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RN Transition to Practice Program in the Primary Care and School Settings: Development, Implementation, and Evaluation

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Abstract

New graduate registered nurses (RN) are facing a difficult time finding jobs since the economy of the United States has declined. Since then the California Institute of Nursing and Health Care, along with funding from the Betty Moore Foundation, have developed RN transition programs. These programs were developed to increase skills, confidence, and experience among new RN graduates to promote their transition into the nursing workforce. The programs also were designed to retain newly licensed nurses in the nursing profession while engaging competencies that could be transferred to both acute and outpatient care settings. In addition, the programs are intended to increase the employability of new nurses finding it difficult to secure a nursing position. This was a pilot program conducted in an ambulatory patient care setting as opposed to an acute care setting. This study used two cohorts of RN graduates to participate in a transition-to-practice program using qualitative analysis to measure the experiences and skills of new RN graduates during the program. Most residents in the program felt more confident after participation in the program and most were able to find employment as well. There were positive results from this study; however, more transition programs need to be developed and evaluated in different health care settings such as school and community health care settings.
(keywords: registered nurse, transition, residency, competency, skills, and confidence)

Section I: Introduction

It has been estimated that the United States (U.S.) will experience a growth of registered nurses (RNs) by 22% from 2008 to 2018 (Bureau of Labor Statistics, 2011). In 1998, reports of nursing shortages emerged in the United States (Buerhaus, Auerbach, & Staiger, 2007). As a result of previous nursing shortages, wages increased, working conditions began to improve, and the enrollment of nursing students increased. After the year 2000, nursing job salaries and benefits became competitive, and an interest in nursing careers peaked (Rother & Lavisso-Mourey, 2009). In 2001, 13% of nursing vacancies and over 120,000 nursing jobs remained unfilled. As a result, in 2005 funding was increased to support the nursing workforce in the state of California (Khazan, 2010). In the United States, baccalaureate-nursing programs turned away more than 30,000 applicants between 2007-2008 (American Association of Colleges of Nursing [AACN], 2007). Nursing schools continue to have high numbers of student applicants even though there are fewer jobs as a result of (a) the economic turmoil currently being experienced in the United States and (b) changes that have occurred in reimbursement for inpatient care since the development of diagnostic related grouping (DRG; Averil et al., 2003).

In the state of California, RNs are having a difficult time finding a job (California Institute of Nursing and Health Care [CINHC], 2010). According to data collected from a new graduate hiring survey conducted by CINHC from January 2009 to March 2010, 43% of nursing graduates in California currently are not working as RNs (CINHC, 2010). The major reasons given for not hiring new nurse graduates were no experience (93%), and no positions available (67%). The study also revealed that 37% were told a baccalaureate prepared nurse graduate was preferred. When the graduates were asked if they would be interested in participating in a non-paying internship, 85% indicated they were. Ninety-six percent of participants were willing to

participate in an internship to increase skills and competency. Eighty-five percent of them were willing to be unpaid, while others (46.8%) were willing to pay tuition to be in an internship program. In 2009, the Hospital Association of Southern California stated that 40% of new graduates could not find jobs. The survey conducted by employers stated that there were positions in non-acute areas, but they do not have the resources to hire and train new RN graduates (CINHC, 2010). This failure to hire new nurses is due to an immediate funding crisis, but if new nurses are not hired, will lead to a more severe nursing shortage in the years to come—a shortage that is already being felt—as the baby-boom generation nurses retire and the baby-boom generation ages and needs more frequent healthcare. Buerhaus (2008) estimated the nursing shortage is likely to reach a deficit of 500,000 registered nurses by 2025. The current number of RNs must increase by 90% to meet demands of the next decade (American Association of Colleges of Nursing, 2007).

In order to ensure a sufficient supply of RNs for the future, there needs to be a force in place to help increase the RN workforce (Buerhaus, 2008). In addition, nurses need to participate in health care policymaking in order for their voices to be heard and develop innovative solutions to help prevent an ongoing shortage of nurses in the United States. Nurses need to develop strategies to keep our current new RN graduates engaged and connected to their profession while developing their professional role as an RN. Programs that support RN transition-to-practice help decrease high turn-over rates by providing a framework in which the new RN graduate can further develop skills, safety, and quality of patient care (Institute of Medicine [IOM], 2010). The IOM supports the idea of RN residency programs; however, the programs need to be created and evaluated for effectiveness in non-acute care settings not just acute care. The purpose of this project is to explore how an RN transition program can make a

significant change in skill competency, professional role development, and job acquisition, as well as how it can be applied today while nurses are not able to find jobs.

Section II: Review of the Evidence

Many institutions have created ways to help new nursing graduates become more skilled, attract nurses with higher education degrees, and retain them in the workforce (Williams, Goode, Krsek, Bednash, & Lynn, 2007). In 2000, the Chief Nursing Officers Council of the University Health System Consortium, a working group of nurse executives, along with deans from nursing schools in the American Association of Colleges of Nursing (AACN) designed a yearlong residency program in acute care university hospitals across 24 states (Williams et al., 2007). The residency came about to address the increase of patient acuity level, the rising complexity of the acute care setting, and high turnover rate among nurses in their first year of work (Beecroft, Kunzman, & Krozek, 2001; Hamilton, Murray, Lindholm, & Myers, 1989; Mathews & Nunley, 1992). In one study, William, Goode, Krsek, Bednash, and Lynn (2007) found that turnover after the first year had decreased in a residency program to 16.5% compared to current literature that reported turnover rates at 35% to 61% after the new RNs first year of practice (Halfer & Graf, 2006; PricewaterhouseCoopers' Health Research Institute, 2007). A literature search was conducted for studies pertaining to RN residency programs. The tool used to evaluate the research studies was Appraise the Evidence (see Appendix A) used from the Northern California nursing pathways website for the Kaiser Permanente® Northern California research division. The literature presented in this section consists of the highest quality studies according to the Appraise the Evidence tool.

Bowles and Candela (2005) surveyed new RN graduates and found that turnover was related to work environment as a reason for leaving. Specific areas of work environment

stressors included lack of support and guidance, hospital management, and too much responsibility for the new RN. In another residency program research project, Fink, Krugman, Casey, and Goode (2008) found that residents became more confident over time, experienced similar stressors in the work environment, but felt more supported towards the end of the residency. RN residency programs have been shown to help with nurse retention, job satisfaction, and improved returns on investment by decreasing costs of training through a program, as compared to not having a program. The Methodist Hospital of Texas found that a residency program was cost effective with a savings of $823,680 (Pine & Tart, 2007). Residency programs can help increase the nursing workforce by reducing turnover, increasing nurse satisfaction, and providing a cost-effective way of developing the professional role of the new RN graduate.

Residency Programs

RN residency programs were designed to provide new nurse graduates with new learning opportunities through mentorships within a framework that supported the advancement from beginner nurse to advanced beginner nurse role, while promoting increased competency in the RN role (Benner, 2010; Williams, Goode, Krsek, Bednash, & Lynn, 2007). RN residency programs consist of a curriculum, guidance from a preceptor, and access to a facilitator who guides the residents in professional role development (Williams, Goode, Krsek, Bednash, & Lynn, 2007). A majority of residency programs currently occur in acute-care setting environments. Unlike nursing students, nursing residents can work in areas such as community health, school, and ambulatory clinics. They are allowed to practice as nurses without being supervised by an instructor like nursing students.

Williams, Goode, Krsek, Bednash, and Lynn (2007) evaluated a nurse residency program at six sites in 2002, which then expanded into 34 sites in 24 states. The committee decided to collect data to evaluate the effectiveness of the residency program in addressing stress, skill development, retention, and job satisfaction for new RNs. The data collected by Goode et al. (2007) showed a positive effect on the RN residents. The Casey-Fink Graduate Nursing Experience Survey® (CFGNES®), Gerber's Control Over Practice (GCOPS), and McCloskey-Mueller Satisfaction (MMS) surveys were used to evaluate the residents' experiences. Data were collected using these tools at the beginning, at 6 months during the program, and at 12 months at the end of the program. The researchers found that RN turnover rates dropped to 12% compared to the national average of 36% to 55%. Stress also declined from the beginning to end of the program. At 6 months there was more stress. At this time residents were engaged in classes related to their work environment, such as critical care, fetal heart monitoring, and chemotherapy classes. This was expected as learning new material can be a stressor. According to the residents, they were able to be more organized with care, communicate with others, and provide leadership as a result of the program (Williams, Goode, Krsek, Bednash, & Lynn 2007).

Until recently, residency programs have only been evaluated in acute care settings. With changes occurring in our healthcare delivery system and a shift in acute care to ambulatory care settings, there is a need to evaluate RN residency programs in ambulatory care and community health care settings.

Theoretical Framework

Through education and research, a model was created on how students acquire skills through instruction and practice. This model, known as the Dreyfus model of skill acquisition, consists of five stages (Dreyfus & Dreyfus, 1980). The first stage is novice, at which time the

learner is set on rules and plans, following tasks as a list, with no judgment. The second stage is advanced beginner, at which time judgment is beginning to develop but still with a limitation on perception. The third stage is competent, at which time the learner now can multitask, has more perception, and has planning skills. The fourth stage is proficient, at which time the learner has more recognition of the learning in a holistic way rather than as a task. The fifth stage is the expert stage, where the rules or guidelines no longer apply and the learner has more analytical ways of dealing with situations.

Since the development of this theory, nursing has adapted the theory into nursing as well. Benner (1982) developed the fived stages of skills from novice to expert. The novice stage consists of the beginner nurse who learns to follow rules to perform tasks, has no experience, and needs to be told what to do. In the next stage the advanced beginner has more experience but principles are based on past experiences that have developed. The third stage, competent, is a nurse with 2 to 3 years of experience, who has obtained more analytical and abstract manners in thinking. The fourth stage is proficient, which the nurse sees everything as a whole, learned from past experiences and knows what to expect given the situation. The last stage is expert, this is when the nurse no longer needs the rules, has intuition, and is more proficient.

The Dreyfus and Benner model of acquisition is the learning process in which learners/students progress through the stages. This can be applied to any type of learner/student in any new job setting. During this pilot program the researcher hypothesized that participants in the program would be more competent once experience was obtained and would follow a learning path that would match Benner's novice to expert theory.

Characteristics of New Nurse Graduates

A new nurse graduate is not yet fully effective in assessing, observing, recognizing patterns and deviations, or seeking information. He or she takes an unfocused approach to organizing data and requires assistance in diagnosing problems, planning interventions, and carrying out skills. A new nurse graduate often shows hesitance in communicating and responding to clinical scenarios. In developing competency, the nurse in a residency program captures obvious patterns, makes attempts to monitor a variety of data, but overlooks some important information. He or she performs basic assessment and clinical skills, but still requires some guidance and direction. The developing resident may show a solid foundation in leadership and communication abilities, though remain disorganized and hesitant in some aspects of clinical situations. In the accomplished competency level the resident effectively assesses, seeks information, recognizes patterns and deviations, plans interventions, displays confidence and leadership ability, communicates effectively, and requires guidance only in complicated cases. He or she demonstrates proficiency in most nursing skills and requires minimal prompting in responding to clinical scenarios.

Section III: Implementation of the Program

The state of California has to keep new nursing graduates in the workforce to care for the people of California despite the current economic situation in healthcare. New RN graduates are not being hired due to their lack of experience in an RN role. The associated cost to train a new RN in the workforce has affected their employability (CINHC, 2010). In response to this, CINHC allocated grant funds provided by the Gordon and Betty Moore Foundation to help develop new graduate RN transition programs. The RN transition programs were developed to help prepare new RN graduates to gain skills, confidence, and experience to enter the nursing

workforce. A multisite pilot program comparing and contrasting the various transition programs was developed to include the various schools of nursing transition to practice programs in the five counties of the San Francisco Bay Area (SFBA), which includes San Francisco, San Mateo, Alameda, Santa Clara, and Marin.

The evaluation of the program discussed in this article consisted of two cohorts of 20 new graduates. The program was conducted in an ambulatory patient care setting as opposed to an acute care setting. Impact on participant knowledge, attitudes, skills, and ability to secure employment was measured. Permission was obtained from the university's institutional review board (IRB; see Appendix B)

Aim of the Program

1. To increase skills, confidence, and experience among new RN graduates to develop their transition into the nursing workforce.
2. Retain new nurses in the profession while engaging competencies that can be transferred to both acute and outpatient care settings.
3. To increase employability of new nurses who find it difficult to secure a nursing position.

