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STAFF EDUCATOR'S GUIDE TO
Clinical Orientation
Second Edition

Staff educators, are you struggling with developing a new-hire orientation program?

We all know how important onboarding can be in lowering turnover rates. Is there a sure-fire way to ensure a new nurse's success?

Staff Educator's Guide to Clinical Orientation guides you in creating and sustaining a high-quality orientation and onboarding program that meets the needs of nurses, organizations, and patients. In this fully revised second edition, authors Alvin Jeffery, Robin Jarvis, and Amy Word-Allen provide all the tools you need to successfully develop a nursing and healthcare workforce.

Whether you're new to leading orientation efforts or a seasoned nursing staff development specialist, this book will help you:

- **Understand and use the ADDIE model**
- **Analyze, design, and implement an orientation program**
- **Evaluate an individual's competency**
- **Conduct surveys and focus groups**
- **Manage orientee errors and personality conflicts**

NEW:
- **Understand the role of the preceptor in clinical orientation activities**
- **Assess and ensure competency of contract or temporary staff**
- **Collaborate with academic affiliates**

Alvin D. Jeffery, PhD, RN-BC, CCRN-K, FNP-BC, is a Research Fellow with the U.S. Department of Veterans Affairs, where he studies nursing-focused informatics interventions. He currently holds part-time appointments as an Education Consultant at Cincinnati Children's Hospital Medical Center and as a Nurse Scientist with Hospital Corporation of America.

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STAFF EDUCATOR'S GUIDE TO

Clinical Orientation

Second Edition

Onboarding Solutions for Nurses

Alvin D. Jeffery | Robin L. Jarvis | Amy J. Word-Allen

Foreword by Jane Englebright

Praise for *Staff Educator's Guide to Clinical Orientation*

"This marvelous resource will positively enrich your clinical onboarding program. The book is comprehensive and harmonizes theory and practice with easy-to-implement tools. A must-have for all nursing professionals involved in new employee orientation."

–Cindy Borum, MSN, APRN, FNP-C
Assistant Vice President, HCA Healthcare

"The second edition of *Staff Educator's Guide to Clinical Orientation* provides a comprehensive yet easy-to-navigate resource to effectively onboard and orient nurses to clinical departments. The book provides guidance in establishing a new program as well as helpful advice to those needing to refresh their existing program—with both low and high technology options to meet the needs of facilities with varying levels of means. This comprehensive resource includes information for leaders, educators, and preceptors, emphasizing that onboarding is a process, not an event, and can continue well beyond the allotted orientation time. The book covers numerous aspects of the onboarding process, including the critical aspect of providing effective feedback for the orientee. It pulls from different industries, expanding the reader's global thinking outside of the healthcare industry for application of concepts. Lastly, this well-written resource provides wide-ranging examples, case studies, and lessons learned to guide the reader through the development of a clinical orientation program in these complex healthcare times."

–Vicki Good, DNP, RN, CPPS
Administrative Director Clinical Safety
CoxHealth, Springfield, Missouri

"Jeffery, Jarvis, and Word-Allen put the orientation and onboarding process into contemporary language and recognize the complexities of good onboarding in healthcare. The book is easy to read and offers real-world solutions to implementing and evaluating onboarding programs. Well done!"

–Catherine H. Ivory, PhD, RN-BC, FAAN
Associate Chief Nurse Executive, Vice President,
Professional Practice & Care Transformation
Indiana University Health
Assistant Dean for Care Transformation,
Indiana University School of Nursing

“This well-written book will be a wonderful resource for individuals who are deeply involved in onboarding new nurses in their organizations—including preceptors, staff development specialists who design and execute onboarding programs, and nurse leaders who are considering adopting, revamping, or expanding existing programs. The book is infused with theory-based principles and practical illustrations. The practical examples bring theoretical concepts to the level of the practitioner who is charged with successfully and efficiently integrating new nurses into the workforce. The book references multiple resources for those who wish to delve further into particular topics. The authors’ discussion of differences in onboarding new graduate nurses versus experienced nurses new to a particular care setting is especially important, as there are fine, nuanced differences between these populations of nurses and their onboarding.”

–Deonni P. Stolldorf, PhD, RN
Assistant Professor
Vanderbilt University School of Nursing

“Current driving forces demand that we expedite the developmental trajectory to ensure that newly licensed registered nurses are proficient to practice within the first 2 years of licensure. The current orientation and ongoing development playbook is insufficient to meet this demand. The *Staff Educator’s Guide to Clinical Orientation: Onboarding Solutions for Nurses* is a must-read reference for those serving both practice and academic environments. The authors review and recommend models that provide a framework for the reader to predict, describe, and explain factors influencing orientation program outcomes. The format is engaging and directional, guiding the reader to reflect and apply chapter content enabled by questions for reflection, discussion, and summary takeaways complementing each chapter. Of particular relevance is how Jeffery and team integrate necessary elements of orientation program design, including learning objectives, scalability, pragmatism, and cost. Well done!”

–Mary Sitterding, PhD, RN, CNS
Vice President – Patient Services
Center for Professional Excellence
Assistant Professor, Research (Affiliate Faculty)
University of Cincinnati College of Nursing
Cincinnati Children’s Hospital Medical Center

STAFF EDUCATOR'S GUIDE TO

Clinical Orientation

Second Edition

Onboarding Solutions for Nurses

Alvin D. Jeffery, PhD, RN-BC, CCRN-K, FNP-BC
Robin L. Jarvis, MS, SPHR
with **Amy J. Word-Allen, BSN, RN**

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Introduction to the Second Edition

Welcome to the second edition of the *Staff Educator's Guide to Clinical Orientation*! We are so excited that we have this opportunity to improve and expand on the content from the first edition!

In speaking with staff educators and preceptors about the book over the last few years, we've heard amazing stories of nurses overcoming orientation challenges through their innovation, creativity, and unending passion for training new employees. Since publishing the first edition in 2014, many aspects of the nursing landscape have remained unchanged: Turnover and satisfaction remain problematic, schools are still producing new graduate nurses, and organizations are asking that we reduce the length of orientation. But a few things are changing: Patients are getting sicker, payments for healthcare services in the US are becoming more complex, and technology is playing a larger role in healthcare delivery.

