A NURSE RESIDENCY MODEL FOR RURAL AND COMMUNITY HOSPITALS'

MAKING A DIFFERENCE IN GRADUATE NURSE TURNOVER RATES

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Abstract

Vulnerability of new graduate registered nurses (NGRN) requires organizational support when transitioning to a professional role. Varner and Leeds (2012) show 83% of NGRNs are employed in hospitals, and 50% plan on changing employers within 3 years. With the United States (U.S.) in the middle of a nursing shortage caused by an aging workforce, expanding field of practice, aging clientele, decreasing enrollment of nurses due to qualified faculty shortages and limited clinical sites; there is need to offer an enhanced orientation (Booth, 2011). Recommendations easing transition, through implementation of nurse residency programs designed to introduce new nurses to the role of a professional nurse include critical thinking, skill building, confidence building, time management, and socialization; important factors in NGRN satisfaction (Thomas, Bertram, & Allen, 2012; IOM, 2010). Rural healthcare facilities being remote often lack resources, as well have additional concerns due to cultural differences. Being a global concern, nurse turnover has significant impact on the financial performance of health care systems (Li and Jones, 2013). Cost of turnover, estimated from $36,000 to $48,000 (Nursing Solutions, 2013), significantly impacts profit margins. In rural hospitals a greater impact occurs, due to already diminishing profit margins. In response, a model is developed for a residency program with the purpose to offer residencies in rural communities improving care. Objectives of the model include; (a) improvement of the transitional experience of new nurses to their professional roles, improvement of turnover rates, (b) ability to offer safer high quality care with stabilization of the nurse workforce, and (c) decrease training costs for the organization, offering a 12 month nursing residency programs (NRP). The "Nurse Residency Model for Rural and Community Hospital's, making a Difference in New Nurse Turnover Rates" (NRM) offers guidelines for didactic content, clinical immersion through a preceptor, and evaluation strategies for validation.

Key Words

Rural Community, Nurse Residency Program, Looping Experience, Clinical Immersion, Nurse Preceptor, Nurse Mentor, Turnover Rates, Cost of Turnover

Introduction

Reports on projections of nursing shortages in the United States (U. S.) vary tremendously from nearly one million (Juraschek, Zhang, Raganathan, & Lin, 2012) to a surplus of 340,000 by the U. S. Health Resources and Services Administration (HRSA, 2014). By 2020 the shortage is predicted to effect the entire nation partially due to the aging Baby Boomer generation, putting an increased demand for nurses straining the healthcare system (Zinn, Guglielmi, Davis, & Moses, 2012). As reported by the American Association of Colleges of Nursing (AACN, 2014), a geographical shortage is projected in the southern and southwestern states to be higher than other areas. With a rapidly changing healthcare environment and changing client expectations, complexity of acute care inpatients has increased, lateral incivility continues to grow causing challenges; shortages of highly qualified nurses is becoming common place, and there continues to be high turnover rates of new nurses (Kramer, Lindgren, High, Ocon, & Sanchez, 2012; Rush, Adamack, Gordon, & Janke, 2014; Booth, 2011). As a result healthcare organizations are hiring higher numbers of NGRNs. The transition of these nurses will determine their success (Spiva, Hart, Pruner, Johnson, Martin, Brakovich, et al., 2013; HRSA, 2013). Additionally, with the growth of Magnet status accreditation for hospitals, competition for nurses also includes staffing ratios. Magnet Accredited hospitals have shown better patient outcomes and lower mortality rates associated with better staffing ratios, as-well-as higher levels of nursing education among staff (Schuelke, Young, Folkerts, & Hawkins, 2014). With these changes, the demand for fully functioning competent nurses exists (Schuelke, et al.; Goode, Lynn, McElroy, Bednash, & Murray, 2013; Fink, Casey, Krugman, & Goode, 2008).

After a literature review, needs analysis, and study of successful orientations previously established across the country, it was determined that a nurse residency program would be beneficial for rural hospitals as well as urban. Responding to the need, a NGRN residency

program was developed and piloted in a community hospital in Missouri, to see if it indeed helped transition new nurses, improved patient safety, and decreased costs as shown in the literature. The discussion that follows presents the developed NRP, pilot results, future plans and impact on nursing.

Characteristics and Definition of Rural Way of Life and Nursing

People living rurally have a different culture from urban communities that is unique to the area. Native residents (being from the area for generations) often have their "own" language with a thick accent and more moderate speech patterns, often slower than urban residents. Being a very close knit family oriented group of people rural residents can exhibit lack of trust in newcomers creating difficulty in communication for nurses. Because most residents know or often are related to each other, privacy can be very difficult to maintain. As well, when one becomes part of the community curiosity often interferes with the ability to perform assessments and patient interviews. Knowing residents on first name basis is common and the grapevine web allows for information to be spread rapidly (Barnholdt, Mowinski, Merwin, & Thornlow, 2010). Bushy (2006) also discussed demographic differences such as sparser population, greater distance and lack of transportation, fewer resources, and lack of available education that can be prevalent in rural areas. More single parent families exist with many of them living in poverty and lacking education. The cultural, social, economic, and geographical characteristics actually place residents in rural areas at an elevated risk for chronic illnesses and disease with more cases of tobacco use, alcoholism, and drug abuse. Shortages of providers and specialists often adds more stress for nurses to be competent as a generalist nurse being able to handle almost all situations with a holistic approach (Bushy).