Participants

Eligible participants of the program had to (a) be graduates of a school of nursing certified by the board of registered nursing (BRN) and certified by the National League of Nursing (NLN), and (b) have received their baccalaureate or masters degree during or after 2008. All participants had to be from the five SFBA counties, currently unemployed as an RN, and a U.S. citizen or have documentation to work in the United States. All participants had to complete a 12-week program with a total of 240 clinical hours in ambulatory care nursing and

simulation or seminar 1 day a week at the university campus. After completion, RN residents received a certificate of completion with a concentration in ambulatory care setting. In order to participate in the RN transition program, the applicant had to (a) send an application with resume; (b) describe what ambulatory care meant to the resident; and (c) send copies of their RN license, CPR card, and public health certificate if applicable. The applicant was required to describe a learning outcome that the resident wanted to achieve. If the applicant was admitted, he or she had to submit (a) preclinical requirements for health and security screening since he or she would be working with children in school districts or in the community, (b) proof of malpractice and workers compensation insurance (provided by the program), and (c) any other site requirements. No tuition was charged for the program and the residents were not paid for their participation in the program. Applicants accepted into the program were selected from a grid developed by the program facilitator to assess the applicant's resume and application information. There were selective telephone interviews conducted by the program coordinator to clarify information with applicants. As part of the program contract and as stipulated in the programs grant language, residents could no longer participate in the program if they obtained employment as an RN during the program. Residents also had to agree to fill out a tracking tool that notified the program coordinator when they obtained an RN job whether pre, during, or post RN transition program.

Methods and Instruments

The investigators used data collected from survey tools both approved and developed by the RN transition program collaborative members from CINHC. These instruments and the timeline of their use are described in this section.

CFGNES®. The Casey-Fink Graduate Nurse Experience Survey® 2006 (CFGNES®; see Appendix C) was used to measure skill and competence. The CFGNES® has a reliability factor of .71 to .90 with an internal consistency of $\alpha = .89$. This survey was taken during the program after a week of completion of clinical residency and at the completion of the program. The survey consists of five sections: demographics, skills/procedures performance, comfort and confidence, job satisfaction, and five open-ended questions that allowed the residents to express their experiences. Permission was obtained for both the Casey-Fink Graduate Nurse Experience Survey®.

QSEN. Questions in the survey use anchors of *strongly agree* to *strongly disagree* and *not applicable*. A tool to assess participant development of knowledge attitudes and skills—as outlined by the Quality and Safety Education for Nurses (QSEN) competencies for preparing future nurses (QSEN, 2010)—was developed by a team of experts. The tool was created to help evaluate nurses in patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics. The CINHC-sponsored expert panel developed a brief QSEN transition program competency assessment tool (see Appendix D). The Lasater Clinical Judgment Rubric was used to score the QSEN evaluation tool and rate the participant as beginning, developing, or accomplished (see Appendix E).

QSEN (brief version). In addition, six more extensive QSEN competency assessment tools were also used for self-analysis in the middle of the program (see Appendix F-K). The brief QSEN tools measured competencies on a Likert scale from 1-3 and *not applicable*. The preceptors used the QSEN material as guides in filing out the shorter brief assessment tools at the beginning 2 weeks of the program and 1 week before the program ended. The RN participants filled out the more extensive QSEN tools as a self-assessment at the beginning and at the end.

This helped the participant understand the area for self-development of their professional role in the program. Participants were encouraged to discuss these with their preceptors in guiding their plan for transitioning to their professional RN role as an advanced beginner nurse. The extensive versions of the assessment competency tools were also rated on the same type of scores as the brief assessment tool, though in more detail.

PES. Another tool used as part of the evaluation included the Preceptorship Experience Questionnaire (PES), which evaluated the residents' account of their perceptorship by allowing them to score the effectiveness of their preceptor (Kim, 1992; see Appendix L). The PES tool has three sections: section one is a rating by the resident on a Likert scale from *not important* to *very important* (1-5), section two rates his or her own competency level from less competent to very competent (1-5), and section three asks for demographic information. The PES survey has a Cronbach's alpha of .97, with validity and reliability not yet determined. Permission was obtained for use of the Preceptorship Experience Questionnaire.

Data Collection

The convenience sample consisted of 20 participants from the new RN transition program in ambulatory care between September 2010 to December 2010 and 20 participants in the second cohort from February 2011 to May 2011. Participants were asked to complete the CFGNES® online voluntarily through SurveyGizmo™ to maintain confidentiality. The preceptor completed the brief QSEN competency assessment tool. Completed data was then entered into excel by the researcher. The PES was completed by the residents then collected by the program coordinator and entered into an excel spreadsheet by the researcher.

Data Analysis

Data analysis was conducted using pre and post data from the CFGNES® and comparing the answers and evaluating the differences from pre and post data to determine Cohen's *d* to evaluate effectiveness of the program. The PES brief competency assessment tool was evaluated to measure confidence in the preceptee from pre and post data. The long competency assessment tools were used to help measure the growth in competency between the brief competency assessment tool done pre and post residency as perceived by the RN participant.

Section IV: Project Outcomes

Demographics

Demographics collected from the first CFGNES® in cohort 1 showed that (a) participants' mean age was 27.8; (b) 95% were female; and (c) 57.9% were Asian, 31.6% were Caucasian, and 10.5% chose not to disclose their ethnicity. The majority of participants were from the University of San Francisco (57.9%), followed by San Francisco State University (15.8%), San Jose State University (10.5%), Samuel Merritt University (5.2%), and (10.5%) unknown or not reported. The majority of participants graduated in 2009 (52.6%), in 2010 (31.6%), and (15.8%) reported unknown. Eighty-four percent were baccalaureate prepared nurses and 18% were masters prepared. Other educational backgrounds included degrees in sociology, psychology, women's studies, and chemistry. Clinical placements for the RN residents included ambulatory care clinics (71.4%) and school nurse setting (28.6%). For more detailed demographic data see Table 1.

The second cohort mean age was 30.4 and 100% were female. Most of the residents were Asian (53.3%), Caucasian (26.7%), Hispanic (6.7%), other (6.7%), and a few who did not want to disclose (6.7%). The year of graduation for residents was from 2010 (53%) unlike the

first cohort, 2009 (30.7%), and 2008 (15.3%). The majority of residents in the second group were from a baccalaureate program (80%), masters program of nursing (13.3%), and 6.7% from an associates program. The residents ranged in education from liberal arts, psychology, holistic health, and genetics. Most of the residents were volunteers (64.3%) and from student externships (64.3%). For more detailed demographic data see Table 2.

Skills

The residents were asked to identify the top three skills and procedures they felt uncomfortable performing independently. The most uncomfortable skills/procedures identified for the first cohort included codes and emergencies 55.6% in the pre-assessment, which then decreased to 30% in the CFNGNES survey, even though codes were not practiced during the program. Other skills that residents felt uncomfortable with included ECG/EKG, telemetry monitoring and interpretation (55.6%), vent care and management (50%), and arterial line management (44.4%), opposed to an acute care transition program or residency one (see Table 3).

The second cohort felt that arterial and venous lines (62.5%) were at the top of their list as skills that were uncomfortable, which still remained at the top as shown by scores in the post-CFNGNES. Vent care was second (56.3%) and blood venapuncture was third (31.3%) for the pre- CFNGNES. The post CFNGENS had code emergencies as second (53.8%) and chest tube care (38.5%) for third (see Table 4).

Stressors

Respondents also completed a question regarding the most common stressor in their lives. Pre data showed personal stress was caused by finances (84.6%) and living situation (15.4%). At the conclusion of the residency program, finances (85.7%) remained the most

common stressor among residents followed by their personal relationships (42.9%), which increased from 7.7%. For the second cohort, finances (90.9%) and personal relationships and job performances (36.4%) tied for the second most common stressors.

Role Transition

In response to nurses having difficulties with transitioning from student nurse to advance beginning RN (first cohort), most experienced difficulties after the first week of starting the program in lack of confidence (76.5%), fears (64.7%), orientation issues (64.7%), and role expectations (35.5%). After completion of the program, difficulties in transition included role expectations (60%), lack of confidence (50%), orientations issues (50%), and fears (30%). There were consistencies among the categories; even though confidence and fears decreased, role expectations increased. This may be due to reality; the residents were no longer students so it is not surprising that the expectation of responsibility in the RN role would increase. Residents also reported in pre-program data that they felt more satisfied in their work environment when they had peer support (83.3%), ongoing learning (83.3%), patient and family support (55.6%), and a positive work experience (55.6%). Post data from the CFNGNES survey showed lack of confidence and role expectations remained high but patient and family support increased to 70% after completion of the program.

The second cohort had difficulties in transitioning with lack of confidence (78.6%), role expectations (57.1%), and fears (42.9%). For the post CFNGNES, lack of confidence decreased (58.3%), role expectation increased slightly (58.3%), and fears as well (58.3%). Again, similar to the first cohort, the changes in percentages may be due to the reality that the residents are no longer students and are learning the role and assuming the responsibility of the RN.

Results for the CFGNES individual questions were analyzed using Cohen's *d* for the first and second cohort using pre (*n* = 34) and post data (*n* = 20). After completion of the program, residents felt at ease with asking help from other RNs, with a large difference from pre to post with a Cohen's *d* of 0.80. Residents also felt staff was available during a new situation or outcome (Cohen's *d* = 0.89). The residents felt very supported by the nurses at their preceptor site with a large difference in pre and post data with a Cohen's *d* of 1.07. Other questions in the CFNGNES showed a small or medium difference. There was a difference in feeling comfortable delegating tasks to nursing assistants (Cohen's *d* = 0.52), feeling encouragement and feedback from their preceptor (Cohen's *d* = 0.58), feeling able to communicating with patients and their family (Cohen's *d* = 0.60), and feeling able to complete their work assignment on time (Cohen's *d* = 0.54). There were also good outcomes. For example, there was a reverse in answers to some questions. There was a small decrease in feeling overwhelmed in the resident's responsibilities (Cohen's *d* = -0.38). There was also a moderate inverse difference in residents having a difficult time organizing care (Cohen's *d* = -0.48) and a feeling of causing harm to patients (Cohen's *d* = -0.50). The Casey-Fink tool helped evaluate the experiences during a residency program before and after the program. There were many significant differences in certain areas, but not on other questions, which can help in making changes to the program in that particular area for future RN transition programs. Since many participants had to leave the program once they found a job, the post-program data are limited. For complete data analysis for the CFNGNES, see Table 5.

Competency

There were a total of 35 QSEN brief competency surveys completed by the preceptors; 34 answered the pre QSEN and 23 the post QSEN survey (both cohorts). The competencies measured were based on the QSEN long survey that was divided into different categories as

mentioned before. The data for the QSEN competency was analyzed using Cohen's *d* to determine program effectiveness by measuring the differences. In the category of patient-centered care, all questions showed a significant difference with a Cohen's *d* ranging from 1.32 to 2.04, meaning that many preceptors thought that many of the residents had evolved since the beginning of the program. The highest difference seen by preceptors was that their residents were able to integrate knowledge of pathophysiology of patient conditions (with a Cohen's *d* of 2.04). Also, residents were able to advocate for patients in multidisciplinary discussions (with a Cohen's *d* of 1.887). For questions in regards to safety, Cohen's *d* ranged from 0.20 to 1.80, again making the results statistically significant, except for one regarding the use of equipment using IV pumps (with a Cohen's *d* of 0.20). Highest difference was seen with residents being able to demonstrate safe practices at their site related to medication administration (with a Cohen's *d* of 1.80). Due to this being an ambulatory care program, questions that related to acute care nursing skills did not show any difference. In the category for evidence-based practice, the results also were medium to large significance with Cohen's *d* of 0.73 to 1.03, with a large difference seen in residents being able to use the library, intranet, and colleagues for information (Cohen's $d = 1.03$). Team and collaboration had the highest difference (Cohen's *d* of 1.46) for residents being receptive from others and not being defensive and being able to work as part of the team. Professionalism was showed the highest significance with a Cohen's *d* of 3.07) for residents being able to work autonomously and being accountable. Informatics was the category in which no significant changes were found. Overall pre clinical competence was significant with a Cohen's *d* of 1.08. The QSEN evaluation also had the same problem with data collection in that residents had to leave the program once they have received jobs, which does not allow capture of all data. For a more specific analysis for each question see Table 6.

Preceptorship Experience

As discussed earlier, the PES addressed the relation with the preceptor and was completed at the end of the residency. Questions 1-12 addressed the importance of the experience. A majority of both cohorts thought it was important to have one primary preceptor (first cohort 66.7% with this response and second cohort with 44.4%; question 1). Both groups were able to develop a trusting relationship with their preceptors (first cohort 91.7% and second cohort 88.9%; question 5). For the second part of the survey, in addressing their own competence, the residents determined how competent they felt with certain skills. In both cohorts most residents felt moderately to very competent in identifying and assessing patient health care needs (first cohort at 41.7% [moderate] and second cohort at 62.5% [very]; question 13). Both cohorts felt very competent with checking action and side effects of medications (first cohort at 66.7% and second cohort at 62.5%; question 19). There were in some instances in which the residents did not feel competent. For instance there was a wide range in the competency of maintaining a parenteral intravenous infusion (first cohort not competent at 9.1% and second cohort at 12.5% not competent as well not competent; question 27). The residents also felt less competent in inserting a nasogastric tube (first cohort responded *not competent* at 9.1%, *less competent* at 45.5%, while the second cohort responded *less competent* at 37.5%, *competent* at 62.5%; question 28). The residents scored *not competent* or *less competent* in skills that are more common for acute care nursing. Because residents were in an ambulatory care program, it was expected that they felt less competent in acute care skills.

