Transition to Practice Study in Hospital Settings

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This multisite study of transition to practice included 105 hospitals in three states. Hospitals volunteered to participate and were randomly assigned to either the study group or the control group, and all new graduate registered nurses hired between July 1 and September 30, 2011, were invited to participate. The study hospitals adopted the National Council of State Boards of Nursing'sTransition to Practice model program; control hospitals continued using their existing onboarding programs, which ranged from simple orientation procedures to structured transition programs with preceptorships.

The new graduate nurses who volunteered for the transition to practice study (*n* = 1,088) filled out surveys at baseline, 6, 9, and 12 months after beginning their first nursing position. Competence was reported by both the new nurses and their preceptors. New nurse self-reported data included the number of errors, safety practices, work stress, and job satisfaction. The hospitals provided retention data on the all the new graduates hired during the study period. Though the results showed few statistically significant differences between the two groups, when the hospitals in the control group were categorized as having established or limited programs, differences were detected. Hospitals using established programs had higher retention rates, and the nurses in these programs reported fewer patient care errors, employed fewer negative safety practices, and had higher competency levels, lower stress levels, and better job satisfaction. Structured transition programs that included at least six of the following elements were found to provide better support for newly graduated RNs: patient-centered care, communication and teamwork, quality improvement, evidence-based practice, informatics, safety, clinical reasoning, feedback, reflection, and specialty knowledge in an area of practice.

The need for an effective transition to practice program in nursing has been documented for more than 80 years (e.g., Townsend, 1931). Yet, comprehensive study of transition to practice in nursing did not begin until the 1970s. Marlene Kramer published her seminal work, *Reality Shock,* in which she proposed and assessed strategies to ameliorate that shock (Kramer, 1974). Patricia Benner also began studying the nurse's transition from novice to expert (Benner, 1984, 2004) based on the Dreyfus model of skill acquisition (Dreyfus & Dreyfus, 1986).

Today, the transition of new nurses to practice is even more important. Health care is becoming increasingly complex, and the need for systems thinking continues. The patient population is more diverse, sicker, and older, and patients have multiple conditions. Technology is growing exponentially, and nurses are working at a "staccato pace" (Wiggins, 2006). Patients are discharged so quickly that they go home with complex medical, social, and economic issues. Moreover, McMenamin (2014) has issued a "tsunami warning" regarding the looming nursing shortage that will be triggered by massive nurse retirements. Soon there will be fewer seasoned nurses and more novice nurses in the workplace. Along with the complexity of health care and the projected increase of the proportion of novice nurses, medical errors continue to be a pervasive problem. Recent estimates are that between 210,000 and 400,000 premature deaths occur each year from preventable harm (James, 2013).

A survey of 400 nursing school deans and 5,700 nurse leaders showed a wide gap between perceptions of the deans and the practicing nurse leaders regarding the preparation of newly graduated nurses (Berkow, Virkstis, Stewart, & Conway, 2008). Focusing on 36 competencies, 90% of the deans and directors believed their nursing students were fully prepared to provide safe, effective care to patients, but only 10% of the nurse leaders believed they were fully prepared.

Despite the increased complexity of health care, the alarming number of medical errors, and the expertise gap, nurses, unlike other professionals, often have no comprehensive transition programs to support them as they enter the profession. The Joint Commission, the Institute of Medicine (IOM), and the Carnegie Study of Nursing Education have called for robust transition to practice, or residency, programs for nurses (Benner, Sutphen, Leonard, & Day, 2010; Institute of Medicine [IOM], 2011; The Joint Commission, 2002). Yet, comprehensive, evidence-based nurse residencies are offered by only a minority of employers. A

survey of 628 new graduate registered nurses (RNs) found that only 33% had transition programs separate from orientation programs (NCSBN, 2006). One survey of 219 chief hospital nurse executives reported that only 37% offered nurse residencies in 2011 (Pittman, Herrara, Bass, & Thompson, 2013). A second survey of 203 U.S. hospitals with 250 beds or more found that 48% had nurse residency programs, and these programs differed greatly in content and length (Barnett, Minnick, & Norman, 2014).