Admittedly, we are a bit biased, but we believe the nursing professional development specialist (that is, the staff educator) is well-poised to help address these challenges. Staff educators are leaders within the organization who are sufficiently skilled (and trusted!) to communicate directly with C-suite leaders and direct care clinicians. The opportunities for staff educators to develop a nursing and healthcare workforce that can address current and future barriers to optimal care are plentiful! Although it's not the end of the story, a significant portion of this work begins with orientation and onboarding programs.

A high-functioning orientation program is essential to delivering high-quality care. But a good program doesn't happen overnight, or all by itself. Developing and sustaining a great onboarding program requires time, commitment, critiques, and constant evolution. And that's exactly what we want to help you with!

The *Staff Educator's Guide to Clinical Orientation* covers conceptual and practical advice for all aspects of orientating and onboarding nurses. Of course, the content could be applied to several other healthcare and non-healthcare professionals, but all of our examples are nursing-centric. In this second edition, we have added several new resources, updated the references (when available), and included a whole new chapter focused on students and contract employees. Much of the flow and content, however, has remained unchanged because readers have expressed they've found it helpful.

We'll begin with an overview of the more conceptual pieces of orientation and introduce the ADDIE model for instructional design. We include examples, tables, and worksheets to help you apply the principles immediately. We become more concrete as we move into a discussion of implementing the various facets of an orientation program, and we spend some time providing tips and tricks for a wide variety of orientee types and challenges. We finish the book with some thoughts on regulatory and legal issues as well as several resources for staying organized.

In addition to the new chapter and updated resources, we've also added a new voice in the book—the preceptor. The role of the preceptor cannot be overstated in orientation activities, and in some organizations where there is not a formal staff educator to oversee education, preceptors might be responsible for most of the orientation and onboarding activities. To provide this perspective, we have invited Amy Word-Allen to write preceptor and mentor-focused content for us.

Alvin's most recent clinical position was in a 10-bed pediatric ICU at a community hospital, and Amy was his preceptor for orientation. Amy recounts, "I crossed paths with Alvin in 2015. I had assumed my primary preceptor role and had developed what I felt was a comprehensive program, but like any new task or skill, you are always unsure of how implementation will look.

"Our unit-based orientation was small enough that I could take on the task of orienting new staff. When I saw Alvin's résumé, I knew he would be mine. The other preceptors were younger and finding their solid footing, so they didn't need the super educated to come in and ask the 'Why?' question so much they didn't feel successful. And by all of my assessments, Alvin was going to be smart, he was going to know what he was doing, and he would be able to recite research like the back of his hand.

"I was skeptical the first day. He was perky, motivated, ready to dive into practical care, and highly knowledgeable of the 'how.' My job was to dig into the 'why' and let his muscle memory have time to kick back in. I dreaded it because I knew he was going to know more than me, but it was evident that not only could I have a skill set to teach him, but he was enthusiastic about being in touch with the practical side of nursing.

"We ended up being a great pair. Our time flowed together, and he was really ready to not only share his knowledge in a nonjudgmental way but also glean knowledge of the practical side of nursing. We shared meals, we laughed, we cried, we shared frustrations of our professional careers, and we discussed how to make him better. I felt really good about letting him out into the unit to practice by the end of our time together."

We're excited to expand the book's audience to be a bit more inclusive of preceptors with the addition of Amy's "Preceptor Pointers."

We hope you'll find the book an engaging read with helpful advice on creating and maintaining a high-quality orientation and onboarding program. We have enjoyed creating the content for you, and we wish you success in all your teaching and mentoring efforts!

Foreword

I have often referred to the first few days of orientation as a "parade of stars." For several days, a parade of experts from across the organization tell new employees all about their own role, touching very little on useful information that will help newcomers learn their jobs. The cumulative impact of this approach is often a bewildered and confused new nurse. The second edition of *Staff Educator's Guide to Clinical Orientation* provides educators and leaders with the antidote to this very common ailment in nurse orientation and onboarding programs.

I have experienced the parade of stars approach to orientation as a nurse, preceptor, educator, and leader. Now, as the Chief Nurse Executive of a large healthcare system, I am on a mission to obliterate it. This book offers meaningful alternatives and practical tools for how to design and implement an effective orientation and onboarding approach that engages and supports new nurses starting with their first day.

I've had the pleasure of working with Alvin Jeffery when he was a doctoral student and more recently as a nurse scientist. This book is grounded in evidence, as you would expect from a nurse scientist, but also has practical tools and real-world case examples provided by all the authors. Amy Word-Allen's focus on preceptors is a welcome addition to the second edition.

Robin Jarvis and Alvin Jeffery have structured the entire book as an illustration of adult learning principles. They alternate theory and application throughout the book. Each chapter concludes with questions for reflection and key takeaways. Chapters on temporary staff and regulatory compliance reflect their awareness of the day-to-day challenges of nurse educators.

So, join the movement! Let's replace the parade of stars with meaningful orientation and onboarding programs that engage and support nurses from the first day of employment. This book shows us how to do it.

–Jane Englebright, PhD, RN, CENP, FAAN
Senior Vice President & Chief Nurse Executive
HCA | Clinical Services Group

Introduction

> *"I never teach my pupils; I only attempt to provide the conditions in which they can learn."* –Albert Einstein

Welcome to the *Staff Educator's Guide to Clinical Orientation*! Throughout this book, we want to provide you with tools and techniques for creating and sustaining those ideal conditions to which Einstein refers. We hope you'll find this book an enjoyable and insightful discussion of how to develop orientation and onboarding programs for nurses that will result in well-prepared orientees and satisfied organizational stakeholders.

Our goal in writing this book is to provide you with a quick reference or just-in-time field guide to making your orientation programs successful. We know that you have a busy schedule, so we have included several worksheets and tools that can be used immediately in case you don't have the time to read a more lengthy discussion on a particular topic. We hope you will read the entire book so that you can understand the tools and adapt them more to your individual needs, but we wanted to give you something you could use *today*.