Section V: Evaluations

The RN residency program was developed to provide both a classroom and precepted clinical experience to inexperienced nurses. This program aided current graduates in finding jobs and provided a transition from student to RN. From both cohorts, 90% of our participants were able to find employment in acute, non-acute, and school settings. The results of this ambulatory RN transition program help add to the body of literature, since most residency programs are focused in acute care settings. The results of this study were from a small number of participants, but differed compared to other studies that were in a different geographic location and setting. The length of the program was limiting due to funding as previously mentioned.

There were similarities and differences with previous studies for the CFGNES®. Like previous studies, most participants were female and were baccalaureate prepared (Williams, Goode, Krsek, Bednash, & Lynn, 2007; Fink, Krugman, Casey, & Goode, 2008). However, most residents in the ambulatory transition program were Asian, compared to Caucasian, which can be due to the study's geographic region. Most skills with which residents felt uncomfortable were skills performed in acute care settings, which remained high after the residency due to the type of residency. The stressors of the residents differed compared to other studies. In other studies stressors were due to waiting for results of licensure, moving, and expectations of work (Williams, Goode, Krsek, Bednash, & Lynn, 2007; Fink, Krugman, Casey, & Goode, 2008). Residents from our program stated that finances and living situations were their stressors, which can be due to the economic differences in the location and timeframe of the studies. Currently graduate RNs are having a difficult time in finding jobs. Role transition difficulties in studies were the change in role from student to RN, such as role changes, lack of confidence, workload,

orientation issues and fears (Williams, Goode, Krsek, Bednash, & Lynn, 2007; Fink, Krugman, Casey, & Goode, 2008), which were similar to the residents in this pilot program.

At this time the data is still being collected from other study sites, so comparisons cannot be analyzed at the present time. Analyses are still being done for the other measuring tools (PES and brief QSEN). Once collection and analysis is complete, a thorough detailed report will be published.

Section VI: Continuous Quality Improvement

The RN residency program has had changes since the beginning of the program start date. From reviewing data from different study sites, the program director has decided to change the surveys to electronic format in order to capture data quickly for different study sites. It is recommended for all program coordinators involved to review all policies and data gathering procedures for study sites and choose one way for sites to review and gather data. Once the committee has approved all policies and procedures, then all coordinators will make changes at all study sites. The plan, do, study, act/standardize, do, study, and act model (PDSA/SDSA) is a more detailed outline of what the project looks like (see Appendix M & N). In order for this project to continue, the PDSA/SDA method can be used to make changes to the program as it continues to grow and change. Implementing a method of change in the program can aid in assisting all sites in agreement instead of each site following different procedures for the multi-site program.

For this RN transition program, the coordinators can utilize the PDSA/SDSA tool to demonstrate how the project will function. The PDSA/SDSA tool will help in displaying the team members and the functions of all team members. The tool also describes the measures that need to be accomplished, how they will be accomplished, and at what time. Appendix M and N

show how the PDSA/SDSA cycle has affected the project as well as the ongoing cycle of trying different strategies in reviewing best practices, evidence-based practice, review of the literature, and best results from the project. A budget is still being analyzed for each individual program and also for the entire program at all sites. By implementing this PDSA/SDSA model program, coordinators can duplicate the process to start new programs for the future.

Section VII: Implications for Nursing

The aims of the RN transition program were accomplished for the participants in the present study. The residents had an increase in confidence, remained in the RN profession, and the majority were able to find RN positions. This program has helped change how RN graduates can be introduced into the workforce. A transition program can help in many different areas that have shortages and teach RN graduates other areas of nursing not taught in nursing schools. Nursing schools mainly teach how to be acute care nurses unless a master's degree or advanced training is pursued. This program can help explore other transition programs for those interested in a change in specialty, for example to school nursing, home health, hospice, and ambulatory care. Since the results of this program show it to be successful, the University of San Francisco plans to expand the program to home health and hospice once funding is secured. Currently there has also been expansion in advanced practice.

Funding

Starting in January of 2012, the Santa Rosa Community health center will offer a nurse practitioner (NP) residency program due to the shortage of primary care providers. This program was made possible by a grant from the federal government, as part of the Affordable care Act of 2010, in an attempt to increase the nursing workforce (Verel, 2011). This NP residency program will be the first in the State of California. With more residency programs being created to

increase competence and workforce, this can help the nursing profession in adapting residency programs into the practice.

In addition, nurses should be made partners in health care along with other providers. This includes in all types of settings such as schools and community health centers. With current recommendations from the IOM, it is time that RNs and APRNs unite and help change legislation impacting the future of nursing in addition as well as funding for the millions of Americans who might have insurance by 2014 according to current national goals for healthcare reform.

Lessons Learned

This was a program evaluation project. As with all programs, sometimes there are aspects that should be modified. Due to the nature of the program goals, there was a high attrition rate during the residency program since most acquired jobs during the program. With that as a focus, it is key to put into place mechanisms that will allow for participants to complete evaluation requirements even after employment as a professional nurse is secured. The transition to practice residency program was conceptually different from previously implemented residency programs that were implemented to address the nursing shortage. The cost and time related to recruiting, orienting, and reducing turnover in the nursing workforce was the paramount concern. The focus of this program was not on retention of nurses but on an intervention to keep new graduates linked to the profession. The goal was not to keep them from leaving a job, but increasing their employability by providing additional practice experience and opportunities to develop competence in clinical decision-making, priority setting, and professionalism. Traditional programs were 12 months, while this program was only 3 months. The residents were not employees and not required to fill out the information, which led to some unanswered

questions and lower amount of participant data. There were also no monetary benefits for the residents and/or elective college credit earned by the resident. In the beginning of the program it was very difficult to find preceptors, which showed the need to have trained preceptors ready to participate at the start of any residency program.

Dissemination Plan

A manuscript is currently being written in the process of this project. The information will be submitted to a peer-reviewed journal for publication. In addition, the material presented will be submitted to a poster presentation for a conference next year. The project will also continue, and data will continue to be gathered and be disseminated as well. The program has extended also to Southern California.

Section VIII: Conclusion

Hospital emergency rooms are filled in part because clinics and community-based health centers are not utilized to their full potential for management of chronic diseases and preventive care, contributing to cost increases and poor patient and system outcomes (Rother & Lavisso-Mourey, 2009). This is why chronically ill people continue to seek care in acute care settings. In order for health care reform to work, models of care are being developed to promote increased access, improved quality care, safety, and reduced costs for clinics and community-based health centers (Rother & Lavisso-Mourey, 2009). These models in public health care systems can aid in caring for those chronically ill patients by preventing costly admissions in acute care settings. Community health centers provide high quality care for patients, provide care to millions of Americans, and care for vulnerable populations (HealthCare, 2010). In 2011 there was $250 million to establish 350 new community health care centers. This money will help in expanding current community health centers, make care affordable regardless of insurance or ability to pay,

help provide quality care to an additional 2.5 million people, and create jobs (HealthCare, 2010). With the Affordable Care Act 2010, emphasis is being applied to community health care clinics to provide primary care and prevention services for populations with health disparities. The clinics will be able to provide comprehensive care, managed care, and have a team-based approach for care (HealthCare, 2010). With expansion of new clinics, RNs will be needed in community health care clinics. Currently RN programs do not focus on ambulatory care but acute care. Expanding the nursing role to ambulatory care can help in increasing the work force in clinics. Having an ambulatory care residency program can help add additional training to the outpatient setting compared to traditional training such as acute care. According to the Institute of Medicine (IOM) report, nurses should practice to their fullest capacity and achieve higher education (IOM, 2010). Nurses can work in many settings such as schools, homes, retail clinics, and community health care centers. Nurses have different educational backgrounds and competency levels. The IOM recommends changes in nursing leadership and in expanding nursing (IOM, 2010). The IOM recognizes that there are high levels of job turnover among nurses. This study holds significance for transition programs and residency programs for nurses, because they traditionally have been in acute care settings. The ambulatory RN transition program was able to meet the goals. New RN graduates gained confidence, maintained their skills, and 90% were able to find jobs, during or after completion. RN transition programs can help in initiating the recommendations from the IOM report.

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Appendix A: Appraise the Evidence

The first step to appraise the evidence is to summarize the evidence accumulated in your search. The evidence table below is designed to assist the reader in extracting the most important information from each article needed to assess the reliability and validity of the results.

First Author Year ID	Study Characteristics	Population	Interventions	Outcome Results

Source: Kaiser Permanente® (2005)

Appendix B: IRB Approval

August 2, 2010

Dear Ms. Lens:

The Institutional Review Board for the Protection of Human Subjects (IRBPHS) at the University of San Francisco (USF) has reviewed your request for human subjects approval regarding your study.

Your application has been approved by the committee (IRBPHS #10-068).
Please note the following:

1. Approval expires twelve (12) months from the dated noted above. At that time, if you are still in collecting data from human subjects, you must file a renewal application.

2. Any modifications to the research protocol or changes in instrumentation (including wording of items) must be communicated to the IRBPHS.
Re-submission of an application may be required at that time.

3. Any adverse reactions or complications on the part of participants must be reported (in writing) to the IRBPHS within ten (10) working days.

If you have any questions, please contact the IRBPHS at (415) 422-6091.

On behalf of the IRBPHS committee, I wish you much success in your research.

Sincerely,

Terence Patterson, EdD, ABPP
Chair, Institutional Review Board for the Protection of Human Subjects

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IRBPHS – University of San Francisco
Counseling Psychology Department
Education Building – Room 017
2130 Fulton Street
San Francisco, CA 94117-1080
(415) 422-6091 (Message)
(415) 422-5528 (Fax)
irbphs@usfca.edu
http://www.usfca.edu/soe/students/irbphs/

Appendix C: Casey-Fink Graduate Nurse Experience Survey (revised)

I. List the top three skills/procedures you are *uncomfortable performing* independently at this time? (Please select from the drop down list) list is at the end of this Appendix.

1. _____
2. _____
3. _____
4. _____I am independent in all skills

II. Please answer each of the following questions by placing a mark inside the circles:

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
1. I feel confident communicating with physicians.	○	○	○	○
2. I am comfortable knowing what to do for a dying patient.	○	○	○	○
3. I feel comfortable delegating tasks to the Nursing Assistant.	○	○	○	○
4. I feel at ease asking for help from other RNs on the unit.	○	○	○	○
5. I am having difficulty prioritizing patient care needs.	○	○	○	○
6. I feel my preceptor provides encouragement and feedback about my work.	○	○	○	○
7. I feel staff is available to me during new situations and procedures.	○	○	○	○
8. I feel overwhelmed by my patient care responsibilities and workload.	○	○	○	○
9. I feel supported by the nurses on my unit.	○	○	○	○
10. I have opportunities to practice skills and procedures more than once.	○	○	○	○
11. I feel comfortable communicating with patients and their families.	○	○	○	○

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
12. I am able to complete my patient care assignment on time.	○	○	○	○
13. I feel the expectations of me in this job are realistic.	○	○	○	○
14. I feel prepared to complete my job responsibilities.	○	○	○	○
15. I feel comfortable making suggestions for changes to the nursing plan of care.	○	○	○	○
16. I am having difficulty organizing patient care needs.	○	○	○	○
17. I feel I may harm a patient due to my lack of knowledge and experience.	○	○	○	○
18. There are positive role models for me to observe on my unit.	○	○	○	○
19. My preceptor is helping me to develop confidence in my practice.	○	○	○	○
20. I am supported by my family/friends.	○	○	○	○
21. I am satisfied with my chosen nursing specialty.	○	○	○	○
22. I feel my work is exciting and challenging.	○	○	○	○
23. I feel my manager provides encouragement and feedback about my work.	○	○	○	○
24. I am experiencing stress in my personal life.	○	○	○	○

25. If you chose agree or strongly agree, to #24, please indicate what is causing your stress. (You may circle more than once choice.)

    a. NCLEX
    b. Finances
    c. Child care
    d. Living situation
    e. Personal relationships
    f. Job performance
    g. Graduate school

III. How *satisfied* are you with the following aspects of your job:

	VERY DISSATISFIED	**MODERATELY DISSATISFIED**	**NEITHER SATISFIED NOR DISSATISFIED**	**MODERATELY SATISFIED**	**VERY SATISFIED**
Salary	○	○	○	○	○
Vacation	○	○	○	○	○
Benefits package	○	○	○	○	○
Hours that you work	○	○	○	○	○
Weekends off per month	○	○	○	○	○
Your amount of responsibility	○	○	○	○	○
Opportunities for career advancement	○	○	○	○	○
Amount of encouragement and feedback	○	○	○	○	○
Opportunity to work straight days	○	○	○	○	○

