NEW GRADUATE NURSE RESIDENCY PROGRAM DEVELOPMENT

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ABSTRACT

This Project reports perceptions of how a new nurse residency addresses essential nursing competencies and transition stress. This Project involved development of content for a new graduate nurse residency program. Part of the Project evaluation was answering the questions: Does knowledge level of the Quality, Safety and Education for Nurses' competencies at a Midwest critical access hospital increase for program evaluators after review of the content in the developed new graduate residency program? Is the content presented in the five modules relevant to new graduate nurse needs at the Midwest critical access hospital in order to decrease transition stress in the acute care setting? The Project involved program coordination and development. Content of the new graduate residency program was evaluated through surveys completed by 11 Program evaluators. The findings conclude the developed program may assist in reducing new nurse transition stress, and assist in the development of new nurse competency.

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CHAPTER 1. PROBLEM AND ITS ENVIRONMENTAL CONTEXT

Significance of Problem

An exponential shortage of registered nurses in hospitals across the United States looms in the future of healthcare as one of the many challenges to come. The baby boomer generation will be aging out of the workforce and generation Y will need to prepare to take their place (Institute of Medicine [IOM], 2011). According to the United States Bureau of Labor Statistics' (2012), employment projections 2010-2020 indicate the total number of job openings for registered nurses due to growth and replacements will exceed 1.2 million by 2020, but only 60 percent of the 1.2 million needed nurses will enter into the workforce. Rural hospitals are expected to experience severe shortages as well, a major problem confounded by numerous variables that are unique to rural communities (Keahey, 2008). New graduate nurses will be the pipeline to fill employment gaps in hospitals nationwide (Goode, Lynn, Krsek, & Bednash, 2009). New nurses must not just fill and maintain these positions but must uphold the trustworthy reputation of nursing. To meet the need of the nursing shortage, mass amounts of new nurses must graduate and be instilled with competency in nursing knowledge, skill and ability (QSEN, 2013).

Rates of new graduate nurse turnover within the first year are high, and related directly to escalating stressors in the workplace as found by the American Association of Colleges of Nursing (AACN) and the University HealthSystem Consortium (UHC) (UHC & AACN, 2013). The National Council of State Boards of Nursing (NCSBN) found that approximately 30 to 60% of new nurses leave a position within their first year of practice (NCSBN, 2013). According to Keahey (2008), new rural nurses leave the workforce at the same rate, and experience many similar stressors to their urban and city counterparts, but also experience a set of additional

stressors related to the inherent wide range of competency expectations of rural nursing. Increased turnover influences patient safety and health care outcomes negatively. Lowering turnover rates and increasing new nurse competency decreases fragmentation found amongst nursing units with high turnover rates.

On a national level, the United States passed legislation in March 2010 to reform health care through the Patient Protection and Affordable Care Act (PPACA), which provides health insurance to over 32 million more Americans (IOM, 2011). The PPACA has a significant impact on the nursing profession as they represent the largest sector of health care professionals and will be greatly needed. It is imperative to recruit and retain competent new graduate nurses in acute care to fill the gap. The IOM (2011) emphasizes "Having enough nurses and having nurses with the right skills and competencies to care for the population is an important societal issue" (p. 250).

Nurse managers and organizational leaders have an interest in implementing cost effective strategies to improve recruitment and retention of new graduates. Duffield, Roche, Blay and Stasa (2010), explain how the management of complex clinical units is possibly more difficult today due to multiple factors. Challenges included shortages of trained nurses, turnover, and the exponential costs associated with recruiting and retaining staff. The cost of a single graduate leaving the health care facility within a year of employment is estimated at $88,000 (UHC/AACN, 2013).

Multiple implications affect the future of nursing. Impending difficulties include the aging population and projected high retirement rates of nurses, increased healthcare coverage, and the complex challenges in healthcare institutions. Solutions need to be aimed at retaining and creating competent nurses to avoid poor patient care in the years to come.

Characteristics of the Environment and Problem

The nursing role is constantly changing with increased challenges in the health care system and rising levels of job related stress (Goode et al., 2009). According to the NCSBN, high levels of stress are reported for new nurses related to increased patient acuity and the increased complexity of the current health care system (NCSBN, 2013). Lavoie-Tremblay et al., (2008) found new nurses to experience high levels of job strain related to multiple psychological demands. Demands included heavy workloads, time and the increasing complexity of patient care.

While adapting to the reality of the clinical workload, new graduate nurses entering as frontline caregivers are also faced with feelings of incompetency in the workplace as a novice health care professional. In seminal work by renowned nurse theorist Patricia Benner (1984), a model of the five levels of nursing experience a registered nurse passes through in his or her clinical career from novice to expert is described. Nurses must pass through two levels of nursing experience in order to achieve comfort in caring for complex clinical patients. Commonly cited stressors for new nurses include lack of knowledge and confidence, communication difficulties, cost containment efforts by hospitals, and horizontal violence in their new environment as noted by Dyess and Sherman (2009). Deployment into the workplace as registered nurses, with full use of their scope of practice, occurs rapidly due to the vanishing nurse technician positions where new graduates worked under another nurse at times for several months prior to licensure. The transition in nursing today is fast, and dynamic.

New graduate nurses are faced with monumental tasks to transition in any setting, and rural areas present a unique set of obstacles (Molinari and Bushy, 2012). Workplace expectations differ from what is experienced during clinical rotations in school. Rural nurses must quickly

identify and efficiently use scarce resources in an often geographically and professionally isolated area, Molinari and Bushy (2012) explained how the transition to rural nursing can be "daunting for new graduates with urban orientation and are accustomed to specialized practice and abundant resources," (p.xvii). These new nurses must build inter-professional relationships, autonomy, and accountability into an often wide breadth of practice areas. To assure patient safety, new graduate nurses must be oriented to a standard level of competency, which is lacking in today's traditional orientation process (Trepanier, Early, Ulrich & Cherry, 2012).

Joynt, Harris, Orav and Jha (2011) from the American Medical Association found that critical access hospitals in the Midwest struggled with poor patient outcomes when compared to non-critical access hospitals. The unique challenges to rural hospitals included lack of specialists, fewer clinical and technological resources, inconsistent standardized care, and caring for populations not routinely accessing primary care services. With the PPACA, quality indicators of good patient care will be scrutinized more closely, and hospitals not measuring up to the national standard will be financially penalized by the government. With the expected staffing shortages of nurses and mass hiring of new graduates, it will be imperative to keep stressors manageable and orientation of high quality at the time of transition to clinical practice for a seamless shift in the future (Goode et al., 2009). The IOM (2011) summed up the significance of the problem by stating, "How well nurses are trained and do their jobs is inextricably tied to most health care quality measures that have been targeted for improvement over the past few years." (p. xi).

Due to dynamic concerns as reported from the IOM (2001) regarding poor patient outcomes in the Nation's healthcare system, the QSEN was developed in 2005 as a response initiative (QSEN, 2012). From the initiative, six quality standards were formed by nursing education and practice experts. The standards created include the knowledge, skills and abilities

(KSAs) in the competency areas of patient-centered care, communication and teamwork, evidence based practice, quality improvement, and informatics. QSEN competencies and associated KSAs have been widely accepted and placed in nursing education curriculum and have been adopted by many new graduate residency (NGR) programs. A significant challenge for the healthcare system is to instill QSEN competencies into new nurses to improve quality, safety and reliability of nursing care in the institutions where new nurses are employed. With the adoption of QSEN competencies in NGR programs, competency of new nurses as well as patient outcomes may improve.

Nursing Intervention to Resolve or Reduce the Problem

The aim of this project was to determine if the QSEN content of the developed NGR program for nurses in acute care is relevant to the transition needs of new nurses and assists in promoting new nurse competence at a Midwest Critical Access Hospital (MCAH) in rural North Dakota. The student studied participant knowledge of QSEN principles as they directly relate to the MCAH nursing department prior to and after viewing all content of the developed MCAH Nurse Residency program. The project was also developed to gain qualitative feedback on the five project modules of the NGR to determine if the program could decrease transition stress for new nurses. The student developed three of five learning modules for the MCAH NGR Program, assisted in development of the other two, and coordinated the entire program development. The MCAH Project site had no formal NGR program. The Project contributes to nursing knowledge and transition of new nurses, with emphasis placed on the rural critical access hospital setting. The project evaluated a NGR program developed for nurses in the MCAH and identifies how the program may ease transition stress and increase competency in new nurses entering the workforce.

Questions. Research questions for this study include the following:

1) Does knowledge level of the Quality, Safety and Education for Nurses' competencies at a Midwest critical access hospital increase for program evaluators after review of the content in the developed new graduate residency program?

2) Is the content presented in the five modules relevant to new graduate nurse needs at the MCAH in order to ease transition stress into the acute care setting?

Conceptual and operational definitions. In the developed Project, the variables of *transition stress* and *competency* in new graduates were evaluated. The conceptual definition of transition stress refers to a multitude of transition difficulties in the workplace leading to physical, emotional and psychological strain (Fink et al., 2008). The stressors of role change, lack of confidence, workload, fears, and orientation issues create stress for the new graduate. The operational definition of new nurse transition stress is a combination of factors including challenges experienced during transition to practice. It is measured operationally on Pre and Post Evaluation of Content Survey scores (see Appendix E and Appendix F) using a Likert-type scale. Individuals evaluating the NGR program expressed their level of knowledge and awareness on a variety of topics related to patient-centered care, teamwork and communication, evidence based practice, quality improvement and informatics. Topics included financial issues, work environment frustrations, desiring to be independent yet lack of confidence in skills and critical thinking, and inconsistent support systems in the hospital (Fink et. Al., 2008). Qualitative feedback from the Evaluation of Content Surveys was measured. The feedback included identifying how, if at all, the content of the MCAH Nurse Residency program would ease new nurse transition stress.

The conceptual definition of competency in nursing as defined by the NCSBN (2011) is:

> The ability to observe and gather information, recognize deviations from expected patterns, prioritize data, make sense of data, maintain and professional response demeanor, provide clear communication, execute effective interventions, perform nursing skills correctly, evaluate nursing interventions, and self-reflect for performance improvement within a culture of safety. (p. 1)

Competency was measured quantitatively by responses to questions on the Pre and Post Evaluation of Content Surveys. The operational definition of competency was the score received on the Pre and Post surveys. Each competency was embedded within the stem of one or more questions. Competencies included patient-centered care, teamwork and communication, evidence based practice, quality improvement, and informatics as they directly relate to the nursing culture at the MCAH.

Patient-centered care. This competency was measured by evaluating participant knowledge about; patient satisfaction, safety, cost effectiveness, how the MCAH empowers patient, family and healthcare team partnerships in a plan of care, and awareness of standards of nursing practice policies and procedures at the MCAH. It also included knowledge of how nurses can advocate for patients and knowledge of common priority setting traps interfering with the nurse's ability to prioritize patient needs. Patient-centered care was operationally defined in this study by scores received on questions 1, 2, 3, and 4 on the Evaluation of Content Pre and Post Surveys (see Appendix E and Appendix F).

