that we use, first of all, we do -- we use the performance based development system, and I don't know how many of you may be familiar with that system. It is Dorothy del Bueno's out of Performance Management Incorporation, where we bring our new hires in and the first week we actually sit them down and do an assessment with them. It's using vignettes. The vignettes are based on patient problems. The new nurse is shown the vignette. She is shown some patient data. It may be patient symptoms. It
could be vital signs. It could be lab values. And then the
individual, the nurse, tells us what she does, identifies
what the problem is and how she's gonna intervene. Now prior
to the implementation of this program, we implemented it back
in 2001. Prior to implementation of it, we worked very
closely with Dorothy del Bueno and her staff with the
vignettes. We came up with model answers as far as looking
at what's acceptable and what's unacceptable to practice. We
use the system not just on new nurses but also on all new
hires. So we recognize that experienced nurses come in with
a certain experience that new grads don't have. So we
develop model answers to the vignette. We took our educators
through an extensive training. It actually took about a year
to do some liability, validity testing as far as them as
raters, because they actually are the ones who review the
answers that the new grads responds to, to the vignettes. So
with that information, we individualize their orientation
plan. And again, I'll get into a little bit more specific
about the orientation plan.

The other program that we have, we call it the
Go for the Gold Program, and I'll speak to that shortly.
Cornerstone, technical skills, and then continuing ed. And
again, it's based on the staff development. I mention the
orientation and your orientation assessment and the
individualized. We have a competency based orientation plan.
It's based on four competencies. One, the unit environment, back to socialization. One about how to maintain a safe work environment. One is how to work effectively with other team members, and the fourth is around standards of care or their job description. Now the standard of care is really based on nine subsets. We look at problem recognition. We look at problem management. We look at the differentiation of urgency. We look at the rationale, as far as how they're handling that patient population. We look at communication. We look at continuity through this period of time, and then, of course, patient teaching. All of that is documented with the preceptor as part of that ongoing plan during the orientation. Now their orientation may range anywhere from eight to twelve weeks. We could extend it as long as six months. Again, it's somewhat individualized and it varies from specialty to specialty also. Our general med-surg has a little different orientation plan than our critical care unit, as well as our other specialty units.

The other component that we have built into that first eight to twelve weeks is what we call our Cornerstone Program. And that's where we have ten topics where we meet -- there's five sessions through that period of time, where we bring the group together with the whole focus around problem identification, management, and urgency. And the topics that we focus on, again, is built around del Bueno's
curriculum and we're looking at circulatory problems. We're looking at adverse reaction to medication. We're looking at changes in mental status. We're looking at chest pain. We're looking at urgency and bleeding. Again, many of the vignettes that we're using reflects back to some of these topics, as we address that.

Also, at the latter part of that day, we have what we call the Go for the Gold Program, and that's really a socialization piece of our program. Prior to the arrival of our new grads to our organization, we have what we call a new grad dinner, in which we invite them out to one of our hotels where they can meet with a preceptor, the managers, sort of get an orientation to this whole process. And we also give them a relaxation tape in preparation for them to take NCLEX, also, some resources. We have a retention coordinator on staff where we link her into the process with them.

The Go for the Gold Program, we have also five sessions where we meet with them where we have taken staff nurses, they're not preceptors or clinical coaches, but they're actually experienced staff nurses that we have taken them through extensive facilitation training. And they actually come in and work with the new grads to talk with them more from a support perspective in how to deal with difficult physicians or team members. Conflict management, juggling roles, the whole concepts of reality, shock,
transitioning, you know, from being a student to practice. They're not necessarily grouped by their specialty areas, so it gives them an opportunity to share some of the experiences. A lot of what we hear from some of this is where we'll sometimes find out what some of the issues are with the preceptors and some of the other issues that we may be able to intervene with, but again, this is a very confidential session. The facilitators at time -- there is a retention coordinator who works with our facilitators so if there are circumstances where there needs to be some intervention early on, then we try to work with that individual, that nurse, to redirect them to the retention coordinator. Again, respecting confidentiality of what they're feeling. But a lot of it is validating that it's okay to feel the way they're feeling at this point during their transition to practice.

The other component is just the technical skill itself. And again, I've spoken a little bit about the competency based orientation plan. Again, we focus during this period of time around our policies and procedures and our equipment, you know, based on the areas that they're in.

What kind of outcome measurements? I think we've struggled with this, you know, as far as ongoing monitoring. We're looking at a PBDS assessment. I mentioned earlier we give that assessment early on. We don't
anticipate new grads to do -- to come out with high success rate. We -- Those new grads who -- as well as any new hires, once they do the initial assessment, we take them through the orientation program. At the end of orientation, if they have not done well initially on their PBDS assessment, we take them back through a second assessment. At that time with the reassessment, if they do not do well at that time, we go back to the manager and to the clinical coach to talk about what has their clinical documentation, what's their clinical skills like, because we're using this as a tool. But if they're not doing well on the assessment the second go-around, then we have to readdress is this a good fit for the individual in that specific area? Do we need to extend the learning contract and extend their orientation versus their clinical experience outweighs how well they're taking the assessment test.

Our competency based orientation plan, performance appraisal, is based on our job description, both at six months and annual and then again, that's driven around our competency based orientation program. In this past year we've had the pleasure to work with AACN and UHC in the comparison study project related to the residency program. We are not a formal participant of the residency program at this point. We certainly have talked about it and have had it on the table and very interested in where that project
goes and the results of the findings of those studies as we revisit where we are and our whole transition program.

In looking at some of the results, just to kind of share with you a little bit about what we're seeing with our PBDS findings, I think, as you can see, the initial assessment on new hires, and that's new graduates. The national benchmark is around 30 percent. We're fluctuating between 25 to 30 percent with our new hires. On the reassessment, we're ranging around the 67, 68 percent. I think the national average there is somewhere between 65 and 70 percent for the new -- for the new grads. What's interesting is we have worked with this program over the years, over the past couple of years, a couple of things that we've noticed. We've noticed that new grads that comes in that tells us that they have case studies in their curriculum seem to do better over time, that there is some common trends with the specific schools that may utilize case studies as part of their curriculum development.

The other piece that we have recognized is that the students or the new grad seems to have the knowledge. It's translating it to practice and applying it to practice is where they seem to struggle. With the recognition of some of the vignettes, they seem to be able to identify what the issue might be. It's how they manage that issue is where we see some of the difficulties. And again, you know, how much
of that is realistic at this point in time versus it comes with experience.