IV. Transition (please circle any or all that apply)

1. What difficulties, if any, are you currently experiencing with the transition from the *"student"* role to the *"RN"* role?

a. Role expectations (e.g. autonomy, more responsibility, being a preceptor or in charge)
b. Lack of confidence (e.g. MD/PT communication skills, delegation, knowledge deficit, critical thinking)
c. Workload (e.g. organizing, prioritizing, feeling overwhelmed, ratios, patient acuity)
d. Fears (e.g. patient safety)
e. Orientation issues (e.g. unit familiarization, learning technology, relationship with multiple preceptors, information overload)

2. What could be done to help you feel more supported or integrated into the unit?

a. Improved orientation (e.g. preceptor support and consistency, orientation extension, unit specific skills practice)
b. Increased support (e.g. manager, RN, and educator feedback and support, mentorship)
c. Unit socialization (e.g. being introduced to staff and MDs, opportunities for staff socialization)
d. Improved work environment (e.g. gradual ratio changes, more assistance from unlicensed personnel, involvement in schedule and committee work)

3. What aspects of your work environment are most satisfying?

a. Peer support (e.g. belonging, team approach, helpful and friendly staff)
b. Patients and families (e.g. making a difference, positive feedback, patient satisfaction, patient interaction)
c. Ongoing learning (e.g. preceptors, unit role models, mentorship)
d. Professional nursing role (e.g. challenge, benefits, fast pace, critical thinking, empowerment)
e. Positive work environment (e.g. good ratios, available resources, great facility, up-to-date technology)

4. What aspects of your work environment are least satisfying?

a. Nursing work environment (e.g. unrealistic ratios, tough schedule, futility of care)
b. System (e.g. outdated facilities and equipment, small workspace, charting, paperwork)
c. Interpersonal relationships (e.g.gossip, lack of recognition, lack of teamwork, politics)
d. Orientation (inconsistent preceptors, lack of feedback)

5. Please share any comments or concerns you have about your residency program:

V. ***Demographics:*** **Circle the response that represents the most accurate description of your individual professional profile.**

1. **Age: _____ years**

2. **Gender:**
   a. Female
   b. Male

3. **Ethnicity:**
   a. Caucasian (white)
   b. Black
   c. Hispanic
   d. Asian
   e. Other
   f. I do not wish to include this information

4. **Area of specialty:**
   a. Adult Medical/Surgical
   b. Adult Critical Care
   c. OB/Post Partum
   d. NICU
   e. Pediatrics
   f. Emergency Department
   g. Oncology
   h. Transplant
   i. Rehabilitation
   j. OR/PACU
   k. Psychiatry
   l. Ambulatory Clinic
   m. Other: _____

5. **School of Nursing Attended (name, city, state located): _____**

6. **Date of Graduation: _____**

7. **Degree Received:** AD: _____ Diploma: _____ BSN: _____ ND: _____

8. **Other Non-Nursing Degree (if applicable): _____**

9. **Date of Hire** *(as a Graduate Nurse)***: _____**

10. **What previous health care work experience have you had:**
    a. Volunteer
    b. Nursing Assistant

c. Medical Assistant
d. Unit Secretary
e. EMT
f. Student Externship
g. Other *(please specify)*: _____

11. Have you functioned as a charge nurse?
a. Yes
b. No

12. Have you functioned as a preceptor?
a. Yes
b. No

13. What is your scheduled work pattern?
a. Straight days
b. Straight evenings
c. Straight nights
d. Rotating days/evenings
e. Rotating days/nights
f. Other *(please specify)*: _____

14. How long was your unit orientation?
a. Still ongoing
b. ≤ 8 weeks
c. 9 – 12 weeks
d. 13 – 16 weeks
e. 17 - 23 weeks
f. ≥ 24 weeks

15. How many *primary* preceptors have you had during your orientation?
_____ number of preceptors

16. Today's date: _____

Drop down list of skills

Arterial/venous lines/swan ganz (wedging, management, calibration, CVP, cardiac output)
Assessment skills
Bladder catheter insertion/irrigation
Blood draw/venipuncture
Blood product administration/transfusion
Central line care (dressing change, blood draws, discontinuing)
Charting/documentation
Chest tube care (placement, pleurovac)
Code/Emergency Response
Death/Dying/End-of-Life Care
Dobhoff/NG care/suctioning/placement
ECG/EKG/Telemetry monitoring and interpretation
Intravenous (IV) medication administration/pumps/PCAs
Intravenous (IV) starts
Medication administration
MD communication
Patient/family communication and teaching
Prioritization/Time Management
Trach care
Vent care/management/assisting with intubation/extubation
Wound care/dressing change/wound vac
Unit specific skills _____

Appendix D: Brief QSEN Evaluation

New Graduate RN Transition Program Competency Assessment Tool: [School/Program Name]

Participant Name: _____

Evaluator Name: _____Date: _____

Evaluation period: □ Initial □ Final

COMPETENCIES	Beginning	Developing	Accomp - lished	Not Applic- able
PATIENT CENTERED CARE				
1. Conducts comprehensive psychosocial and physical health history that includes patient's perspective and considers cultural, spiritual, social considerations.	**1**	**2**	**3**	**N/A**
2. Complete understanding and interpretation of assessment data.	**1**	**2**	**3**	**N/A**
3. Able to anticipate risks related to assessment data.	**1**	**2**	**3**	**N/A**
4. Integrates knowledge of pathophysiology of patient conditions.	**1**	**2**	**3**	**N/A**
5. Decision-making is based on sound clinical judgment and clinical reasoning.	**1**	**2**	**3**	**N/A**
6. Advocates for patient as appropriate in multidisciplinary team discussions.	**1**	**2**	**3**	**N/A**
7. Recognizes changes in patient status and conducts appropriate follow up.	**1**	**2**	**3**	**N/A**
8. Prioritizes actions related to patient needs and delegate's actions if appropriate.	**1**	**2**	**3**	**N/A**
9. Establishes rapport with patients and family.	**1**	**2**	**3**	**N/A**
SAFETY				
10. Demonstrates safe practices related to medication administration including rights, verification of allergies, two patient identifiers, read-back process, and independent double checks for high alert medications.	**1**	**2**	**3**	**N/A**
11. Demonstrates the safe use of equipment appropriate to setting such as IV set up, pumps.	**1**	**2**	**3**	**N/A**
12. Educates patient on safety practices when administering medications, drawing blood,	**1**	**2**	**3**	**N/A**

starting and IV, using PCAs.				
13. Communicates observations or concerns related to hazards to patients, families and the health care team and uses the organizational reporting system for errors.	**1**	**2**	**3**	**N/A**
14. Applies basic principles and practices of sterile asepsis while administering injections, placing urinary catheters, performing open wound care.	**1**	**2**	**3**	**N/A**
EVIDENCE BASED PRACTICE				
15. Uses library, internet, and colleagues to efficiently manage information.	**1**	**2**	**3**	**N/A**
16. Locates, critically reviews and applies scientific evidence and medical literature.	**1**	**2**	**3**	**N/A**
17. Understands the principles of evidence based practice and applies to pain management.	**1**	**2**	**3**	**N/A**
TEAMWORK AND COLLABORATION				
18. Establishes rapport with patients and family.	**1**	**2**	**3**	**N/A**
19. Communicates with inter-professional team.	**1**	**2**	**3**	**N/A**
20. Asks questions to appropriate team member when unsure about any aspect of care.	**1**	**2**	**3**	**N/A**
21. Is receptive to input from others, not becoming defensive.	**1**	**2**	**3**	**N/A**
COMPETENCIES	**Beginning**	**Developing**	**Accomp - lished**	**Not Applic- able**
22. Documents patient assessment data in complete and timely fashion.	**1**	**2**	**3**	**N/A**
23. Able to interpret physician and inter-professional orders.	**1**	**2**	**3**	**N/A**
24. Able to work as part of a team.	**1**	**2**	**3**	**N/A**
25. Uses appropriate language and tone when resolving conflict.	**1**	**2**	**3**	**N/A**
PROFESSIONALISM				
26. Able to keep track of multiple responsibilities and complete tasks within expected time frames.	**1**	**2**	**3**	**N/A**
27. Recognizes and reports unsafe practice by self and others.	**1**	**2**	**3**	**N/A**
28. Able to work autonomously and be accountable for own actions.	**1**	**2**	**3**	**N/A**

29. Behavior is ethical & honest as judged by ANA ethical principles.	**1**	**2**	**3**	**N/A**
30. Expresses importance and demonstrates habits for life-long learning.	**1**	**2**	**3**	**N/A**
31. Complies with legal and regulatory requirements relevant to nursing practice.	**1**	**2**	**3**	**N/A**
QUALITY				
32. Evaluates and implements systems-improvement based on clinical practice data.	**1**	**2**	**3**	**N/A**
33. Understands quality improvement methodologies.	**1**	**2**	**3**	**N/A**
INFORMATICS				
34. Navigates the electronic health record.	**1**	**2**	**3**	**N/A**
35. Utilizes clinical technologies (e.g. Smart Pumps, monitors).	**1**	**2**	**3**	**N/A**
OVERALL CLINICAL COMPETENCE [RATE]	**1**	**2**	**3**	

Comments

Created by Lyn Marshall, RN, MSN at Kaiser Foundation Hospitals, Susan Herman, RN, MSN at Lucile Packard Children's Hospital at Stanford, and Maria- Jean Caterinicchio, RN, MS at Saddleback Memorial Medical Center & MemorialCare Medical Centers, Southern California as part of the RN Transition Program Evaluation Advisory Committee.

Appendix E: California Institute for Nursing and Health Care

San Francisco Bay Area New Graduate RN Transition Program

Definition of RN Post-Grad Competency Levels

Beginning: Not yet effective in assessing, observing, recognizing patterns and deviations, or seeking information. Takes unfocused approach to organizing data, and requires assistance in diagnosing problems, planning interventions, and carrying out skills. Shows hesitance in communicating and responding to clinical scenarios.

Developing: Captures obvious patterns, makes attempt to monitor a variety of data, but overlooks some important information. Performs basic assessment and clinical skills, but still requires some guidance and direction. Shows solid foundation in leadership and communication abilities, though remains disorganized and hesitant in some aspects of clinical situations.

Accomplished: Effectively assesses, seeks information, recognizes patterns and deviations, and plans interventions. Displays confidence and leadership ability, communicates effectively, and requires guidance only in complicated cases. Demonstrates proficiency in most nursing skills, and requires minimal prompting in responding to clinical scenarios.

Adapted from the Lasater Clinical

Appendix F: Patient Centered Care Evaluation

Competency: Patient Centered Care: School/Program Name

Description: Recognizes the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences

Participant Name: _____

Participant Number: _____Date: _____

Evaluation Period: □ Midterm

Applies Knowledge

Complete understanding and interpretation of assessment data (#28) and able to anticipate risks related to assessment data (#35)

- Analyzes how diverse cultural, ethnic, spiritual and social backgrounds function as sources of patient, family, and community values
- Analyzes multiple dimensions of patient centered care:
  1. Patient/family/community preferences, values
  2. Coordination and integration of care
  3. Information, communication, and education
  4. Physical comfort and emotional support
  5. Involvement of family and friends
  6. Transition and continuity
  7. Health literacy
- Integrates knowledge of psychological, spiritual, social, developmental and physiological models of pain and suffering

Integrates knowledge of pathophysiology of patient conditions (#13*)	**D**	**1**	**2**	**3**	**N/A**
As evidenced by documentation in electronic health record (#1) or written record if applicable:		**Level**			
Completes a comprehensive health history incorporating an appraisal of patient's current psychosocial and physiologic issues and learning needs incorporating knowledge of age, cultural, development, religious, and language and communication considerations. (#6)	**Method D**	**1**	**2**	**3**	**N/A**
Creates a plan of care incorporating strategies that empower patients or families in all aspects of the health care process. Identifies patient's individualized problems and care needs that includes patient concerns, what the patient is experiencing, the cause of the concern and what will be done regarding the concern.		**1**	**2**	**3**	**N/A**
Evaluates/Revises plan of care at least every 24 hours, or as appropriate to setting, based current patient assessment.		**1**	**2**	**3**	**N/A**
Establishes rapport with patients and family (#2) as evidenced by:		**Level**			

	• Introduces self to patient and family; speaks in a clear concise manner • Orients patient/significant other to unit and routine care during admission • Reorients to time, place and person as needed. • Provides explanations of all tests, procedures and treatments prior to initiation • Maintains dignity, privacy and confidentiality • Uses active listening skills and displays professional demeanor • Answers questions openly and honestly • Demonstrates compassion by asking questions that convey interest in patient's concerns	Method D	1	2	3	N/A
	Ensures patient's comfort and safety	Method D	1	2	3	N/A
	Promotes patient involvement if possible by eliciting patient values, preferences and expressed needs as part of clinical interview, diagnosis, implementation of care plan and evaluation of care.		1	2	3	N/A
	Provides patient education as needed (#14)	D	1	2	3	N/A
	Conducts comprehensive physical assessment of all patient systems (#4)	D	1	2	3	N/A
	Accountability for Actions as evidenced (#12) by:		**Level**			
	Provides patient-centered care with sensitivity, empathy and respect for the diversity of human experience and reflects value of patient's expertise with their own health and symptoms.	Method D	1	2	3	N/A
	Demonstrates safe practices in infection control, maintaining safe environment		1	2	3	N/A
	Decision making is based on nursing progress (#24)		1	2	3	N/A
	Recognizes changes in patient status and initiates request for help appropriate for situation. (#26)		1	2	3	N/A
	Prioritizes actions related to patient needs and delegate's actions if appropriate. (#34)		1	2	3	N/A
	Recognize and report unsafe practices by self and others (#18)		1	2	3	N/A
	Advocates for patient as appropriate in multidisciplinary team discussions (#8)		1	2	3	N/A

_____ _____

Preceptor Signature Date

Validation Method Level of Competence

D = Demonstration S = Simulation T = Test 1 = Beginning 2 = Developing 3 = Accomplished

Appendix G:Evidence Based Care Practice Evaluation

Competency: Evidence Based Practice: [Pain Management School/Program Name]

Description: Integrates best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.

