



Fall 2013

## Message from Shella Associate Director for Patient Care Services

First let me extend congratulations for a successful Joint Commission! I had no doubt that the outcome would be positive! That said, every day, I am reminded of the remarkable work being done in VA Salt Lake City Health Care System. More importantly, I am proud of the nurses and how you provide compassionate care to our Veterans.

I am currently serving as the "interim" Nurse Executive at the VA Pacific Islands Health Care System. Things are very different here and yet the mission is the same. For that, I am grateful. On 9/11 one of the doctors showed up to morning report dressed all in black. I told him that he looked like Johnny Cash. He then shared his story

about his brother who was in the World Trade Center when one of the planes hit the tower. He had two brothers in the building. One of his brothers had just left the building. Then, he described the moment he learned that his one brother was missing. He has never seen him since. His story was emotional and yet he spoke proudly about why he comes to work every day and why he wore black that day. Regardless of the demands we have each and every day, it is important to keep things in perspective.

While I am temporarily away from VASLCHCS, know that my heart and mind are never far from you. I intend to help the leadership here find a new Nurse Executive that will

embrace the culture and who can represent and advocate for nursing as they deserve here in Hawaii. After that, I will return to Salt Lake City and re-join the great team I left. Thank you for your support and for the amazing service you give our Veterans each and every day. Aloha~ and I will see you soon!



## JOIN US IN CONGRATULATING 3 VA NURSES WHO WILL BE INDUCTED INTO THE AMERICAN ACADEMY OF NURSING 2013 CLASS OF FELLOWS:

**Dr. Penny Kaye Jensen (Salt Lake City/VHACO)**

**Dr. Anna Alt-White (Washington, DC VHACO)**

**Dr. Mary Hagle (Milwaukee)**

The Academy is composed of more than 2,000 nurse leaders. The selection for fellowship in the Academy is one of the most prestigious honors in the field of nursing.



## Name Our Sim Man!

Our VA Nursing Academy has new Sim Man and we want you to name him! Please submit your suggestions to [Ismael.Quiroz@va.gov](mailto:Ismael.Quiroz@va.gov) by October 7, 2013. If your suggested name is chosen, you will receive a gift card to the Corner Bakery from your friends at VANA.



# VASLCHCS NURSE SERVING AT HOME AND AWAY

In 2012-2013, Sean Graff volunteered at La Albarrada CEDECO, a governmental community education program of the state of Chiapas, Mexico. Initially he was assigned to their Casa de Salud (house of health) but due to lack of supplies/equipment and no patients, Sean ended up assisting with their public health programming for high school students. The main topic he presented to the students in their schools or the facility was about violence against women and children.

Through La Albarrada, Sean was approached by a representative of a nearby technical high school that teaches nursing. He developed and translated (with help of some University of Utah nursing faculty and his Spanish tutor) an hour long PowerPoint lecture in Spanish, which he presented to the 5 sections of the 3rd semester nursing students- about 200 students in total.

For Sean, the most fulfilling clinical work was volunteering with



Don Sergio Castro and Sean Graff

Don Sergio Castro, a 73 year old humanitarian (ex-veterinarian/ agronomist) who has been serving the poor in Chiapas. For almost 50 years he has helped in producing clean water projects, treating their animals, and treating their wounds and burns. Don Sergio doesn't drive, Sean drove him in his van every Monday on his house calls to patients up to 30 minutes away. He treated those in need seven days a week without requesting payment. During these visits, Sean sometimes helped with wound care and also tried to

help Don Sergio Castro with fundraising or other projects. One such project involved photographic documentation of a water storage and filtration system for a local community that a Washington State Rotary Club donated money to build.

Sean Graff spent a year helping in various humanitarian efforts in Mexico.



Don Sergio Castro tending to a severely ill man

If you are interested in learning more, check out Don Sergio Castro's website.  
<http://www.yokchij.org/>

## We Want to Hear From You!

We encourage you to contribute to the Nightingale Newsletter. We want to hear about you, your co-workers, or your department. Tell us about an outstanding staff member, a unique experience, or whatever you want to share with your fellow nursing staff.

E-mail [Ismael.Quiroz@va.gov](mailto:Ismael.Quiroz@va.gov) or call ext. 4399

# VA LPN'S, WE SALUTE YOU!

PACT (Patient Aligned Care Team) is a care model used in the VA Health Care System, whereby each Veteran works with health care professionals to plan for whole-person care and life-long health and wellness. These PACT teams or Teamlets consist of a Provider, RN, LPN and a Clerk. Their role is to focus on a Veteran's clinic visits, exams and treatment.

LPN's working within the PACT Teamlet have a variety of responsibilities. They schedule upcoming appointments, order needed lab work, make pre-visit calls and assist with rearranging the offices schedule and coordinating telephone visits between patients and their primary care provider. LPN's also access, monitor, and utilize My Healthy Vet to communicate with the patient's along with the Teamlet. Some additional responsibilities of an LPN in a Teamlet include reviewing daily schedules for patient care needs, rooming patients, screening clinical performance reminders, assisting with medication reconciliation,