As a participant of the UHC/AACN comparison study group, we are monitoring this past year group of new grads, have been working with Dr. Kathy Krsek very closely on our specific data because we've been working with a university in the area and looking at our data, especially around the transition the new grads experience, their satisfaction as well as the control over practice. With that we are surveying the students or the new grads, you know, at ten weeks, which is not -- it's just prior to their completion of orientation and then again at six weeks and again in a year. And just looking at some of our data, because we're very interested in what some of our staff are saying as we look at our program and trying to keep a pulse on where our new hires are at and what kinds of things that we can put in place to support them, I think when we first look, and again, this is a very small sample and it's, you know, our particular, you know, grads, you know, what they're saying as we look at their new grad experience -- when we look at the means of that graduate nurse experience survey, a couple of points that we've been looking at is what are they saying right now. And basically, at that first initial hire at ten week, they feel supported. You know, if you look at the top five things as far as around the means of what
they're saying, they feel supported. They feel that the staff is available to them. They're comfortable in asking questions, and they're excited about what they're doing. If you look at where they don't feel quite as comfortable, it's really around prioritizing, organizing, the fear of being -- providing harm to the patient, and again, they feel overwhelmed with the responsibilities.

As we look at what they're saying at six months, again, they feel supported. They feel comfortable but they continue to feel, you know, much more a higher means around that they're going to provide harm to patients, and they're comfortable. What they don't feel quite as comfortable, you begin to see a little bit about the expectations. Are they really being -- Are they being -- Are we being realistic in what we're expecting out of them? Are we providing them the feedback that they need, and the stress in their personal life. Again, this is preliminary stuff that we're looking at and what we can do differently. We are very interested to see what the AACN and the UHC findings will be across the nation as we look at where some opportunities that we have.

I'd like to end by this quote that says, "To know even one life has breathed easier because you have lived." And that's back to how can we really make a difference. Questions? Thank you very much.
Cindy Craven, RN, BSN, Director of Clinical Practice
Carole Ricker, RN, BSN, Employment Manager
High Point Regional Health System

"Expected and Achieved Outcomes in the High Point Regional Residency Program"

BRENDACLEARY: Good afternoon. I am Brenda Cleary from the North Carolina Center for Nursing. I have the real distinct pleasure of introducing two colleagues from High Point Regional Health System. The first speaker is Cindy Craven and she is the Director of Clinical Practice at High Point Regional Health System. She also oversees the graduate nurse orientation success and specialty program, one of the kind of innovation models we have here in North Carolina. She does a lot of other things that sound Magnet-like, very involved in shared governance councils, etc., and Cindy is a graduate of UNC Greensboro. Carole Ricker is the employment manager at High Point Regional Hospital, and she is, proud to say, the President-elect of the National Association of Health Care Recruiters. She also recently the national certification for recruitment. She's a graduate of the University of Maryland, and Carol, -- she's an external committee member of the Center for Nursing's Board of Directors. I am happy to bring these colleagues forward from High Point Regional Health System. Thank you.

CINDY CRAVEN: Good afternoon. I'm gonna take about fifteen minutes and tell you a little bit about our
nurses' program and then Carole is gonna talk a little bit more about the specifics of getting the folks in and what we do with them. What made us decide to look at our orientation program for our new grads was really back in 1996, '96/'96, we realized we were having to extend orientation for our graduates. And at one of our nursing leadership meetings we said, We've got to do something about this. And that was in 1997. We looked at a lot of things that were occurring, basically, our whole world was changing. Patients were much sicker than they used to be. Length of stay was going down.

We were getting more and more technology that some grads had exposure while they were in school, some did not. Our expectations for graduates, for nurses, in general, was going up, primarily because the patients were sicker and we've heard the phrase a couple times this morning, we wanted our grads to be able to hit the road running. But they just couldn't do it when they came out of school. And our peers, the nurses on the units, were expecting them to be able to hit the road running. And then, of course, we were heading into a nursing shortage. So I can never forget Martha Barnes saying, Well, do what you need to, to fix this. And that was our blessing to get started.

We really sat down and looked at why -- what were the reasons why we were having to extend our nurse orientation. And you can see the basic ones listed here. We
identified deficits, very specific deficits in basic patient care functions. There were a lot of medication administration challenges. The realities were that when you're in nursing school, you take care of one or two or possibly three patients just before graduation. And then we bring them in, put them to work, and say, here, give meds to eight patients; give meds to nine patients. And they're just kinda standing there going, I'm not sure I know how to do this. We recognize that they have an inability to care for two to three patients -- more than two and three patients. Definitely, one of the things that we were beginning to run into in the mid-'90s were the new nurses were coming out. They -- A lot of them had not ever worked in health care before, had no exposure to 3 to 11, 11 to 7, a 12-hour shift. So very hard for them to come out of orientation and then all of a sudden be working on nights. And then the last thing, again, one of the things we've heard a lot about today is the lack of critical thinking skills.

There was a group of educators and we all met together and identified all these things as issues that we wanted -- that we recognized in our graduate nurses. We realized, also, that we really had a big, big opportunity for improvement. We had a lot of staff concerns voiced. Again, going back to that why can't they do what I want them to do? I could do it in five weeks; why can't they do it in five
weeks? We also had a lot of concerns voiced by our physicians on staff. They're asking me questions and I'm not sure what they even know to be asking me this question. Phone calls from physicians who were upset in the morning because they had got, quote, unquote, a dumb question during the night. And part of it sometimes was they just were not thinking enough. They didn't have those critical thinking skills to know what to get ready before they called the physician. So we were getting physician concerns verbalized.

There were preceptor frustrations. Part of what's happened that's not included in this slide is that as we've gone through these years with our program, we recognize our precepts had to be beefed up. We heard a good talk about that before lunch, about preceptor development. We've done a lot of that and that has addressed some of the preceptor frustrations that we were hearing in the mid-'90s.

Work environment issues. Again, we heard about the socialization that new grads need. We recognize that there were some issues at our hospital that we needed to address with that. The opportunity also -- the threats to a patient's safety we see more and more focus on that and I can still remember talking to nurses who were just not thinking safety-wise. They just didn't have enough knowledge to even go that far yet. They were just trying to think of what do I need to do to stay alive today and not kill anybody, and they
were very frustrated. Very frustrated. And a lot of time -- and then they also felt like when an educator went to them at the end of their set orientation time and said, You're not ready, that just shot their confidence down even more. And so these were all things that we knew we needed to work on. And our big aha! moment was when we went back and just looking at '95 and '96, we were at that point -- Carol, you can help me -- we were, I think, at that point doing eight weeks orientation for just about everybody on med-surg. '95/'96 everybody come in and got eight weeks orientation. Went back and looked at what was our retention rate. We just looked at 18 months and we were barely keeping 48 percent of the new nurses that we were bringing in at the 18-month point, which really, we had just gotten through orientation. They were just beginning to be where we wanted them to be and they said, We're outta here. So we knew we had to do something at that point. That just sort of brought it all together for us.