Based on the apparent need for transition to practice programs, NCSBN convened a committee that developed the evidence-based TTP model. Input regarding the TTP model and the needs of new graduate nurses was gathered from more than 35 nursing and health care organizations (Spector & Echternacht, 2010).

The consensus of the committee was that the Quality and Safety Education for Nurses (QSEN) competencies (Cronenwett et al., 2007; Sherwood & Barnsteiner, 2012) should be an integral part of the TTP model. QSEN is based on the 2003 IOM competencies (Greiner & Knebel, 2003) for driving quality and improving safety. The QSEN competencies include: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics.

Based on feedback from the many experts consulted during the development of the TTP model and extensive research, the committee determined the essential elements of transition. The following elements were developed into an evidenced-based transition to practice program for adoption by hospitals in the United States.

- An institution-based orientation program. Orientation programs for this study were considered to be "the process of introducing staff to the philosophy, goals, policies, procedures, role expectations and other factors needed to function in a specific work setting. Orientation takes place both for new employees and when changes in nurses' roles, responsibilities and practice settings occur" (American Nurses Association, 2000).
- Trained preceptors. A key to the TTP model is that a trained preceptor is assigned to work with and guide the new nurse for the first 6 months of practice. The preceptors are educated in their role through an online training module.
- Modules. In the first 6 months of the program, the new nurse will complete five modules:
  - Module 1: **Patient-centered care** with such major subcategories as content specialty (work with preceptor); multiple dimensions of patients; prioritizing and organizing; just culture; moral/ethical concerns; health care systems; professional boundaries
  - Module 2: **Communication and teamwork** with such major subcategories as transitioning from student to an accountable nurse (role socialization); communicating to ensure safe and quality care (TeamSTEPPS, 2014); delegating and decision making; work environment and conflicts; growing as a professional nurse
  - Module 3: **Evidence-based practice** with such major subcategories as defining evidence-based practice with scenarios; using databases; critically appraising the literature; using clinical practice guidelines; evidence-based practice models; implementing evidence-based practice in practice settings
  - Module 4: **Quality improvement** with such major subcategories as overview of quality improvement; identifying improvement gap opportunities; quality improvement tools; measuring and monitoring the data; using quality improvement in practice (case study); keys to successful improvement
  - Module 5: **Informatics** with such major subcategories as informatics as the foundation of nursing; computer and information literacy skills; information management skills with cases; informatics and the nurse's role in delivering safe patient care.
- Safety and clinical reasoning threaded throughout the modules.
- Institutional support during the second 6 months of the program. After completing the formal program, the new nurse would be encouraged and supported to participate in system activities, such as committees, unit projects, grand rounds, and other learning opportunities offered by the institution.
- Feedback and reflection. These components are threaded throughout the first year of practice and facilitated by the nurses, preceptors, and managers.

The TTP Model program (See Figure 1), hereafter called the TTP program, was then examined in a randomized, multisite study involving 105 hospitals from three states and more than 1,000 new graduate nurses.

Literature Review

Two national programs (Goode, Lynn, & McElroy, 2013; Ulrich et al., 2010) have reported their experiences with 10 years of longitudinal data. Goode and colleagues (2013) reported on data from the University Health System Consortium/American Association of Colleges of Nursing (UHC/AACN) residency program from 2002 through 2012. The UHC/AACN residency content includes leadership, patient-centered care, interprofessional collaboration, quality and safety, and related nurse-sensitive outcomes, and the professional role, which includes professional issues and the management of changing patient conditions. The UHC/AACN program also requires an evidence-based practice project, face-to-face seminar sessions, and facilitated peer discussions. Goode et al. (2013) found that competence and confidence increased across their three time points during the year, but satisfaction declined significantly from the start to the 6-month point and then stabilized at the 6-month point until completion at 12 months. Goode et al. also found that retention increased from

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