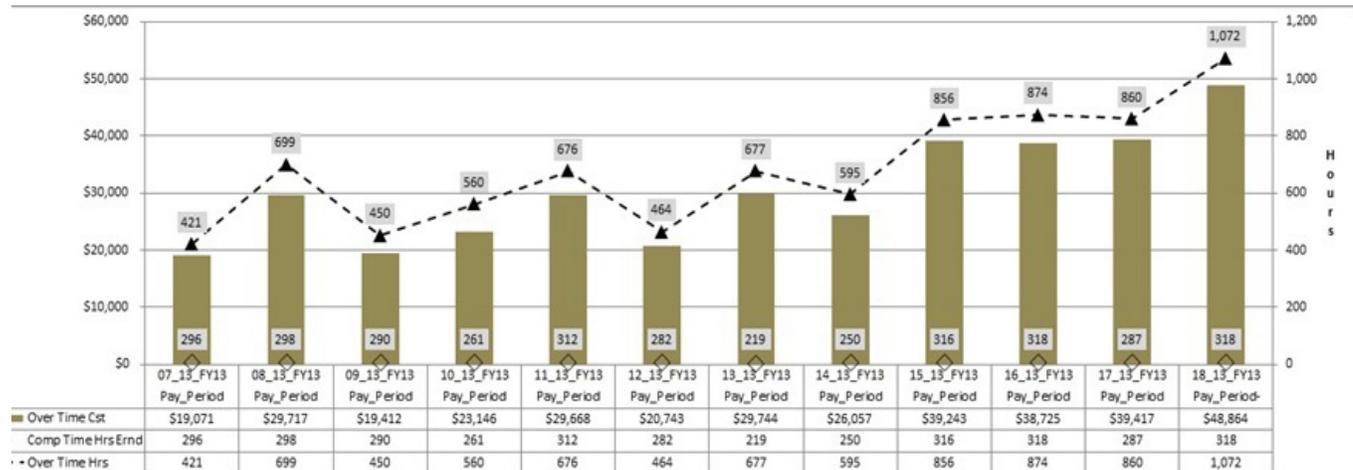


Western Salt Lake CBOC LPN Crew

printing and reviewing medication lists with the patient, checking vital signs, tracking immunizations as well as administering and performing procedures (EKG's, PVR's, injections, ear irrigations, etc.) ordered during a Veterans appointment. They are also responsible for ensuring that the clinics have all of the necessary supplies and medication in stock.

Additionally, LPN's may be responsible to more than one Teamlet at a time. The role of an LPN within the VA Healthcare System is a large role with a lot of challenge and responsibility. The challenge and responsibility make this an enjoyable and exciting job, but the best part of the job is being able to work closely with Veterans to help them achieve their health care goals!

## NURSING OVER TIME AT A GLANCE



# MAKING A DIFFERENCE AT THE WESTERN SALT LAKE CBOC

Some grow up knowing exactly what career path they want to follow. Others play it by ear and find their calling. Jerry Sagers was born and raised in Tooele, Utah. As a young adult, he worked at a local smelter with his father. He imagined that he would spend the rest of his work-life there. His grandfather retired from there, his father planned to retire from there, and Jerry thought he would do the same.

Jerry's path took a major turn when the smelter plant he was working for was in need of someone to teach CPR classes and run its ambulance service. The plant director sent Jerry to EMT training and he became the facility first responder. He was hooked. After gaining experience at the plant, Jerry later worked as an EMT for the local ambulance service. He also volunteered at the Tooele Hospital's Emergency Room. "They never had a full staff there all of the time. When you showed up in the ambulance, you never knew who was going to meet you at the door. It could be the janitor, the doctor, a nurse, or a clerk. You just never knew", Jerry said.

None of Jerry's eight children are in the medical field. He has become a



Jerry Sagers, LPN, Western Salt Lake CBOC

great asset to his family. "They call me all of the time asking questions like "What do you think about this? Do I need to go to the doctor for something like this?"

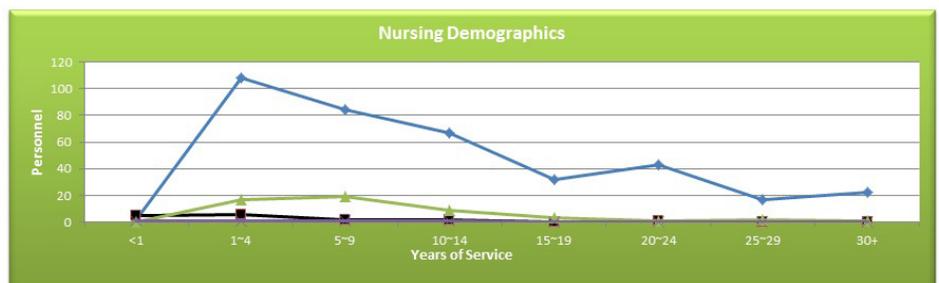
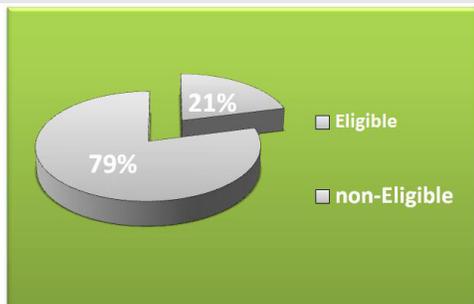
I love the VA, that's where my heart is." His time in the Navy Reserve has helped him connect with Veterans of all eras.

## "I love taking care of Veterans"

When asked what the best part about his job is, there was a genuine sense of pride and fulfillment in Jerry's voice. "I love taking care of Vets. That's the highlight of my job.

The field of nursing is ever-changing. The equipment, procedures, and technology moves rapidly. Jerry has kept up with the fast pace of the field. When asked about his advice to nurses who are new in the field, Jerry stated "Don't get cocky. Accept people for who they are. Keep yourself on an even keel. Don't put yourself on a pedestal because someone will knock you off."

## NURSING DEMOGRAPHICS AT A GLANCE



# NURSES, PROTECT YOURSELVES AND YOUR PATIENTS!



When you are administering a controlled substance medication from a vial, syringe or PCA cassette make sure that it is **COMPLETELY EMPTY** when wasting the remainder of the medication before you place the vial, syringe or cassette in the sharps container.

- **VIAL:** Withdraw all the medication from the vial using a syringe, if you will not be administering the entire contents, squirt the portion that is to be wasted onto a cotton ball or gauze pad and then dispose of it in the sharps container. You may take the empty vial to the bedside in order to scan it prior to administering the medication to the patient, then dispose of the empty vial in the sharps container.
- **SYRINGE:** If you are using a prefilled syringe and are not going to administer the entire contents, squirt the portion that is to be wasted onto a cotton ball or gauze pad and then dispose of it in the sharps container prior to administering the required dose to the patient.
- **PCA:** IF there is medication remaining in the cassette, use a syringe to withdraw the liquid and squirt the liquid onto cotton balls or gauze pads depending on the volume to be disposed of.
- When wasting you need a witness and this person needs to actually “see the medication being wasted” by observing the medication that is to be wasted being squirted onto the cotton ball or gauze pad.