We have written this text for nursing professional development specialists (that is, nurse educators in the clinical setting) as well as managers and administrators who work with nurses in orientation. Although preceptors and senior-level administrators may learn new concepts from these readings, the intended audience includes those mid-level leaders who dabble in day-to-day orientation/onboarding activities as well as the design, development, and implementation of orientation/onboarding programs. Our experience has shown that many mid-level leaders are not fully equipped in formal training and development concepts that are essential to effective and efficient orientation/onboarding programs. This book is intended to help bridge this knowledge gap.

Because we want you to use this as a field guide, we are providing an overview of each chapter so that you know where to go for your specific issue or concern. Each chapter has some suggested reflection/discussion questions for you to consider. We hope that you find these questions as well as the worksheets, tables, etc., helpful.

Chapter 1
Important Considerations for Onboarding and Orientation

This chapter provides you with an overview of the ADDIE model (Analyze, Design, Develop, Implement, and Evaluate), which is the standard model for designing training programs such as onboarding and orientation. You might notice the similarities between the ADDIE model and one you use every day in nursing (Assess, Diagnose, Plan, Implement, and Evaluate).

The ADDIE model really provides the basis for the rest of the book. We look at each step in the model throughout the book. The remainder of Chapter 1 looks at principles and principals for your program. Principles are key things to consider during the development of your program. The principals are all the stakeholders in this important program and process.

Chapter 2
Analysis and Design of an Onboarding Program

Chapter 2 looks at the first two steps in the ADDIE model—Analyze and Design. In the Analyze step, we address a few data-gathering modes and even provide a focus-group agenda for you to use. If you have an existing program, we provide some tips on how to assess the strengths and weaknesses of your program, as well as point out some errors to avoid. If you're creating a new program, this chapter will give you the tools you need to get started by ensuring you know what your organization needs.

During the Analyze step, you must understand your learners, so we talk about some models that address how people learn. We limit it to three models, as we believe that the application of these three will ensure that your learners' needs are met. Many of you are familiar with the American Association of Critical-Care Nurses (AACN) Synergy Model, and we discuss how that can be applied to your analysis and design. We also discuss making recommendations to key stakeholders when you have finished the Analyze phase, and we provide some worksheets and examples to get you started with the Design phase.

Chapter 3
Developing and Implementing an Orientation Program

This chapter takes the design worksheets we introduced in Chapter 2 and guides you on how to use those to develop your orientation and onboarding modules. We provide examples at the organizational and unit level, just as we did in Chapter 2. We also include examples of facilitator notes and pages from participant guides.

In Chapter 3, we address the concepts of centralized and decentralized programs. These concepts are especially important for those of you working in larger organizations; however, regardless of the size of your organization, you should be addressing items at the organization and unit levels. We also take a peek at a unit's onboarding program and, specifically, the importance of the preceptor.

Chapter 4
Evaluating an Individual's Competency

This chapter may be the most important chapter in the book, because at the end of the day your onboarding and orientation program should ensure that each new nurse is working in a safe and competent manner. The first thing we address is whether time-based or competency-based programs are more effective. We believe that competency-based is best; however, we also are well aware of organizational challenges, such as budgeting, scheduling, etc.

The remainder of the chapter is devoted to competence—what it is, what it isn't, how to evaluate it, and what to do if you are not seeing it. We make some distinctions between competence and confidence that we know you will find useful. Additionally, we delineate among cognitive learning, psychomotor skills, and affective thoughts and behaviors and provide some tips on how to teach each and how to evaluate each.

Chapter 5
Working With Orientees

OK, maybe this is the most important chapter! In this chapter, we identify several different types of orientees:

- The new college graduate
- The experienced nurse
- The nurse who is progressing quickly
- The one who has made an error
- The one who doesn't get along with his/her preceptor
- The one who has a learning style that is different from his/her preceptor
- The one who struggles with interpersonal communication
- The one who wants to quit
- The one who likely will not complete onboarding successfully

Whew! This chapter provides specific examples of what an orientee may do or experience and provides practical tips for what a preceptor and/or nurse educator can do to help the orientee be successful.

Chapter 6
Evaluating an Orientation Program

Chapter 6 looks at different models of evaluation. You will note some overlap of the models, and that is intentional. The bottom line with evaluation is that (a) you must be able to show that the orientees are successful after completing the program, and (b) the principal stakeholders can see that the program is efficient and cost-effective.

We provide examples of evaluation at the organization and unit levels to help you as you navigate the evaluation process. A key point in evaluation is that you must begin thinking about it during the Analysis phase, as Analysis is where you determine what you want people to be able to do better and/or differently as a result of your program. We have also added a new section on mentoring in order to facilitate new employees' success beyond the formal learning environment of orientation.

Chapter 7
Temporary Employees and Students

New to this edition, Chapter 7 focuses on how educators and preceptors can facilitate successful learning experiences for travelers, float staff, and students. While many teaching strategies from other chapters apply to temporary employees and students, some of the regulatory, documentation, and organizational culture specifics are unique. This chapter provides tips and strategies focused on these nuances.

Chapter 8
Regulatory Considerations

We would be remiss if we didn't include information for you about accrediting bodies, federal regulations, etc. This chapter highlights the importance of working with your Human Resource professionals as well as key pieces of legislation that may impact you and your orientees. We also discuss the importance of documentation and talk about when, where, and how long to make it and keep it.

Chapter 9
Practical Tips for Staying Organized

Juggling orientees, paperwork, and schedules can be overwhelming. In our final chapter, we provide easy-to-implement ideas for keeping your electronic and paper files organized. We also discuss ways to use email and calendar software to keep the schedule from getting the best of you.

We have also provided an appendix that lists some of our favorite books, websites, literature, etc. regarding onboarding and orientation. We hope that you find the book helpful, enlightening, and perhaps even a bit humorous from time to time.

As you can see from what we plan on covering in each chapter, we aim to provide a well-rounded approach to creating and sustaining high-quality orientation and onboarding programs that meet the needs of the individual, organization, and the patients they serve. By providing you with a combination of practical advice and theoretically sound recommendations, we intend for you to have everything you need at your fingertips to ensure a successful orientation and onboarding program.