When people hear the term rural nursing they often think of an easier place to work when in all actuality, these nurses have to be able to handle almost anything. Often rural facilities are not large enough to have specialized nurses in individual departments (Dowdle-Simmons, 2013). In addition, as discussed by Dowdle-Simmons, rural nurses are expected to perform therapies that usually are performed by others such as Respiratory Therapy. Rural nurses are also expected to work more independently, while having less access to resources similar to nurses practicing in larger healthcare facilities. Nurses in rural settings experience feelings of isolation both professionally and personally which can actually, be a barrier for practice (2013). Because rural community hospitals are faced with the additional challenges of caring for generally, an older population with less income; understanding this generation is paramount. Competing with urban counterparts has become difficult in the areas of recruiting and maintaining a qualified workforce, due to decreasing revenues and increasing salary costs (Bratt, Baernholdt, & Pruszynski, 2012), causing a very difficult market. Rural nursing requires the nurse to be a generalist with the ability to change on a dime to respond to the patient need.

Background

Reports on projections of nursing shortages in the United States (U. S.) vary tremendously from nearly one million (Juraschek, et al., 2012) to a surplus of 340,000 by the HRSA (2014). By 2020 the shortage is predicted to affect the entire nation partially due to the aging Baby Boomer generation, putting an increased demand for nurses straining the healthcare system (Zinn et al., 2012). As reported by AACN (2014), a geographical shortage is projected in the southern and southwestern states to be higher than other areas. With a rapidly changing healthcare environment and changing client expectations, complexity of acute care inpatients has increased, lateral incivility continues to grow causing challenges; shortages of highly qualified

nurses is becoming common place, especially in rural areas, and high turnover rates of new nurses continues (Kramer et al., 2012; Rush et al., 2014; Booth, 2011, Barnholdt et al., 2010). Because of, the growth of Magnet status accreditation for hospitals, competition for nurses also includes staffing ratios. Magnet Accredited hospitals have shown better patient outcomes and lower mortality rates associated with better staffing ratios, as-well-as higher levels of nursing education among staff (Schuelke et al., 2014). With these changes, the demand for fully functioning competent nurses exists (Schuelke et al., 2014; Goode et al., 2013; Fink et al., 2008).

Adding to that, recruitment of new nurses is complicated. The new graduate nurse experience can be stressful trying to adapt to a new role, fit into the environment, and accept new responsibilities (Zinn et al., 2012). As nursing continues to advance and adapt to an ever changing health care environment and client expectations, the complexity of acute care inpatients has increased, shortages of nurses is becoming common place, and high turnover rates are staggering. With these changes, the demand for, fully functioning competent nurses exists (Olson-Sitki, Wendler, & Forbes, 2012).

Other barriers occur for new graduate registered nurses (NGRN) entering the workforce. Some of these barriers include; lack of educational opportunities in classrooms and clinical areas caused by environmental challenges, lack of clinical instructors with current experience, fear of the clinical facility and/or instructor, and subjective reports from prior students attending the school (Kowalski, Druva-Horner, & Houser, 2011). Lin, Viscardi, and McHugh, (2014) and Olson-Sitki et al. (2012) reported, post-graduation, the new responsibilities, patient ratios, expectations, and lack of support contribute to the role stress a NGRN feels. Increased patient loads, create complexity and challenge skills in prioritization and appropriate delegation causing the NGRN to find themselves falling behind in his/her work. Often, they are challenged by other

more experienced staff, because NGRNs are thought to lack the ability to organize and manage their work. Limited technical and critical thinking skills may leave the NGRN unprepared to perform, especially during emergency rapid response situations. Larson suggests that this can possibly lower the quality of patient care (2013). Lack of confidence may leave the NGRN isolated and afraid to seek support from more experienced staff. Booth (2011), reports four main reasons for a high attrition rate in NGRNs; a need for further development of knowledge, job conflict and stress including lateral violence, lack of time management skills, and conflict in balancing the role of the nurse with the role of the patient.

The National Advisory Council on Nurse Education and Practice (NACNEP, 2010) in the eighth annual report to the Secretary of the U.S. Department of Health and Human Services and the U.S. Congress, discussed changes needed to enhance education for the future of healthcare including the enhanced training needed for critical knowledge and skills of NGRNs who perceive their skills and knowledge to be adequate as a caregiver; while preceptors and management reported the NGRNs actually lack important skills training (NACNEP, 2010; Yurdin, 2007). Welding (2011) additionally reported only 41% of NGRNs with a Bachelor's Degree, as reported by employers were actually prepared to care for patients.

More challenges reported by Kramer et al. (2012) include lack of clinical training to perform skills needed for patient care. Finally, students often are not considered part of the healthcare team, and fear of risks to the agency cause lack of inclusion to participate in special or complex cases. Thus, causing a challenge to the instructor to develop skills and relationship sets to help merge the clinical experience with the unit dynamics and facility culture which, increase learning opportunities for students. Unfortunately, the result is often an unprepared NGRN joining the workforce.