Following these steps will help ensure that there are no controlled substance medications in vials, syringes or cassettes in the sharps containers that may be vulnerable to theft or diversion from the sharps container. Failure to follow these procedures puts the nurse, patient and other staff members at risk by allowing possible access by unauthorized persons to wasted controlled substance medications in the sharps container.

Laurie Thompson RN  
Controlled Substance  
Coordinator  
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# The Organizational Transformative Power of Nurse Residency Programs

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**E**VENTS IMPACTING our world today and specifically the health care system are causing societal and organizational shifts as dramatic as those occurring in the Renaissance and during the Industrial Revolution. These events and societal shifts demand individual and organizational transformative changes. Organizational transformation follows a 7-stage cycle, that is, a transition from the present state wherein identification of a need and a vision is made to an altered future state wherein integration into the desired state is achieved.

Cultural adaptation is an inherent, essential component of the transformation process. In medicine, a transformative change is movement from a culture that promotes autonomy, entitlement, and protection to one valuing alignment, action, and accountability. Cultural value changes in nursing that are fast gaining momentum feature the values of respect, alignment, continuous improvement, and accountability. To achieve the cultural adaptation necessary for transformative change, clinical nurses must be involved as only nurses at the bedside can tell us what it is really like to be a clinical nurse.

The transformative change of interest in this report are Nurse Residency Programs (NRPs) as operationalized in 20 Magnet hospitals, site visited in the last quarter of 2009 and in the first half of 2010. These hospitals were selected from 34 hospitals participating in a 7-study, 5-year research program designed to empirically assess direct and interactive effects of 2 independent variables—healthy unit work environments and NRPs on expectations, environmental reality shock, transition, integration, and 3-year retention rate of newly licensed registered nurses (NLRNs). In the course of interviewing more than 900 NLRNs, nurses, managers, and educators in these 20 hospitals to ascertain people, activities, and events instrumental in NLRN transition, integration, and retention, it became clear that NRPs not only have a positive effect on NLRN professional socialization but also impact the organization and the practice of other health care practitioners. Thus, they are a source of transformative organizational change. If it can be demonstrated that, through these transformative changes, NRPs also lead to improved patient outcomes, NRPs may be the most significant organizational transformation instituted by nurse leaders in recent years. This article traces the development and evolution of NRPs through the 7 stages of organizational transformative change. Descriptions and excerpts from the

interview that exemplify how components of NRPs have produced transformational changes that extend beyond NLRNs will then be presented. (The impact of NRPs on NLRNs is presented elsewhere.)

## ANALYSIS AND EVOLUTION OF NRPS AS A SOURCE OF ORGANIZATIONAL TRANSFORMATION

A NRP, as with any transformative change, is accompanied by a fundamental shift in individual and organizational consciousness, values, and perceptions. It entails a profound transmutation of the prevailing vision of the reality of nurses' work in hospitals. In the early and mid-decades of the last century, NLRNs transitioning from school to work received little more than a day or 2 of hospital orientation. Many who had "worked for pay" as students did not need such orientation and, upon graduation were often, other than the head nurse, the only registered nurses on the unit. It was not uncommon for the new graduate to be responsible for monitoring IV fluid replacement and administering medications to all patients on the unit. Licensed vocational nurses were assigned to treatments, taking vital signs, and monitoring patient output. Four or 5 nurse aides with very limited training were responsible for "baths", "beds", and ambulation for all patients on a unit of about 40 patients—many of whom were admitted for tests, x-rays, and treatments now performed on an outpatient basis.

The paragraph given earlier describes the Unconscious stage of the 7-stage—Unconscious, Awakening, Reordering, Translation, Commitment, Embodiment, and Integration—Transition cycle through which all transformative changes pass. The Awakening (second) stage is a passive time during which individuals and the organization develop the capacity to acknowledge that "something is wrong". The NRP Awakening stage formally began in 1974 with the research describing Reality Shock, the cognitive dissonance, and shock like reaction experienced when NLRNs discover that the professional whole-task concept of nursing taught in school differs from the industrial/bureaucratic part-task, efficiency concept extant in the work world. The Reordering (third) stage, that is, the processes of analyzing existing situations and challenging underlying patterns, began with the empirical testing of the Anticipatory Socialization program.<sup>5</sup> Offered in the last semester of the senior year and based on the premise that student nurses need to understand and practice blending the 2

disparate role conceptions, values and care delivery systems, the program was somewhat but not completely effective. Only half of the functionaries in the equation were doing the blending. The creative chaos, instability, and turmoil typical of reordering patterns<sup>2</sup> continued. Two federally funded research grants led to empirical testing of Bicultural Training Programs<sup>6</sup> and Reflective Seminars<sup>7</sup>—didactic information and exercises based on the major challenges to professional role performance as identified by NLRNs—in 8 major academic medical centers nationwide. The seminars and programs were offered to NLRNs weekly during the first 6 weeks post hire. This was followed by conflict resolution workshops held monthly for NLRNs and head nurses, first alone and then together.

Translation (fourth) stage, that is, the process of formulating a vision, of NRP transformation change began in the 1980s with development of structured NLRN orientation/internship programs. The decade of the 1990s saw a sharpening and Commitment to the vision (fifth), solidity, and a runway for launching NRPs. Organizations such as the United Health Consortium, Versant, Vermont, and Milwaukee State Nurses Associations implemented and empirically tested the new vision with structured, organized NRPs. Some of these programs (2-4 months in length) covered only the guided, dependent, cognitive apprenticeship, transition experience, during which a preceptor was the dominant Career Development Relationship.<sup>8</sup> Other NRPs of 10 to 15 months in length provide opportunity for clinical coaching and mentoring experiences, and for integration of NLRNs into the professional practice role.

The Embodiment (sixth) stage requires completed shifts in behavior, structure, and consciousness. This triangle of embodiment is a useful tool in diagnosing incongruities and assessing progress toward organization-wide changes. Achievement of change in all 3 areas culminates in a fuller change and the focused action of integration. Movement through Embodiment to Integration (seventh) stage is evidenced by empirical assessment of outcomes, institution of changes based on this assessment, and reassessment. There is published evidence that NLRNs in some NRP have achieved full integration.