Communication and teamwork. To evaluate communication and teamwork, participants indicated their knowledge of communication strategies to solve problematic situations. Participant knowledge levels were obtained on knowing how to utilize tools for team

strategies to improve teamwork and patient safety and how to utilize a decision making process. Communication and teamwork were combined and operationally defined as the score received on questions 5, 6 and 7 on the Evaluation of Content Pre and Post Surveys (see Appendix E and Appendix F).

Evidence-based practice. Identification of participant knowledge of EBP included identifying databases located within and outside of the MCAH relevant to nursing practice. Participants also reported their knowledge levels of identifying the process to change or recommend changes in practice based upon evidence at the MCAH. EBP was operationally defined by individuals evaluating the MCAH NGR program by selecting responses from "no knowledge of this" to "excellent" knowledge and awareness of evidence-based practice on a Likert-type scale on the Evaluation of Content Surveys. The fourth subset, evidence-based practice (EBP) was operationally defined as scores received on Evaluation of Content Pre and Post Surveys for questions 8 and 9 (see Appendix E and Appendix F).

Quality improvement. To evaluate the competency of quality improvement, participant knowledge of resources available at the MCAH to assist in analyzing and identifying commonalities in healthcare errors was identified. Participants reported their levels of knowledge on how to identify ways to promote prevention of error, participant awareness of how to address quality improvement opportunities at the point of care for nurses and knowledge of how to overcome barriers to implement or suggest improvements. Quality improvement was operationally defined by Evaluation of Content Pre and Post Survey scores for questions 10, 11 and 12 (see Appendix E and Appendix F). Individuals evaluating the MCAH NGR program selected responses from "no knowledge of this" to "excellent" knowledge and awareness of

quality improvement on a Likert-type scale on the Evaluation of Content Surveys to operationally measure quality improvement.

Informatics. The final subset definition of competency is that of informatics, which can be defined as the knowledge of information technology skills needed for safe patient care. This also includes knowledge of how to maintain boundaries with patients through social media and electronic medical record for maintenance of patient confidentiality. The operational definition of informatics was the scores received for questions 13 and 14 on the Evaluation of Content Pre and Post Surveys (see Appendix E and Appendix F). Responses to informatics questions ranged from "no knowledge of this" to "excellent" knowledge and awareness of informatics on a Likert-type scale on the surveys taken.

CHAPTER 2. REVIEW OF LITERATURE

Nature of the Problem and Current Approaches for Resolution

The NCSBN (2011) as a collective voice for individual state Boards of Nursing, recognizes an education to practice gap exists and is widely observed by employers and educators alike across the nation. Rich and Nugent (2009) explained how nursing education today places value and emphasis on higher education. NGR programs are the critical link to enhance transition from education to practice. With anticipation to lessen the problem, NGR programs are an attempt to recruit and retain competent nurses working in the hospital to fulfill the calling of the Nation (NCSBN, 2011). Unfortunately, few uniform programs exist and many research outcomes are based on studies in large academic based hospitals.

For certain, the United States' healthcare delivery system is becoming increasingly complex, requiring advanced technological and practical skill application (NCSBN, 2011). The NCSBN addresses frequently asked question from those who are skeptical about the necessity of NGR programs including questions about whether the need for NGR programs are due to a failure of education and/or practice in nursing. They attribute the need for NGR programs to the increase in patient acuity, sophisticated technologies, and need for systems thinking. Today's nursing practice is not what it was just twenty years ago, and nurses must make critical decisions associated with care for sicker, frailer patients (IOM, 2011). The acute care setting requires skill in analysis and synthesis along with competence in areas set forth by QSEN (2013) and the IOM (2011) including: patient-centered care, teamwork and communication, evidence based practice, quality improvement strategies, and informatics. The nursing workforce will be better equipped when more nurses pursue graduate education and healthcare organizations require an increase in competency levels and preparation through transition programs after professional licensure.

In an extensive research study headed by the IOM on health care concerns for the United States nursing workforce, several strong recommendations were made to advise health care policy (IOM, 2011). A vital recommendation is the implementation of NGRs across all care settings, and with financial incentive for rural areas. The IOM highly suggests the redirection of funding from diploma programs to nurse residencies in rural and critical access areas (IOM, 2011).

Current NGR programs in the US vary in length, content, and framework (NCSBN, 2013). There are programs developed within institutions that build upon a new nurse's orientation, yet others that are distinct from orientation lasting up to twelve months. Some programs have been built by university systems or private organizations and allow purchase by institutions. The lack of standardization leads to variable experiences by the new graduate nurses.

Transition to Practice. Additional classroom training for new graduate nurses in the workplace has existed since the mid 1990's, but no uniformity of curriculum was present (UHC & AACN, 2013). The NCSBN collaborated with over 35 professional nursing organizations to research and create a regulatory model of guidelines and modules in 2007 for a NGR Transition to Practice (TTP) program (NCSBN, 2013). The TTP model is a robust standardized tool for use by unlimited practicing institutions wanting to implement NGR programs and by use for nurses from any educational background. The NCSBN anticipates NGR program completion for all new graduate nurses will become mandatory for licensure renewal across all state boards of nursing in the future. The TTP model outlines a six month long program with use of five transition online modules to be implemented. Topics of the five modules include: communication and teamwork, patient-centered care, evidence-based practice, quality improvement, and informatics. The

program is based upon competencies from the IOM (2011) recommendations and QSEN (2013). Clinical reasoning and patient safety are integrated throughout all topics. The TTP model is composed of many inter-related parts, with the aspects of education, practice and regulation being critical to the optimal operation of the program. Experts in education assist in creating modules and designing curriculum. Regulatory bodies ensure compliance with state nursing licensure, Nurse Practice Acts and the completion of the NGR program for license renewal. Practice is the critical link and includes educating preceptors as mentors to be paired with new graduates during orientation on their designated unit.

The TTP model (see Figure 1) builds upon the base level of the new graduate passing the NCLEX© exam and entering workforce orientation, which is separate from the transition program. After orientation, the new graduate nurse enters the residency program. There is ongoing feedback and regulation for the new graduate, and support for the first year of work, or six months beyond the ideal residency program time period. After 12 months of work, the new graduate applies for license renewal and provides proof of competing the TTP program.

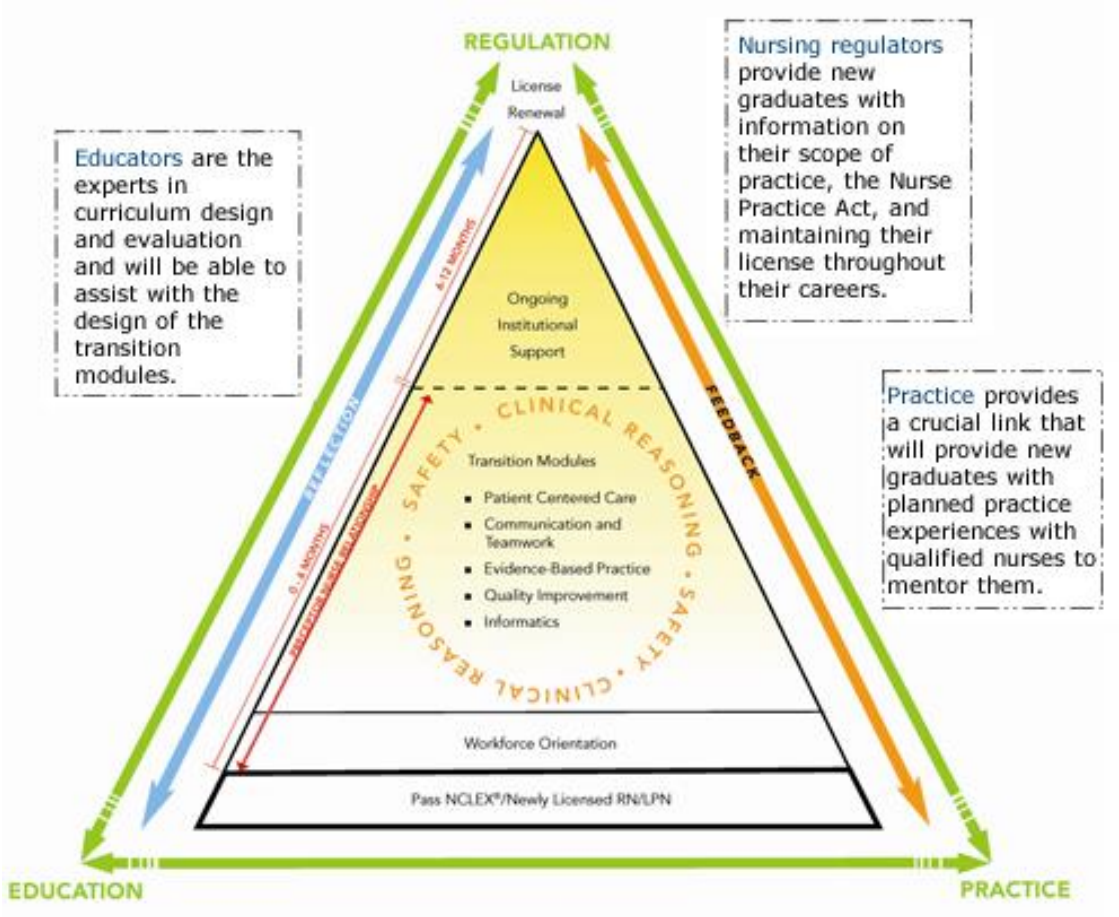

Figure 1. Transition to Practice© Model. From National State Council Boards of Nursing. (2013) Retrieved from https://www.ncsbn.org/transition-to-practice.htm. Reprinted with permission (Appendices A & B).

The TTP program is meant to be customizable to any institution or specialty nursing area (NCSBN, 2013). Currently, online modules are not available publicly for use but only to current hospitals participating in a pilot study determining effects for safety and quality outcomes. The NCSBN anticipates certain module pieces will be available for use in the future. The groups of nurses participating in the formal TTP program are separated into phase I group, or those that are registered nurses in the hospital setting and phase II group which are nurses in the workforce outside of the hospital setting. Phase I currently includes participants from three states in 75 hospitals with 750 new nurses and 750 preceptors. The NCSBN promotes the use of their model

and provides free range use of their evidence based material provided on their website. The online modules are expected to be available as well after the study has been analyzed. NGR programs in the near future may need to comply with standards set forth by formal transition programs such as the TTP, and may require accreditation through such organizations as the Commission on Collegiate Nursing Education (CCNE). The NCSBN states the modules are especially helpful for areas with limited resources such as rural settings where experts in certain areas may not be readily available.