No matter the type of nursing program preparation, diploma, associate degree or bachelor's, these same stressors are reported and include limited clinical experiences, offering poor development of bedside decision making (Kramer et al., 2012; Olson-Sitki et al., 2012). In addition, the lack of properly designed orientations to new roles does not prepare the NGRN and sometimes contributes to dissatisfaction. Current orientations, other than residencies offered, are usually two to six weeks in duration, focus on perfecting nursing skills not critical thinking or knowledge development. This challenge is reflected in the opinion of the Missouri Hospital Association (MHA, 2013) workforce report which discussed patient safety being affected, and possibly compromised, by high turnover rates of nurses, sometimes caused by inadequate orientations. These orientations lack the ability to meet the NGRN needs; while at the same time cost the organizations thousands of dollars when he/she leaves the facility in less than one to two years.

With the continued nursing shortage and increasing needs of the patient, requiring a better acclimated, confident, skilled nurse, the following discussion will present a nurse residency model designed to be adopted in rural and community healthcare facilities seeking to improve the current state of transition to professional practice and increase retention of qualified nursing staff; allowing smaller facilities to compete with their urban counter-parts. Further, there will be discussion of associated costs, the model design, and the pilot program that occurred in a rural community hospital in Missouri (MO). Included will be an outline of the curriculum developed, clinical immersion, and the evaluation processes used, lessons learned, and further recommendations surfacing during the pilot process.

Local Concerns

After evaluation of current orientation (four days of house wide orientation, with one day

of computer training, and an additional four weeks of unit specific orientation with an

inconsistent preceptor) by the Education Department of a rural community hospital in southern

Missouri there was an identified need to develop a program that could better meet the needs of

the NGRNs hired. Turnover rates of 30.8% in 2012, staffing shortages, and training costs, were

found to be unacceptable to management, and staff (Jones, 2013). There was additional

consideration given to comments from the MHA (2013) workforce report, which shared that

patient safety was affected and possibly compromised by high turnover rates of nurses, caused

by inadequate orientations. Along with these concerns, the cost to organizations was thousands

of dollars when the NGRN leaves the facility in less than one to two years. The findings

triggered a decision to search out alternative orientation plans for NGRNs, which would make

the transition from school to the workforce more satisfying by enhancing previous education

received, while building confidence and competence in the individuals. Through review of

options and stakeholders meetings, the goal became the development of a nurse residency

program for NGRNs, which was in line with the recommendations of the IOM (2010), the

Carnegie Foundation report by Benner, Sutphen, Leonard-Kahn, & Day, (2010), AACN (2001 &

2014) the National Council of States Boards of Nursing (NCSBN, 2011), the Commission on

Collegiate Nursing Education (CCNE, 2008) to support the transition into practice for new

graduate nurses.

Significance of NRP

The significance of the NRP project was the impact felt by the organization of the pilot

and the people of the community served. With implementation of the pilot, the rural community

hospital was able to provide high quality safe patient care by offering a nurse residency to the

new nurses hired allowing for improved confidence and competence through didactic classes and immersion experiences. Additionally, the agency reported decrease in the turnover rate of the NGRNs. Through review of the anecdotal information common themes surfaced showing the confidence level was improved through knowledge growth, experience, and hands on engagement with equipment. Additionally, established competence level expectations were formulated, with input from the NGRNs and Nurse Managers. Critical thinking skills improved through the use of advanced case studies, brainstorming in the classroom, and sharing of experience and knowledge among the participants. Responses of participants on the Casey-Fink qualitative survey (Fink et al., 2008; Goode et al., 2013) led to addition of activities, promoting a feeling of belonging that were employed through the weekly classroom sharing experience, including increased involvement of some of the floor staff in the teaching of the classes. This alone changed some of the negative feelings while increasing feelings of belonging promoting loyalty and dedication to the facility. Implementing the NRP significantly smoothed the transition to the professional environment. The hospital valued the relationships developed, the projects enhancements to their mission, and encouraged the continuation of the NRP to create a healthier culture and fiscal environment.

Project Objectives

Objectives of a NRP based on the current model included (a) improvement of the transitional experience of new nurses to their professional roles in rural communities, resulting in improvement of turnover rates, assessed through results of the Casey-Fink survey used, (b) the provision of safer and higher quality care through stabilization of the nurse workforce, measured through Press Ganey scores for patient satisfaction; compared every quarter, (c) decreased training costs for the organization which over time could be used to enhance funding for

educational offerings to the entire nurse workforce, as compared to prior year costs, all tracked through Human Resources (HR), and (d) add to support of the currently published literature regarding 12 month nursing residency programs.

Discussion

Many problems exist with current orientations of NGRNs including failure to transition NGRNs to the work environment and the high cost of training. Nursing Solutions (2013) reported the cost of turnover of one nurse to be from $36,000 to $48,000 for an average per hospital loss of $3.74 Million (M) - $4.98M per year (Foster, Benavides-Vaello, & Eide, 2012). The costs come from training, use of outside agency nurses, overtime, and recruitment processes. In 2012, the community hospital in this project, estimated the costs of training to be $1,474,000 just for salaries of the NGRNs that left before completing the first 12 months of employment at their facility (Jones, 2013). However, this amount does not include all of the soft costs such as reduced productivity or errors caused by new employees.