## RESEARCH DESIGN AND SAMPLE

This mixed-method, primarily qualitative study was designed to answer the question—what does this hospital do to help you (NLRNs) make an effective transition from

academia to work and become integrated into the professional nurse practice role and into professional communities? Answers were sought from nurses working on the "Best units" in the "Best Hospitals". Best units were defined as those in which a representative group of experienced nurses (not NLRNs) on a clinical unit confirmed that they had very healthy work environments,<sup>10</sup> that is, an environment that enabled them to engage in the work processes essential for quality patient care.<sup>11,12</sup> To obtain the best hospitals, 40 Magnet hospitals were selected on the basis of additional "excellent hospital" designations such as Baldrige, Thomson Reuters Top 10, Top 100 Hospitals, Health Grades Awards, and Best Places to Work. All hospitals selected had organized, structured NRPs operative for at least 3 years. (These programs were differentially labeled internships, fellowships, NLRN orientations, residencies, and mentorships. In this research, all are referred to as NRPs.)

Twenty of the 40 hospitals were assigned to a Transition group to study/map NLRN transition challenges, experiences, and effective strategies, and 20 to an Integration group to study structures and components instrumental in NLRN professional role and community integration. Ten hospitals from the transition group and 10 from the integration group were site visited to obtain answers to the research question guiding this study.

#### DATA COLLECTION INSTRUMENTS AND PROCEDURES

Site visits of 1 1/2 to 4 days (average = 2 1/2 days) were made by one of 3 Health Science Research Associates investigators to each of the 20 hospitals to conduct interviews and participant observations. An interview schedule, consisting of questions related to the 7 challenges identified by NLRNs<sup>13</sup> as critical in management of their professional role responsibilities (MPRR), was developed and pretested. Care was taken and efforts made to consistently address these 7 areas in a positive vein, as challenges rather than as problems. The 7 MPRR areas are delegation, prioritization, nursing care delivery systems, making autonomous decisions, collaborating with physicians, obtaining feedback, and constructive conflict resolution.<sup>13</sup> At the end of each interview, nurses were requested to complete a short (<5 minutes) survey estimating length of time required for NLRN achievement of competency in each of these 7 MPRR areas.

Participant observations<sup>14</sup> included activities such as change-of-shift report, interdisciplinary patient rounds, team huddles, individual or group evidence-based management presentations, participation in shared governance councils, conflict

resolution, or Crucial Conversations sessions.

#### DATA ANALYSIS

Interviews were digitally recorded and transcribed. Participant observation notes were analyzed and tentative interpretations made as soon after each site visit as possible. As is customary in qualitative reports, interview excerpts will be used to illustrate ideas and experiences, evoke emotion, and support researcher conclusions. Standard principles and cautions were used to achieve a proper balance between the obligations of scientific reporting and the taking of artistic license. Multiple interviewee quotes illustrating a construct will be separated by ellipses points. Analysis of variance by position of the nurse was used to analyze "the number of months to competency" survey data.

#### RESULTS

##### Characteristics of the interviewees

A total of 907 nurses were interviewed during the 20 site-visits—330 NLRNs, 401 experienced nurses/preceptors, and 138 nurse managers working on 174 units with confirmed "very healthy work environments";<sup>10</sup> and 38 nurse educators; 82 participant observations were made. The number of nurses interviewed ranged from 25 to 76 with a mean of 45 per hospital. The number of units ranged from 5 to 14 with an average of 9 per hospital. The largest number was intensive care units (n = 40; 23%) followed by telemetry (n = 28; 16%); surgical specialties (n = 26; 15%); general medical/surgical (n = 21; 12%); medical specialties (n = 19; 11%); oncology (n = 12; 7%); obstetrics (n = 9; 5%); emergency (n = 7; 4%); orthopedic (n = 5; 3%); and psychiatric, rehabilitation, and post anesthesia recovery unit/operating room with (n = 7; ≤2% each).

Almost three-quarters (n = 236; 71.4%) of the 330 NLRN interviewees were between 9 and 12 months post hire, well into the integration stage of professional socialization.<sup>9</sup> The other 29% were evenly divided between those who had 6 to 8 months of experience and those who had between 13 and 15 months of experience. Almost 80% of the NLRNs participating in this study were prepared at the baccalaureate level; 5% had earned a master's degree as their initial nursing preparation.<sup>10</sup> Additional demographic characteristics related to prior degrees, occupation, and work experiences in the employing hospital can be found in reference 9. More than half of the 401 experienced nurse interviewees had between 5 and 15 years of experience; the other half were evenly divided between those who had less than 5 or more than 15 years of experience. Almost 90% of the experienced nurses were

preceptors, and more than 80% for several cohorts of NLRNs. Twenty-two percent served as clinical coaches; less than 2% identified themselves as mentors.

##### Characteristics of residency programs in the 20 site-visited hospitals

Eight hospitals had published, national NRPs, that is, a NRP present in more than 1 hospital; the other 12 had homegrown programs, or programs adapted from the national programs. All NRPs had well-developed, empirically evaluated, Transition stage programs (initial 2-4 months post hire) consisting of reflective seminars/debriefing sessions, dependent precepted experiences, skill demonstrations/ classes, and other didactic content. Some offered observations/ experiences in other departments; a few offered a mentoring experience. In 11 of the 20 hospitals, NRPs were or had the potential to be multi-staged; that is, they were 10 to 15 months in length and included, in addition to the Transition stage, some integration-stage components/ programs/activities. Three of the 11 NRPs had clearly differentiated goals and expected NLRN role performance for each stage, included integration-stage components and all 3 career-development relationships— preceptor, coach, and mentor.<sup>8,9</sup>

##### COMPONENTS/STRATEGIES OF NRPS EVIDENCING TRANSFORMATIVE ORGANIZATIONAL CHANGE

Results will be presented for each of the 7 MPRR challenges identified by NLRNs. Each section will begin with clarification of the dimensions of the challenge, followed by examples of effective transformative changes. The latter were usually cited by experienced nurses and managers.