Participant Name: _____

Participant Number: _____

Date: _____

Evaluation period: □ Midterm

Applies Knowledge

Understands best available evidence related to pain (#15*)

- Pain is multidimensional & highly subjective
- Pain is the most common reason for patient to seek medical care. If unrelieved, pain is associated with: depression; sleep disturbances; withdrawal and decreased socialization; functional loss and increased dependency; exacerbation of cognitive impairment; increased health care utilization and costs
- Pain is usually characterized according to:
  - duration of pain (e.g., acute versus persistent)
  - cause of pain (e.g., nociceptive versus neuropathic)
  - Location
- Pain is variable and changing requiring ongoing assessment. Major side effect of narcotic medication and decreased mobility related to pain is constipation. The nurse will be familiar with evidence-based resources in dealing this side effect.
- Both patients and health care providers have personal beliefs, prior experiences, insufficient knowledge, and mistaken beliefs about pain and pain management that (a) influence the pain management process, and (b) must be acknowledged before optimal pain relief can be achieved.
- The pain experience is defined and experienced by the client / patient and thus promotes empowerment of the patient in the patient centered pain plan of care.

As evidenced by:

Demonstrates in Practice

Conducts patient assessment (#4)	Method D S T	Level
Reviews the medical history, physical exam, and laboratory and diagnostic tests to understand sequence of events contributing to pain		1 2 3 N/A
Reviews the medications, including current and previously used prescription drugs, over-the-counter drugs, and home remedies. Determines which pain control methods have previously been effective for the patient.		1 2 3 N/A
Assesses patient's attitudes and beliefs about use of analgesics, adjuvant drugs, and nonpharmacological treatments		1 2 3 N/A

	Uses a standardized tool to assess present pain, including intensity, character, frequency, pattern, location, duration, and precipitating and relieving factors at least every four hours or more frequently as warranted.		**1 2 3 N/A**
	Decision making is based on the nursing process (#24)		**Level**
	Intervenes as appropriate (pharmacologic as well as non-pharmacologic)	**Method D S T**	**1 2 3 N/A**
	Monitors treatment effects within 1 hour of administration and at least every 4 hours.		**1 2 3 N/A**
	Observes for nonverbal and behavioral signs of pain, such as facial grimacing, withdrawal, guarding, rubbing, limping, shifting of position, aggression, agitation, depression, vocalizations, and crying. Also watch for changes in behavior from the patient's usual patterns.		**1 2 3 N/A**
	Assesses client for side effects related to pain medication and immobility related to pain. Develops a plan of care to address side effects with healthcare team. (constipation, drowsiness, adverse reactions). Provides ongoing assessment for effectiveness of addressing side effects.		**1 2 3 N/A**
	Implements strategies to minimize side effects.		**1 2 3 N/A**
	Demonstrates openness to complimentary and alternative therapies seen as effective by the client / patient and family		**1 2 3 N/A**
	Accountability for actions (#12)		**Level**
	Takes initiative to advocate for patients	**Method D S T**	**1 2 3 N/A**

_____

Preceptor Signature Date_____

Validation Method **Level of Competence**

D = Demonstration S = Simulation T = Test

1 = Beginning 2 = Developing 3 = Accomplished

Appendix H: Informatics Evaluation

Competency: Informatics: [School/Program Name]

Description: Use information and technology to communicate, manage knowledge, mitigate error, and support decision making

Participant Name: _____

Participant Number: _____**Date:** _____

Evaluation Period: □ **Midterm**

Applies Knowledge

- Explains why information and technology skills are essential for safe patient care
- Identifies essential information that must be available in a common database to support patient care
- Describes examples of how technology and information management are related to the quality and safety of patient care
- Recognizes the time, effort, and skill required for computers, databases and other technologies to become reliable and effective tools for patient care
- Compares and contrasts benefits and limitations of common information technology strategies used in the delivery of patient care
- Contrasts benefits and limitations of different communication technologies and their impact on safety and quality

As evidenced by:

Demonstrates in Practice

Utilization of information technologies (#1*)	Method	Level of Competence
Navigates the electronic health record	D S T	1 2 3 N/A
Documents and plans patient care in an electronic health record		1 2 3 N/A
Employs communication technologies to coordinate care for patients		1 2 3 N/A
Evaluates online patient education materials		1 2 3 N/A
Values technologies that support clinical decision-making, error prevention, and care coordination		1 2 3 N/A
Utilization of clinical technologies (i.e., IV Smart Pumps, medical monitors, etc, #21)	**Method**	**Level**
Applies technology and information management tools to support safe processes of care	D S T	1 2 3 N/A
Uses information management tools to monitor outcomes of care processes		1 2 3 N/A
Evaluates strengths and weaknesses of clinical technologies used in patient care		1 2 3 N/A
Accountability for action (#12)	**Method**	**Level**
Understands how the HIPAA applies to computerized systems	D S T	1 2 3 N/A

	Protects confidentiality of protected health information in electronic health records by following the agency protocol		**1 2 3 N/A**
	Values nurses' involvement in design, selection, implementation, and evaluation of information technologies to support patient care		**1 2 3 N/A**

_____ _____

Preceptor Signature Date

Validation Method **Level of Competence**

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Appendix I: Quality Improvement Evaluation

Competency: Quality Improvement (QI): [School/Program Name]

Description: Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems

Participant Name: _____

Participant Number: _____**Date:** _____

Evaluation period: □ **Midterm**

Applies Knowledge

- Recognizes unsafe behaviors by self and others
- Describes approaches for changing processes of care
- Describes strategies for learning about the outcomes of care in the setting in which one is engaged in clinical practice
- Explains the importance of variation and measurement in assessing quality of care
- Uses quality measures to understand performance
- Seeks information about quality improvement projects in the care setting

As evidenced by:

Demonstrates in Practice

Documentation of patient assessment data (#6*)	**Method**	**Level of Competence**
Documents accurately patient's clinical condition	**D S T**	**1 2 3 N/A**
Documents therapeutic interventions and patient outcomes		**1 2 3 N/A**
Completes and document risk assessments		**1 2 3 N/A**
Documents medication at the time of administration		**1 2 3 N/A**
Accountability for actions (#12)	**Method**	**Level**
Engages in behaviors that promote quality and patient safety such as assessment of risks for falling, recognizing patient needs and prevention of failure to rescue	**D S T**	**1 2 3 N/A**
Implements nursing actions accurately and in a timely manner		**1 2 3 N/A**
Recognizes errors and take corrective actions		**1 2 3 N/A**
Adheres to the aims, measures and changes involved in improving care		**1 2 3 N/A**
Decision making based on the nursing process cycle (#24)	**Method**	**Level**
Progressively demonstrates ability to identify concerns and intervene in an effective and timely manner	**D S T**	**1 2 3 N/A**
Notifies physician of significant changes in patient status utilizing the SBAR communication and		**1 2 3 N/A**

	documents information given to and received from physician		
	Evaluates the effectiveness of therapeutic interventions and documents patient outcomes accurately and in a timely manner		**1 2 3 N/A**
	Appreciates that continuous quality improvement is an essential part of the daily work of all health professionals		**1 2 3 N/A**
	Appreciates the value of what individuals and teams can to do to improve care		**1 2 3 N/A**

_____ _____

Preceptor Signature Date

Validation **Level of Competence**

D = Demonstration S = Simulation T = Test 1 = Beginning 2 = Developing 3 = Accomplished

Appendix J: Safety Evaluation

Competency: Safety: Medication Administration: [School/Program Name]

Description: Minimizes risk of harm to patients and providers through both system effectiveness and individual performance.

Participant Name: _____

Participant Number: _____

Date: _____

Evaluation period: □ **Midterm**

Applies Knowledge

- Knowledge of nursing interventions associated with each medication, including indications, dosage, route, drug interaction/contraindications, side effects and nursing considerations (#19*)
- Describes the benefits and limitations of selected safety-enhancing technologies (such as, barcodes, Computer Provider Order Entry, medication pumps, and automatic alerts/alarms) (#21)
- Recognizes High Alert Medications and understands nursing interventions associated with these medications
- Understands blood typing and blood compatibility
- Recognizes signs and symptoms of a blood reaction and the measures taken in the event of a blood reaction
- Understands principles of infection control, including handwashing, maintaining a sterile field, wound care and preventing infection.
- Understands the process of reporting an error
- Understands rationale behind other standardized safety measures such as checklists, timeouts, RRT
- Understands own role in preventing errors
- Understands the importance vigilance and monitoring (even of own performance of care activities) by patients, families, and other members of the health care team

As evidenced by:

Demonstrates in Practice

Administration of medications and blood products (#7)	Method	Level			
Successful completion of medication math test	D S T	1	2	3	N/A
Demonstrates safe practices related to medication administration including Rights, two patient identifiers, verification of allergies, read-back process and independent double check for High Alert Medications		1	2	3	N/A
Demonstrates the safe use of equipment appropriate to setting such as IV set-up, IV pumps		1	2	3	N/A
Follows policy and procedure for administration of IV medications, blood/blood components (e.g. double checks blood product with another RN, frequency of VS, etc)		1	2	3	N/A

	Oral Medication Administration a. Follows standard medication administration expectations listed above. b. Opens medication packages at bedside. c. Remains with patient while patient takes medication.		**1**	**2**	**3**	**N/A**
	Able to keep track of multiple responsibilities (#32)		**1**	**2**	**3**	**N/A**
	Able to anticipate risk. Conducts appropriate follow up after medication is administered (#35)		**1**	**2**	**3**	**N/A**
	Completes medication administration within designated time frames (#31)		**1**	**2**	**3**	**N/A**
	Conducts Clinical Procedures (#20)		**Level**			
	Applies the basic principles and practices of sterile asepsis while administering injections, placing urinary catheters, performing open wound care (#20)	**Method D S T**	**1**	**2**	**3**	**N/A**
	Washes hands prior to and following all procedures performed on patients, when entering and exiting a patient room		**1**	**2**	**3**	**N/A**
	Complies with Legal/Regulatory Issues (#17)		**Level**			
	Communicates observations or concerns related to hazards and errors to patients, families and the health care team if applicable	**Method D S T**	**1**	**2**	**3**	**N/A**
	Passes knowledge test of TJC patient safety goals		**1**	**2**	**3**	**N/A**
	Educates patient on safety practices when administering medications, drawing blood, starting an IV, using PCAs, administering blood; uses teach back technique to ensure understanding		**1**	**2**	**3**	**N/A**
	Use organizational error reporting systems for near miss and error		**1**	**2**	**3**	**N/A**

_____ _____

Preceptor Signature Date

Validation Method **Level of Competence**

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Appendix K: Teamwork and Collaboration

Competency: Teamwork and Collaboration: [School/Program Name]

Description: Function effectively within nursing and inter-professional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care

Participant Name: _____

Participant Number: _____

Date: _____

Evaluation period: □ Midterm

Applies Knowledge

Able to work as part of a team (#10*)

- Analyze differences in communication style preferences among patients and families, nurses and other members of the health team
- Understands the relationship between effective communication and a culture of safety
- Understands process and benefit of use of standardized approaches to handoff communication such as SBAR
- Analyze approaches to conflict resolution
- Identifies key team members and their roles and reporting through chain-of-command
- Recognizes areas of actual or potential conflict with (a) patients/visitors, (b) peers, and (c) healthcare team

As evidenced by:

Demonstrates in Practice

Communication with inter-professional team (#9)	**Method D or S**	**Level**			
Provides clear concise patient report to other members of the healthcare team utilizing (SBAR) or other organization standard handoff tool. Modifies own style of communication to the needs of the team in the situation.		**1**	**2**	**3**	**N/A**
Able to interpret physician and inter-professional orders (#22)		**1**	**2**	**3**	**N/A**
Conducts appropriate follow-up communication as needed		**1**	**2**	**3**	**N/A**
Takes initiative to ensure effective information transfer to other professionals		**1**	**2**	**3**	**N/A**
Complies with Legal/Regulatory issues (#17)		**Level**			
Communicates patient information within HIPAA regulations	**D**	**1**	**2**	**3**	**N/A**
Accountability for Actions as evidenced (#12) by:		**Level**			
Asks questions to appropriate team member when unsure about any aspect of care. (#11)	**Method D**	**1**	**2**	**3**	**N/A**
Is receptive to input from others, not becoming defensive. (#16)		**1**	**2**	**3**	**N/A**
Seeks additional information and resources to improve		**1**	**2**	**3**	**N/A**

	skill deficits		
	Demonstrates improved performance in area of needed growth		**1 2 3 N/A**
	Conflict Resolution (#33)		**Level**
	Uses appropriate language and tone when resolving conflict.	**Method D**	**1 2 3 N/A**
	Seeks additional information and resources to improve skill deficits		**1 2 3 N/A**
	Seeks out a mentor or facilitator to assist with conflict resolution if needed		**1 2 3 N/A**

_____ _____

Preceptor Signature Date

Validation Method Level of Competence

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Appendix L: Preceptorship Experience Questionnaire

The purpose of this survey is to seek data for the evaluation of a clinical preceptorship program for participants in a postgraduate RN transition program. Your response will be valuable for improving future preceptorship experiences and placements. The following statements indicate goals and objectives identified both by faculty and students entering the clinical preceptorship experiences for the clinical practicum in the nursing program. Statements are divided into two categories. The first category consists of opinion statements that evaluate your relationship with the preceptor and the second category consists of competency-oriented statements that indicate your perceptions of feeling competent while performing nursing tasks in clinical settings.