Economic outcomes of an NRP have been reported previously, with a cost-benefit analysis using turnover rate and contract labor usage data by Trepanier, Early, Ulrich and Cherry, (2012) and Letourneau and Fater (2015). Studies performed, indicated that NRPs that were established at a multisite organizations showed a decrease in the 12-month turnover rate and a reduction in contract labor. The Trepanier et al. study evaluated the financial implications of a NRP and the expected benefits and associated costs. The results suggest that NRPs should be respected as investments and not as an undesired expense.

While costs associated with recruiting and orientation of new staff due to high vacancy rates and hiring of temporary agency or travel nurses will affect hospital efficiency, constant changing and chaos in nurse staffing decreases effectiveness of team-building, resulting in less

effective working relationships among staff, physicians, and resource personnel. In a study released by Nursing Solutions (2013), the national average turnover rate for registered nurses (RNs) was 13.1% up from 11.2% in 2012. According to Browning (2013), the turnover rate for RNs in MO in 2012 was 14.3%. The rural community hospital that piloted the model had a turnover rate of 17% in 2011 and 30.8 % in 2012 showing an increasing trend (Jones, 2013) which was almost three times that of the national average, and more than double the MO rate.

In addition to concerns of turnover, there are concerns of competence of the NGRN. Berman, Beazley, Karshmer, Prion, Van, Wallace et al. (2014), reported the existing gap concerning the actual practice of nursing and the instruction provided to nurses is estimated at about 10% by 3500 hospitals and nurse executives that were studied; with only about 25% actually satisfied with the preparation of nursing skills in NGRNs. Several gaps were listed including; ability to critically think, lack of communication skills, skill knowledge, time management, assessment skills, and ability to work as a team member. With the high turnover rates across the country, the lack of NGRNs fully trained to handle today's chaotic healthcare systems, high acuity patients, and the progressing age of the Baby Boomers causing increasing numbers of elderly with chronic illnesses, the following PICOT question was raised: "Would the development of a nurse residency model for rural community facilities, allow new graduate nurses hired into the program to have more confidence in NGRN skills and abilities, offer improved safe quality care, and promote better retention numbers, while decreasing costs of new nurse orientation over the first 12 months of practice?" As a result, a DNP capstone project was chosen to develop "A Nurse Residency Model for Rural and Community Hospitals' Making a Difference in Graduate Nurse Turnover Rates (NRP). Focus of the project include development of a one year residency program for community and rural facilities. The model assists in

attainment of the recommendations of the IOM for the future of nursing (2010) which includes; the ability for nurses to function to the full extent of their license and training, nurses achievement of higher levels of education and offering smooth transition to practice, nurses to become partners with all healthcare positions including physicians, and the ability to access improved information technology to enhance data collection (IOM). The NRP offers smaller rural healthcare facilities, the ability to conduct an organizational designed residency program and compete with their urban counterparts in the recruitment of new nurses and improvement of staffing shortages.

The orientation environment depends on the type of facility in which the model is implemented as it is designed to be flexible depending on population served. In most facilities it will include orientation of existing staff to the new orientation plans while promoting a positive welcoming environment, didactic classes to serve clientele of the facility, and looping experiences also designed to reflect the patient experience within the specific facility.

Assumptions

Many assumptions were made based on the evidence reviewed. The first assumption was that if a residency program was implemented, new nurses would have greater job satisfaction, gain more confidence, become more competent, and would remain an employee for at least 24 months if a residency program was implemented (Goode et al., 2013). The second assumption was that patient safety and quality of care would improve, with continued developmental activities and support of new nurses for the first 12 months. Finally, the third assumption was that the cost of hiring and training nurses would decrease over the first 12 to 24 months with improved turnover rates (Fink et al., 2008; Goode et al., 2013; Lin et al., 2014).

Limitations

  Limitations to the project included the small numbers of residents in the cohorts. The goal of 15 to 20 participants projected was obtained but, the small numbers provided experiences at this particular rural community hospital that may not be congruent with the rest of like hospitals in the United States. The Casey-Fink Nurse Experience Survey used (Casey & Fink, 2006), was voluntary and all of the residents did not continue to complete the surveys as often as requested; limiting the amount of actual data, and the facility failed to disclose the actual final statistics. The final limitation experienced, was the lack of number of qualified preceptors and mentors available to provide monitoring and assistance to the residents.

Theoretical Framework

  Several nursing models were reviewed in determining the design and framework for the capstone project. Two models stood out and were felt to be applicable to what this author was trying to accomplish. The first is the Generative Leadership Model; developed by faculty at the Katherine J. Densford International School of Nursing Leadership at the University Of Minnesota School Of Nursing in 2007 (UMNSoN); with foundational threads from Wheatley's concept of organizations changing into more fluid forms and Gelb's belief that to function during stormy times requires confusion endurance (Disch, 2009). This model addresses today's challenges faced in the nursing profession and looks at different ways to address the challenges. Between higher acuity care of patients needed, and higher staffing ratios nurses are presented with higher demands and must be able to adapt. Disch goes on to discuss the definition of generativity being, the ability to create new options and/or approaches to long-standing problems, while working through and with a team to encourage needed change; leaders taking a generative approach are curious and never satisfied with current situations; bounce back easily

with an optimistic approach, seeing opportunity where someone else might see an unsolvable problem. These individuals are willing to work with a team to enhance the possibility of all to improve situations. Following are the eight principles of Generative Leadership (Disch, 2009, pp. 172)

Principles of Generative Leadership

- See possibility in all situations.