Whether you're new to leading orientation efforts or a seasoned nursing staff development specialist, we think you will find this book a great addition to your personal library. Once you've finished reading it, we hope you'll have new perspectives, found a greater insight, or at least gained a few nuggets of how to do some things better. Regardless of what you discover along the way, we hope you enjoy the journey through these pages as much as we enjoy sharing them with you!

CHAPTER 6

Evaluating an Orientation Program

Introduction

Orientation programs, regardless of their design or structure, should be evaluated for their efficacy. Just as the nursing process and ADDIE model complete their cycles with Evaluation, so too, do all successful programs. By evaluating your orientation program from various perspectives and levels, you ensure an effective, efficient orientation program that adds value to the individual, the unit/department, and the organization—a win-win-win situation.

Evaluating an orientation program should provide you with useful information that will do one of two things:

1. Describe areas of the program that need to be modified because they are not as effective or efficient as they could be
2. Supply evidence that the program is in fact doing what it's supposed to do

Although this may sound simple and self-evident, consider the following two examples in which having documented, objective evaluation data proved useful.

REAL-WORLD EXAMPLE: THE NEED FOR EVALUATION #1

Dan was the staff development specialist in charge of the first week of nursing orientation for all new hires entering his organization. When he assumed this role, he discovered that evaluation of this first week of training was performed by a simple survey on the last day of the week which asked these new hires if they liked the content they learned. Although Dan knew this was a good start, he felt more should be done to evaluate his program. So, he developed a survey for preceptors to complete within the first 2 weeks a new hire spent on the unit taking care of patients. This survey evaluated basic skills observed by the preceptor.

Dan quickly discovered that documentation in the electronic medical record was a problem among new hires in most departments. Therefore, he modified the training day on documentation to include more case-based and simulation scenarios. Post-intervention data revealed improved documentation performance, and anecdotal feedback came to him from unit-based educators who said the new hires' ability to document efficiently had drastically increased preceptor satisfaction and allowed them to cover more advanced skills much earlier.

This example shows how including various levels of evaluation provides for a more well-rounded assessment of program efficacy and highlights potential opportunities for improvement.

REAL-WORLD EXAMPLE: THE NEED FOR EVALUATION #2

Marie, a unit-based educator, was invited to attend a meeting with other unit-based educators as well as several senior-level managers who had a strong influence on training and development in the organization. Due to economic hardships, the managers informed the educators that various "non-essential" components of initial orientation would be removed. Notably, an 8-hour class on medication safety was being removed from central orientation based on the rationale that licensed healthcare providers should already be familiar with this information, and preceptors should be reinforcing it at the unit level.

Although Marie had a "gut feeling" that this class should not be removed (and she knew that her own new hires found this class beneficial), she knew she would need more objective data to prevent the removal of the class. After the meeting, Marie gathered already-available data on rates of serious adverse drug events, starting with data collected approximately 2 years before the medication safety class was added to central orientation. Marie shared the data with managers and showed them how implementation of this class resulted *in a 50% decrease of serious adverse drug events and saved the organization more money than what was spent on salary for attending the class. The managers decided to keep this class in orientation.*

This example shows the value of collecting objective evaluation data for the purpose of maintaining orientation components that have proven value.

Alvin's experience in teaching project-management strategies to nurses has revealed that objectively evaluating a project or program does not come naturally for many nurses. Evaluation of a program (or even a change in a program) should stem from the assessment data that warranted its presence. Unfortunately, many nurses settle for a level of evaluation as simple as satisfaction with the program, even though the program was created due to a problem noted with patient care. These various levels of evaluation will be discussed throughout the chapter, but first we want to provide you with an example that will hopefully hit home.

We want to share this example as a way of showing the parallels between evaluating an orientation program and a patient's pain.

EVALUATING A PROGRAM IS LIKE EVALUATING A PATIENT'S PAIN

Consider the case of a 35-year-old patient with multiple rib fractures due to a motor vehicle accident. The patient is in pain because of the presence of a chest tube as well as movement of his ribs while breathing. He rates his pain as an 8 out of 10 on the numeric rating scale, and you (as the nurse) provide him with a standard, adult dose of intravenous morphine. Which of the following sets of questions would be most valuable for evaluating the effectiveness of the pain medication after administration?

QUESTION SET A	QUESTION SET B
On a scale of 0–10, how satisfied are you with my ability to administer a pain medication?	On a scale of 0–10, how would you rate your pain now?
Do you think your pain level has changed as a result of the administering of this medication?	Is the pain level you're experiencing now manageable?
Would you recommend this pain medication to other patients?	Do you need additional help in managing your pain?

Obviously, Question Set B is the appropriate response.

Nurses are phenomenal at assessing and reassessing pain, and they are focused on one major goal—keeping the patient as comfortable as possible. As the patient's pain increases, an intervention is carried out, and the nurse reassesses to ensure the pain has decreased. Similarly, if there is a performance issue in the organization, and a new component were added in orientation to address this performance issue, the best evaluation would involve assessing the continued presence of the performance issue (not whether new hires enjoyed the training or scored better on a test).

We're not trying to minimize the importance of evaluating satisfaction with an orientation program; however, we want you to realize that evaluating an orientation program should not stop at this first level. Appropriate evaluation will relate back to the assessment data that initially suggested the need for the intervention's creation. We hope you'll keep this in mind as you read this chapter.

Levels and Types of Evaluation

Several models are used in business and education for evaluating the efficacy of a program or project, but Kirkpatrick's Four Levels of Evaluation is probably the most notable and the one from which many other evaluation models originate.

Kirkpatrick's Four Levels of Evaluation

The reason for widespread use of Kirkpatrick's model is primarily due to the simplicity and practicality of his approach (Kirkpatrick, 1996). His four levels are: reaction, learning, behavior, and results. Pros and cons of each level are listed in Table 6.1, and you can see examples of how to apply each of these levels to actual programs in Table 6.2.