I. Opinion Statements and Scale

The following 12 opinion statements address 'your relationship with your preceptor. As you consider your own experience, on a scale of 1 (not important) to 5 (very important), indicate your feeling about the degree of the importance of each statement.'

Scale 1 = not important
2 = somewhat important
3 = important
4 = moderately important
5 = very important

Opinion Statement	**Rating Scale**				
I feel it is important to:	Not important	Somewhat important	Important	Moderately important	Very important
1. Have a primary preceptor in the clinical agency	1	2	3	4	5
2. Discuss and clarify my role as a new graduate with my preceptor	1	2	3	4	5
3. Set goals and objectives with my preceptor	1	2	3	4	5
4. Receive assignments based on my ability	1	2	3	4	5
5. Develop a trusting relationship with my preceptor	1	2	3	4	5
6. Receive constructive feedback from nurses on the unit	1	2	3	4	5
7. Develop a positive relationship with other staff members, including medical and auxiliary staff	1	2	3	4	5
8. Do formal self-evaluation with the preceptor, faculty, and myself	1	2	3	4	5
9. Evaluate my strengths and weaknesses with my preceptor	1	2	3	4	5

10. Participate in team conferences and unit meetings	1	2	3	4	5
11. Attend the continuing education program	1	2	3	4	5
12. Implement the agency's policies, procedures and standard protocols	1	2	3	4	5

II. Competency Oriented Statements and Scale

The following 40 statements address 'your feeling of competency in implementing nursing skills. As you consider your own experience, on a scale of 1 (not competent) to 5 (very competent), indicate your feeling of degree of competency with each statement.'

Scale 1 = not competent
2 = less competent
3 = competent
4 = moderately competent
5 = very competent

Competency-Oriented Statement	**Rating Scale**				
I feel I have the competence to:	Not Competent	Less Competent	Competent	Moderately Competent	Very Competent
13. Identify and assess patients' health care needs	1	2	3	4	5
14. Identify my patients' cultural needs in giving nursing care	1	2	3	4	5
15. Identify specific learning needs for patients and family members	1	2	3	4	5
16. Receive relevant patient reports at the beginning of the shift	1	2	3	4	5
17.know when to call physicians to report abnormal conditions of my assigned patients using SBAR	1	2	3	4	5
18. Assess patients' emotional needs	1	2	3	4	5
19. Check actions and side effects of medications before administering utilizing 5 rights of medications	1	2	3	4	5
20. Identify signs and symptoms of disease processes for each patient	1	2	3	4	5

assigned					
21. Seek out information to expand my understanding of the agency where I am working as a new nurse	1	2	3	4	5
22. Initiate and update written patient care plans based on systematic nursing assessment	1	2	3	4	5
23. Organize and prioritize patient care activities	1	2	3	4	5
24. Write specific objectives which show a plan for growth & learning	1	2	3	4	5
25. Collaborate with patients and health team members to establish short- and long-term patient goals	1	2	3	4	5
26. Implement patient and family teaching	1	2	3	4	5
Competency-Oriented Statement	**Rating Scale**				
I feel I have the competence to:	Not Competent	Less Competent	Competent	Moderately Competent	Very Competent
27. Maintain satisfactory parenteral, intravenous (IV) infusion therapy	1	2	3	4	5
28. Insert naso-gastric (NG) tubes and maintain their patency	1	2	3	4	5
29. Apply sterile techniques for open wound care	1	2	3	4	5
30. Complete my work on time	1	2	3	4	5
31. Communicate effectively with people I work with	1	2	3	4	5
32. Set up I-Med, suction set, and feeding equipment without supervision.	1	2	3	4	5
33. Do systematic assessment for my assigned patients within a specified time	1	2	3	4	5
34. Document relevant information, including vital signs, intake and output, and all other nursing data	1	2	3	4	5
35. Implement a discharge					

plan with patient and family including teaching	1	2	3	4	5
36. Admit a new patient without supervision	1	2	3	4	5
37. Transcribe physicians' orders to medication administration records and follow up with the pharmacy	1	2	3	4	5
38. Delegate assigned tasks to LVN, CNA, UAP and auxiliary personnel	1	2	3	4	5
39. Communicate with family about patient care and progress	1	2	3	4	5
40. Give complete physical care to assigned patients, including activities of daily living (ADL)	1	2	3	4	5
41. Teach and implement patient safety practice	1	2	3	4	5
42. Evaluate the effectiveness of nursing care given to each assigned patient	1	2	3	4	5
43. Modify care plan based on evaluation of care	1	2	3	4	5
44. Determine that appropriate data is recorded and communicated to the necessary individuals	1	2	3	4	5
Competency-Oriented Statement	**Rating Scale**				
I feel I have the competence to:	Not Competent	Less Competent	Competent	Moderately Competent	Very Competent
45. Suggest or modify new improved techniques and procedures for patient care based on evaluation data	1	2	3	4	5
46. Work effectively with all members of the healthcare team to assure comprehensive care to patients	1	2	3	4	5
47. Cope effectively with my own feelings related to patients, coworkers, and supervisory personnel	1	2	3	4	5
48. Manage stress related to	1	2	3	4	5

personal and professional situations					
49. Act as an advocate for patients.	1	2	3	4	5
50. Utilize and navigate patient care information via health information technology (HIT) systems	1	2	3	4	5
51. Describe multidimensional aspects of pain perception.	1	2	3	4	5
52. Assess patient's pain during each vital sign and describe treatment plan	1	2	3	4	5
53. Integrate research findings into practice (i.e., applies knowledge of evidence-based practice).	1	2	3	4	5
54. Use time management tools to organize work load/assignment	1	2	3	4	5
55. Demonstrate understanding of reasons for checking at least two identifiers prior to each procedure and administration of medications	1	2	3	4	5

Please provide additional comments regarding your preceptorship experiences:

III. Demographic Information: please provide answers as indicated or circling the appropriate number(s).

56. Age: ____year

57. Gender:
   c. Female
   d. Male

58. Ethnicity:
   g. American Indian
   h. Asian American
   i. Black, non Hispanic
   j. Caucasian
   k. Filipino American
   l. Hawaiian
   m. Hispanic Central South American
   n. Pacific Islander

o. Other

59. School of Nursing graduated from (name, city, state located): _____

60. Date of graduation from School of Nursing: _____

61. Degree received:
    1. Associate Degree in Nursing
    2. Baccalaureate Degree in Nursing
    3. Diploma Degree in Nursing
    4. Fast Track - Master Degree in Nursing
    5. Other _____

62. Language spoken other than English: _____

63. Please indicate your clinical practice area during the current preceptorship:
    n. Adult Medical/Surgical
    o. Telemetry
    p. Oncology
    q. Adult ICU/CCU
    r. Emergency Department
    s. Maternity
    t. Pediatrics
    u. NICU/PICU
    v. Transplant
    w. Rehab/Sub-Acute
    x. OR/PACU
    y. Public/Community Health
    z. Tele/Advice Nursing
    aa. Other: _____

64. Total clinical hours completed during the preceptorship: _____hours

65. What is your scheduled work shift and hour?
    1. Day shift 8 hour
    2. Day shift 12 hour
    3. PM shift 8 hour
    4. Night shift 8 hour
    5. Night shift 12 hour
    6. Day and night shift 12 hour rotation
    7. Other: _____

66. Previous healthcare work experience(s) (select all that apply):
    h. Certified Nursing Assistant
    i. EMT
    j. Flu Vaccination Nurse

k. Medical Assistant
l. Phlebotomist
m. Translator
n. Unit Secretary
o. Volunteer
p. Other *(please specify)*: _____

67. Weekly work hours in addition to the preceptorship
1. < 10 hours
2. 11-15 hours
3. 16-20 hours
4. 21-25 hours
5. 24-30 hours
6. 31-35 hours
7. 35-40 hours
8. > 40 hours

Thank you!
Comments:

Appendix M: PDSA/SDSA Cycle

PDSA/SDPA Worksheet: RN Transition Program

Group Name: RN Transition Program Start Date: September 1, 2010

Team Members: Leader: Program Coordinator

Facilitator: Program Coordinator, Project Manager, Dean of school

Coach: Project Manager

Assistants: DNP students, teaching assistants

Meetings: Roundtable meetings as needed

Data Support: IT Place: CINHC headquarters

1. Aims:
    1. Aim: To increase skills, confidence, and experience among new RN graduates to develop their transition into entering the nursing workforce.
    2. Retain new nurses in the profession while engaging competencies that can be transferred to both acute and outpatient care settings.
    3. To increase employability of new nurses finding it difficulty to secure a nursing position.
2. Measures: Use tools from current literature to measure outcomes (QSEN, CFGNES, Kim Survey).
3. Current Measures: QSEN tools, CFGNES, and Kim surveys used in previous research studies with good outcomes.
4. Plan: Gather best practices implemented in other hospitals, clinics, and review the literature, and adapt in program. In addition, find what else works currently and adapt in future programs.

Tasks to be completed to run test change	**Who**	**When**	**Tools or training needed**	**Measures**
Lead teams/ Lead project Determine need and discuss with stakeholders	Dean of School Program Coordinator Program Manager Stakeholders Research Assistants	May 2010- August 2010	PM tools PDSA/SDSA	Meetings
Facilitate Project Determine need and discuss with stakeholders	Dean f School Program Coordinator Program Manager Stakeholders Research Assistants	June 2010- September 2010	PDSA/SDSA tools	Have current tools to be used.
Oversee unit and data collection process	Program Coordinator Research Assistants Teaching Assistants	September 2010- December 2010 February 2011- July 2011	Brief QSEN, Long QSEN, CFGNES, Kim survey	Statistics, Cohen's d, Effect size
Committee Meetings, and determine educational planning, IRB, current results	Program Coordinator Research Assistants Teaching Assistants	August 18, 2010 September 16, 2010, September 28, 2010 January 26, 2011, March, 2011, April 5, 2011, June 2011, August 2011, September 2011, October 28, 2011	Articles, recent literature, protocol development, Review previous classes done at other institutions.	Review of data, problems, financial, collection processes, sharing of information
Overview	Program Coordinator Research Assistants Teaching Assistants	October 28, 2011	Brief QSEN, Long QSEN, CFGNES, Kim survey	Data Results, Discussion

5. Do: The team will discuss with stakeholders how the implementation of the RN transition program can help increase competency, skill, and current RN graduates. Maintain current graduates or participants of the program in the nursing field and help in acquiring jobs in nursing.

6. Study: Discuss current data from study cohorts, rates of RN employment, and other relevant information. In addition, discuss costs related to these events and any new incidents or occurrences related to the program.

7. Act: Review current literature, evidence-based practice, and current results to design RN transition program.

8. Standardize: Establish RN transition program guidelines for all study site facilities.

9. Trade-offs: Determine changes in: education, assessment tools, preceptor sites, and preceptors. Encourage members of CINHC and site facilities as part of the project to help promote support through use of mentorship. Seek assistance from faculty or staff for support of the RN transition program. Engage faculty members to assist data collection analysis. Ask for leadership support for helping to determine best practices for the RN transition program.