A group of us met. All the staff educators that we had at that point, the nursing directors, and we went through several meetings and processes and we designed -- looked at assessment, got feedback from key stakeholders, which were our preceptors, our nursing directors, some of our physicians, and a group of us met to start developing a program. And we made sure that what we designed would
address the skill deficits, the knowledge deficits, the issues that we had identified and struggled with over the previous couple of years. We spent the fall of '97 designing the program. And we got approval, CEO approval, for it in January of '98 and our first pilot group of 70 grads started in February.

Our objectives for the GNOSIS Program were and still continue to be, to prepare the nurse to function safely in an acute care setting and to improve their confidence. And then also one thing we can definitely measure, decrease our 18-month turnover rate. Our original pilot group was seven. We started with a four-month plan, so they were in the GNOSIS Program for 16 weeks, and it was a combined program of classroom clinical. We did not give new grads a choice. It was mandatory. If they wanted to come to work with us, they had to agree to go through this program. We also took in, and continue to take in, RNs who have minimal to no acute care experience, so recently, in the last couple of years, we've had nurses who have done nothing but physician practice. They decided they wanted to come in -- a physician office practice, I should say. They wanted to come into an acute care setting. We offered them GNOSIS and they go through it and find it very valuable. And we also do it for LPNs that we hire.

Carole is gonna talk about the next piece, the
required three-year work agreement when she comes up in a few minutes. But that is an upfront understanding they have to sign to come to work with us. And we offer it right now three times a year. We have schools that graduate nurses around December so we bring a group in, usually a small group, in February; average size about eight to twelve. And then we bring in a huge group in July. Right now I'm finishing with 21 that started in July. That's big for us. And we were bringing in a group in October. What we found is that for some reason they don't want to wait until October to start work. They just seem to think they need a paycheck. So we bring them in late August and that gives those that want to take a vacation, that want to put off taking boards a little bit, who want to have a little free time before they come to work, that gives them that opportunity. And we just started our late August/early September and we have 16 in it. So we have a little bit of overlap in the fall, but that seems to work out very well.

Based on the first original plan, we have eight hour days -- class days on Mondays and Tuesdays, a wide variety of topics. Meant to address, again, a lot of what we heard this morning, identification of problems, the urgency of problems, how do our physicians take care of things at High Point versus what you might have seen in your clinical in another place. A wide variety of topics.
One of the big issues for new grads is that medication administration. I was not surprised at the results of the study this morning that showed that medication administration was their big concern. They all come in with that. And so to address that, we give them two days on nothing but medication administration and how to do it right and all kinds of information, and they all come out of that feeling a whole lot better about it. But we have a wide variety. They are in class every Monday and some weeks Monday and Tuesday. They are expected to rotate through med-surg and telemetry units. I rotate them through -- right now seven different units, and there's a reason for that. What we found is in the past if you came in and you went to work straight on your unit, you never learned about the rest of the hospital. And there is an advantage to being able to say, Well, back when I was oriented last year, you know, I did a couple of weeks on the cancer unit and this is what they experience up there. Or, Oh, yeah, I was down in cardiac telemetry and this is why they want to bring that patient up here so quick. So it's helped them to learn the whole organization and the ways that different units can work together. So we purposely rotate them through. They are expected to work whatever shifts they're hired for, so I do a schedule for them. If they're hired for day/evenings, they will do a combination of days and evenings during the
program. If day/nights, they do days and nights. They understand upfront that it is not all straight days.

The goal is to -- Oh, excuse me. And they also spend some time in non-nursing departments. Their first week with me I find out what have you not ever seen? I've never been to cardiovascular department. Well, cath patients can go anywhere, okay, you're going to the cardiology department. I've never been in radiology; I've never seen an arteriogram. Okay, we're gonna get you to see that. They identify things, experiences that they have not had but that they learned about in nursing school. And I make sure that they get those pieces while they're oriented.

The goal is to cover the generic nursing care. It does not matter where you go to work, there are certain basic things in an institution and a hospital that apply across the board. So these weeks that they're with GNOSIS is to get the generic stuff out of the way, so that when they do start their unit specific orientation they -- they've got all this under their belt. They've got a very high level of confidence to start with and they can learn -- they just focus on what they need to know for orthopedics, what they need to know for critical care. So I tell them up front, this is generic nursing orientation to get you ready to start your specialty orientation.

One of the big pieces that I think makes it
successful is there is absolutely no focus on taking a quote, unquote, full patient assignment. If they don't take but one patient for the weeks that they're in GNOSIS, I'm happy. Because what I want them to be able to do is they could be doing care for Carole and one of their peers comes along and says, Dr. So and So is over here putting in chest tubes and I remember you said you've never seen chest tubes put in. They can turn around to the preceptor, say, Here's where I am with this patient; I'm going over here to see chest tubes put in. If you've got a full assignment or if you've got more than one or two, you can't do that. So I really don't stress. They will learn to take a full assignment when they start their specialty orientation. And that, I think, has been one of the things that makes this very, very rewarding for me, whereas they can grow in little steps.

We have a standing Friday afternoon meeting. It's Friday afternoon for anybody working days, working evenings. They come in early and the closest thing I can relate this to is clinical conferences when we were in nursing school. This is the chance for them to come together and share, because they've been split up all week, what they've learned, what they've seen, get questions answered that they could not get answered or did not get answered to their satisfaction. We also have some topics that we cover. One of the things we cover is communication with physicians.
We talk on Friday afternoons how do you get ready to call a physician, what did you do? Whatever it is that they need, we cover in those Friday afternoon meetings. And then we're getting ready to have graduation this coming Friday for our July group. We have that the last Friday of the program. They get a certificate and we buy them a book. As you can see here, it's called Your First Year as a Nurse. Our CNO always comes, Martha, and the directors and we have a celebration. And they all stand up and talk about where they're gonna go and then they start their unit specific orientation the following week.

One thing I want to add that I realize is not in this handout or in this overhead, the GNOSIS Program now is ten weeks. We shortened it based on feedback from the groups. Each time I have a group finish, we always spend that last Friday afternoon after graduation getting evaluation of the program. And the first group said 16 weeks is way too long. We dropped it to 13. And that seemed to work. And several years ago we realized we had a preponderance of new nurses on nights and let's face it, it takes a couple years to get really comfortable with what you do. We were again beginning to see some phone calls at night, physicians not being happy. We chose in 2000 to create a clinical mentor position and these are two registered nurses with very extensive backgrounds who worked,
as you can see, 12-hour nights, one per night. And their job is to run the halls helping anybody who needs help. They know who the GNOSIS nurses are on the evenings, who are on nights. They make a point of stopping by and visiting with all of them, but they are accessible to anyone, experienced staff, inexperienced, it doesn't matter. They go to the childbirth suite and help birth babies. They go to critical care. They do whatever is needed.