Reaction

The first level, reaction, deals with the learners' reaction to the training program (what their experience was like during the activity). Assessment of this level could include any aspect of the program from speaker, to content and environment, to delivery style. This level of evaluation provides insight into learner satisfaction. Many training and development professionals refer to this level of evaluation as "smiley sheets." As many of you are probably aware, if content isn't delivered in a way that makes it interesting to the learner, there is little chance that the learner will put forth any effort to absorb the information (Kirkpatrick, 1996).

The reaction level is commonly evaluated in training programs due to its ease of measurement and the ability to make quick changes based on feedback. It should be measured relatively soon after a program is delivered because participants may quickly forget things like how conducive the room was to learning.

Learning

The next level, learning, assesses how well knowledge is transferred to the learner. This could include learning in any of the cognitive, psychomotor, and even affective (attitude) domains (Kirkpatrick, 1996). While the first level asks participants for their perspective of the program, learning will be a more objective assessment that is typically measured through written tests and/or observation.

This level of evaluation is slightly more complex than the reaction level of evaluation, but it is still fairly simple to design and quite common in training programs. For example, anyone who has participated in a continuing education program online and taken a test at the end regarding the content has had their learning assessed. The best way to measure learning would be to provide pre- and post-program tests and calculate the difference between the two scores. Also, it is possible to assess learning through simulations and/or case studies.

Behavior

At this third level, evaluation begins to become much more difficult. Evaluating the level of behavior involves what Kirkpatrick (1996) refers to as transfer of training. To assess this level of evaluation, you must observe behavioral changes in the learner in their actual job setting. A challenge with this level is that you do not have control of what the learner encounters in the real-world setting.

For example, if you delivered a program on pressure ulcer reduction, you might want to observe whether or not nurses are turning patients at the appropriate frequency, as well as if they are properly using pressure-relieving equipment. If they are not, then you might want to see what is preventing them from following what they know to be the correct procedure and frequency. Are there environmental factors that prohibit them from doing it at the right frequency? Are there issues with the equipment they are using? Or are they simply not following the procedure they learned in the program?

NOTE

Robin had an interesting experience rolling out a project-management training program at a previous employer. People were given pre- and post-tests and showed a great deal of skill improvement. Robin wanted to see how they were applying those skills on the job and conducted a qualitative (anecdotal) survey. She asked one project manager how his leader liked the weekly reports recommended in the training program. He responded, "The first time I sent a report to my manager, he told me that he never wanted to see one of them again. So, I stopped sending them." We hope that this is not happening in clinical settings, but the example does allow you to see how environment and leaders can wreak havoc on the great training you have delivered!

Results

The final level, results, may be the only level in which senior-level leaders are interested. Although this is definitely important, Kirkpatrick (1996) warns against *only* evaluating this level, stating that as many levels as possible should be evaluated because each provides a different perspective into a training program. When evaluating results, you are looking for the final products of a training program. These could include, but are not limited to:

- Improved quality of care
- Reduction in costs
- Increased job satisfaction (and more importantly, reduced staff turnover)
- Any metrics/indicators the organization reports to external agencies (e.g., pressure ulcers or fall rates)

TABLE 6.1 Comparison of Kirkpatrick's Four Levels of Evaluation

	PROS	CONS
Reaction	Easy to measure Easy to make quick changes Assists in determining learner satisfaction and motivation	Does not provide an objective assessment of knowledge transfer
Learning	Relatively simple to create the instrument Quick and easy to gather data Provides an objective assessment of knowledge transfer	Does not ensure knowledge is transferred to on-the-job behavior
Behavior	Higher level of evaluation that assesses application/use of training concepts Potentially serves as an opportunity for the observer to correct behaviors in real time	Resource-consuming (time spent observing behavior) Does not ensure the program will have an impact on desired outcome (e.g., patient care or cost savings)
Results	Likely to be of greatest interest to senior-level leaders who manage the budget and other resources	Complex Resource-consuming (both time and money)

TABLE 6.2 Examples of Using Kirkpatrick's Four Levels of Evaluation

Scenario: Imagine you are given the task of assessing the effectiveness of an entire orientation program for new graduate nurses in an adult medical-surgical unit. The following questions are possible measurements that could be used to assess the various levels of evaluation.

Reaction	According to a Likert scale (e.g., on a scale of 1–5 [from Strongly Disagree to Strongly Agree]) survey, did the orientees like the orientation program? Based on anecdotal feedback from orientees, what could be changed about the orientation program to make it better?

Continues

TABLE 6.2 Examples of Using Kirkpatrick's Four Levels of Evaluation

Scenario: Imagine you are given the task of assessing the effectiveness of an entire orientation program for new graduate nurses in an adult medical-surgical unit. The following questions are possible measurements that could be used to assess the various levels of evaluation.

Learning	What was the measurable difference between pre-orientation and post-orientation tests used to assess cognitive knowledge in caring for adult patients with general medical and surgical problems? In a *simulated setting*, can nurses who have recently completed the orientation program perform the skills required in that unit?
Behavior	In the *actual unit*, can nurses who have recently completed the orientation program perform the skills required in that unit? What progress do preceptors, educators, and/or peers observe in the orientees with respect to clinical skills, decision-making, delegation, etc.?
Results	Did the reduction in orientation length yield the same degree of competency as nurses who completed a longer orientation? Do patients report a comparable degree of care received between nurses who recently completed orientation and those who have been working on the unit for an extended period of time?

You may note that many of the examples we used to describe Kirkpatrick's model involved assessing an orientation program rather than an individual's competency. Unfortunately, there is no single model that is widely accepted as the foundation of assessing a nurse's competency (that is, when they have successfully completed orientation). Some of the outcome measures of an orientation program's efficacy may involve nursing behaviors (for example, Kirkpatrick's learning and behavior levels can provide evaluation of an individual's performance). However, a holistic evaluation of an orientee is different from that of the organization, and the former is covered in Chapter 4.

Other Evaluation Models

Additional models (or methods) for evaluation include RSA, CIPP, ROI, and CBR. It may also be appropriate to choose a QI approach. (And you thought you had been in healthcare long enough to know all the abbreviations out there!) Let's briefly explore these.