##### DELEGATION

The most frequently cited dimension of delegation requiring clarification was the accountability-responsibility issue. Newly licensed registered nurses indicated that "this is a major source of confusion because it is not taught in school. Unless you get some help, it remains a problem" . . . "When you delegate, do you delegate responsibility and accountability as well as the task? Or, do you delegate the task only and retain responsibility and accountability?" Newly licensed registered nurses frequently inquired:

What's the difference in delegating to an RN or to a patient care assistant (PCA)? .. The ANA Code of Ethics says that the nurse is responsible and accountable for tasks delegated to UAP. That suggests that responsibility and accountability are the same. But the ANA Principles of Delegation

says that delegation is the transfer of responsibility for performance of a task from one individual to another while retaining accountability for the outcome. That means that the two concepts are different and that PCAs are responsible but are not accountable for tasks delegated to them. That makes a difference to me. If I'm still accountable, professionally and legally, I'm going to think twice about delegating to an aide who I don't know or don't think is quite up to snuff. Then, if I don't delegate, I get behind in my work, and then I'm really in a mess.

Experienced nurses and managers indicated that clarification of this accountability responsibility issue helped all nurses on the unit to really understand what it means to be a professional practitioner.

#### **NRP activities/strategies with potential for promoting transformative change**

In response to the Delegation question, interviewees in 13 of the 20 hospitals described Evidence-based Management Practice projects (EBMPP) that were also used in conjunction with other MPRR challenges.

Evidence-based Management Practice projects were usually conducted by several NLRNs or NLRN—clinical coach pairs. Evidence-based Management Practice projects used the same steps as the Iowa model of Evidence-based Practice<sup>15</sup> with the addition of the internal organizational data step (conduct of interviews, making observations, checking job descriptions) when the problem related to organizational nursing practice.<sup>16</sup> The internal data-gathering step was often coffee-chat interviews with experienced nurses, physicians, or other health care professionals. (Above references were provided by interviewees. Accuracy of attributions made by interviewees, for example, the ANA definition of delegation in the preceding paragraph, was verified by the coauthor responsible for that MPRR challenge.) In 11 hospitals, presentations of the EBMPP results were made during the integration stage coaching/ focused group/debriefing sessions (usually 6-8 months post hire). It was common for physicians, residents, other nurses, and nurse managers to attend these presentations.

In one hospital, a copy of a joint Power-Point presentation titled: What Is Safe Delegation? A New Grad Perspective was presented to the interviewer. This presentation included the "Dead on" delegation game strategy<sup>17</sup> that NLRNs, preceptors, and coaches found very helpful.

A symbiotic result of EBMPP was that experienced nurses often stated that they provided them a "face-saving" opportunity to learn, participate in, and more fully understand not only the EBMPP process but

also the evidence based practice process and model to which many had not been exposed during their preparatory programs. Other than changes in their own practice, none of the interviewees cited specific changes in the practice of other health care professionals as a result of participation in EBMPP. The events with the greatest potential for change were the relatively short, "coffee-break" EBMPP presentations that were attended by physicians, residents, therapist, other nurses, and managers.

#### **PRIORITIZATION**

Two dimensions of prioritization identified by some preceptors and/or clinical coaches in all 20 hospitals encapsulate the issues that required repetitive clarification. Prioritization challenges began during the integration stage, "peaking the month after precepting when NLRNs are on their own for the first time".

New grads do not understand that there are two levels of prioritizing; you can prioritize patients and you can prioritize care, tasks and activities for multiple patients. When they work our (preceptor) assignment, they may have 1 to 3 patients, but they prioritize patients—which patient are you going to care for or manage the care of first?—just like they learned in school. And it makes sense. If they are caring for a patient and one of their other patients needs something, I get it rather than interrupting the new grad. . . The same if they have 2 patients in ICU. They prioritize patients not care/cure tasks and activities. . . When new grads move from assignment with a preceptor to independent practice and have a 5 or 6 patient assignment, prioritization is a real problem. They have to look at the care activities for their whole assignment—assessments, meds, observations, treatments, teaching, talking to the family, meeting with the doc and therapists, is the patient going off unit for something and at what time, IV replacement—and then they have to decide how and in what order am I going to accomplish all of this. You may decide that you need to assess Patient A, then change the IV tubing on Patient B, then pass meds to all your patients, but its come and go among your assigned patients. . . Yes, and then someone codes. Giving that nurse a hand is top priority. You may first need to do an assessment on the patient who is most critical or who is scheduled for surgery first, but I teach them to always ask the nurse reporting off how much fluid is left in IVs, so that when you go to see patients, you take replacement IVs along. And then there are the interruptions, and you have to try to remember where you were in your plan. . . You also have to be able to manually and cognitively multitask.

A second dimension of prioritization that NLRNs do not understand is the unit priority system.

Everyone knows ABC (Airway, Breathing, Circulation) comes first, but it's after that. For oncology patients—pain control is top priority. . . In the ER, after ABC, the next priority is doing what you need to do to get patients home or transferred up to the units so there's room for other patients. . . I never thought about it before, but, in a way, that's also true on rehab. Who's scheduled first for therapy? You pass meds, do assessments, get patients ready so they can make their therapy appointment on time. That's why those patients are here. . . You save yourself a lot of time and give better care if and when you figure out the unit priority system. . . At first, NLRNs shrink back at the suggestion that "moving patients along" enters into your priority—it sounds so bureaucratic and money oriented. They have to learn that nurses are not giving good care, making patients sit and wait and their conditions deteriorate and worsen.

#### **Strategy that evidences transformational change**

The transformative change strategy most frequently mentioned in relation to the prioritization challenge was the acquisition and sharing of information, ideas, and prioritization systems (4 Ps, 5 Fs, and CURE technique) in preceptor and coaching councils.<sup>18</sup> These councils were an expansion of shared governance. Eleven hospitals had preceptor councils; 3 had coaching councils; mentoring councils were not mentioned.

Preceptor Council meetings are wonderful! They opened my eyes to many possibilities. I got great feedback from new grads on the Heart analogy that we learned in Council meeting as a way of helping new grads to handle the stress of having too many things to do at once. . . After 18 years in practice, it is absolutely amazing how many things I learn in Council, related to all sorts of patient care management issues and problem, that I not only teach new grads, but that I can and do incorporate into my own practice.