- Reframe Challenges.

- Embrace diversity in all its forms.

- Understand that there are many possible answers.

- Engage others to explore and excel.

- Question all underlying assumptions.

- See connections and relationships.

- Extend trust and a spirit of gratitude.

  (Disch, 2009, pp. 172)

Several characteristics of generative leaders that can be developed and learned over time exist which include; emotional intelligence, risk taking and the ability to be creative, to adopt systems thinking, diversity, and to be inspiring to others while leading change. Additionally, the ability to develop interpersonal relationships through professional communication, use evidence-based leadership and management qualities to reframe the needed changes, and the ability to set and accomplish predetermined goals. The generational leadership model also proposes there are three areas of the nursing profession causing job dissatisfaction: compassion fatigue and vicarious trauma, moral stress, and disruptive behavior both in social environments and through

incivility. Research shows job dissatisfaction is one of the contributing factors to turnover in new nurses (Thomas, et al., 2012; Walker, Costa, & Cuddihy, 2013).

The Generative Model encourages new ways of thinking and alternate approaches to problem solving and suggest three ways one can achieve this goal. The first is to embrace paradox which is defined by Merriam-Webster online (2015), as a statement that is seemingly contradictory or opposed to common sense and yet perhaps true. Today many inconsistencies exist for the clinical nurse including having to do more with less, offer improved quality care while having to reduce costs, the business of medicine must meet ethical guidelines and meaningful use while being successful, be competitive yet collegial, be able to create strong nurses and teams, learn to embrace diversity and work with consensus, and develop the ability to function in an emergent situation while remaining calm.

The second way to achieve the goal of new ways of thinking is to seek ambiguity which as defined (Merriam Webster collegiate dictionary ®, 2012) is something that can be understood in two or more ways. Even though nurses are sometimes taught there is one right answer or solution reality is, there are often more than one. Finally, the third suggestion is to learn to reframe existing conditions and expand the possible available options for solutions. One who has adopted this behavior understands that other options to complete work and maintain a staff, might be needed to expand the ability to provide quality nursing care (Disch, 2009).

Another model used for framework is Benner's Novice to Expert (Benner, 1984) which describes different stages of clinical competence the nurse goes through in the journey of nursing professionalism and has served as the framework for numerous studies including Beecroft, Dorey, & Wenten (2007), Schoessler and Waldo as cited by Olson-Sitki et al. (2012). Included,

as well, were the theories of Bridges (2009) and Kolb (1984) which address learning styles and experiential learning.

The first stage is the Novice Nurse, who has little or no experience in the situations they are asked to participate in. This is usually the student needing the teaching of rules to be applied universally. The novice is limited in abilities and need to be instructed on what to do. The second stage is the advanced beginner; who actually can show acceptable performance of skills and have had some experience in clinical situations. Advanced beginners are beginning to develop their own principles based on their prior experiences. Stage three nurses are considered to be competent. This stage usually develops over a two to three year time frame at which time the nurse can see their experiences and consciously set long-term goals. Nurses at this stage have the ability to use analytical examination and abstract thinking to put together a patient care plan for positive outcomes. However, they are not able to always determine the most important. In the fourth stage the nurse is considered proficient; perceiving situations with a holistic approach looking at long-term goals. The proficient nurse has experienced many classic events and can determine what to expect based on presenting symptoms and treatment provided. This nurse is able to modify the care plan when necessary, and identify the times when the normal response is not occurring and what needs to be done, feeling comfortable while acting on the decision made. Proficient nurses can see and use maxims as guidelines for the decisions. The final stage is considered the expert nurse who can intuitively respond to circumstances through an enormous background of experience allowing them to focus intently on the problem, without using valuable time. The actions become fluid and flexible offering expertise (Benner, 1984).

Using Benner's Stages of Clinical Competence the curriculum of the residency program was designed focusing on the second and third stages of development with a goal to develop

nurses that were closer to the competent level by the end of the orientation. This also helped

determine who of our residents would definitely need to go through the higher level classes in

weeks 13 through 16. If the nurses were working in the higher acuity units such as the Intensive

Care (ICU), Cardiac Care (CCU), or Emergency Department (ED), more training would be

needed to help build confidence and competency.

After review and setting the goals of improved satisfaction of employees and improved

quality of patient care both the Generative (Disch, 2009) and Novice to Expert Models (Benner,

1984) were used as framework. Understanding that encouraging the ability of the new nurses to

function from a generative leadership approach would help in developing the confidence needed

for the cultural environment of the facility, team engagement, professional communication, and

feeling of belonging; to help improve satisfaction, these models allow for the desired framework.