RSA (Roberta S. Abruzzese)

The RSA model gets its name from the originator of the model, Roberta S. Abruzzese (1992). Her model is described in Table 6.3. It looks pretty similar to Kirkpatrick's model, right?

TABLE 6.3 RSA Model Overview

	DESCRIPTION	EXAMPLES
Process	Known as the "happiness index," this level measures learner satisfaction	Surveys Facilitated Group Discussions
Content	Measures the degree to which knowledge, skills, or attitudes were acquired or changed	Pre-Test/Post-Test Self-Assessments Simulations Case Studies
Outcome	Measures behavioral or performance change after returning to the clinical environment (typically assessed several months after the program)	Self-Assessments Direct Observation
Impact	Measures organizational results	Retention/Turnover Rates Quality Indicators Cost-Benefit Ratios
Total Program	Includes all other components (process, content, outcome, and impact) for a "big picture" view	Annual Reports

Source: Abruzzese (1992)

ROI (Return on Investment) and CBR (Cost-Benefit Ratio)

Determining an ROI or CBR allows you to place dollar signs into your evaluation data, which may speak with greater influence than other evaluation methods (depending on your audience). Both calculations provide similar data, but their formulas are slightly different:

$$\text{ROI (\%)} = (\text{Benefits} - \text{Costs}) / \text{Costs} \times 100$$

$$\text{CBR} = (\text{Program Benefits}) / (\text{Program Costs})$$

The goal result in these calculations would be to obtain a number greater than or equal to 100% (for an ROI) or 1 (for a CBR). That would indicate the benefits (return) are greater than the costs (investments). Unfortunately, determining these values may be costly (pun intended). Consider the following two examples…

REAL-WORLD EXAMPLE: USING ROI/CBR IN YOUR EVALUATIONS, EASY EXAMPLE

Beth is a unit-based educator who would like to implement a preceptor training and development program because she believes it will enhance the orientation experience for both preceptors and orientees. She would like to provide a 4-hour class to 10 of her preceptors (who make $25/hour). Additionally, it will cost Beth about $500 in preparing content and developing learning materials. This means the cost of the program is $1,500 for both the preceptors' salaries along with the program development.

If she has a hunch that this could decrease the length of orientation (because the preceptors have gained additional skills), Beth could measure this impact in terms of salary. Let's say each preceptor oriented two nurses during the year, and these orientees had a shorter orientation than the previous year (by an average of two shifts, or 16 hours). If these orientees made $20/hour, that would mean they saved $6,400. Beth could display her results as follows:

ROI = ($6,400 – $1,500) / $1,500 x 100 = 327%

CBR = $6,400 / $1,500 = 4.3

Either way, it is obvious the benefits (return) were well worth the costs (investment).

I call that an easy example because the number of factors to consider for calculation are few. Consider this example that falls on the other end of the spectrum…

REAL-WORLD EXAMPLE: USING ROI/CBR IN YOUR EVALUATIONS, DIFFICULT EXAMPLE

Dena is unit-based educator who is frustrated with the difficulty orientees experience in constructing complex intravenous line set ups in an intensive care unit. She would like to standardize the process among all of the units and create charts and figures the orientees could use as a reference (rather than learning and re-learning various approaches from different preceptors—a time-consuming endeavor).

To determine an ROI or CBR, Dena will need to consider, at minimum, the following factors in her calculations:

Cost/Investment—Dena's time (salary) spent in meetings with other units and stakeholders, chart/figure development, simulation supplies for teaching the new setup, etc.

Benefit/Return—Decreased time in training, decreased amount of wasted supplies, decreased cost of line infections (if any), etc.

Do you see the difficulty in collecting data in the latter example? Not only is there a large number of variables to measure, but assigning a dollar amount to some of the items (in this case, developing charts/figures or wasted supplies) can also be extremely challenging. Unfortunately, it may not be practical to use this type of evaluation for this particular project. Dena may have to settle for objective data only at the satisfaction level in this case.

QI (Quality Improvement)

QI has recently become a buzzword in many organizations as it allows clinicians who have relatively little experience in research to implement change projects rapidly, while ensuring valid statistical analysis of changes in outcome measures. Nursing professional development specialists could consider the use of these methods for evaluating the statistical significance of changes in metrics that are both objective and quantifiable in nature. There are several variations in methodological approaches (e.g., Six Sigma or Lean). Unfortunately, the process for engaging in rigorous QI projects is a bit more complex than we can place in one chapter. If you want more information on these methodologies, we invite you to contact your organization's quality improvement staff or check some of the reliable Internet sites we provide in the nearby sidebar.

KEY QI METHODS

The following are some of the key QI approaches you could choose to implement and where you can go to find more about them:

- *The Institute for Healthcare Improvement is a great resource dedicated to many facets of process and quality improvement within healthcare (http://www.ihi.org/)*
- *Six Sigma focuses on developing highly efficient, standardized processes (http://www.6sigma.us/)*
- *Lean is similar to Six Sigma but focuses more on reducing and eliminating waste (http://www.lean.org/)*

Summary of Models

It doesn't really matter which evaluation model or method you use as long as you use one that provides a systematic approach to evaluating program efficacy. They are all valid approaches, so you should pick one that makes sense to you, that you enjoy using, and that is practical given the resources you have at your disposal.

Additionally, you don't necessarily need to use every level of evaluation in every program. As you have hopefully seen in these examples, different levels are more appropriate in different situations, and some levels aren't even feasible in some cases. The goal is to have the greatest number of evaluation levels and/or the levels that demonstrate the greatest impact on patient care, but time and other resources will likely limit the degree to which this can be accomplished.

Evaluating an Organization's Orientation Program

Because we have already listed several examples of applying Kirkpatrick's model to an orientation program, let's now look at the big-picture, organizational view of evaluating an orientation program. As you know, hospitals, clinics, and other organizations come in various shapes and sizes with different infrastructures for a nursing professional development (or nursing education) department. Some organizations have adopted an entirely centralized department, some are completely decentralized, and some have eclectic combinations of the two. Smaller organizations may not even have a dedicated education department, but rather the nurse manager or director is responsible for staff development.