The UHC/AACN Nurse Residency Program. Hospitals adopting NGR programs have seen tremendous returns on their investment in new graduate nurses. The University HealthSystem Consortium and American Association of Colleges of Nursing (UHC/AACN) boasts a 94.3% retention rate in the first year amongst new graduates enrolled in their evidence based NGR programs, a collaborate effort that began in March 2000 (UHC & AACN, 2013). Lower turnover, improvement in confidence and leadership, increased skills in organization and prioritization including competency, and decreased levels of stress are just some of the outcomes resulting from completion of their residency. The AACN/UHC standardized NGR program has grown immensely since its implementation in six academic hospital settings in 2002, to being utilized today in over 92 practice sites in 30 states, with more than 26,000 nurses completing the program (UHC & AACN, 2013). Their program mission incorporates improvement in new graduates as well as retention in academic medical centers. The one year program is built on evidence-based curriculum and meets the NCSBN's national residency standards, along with accreditation standards set forth by the CCNE for nurse residency programs. The program is designed exclusively for bachelorette prepared nurses in academic hospitals. New graduates participate in monthly seminars of approximately four hours each, addressing the program's core

content. The core curriculum is focused on three critical areas including leadership, patient safety and outcomes, and professional role.

Objective outcomes upon completion is transition from entry-level, advanced beginner nurses to competent professional nurses as indicated by Benner's (1984) model for levels of nursing experience. The graduates develop effective decision-making skills related to clinical judgment and performance, provide clinical leadership at the point of patient care, strengthen their commitment to nursing as a professional career choice and use research outcomes in practices (UHC & AACN, 2013). The program curriculum was designed by nursing experts from academic medical centers from around the country. The program can be purchased, and implemented by any institution with available resources. It complements regular hospital orientation. The purchasing hospital needs an academic affiliation for collaboration with a school of nursing due to the nature of the academic based program.

The Versant Program. Versant is a corporation formed in 2004 after a hospital transition program was created in 1999 at a Los Angeles based children's hospital to address recruitment and retention challenges facing their nursing population. The Versant program has been widely adopted and now includes over 6,000 nurse residency graduates in acute care hospitals (Ulrich et al., 2010). The program is 18 weeks, and consists of clinical immersion, mentoring and debriefing sessions, self-care, competency validation, and departmental specifics. The aim of the Versant program is to assist in the transition journey from "knowledge to knowing", or moving towards competent performance at the bedside based upon the theoretical principals of Patricia Benner (1984). The program is split into two sections. For the first six weeks, new nurses can expect to spend half of his or her time each week in class and half in practice with a designated preceptor. As the program proceeds, there is more time per week

designated at the bedside and less class time. The curriculum is evidence based, accredited by the CCNE and is intended to assist hospitals in preparation for Magnet recognition by the American Nurses Credentialing Center (ANCC). Emphasis on mentorship and team precepting are critical components in the program. In team precepting, the new graduate is placed on a designated unit with a mentor relatively close in experience to the new graduate. As the program progresses, the nurse is placed with more experienced or expert nurses on his or her unit. The program is purchased through Versant, and a representative of the purchasing organization works directly with company representatives for ongoing support.

Hospitals wanting to implement a NGR program can handpick from existing variations available for the one most suitable to their organization. The UHC/AACN collaborative Nurse Residency Program and the Versant RN Residencies are programs that include national guidelines set forth by the NCSBN for implementation into any chosen or created program. There are many overlapping theoretical concepts found amongst these programs. The following section will describe the common theoretical concepts with analysis of frameworks describing new graduate experiences in transition stress.

Nurses Ethical Reasoning Model. In a study by Fairchild (2010) an ethical theory and corresponding model was presented to respond to the ethical distress nurses experience by means of implementing an ethical theory into practice. Fairchild's model is depicted in figure 2. Fairchild proposed a paradigm shift in the clinical setting, to give new graduates adequate support and promote healthy work environments in today's complex health care setting. The environments in which nurses work can promote decreased motivation and low moral satisfaction leading to dissonance in the workplace. In all experience levels of nursing,

workplace dissonance in combination with other work related factors increase emotional stress and burnout for nurses and leads to turnover and an increased nursing shortage burden.

The model was built upon Fairchild's intuition and many years of clinical experience in a hospital emergency room, and upon extensive review and analysis of nursing and psychological literature on ethical reasoning skills and meta-cognition. The theoretical model for Nurses' Ethical Reasoning Skills (NERS) evolved and is presented for integration in the clinical setting. NERS consists of the meta-cognitive thinking skills of reflection, reasoning and review of competing values (Fairchild, 2010). Use of the NERS model (as seen in Figure 2) proposes nurses need to apply, use, and master the three R thought processes (reflection, reasoning and review) during patient care to assist in supporting nurses to maintain a caring ethical stance. The theory emphasizes use of mindfulness through critical thinking consciousness.

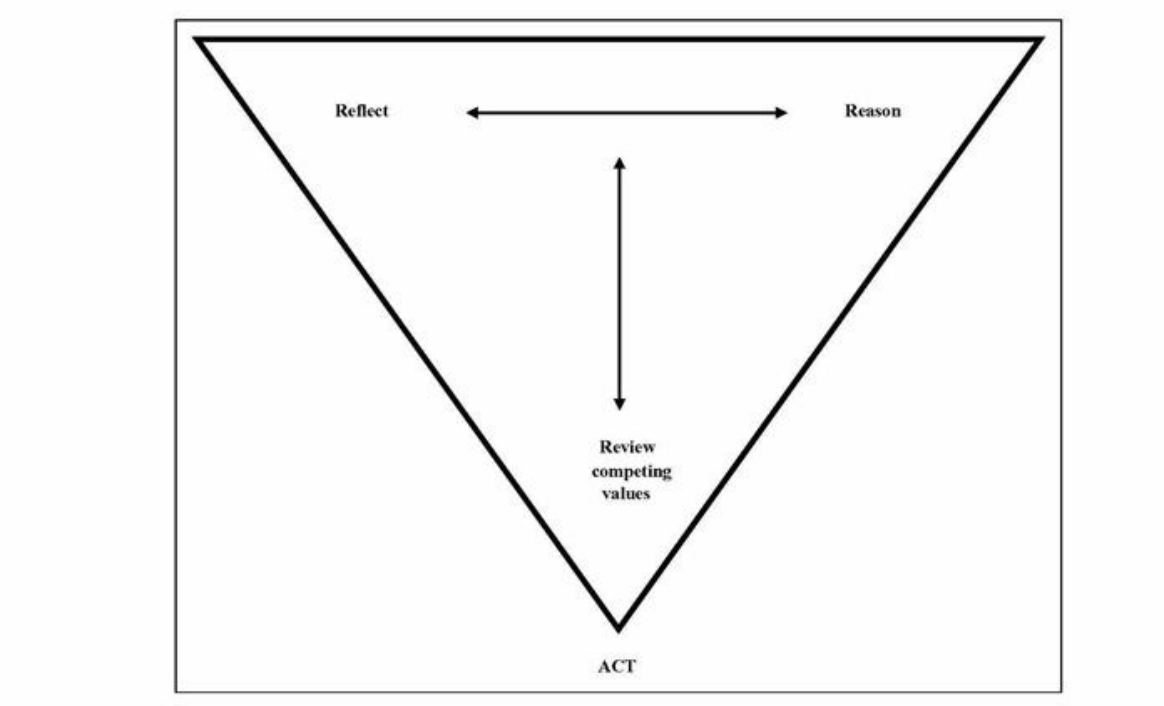

Figure 2. Nurses Ethical Reasoning Model. Fairchild, R. (2010). Practical ethical theory for nurses responding to complexity in care. Nursing Ethics, 17(3), 353-362. Reprinted with Permission (Appendix C).

Astute critical thinking is displayed when a nurse is able to reflect, know and act consciously under pressures of the environment as opposed to simply following rigid rules of the institution (Fairchild, 2010). Dialectic reasoning plays a key role in assisting nurses to reduce tensions between themselves and patients and families. Tension often occurs due to the quick changes and uncertainty in the health care setting. When a nurse masters dialectic reasoning skills, he or she views opposing forces in the workplace along dimensional continuums and functions while simultaneously keeping in mind an awareness of the big picture. Choosing an act is ultimately based upon competing values, and is shown purposefully at the "sharp end of the NERS theoretical model, meaning that this is where individual or collective decision ultimately lies, as they take action to achieve an outcome" (p. 360).

The NERS model has yet to be tested empirically, but offers added knowledge to nursing research. Two outcomes exist for NERS research. The first is to enable the nurse to see the overall big picture or evaluate opposing or competing values as they arise to purposefully reflect and manage situations given the complexity of the health care system. A second outcome gives nurses knowledge to be mindful of themselves, their collective actions, and the practice context. The NERS model creates ethics in practice and meaningful connections with patients and families. Rural nurses may need to balance expectations and values of the community with viewpoints from principles taught in education while also factoring in a nurse's expectation to adhere to regulations in the workplace. Fairchild's (2010) theoretical framework offers a way to battle the stressors of the health care setting with escalating levels of new nurse stress and unit dissonance.

Transition Shock Model. Judy Duchscher (2009) addressed an old problem with a contemporary lens. Kramer (1974), has documented that nurses experience discrepancies between education and the working world. She termed this concept transition shock, which serves as the initial stage of role adaptation for newly licensed registered nurses. The basis of the theory was presented, and developed as a result of a compilation of findings from ten years of qualitative study. Four separate studies were examined, three of which Duchscher conducted, in addition to knowledge gained from an extensive literature review of the transition experience of new graduates. Duchscher (2009) explains,

"the concept of transition shock builds on elements of transition theory, reality shock, cultural and acculturation shock, as well as theory related to professional role adaptation, growth and development, and change" (p. 111).

The new graduate is faced with stress when transitioning from his or her familiar and comfortable role as a student to the role as a nurse (Duchscher, 2009). Transition stress occurs when contradiction between knowledge, roles, responsibilities and expectations in the new facility is present. The new graduate is theorized to spiral these contrasted expectations into feelings of doubt, loss, confusion and disorientation. The model in Figure 3 presents a demonstration of ongoing struggles new graduates face leading to ultimate distress within the first one to four months post orientation period.