#### **MANAGING PATIENT CARE DELIVERY**

Several dimensions of this challenge were cited. The most frequently mentioned was:

I can't get my work done and done on time. . . It's sheer chaos; I'm constantly being interrupted. . . I have 5 patients; I can't keep it all in my head, or on paper—what have I done for this patient; what does this one need next; what's the plan for the third? . . . There's so much information coming in and going out, and so many people I have to relate to that I feel like I'm drowning.

For a new professional, knowledge worker, getting work done, coping with high information intake and output, and

managing the therapeutic environment for multiple clients are a major challenge. This was the issue of highest concern to 468 NLRNs<sup>13</sup> in the study that generated the 7 MPRR challenges investigated in this study.

Another dimension of this challenge was fear of harming patients due to the number of assigned patients. On non-intensive care units, assignments on days ranged from 4 to 7 (mean = 5), with a third or a half of a PCA assigned to the nurse. Newly licensed registered nurses' biggest concern was, not that they would be challenged or have to work hard, but that "I might miss something; I might cause the patient harm". Several NLRNs in one hospital returned to the interview room with articles describing their concerns.

A nurse caring for 4 to 6 patients at the same time results in a 14% increase in likely death for those patients; a RN caring for 8 patients simultaneously translates into a 31% greater likelihood of patient death.<sup>19</sup> There is a significant association between exposure to unit shifts in which RN staffing is 8 hours or more below target level and increased patient mortality.<sup>20</sup> It is chaotic; we are constantly interrupted. There is little flow in workflow. Another study shows that the duration of 40% of nurses' work is less than 10 seconds and nearly 77% lasts less than 30 seconds. We can rarely finish one thing before being interrupted and having to switch to another.

Another dimension was NLRN difficulty in understanding the nursing care delivery system on the unit. This was cited by NLRNs, experienced nurses, and managers on many units in many hospitals.

In school, our delivery system, if you want to call it that, was total patient care. And that I understand;

I know what I'm supposed to be doing. With my preceptor, we did sort of "total patient care/teamwork". She assigned me 1 or 2 of her patients and I was responsible for giving each of them total care. Sometimes if there was something she wanted me to observe or do for another patient, then she would come take care of my patients while I did that . . . Or some days, she'd have me do all the IVs or all the assessments so that I developed some skill and quickness in those areas . . . You can always count on your preceptor to fill in for you with your assigned patients . . . They have so many different names for different ways of doing things, I have no idea what our "system" is?

#### **Strategies that evidence transformational change**

This was the only MPRR challenge for which no solutions were proposed or no transformational changes identified by either experienced nurses or nurse managers. Many talked about NLRNs having to understand

the care delivery system on the unit. They commiserated with NLRNs when they described the chaotic conditions under which they had to work, the complexity of caring for a multiple patient assignment, and accepting the fact that they have some responsibility for all patients on the unit. The problem, as identified by many interviewees, was that the care delivery system did not particularly resolve the dimensions of the challenge faced by NLRNs when they left the protected, dependent, precepted experience and had to assume responsibility for the care and management of the clinical situations for multiple patients, simultaneously. "In school or with my preceptor, I took complete care of one patient and then I moved to the next patient. Now, I am responsible and accountable for the care of 5 patients at the same time."

#### **CLINICAL AUTONOMY: MAKING THE RIGHT DECISIONS; DOING NO HARM; NEED TO RESCUE**

##### **Dimensions of the challenge**

"I know that as a professional nurse, I need to make clinical decisions in the best interests of the patient, and ultimately, I have to develop competence and confidence in doing this and in working with physicians but it's too soon. Right now, I can only focus on my clinical skills, assessments, and direct care of the patient."

Another dimension frequently identified by preceptors, coaches, and managers is related to the advice: "If you don't know, ask" and "The only stupid question is the one you don't ask."

The problem is that new grads forget the 1st part of that sentence—if you don't know . . . Right! They continually ask questions, even when they know . . . It's OK while you are precepting them, but when they are 6 months out and you are coaching them and they still ask the same questions, it drives me crazy. How do you help them understand that they really know?. Whenever they ask me a question, I always ask them, what do you think you should do, and they tell me and I tell them, yes, that's right. And two days later, they are asking a similar question. New grads say that it's safer to always ask for verification before making a decision that can potentially affect or cause harm to the patient . . . You can't get them turned off of verifying, even when they are correct 99 to 100% of the time . . . It's a real problem when you are coaching because you don't dare tell a new grad to stop asking questions; that would be like breaking one of the 10 Commandments! This is a real problem that we have discussed over and over again, both in Preceptor and in Coaching Council meetings.

#### **Strategies that evidence transformational change**

Didactic presentations and computer simulations were identified by a large number of NLRNs as effective in developing the critical thinking aspect of autonomy. The problem in autonomy is not the critical thinking but making the decision.

The major problem is that new grads have difficulty making decisions outside their sphere of practice—like giving a bolus of fluid when a patient's BP suddenly drops. They have an IV going and you know that that's what the doctor is going to order, but he's tied up in the OR and you have to do something NOW. . . I never realized before how much knowing the physician and knowing that he trusts your competence and judgment that you will do what is right for the patient is an advantage that we (coaches) have that new grads don't . . . I think that the best thing that can be done is anything that helps new grads establish a collaborative relationship with the doctors, based on a mutual appreciation of the competence of doctor and nurse.

The next most frequently cited, effective strategies (by all interviewees) were clinical coaching presentations/discussions that covered independent and interdependent decision-making,<sup>21</sup> spheres of practice and relationships between protocols, standing orders, nursing orders, and interdependent autonomous decision-making.

Following these presentations, NLRNs observed their own practice and that of others and informally interviewed experienced nurses on their units regarding decisions they had made. At the next coaching session, they described autonomous—dependent and interdependent—decisions that they and others had made and the bases for the interdependent decisions made. Many preceptors/ coaches commented that "going over these decisions and the reasons why I made them helped me understand when I could make a decision and when I couldn't."

Another effective transformative strategy was evidence that managers/leaders sanctioned autonomous decision-making. In one hospital, the chief nursing officer presented a class on autonomous decision-making. She described clinical situations and decisions she had made. In another hospital, the interviewer was shown a computer screen saver that depicted a picture of the nurse on the unit who had won the safety award for the month by making an autonomous decision not to administer a particular medication to a patient. The winner of this safety-first initiative (top selection from all submitted safety stories that month) was honored with a safety star, certificate, and picture on the screen saver.