Regardless of the structure in your organization, the following methods and ideas can be modified to meet your needs. Also keep in mind that no one, single path should be considered the "right" way of doing orientation, and the most important consideration in evaluating an orientation program is answering the question: "Does the orientation program meet the needs of the organization while supporting its mission, vision, and values?"

Because we can't directly answer that important question for you, we want to provide you with additional questions that could help you answer that foundational one. Use Worksheet 6.1 to help you evaluate your organization's orientation program through a "define and discover" approach.

WORKSHEET 6.1 Evaluating an Organization's Orientation Program

DEFINE ("What is/are…")	DISCOVER ("How is your orientation program…")
…the organization's mission?	…contributing toward the organization achieving its mission?
…the organization's vision?	…helping the organization move toward its vision?
…the organization's values?	…assisting new employees in learning, incorporating, and supporting the values of the organization?
…the organization's greatest needs at this time (e.g., recent sentinel events, poor quality indicators, recommendations from an accrediting body survey, cost reduction, etc.)?	…addressing those needs?
…the principals (key stakeholders) in the organization, and what do they want out of the orientation program?	…meeting their goals and desires?
…other important factors to consider from your Assessment/Analysis performed in Chapter 2?	…meeting the needs identified in the Assessment/Analysis stage?
Final Question: Are there any other components currently included in your orientation program that are not listed elsewhere?	**Final Question:** If so, are they still needed, or should you consider removing them?

As you complete Worksheet 6.1, try to think of the outcome measures that will provide the highest level of objective evaluation while also being feasible. Doing this will help you stay on track to provide the principals (stakeholders) with evidence for changing or maintaining an orientation's activities. (It will also help you in preparing for a presentation or writing a publication when you discover a best practice worth sharing with others in the profession!)

Evaluating a Unit/Department's Orientation Program

Many of the concepts mentioned in evaluating an organization's orientation program also will be applicable to a unit/department's orientation program. However, the principals at this level may be different, so desired outcome measures may vary. For example, principals at the organizational level may include senior-level managers, while principals at the unit/departmental level may include preceptors and even patients.

Therefore, the "define and discover" approach used at this level will be very similar to the one used at the organizational level. However, we thought it was worth placing the worksheet here again with modifications already made to make it easier (and quicker!) to use—that's Worksheet 6.2.

WORKSHEET 6.2 Evaluating a Unit/Department's Orientation Program

DEFINE ("What is/are…")	DISCOVER ("How is your orientation program…")
…the unit/department's mission?	…contributing toward the unit/department achieving its mission?
…the unit/department's vision?	…helping the unit/department move toward its vision?
…the unit/department's values?	…assisting new employees in learning, incorporating, and supporting the values of the unit/department?
…the expected behaviors (i.e., competencies) of other staff in the unit/department?	…helping new hires learn those expectations and practice them consistently?
…the unit/department's greatest needs at this time (e.g., recent sentinel events, poor quality indicators, recommendations from an accrediting body survey, cost reduction, etc.)?	…addressing those needs?
…the principals (key stakeholders) in the unit/department, and what do they want out of the orientation program?	…meeting their goals/desires?
…other important factors to consider from your Assessment/Analysis as discussed in Chapter 2?	…meeting the needs identified in the Assessment/Analysis stage?

WORKSHEET 6.2 Evaluating a Unit/Department's Orientation Program

DEFINE ("What is/are…")	DISCOVER ("How is your orientation program…")
Final Question:	**Final Question:**
Are there any other components currently included in your orientation program that are not listed elsewhere?	If so, are they still needed, or should you consider removing them?

Evaluating an Individual's Orientation

Many evaluation strategies apply to an individual's orientation, too. The biggest difference will be that the behavior/outcome level (how they are performing in the clinical setting) is probably always being evaluated by a peer, preceptor, or educator and will determine *when* they are done with orientation (if you use a competency-based orientation program). This component is discussed more thoroughly in Chapter 4.

Additionally, unlike many programs in which evaluation is performed at the completion of the program, evaluating an individual's orientation experience will occur both during the process and at its completion.

You want to evaluate an individual's orientation experience for several reasons:

- Individuals may provide more insight into opportunities for improving an orientation program than aggregated survey data.
- Feedback can be acquired on preceptor performance.
- An individual's experiences during orientation will set the stage for his/her attitude toward his/her work environment, and you have the opportunity to check for any negative attitudes that may have surfaced.
- Evaluating an individual's experience (and making modifications, if required) demonstrates to the employee that you care about him/her as a person.

Following a similar format to the models discussed previously in this chapter, Table 6.4 is a guide to help evaluate an individual's orientation program and experience.

TABLE 6.4 Evaluating an Individual's Orientation

COMPONENT	EVALUATION ACTIVITIES
Satisfaction/Reaction/Process	Ask: How was your orientation experience? What did you like or dislike about it? Do: Post-Evaluation Survey with Likert scales as well as open-ended questions
Learning/Content	Ask: What was the best thing you learned in orientation? What were the easiest/hardest things to learn? What are your current strengths and areas for improvement? Do: Multiple-Choice Exam(s) assessing basic competencies, Acquire Preceptor Feedback
Behavior/Outcome	Ask: Do you see yourself performing patient care in a safe manner? What are your current strengths and areas for improvement? Do: Chart Audits, Direct Observation, Acquire Preceptor Feedback
Results/Impact	Not Applicable

**Note:* These questions do not necessarily need to be asked in the past tense. You could (and should) modify these to ask them in present tense while the orientee is currently in orientation, too.

Tools/Handouts

Worksheet 6.3 can be used to help you evaluate your own program. It combines features of several models discussed in this chapter.