10. Measures: Develop a survey/assessment tool to help determine if aims are being meet. Continue to measure outcomes if new cohorts or new programs are implemented.

11. Possible Changes: If any new changes need to be implemented follow the same process of escalating to project manager/program coordinator and set a meeting with program project manager/coordinator. If change is needed develop a new PDSA/SDSA process or may use same process.

12. Standardize: Meet on quarterly basis and discuss how it will affect daily practice and discuss with dean of school, program coordinator, and project manager. Follow same tasks as 4 and above.

13. Do: Learning any new conflicting data analysis.

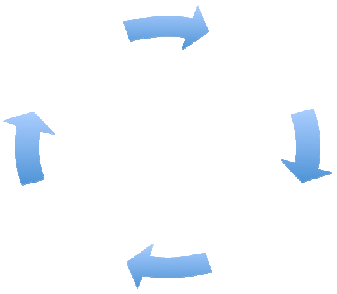
14. Study: Learn as the data is entered and analyzed what are the major weaknesses and strengths of the RN transition program and implement change or stabilization.

15. Act: Make changes to RN transition program as indicated by review of literature and evidence-based practice.

Follow up: Follow up quarterly or as needed if result data increases/changes. Reassess with as needed.

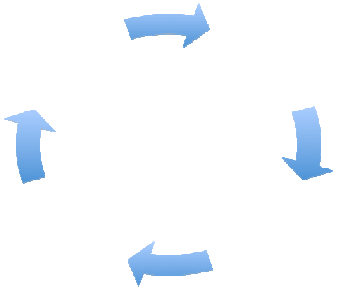
Appendix N: PDSA/SDSA Ramp for RN Transition to Practice Program

Maintain RN competency, increase job rates, maintain new RNs in nursing profession



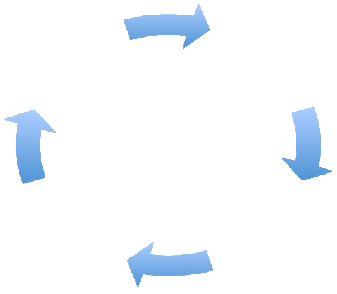
Repeat PDSA/SDSA cycle as needed

Standardize: Establish protocol Do: Develop criteria



Study: Evaluate after implementation Act: Review and change as needed

Plan: Meet with stakeholders Do: Discuss benefits of program



Study: Current residency programs Act: Review current literature and apply

Table 1

Demographic Data for Casey-Fink New Graduate New Experience Survey (N = 19) Cohort 1

Age: 21-43, mean: 27.8	Degree received: BSN: 82.4% MSN: 17.6%
Gender: Female: 94.7% Male: 5.3%	Other Educational Background Sociology Psychology of Women's Studies Chemistry
Ethnicity: Asian: 57.9% Caucasian: 31.6% Unknown: 10%	Previous work experience: Volunteer: 94.4% Nursing Assistant: 5.6% Medical Assistant: 5.6% Unit Secretary: 5.6% Student Externship: 16.7% Other: 11.1%
Nursing School USF: 57.9% SFSU: 15.8% SJSU: 10.5% SMU: 5.2% Unknown: 10.5%	Scheduled Pattern of Precepting Days: 88.2% Evenings: 5.9% Days & Evenings: 5.9%
Year of graduation: 2009: 52.6% 2010: 31.6% Unknown: 15.8%	

Table 2

Demographic Data for Casey-Fink New Graduate New Experience Survey (N = 16) Cohort 2

Age: 21-43, mean: 30.4	Degree received: AND: 6.7% BSN: 80% MSN: 13.3%
Gender: Female: 100%	Other Educational Background Liberal Arts Psychology Holistic Health Genetics
Ethnicity: Asian: 53.3% Caucasian: 26.7% Hispanic: 6.7% Other: 6.7% No answer: 6.7%	Previous work experience: Volunteer: 64.3% Student Externship: 64.3% Other: 28.6%
Nursing School USF: 18% SFSU: 27% SJSU: 18% SMU: 18% UCSF: 9% Ohlone: 9%	Scheduled Pattern of Precepting Days: 100%
Year of graduation: 2008: 15.3% 2009: 30.7% 2010: 53% Unknown: 15.8%	

Table 3

List the top six skills/procedures the group was uncomfortable performing independently at this time? Pre and post (Please select from the drop down list)

Cohort 1

Pre (n = 19)	Post (n = 10)
Code/Emergency Response (10) 55.6%	Arterial/venous lines/swan ganz (Wedging, management, calibration, CVP, cardiac output (5) 50%
ECG/EKG/telemetry monitoring and interpretation (10) 55.6%	Chest tube care (placement, Pleurovac) (4) 40%
Vent care/management assisting with intubation/extubation (9) 50%	Vent care/management assisting with intubation/extubation (4) 40%
Arterial/venous lines/swan ganz (wedging, management, calibration, CVP, cardiac output (8) 44.4%	Code/Emergency Response (3) 30%
Chest tube care (placement, Pleurovac) (7) 38.9%	Intravenous (IV) medication administration/ pumps/PCAs (3) 30%
Trach care /IV starts (6) 33.3%	Prioritization/Time management (3) 30%

Table 4

List the top six skills/procedures the group was uncomfortable performing independently at this time? Pre and post (Please select from the drop down list)

Cohort 2

Pre (n = 16)	Post (n = 13)
Arterial/venous lines/swan ganz (wedging, management, calibration, CVP, cardiac output) (10) 62.5%	Arterial/venous lines/swan ganz (Wedging, management, calibration, CVP, cardiac output (8) 61.5%
Vent care/management assisting with intubation/extubation (9) 56.3%	Code/Emergency Response (7) 53.8%
Blood draw/venapuncture (5) 31.3%	Chest tube care (placement, Pleurovac) (5) 38.5%
Central line care (5) 31.3%	ECG/EKG/telemetry monitoring and interpretation (5) 38.5%
Chest tube care (placement, Pleurovac) (5) 31.3%	Vent care/management assisting with intubation/extubation (4) 30.8%
Blood products administration (6) 37.5%	Central line care (4) 30.8%

Table 5

Casey-Fink Survey results

Question	Pre n = 34	Post n = 23	Cohen's d
1. I feel confident communicating with physicians.	1. Strongly Disagree (0) 2. Disagree (11) 3. Agree (20) 4. Strongly Agree (3) Mean: 2.76 STD: 0.61	1. Strongly Disagree (1) 2. Disagree (4) 3. Agree (14) 4. Strongly Agree (4) Mean: 2.91 STD: 0.73	d= 0.22
2. I feel comfortable knowing what to do for a dying patient.	1. Strongly Disagree (3) 2. Disagree (23) 3. Agree (8) 4. Strongly Agree (0) Mean: 2.15 STD: 0.56	1. Strongly Disagree (1) 2. Disagree (14) 3. Agree (8) 4. Strongly Agree (0) Mean: 2.31 STD: 0.56	d= 0.29
3. I feel comfortable delegating tasks to the Nursing Assistant.	1. Strongly Disagree (1) 2. Disagree (10) 3. Agree (22) 4. Strongly Agree (1) Mean: 2.68 STD: 0.59	1. Strongly Disagree (1) 2. Disagree (0) 3. Agree (21) 4. Strongly Agree (1) Mean: 2.96 STD: 0.47	d= 0.52
4. I feel at ease asking for help from other RNs on the unit.	1. Strongly Disagree (0) 2. Disagree (1) 3. Agree (21) 4. Strongly Agree (11) Mean: 3.30 STD: 0.53	1. Strongly Disagree (0) 2. Disagree (0) 3. Agree (7) 4. Strongly Agree (16) Mean: 3.70 STD: 0.47	d= 0.80
5. I am having difficulty prioritizing patient care needs.	1. Strongly Disagree (2) 2. Disagree (23) 3. Agree (9) 4. Strongly Agree (0) Mean: 2.21 STD: 0.54	1. Strongly Disagree (1) 2. Disagree (22) 3. Agree (0) 4. Strongly Agree (0) Mean: 1.96 STD: 0.21	d= -0.61
6. I feel my preceptor provides encouragement and feedback about my work.	1. Strongly Disagree (0) 2. Disagree (6) 3. Agree (24) 4. Strongly Agree (2) Mean: 2.88 STD: 0.49	1. Strongly Disagree (0) 2. Disagree (3) 3. Agree (12) 4. Strongly Agree (8) Mean: 3.22 STD: 0.67	d= 0.58
7. I feel staff is available to me during new situations and procedures.	1. Strongly Disagree (0) 2. Disagree (0) 3. Agree (27) 4. Strongly Agree (5)	1. Strongly Disagree (0) 2. Disagree (1) 3. Agree (7) 4. Strongly Agree (14)	d= 0.89

	Mean: 3.16 STD: 0.37	Mean: 3.60 STD: 0.59	
8. I feel overwhelmed by my patient care responsibilities and workload.	1. Strongly Disagree (1) 2. Disagree (28) 3. Agree (2) 4. Strongly Agree (1) Mean: 2.09 STD: 0.47	1. Strongly Disagree (4) 2. Disagree (15) 3. Agree (2) 4. Strongly Agree (0) Mean: 1.90 STD: 0.54	d= -0.38
9. I feel supported by the by the nurses on my unit.	1. Strongly Disagree (0) 2. Disagree (2) 3. Agree (25) 4. Strongly Agree (5) Mean: 3.09 STD: 0.47	1. Strongly Disagree (0) 2. Disagree (1) 3. Agree (6) 4. Strongly Agree (16) Mean: 3.65 STD: 0.57	d= 1.07
10. I have opportunities to practice skills and procedures more than once.	1. Strongly Disagree (1) 2. Disagree (9) 3. Agree (18) 4. Strongly Agree (2) Mean: 2.70 STD: 0.65	1. Strongly Disagree (3) 2. Disagree (2) 3. Agree (11) 4. Strongly Agree (7) Mean: 2.96 STD: 0.97	d= 0.31
11. I feel comfortable communicating with patients and their families.	1. Strongly Disagree (0) 2. Disagree (5) 3. Agree (20) 4. Strongly Agree (5) Mean: 3.00 STD: 0.59	1. Strongly Disagree (0) 2. Disagree (1) 3. Agree (13) 4. Strongly Agree (9) Mean: 3.35 STD: 0.57	d= 0.60
12. I am able to complete my patient care assignment on time.	1. Strongly Disagree (0) 2. Disagree (3) 3. Agree (25) 4. Strongly Agree (3) Mean: 3.0 STD: 0.45	1. Strongly Disagree (0) 2. Disagree (1) 3. Agree (14) 4. Strongly Agree (7) Mean: 3.27 STD: 0.55	d= 0.54
13. I feel the expectations of me in this job are realistic.	1. Strongly Disagree (0) 2. Disagree (0) 3. Agree (27) 4. Strongly Agree (5) Mean: 3.16 STD: 0.37	1. Strongly Disagree (0) 2. Disagree (0) 3. Agree (16) 4. Strongly Agree (7) Mean: 3.20 STD: 0.41	d= 0.10
14. I feel prepared to complete my job responsibilities.	1. Strongly Disagree (0) 2. Disagree (6) 3. Agree (23) 4. Strongly Agree (3) Mean: 2.91 STD: 0.53	1. Strongly Disagree (0) 2. Disagree (3) 3. Agree (13) 4. Strongly Agree (6) Mean: 3.14 STD: 0.64	d= 0.39

15. I feel comfortable making suggestions for changes to the nursing plan of care.	1. Strongly Disagree (0) 2. Disagree (17) 3. Agree (13) 4. Strongly Agree (1) Mean: 2.48 STD: 0.57	1. Strongly Disagree (0) 2. Disagree (2) 3. Agree (16) 4. Strongly Agree (5) Mean: 3.13 STD: 0.55	d= 1.16
16. I am having difficulty organizing patient care needs.	1. Strongly Disagree (2) 2. Disagree (25) 3. Agree (4) 4. Strongly Agree (0) Mean: 2.06 STD: 0.44	1. Strongly Disagree (3) 2. Disagree (20) 3. Agree (0) 4. Strongly Agree (0) Mean: 1.87 STD: 0.34	d= -0.48
17. I feel I may harm a patient due to my lack of knowledge and experience.	1. Strongly Disagree (4) 2. Disagree (12) 3. Agree (14) 4. Strongly Agree (3) Mean: 2.48 STD: 0.83	1. Strongly Disagree (5) 2. Disagree (11) 3. Agree (7) 4. Strongly Agree (0) Mean: 2.09 STD: 0.73	d= -0.50
18. There are positive role models for me observe on my unit.	1. Strongly Disagree (0) 2. Disagree (0) 3. Agree (23) 4. Strongly Agree (8) Mean: 3.26 STD: 0.44	1. Strongly Disagree (0) 2. Disagree (1) 3. Agree (9) 4. Strongly Agree (12) Mean: 3.5 STD: 0.60	d= 0.46
19. My Preceptor is helping me to develop confidence in my practice.	1. Strongly Disagree (0) 2. Disagree (6) 3. Agree (21) 4. Strongly Agree (4) Mean: 2.94 STD: 0.57	1. Strongly Disagree (1) 2. Disagree (2) 3. Agree (9) 4. Strongly Agree (10) Mean: 3.27 STD: 0.83	d= 0.46
20. I am supported by my family/friends.	1. Strongly Disagree (0) 2. Disagree (0) 3. Agree (19) 4. Strongly Agree (12) Mean: 3.39 STD: 0.50	1. Strongly Disagree (0) 2. Disagree (0) 3. Agree (8) 4. Strongly Agree (13) Mean: 3.62 STD: 0.50	d= 0.46
21. I am satisfied with my chosen nursing specialty.	1. Strongly Disagree (1) 2. Disagree (8) 3. Agree (18) 4. Strongly Agree (5) Mean: 2.84 STD: 0.72	1. Strongly Disagree (0) 2. Disagree (2) 3. Agree (13) 4. Strongly Agree (8) Mean: 3.26 STD: 0.62	d= 0.63
22. I feel my work is exciting and challenging.	1. Strongly Disagree (0) 2. Disagree (7) 3. Agree (18) 4. Strongly Agree (7)	1. Strongly Disagree (0) 2. Disagree (0) 3. Agree (13) 4. Strongly Agree (9)	d= 0.69