#### **NURSE-PHYSICIAN COLLABORATION**

### Dimensions of the challenge

From the perspective of NLRNs, preceptors, coaches, and managers, there are 2 major deterrents to NLRN-MD collaboration: (1) NLRNs lack the competence and self-confidence and (2) lack of structure and opportunity for collaboration.

### Strategies that evidence transformational change

In one hospital, many interviewees talked about a presentation that a nurse manager had made at a Council meeting.

True collaboration requires a balance of power. A balance of power provides the basis for collaboration. Where does nurses' power come from? Power comes from knowledge, competence and understanding the scope of one's own and the other's practice roles and responsibilities. Nurses' close and constant surveillance and vigilance, knowing the patient well, being the physician's source of information about the patient, grants to nurses "a parallel-influence power". This power enables nurses to make decisions, and to contribute the perspective of nursing to the effective, interactive, symmetrical dialogue with physicians that constitutes true collaboration.

These interviewees explained that they were using this manager's presentation as the basis for working with their preceptees, peers, and themselves to build self-confidence in collaborating with physicians.

In another hospital, interviewees talked about an interview study<sup>22</sup> that had been discussed in Coaching Council. Medical residents in 5 states reported that the major reason for lack of RNMD collaboration was that physicians lack confidence in nurses' competence. Residents perceive the nurses' role as one of simply following orders. This group of interviewees were planning on repeating this study in their hospital with residents and attendings and, if they found the same thing, "We will work with the hospital councils to do something about it".

It has been well-established and documented that interdisciplinary, patient care rounds are an effective avenue for promotion of interdisciplinary collaboration. Almost all of the 20 hospitals had such rounds, at least in the intensive care units. In some hospitals, these rounds were co-led by a physician and a nurse. In others, the nurse caring for the patient presented the overview of the patient.

In one hospital, the Chairman of the Department of Pulmonary Critical Care specifically hires physicians with the expectation that they will work collaboratively with other disciplines. I have seen him counsel a physician that if they did not work in a more interdisciplinary fashion, they needed to look toward other non-clinical roles in medicine.

A good deal of what makes our ID rounds so successful is that this physician really values interdisciplinary collaboration. It is in these rounds and work groups that nurses, physicians, and other disciplines learn to appreciate the competence of one another, learn what each brings to quality patient care, learn how each group defines their sphere of practice and where spheres of practice overlap and require interdependent rather than independent decision-making, learn how to make interdependent decisions and how to collaborate and practice as colleagues.

In 2 hospitals, a relatively new<sup>23</sup> but effective collaboration strategy was operative—Physician-Nurse Collaboration Councils (a joint council appointed by the Medical and Nursing Council of the hospital) or a hospital-wide Nurse-Physician Collaboration Committee. Council members included an oncologist, a hospitalist, the chief medical resident, a surgeon, pharmacist, 2 nurse managers, 2 clinical nurses from the Nurse Practice and the Evidence-based/Research council, and the chief nursing officer. The council is co-chaired and meets monthly. An initial council activity was to read/discuss the book, *Crucial Conversations: Tools for Talking When the Stakes Are High*.<sup>24</sup>

Outcomes from the RNMD Collaborative committee in one community hospital included: an "Interdisciplinary Communication Form" that can be used by any discipline to write a note to the physician to request a follow-up on something needed or a suggestion/request by a family member that is not urgent. The form is neon pink in color and is a communication worksheet only, not a permanent part of the record. It is housed under the tab in the chart for physician progress notes, right on top so they can glance at it and see if there are questions or requests. It also alerts physicians about any family dynamics or situations they need and may want to know about before walking into the room.

Another outcome was a Cookie/fruit Cart available for Physicians who come in at night to round with nurses. This gives night nurses an opportunity to meet physicians, discuss the patient plan of care, and obtain nurse input into the plan of care.

## CONSTRUCTIVE CONFLICT RESOLUTION

### Dimensions of the challenge

Types of disagreements and need for constructive management of conflicts between and among nurses, patients, physicians, and other health care providers are well documented. The primary source of NLRN-specific conflict is in the area of delegation.

### Strategies that evidence transformational change

Two structural components, cited as effective in constructive conflict resolution, were *Crucial Conversations*<sup>24</sup> programs, operative in 2 hospitals, and nurse/human resource educators workshops that included principles of constructive conflict resolution and scripted role playing,<sup>6</sup> operative in 6 hospitals. Both were held for all employees.

## FEEDBACK TO RESTORE SELF-CONFIDENCE

### Dimensions of the challenge

Dimensions of the Feedback challenge—loss of confidence due to expectation-reality generated stress, unclear statement of goals and expected role performance during transition and integration stages, and premature rites of passage such as graduation exercises signaling readiness to perform when competence was not established—are specific to NLRNs.

### Strategies that evidence transformational change

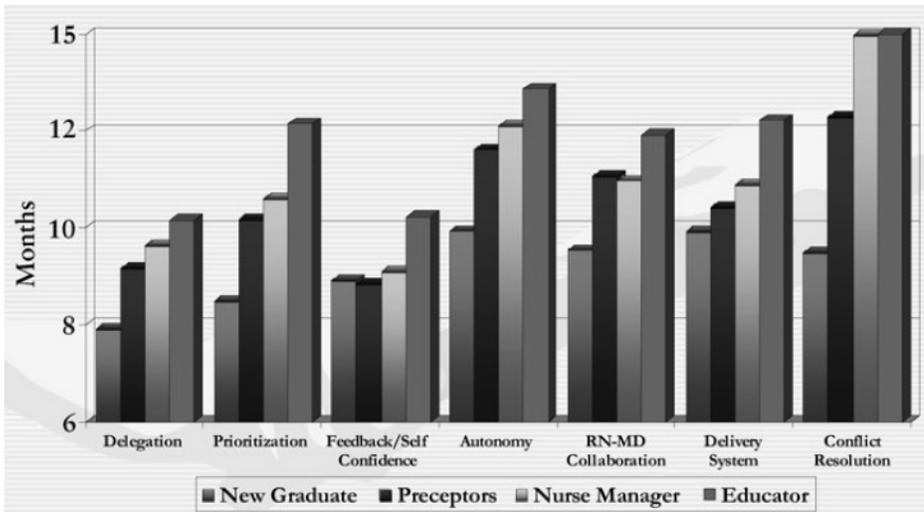
Two programs that offered opportunity for transformative change at all levels in the organization were 180 and 360 feedback sessions (in 1 hospital) and full- or half-day Feedback Workshops (in 9 of the 20 hospitals). These programs were heavily cited by interviewees as effective in reducing conflict and in promoting professional practice.