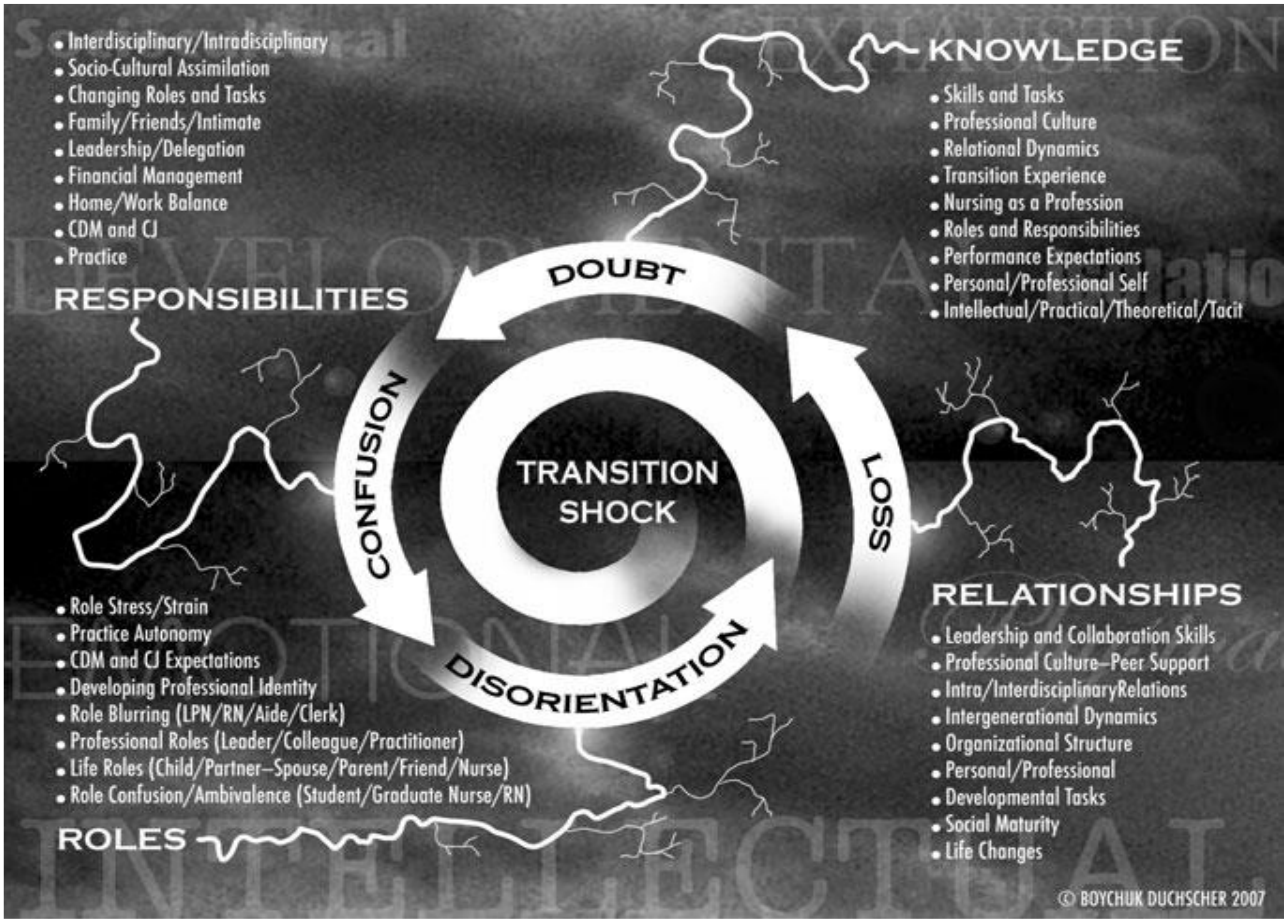

Figure 3. Transition Shock Model. From Duchscher, J. (2009). Transition shock: The initial stage of role adaptation for newly graduated registered nurses. *Journal of Advanced Nursing, 65*(5). Reprinted with permission (Appendix C).

Duchscher (2009) states multiple factors are experienced in transition not limited to physical, emotional, cultural, socio-developmental and intellectual challenges. Multiple transition factors are compounded by the fact that the student is not fully exposed to the practice level of the professional nurse during school clinicals or patient situations as a student, but will be faced with a heightened level of responsibility and accountability within a short amount of time during transition. The use of Duchscher's theoretical framework in NGR programs offers preparation for the transition phenomena and its impact on the new graduate and the understanding that stress in transition leads to feelings of incompetence as a nurse. Aims include educating professionals involved with new graduate nurses such as educators, managers and peer trainers of all elements of transition shock to positively modify orientations, expectations, and experiences with new graduate nurses. In most programs, emphasis is placed on support for the new graduate, as they progress through NGR programs. Duchscher believes new graduate nurses can be better equipped with tools for managing the transition if her theoretical framework is integrated into the NGR program.

Multiple authors have created models, theories, and frameworks to explain and correlate phenomena and concepts described in the models to new graduates experience. The frameworks presented represent two of many theoretical perspectives of meaning in the literature. Fairchild (2010) links mastering of the constructs, or "three R's", to effectively deliver meaningful patient care despite stressors in the workplace leading to turnover. Duchscher (2009) chooses to create awareness of the concept of transition shock to explain the turmoil a new graduate experiences based upon today's stressful environment in the hospital setting. Theory and framework which guided the development of empirical research studies and will be presented in the following section of the literature review (Grove, Burns & Gray, 2013).

Transition Stress in New Nurses

To keep new graduates in the workplace, new graduates must have positive experiences, learn essential new nurse competencies, and be able to manage stressors (Goode et al., 2009). Researchers Dyess and Sherman (2009) identified specific stressors found to be most negatively impactful to new nurses in a qualitative research study. The sample population included 81 new nurses participating in the Novice Nurse Leadership Institute (NNLI) nurse residency program in a South Florida community hospital. Three cohorts from 2006-2008 were studied to evaluate new graduates' transition and learning needs in their first year of practice to reconstruct the content of the NNLI. The nurses were graduates of an associate or baccalaureate nursing program. The methodology for the study was focus group discussion with facilitators having no connection to the institution of employment. Hermeneutic analysis was performed upon the reported data.

Outcomes from the phenomenological study by Dyess and Sherman (2009) included seven emerging concepts relating to distress for new graduates, with recommendations to address each. The first concepts included confidence and fear. The new graduates felt confident in what they had gained in their educational background, but fearful of the unknown. A second theme presented was less than ideal communication. Conflict arising out of poor communication was experienced between the new nurses and physicians, interdisciplinary team and unlicensed assistants. Horizontal violence in the form of unsupportive and unkind nurse coworkers was experienced by most participants in the study. Another theme was the perception of professional isolation in which, within the chaotic nursing unit, the new graduate did not receive help from any coworkers due to their own busy assignments leaving the new graduate to feel very alone and unsupported. Patient care required complex critical decision-making which was a stress for

the new graduates. They often felt unprepared to make on the spot critical interventions based on little clinical knowledge, as they were expected to do in their assignments. Overall, graduates received too much conflicting information to make sound decisions often fueled by consulting multiple colleagues and receiving contradicting information.

As a qualitative study, Dyess and Sherman's (2009) study was evaluated for rigor. The findings may not be generalized to the total population due to strict inclusion criteria by the composing institution. Only participants with a high potential for professional and leadership contributions amongst NNLI participants were recruited. The results may not reflect the phenomena other new graduates experience. Validity was questioned by means of undisclosed information regarding rationale for the semi-structured questions. How questions were developed or if past researchers have also used these questions to determine comparable reliability is unknown (Grove et al., 2013). Group interviews do have advantages in technique to allow a greater breadth of information to be collected. The study complements and adds to the body of current knowledge through congruent themes.

Casey-Fink Graduate Nurse Experience Survey. Goode et al. (2009) conducted a quantitative quasi experimental study of 26 academic medical centers across the United States of 655 new graduate nurse participants in the AACN and UHC residency program. The aim was to report findings from the first 12 sites using UHC/AACN program. The sample population met inclusion criteria by holding bachelors' degrees in nursing and being employed at an academic UHC affiliated hospital. The measurement tool utilized was the Casey-Fink Graduate Nurse Experience Survey. The tool evaluates stress levels including those of personal and financial issues, workload frustrations, desires to be independent yet not confident in skills and critical thinking, and inconsistencies in support from preceptors, mangers and educators (Fink, Casey,

Krugman & Goode, 2008). Statistically significant decreases were found in new graduates at both six month scores and one year scores in the stress subscale component of the survey as compared to the scores found prior to residency implementation. The residency curriculum content was supported by an associative relationship with the dependent variable of lowered stress levels. Study strengths included measurement of tool validity and statistical analysis methods. The authors disclosed the Casey-Fink Graduate Nurse Experience Survey has alpha of 0.89. Level of significance was set at 0.05, and use of ANOVA over time determined statistically significant F values. A decrease in making Type I error was evident by use of post hoc comparison of cohort groups. Weakness of the study were reported poor response rate of 46% of the sample population, non-random sampling methods and no information being found in the literature to ensure a power of analysis was conducted. The limitations in the study produced information that cannot be generalized to total population findings.

Variation in New Graduate Residency Programs. NGR programs are variable in their content although following the national guidelines set by the NCSBN may lead to better outcomes (NCSBN, 2013). A preliminary study in Las Vegas, Nevada sought to evaluate a local NGR program outcomes and compare with those of well-established programs (Kowalski & Cross, 2010). The Nevada year-long program was divided into two phases. The first phase was two weeks of orientation and twelve weeks of preceptor paired work on assigned clinical units. The second phase was composed of monthly meetings for the new graduate, and the preceptor was no longer paired one-on-one with the graduate nurse, but remained a designated mentor person for support. The monthly meetings contained education modules, support sessions, skill practice and presentation, and case studies. The residents were also participants in a simulation experience four times throughout the program.

The relatively small number of respondents participating in Kowalski and Cross' (2010) study was a limitation to the findings. Two cohorts of new graduate nurses within a community hospital composed of 30 and 50 nurse graduate residents respectively were studied. A population sample to derive acceptance or refusal rate was not reported.

Measurements of stress, anxiety, professional transition and turnover were included through a quantitative, Pre and Post survey method by Kowalski and Cross (2010). Instruments were presented in the text with validity according to Cronbach's alpha coefficients for threat and challenge. Pagana's Clinical Stress Questionnaire (1989) was implemented to measure clinical stress levels by means of threat and challenge across time periods of three and 12 months. The Pagana threat score revealed a statistically significant decrease, however challenge scores did not. The authors stressed their exhaustive efforts in deriving exact *P*-values by permutation distribution and calculation using Statistical Package for the Social Sciences (SPSS) for Windows. The statistical analysis method was performed to obtain statistically valid data despite small sample size. The study found a lower than expected retention rate of new residents at 78% in the first year of work. Authors claimed turnover was due to reasons not related to job stress or lack of support, but personal reasons. Kowalski and Cross (2010) illustrated the positive growth seen in their results from attributes in their residency program such as peer support, educational offerings and a "platform for skill development"(p. 103).

Kowalski and Cross (2010) as well as Goode et al., (2009) used the Casey-Fink Nurse Experience Survey (CFNES) to measure professional transition, though each participating new graduate groups utilized different NGR programs. Statistically significant findings with positive outcomes for the subscales of the CFNES for support, patient safety, communication, and leadership were found. A decline was also found in stress sub-scores by Goode et al., (2009) in

their comparison of scores from date of hire to one year or completion of the program. An increase in stress scores was observed by Goode et al. (2009) at six months by the new graduates, however Kowalski and Cross (2010) did not survey their participants during the six month time period. Goode et al. (2009) reported that new nurses need ongoing support in a yearlong program to smooth feelings of incompetence and the transition stress level peak at six months.

Demographic characteristics of participating new graduate residents in all three studies were disclosed. These included such items as age, gender, race, clinical area, marital status and degree achievement (Dyess & Sherman, 2009; Goode et al., 2009; Kowalski & Cross, 2010). Goode et al., (2009) did not disclose geographical information, but revealed the study was from participants in the first 12 sites of their UHC and AACN program in academic medical center hospitals across the United States. Kowalski and Cross (2010) revealed their study was conducted in Las Vegas, Nevada and Valley or Dessert Springs Hospitals. Dyess and Sherman (2009) stated their study participants were located in South Florida. No city or community populations were cited in any of the other studies. Rural institutions or critical access hospitals were not found as primary participating sites in the research, however the IOM (2011) recommended NGR programs be implemented in rural sites for anticipation of similar results.