	Mean: 3.00 STD: 0.67	Mean: 3.41 STD: 0.50	
23. I feel my manager provides encouragement and feedback about my work.	1. Strongly Disagree (0) 2. Disagree (8) 3. Agree (17) 4. Strongly Agree (5) Mean: 2.90 STD: 0.66	1. Strongly Disagree (1) 2. Disagree (4) 3. Agree (10) 4. Strongly Agree (6) Mean: 3.00 STD: 0.84	d= 0.13
24. I am experiencing stress in my personal life.	1. Strongly Disagree (4) 2. Disagree (3) 3. Agree (19) 4. Strongly Agree (5) Mean: 2.81 STD: 0.87	1. Strongly Disagree (3) 2. Disagree (4) 3. Agree (10) 4. Strongly Agree (6) Mean: 2.83 STD: 0.98	d= 0.02

Pre and post data for first and second cohorts

Table 6

Table 3: Pre and post Brief QSEN competency assessment tool combined Cohort 1 and Cohort 2

Patient Centered Care

	Pre-data (n = 15)	Post-data (n = 20)	Cohen's d
1.Conducts comprehensive psychosocial and physical health history that includes patient's perspective and considers cultural, spiritual, social considerations (#4*)	1. (8) 2. (5) 3. (0) N/A (2) Mean: 1.20 SD: 0.68	1. (0) 2. (10) 3. (13) N/A (0) Mean: 2.57 SD: 0.51	d=1.78
2.Complete understanding and interpretation of assessment data (#28)	1. (5) 2. (7) 3. (1) N/A (1) Mean: 1.57 SD: 0.76	1. (0) 2. (8) 3. (15) N/A (0) Mean: 2.65 SD: 0.49	d=1.69
3.Able to anticipate risks related to assessment data (#35)	1. (4) 2. (10) 3. (1) N/A (0) Mean: 1.80 SD: 0.56	1. (0) 2. (8) 3. (16) N/A (0) Mean: 2.66 SD: 0.48	d=1.65
4.Integrates knowledge of pathophysiology of patient conditions (#13)	1. (5) 2. (10) 3. (0) N/A (0) Mean: 1.69 SD: 0.49	1. (0) 2. (8) 3. (16) N/A (0) Mean: 2.66 SD: 0.48	d= 2.04
5.Decision making is based on sound clinical judgment and clinical reasoning (#24)	1. (3) 2. (11) 3. (1) N/A (0) Mean: 1.87 SD: 0.52	1. (0) 2. (7) 3. (15) N/A (0) Mean: 2.68 SD: 0.48	d=1.62
6.Advocates for patient as appropriate in multidisciplinary team discussions (#8)	1. (6) 2. (7) 3. (0) N/A (1) Mean: 1.43 SD: 0.65	1. (1) 2. (8) 3. (15) N/A (0) Mean: 2.58 SD: 0.58	d= 1.87
7.Recognizes changes in patient status and conducts appropriate follow up (#26 and #25)	1. (5) 2. (7) 3. (1) N/A (2)	1. (1) 2. (10) 3. (11) N/A (2)	

	Mean: 1.47 SD: 0.83	Mean: 2.45 SD: 0.60	d=1.35
8.Prioritizes actions related to patient needs and delegates actions if appropriate (#34)	1. (5) 2. (9) 3. (0) N/A (1) Mean: 1.53 SD: 0.64	1. (1) 2. (9) 3. (15) N/A (1) Mean: 2.46 SD: 0.76	d=1.32
9.Establishes rapport with patients and family (PCC #2)	1. (2) 2. (9) 3. (4) N/A (0) Mean: 2.13 SD: 0.64	1. (0) 2. (2) 3. (22) N/A (0) Mean: 2.92 SD: 0.28	d= 1.60

Safety

10.Demonstrates safe practices related to medication administration including rights, verification of allergies, two patient identifiers, read-back process, independent double checks for high alert medications (#7)	1. (2) 2. (9) 3. (2) N/A (1) Mean: 1.86 SD: 0.77	1. (0) 2. (2) 3. (21) N/A (1) Mean: 2.91 SD: 0.29	d= 1.80
11.Demonstrates the safe use of equipment appropriate to setting such as IV set up, pumps	1. (2) 2. (5) 3. (0) N/A (7) Mean: 0.86 SD: 0.95	1. (1) 2. (5) 3. (5) N/A (13) Mean: 1.08 SD: 1.28	d= 0.20
12.Educates patient on safety practices when administering medications, drawing blood, starting and IV, using PCAs (#14)	1. (2) 2. (6) 3. (0) N/A (6) Mean: 1.00 SD: 0.96	1. (1) 2. (8) 3. (11) N/A (4) Mean: 2.08 SD: 1.10	d=1.05
13.Communicates observations or concerns related to hazards to patients, families and the health care team and uses the organizational reporting	1. (5) 2. (6) 3. (1) N/A (2) Mean: 1.43 SD: 0.85	1. (1) 2. (8) 3. (13) N/A (2) Mean: 2.33 SD: 0.92	d= 1.02

system for errors			
14.Applies basic principles and practices of sterile asepsis while administering injections, placing urinary catheters, performing open wound care (#20)	1. (1) 2. (8) 3. (3) N/A (2) Mean: 1.86 SD: 0.95	1. (0) 2. (5) 3. (17) N/A (2) Mean: 2.54 SD: 0.88	d=0.74

Evidenced based Practice

15.Uses library, internet and colleagues to efficiently manage information (#1)	1. (3) 2. (9) 3. (3) N/A (1) Mean: 1.88 SD: 0.81	1. (0) 2. (5) 3. (18) N/A (1) Mean: 2.66 SD: 0.70	d=1.03
16.Locates, critically reviews and applies scientific evidence and medical literature (#13)	1. (5) 2. (6) 3. (1) N/A (2) Mean: 1.43 SD: 0.85	1. (0) 2. (10) 3. (9) N/A (2) Mean: 2.24 SD: 0.89	d= 0.93
17.Understands the principles of evidence based practice and applies to pain management (#15)	1. (6) 2. (5) 3. (2) N/A (2) Mean: 1.47 SD: 0.92	1. (0) 2. (6) 3. (11) N/A (3) Mean: 2.21 SD: 1.10	d=0.73

Team & Collaboration

18.Establishes rapport with patients and family (PCC #2)	1. (1) 2. (9) 3. (5) N/A (0) Mean: 2.27 SD: 0.93	1. (0) 2. (4) 3. (20) N/A (2) Mean: 2.62 SD: 0.85	d=0.39
19.Communicates with inter-professional team (PCC #9)	1. (0) 2. (10) 3. (5) N/A (0) Mean: 2.33 SD: 0.49	1. (0) 2. (7) 3. (17) N/A (0) Mean: 2.71 SD: 0.46	d= 0.80

20.Asks questions to appropriate team member when unsure about any aspect of care (#11)	1. (2) 2. (8) 3. (6) N/A (0) Mean: 2.25 SD: 0.68	1. (0) 2. (5) 3. (19) N/A (0) Mean: 2.79 SD: 0.41	d=0.96
21.Is receptive to input from others, not becoming defensive (#16)	1. (0) 2. (9) 3. (6) N/A (0) Mean: 2.40 SD: 0.51	1. (0) 2. (1) 3. (23) N/A (0) Mean: 2.96 SD: 0.20	d=1.46
22.Documents patient assessment data in complete and timely fashion (#6)	1. (4) 2. (8) 3. (3) N/A (0) Mean: 1.93 SD: 0.70	1. (1) 2. (2) 3. (21) N/A (0) Mean: 2.83 SD: 0.48	d=1.50
23.Able to interpret physician and inter-professional orders (T&C #22)	1. (5) 2. (2) 3. (1) N/A (1) M: 1.33 SD: 0.87	1.(0) 2. (7) 3. (15) N/A (2) M: 2.46 SD: 0.88	d= 1.29
24. Able to work as part of a team (#10)	1. (0) 2. (9) 3. (6) N/A (0) Mean: 2.40 SD: 0.51	1. (0) 2. (2) 3. (20) N/A (0) Mean: 2.91 SD: 0.29	d= 1.23
25.Uses appropriate language and tone when resolving conflict (#33)	1. (0) 2. (8) 3. (3) N/A (2) Mean: 1.92 SD: 0.95	1. (0) 2. (4) 3. (18) N/A (1) Mean: 2.70 SD: 0.70	d= 0.93

Professionalism

26.Able to keep track of	1. (2)	1. (0)	

multiple responsibilities and complete tasks within expected time frames (#32 and 31)	2. (10) 3. (3) N/A (0) Mean: 2.07 SD: 0.59	2. (6) 3. (18) N/A (0) Mean: 2.75 SD: 0.44	d=1.31
27.Recognizes and reports unsafe practice by self and others (PCC #18)	1. (4) 2. (8) 3. (2) N/A (1) Mean: 1.73 SD: 0.80	1. (0) 2. (8) 3. (13) N/A (3) Mean: 2.29 SD: 1.00	d= 0.62
28.Able to work autonomously and be accountable for own actions (#29 and 12)	1. (3) 2. (8) 3. (4) N/A (0) Mean: 1.38 SD: 0.51	1. (0) 2. (5) 3. (19) N/A (0) Mean: 2.80 SD: 0.41	d= 3.07
29.Behavior is ethical & honest as judged by ANA ethical principles & SDHPC values and core beliefs	1. (1) 2. (7) 3. (7) N/A (0) Mean: 2.30 SD: 0.62	1. (0) 2. (2) 3. (23) N/A (0) Mean: 2.92 SD: 0.28	d=1.12
30.Expresses importance and demonstrates habits for life-long learning (#12)	1. (1) 2. (8) 3. (5) N/A (1) Mean: 2.13 SD: 0.83	1. (0) 2. (2) 3. (21) N/A (1) Mean: 2.79 SD: 0.66	d=0.88
31.Complies with legal and regulatory requirements relevant to nursing practice (#17)	1. (1) 2. (10) 3. (4) N/A (0) Mean: 2.20 SD: 0.56	1. (0) 2. (8) 3. (16) N/A (0) Mean: 2.67 SD: 0.48	d=0.98

Quality

32.Evaluates and implements systems-improvement based on clinical practice data	1. (8) 2. (3) 3. (2) N/A (2) Mean: 1.83 SD: 0.90	1. (0) 2. (14) 3. (8) N/A (2) Mean: 2.17 SD: 0.82	d= 0.98
33.Understands quality improvement methodologies (PDSA, RIM) (#30)	1. (8) 2. (3) 3. (1) N/A (3) Mean: 1.13 SD: 0.83	1. (1) 2. (13) 3. (7) N/A (3) Mean: 2.00 SD: 0.93	d= 0.99

Informatics

34.Navigates the electronic health record (#1)	1. (2) 2. (3) 3. (5) N/A (4) Mean: 1.64 SD: 1.28	1. (0) 2. (4) 3. (10) N/A (9) Mean: 1.65 SD: 1.40	d= 0.01
35.Utilizes clinical technologies (e.g. Smart Pumps, monitors) #21	1. (2) 2. (4) 3. (0) N/A (7) Mean: 0.77 SD: 0.93	1. (1) 2. (5) 3. (4) N/A (13) Mean: 1.24 SD: 1.55	d= 0.37

OVERALL CLINICAL COMPETENCE [RATE]

Pre	**Post**	**Cohen's *d***
1. (0) 2. (6) 3. (4) N/A (3) Mean: 2.4 SD: 0.5164	1. (0) 2. (5) 3. (18) N/A (0) Mean: 2.78 SD: 0.42	d= 1.08

QSEN survey results