One of the things that we did to help finance that, quite realistically, was we recognized we needed it but we had to come up with some money. So I went to the current group that when we had them and said, Look, if I could offer you this backup on nights, now and also when you come out of orientation, would it be worth it to you if I, you know, would that be a good tradeoff if I shorten a couple of weeks in the program? And they all said, Sure, we think that would be excellent if we could have a shorter program right now and know that we've always got this resource on nights, great tradeoff. So I voluntarily chose to shorten the program to ten weeks and it's been ten weeks now since 2000. I really have not seen any difference in their competency levels and their preparation. They know they've got that person, plus, they've already formed a relationship with them during this ten weeks because some of them are on nights and see them.

It's been such a success that we now have a --
the staff educators take turns carrying a phone during the day so there is not a clinical mentor, per se, designated but there is always one of the educators who is available that carries a cell phone. That way they don't have -- the nurse doesn't have to wait to be beeped, all that process, they got a question, they dial the number, they get an answer. And that's been a big help.

The other spin-off that's come is we are in the process of creating a performance coach role. We're working on the education for that now and the orientation and those are people who will be assigned to each unit and their job is to be just what it says here, to be a coach for all of the staff. So it's gonna incorporate some of the clinical mentor role. It's gonna incorporate some management role. The primary focus is development of all staff, not just the new staff.

We've had a very great immediate success. The first seven were as happy as, one of my favorite phrases, happy as pigs in mud. They thought it was great. They enjoyed it. Learned a lot. It's amazing. I spoke with a group that's getting ready to finish now and said to them last Friday, How are you feeling, compared to when you started in July and where you are now, how do you feel about being out on units? And all of them to a T, We're more confident. We know where things are. We know more about the
hospital. We can -- It's still amazing to me that they don't feel like they're nursing 'til they can give medicines, so we can give medicines and we're doing it right. Very happy with where they are. We've had a total of 314 so far since we started in February of '98. Everybody's happier. The physician phone call, complaints from physicians went down. It went up a little bit before the clinical mentor role came in, but phone calls, complaints as far as I'm getting crazy phone calls at night from new nurses, we don't hear those but once in a great blue moon now. Our 18-month turnover rate is now down to 11 percent and that's pretty consistent across all the years. And one thing we did look at before we started, but we've looked at since then is our overall retention rate is at 82 percent. Thank you.

CAROLE RICKER: While we're switching over here, I'm gonna give you a little bit more of how the program really fits together with a lot of the other things that we do. We have several programs that we get students involved in very early. And one of them is a sophomore program that we actually got a grant from the Center for Nursing to start. So it's a program that's called a Pre-Nursing Mentorship Program. That's between sophomore and junior year in a BSN program. That's followed by the junior internship, and then in most cases they move into our new graduate program once those things are finished. So it really is a progression for
a lot of people. We have 284 beds in the hospital and what we do really is we look at where the needs are but we allow the new graduates to go anywhere. They can go to any unit they want to go to. When we make them the job offer, if the job is available, we offer them where they want to go from the very beginning.

The word "GNOSIS" is kinda funny. Martha Barham found that word in the dictionary and it actually means "new beginnings." Think of "diagnosis" and you won't forget it, but some of the pronunciations I get are incredible. It also can mean "having special knowledge," and that's the piece that we take and move forward with. We have 756 nurses in our facility, about 410 FTEs. So what that tells you is we have a lot of people working very flexible schedule. We are a Magnet hospital, but so now is everyone else in the Triad. So what we are working on is Baldridge certification now. We are on that adventure and we are trying to go toward that goal, which is gonna take awhile, but we are working on that.

Someone talked earlier today about the foreign nurse recruitment. We are working -- I never thought High Point would ever be doing foreign nurse recruitment, but we now have four nurses from Eastern Europe. Cindy and I took a trip and we would put those nurses through the same program, and it's been very successful. One of the funny things we learned, though, is we might speak English, but we speak
Southern English. And that is very different for people coming from Eastern Europe.

As an overview of the GNOSIS Program, the first two weeks we really try to develop trust and relationships with the students that take this. I put on here "prepares new nurses to function competently and safely," but I would like to change that to say "begins to prepare." We certainly can't do that in two weeks. It provides them with an introduction to our facility, but quite frankly, most of the people that we recruit have already built a relationship with our facility. We have four AND programs and two BSN programs in our area that send students to do clinical experiences with us. And they get to talk to the new nurses who have completed this program and that is our best recruitment tool. Also, they learn about the care delivery model and the standards of nursing practice in our hospital.

The next nine to eleven weeks, it used to be eleven. Now it's down to ten. We really take time to have classes and carefully planned things for them to do. For example, if I feel like I haven't had enough time to practice foley catheters, we take -- we can take that student and -- that new graduate, we could put them in the emergency room in an area where they would do 20 in a day, and they feel proficient when that is finished, and they like that flexibility.
The course objectives are outlined for you. I'm really not gonna go through those individually. There are two handouts I will point you to, outside on the table. One of them is -- are these slides, and another one is just an outline that we give every new graduate, that has an overview of the program, what they can expect to get out of it, and a copy of the work agreement.

Okay. The work agreement. When we started this program, people said to me, I'm offering sign-on bonuses; how in the world are you gonna get a new graduate to sign a three-year work agreement? We said that we are investing in their future. And that it was very important for us to be able to have some return in order to sell it to administration and to make it effective for us. We drew that line at three years. And we said if we can keep them for three years, we're fine with that. Even after that point, if they have to go somewhere else, at least three years gives us a good return. What you might be interested to know is that these -- while they're in the GNOSIS Program, and the GNOSIS Program is only their introduction. This has nothing to do with their orientation to their unit. That is separate and after this program is finished. So for these ten weeks they may not even see the unit they've been hired for. And that really helps them to get the skills that they need. But once they're finished this program, then they go through a whole
other piece which is -- it could be as long as a year following that, depending on where they've been hired for. The GNOSIS agreement says the first year doesn't count. If you leave High Point Regional Health Systems one year or less, you owe me $3,000. And I'm also the collecting agent. The good news is we allow them to use their accumulated paid time off to satisfy that agreement. When we first started this program, it took them more than a year to accumulate enough paid time off to pay us back. As hourly rates have increased over the years, now it's less than a year. So they can take the number of PAL hours to equal $3,000 and they can leave in peace, and we're fine with that. But it does make them think twice about taking the training and not staying.