WORKSHEET 6.3 Questions to Guide Program Evaluation

COMPONENT	QUESTION TO ASK
Satisfaction/Reaction/Process	How will you measure learner satisfaction? *(surveys, Likert scales, open-ended responses, in-person or group interviews, immediately following program vs. delayed, etc.)*
Learning/Content	How will you measure the degree to which knowledge, skills, or attitudes were acquired or changed? *(pre-test and post-test exams, case studies, self-report, etc.)*

WORKSHEET 6.3 Questions to Guide Program Evaluation

COMPONENT	QUESTION TO ASK
Behavior/Outcome	How will you measure performance while in the clinical setting? *(direct observation, self-report, peer assessment, chart audits, etc.)*
Results/Impact	How will you measure the unit/organizational impact? *(cost [ROI/CBR], patient care [quality indicators or dashboards], etc.)*
Already Measuring	Are there any measures currently being assessed in the organization that could relate to your program? *(quality indicators, length of orientation, etc.)*
Who/When	Who is going to collect the data you would like measured, and when are they going to do it?
Other	What other components should be considered in evaluating this program?

Looking Beyond Orientation: A Note on Mentoring

Hopefully, this discussion on evaluating your orientation and onboarding programs has caused you to reflect a bit on the huge role your program plays in employees' success in the organization. This is a good time to begin thinking *beyond* the orientation experience and consider your role in the orientee's (and preceptor's!) transition out of those roles. Mentoring plays a significant role in this transition, and although an in-depth review of mentoring is beyond the scope of this book (and available from many other sources), we want to provide a few thoughts on the topic.

As a lead preceptor, Amy has a solid understanding of the difference between a preceptor and a mentor. "Just because a preceptor is a good teacher does not make them a good mentor and vice versa. Mentoring is more of a nurturing, emotionally comforting, mothering role than precepting is. Precepting is the building of knowledge and mentoring is the building of a support system."

“Mentoring is taking the relationship away from intense teacher to a concerned, interested, and nurturing coworker. Mentoring is interested in the coping, integrating, and building of new staff in their first year of employment. Mentoring allows for a more fluid conversation about how to tackle problems or navigate a unit’s culture.

“For instance, my last mentee asked about the least costly way to utilize aspects of our health insurance. This isn’t the common nursing knowledge that one would share when precepting but an important piece of information to that new employee seeking to make the best of their working environment.”

Amy also encourages us to think back to when we started our careers with our current facility. By the 3-to 6-month mark, most employees are ready to dig deeper into what their employer has to offer in the way of climbing the ladder. They want to know: Who do you call to get your flu shot record? How does our yearly evaluation process work? Is there shared governance here? How does one navigate this medical insurance? Do the parking rules apply on weekends?

There is so much to a unit culture that is impossible to learn in just 6 to 12 short weeks. We know that information overload is not truly effective learning. Shoving information out into the room doesn’t mean it is well absorbed to be utilized by new employees. There is a quote from Sydney J. Harris (an American journalist) about communication versus information that we would like to share with you. “The two words ‘information’ and ‘communication’ are often used interchangeably, but they signify quite different things. Information is giving out; communication is getting through.”

Mentoring allows time for absorption. It allows the employee the time to get used to working for a facility and the typical care routines so they can start making connections, looking past the “how to do” and asking more in-depth questions.

Amy notes, “Mentoring is also about relating to both the needs of the mentor and the mentee. It takes away from the view of a teacher teaching ‘at’ you to a friend who has coffee ‘with’ you and with whom you can share your successes and concerns. The mentor and mentee relationship can actually be a wonderful two-way street. Mentors can take away just as much as the mentee can in personal or professional growth. Precepting is very one-sided in the learning and intensity within a defined set of time. Mentoring, if done in a way that addresses both needs of mentor and mentee, can last for an indefinite amount of time."

Amy and a search of best mentoring practices suggest that your mentor programs should consist of basic requirements such as goals for time together, mutual desire to build a relationship (for instance, both mentor and mentee should want to share with one another), and specified time limits for professional mentoring.

Basic requirements must be set to help the mentor know what your organization's goals are for mentoring. Basic requirements such as time frames, how often they should meet, and any monetary payment related to the mentor should be covered in an introductory session for potential mentors.

Goals for time together must have specific end dates. Beyond the goal of helping support nurses through their first year, mentees need focused attention to their goals for long-term professional development, and a senior nurse mentor can help with specific attainable goals.

We encourage you, as a staff educator (or other leader) involved in orientation, to think about the role you might play in helping build a mentoring program. Mentoring programs are natural extensions of orientation programs, and the mentor-protégé relationship could even start at the beginning of orientation!

Conclusion

Using a systematic evaluation approach, regardless of what specific model you use, will keep you on track and prevent overlooking an important component of the program. Structured evaluation, especially at higher and/or multiple levels, also demonstrates to others that you have a solid orientation program that wasn't created on a whim.

On a final note, in any organization, there will always be changes in leadership structure and/or new personnel in various decision-making positions. Keeping records of evaluation data will help in telling the story of how programs came to be what they are and prevent new people from "learning the hard way" when they want to try something new. Don't let all your hard work go to waste; keep records (at least summaries) of the evaluations you perform.

Questions for Reflection/Discussion

1. What processes do you currently have in place for evaluating your orientation program?
2. Do you feel your current orientation program meets the needs of your unit/department or organization?
3. Could you use additional models or levels of evaluation to more fully demonstrate the efficacy of your orientation program?
4. How do you see the use of multiple evaluation methods assisting you in building a case for additional orientation resources?
5. What processes do you currently have in place for evaluating an individual's orientation experience, and what (if anything) could be done to enhance this evaluation?
6. How would you describe the current mentoring environment? What improvements could be made to promote healthy mentor-protégé relationships?

KEY TAKEAWAYS

- *Evaluating an organization's, unit's, and individual's onboarding program/experience is vitally important in the continued efficacy of the onboarding process.*
- *Perform evaluations regularly and as close as possible to the end of a program.*
- *Seek feedback from multiple sources.*
- *Multiple models can be used to evaluate an onboarding program, and while each one has its strengths and weaknesses, using a variety of models and levels will likely be the best approach.*
- *Onboarding doesn't have to end once a new employee finishes his/her time with a preceptor—mentoring can be a key element to facilitate a successful transition to independent practice.*

References

Abruzzese, R. S. (1992). *Nursing staff development: Strategies for success*. St. Louis, MO: Mosby.

Kirkpatrick, D. (1996). Great ideas revisited: Revisiting Kirkpatrick's four-level model. *Training and Development*, *50*(1), 54–59.

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