Summary of Relevant Literature

A thorough literature review was performed to understand the background that has been

the basis for the development of nurse residency programs, the best evidence, the process for

development of residency programs, the types of curriculum that is recommended by successful

residencies already in existence that would be in-line with Q-sen, and the essentials developed by

the AACN. Additionally, the CCNE (2008) developed accreditation standards that would be

considered. Several databases were reviewed using keywords and catchphrases chosen during the

development of the PICOT question which included; Nurse Residency, new nurse orientation,

NGRN transition, nursing education challenges, NGRN competencies, nurse residency

evaluations, and theories for NRPs. Finally, NGRN turnover, rural nursing, rural nursing

turnover, cost of nurse turnover, staffing ratios, and Magnet Status staffing differences. The

databases included in the search: Cumulative Index to Nursing and Allied Health Literature

(CINAHL) complete, ProQuest Medical Library, Ovid Nursing Full Text PLUS, and Summon. (See Table 1).

Numerous articles were found related to NRPs, nurse education, nurse turnover, costs, competencies, and NGRN Satisfaction but, fewer for rural nursing. To narrow the search, guidelines were chosen to evaluate the articles for relationship to project. The guidelines included the year of publication (2008-2014), English, peer reviewed, scholarly journals, United States, and full text. Articles were further filtered by review of abstracts and titles and included articles that pertained to NGRN programs in rural and community hospitals. The results of this search provided, an abundance of articles for final consideration which included the type of study performed, the sample, setting, methodology, if there was a theory used as framework for the study, and results. Evidence levels used for the project included well organized controlled studies, retrospective studies, peer reviewed, and theory based framework.

Gaps found in the research literature including lack of level I studies, show a need for newly documented up to date projects offering proof of past findings, and the need for current studies to add to knowledge and understanding of the transition process of NGRNs. It was important to look at recommendations and best practice evidence from previous successful orientation and residency programs. Review revealed job dissatisfaction as one of the contributing factors to turnover in new nurses by several authors (Thomas et al. 2012; Walker et al., 2013; AACN, 2010; Molanari, Jaiswal, Hollinger-Forrest, 2011; Rural Health Research Center, 2012).

Walker et al. (2013), in a three year longitudinal qualitative study, approached job dissatisfaction through looking at the different perceptions between NGRNs and Unit Managers regarding the workforce environment and factors that affected the NGRNs during their first year

of professional practice. The following factors surface: (a) death and dying, (b) co-worker relationships, (c) leadership styles, (d) lack of recognition for positive outcomes, (e) off-shift work (2nd & 3rd), and (f) lack of confidence and competence.

Krozek (2008) reports a "Perfect Storm" in nursing currently occurring due to the number of novice nurses entering the workforce while a massive number of experts are leaving the profession due to retirement, job dissatisfaction, and the changes in healthcare. Krozek's recommendations included purchasing a highly priced orientation residency package, contracting to have an outside company provide the orientation, or developing a program based on facility needs.

Anderson, Hair, and Todero (2012) in a systematic review of 20 studies, presented the implementation and evaluation of nurse residency programs that are successful in improving the NGRNs transition to practice. Addressed in this article, was a clear five step system to evaluate the effectiveness of nurse residency programs. The plan sought to answer the questions of program design and the variables that are important to measure efficacy. Also discussed were the methods and instructional strategies that might be incorporated into a successful plan. Some of the recommendations were use of preceptors, building cohort relationships, scheduling discussion times, using clinical experts as instructors, case studies, concept maps, and use of advanced simulation when available. The Casey-Fink survey was a recommended strategy that was used by several of the studies for evaluation.

Clark and Springer (2012) took a different approach with a descriptive qualitative study, looking at the actual lived experience of NGRNs and their level of job satisfaction during the first 12 months of clinical practice. Certain themes surfaced including rhythm in chaos, feeling valued, stress from the unknown about their responsibilities, the importance of life-long learning,

and the need to preserve the profession. It was quite evident that the first 12 to 24 months are the most important in the development of a satisfied, successful, competent nurse; while retention is based very much on satisfaction. The most frequent outcomes measured included; economic return on investment; both long and short-term, retention and turnover rates, and replacement and recruitment costs.

Due to additional challenges of the community and rural hospitals with lesser available resources and patient demographics, rural nursing has been plagued with chronic shortages for decades. Current literature reviewed, discussed the importance of education to create a strong foundation for future results. Differences between rural and urban nurses are related to the type of nursing needed in the rural areas being more of a generalist position having to address additional factors such as a higher number of senior age people, higher percentages of poverty, higher number of uninsured, and increased comorbidities. The rural nurse actually needs to have a higher level of preparation. A result being higher stress levels on the education of nurses in rural communities, while the truth is there are higher numbers of ADNs and LPNs. Additional factors such as; feeling of professional isolation, not fitting into the culture, and lack of the ability to socialize with fewer venues cause a higher level of anxiety and burnout in the first 24 months of the rural nurse's career. The use of evidence-based practice is hindered with a higher percentage of ADNs and LPNs who may lack the knowledge and experience to access current literature or to initiate change (Molanari et al., 2011; Rural Health Research Center, 2012; Jukala, Greenwood, Ladner, & Hopkins, 2010; Wakefield, 2011). Other factors found that contribute to new nurse turnover include job dissatisfaction, lateral violence, lack of feeling part of the system, lack of recognition, poor staffing, shift hours, and lack of confidence. In her remarks to the Joint Commission, Williams (2012) presented challenges of rural areas and

suggests the Nation needs to look at the opportunity presented and how nursing can change the problems. A lack of current literature for rural and community hospital nurse orientation programs supported the development of a model for a residency program.