The other thing that we do is we say after the first year, if you've found that you're not in the place you want to be, you can request a transfer to another unit. Suppose you start out in med-surg and you decide critical care is where you want to be. After the first year you can request a transfer. Critical care will give you all of the education that it takes to get there and to be successful, but it does not increase the time that you owe us. You still only owe us three years. After the first year, the way that it's set up, you earn $125 credit every month you stay an employee after the first year. So if you stay two years, you'll have 1,500. Two-and-a-half years, 750. So they can
work toward the goal of reducing that amount. And at the end of the year, they're free and clear to go.

We also have scholarship programs and other kinds of programs that encourage people to go back to school and continue their education, which goes along with the GNOSIS Program. I have included a copy of the work agreement in the packet that's out at the front desk, if you want to look at that and try to figure out how we do it.

The best tool for us is really word of mouth. This is an outline of their first week and all of the expectations and things that they do, but really, they know up front. They get a notebook that shows all of the weeks, the first day that they have class, and then all of the competencies that are related to the things that they cover in class are covered with them in clinical by their preceptor. It works very well and they establish great relationships with the people that they work with during this program.

And that just tells you more about the clinical focus. I think that the most important part of all of this is to know that the retention rate changes when they have some buy-in and some relationship, not only with the people that they learn and get to know, but our hospital is more family. People become dependent on each other and they help each other. It's not so large that you get lost and it's not
so small that -- well, maybe sometimes you get to know a little bit more about people than you want to, but I think it's very -- the relationships and the trust are very important in the program.

I'll be happy to answer any questions that you have. And if you ever want any information, e-mail me and we'll be happy to send you whatever you need. Thank you.
Polly Johnson, RN, MSN, President and Chair of the Board, Foundation for Nursing Excellence and Executive Director NC Board of Nursing

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Next Steps in building an evidence based transition to practice

POLLY JOHNSON: (This is) an opportunity for us to share some of our ideas about where we're going next with this whole project of evidence-based practice. So I'll start off and share with you.

I'm sure that most all of you from North Carolina have read the North Carolina Institute of Medicine Task -- Nursing Work Force Task Force Report. One of the recommendations related to transition to practice was for the Board of Nursing to convene a stakeholder group and identify the number of the stakeholders to look at a post-graduation residency type program. And so we started talking about this and decided the first thing that we wanted to do was go after this opportunity to have a conference, get it funded by AHRQ, which we were thrilled to have happen. And then our next step will be to convene a broader stakeholder group to begin looking at how do we frame some of the ideas out of today and some of our -- meshed with some of our dreams for a residency type program. Then begin looking at models, developing a
model or models, that we could hopefully then demonstrate, which means that at some point in the future we're thinking of going for a major grant to be able to have a demonstration project in this state. And we think that there are lots of possibilities for that. So I would just share with you some of the visions that I've had as we've worked from a regulatory standpoint to do a number of things related to competency and transition to practice is one area that competency is really important. But as many of you know, the general assembly enacted legislation authorizing the board to begin requiring evidence of continued competence on licensure renewal and reinstatement. So one of my dreams and it will be after I'm certainly gone from this position, and who knows, I may be dust in the air by then, is that we would have centers for excellence around the state where, in fact, we could do -- when we get the research behind us that tells us what we need to do to measure competence, whether we're talking about continuing competence, entry level competence, and/or transition level competence, that we would perhaps have some centers around the state where, in fact, we could carry out some of those measurement activities. Given the world of simulation, which is only going to become more available to us, I think there are lots of -- lots of possibilities. But we may be able to use resources that we already have in the state. For instance, you heard a bit
about the del Bueno model and we know that that's being used by at least three or four systems in our state as one -- It's just one mechanism -- objective opportunities for measurement. But we're really just beginning to build an evidence base, so we'll try some things and measure them and figure out what works and what doesn't work. So being sort of a person who likes to think ten to fifteen years down the road, I have this model or vision in my head that we will have this opportunity so that if there's -- for competency assessment centers could be used for any number of things, including from orientation to, from a regulatory perspective, re-entry for people who have had major problems in their practice. You may be aware, in fact, that we have a program that's been very successful in North Carolina called -- it's a prep program. It's a practitioner remediation and enhancement partnership and early intervention, non-punitive, non-public program, where we already have a number of individuals who have had practice deficiencies participate in that along with their employers and it's an agreement process that's reached whether the individual needs some further education, whether they need further monitoring, those kinds of things. But the truth of the matter is that we don't really have the research behind us yet to know exactly how to -- to measure competency. But we're on that road. So the first thing that we will be doing is pulling together a
stakeholder group. We had hoped to do this in early December, finding out that we probably have a conflict with the date that we had set so we'll probably go back to the drawing boards as our core group and look at that, but I'm sure that a number of you will be asked to come and participate in okay what next and how do we move forward. So that's, I guess, from my angle, where we are.

BRENDA CLEARY: And I'm just gonna pick up there and talk a little bit about why this is so important and kind of piggyback on a lot of wonderful things that were said today. First and foremost, it is, I think, a patient safety issue, so naturally, the Board of Nursing that exists to really protect the public safety would be vitally interested and a leader in this work. The Center for Nursing's mission is to assure nursing resources for North Carolinians so there's an overlap there, you can see, because we want those to be really good, strong resources, but also from our whole emphasis on recruitment and retention, it is -- it is certainly a nurse retention issue. It's about retaining -- trying to lower turnover in places of employment which is -- has huge cost implications. But also it's about keep -- nurturing our new nurses so they want -- they become committed members of our profession. So that's a real issue to us, and then when we first started talking we said, but you know, this is -- if we did something statewide, we've
gotta get AHEC involved because they would be critical to being able to do something that was available throughout the state. And I know this is -- you know, like anything new, there are concerns. What's it gonna cost and can we do this and can every new graduate have accessibility, but I think you're gonna see kind of a tipping point happening around the country. I heard Dennis O'Leary, the chief -- the CEO of JCAHO, speak twice recently. One was at a JCAHO meeting and then he brought it up. Very alarmed that it's -- there's so much variability in what happens after a person finishes nursing school and -- and passes a licensure exam. And then he spoke to the Robert Wood Johnson Executive Nurse Fellows and his -- the pitch went up. He was even more concerned and he -- and he was pacing back and forth and he said, You know, either -- either physicians are very, very slow or nurses are very fast or we, in nursing, we've been smoking something, to think that this -- we could sustain, you know, life as we now know it. And when we have surveyed new graduates from the Center for Nursing, you would just be amazed at the wide variation in terms of any formal transition from school to work, including orientation, that varies from as much as eight hours to eighteen months to two years. I mean, that's the variability and so depending on where you land, if you -- you can be at great risk as you start your career. We -- It's wonderful when doctoral students want to come and
massage our data further and look at relationships in a greater detail than we really have the resources to do, and Elaine did just that. She took that last new graduate survey and I think it's just -- it sounds intuitive, but to have it borne out in the numbers, the fact that the relationships between good orientation and job satisfaction, more positive job satisfaction and decreased turnover are gonna be selling points for even maybe the people that, you know, say, Well, you know, we can -- we're getting by just fine. But if we can show that the bottom line changes, because turnovers reduce. Turnover is extremely expensive. And it's not just the monetary cost. It's the loss of continuity and more expert care and people who are accustomed to the environment and -- and really can -- don't -- don't really take -- others have time, for instance, to find their way around, so I think -- I think those are just really -- gives an important backdrop for why it probably is past time, but certainly the time is right for these conversations. I just -- I wanted to mention this because I was so grateful to the Agency for Health Care Research and Quality for their support for this conference, but a recent -- recent piece of research that they published really says that nurses really struggle with the whole notion of evidence-based practice. And that's the world we live in. Certainly, we're blessed that so many hospitals in North Carolina now are pursuing Magnet status.
I -- I am a Magnet appraiser and that's really important that staff nurses understand how to apply evidence to practice. However, this ARC study, which was actually done by Dr. Melnick, from Arizona State University, an ARC funded study, found that 44 percent of nurses surveyed said they had a mentor. It wasn't even necessarily a formal residency program, but if they had a facilitator -- for instance, a clinical nurse specialty on their unit, they mentioned that group by name, they -- they could -- they could -- they were so much more able to keep this evidence-based practice in front of them and kind of guiding the decisions they made. And so, you know, these things we do to help mentor new graduates and staff nurses in general really do have a payoff. I'm gonna turn it over to Gail.