All studies reviewed of NGR programs found new nurses to experience stressors and challenges in transition to practice. All three studies used different NGR program content and found positive effects on the new graduates studied. Kowalski and Cross (2010) implied their residency program provided the new nurse with strong clinical foundations and increased critical thinking skills. Goode et al., (2009) addressed their residency program as a success with resident outcomes of improvement in skill, organization, and clinical leadership and decreased stress and

turnover. Dyess and Sherman (2009) stated key findings from their studies and identified needs in the hospital setting. The major outcome indicated the importance for continuing education initiatives to meet new nurses' needs beyond traditional orientation and basic preceptor programs. The recent studies inferred that well composed NGR programs are an invaluable benefit both to the new graduate and the institution.

Rural Nurse Residency Programs. Keahey (2008) focused on addressing the need to effectively orient and retain new rural nurses and stated, "standardized orientation and residency programs do not begin to meet the needs of the new nurses and may directly contribute to the low retention rate experienced by many rural hospitals" (p. 15). Key elements for successful nurse residencies were found in a review by Keahey (2008) on rural hospital programs. Key elements included providing a caring environment, permitting accommodation to different learning techniques, providing preceptors that were best qualified and committed to their new nurses' success, and management advocating and supporting NGR programs. Molinari and Bushy (2011) identified successful TTP program components for rural areas to address the specialty of rural nursing in which nurses are often expected to become expert generalists. Key components for a rural nurse residency program included identification and utilization of scarce resources, collaborating with communities and academic institutions, and recognizing the need for rural nurses to have increased autonomy and accountability to the profession.

The current research Project addressed gaps found in the literature review, and added to the current body of knowledge. The study was implemented in a rural critical access hospital. Rural hospitals have not been well documented as primary sites for NGR program implementation in current literature. The Project added to the current body of information regarding transition program development and the potential benefits.

Theoretical framework. The theoretical framework for this study is based on the seminal work of nurse theorist Patricia Benner (1984). Benner's framework views the nurse as progressing through five levels of nursing experience, from novice to expert. In the *Novice* level, the person has no background experience in the current situation. It is difficult for the nurse to discriminate between relevant and irrelevant situational aspects. Nursing students are typically at a novice level. The next stage is *Advanced Beginner* in which the person demonstrates minimally acceptable performance and task completion, but continue to function under the guidance and orientation of others. The next level is *Competent*, in which after two to three years the person is able to determine which elements of the situation warrant attention and has the ability to recognize patterns. Competent nurses are able to reason and apply learned concepts to situations. The next level in Benner's model is *Proficient*, in which the nurse has been in the same area for three to five years and is able to perform skilled and holistic responses to patient situations. The nurse is able to adapt to changing or evolving situations that require rapid response and recognition. The last step in the continuum is *Expert*. Expert nurses have been in the same area for five or more years. Nurses have developed intuitive approaches to each situation and are able to focus on the area of concern while understanding the whole situation with deep understanding. They are not only competent, but able to achieve their goals with little or no wasted energy (Benner, 1984).

The passage through experience levels, however, does not simply refer to the passage of time or longevity (Benner, 1984). Movement through experience levels includes changes in two aspects of skilled performance. First, there is change in reliance of the nurse on past abstract principles learned, to utilizing concrete experiences as paradigms for guiding nursing judgment. Secondly, change occurs when the nurse is able to judge situations as having aspects that are

more important than others, or aspect recognition, and the nurse does not waste time or energy on irrelevant pieces. Expert nursing leads to positive patient outcomes.

Nursing students begin in the novice stage due to limited experience (Benner, 1984). In the study by Goode et al (2009) new graduates beginning in their residency programs were considered advanced beginners with Benner's theory due to their lack of experience, expertise, and confidence in caring for complex patients. Advanced beginners only demonstrate marginally acceptable performance, and are unable to successfully perform a magnitude of aspects, or required nursing functions that only a nurse with prior experience can adequately complete (Benner, 1984). Teaching-learning strategies in NGR programs can be formulated to include experience based principles with meaningful elements. Experience based principles include aspect recognition in clinical skill, meaningful patterns, and priority setting for protection in doing no harm to the patient, or new nurse.

As the new graduate progresses through a NGR program, Goode et al (2009) anticipated that nurse residents would progress to the competent or proficient stage by displaying recognition of reoccurring meaningful components and begin utilizing comprehension of the concept elements in practice. Nurses, in the competent stage, are finally able to see the clinical world as organized, but only after much effort. They are able to plan and organize care for multiple complex patients (Benner, 1984). Proficient stage nurses begin to critically think of the whole of clinical situations. They understand meanings of scenarios, and can base perspective on experience, which ultimately, modifies their responses to be directed at more important attributes. The same expectations were applied to the current Project.

CHAPTER 3. INTERVENTION AND IMPLEMENTATION

Assumptions

The author of this Project has several assumptions regarding NGR programs. From the framework of the developed Project, new graduates nurses entering work at the MCAH will be at the experience level of advanced beginner as stated by Benner (1984). The new graduate lacks experience, expertise and confidence in his or her abilities of giving nursing care to complex patients. Project participants are assumed to understand the context of Benner's framework as it relates to new nurses in transition to acute care nursing. The participants will also answer survey questions truthfully given that the information collected will remain confidential and anonymous. The MCAH will support the development and evaluation of a NGR program. The project is recognized as highly important by hospital management as part of their facility vision.

Implementation of Planned Intervention

Program development. The MCAH Nurse Residency program developed was based upon the principles of the NCSBN's regulatory model for Transition to Practice (TTP), and follows the five outlines available from the TTP modules. Permission was granted to utilize the TTP materials on the NCSBN website for distribution and development of the MCAH Nurse Residency program (Appendices A & B). The five NGR module topics included: patient centered care, communication and teamwork, evidence based practice, quality improvement and informatics. Each module was composed of content related to the overall module topic with incorporation of material to meet the needs of new nurses specific to the culture at the MCAH. Each module was created by the student and/or Nurse Residency Committee at the MCAH, using the TTP material. The student developed the entire modules of patient-centered care, teamwork and communication and evidence based practice. The student also led committee meetings

coordinating all pieces of the Project. The committee consisted of four nursing managers, two quality improvement nurses, two charge nurses, two medical surgical floor nurses, an emergency room nurse, a family birthplace nurse and the Chief Nursing Officer (See Figure 4).

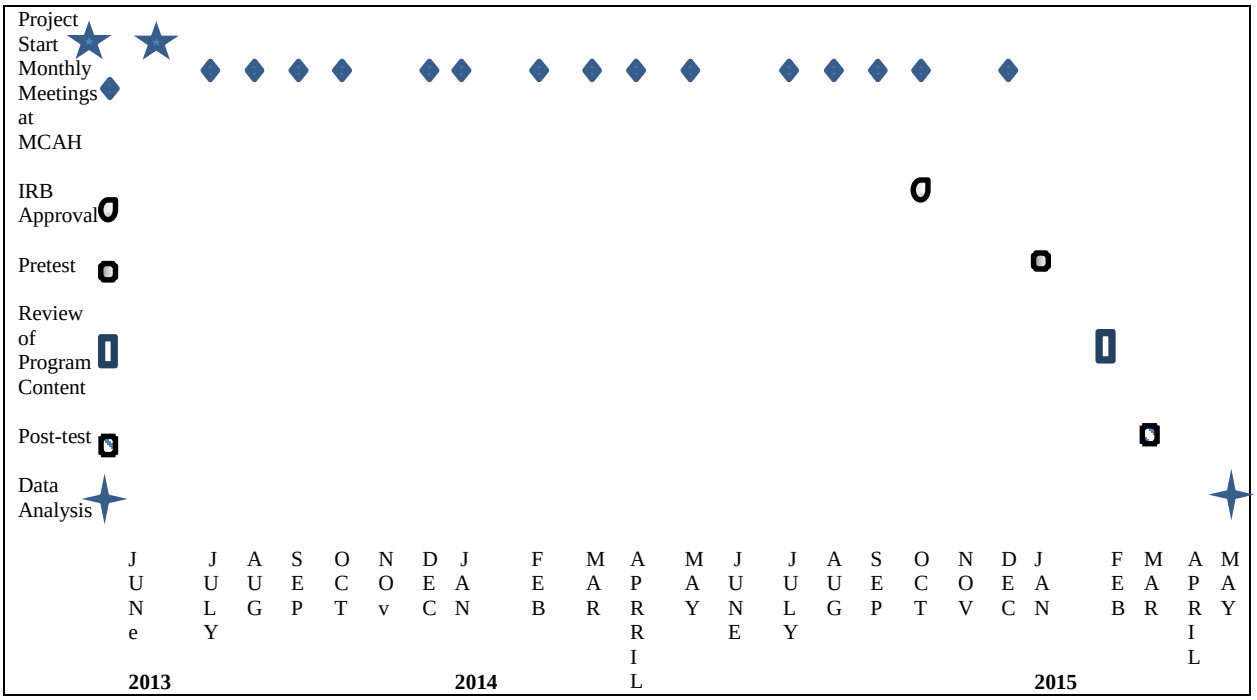

Figure 4. Program Outline.

During the time of program development and study implementation, the student Project developer was also employed at the MCAH as a medical surgical staff registered nurse. As a graduate student, the student led in the complete development of three of five modules and completed sections of the other two modules. Part of the role also included coordinating development and evaluating all five modules for consistency and relation to the learning objectives of the program. The student developed the entire modules of patient-centered care, teamwork and communication and evidence based practice. Learning objectives from the NCSBN TTP© guided the development of each module's content. Development included creating voice over PowerPoint presentations, identifying and posting institutional policy to the

online platform with discussion board, generating interactive quizzes for evaluation participants as well as designing case studies with discussion questions. Further development efforts included identifying and meeting with expert nurses in various fields at the institution to gain insight into developing program activities to assist in meeting program objectives and new nurse transition needs in departments to which they may float. For example, checklists were created, one of which was titled, "What do I need to know when I float as a new nurse to this unit" for Same Day Surgery, Emergency Room and the Obstetrics units. Tip sheets and expectations of the new nurse as well as resources on float units were developed. Case studies about patients with respiratory failure, deep venous thrombosis, surgical site infection and pneumonia were developed. The student utilized work experience with real clinical scenarios to develop the case studies so the new graduates would be able to relate and envision the situations. Discussion questions for each case study were developed to gain insight into the critical thinking abilities of the new graduate nurse. In the case studies, interdisciplinary team members were also incorporated to give a comprehensive experience. The case studies could be completed by the new graduates and then discussed, but also could easily become a role playing activity. Videos were created for the modules that included steps in delegation decision making, and another on how to critique evidence based nursing articles. The TTP program outlines a "delegation decision making tree" (NCSBN, 2011), and the student created a video to help explain the steps to take in delegation. Two registered nurses, a licensed practical nurse and an unlicensed assistive personnel played roles in the video. By utilizing the various members of the nursing team, the student was able to bring the responsibilities of the registered nurse during delegation to life.