Table 1

Research Studies and Articles Reviewed from Databases

	CINAHL	ProQuest Medical Library	Ovid Nursing Full-text PLUS	Summon
New Nurse Residency Programs	73	186	145	577
New Nurse Orientation	199	114	19	479
NGRN Transition	8	196	18	192
NGRN Satisfaction	19	193	26	2066
Nursing Education Challenges	8	1522	252	6944
Nurse Residency Theories	1	92	386	308
Graduate Nurse Competencies	35	82	217	149
NGRN Turnover	1	128	114	168
Rural Nursing & Healthcare	129	48	98	176
Rural Nurse Turnover	10	56	9	98
Cost of Nursing Turnover	81	196	9	47
Staffing Ratios	262	153	255	153
Magnet Status Staffing Differences	191	269	193	25

Ethical Considerations

With any proposed project ethical considerations are necessary and guidelines must be followed. With that in mind, Internal Review Board (IRB) approval was pursued. The project was deemed exempt from formal approval by Capella University IRB, as the pilot was used for orientation of all newly hired graduate nurses and was considered quality improvement. Still, all data gathered maintained privacy of participants through blind surveys, with no identifying information. Final statistical data was not available from the pilot facility, but through discussion

with educators the anecdotal information was exciting and reflected findings of previous residency programs reviewed for the project.

Intervention

A Nurse Residency Model for Rural and Community Hospitals', making a Difference in Graduate Nurse Turnover Rates was developed to provide a one year transition from student nurse to professional nurse. The NRP model consists of 12-16 weeks of a four to eight hour classroom educational experience including 12 sessions of general nursing topics plus an additional four weeks of specialty service training for NGRNs hired to Obstetrics, Intensive Care Unit, Cardiac Care Unit, and Emergency Department. Every classroom session had a period of sharing of personal experiences from the previous week's clinical training in order to encourage relationship building and peer learning. The classes were set up so they could be adjusted based on the needs of the facility. Several instructional strategies were employed during development including, presentations from nurses with expertise in the topic area, interactive media, videos, case studies, concept maps, skills review, and simulation. For this rural community hospital the following topics were included:

1. Orientation/Shift Schedules etc.

2. Difficult Patient and Family/ Bullying/ Communication & Social Media

3. Pre and Post op Care/Complications/Pain Management

4. Diabetes/Renal/Wounds

5. Cardiac/Myocardial Infarction/Heart Catheterization/Arrhythmias/Electrolytes (two weeks)

6. Geriatric/Normal Aging/Pneumonia/Dementia/Death & Dying

7. Respiratory/Acute Respiratory Distress Syndrome/Asthma/Bi-Pap/C-Pap/Arterial Blood Gases

8. Neuro/FAST/Stroke/Hemorrhagic Event

9. Gastrointestinal/Nutrition/Tube Feedings

10. Fluid Replacement/Dehydration/Blood Replacement/Lab Values

11. Multi System Failure/Shock

12. Leadership/Delegation/Time management

13. Trauma/Accidents/Injuries

14. Post-Partum/Obstetrics (two weeks)

15. Intensive Care Unit Day (Ventilation/Central Lines/ Swan Ganz/PICC Lines/ Intravenous Pressure Monitoring

16. Pediatrics/ Review

The process included the formal classes as well as two 12-hour shifts per week on the employing unit with a preceptor (Baxter, 2010) for a clinical immersion experience, a six hour clinical looping experience allowing for shadowing in other departments to understand the full patient experience, and weekly one-on-one meetings with preceptors and clinical educators. At the end of the 12-16 weekly sessions of formal class experiences, the nurses were assigned to a mentor for monthly follow-up meetings to assess satisfaction and outcomes. These meetings included additional training consisting of a once a month education day, focusing on specific areas of concern, debriefing, and review of disease processes. Unit directors had input at these sessions; with nurses and physicians participated in training areas of specialty. The primary goals of the intervention were to build confidence; improve critical thinking skills, relationship

building of the new nurses; reduction of staff turnover; and improvement of quality of care and patient safety.

Evaluation

An outcomes-based evaluation was used with measurement occurring at both the micro and macro levels. At the micro level; weekly evaluations with the preceptor, educator, and director was designed to measure performance and achievement of goals; which helped to identify possible changes needed in individual goals. Moving toward the macro level, preceptors were evaluated by residents at six and 12 weeks to assure a solid relationship and attainment of goals and needs of the resident. At the macro level, the Casey-Fink Survey (2006) was used as an assessment tool to give educators feed-back that identified success or areas of improvement needed. Permission to use the survey was obtained through The Casey-Fink Graduate Nurse Experience Survey Revised: Utilization (2006). Finally, the hospital conducted an annual R.N. National Database of Nursing Quality Indicators^{TM} (NDNQI) survey about the adequacy of the orientation process, allowing for review and changes at the end of the program year.

Primary findings showed challenges with two of the preceptors not understanding their responsibilities and were replaced with alternative preceptors. After the change participants went on and had a very successful experience. The results of the Casey-Fink survey showed necessary areas of change needed in didactic courses to meet the needs of some of the students working in higher levels of acuity. Additionally, some felt the classes were a review of what was learned in school and nothing new. As a result for future sessions, more case studies were developed and incorporated. The hospital also developed a simulation program to give NGRNs opportunity to experience more severe situations in a controlled environment; allowing the residents to assume more responsibility and use stronger critical thinking skills.