GAIL MAZZOCCO: I guess what I want to do is just say a few words first about vision, because we've talked about vision. Certainly, Polly talks about vision all the time. And then because I am a nurse, I'm going to talk about making a vision practical. And that probably is a part of many of our education and practice experiences. And I want to tell you a little story. When I was a child, when I was about five years old I went to school, kindergarten. In those days in Brooklyn, New York, they had kindergarten. Bad school system, but kindergarten was okay. And I had my eyes tested, and the person who tested my eyes might have been a
nurse, maybe not, said, you know, You've got 20/100 vision in one of your eyes. And so they sent me home, and my mother took me in to have my eyes examined and it turned out that I had amblyopia, which many of you may have had some experience with, because one of my eyes was much more farsighted than the other. And I really had 20/200 vision, actually, out of my left eye. And so the solution to that problem, as the doctor saw, was to patch my strong eye. Now anybody who remembers much about eyes understands why they would do that, but I was only five and a half years old and I thought they were all nuts. They sent me to school and I couldn't see anything. Okay. I knew for sure I would not do well in school with no vision at all. Now this was a long time ago so the little patch they had was a little plastic patch that fit on my glasses with the little snaps. And so first I tried the I-can't-find-my-patch approach. And my mother would always find it. And then I took to breaking off the prongs. I figured that was it; they were done.

Now what I came out of that understanding was that everyone of us has a vision that's quite different. And some of us can see hardly anything at all. And often when we talk about residency programs or the transition from school to work, I am struck, as someone who worked as a clinical specialist for a long time and as a faculty member for a long time, that our vision all depends on where we stand. If
you're standing in the acute care side, which is where I was, it's the fault of the schools. Take my word for it. They are -- They are weak. And they certainly are nothing like the three-year school I went to, believe me. And if you're standing on the school side, I can assure you that it is the institution's fault. I mean, how can you get any kind of education in the kind of health care delivery system we've got today, right? Now Polly's vision says, How do we connect those two, that school and that health care institution, without regard for who's at fault here? Because my experience with who's at fault has never gotten me anywhere. If I say to you -- to my children, Who took the cookies? Nobody ever did. So it doesn't serve us anything. So that vision that we're talking about can have a lot of forms. And we certainly don't have a form. In fact, the vision is kind of rough at the moment because we don't have measures of some of the things we want to look at. However, my job certainly in my position, is to think about how to transform that vision into what could be real. And that's what I prefer to do anyway, so I'm very happy about doing that. The question we have is not for large health care institutions that actually have developed residency programs that are functioning beautifully and we've certainly heard evidence of those. Clearly, they may not need a whole lot of support. They might need a structure that says this is what works
best, but not the support. Maybe they do. Maybe I'm misreading that, but maybe they don't. But we certainly understand that there are plenty of places that employ new graduates who have no resources to provide that support and who provide precious little given the limitations. Those might include small, critical access hospitals where people are working, long-term care facilities, health departments, plenty of places that have no resources. The question that I would have is okay, how would we be able to provide them with the sort of support that you would need in order to, I guess, make alive the dream that we're talking about here. That is, the dream of making that transition from school to work, not only less painful, but actually even educational in the process.

Earlier today I mentioned a little bit about the AHEC mission and I'll read it to you in case I'm forgetting the words here, and the AHEC mission in North Carolina is to meet the state's health and health work force needs by providing educational programs in partnership with others. And I said earlier, of course, that's what this program is. The AHEC, as most of you know, but some of you may not, have nine regional centers. The entire state is covered by AHECs, which are divided up. While the AHEC uses the term "system," I probably, as an outsider from -- who knew Maryland's AHEC system, which is definitely not a system. This is a bit of a
quasi system because we're all independent at heart. Nonetheless, that existing system can serve as a jumping off point for some of the sorts of resources that we might want to be able to provide, since it already exists. And a lot of states would have to develop that kind of system or negotiate or contract with someone. The question is can we use the system that is here to provide institutions which need the sort of support that would allow them to develop and to run an effective residency program, including both training and then evaluation thereafter. And I guess I'd be daring enough to say that would even have more use than simply a residency program. It can provide all kinds of services to people in a region. So that the vision we were half talking about was to use the existing AHEC structure to develop what you might call centers of evaluation. I'm inclined to call them centers of excellence 'cause in my experience everything lately is called a center of excellence, don't you think? And why not one more? Okay?

The second thing is that these could provide onsite education, support, and evaluation, more or less and like some of the CPR centers that are out there that provide those kinds of service or the regional regents external degree program that did evaluation. Now that just did evaluation, not education. We would see this more broadly. And we could also provide some other support services for
these folks. Perhaps library, perhaps mentoring services that would be a part of that support service.

Small group activities. It's very clear from the people who've spoken today about effective programs, that it's small groups getting together and supporting one another that makes all the difference. They're the people who keep folks going and just kind of serve a purpose that's hard to measure but is so important. And professional development, continuing education, the AHECs already do that. So that would just kind of roll into the system.