The student collaborated with a local university nursing instructor of research courses to create a standardized EBP critique form for the MCAH to utilize when updating policy and procedure, and an audio presentation was created and implemented in the program on its use. New nurses are encouraged at the MCAH to suggest change and review policy and procedure for continual improvement. Information included on the form was gathered and introduced in a presentation on how to identify and suggest changes to the medical surgical unit based upon evidence. Other responsibilities of the student included identifying resources for new nurses to refer to when concerned about their patient's condition. Reference material listing the MCAH's most common diagnosis, signs and symptoms, treatments and early identification of possible complications was developed. The student organized the reference material in a concise manner so the new nurse could easily reference the information. This material was created to allow the *advanced beginner* (Benner, 1984) new graduate nurse to think like a higher level nurse. Tools were also identified and placed in the program to allow for new nurses to evaluate their learning styles and appreciation type to enhance the teamwork and communication amongst the new nurses and their managers. The MCAH NGR committee decided that if new nurses and their manager(s) were aware of their preferred learning style, annual goals made by the new nurse could be better identified and met through facilitation of the preferred learning style. Managers on the MCAH NGR committee also determined that if they knew how their new nurses liked to be appreciated, they could better praise their new nurses and enhance well-being. For example, some employees prefer gifts, while others enjoy time off, or words of affirmation.

A presentation was created explaining the roles and responsibilities of the interdisciplinary team within the institution as well as identifying unit managers. This material was created to assist the new nurse in his or her transition to recognize co-workers. Reference

forms for high risk procedures (central line dressings, surgical dressing changes, inserting a foley catheter), institutional policies (the MCAH nursing process, supply expiration policies, iv therapy), expert nurse wisdom and advice for new nurses, reflection questions, practice challenges and many other forms of knowledge were utilized to develop the MCAH NGR content. The goal was to obtain a wide variety of material related to the QSEN competencies, but specific to the institution. Each piece of material obtained or created satisfied a learning objective of the program within one of five modules.

The student coordinated all pieces of the developed program and uploaded the files to an electronic Moodle© platform to host the MCAH Nurse Residency program. Program development took place from June, 2013 to December, 2014 and the student held monthly program meetings to identify learning objectives that would be utilized along with content pieces. The student led discussions of how each learning objective could be met by using institutional resources to tailor the program for new nurses at their institution. The committee members were continually updated on the progress of the student on creating three of the five modules during meetings.

As the student created pieces of the program, they were brought to the committee for approval and adjustment prior to being placed on the website. The student led in identifying how program objectives could be met for the modules of quality improvement and informatics, while others from the committee developed and collected pieces to place on the website. The student critiqued these pieces prior to being placed online, and also assisted individuals from the committee in identifying appropriate resources and/or activities to utilize. The content of all five modules included a variety of teaching-learning strategies such as case studies, presentations from experienced nurses and interdisciplinary team members, PowerPoints, discussion boards,

interactive quizzes and surveys, traditional lecture, group projects, and more. The MCAH plans to utilize a platform similar to the one created for the residency content to assist in carrying out the program for new graduate nurses after study completion. The MCAH administration plans to identify ways to present the NGR program after making modifications to the program based upon survey findings.

As an employee, the student collaborated with members of the MCAH Nurse Residency committee outside of her responsibilities as a graduate student. Responsibilities included assisting others in creating content pieces from specialty nursing areas such as family birth place (obstetrics), operating room, emergency department and quality assurance for the program. The material from specialty areas was utilized in the development of the quality improvement and informatics modules.

Population and sample. The target population for the study was clinical nurses with 12-24 months of acute medical surgical nursing experience at the MCAH and nurse educators at a local university with clinical experience and familiarity of the MCAH nursing culture. By having a population that included both clinical nurses and nurse educators, content could be thoroughly reviewed for curriculum and content development as well as needs of new nurses at the MCAH. The sample population was six clinical nurses and six nurse educators. Consent was obtained from Project participants and participation in Pre and Post surveys were optional. Demographic information obtained included age, sex, nursing experience and educational degree. The project began after proposal and Institutional Review Board (IRB) approval in October of 2014.

Institutional Review Board. The proposal was submitted to the IRB of North Dakota State University and the MCAH for review, and was approved by both parties in October of 2014. All participants had the study explained to them with ethical considerations regarding

privacy of their information. This was done through a meeting at the MCAH, and one at a local university. Consents were obtained from six nurses at the MCAH and six educators at the local university. All participants referred to as the Review Group, reported understanding the process for completing the study.

CHAPTER 4. EVALUATION

Evaluation of Module Content by clinical nurses and nurse educators

Program Design. The MCAH Nurse Residency program design for evaluation participants was an online, self-paced course. Each participant was given a secure username and password securely through email for logging into the online platform Moodle©. Participants were encouraged to view all content, participate in discussion boards and take questionnaires and surveys built into the program. Participants were to view the five modules, starting with module one.

Evaluation of Content surveys. The Project design was an exploratory Pre and Posttest design. Project participants completed a Pre and Post Evaluation of Content Survey (See Appendix E & F). Project participants completed the pre survey two weeks prior to entering the online course. They were given eight weeks to independently participate in the program. After the eight week time period, participants were then emailed a post survey to evaluate learning and gain participant feedback on program content. The MCAH Nurse Residency program is the independent variable of the study, and seven identified factors drawn from the survey questions are dependent variables. The quantitative survey variables are patient-centered care, communication and teamwork, evidence based practice, quality improvement and informatics. A dependent variable drawn from qualitative questions on the Evaluation of Content survey was new nurse transition stress. The Review Group evaluated the relevancy of content to the needs of new nurses on the Evaluation of Module Content surveys developed by the student. The survey was carefully designed to measure new nurse needs both by quantitative and qualitative measures, based upon a literature review.

Findings from the proposed NGR program project at the MCAH provided feedback on relevancy of content to new nurse needs and to identify if the program could assist in reducing new nurse transition stress. Suggestions for content refinement was also gained. The data will be utilized to improve the MCAH Nurse Residency program prior to implementation by the institution. Development of NGR programs to date provides reason to be optimistic about stabilizing the future workforce of nursing practice, in an often unstable acute care environment (IOM, 2011).

Results and Discussion

Qualitative data. Responses from qualitative data collected on the post Evaluation of Content surveys were analyzed by the student. The Review Group was asked 1) How is the content presented in the five modules relevant to new graduate nurse needs at the MCAH in order to reduce transition stress in the acute care setting? And 2) How could the MCAH Nurse Residency program better meet the needs of new nurses transitioning into acute care at the MCAH (See Appendix F). These questions evaluated perceptions the Review Group had about the MCAH Nurse Residency program content as presented in the electronic platform format. Perceptions were evaluated to determine if the MCAH Nurse Residency program could reduce transition stress new nurses experience in their first year of acute nursing as detailed in the literature review section. Evaluation consisted of content analysis on the responses for emerging ideas, patterns of thought and labeled emerging codes, or themes, with each response. Qualitative data was used to allow for a rich understanding, and empirical knowledge (Grove, Burns & Gray, 2013). Due to the small number of participants in the review group, qualitative data may allow for better interpretation of perceptions about the developed NGR program.

Codes emerging from data about transition stress reduction included that the MCAH Nurse Residency program was 1) a resource for new nurses, 2) may assist in their transition, and 3) could help improve patient care through nurse empowerment. One respondent stated, “This is a great place to find resources. It's full of important information that could be helpful to any nurse of any age, especially new nurses”. Others supported the program, reporting such comments as, “It would help find areas of potential improvement to better nursing care” and identified the program as potentially helpful to have as a resource to identify common policies and procedures needed to be understood by new nurses. One respondent commented that the program, “Allows new nurses to learn how to implement changes for better patient care”. The comments suggest that the MCAH Nurse Residency program may allow for quicker transition on the unit due to identifying resources early on and being able to reference them when necessary throughout their first year in acute care. The program allows the new nurses to experience patient scenarios, via the role playing or case studies, they have not encountered yet, but would likely encounter during their experience in the first year. One respondent commented the program gives new nurses some “tools in their toolbox”. New nurses, especially those in rural settings, may feel empowered when they know where to locate resources to guide them in patient care. New nurses may feel less stressed if they can easily locate the policies, procedures or recall what to do in high stress situations.

Suggestions also arose from the qualitative data on how the MCAH Nurse Residency program could better meet new nurse needs. Participants identified that there should be more content related to all nursing departments, as new nurses at the MCAH are often asked to float to departments other than their own after six months. They also noted that the program content would need support from the MCAH to maintain current content and be reviewed for any old

procedures or policies and general editing. One respondent stated, “The content was thorough. It would need to be kept up to date as processes and policies change at [the MCAH]”. Respondents also identified that the residency program needs to be evaluated for timeliness of enrollment in the program for new nurses. One respondent noted, “Some of that information might be helpful to learn earlier in the new nurses’ employment”. New nurses may find certain module content more applicable to the beginning of their employment or at five months after general orientation. This feedback was reported to the MCAH Nurse Residency committee for possible program modification and identification of possible benefit of implementing the program for their new nurses. Overall, the feedback gained to improve the program focused on how to better prepare the new nurse for transition into float areas as well as how to keep the program current. Vital for the success of the MCAH Nurse Residency program is the plan to maintain up to date reference material so new nurses can feel confident in their transition to the institution.

Q**uantitative data.** The Evaluation of Content Surveys asked respondents about six dependent variables; patient-centered care, communication and teamwork, evidence based practice, quality improvement, and informatics. Questions 1-14 (See Appendix E & F) addressed these variable before and after respondents reviewed the MCAH Nurse Residency program. Responses were based on a Likert-type scale rating of one to four identifying the respondents’ knowledge of the content in the question stem. One indicated “no knowledge of this”, two indicated “minimal”, three indicated “sufficient” and four indicated “excellent” knowledge level of the topic addressed in the corresponding question.

Evaluation analysis was performed by both paired t-test and Related-Samples Wilcoxon Signed Rank Test. *P*-values were similar for each analysis method. Level of significance was determined at 0.05. *P*-values were identified to determine if the null hypothesis could be rejected

or accepted. If the *p*-value was less than 0.05 the null hypothesis was rejected and was assumed the MCAH Nurse Residency program enhanced participant perception of knowledge of the QSEN competency evaluated. If the *p*-value was greater than 0.05 the null hypothesis was accepted and it is assumed the MCAH Nurse Residency program did not enhance participant knowledge of the QSEN competency evaluated. The Related-Samples Wilcoxon Signed Rank Test results are listed in the tables below, but need to be cautiously interpreted due to small sample size (n=11) and the use of a Likert-type scale. Data results are grouped per competency to give an overall understanding of possible significance in participant knowledge change. Individual questions from pre and post surveys are also included. While survey questions used the initials of the healthcare institution, "MCAH" will be used here for consistency in this paper.

