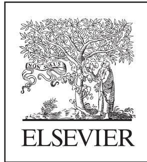

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A description of U.S. post-graduation nurse residency programs

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ABSTRACT

Background: Concern regarding newly licensed registered nurses' abilities to cope with the increasing complexity of care has led to the development of a variety of nurse residency program (NRP) initiatives. The unknowns are the extent to which and how various program elements are implemented across NRPs. Without understanding the extent to which NRPs deliver the same program, determination of their impact on care is limited. The purpose of this study was to describe U.S. NRPs and thereby identify the extent of treatment fidelity across programs.
Methods: Program attributes were measured using a 24-item survey based on the outcomes production conceptual framework. The survey was sent to known NRP directors or chief nursing officers at the 1,011 U.S. hospitals having 250 or more inpatient beds; 203 surveys (a 20% response rate) were returned.
Results: Almost half (48%) of hospitals reported operating an NRP. NRP models included University HealthSystems Consortium (22%), facility based (54%), and "other" (24%). Significant ($p < .01$) differences were noted among and within program model types in terms of career planning, project requirements and types, and mentoring.
Conclusions: The extent of differences within and across program types indicates a lack of treatment fidelity needed to detect objectively the impact of the NRP as a discrete intervention on patient outcomes. NRP expansion may be limited by the number of hospitals of a size most likely able to support such programs.
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A variety of programs exist to support the transition from student to professional nurse. Examples of these role transition programs include internship models (Eigsti, 2009; Newhouse, Hoffman, Suflita, & Hairston, 2007), mentorship models (Halfer, Graf, & Sullivan, 2008; Hayes & Scott, 2007; Sherrod, Roberts, & Little, 2008; Santucci, 2004; Persaud, 2008), and preceptorship models (Beecroft, McClure-Hernandez, & Reid, 2008; Olson et al., 2001; Sorenson & Yankech, 2008). Within the last decade, another program type that combines various elements from these models, the Nurse Residency Program (NRP), has emerged (Anderson, Linden, Allen, & Gibbs, 2009; Beyea, von Reyn, & Slattery, 2007; Bratt,

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2009; Diefenbeck, Plowfield, & Herrrman, 2006; Krugman et al., 2006).

Literature Review

The NRP is gaining the attention of new graduate nurses and hospital leaders (Nursing Executive Center, 2006). New nurse graduates are attracted to these programs because they offer an extensive orientation focusing on skill improvement, professional development, and role transition. Hospital leaders are attracted to these programs because they have the potential to reduce costs related to turnover and to provide a better-prepared workforce. Beginning in 2004, six academic medical centers piloted NRPs based on the collaborative effort of members of the American Association of Colleges of Nursing (AACN) and University HealthSystem Consortium (UHC). These programs are intended to be 1 year in length, to offer monthly residency sessions with expert facilitators, and to be affiliated with one or more local schools of nursing as an academic partner. Monthly course content is supposed to focus on professional role development and select patient outcomes (e.g., fall prevention, medication safety, discharge teaching, pain management, infection control, and skin care management) (University HealthSystem Consortium, 2010). There are now 92 programs using the AACN/UHC model in 30 states (American Association of Colleges of Nursing, 2013). Other NRPs, some resulting from local or state level initiatives and others from facility-based initiatives, have developed their own nurse residency models (Beyea et al., 2007; Bratt, 2009; Diefenbeck et al., 2006; Wandel, 1995). State-based and facility-based programs are mission driven to meet local or statewide needs. The aim for these programs is described as increasing nurse retention.

In 2010, the Institutes of Medicine recommended that all new nurse graduates attend an NRP (National Academy of Sciences, 2012); however, some residency program leaders have proposed that there are differences in how NRPs are implemented and the outcomes that are evaluated (D. Ruth, personal communication, October 21, 2008). In 2002, the Joint Commission suggested that any return on investment in nurse transition programs would stem from savings from the avoidance of continuous orientation and from improvements in the safety and quality of nursing care (Joint Commission on Accreditation of Healthcare Organizations, 2002). To date, only human resource–related (i.e., recruitment, retention, and nurse satisfaction) and professionalism-related (i.e., self-reported autonomy, confidence, and competence) outcomes have been explored as results of NRPs (Altier & Krsek, 2006; Halfer et al., 2008; Pine & Tart, 2007; Williams, Goode, Krsek, Bednash, & Lynn, 2007).

The effects of NRPs on patient outcomes have not been described. If NRPs are merely a way to control cost associated with nurse recruitment and retention, it is difficult, if not impossible, to justify the projected costs of NRPs. Before the impact on patient outcomes can be ascertained, it is essential to understand if there are differences in and among NRPs. If there were differences, then treating NRP as a single intervention contributing to patient outcomes would be erroneous. If program components vary, the attribution of effects on outcomes may be understated or overstated. Moreover, describing these programs will help determine what investments in NRPs might provide if all graduates are required to complete NRPs. The purpose of this study was to describe selected components of U.S. NRPs.

Conceptual Framework

Minnick (2009) described a variable category framework based on von Bertalanffy's general system theory (von Bertalanffy, 1973). Developed by Minnick and Roberts in 1991, this conceptual framework identified system-specific attributes (e.g., capital, employment requirements, and organizational structures) and offered potential relationships among these attributes as they relate to patient outcomes. Figure 1 depicts the modified, variable restricted version of the framework that was used for this study.

Methods

The study's design was descriptive and cross-sectional. Concepts were operationally defined based on literature reviews, tacit knowledge, and experience. A 24-item survey tool was developed based on concepts in the study framework. Figure 1 includes the items' descriptions by conceptual categories that are reported in this article.

Survey Tool Validity

Two independent researchers tested item validity using a card sort method. Each item was assigned to a category within the conceptual framework with greater than 90% agreement. Four NRP experts unrelated to the investigative team participated in a pilot test. The average content validity index among the four expert participants was 0.93, supporting sound content validity of the tool as a method to identify NRP components (Gelinas, Fillion, & Puntillo, 2009; Polit, Beck, & Owen, 2007; Waltz, Strickland, & Lenz, 1991).

Subject Recruitment

Institutional review board approval was obtained before recruitment and distribution of any survey materials. Returning a survey served as consent. U.S. hospitals listed in the 2010 American Hospital Association (AHA) Guide (AHA, 2009) and identified as teaching, community, or public health hospitals with more than 250 beds were included as subjects

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