Now there are lots of details to be worked out. In fact, maybe all the details are to be worked out. However, because we have an existing structure a lot of other states don't, we're kind of one up. Now that doesn't mean that this is the only way this could be done. There's a lot of ways that this could be done. The AHECs were one mechanism that already exists and could provide the source of support for which we are looking. But certainly, plenty of health care agencies, as I said, already have the resources available to them and could do this or maybe there are other opportunities. That is one of the things that we are going to want to explore going forward, what next? And what next in terms of the grant Polly was talking about and how might we, in fact, develop this source of systems that would provide that support for all nurses, not just those nurses
who are wise enough to know that they should choose their first job very carefully.

I guess that's all. Do people have any questions, comments? Any suggestions that come to mind?

NANCY SPECTOR: I was wondering if there's any thought about making this a national plan?

GAIL MAZZOCCH: You'll have to ask the visionary that.

POLLY JOHNSON: Well, I certainly think that what would be really exciting would be to have more than one state participate in this. So that would be great. And it would be nice to maybe have some toward the west, northeast, or something like that.

BRENDA CLEARY: I would just -- I would just add with the ultimate goal, I mean, this is not a problem of any one state. It's actually a global problem and actually some countries are kind of ahead of us but it's -- so I think, you know, and -- and when I had a conversation with Dennis -- Dennis O'Leary, he was really excited, very excited, about this collaborative effort. Not that there aren't other state models, but the fact that these players were getting together and saying, We all think it's important, maybe from a little different perspective. What his concern is with some of the demonstration projects is they're not gonna move fast enough. This needs to be -- This really needs -- We need to have
early converters fast and quickly and move on, because it's that serious of an issue. So I think you're right on target. I think that has to be -- that's -- got to keep our eye on that prize, that at some point, at least in terms of some type of kind of core, you know, transition experience.

UNIDENTIFIED SPEAKER: I guess I have really just a comment and it's by way of thanking you for convening this program today. I just think this is such an important topic and I just wanted to extend my thanks to the three of you for your leadership and bringing us all together to discuss this issue. I do think -- I am a firm believer in the concept of assimilation experiences, and I hope that through the grant mechanisms that we have a way of providing more and more of that type of experience for all the nurses in North Carolina. And lastly, even though some academic health interests may have the resources necessary to now transition to practice programs, they often lack the ability to track the progress and the successes and the evaluation component. And I think that there's something in this grant curve for everyone. Thank you.

POLLY BEDNASH: Hi. Polly Bednash, again. I just wanted to highlight -- Well, first of all, this, I think, has been a marvelous conversation about an issue that's very real. If we can just stop thinking about who's at fault and thinking about the mutual accountability we each
have in preparing professionals for a long life of work and, you know, our son, an engineer, and my husband an engineer, were never allowed to get into a laboratory and work unsupervised with a project for a year. Where the environment felt that the critical issues of the technology they were working with were things that needed mentorship and guidance for these people. Well, we deal with lives. And so our -- our learners are new and deserve that same kind of transition. We do believe we have a national project started now at UHC AACN. We have, as I said, 28 sites. We have five control sites, is that correct, Kathy? Those control group sites that are expecting to come in next year. They've agreed to spend a year as a control group for us so we'll be expanding. We are in the process of developing standards, as with all accreditation processes. Once those standards are developed, they'll need to go out to the community of interest for feedback, and so we believe that we will have a national set of standards about what these residency programs should be either shaped to look like, what they should be trying to achieve. How you would measure a benchmark or place a benchmark in place to assure that you have consistency. Our own look at this issue showed that there's so much diversity around what is called a Transition to Practice Program that we can continue talking about the need to have this and still have so much diversity that we won't
get where we need to go. So I hope that all here will stay
tuned for when our standards come out and give feedback and
participate and think about that for the future as the
standard model for the future.

CARRIE LENBURG: I think it's been a fascinating
conference. I want to comment up front about vision and
almost every movement starts with somebody's vision. And it
starts with one. And then a momentum begins to grow. I can
tell you about being on the forefront of some innovative
things that nobody else thought was possible to do, but the
point is that if you have vision, substance can follow. And
the movement is already afoot. It's in many places, and what
AACN, etc., and other groups are doing is a part of that
movement. And the opportunity we have, state by state, is to
try to connect the dots, to try to see where the similarities
are and I think there's been an effort to do that at this
conference.

There are many facets to be looked at, because
we're on the forefront of a very new entity for nursing. It
breaks the mold, and that's what we know needs to be fixed.
And we had to break it in order to fix it right. So I -- I
am very glad to -- to share with others in participating in
this vision and hope that we will find ways to connect the
dots with multiple organizations, multiple individuals,
multiple institutions, that have the same overall thrust or
idea and ideal of what we want for the profession. So I commend you for having vision, getting the money. Keep doing it. Keep pulling people together, working with other states, and I think as we all begin to pool all of our efforts that we can, from regulatory bodies, accrediting bodies, educational bodies, practice and accountability bodies, we will be able to make that difference. And let's not be deterred by the amount of time it's gonna take, because it is gonna take time. And I would just reflect on one comment that was made from the front there about O'Leary saying that we need to hurry and get something out there. Let's don't rush into another catastrophic situation that we're gonna have to extricate ourselves from somewhere down the line. So let's take our time to do it right but not linger.

POLLY JOHNSON: While the mike is being passed, I had an email on my little wonderful Blackberry from David Leach at noon, and he said, once again, he was sorry that he wasn't here but he hoped that we would get it right this time.

GAIL MAZZOCO: I think one of the things that strikes me that we haven't talked about, it's kind of like the elephant, but this is as much a political issue as an educational one. I just thought I'd leave that out there. I didn't want it to get passed by.

POLLY JOHNSON: Other questions or comments?
Linda Lacey, BBA, MA, Associate Director, Research  
NC Center for Nursing

Reports from Breakout Groups

LINDA LACEY: What I've done is taken the results of all of your group discussions and tried to put them all together so that we could get some sense of when it comes time to convene a work group and sit down with them to -- and get serious about developing a transition to practice program and start talking about the kinds of competencies that we want to begin with, this will give us some guidance on that.

So you all started with the same list of competencies in your work groups. Some of your groups added new competencies. Some of you wanted to delete some of the ones that were on the list. And it wasn't a perfect list, but I should remind you that that original list that you started from, that you worked from this afternoon, that was the result of all of the statements that you sent in to us prior to the conference. Some of you may have even recognized your wording. But in general, what we did was we took the ideas that you all had submitted, because everybody phrased things a little bit differently. And that's how we came up with that list of 20 competencies. And so the results of the voting say that the competency that was considered most important for new nurses was:
1) To perform a basic assessment and identify abnormal findings (42 votes);

2) That new nurses must be competent to use effective communication techniques; verbal, nonverbal, and written, when they're interacting with a patient's family, visitors, coworkers, and other health professionals (27 votes);

3) I recognize events and situations that are an imminent threat to patient safety and intervene appropriately;

4) To recognize when the care demands of a patient have exceeded the new nurse's capability and request assistance (21 votes).