Patient-centered care. Questions 1-4 assessed the participants' perception of their competency of patient-centered care. Questions included:

1) My knowledge of patient centered care and its relation to patient satisfaction, safety, and cost effectiveness at the MCAH is

2) My awareness of strategies the MCAH uses to empower patients and their families to engage in active partnerships within their plan of care is

3) My awareness of how the standards of nursing practice policies and procedures at the MCAH encourages nurses to advocate for patient centered care is

4) My awareness of how common priority setting traps interfere with a nurse's ability to rank priority of needs of patients is

Responses were based on a Likert-type scale rating of one to four identifying the respondents' knowledge of the content in the question stem. One indicated "no knowledge of

this", two indicated "minimal", three indicated "sufficient" and four indicated "excellent" knowledge level of the topic addressed in the corresponding question.

Three of the four questions relating directly to patient-centered care had *p*-values less than 0.05, and rejected the null hypothesis (see Table 1). Question three's *p*-value of 0.096 could not reject the null hypothesis. Question three asked about participant knowledge of "awareness of how standards of nursing practice policies and procedures at [MCAH] encourages nurses to advocate for patient-centered care".

Table 1

Data Analysis of Patient-Centered Care

Question	1	2	3	4
Wilcoxon T statistic	21.00	32.00	18.00	21.00
p-value	0.014	0.035	0.096	0.024
Pre-test Median	3	3	3	2
Post-test Median	4	4	4	3
Difference (d)	1	1	1	1

Communication and teamwork. Questions 5-7 addressed the participants' perception of their competencies of communication and teamwork. Questions included participant's rating their knowledge on

5) My knowledge of communication strategies to solve problematic situations nurses encounter is

6) My knowledge of team strategies and tools available at the MCAH to enhance teamwork and patient safety is

7) My knowledge of how to use the delegation decision making process is

Responses were based on a Likert-type scale rating of one to four identifying the respondents' knowledge of the content in the question stem. One indicated "no knowledge of

this", two indicated "minimal", three indicated "sufficient" and four indicated "excellent" knowledge level of the topic addressed in the corresponding question. The null hypothesis was accepted on all three questions (see Table 2). Participant knowledge of communication and teamwork principles related to the MCAH were not enhanced. A possible explanation for this is that most participants ranked themselves as having at least "sufficient" knowledge of all three questions relating to teamwork and communication on pre-tests, which did not allow for much knowledge enhancement by the intervention.

Table 2

Data Analysis of Teamwork and Communication

Question	5	6	7
Wilcoxon T statistic	21.00	24.00	12.00
p-value	0.206	0.059	0.739
Pre-test Median	3	4	3
Post-test Median	3	3	3
Difference (d)	0	-1	0

Evidence-based practice. Question 8-9 measured the participants' perception of the competency of evidence-based practice. Questions included report of

8) My knowledge of the various databases to locate relevant evidence to support nursing practice available within/or outside of the MCAH is

9) If a process change needs to occur within the MCAH based upon evidence recommendations, how would you rate your awareness of how to present a practice change?

Responses were based on a Likert-type scale rating of one to four identifying the respondents' knowledge of the content in the question stem. One indicated "no knowledge of this", two indicated "minimal", three indicated "sufficient" and four indicated "excellent" knowledge level of the topic addressed in the corresponding question.

According to *p*-values, one question's change was statistically significant and the other was not (see Table 3). Respondents reported they may have a better understanding of how to make a process change based upon evidence at the MCAH, however, data indicates they may not be able to identify resources or databases to locate the evidence after reviewing the MCAH Nurse Residency program.

Table 3

Data Analysis of Evidence Based Practice

Question	8	9
Wilcoxon T statistic	8.00	36.00
p-value	0.257	0.008
Pre-test Median	3	2
Post-test Median	3	3
Difference (d)	0	1

Quality improvement. The participants' perception of their competency in quality improvement was measured through survey questions 10-12. Questions asked included

10) My knowledge of available resources at the MCAH to help analyze and identify commonalities in health care errors to promote prevention

11) My awareness of the best methods to address quality improvement opportunities that affect nurses at the point of care at the MCAH is

12) My knowledge of potential barriers to implementing or suggesting improvements and my ability to identify ways to overcome them is

Responses were based on a Likert-type scale rating of one to four identifying the respondents' knowledge of the content in the question stem. One indicated "no knowledge of this", two indicated "minimal", three indicated "sufficient" and four indicated "excellent"

knowledge level of the topic addressed in the corresponding question. All three items could be interpreted to reject the null hypothesis (see Table 4). The intervention can be assumed to have improved knowledge about quality improvement topics.

Table 4

Data Analysis of Quality Improvement

Question	10	11	12
Wilcoxon T statistic	50.50	33.50	28.00
p-value	0.013	0.026	0.015
Pre-test Median	2	2	3
Post-test Median	3	3	3
Difference (d)	1	1	0

Informatics. The final competency of informatics measured participants' perception of knowledge on survey questions 13 and 14. Questions included:

13) My knowledge of what information technology skills are needed for safety in patient care at the MCAH is

14) My knowledge of how to maintain boundaries with patients through social media and the electronic medical record to protect confidentiality is

Responses were based on a Likert-type scale rating of one to four identifying the respondents' knowledge of the content in the question stem. One indicated "no knowledge of this", two indicated "minimal", three indicated "sufficient" and four indicated "excellent" knowledge level of the topic addressed in the corresponding question.

One question was determined to have a change in knowledge that was statistically significant and so the null hypothesis could be rejected, however, question 14 (see Appendix) had no change in knowledge level upon analysis and the null hypothesis was accepted (see Table 5). The question showing no increase in knowledge level could be due to high levels of knowledge about the competency prior to the intervention. All but one (90.91%) reported

"excellent" "knowledge of how to maintain patient boundaries through social media and the use of electronic medical records for patient confidentiality" on pre surveys. It could be implied that the clinical nurses and nurse educators already knew the components of competent nursing care with regards to the informatics data measured.

Table 5

Data Analysis of Informatics

Question	13	14
Wilcoxon T statistic	21.00	0.00
p-value	0.014	0.157
Pre-test Median	3	4
Post-test Median	4	4
Difference (d)	1	0

Summary of Qualitative and Quantitative Data

Of the six competency subsets, we can report that respondents have identified the MCAH Nurse Residency program to improve their perception of their knowledge of the QSEN competencies patient-centered care, quality improvement and may improve components of knowledge in evidence based practice per statistically significant *p*-values. The other three subsets' data is unable to be interpreted overall as statistically significant due to the majority or all of the subsets' question analysis accepting the null hypothesis. Looking at the raw data for the questions that were analyzed and determined to have no change in knowledge level, respondents commonly identified a level of "sufficient" or "excellent" knowledge level on the pre survey prior to reviewing the MCAH Nurse Residency program. There was minimal room for knowledge improvement on posttest responses.

By reviewing data both by statistical analysis and identifying themes or codes from qualitative feedback, some overall findings arise. The MCAH Nurse Residency Program can be a

vehicle to promote competency in teamwork and communication. The NGR program can allow new nurses to better do their job and care for patients because of the abundant resources available. New nurses will find the program allows for ease of transition and lowered transition stress. However, the findings from these data sets cannot be made across nurse residency programs.

Recommendations for Improved Nursing Practice

The overall Project supports some findings from the literature. NGR programs are variable in their content. Following the national guidelines set by the NCSBN may lead to better patient outcomes (NCSBN, 2013). The Project supports an improvement in knowledge of patient-centered care, quality improvement and components of evidence based practice competencies can occur through the use of a standardized residency program. Through quality improvement awareness, new nurses can assist in preventing or identifying errors in their environments (NCSBN, 2013). NGR programs are the critical link to enhance transition from education to practice to improve patient outcomes while also supporting new nurses.

Findings indicate the MCAH Nurse Residency program developed may provide the support and resources necessary for ease of transition. Support for new nurses from their employing institution in the form of available resources to improve competence and promote retention is key (Fairchild, 2010). There were no studies identified in the literature that evaluated content of a NGR program, rather, many studies are aimed to identify how these programs assist new graduate nurses in role transition. Further, there are few NGR program studies in rural settings (Molinari and Bushy, 2012). In a rural setting it has been identified that successful NGR program components include resources and give guidance on the specialty of rural nursing. This includes identification and utilization of scarce resources with support from

administration. With anticipation to lessen the problem, NGR programs based upon QSEN (2013) competencies and IOM (2003) recommendations are an attempt to recruit and retain competent nurses working in the hospital to fulfill the calling of the Nation (NCSBN, 2011).

It is recommended there be further study of NGR programs developed in critical access hospitals. Critical access hospitals often do not have as many resources, but require their nurses to expand their skill sets into a wealth of patient areas (Molinari & Bushy, 2012). Another recommendation is to repeat this Project with a larger sample. Future studies including research participants in the *Proficient* and *Expert* level of nursing practice according to Benner's (1974) framework may produce identification of areas lacking in NGR programs.

Conclusion

The findings conclude the developed program may assist in reducing new nurse transition stress by providing resources and acting as a support system. Nurse residency programs may assist in the development of competencies required for new nurses, including patient-centered care, quality improvement and components of evidence based care. Recommendations state that standardized programs should be put in place for new nurses (IOM, 2011). These programs should be based upon well-established criteria to not only retain nurses, but to assist them in their transition to acute care. A well-known gap in transition of nurses from student to professional exists. New nurses need a set of knowledge, skills and abilities in several areas in order to improve in their competence while also reducing stress in the workplace (Fink et al., 2008). NGR programs are aimed to assist in solving this problem, and programs built upon NCSBN's Transition to Practice are suggested to be followed for program development (NCSBN, 2013). Areas for new graduate nurses to expand their knowledge include patient-centered care, teamwork and communication, evidence based practice, quality improvement and informatics.

The outcomes of this project suggest the MCAH Nurse Residency program may serve as a resource, extra support and a place to learn more about normal routines and expectations as a new nurse. The literature supports that NGR programs often serve as resources for new nurses, and decrease their stress levels (Fink et al., 2008). The findings and suggestions from this project will serve as the voices for further development of a rich NGR program for nurses at one Midwest critical access hospital.

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APPENDIX A. EMAIL FOR APPROVAL OF TRANSITION TO PRACTICE©

REPRINT AND DISTRIBUTION

From: Nancy Spector [nspector@ncsbn.org]
Sent: Friday, August 09, 2013 9:33 AM
To: Allison Danzl
Subject: RE: Transition to Practice

Hello Allison,

Dawn Kappel, our Director of Marketing and Communications, gives permissions at NCSBN. I will forward your letter to her. In case you want to contact her, Dawn's email is dkappel@ncsbn.org.

Thanks.