Anecdotal information obtained at completion of the first year showed reduction of nurse turnover rates from 30.8% to 20.1 %, which reduced vacancy rates, and significantly improved student perception of comfort and confidence as indicated in comments on the Casey-Fink Survey. Comments included, "I am not sure I would have made it without this orientation," "I am not so afraid to make a decision that effects my patient after participating, and enjoyed the ability to share experiences with other residents in a safe and trusting environment." The quarterly Health Grade reports measured patient satisfaction with care received and gave information that indicated if any changes were needed. All results were disseminated to the stakeholders via meetings, and written reports (Casey, Krugman, & Probst, 2004). Finally, the overall success of the program was obtained showing:

- Improved patient safety and quality of care
- Fewer errors through close preceptor relationships
- Greater satisfaction with choice of employer through the continued mentorship
- Greater feeling of support and knowledge base through offered continuing education
- Decreased nursing turnover and enhanced human capitol

Implications for Practice

With the growing nurse shortages across the United States it is more important than ever that the NGRNs are prepared to enter the professional workforce with adequate skills, confidence, and competence to handle high acuity patients (Wakefield, 2011). The development of a Nursing Model to address the orientation process at rural community hospitals providing direction, practice, and evaluation of the NGRN may offer new nurses the experience and training they need to succeed in the working environment, to improve patient care, and to reduce

nurse turnover. Literature shows the importance of feeling accepted and welcome, competent and confident, and to have a feeling of belonging to build trust and loyalty to one's employer. As a result of piloting the NRP, practice and patient care were favorably impacted by providing an improved transition to professional nursing. Additionally, recruiting and retention of nursing staff improved, which created a teambuilding atmosphere and a favorable environment. The pilot provided this rural community hospital with an employee that was more confident, dedicated, and loyal, who encourages others to seek opportunity at the facility.

Conclusion

Hospitals in the U.S. are facing increasing nurse shortages. Additional challenges faced by the rural community hospitals include an older population and dwindling funds. Competition for nurses is fierce due to decreasing revenues and increasing salaries. Rural community hospitals find it hard to compete with the larger urban hospitals. New graduate nurses from nearby colleges and universities are often where the community hospitals hire from. This presents a challenge of the first position for a nurse that is very stressful and the NGRNS are looking for an employer that will offer a smooth transition to professional practice. The goal is to have the NGRNs feel comfortable with their chosen profession, become embedded into the work environment, develop higher skill levels and knowledge base, and be satisfied with their employer. The development of a model and use of a residency program in the rural setting for NGRNs, would improve patient safety, quality of care and enhance human capitol. The positive collaborative learning relationships built transforms the environment and builds a healthy workplace (Fink et al., 2008; Goode et al., 2013). Additionally, the model developed appears to meet the previously defined goals of the project, is viable while at the same time remains a low cost program for rural hospitals to promote staff retention.

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APPENDIX

A. STATEMENT OF ORIGINAL WORK

Academic Honesty Policy

Capella University's Academic Honesty Policy (3.01.01) holds learners accountable for the integrity of work they submit, which includes but is not limited to discussion postings, assignments, comprehensive exams, and the dissertation or capstone project.

Established in the Policy are the expectations for original work, rationale for the policy, definition of terms that pertain to academic honesty and original work, and disciplinary consequences of academic dishonesty. Also stated in the Policy is the expectation that learners will follow APA rules for citing another person's ideas or works.

The following standards for original work and definition of *plagiarism* are discussed in the Policy:

> Learners are expected to be the sole authors of their work and to acknowledge the authorship of others' work through proper citation and reference. Use of another person's ideas, including another learner's, without proper reference or citation constitutes plagiarism and academic dishonesty and is prohibited conduct. (p. 1)

> Plagiarism is one example of academic dishonesty. Plagiarism is presenting someone else's ideas or work as your own. Plagiarism also includes copying verbatim or rephrasing ideas without properly acknowledging the source by author, date, and publication medium. (p. 2)

Capella University's Research Misconduct Policy (3.03.06) holds learners accountable for research integrity. What constitutes research misconduct is discussed in the Policy:

> Research misconduct includes but is not limited to falsification, fabrication, plagiarism, misappropriation, or other practices that seriously deviate from those that are commonly accepted within the academic community for proposing, conducting, or reviewing research, or in reporting research results. (p. 1)

Learners failing to abide by these policies are subject to consequences, including but not limited to dismissal or revocation of the degree.

Statement of Original Work and Signature

I have read, understood, and abided by Capella University's Academic Honesty Policy (3.01.01) and Research Misconduct Policy (3.03.06), including the Policy Statements, Rationale, and Definitions.

I attest that this dissertation or capstone project is my own work. Where I have used the ideas or words of others, I have paraphrased, summarized, or used direct quotes following the guidelines set forth in the APA *Publication Manual*.

Learner name and date	Jacquelyn J. Graetz RN, MSN, MHA	November 25, 2015
Mentor name and school	Lydia Forsythe, PhD	Capella University