5) To evaluate patient responses to treatment and modify treatment appropriately (17.5 votes);

6) To prioritize, with assistance, patient care activities in order to provide safe care in a timely manner (17 votes).

7) Administer medications correctly, provide patient education regarding the medication, and assess patient responses (16 votes).

8) To provide a safe environment for patients, coworkers, and themselves.

9) Use current knowledge and experience to analyze information and make a correct plan of action based on that information.

10) Was actually a new competency that was recommended by one of the groups, so not all of you had the chance to vote on
this one. And that statement is that new nurses should be competent to collaborate with other professionals, patients, and families to optimize patient outcomes.

So those are top ten competencies as identified by this group, and those will be the ones that we use to start building our tool kit, measures and assessment tools for these particular competencies. So you helped us in that regard, too, by identifying what the various measures are that are currently available and also helping us identify where there aren't any good measures currently, and where we really need to begin from scratch in terms of developing valid and reliable measures.

When we're talking about that number one competency, performing basic assessments, there were a couple of tools that were identified. The one that got mentioned most often was the PBDS, the Dorothy del Bueno system, as being something that is currently in existence. Also, Duke Hospital is using something called problem-based scenarios, in which they directly address this competency. And so that is something that we'll also be able to access and use. There were also a couple of participants who were using simulation labs to directly assess this competence. We'll follow up on those and track down the specific information and start building up a list of tools and sources and also liability and validity tests of those tools when, and if, you
can find them.

There were a lot of suggestions in terms of the best approach to use to deal with assessing whether or not a new nurse has basic assessment skills. And it looks to me like primarily those approaches were around direct observation, skills checklists, standardized case presentations. So apparently, we do have a couple of measures to start with there, but we also have some work to do. It depends on how widely available the tools that currently exist can be applied and also expense is an issue. We talked about this some in that some of these packaged tests -- tools can be prohibitively expensive for any but the largest hospitals and health systems. So that's another thing that we need to take into account as we build this tool kit.

The second competency on the list was being able to use effective communication techniques, and when we asked about what sort of tools might be available for that, standardized patients was something that was mentioned several times. 360 degree feedback mechanisms, which is actually something David Leach talked about this morning. ACGME. They have developed one. Journaling is another tool that some employers are using to help to assess whether or not communication is effective. And then, of course, there were lots of suggestions about what would be the best
approach to take to this and that sometimes wandered off into discussions about techniques and resources that new graduates could use.

Number three on the list, which was recognizing events and situations that are an imminent threat to patient safety. The tools that were identified there were PBDS, again, was named. SimMan, the simulators, were also mentioned. That looks like it for existing tools. 360 degree patient review was something that was mentioned. I'm not sure that that's an existing tool. That may be an approach. So among the different approaches that were mentioned were case scenarios, direct observation, case studies, audit trails. Audit transfers to higher levels of care. So I guess that would be the JCAHO trail. Review of adverse events would also be an approach for this. Review and failure to rescue situations, and I have a note here about return demonstrations for ACLS and BLS as another option.

For the fourth one on the list of recognizing when care demands have exceeded a new nurse's capability and request assistance. I don't know how your group dealt with this, but mine talked about this for quite a long time and the problem of whether or not a new nurse can ever adequately assess their own level of competence and know when is the right time to request assistance, and how would you go about
assessing whether or not a new nurse had those abilities and also was willing to ask for assistance? I don't see any direct measures, available measures, for this sort of thing. There are suggestions about using direct observations, maybe reflective journals, sort of a self-assessment tool. Preceptor evaluations, of course, would be extremely helpful in this regard, but again, that's not a standard tool, as such. Variance reports also were mentioned. Patient outcomes were also mentioned as a way of assessing this.

C, which was number five on the list, was evaluating patient responses to treatment and modifying appropriately. Again, I don't see any specific tools mentioned, other than the PPDS system. Simulation models are also mentioned here, but nothing -- not a specific one. Clinical scenarios and direct observation or reviewing the plan of care, auditing, documentation, using case studies would be an approach. Communicating with the physicians who are involved in a case. Those were the kinds of things mentioned.

For G, the prioritizing patient care activities in order to provide safe care, one -- probably the one here -- Well, there are a couple here. Observation with comparison to the standards of care. There's also something called the critical thinking module, which is an online assessment tool which is available through the -- is this the
one through the National Council, or is this -- yeah, this is the one through the National Council of State Boards of Nursing. And NCLEX review scenario questions, which are available through NLN, are also another tool that can be used to look at this. So actually, there are several that are currently available and we'll follow up on those. ACLS simulation is another one that's mentioned here. An in-basket exercise, which apparently, is a management exercise to prioritize a list of daily tasks was mentioned as another approach that could be used, and auditing the appropriate administration times for medications is another one.

So as we go down the list, the next one would be E. That was number seven on our list, administering medications correctly. There is something called the NLN medication assessment tool. There is also a series of tools put out by Meds called -- it's put out by Meds Publishing and it's called Administration -- Medication Administration Made Easy. They also have a pharmacology set and I believe a peds set, as well. So there are several tools out here that can be used for this, and we'll follow up with those. Simulators, of course, were also mentioned here. Chart reviews. And watching for adverse drug events. O, which is the providing a safe environment. I don't really see any tools here for this. Environment of care was mentioned as a potential tool that is already available and can be used, as
well as the National Patient Safety Goals, another instrument that can be used as a direct measure and the Nurse Practice Act. So all of those are things that could be used in the assessment of these grads as to whether or not they're aware of those issues.

So what we'll do is we'll take all this information, all of the documentation that we gathered up today, as well as the things that you've sent in, the competency statements that you sent in and some of you went ahead and sent in available measures along with those lists and I appreciate that. We have those and we'll hang onto them and we'll use them.

There's a lot of work to do, but I was so encouraged by what we heard this morning about all of the wonderful things that are already being done out there, some of which I knew about, but some of which I didn't. There are obviously a lot of very bright people worrying about this issue and working hard to find ways to make sure that new nurses are being well incorporated into the work force, that they're given the time that they need to develop the experience that they need to become capable and competent nurses, and that's very exciting. And as we embark on that same journey in North Carolina, I look forward to being able to work with a lot of you in the future as we expand on this.

So thank you so much for coming and thank you for helping.