## ESTIMATED NUMBER OF MONTHS TO DEVELOP COMPETENCY IN THE 7 MPRR AREAS

Interviewees were requested to estimate length of time required for NLRNs to achieve competency in each of the 7 MPRR areas. Results for all 4 groups of interviewees are presented in the Figure. Newly licensed registered nurses estimated the least number of months to competency; educators estimated the largest number. Because most nurse educators were not unit-based, analysis of variance was run on NLRNs, experienced nurses/preceptors, and nurse managers only.

Differences in time estimate for competency in the Restoration of Self-confidence Through Feedback and Nursing Care Delivery System areas were not significant. For the other 5 competencies, NLRNs' time estimates were significantly less than those of preceptors and nurse managers (F ratios ranged from 3.77 to 8.62;  $P = .001$  to  $>.000$ ). For Conflict Resolution, difference in time estimate between nurse managers and preceptors was also significant (F ratio = 9.86;  $P \geq .000$ ).

When data were analyzed by the number of stages in NRP, that is, transition-stage only (a NRP of 4 months or less) or Transition + Integration (a NRP of 10-15 months in length), there were significant (F ratios ranged from 9.181 [ $P = .02$ ] to 36.844 [ $P \geq .000$ ]) differences in length of time to competency



Many organizations (Institute of Medicine, American Organization of Nurse Executives) recommend the implementation of NRPs. To the established benefits of such programs must now be added the potential organization transformation power of NRPs. Transformation is a process, not an event. To give transformation efforts the best chance of success, leaders must take the right actions at each stage and avoid common pitfalls<sup>32</sup>—institute well-structured, theory based Transition + Integration-stage NRPs. If it can be demonstrated that NRPs lead to improved practice empirically related to improved patient outcomes, NRPs may well be the single, most cost-effective, hospital organizational transformation instituted by nurse leaders in recent years.

for NLRNs and nurses but not for managers. For 5 competencies—Prioritization, Conflict Resolution, Nursing Care Delivery System, Autonomy, and RNMD Collaboration NLRNs and nurses reported competency was achieved in less time in Transition + Integration NRPs than in Transition-only NRPs.

Conflict Resolution and Restoration of Self-Confidence Through Feedback—the strategies effective in transformative changes were unrelated to NRPs although NLRNs may have benefited from them. There were no NRPs or transformative change strategies identified by interviewees for the Nursing Care Delivery system area.

#### CONCLUSIONS AND SUGGESTIONS

Nurse Residency Programs increase/improve NLRN job satisfaction, retention, and performance. They are effective job attractors,<sup>25</sup> enhance professional work satisfaction,<sup>26</sup> and are cost-effective—cost of program versus turnover/replacement costs.<sup>27-30</sup> Transition plus Integration-stage NRPs are more effective in development of NLRN competence in the 7 MPRR challenges than Transition-stage-only programs.

Nurse Residency Programs of sufficient length (10-15 months) to reflect transition and integration stage goals and expected role performance offered significantly more MPRR content and/experiences than did transition-stage-only NRP of 2 to 4 months.<sup>9</sup> Newly licensed registered nurses in the 2-stage NRPs perceived that it required less time to master Nursing Care delivery systems, Prioritization, RNMD Collaboration, Conflict Resolution, and Clinical Autonomy competencies than did their counterparts in the 1-stage, Transition-only programs.

Interviewees identified 5 instrumental structures or processes: (1) evidence-based management practice team projects; (2) preceptor/coaching councils for sharing of ideas and activities helpful to NLRNs integration into professional practice role; (3) clinical coaching presentations/discussions of “Ideas that worked”; (4) administrative sanction of structures that support MPRR processes; and (5) hospital-wide RN/MD councils/committees, and hospital-wide conflict resolution and feedback workshops. The first 3 are inherent in NRPs; the last 2

The question must be asked: Why do NLRNs in all 20 hospitals report less time required for achievement of competency in MPRR than what experienced nurses report? Logic suggests that NLRNs would perceive that it would require more, not less, time for them to achieve competency. Perhaps the answer lies in different definitions of competency by the 2 groups of nurses. The dictionary defines competency as “functionally adequate”. In an earlier interview study of 446 clinical nurses, nurse managers, and physicians, competency was defined as “more than adequate, above baseline performance needed for safe care, equivalent to quality patient care”.<sup>11,31</sup> The NLRN Timing survey defined competence as “you know how and are reasonably comfortable performing the activity”. Perhaps NLRNs equated this definition with safe, adequate performance and consequently perceived that they could and would reach the parameters sooner, whereas preceptors and coaches equated competence with quality care, more than adequate.

may or may not be inherent. There is more evidence of effective transformational changes in the RN/MD Collaboration area than in any other. Some of these were spearheaded by NRPs, but many innovations emanated from recommendations for improvement in RN/MD/ID collaborative efforts advocated by the Institute of Medicine and other organizations. In 2 MPRR areas—

**"Nursing is an art:  
and if it is to be  
made an art, it  
requires an exclusive  
devotion as hard  
a preparation, as  
any painter's or  
sculptor's work; for  
what is the having  
to do with dead  
canvas or dead  
marble, compared  
with having to do  
with the living body,  
the temple of God's  
spirit? It is one of  
the Fine Arts: I had  
almost said, the  
finest of Fine Arts."**

**-Florence Nightingale**



"As a nurse, we have the opportunity to heal the heart, mind, soul and body of our patients, their families and ourselves. They may forget your name, but they will never forget how you made them feel!"  
- Maya Angelou