Nancy

Nancy Spector, PhD, RN
Director, Regulatory Innovations
National Council of State Boards of Nursing
Specializing in Nursing Education
111 E. Wacker, Suite 2900
Chicago, IL 60601
Direct line: 312-525-3657

-----Original Message-----
From: Allison Danzl [mailto:adanzl@jrmcnd.com]
Sent: Friday, August 09, 2013 6:30 AM
To: Nancy Spector
Subject: Transition to Practice

Hi Ms. Spector,

I am emailing a letter attachment in regards to the phone conversation we had last week requesting permission to utilize the NCSBN's Transition to Practice materials. Thanks!

Allison

[Description: Description: JRMC_apples_RGB]

Allison Danzl, RN, BSN
Patient Care Unit
Jamestown Regional Medical Center
2422 20th Street SW
Jamestown, ND 58401
(701) 952-4555
adanzl@jrmcnd.com

APPENDIX B. LETTER OF REQUEST TO USE TRANSITION TO PRACTICE©

REPRINT AND DISTRIBUTION

North Dakota State University
(NDSU)
PO Box 6050
Fargo, ND 58108

Nancy Spector, PhD, RN
National Council of State Boards of Nursing
(NCSBN)
111 East Wacker Drive, Suite 2900
Chicago, IL 60601-4277

Dear Nancy Spector,

My name is Allison Danzl, and I am an RN in graduate school with North Dakota State University (NDSU) in the MSN Nurse Educator program. I am also a staff nurse at Jamestown Regional Medical Center (JRMC) on the medical-surgical unit. This is a rural, critical access hospital in Jamestown, ND. For my Master's project, I am excited to assist in the creation of a new graduate nurse residency program with the collaboration of NDSU and my co-workers at JRMC. Our first cohort of nurse residents is projected to begin summer 2014. I have extensively researched the available programs, and really like all aspects of the NCSBN's Transition to Practice. This includes the model, outlines of the preceptor and participant modules, and supplemental information on the website. I am writing to ask for permission to use these great resources for my project, with use of appropriate citations for work. I am very excited to spread support to new nurses in the rural Midwest! I look forward to hearing from you, please contact me for any questions or concerns.

Thank you for your time,

Allison Danzl, RN, BSN
Adanzl@jrmcnd.com
Patient Care Unit
Jamestown Regional Medical Center
2422 20th Street SW
Jamestown, ND 58401

APPENDIX C. EMAIL APPROVAL FOR TRANSITION SHOCK THEORY REPRINT AND DISTRIBUTION

Permission to print Transition Shock Model

Delete Reply Reply all Forward ...

AD

Allison Danzl
Wed 8/14/2013 9:17 AM
Sent Items

Mark as unread

To: ☐judy.eldon.duchscher@shaw.ca;

Ms. Duchscher,

My name is Allison Danzl, MSN graduate student at North Dakota State University. I am implementing a new graduate residency program at my place of work, and for the project proposal I would like to request permission to include a copy of your Transition Shock Model with citation. Please let me know if you have any questions or concerns. Thanks!

Allison Danzl

Re: Permission to print Transition Shock Model

Delete Reply Reply all Forward ...

JD

Judy Duchscher <judy.duchscher@me.com>
Thu 8/15/2013 11:37 AM
Research Project

Mark as unread

To: ☐Allison Danzl;
Cc: ☐judy.eldon.duchscher@shaw.ca;

To help protect your privacy, some content in this message has been blocked. To re-enable the blocked features, click here.

To always show content from this sender, click here.

Absolutely you have my permissions Allison - have you got a copy of my book? See the site to order if you haven't (http://nursingthefuture.ca/from_surviving_to_thriving) - this will assist you a great deal. I strongly encourage the residents get this book (perhaps as a gift from the program) as it will WALK them through the entire year. I further recommend that you use the stages to frame the program - those programs that have done this have been entirely successful with the grads.

You can download the models from here:

http://nursingthefuture.ca/transition_theory (just click on each of them and download the pdf)

Hope this assists you Allison.

Judy

Dr. Judy Boychuk Duchscher, RN, BScN, MN, PhD
WINN-NTF Conference Chair (www.winn-ntf.com/conference@winn-ntf.com)
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T2N 1N4
Canada
403-210-7484 (UC Office)
403-220-6575 (Administrative Assistant Lisa Marguiles)
Fax: 403-284-4830
IPHONE # (texts/cell) 403-919-2984
UC Email: jbduchsc@ucalgary.ca
UC Website: http://nursing.ucalgary.ca/profiles/judy-boychuk-duchscher

APPENDIX D. EMAIL APPROVAL FOR NURSES' ETHICAL REASONING SKILLS REPRINT AND DISTRIBUTION

Permission to use NERS model

Delete Reply Reply all Forward ...

AD

Allison Danzl
Wed 8/14/2013 9:15 AM
Sent Items

Mark as unread

To: ☐ roseanne.fairchild@indstate.edu;

Ms. Fairchild,

My name is Allison Danzl, MSN graduate student at North Dakota State University. I am implementing a new graduate residency program at my place of work, and for the project proposal I would like to request permission to include a printed copy of the Theoretical model for Nurses' Ethical Reasoning Skills with citation. Please let me know if you have any questions or concerns. Thanks!

Allison Danzl

RF

Roseanne Fairchild <Roseanne.Fairchild@indstate.edu>
Wed 8/14/2013 10:18 AM
Research Project

Mark as unread

To: ☐ Allison Danzl;

Thank you for letting me know Allison, I give permission to utilize my model in your graduate residency program --

I hope it is helpful to you and your staff :)

Dr. R

Roseanne Fairchild, PhD, RN, CNE, NE-BC
Assistant Professor of Nursing
Dept. of Advanced Practice Nursing
Landsbaum Center for Health Education
Indiana State University
1433 N. 6 ½ Street, Office 217
Terre Haute, Indiana 47807
roseanne.fairchild@indstate.edu
Phone/VM: 317-519-9875

APPENDIX E. PRE EVALUATION CONTENT SURVEY REPRINT AND DISTRIBUTION

Pre-Survey | JRMC Nurse Residency

Directions: Please perform a self-assessment by choosing the option that best represents your current awareness or knowledge level about the following topics.

1. My knowledge of patient centered care and its relation to patient satisfaction, safety, and cost effectiveness at JRMC is:

   1- no knowledge of this 2- minimal 3- sufficient 4- excellent

2. My awareness of strategies JRMC uses to empower patients and their families to engage in active partnerships within their plan of care is:

   1- no awareness of this 2- minimal 3- sufficient 4- excellent

3. My awareness of how the standards of nursing practice policies and procedures at JRMC encourages nurses to advocate for patient centered care is:

   1- no awareness of this 2- minimal 3- sufficient 4- excellent

4. My awareness of how common priority setting traps interfere with a nurses ability to rank priority of needs of patients:

   1- no knowledge of this 2- minimal 3- sufficient 4- excellent

5. My knowledge of communication strategies to solve problematic situations nurses encounter is:

   1- no knowledge of this 2- minimal 3- sufficient 4- excellent

6. My knowledge of team strategies and tools available at JRMC to enhance teamwork and patient safety is:

   1- no knowledge of this 2- minimal 3- sufficient 4- excellent

7. My knowledge of how to use the delegation decision making process is:

   1- no knowledge of this 2- minimal 3- sufficient 4- excellent

8. My knowledge of the various databases to locate relevant evidence to support nursing practice available within/or outside of JRMC is:

   1- no knowledge of this 2- minimal 3- sufficient 4- excellent

9. If a process change needs to occur within JRMC based upon evidence recommendations, how would you rate your awareness of how to present a practice change?

1- no awareness of this 2- minimal 3- sufficient 4- excellent

10. My knowledge of available resources at JRMC to help analyze and identify commonalities in health care errors to promote prevention:

1- no knowledge of this 2- minimal 3- sufficient 4- excellent

11. My awareness of the best methods to address quality improvement opportunities that affect nurses at the point of care at JRMC is:

1- no awareness of this 2- minimal 3- sufficient 4- excellent

12. My knowledge of potential barriers to implementing or suggesting improvements and my ability to identify ways to overcome them is:

1- no knowledge of this 2- minimal 3- sufficient 4- excellent

13. My knowledge of what information technology skills are needed for safety in patient care at JRMC is:

1- no knowledge of this 2- minimal 3- sufficient 4- excellent

14. My knowledge of how to maintain boundaries with patients through social media and the electronic medical record to protect confidentiality is:

1- no knowledge of this 2- minimal 3- sufficient 4- excellent

APPENDIX F. POST EVALUATION CONTENT SURVEY REPRINT AND DISTRIBUTION

Post-Survey | JRMC Nurse Residency

Directions: Please perform a self-assessment by choosing the option that best represents your current awareness or knowledge level about the following topics.

1. My knowledge of patient centered care and its relation to patient satisfaction, safety, and cost effectiveness at JRMC is:

   1- no knowledge of this 2- minimal 3- sufficient 4- excellent

2. My awareness of strategies JRMC uses to empower patients and their families to engage in active partnerships within their plan of care is:

   1- no awareness of this 2- minimal 3- sufficient 4- excellent

3. My awareness of how the standards of nursing practice policies and procedures at JRMC encourages nurses to advocate for patient centered care is:

   1- no awareness of this 2- minimal 3- sufficient 4- excellent

4. My awareness of how common priority setting traps interfere with a nurses ability to rank priority of needs of patients:

   1- no knowledge of this 2- minimal 3- sufficient 4- excellent

5. My knowledge of communication strategies to solve problematic situations nurses encounter is:

   1- no knowledge of this 2- minimal 3- sufficient 4- excellent

6. My knowledge of team strategies and tools available at JRMC to enhance teamwork and patient safety is:

   1- no knowledge of this 2- minimal 3- sufficient 4- excellent

7. My knowledge of how to use the delegation decision making process is:

   1- no knowledge of this 2- minimal 3- sufficient 4- excellent

8. My knowledge of the various databases to locate relevant evidence to support nursing practice available within/or outside of JRMC is:

   1- no knowledge of this 2- minimal 3- sufficient 4- excellent

9. If a process change needs to occur within JRMC based upon evidence recommendations, how would you rate your awareness of how to present a practice change?

1- no awareness of this 2- minimal 3- sufficient 4- excellent

10. My knowledge of available resources at JRMC to help analyze and identify commonalities in health care errors to promote prevention:

1- no knowledge of this 2- minimal 3- sufficient 4- excellent

11. My awareness of the best methods to address quality improvement opportunities that affect nurses at the point of care at JRMC is:

1- no awareness of this 2- minimal 3- sufficient 4- excellent

12. My knowledge of potential barriers to implementing or suggesting improvements and my ability to identify ways to overcome them is:

1- no knowledge of this 2- minimal 3- sufficient 4- excellent

13. My knowledge of what information technology skills are needed for safety in patient care at JRMC is:

1- no knowledge of this 2- minimal 3- sufficient 4- excellent

14. My knowledge of how to maintain boundaries with patients through social media and the electronic medical record to protect confidentiality is:

1- no knowledge of this 2- minimal 3- sufficient 4- excellent

Is the content presented in the five modules relevant to new graduate nurse needs at Jamestown Regional Medical Center in order to reduce transition stress in the acute care setting?

How could the NGR program content better meet the needs of new nurses transitioning into acute care at JRMC?