Transition Within a Graduate Nurse Residency Program

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Graduate nurses are a vulnerable population and they desperately need a supportive organizational culture during their transition to professional practice as well as leadership willing to invest in their future (Duchscher, 2009). Hospitals remain the primary employer of recently graduated nurses (83%); however, more than half of the nurses surveyed indicated that they had changed positions or planned to leave their current job within 3 years (U.S. Department of Health and Human Services, 2010). As the evidence of their effectiveness grows and national agencies such as the Institute of Medicine (2010) and the National Council of State Boards of Nursing (Spector & Echternacht, 2010) call attention to the needs of graduate nurses, educ-
cators and administrators alike feel a heightened sense of urgency to establish high-quality, yet cost-effective transition support programs within their organizations (Hansen, 2011). This article describes the development, implementation, and outcomes of an innovative graduate nurse residency program (NRP).

**BACKGROUND**

Situated in southwestern Ohio, Grandview Medical Center (GVMC) is a 411-bed facility with an urban population; its sister hospital, Southview Medical Center (SVMC) has 123 beds and serves a suburban population. In 1999, these osteopathic medicine teaching hospitals became affiliated with the faith-based Kettering Health Network (2011). GVMC and SVMC experienced overwhelming nurse vacancy rates in 2005. The graduate nurse turnover rate was 50% in the first year, matching national figures (Bowles & Candela, 2005). Graduate nurses who left the organization cited a poor work environment due to staffing, leadership issues, and a perceived lack of support.

Visionary leadership partnered with the Studer Group® and began the Baldridge excellence journey in an effort to change the organization’s culture. Starting in 2005 and lasting for 2 years, GVMC and SVMC served as Versant® RN Residency™ beta testing sites. The 12-month turnover rate decreased to approximately 20%; however, the program costs significantly increased and the recommended structure did not meet the organization’s needs. As a result, nursing leadership, in collaboration with the human resources and finance departments, decided to develop an organization-based program.

![Figure 1. Stages of transition theory.](Reprinted with permission from Duchscher, J. B. (2008). A process of becoming: The stages of new nursing graduate professional role transition. *The Journal of Continuing Education in Nursing*, 39(10), 441-450.)
The graduate NRP task force, comprising nurse executives, unit managers, and staff educators, analyzed the existing program and considered graduate nurse and preceptor feedback. Stakeholder involvement resulted in effectively addressing cost, retention, patient care, and orientation issues. Additional benefits included increased support for the program throughout the organization. The task force established a flexible 20-week graduate nurse internship with didactic and clinical components, but satisfaction with the program remained low. The graduate nurses noted that they felt “dropped off” at the end of the program, and the annual turnover rate rose to 30%. At the end of 2008, nursing leadership agreed to overhaul the existing program again.

In February 2009, the organization employed a full-time, master’s-prepared nurse educator situated within staff development to complete the program redesign with input from the task force. The NRP leader coordinated the graduate nurse orientation experience by collaborating with established division- and unit-based staff educators and participating in clinical rounds. She facilitated didactic instruction and recruited subject matter experts. The NRP leader was the chairperson for the curriculum and debriefing task force subcommittees; she participated in the facility’s preceptor and clinical practice committees. As the graduate nurse advocate, the NRP leader was available at all times by pager to provide psychosocial and transition support. This multifaceted role involved ongoing program development, implementation, and evaluation, along with networking with local nursing schools and selection of residency candidates.

**PROGRAM DEVELOPMENT**

On review of transition theories and current program structures, commonalities emerged. Theoretical input from nursing (Duchscher, 2008) (Fig. 1), along with occupational psychology (Williams, 1999) (Fig. 2) and transition management (Bridges, 2009), provided a greater understanding for the program redesign. A successful program would need to provide support tailored to the unique learning needs of the graduate nurse role transition stages: doing, being, and knowing (Duchscher, 2008). The authors considered the strengths and limitations of various existing programs and educational strategies (Altier & Krsek, 2006; Herdrich & Lindsay, 2006; Keller, Meekins, & Summers, 2006; NCSBN, 2009; Salt, Cummings, & Profetto-McGrath, 2008; Shermont & Krepcio, 2006) and determined that a comprehensive transition program needed precepted clinical experience, role socialization, and didactic sessions. Nurse leaders decided to proactively adopt the NCSBN-recommended structure (NCSBN, 2008), which involved an extended orientation with yearlong organizational support.

The curriculum was based on the developing a curriculum (DACUM) validation from the Versant® experience, Quality and Safety Education for Nurses (QSEN) recommendations (Cronenwett et al., 2007), analysis of
the hospitals’ patient population data, and input from the task force. Residency content presentation would occur throughout the year; class structure involved limited didactic content followed by application exercises, such as case studies and group discussions. Transition education was a curricular thread with a goal of “normalizing” the experience (Duchscher, 2008; Keller et al., 2006).

ANTICIPATED PROGRAM OUTCOMES

The aim of the phased NRP was to ensure excellent nursing care, based on the network’s sacred mission “to improve the quality of life in the communities it serves” (Kettering Health Network, 2011). The purpose of the phased program was to recruit and retain the nursing work force while promoting lifelong learning and commitment to both professional nursing and the organization. Anticipated program outcomes included successful transition to the professional role, socialization to the health care team, and safe delivery of care. Another goal was the development of clinical leadership skills (Nursing Executive Center, 2005).

Based on theory, research results, education best practices, and stakeholder input, a four-phase program structure emerged that was designed to address inherent transition and professional development needs (Fig. 3). The NRP leader focused on program implementation, including orientation and retention of graduate nurses. With executive sponsorship, leadership support, a cadre of trained preceptors, and a nurturing organizational culture, the phased program launched in April 2009.

PROGRAM IMPLEMENTATION

To qualify for the program, a candidate had to be a graduate registered nurse from an accredited nursing school with less than 6 months of acute care experience. Candidates interviewed with a nurse leader panel that included nurse managers with unit vacancies, the nursing school liaison, and the NRP leader. A peer interview process followed for top candidates. During the selection process, individual characteristics, such as academic performance, clinical experience, references, and area of interest, were strong considerations (Beecroft, Dorey, & Wenten, 2008). After achieving licensure, the graduate nurses attended the monthly orientation designated for program participants. In late January 2009, 17 residents who were hired under the previous model later became the phased program pilot group; all subsequent graduate nurses entered the

Figure 3. Phased graduate nurse residency program.
had completed their school preceptorship in an emergent course, Periop 101. All emergency department residents predominantly for critical care units (48%), followed by medical-surgical units (38%). Perioperative residents also participated in the Association of periOperative Registered Nurses (AORN) specialty preparation course, Periop 101. All emergency department residents had completed their school preceptorship in an emergency department or critical care unit before hire. Maternity residents had worked as obstetrical technicians on that unit.

PHASED APPROACH TO GRADUATE ROLE TRANSITION

Phase 1: Orientation

At GVMC and SVMC, experienced nurses attended a brief network patient care services overview, followed by a unit-based orientation that lasted approximately 4 to 6 weeks. A competency-based orientation evaluation substantiated clinical readiness for practice (Lenburg, 1999). Nurses completed online learning and specialty-specific classes throughout the first year. The NRP extended orientation was a mandatory “addendum” for all contracted graduate nurses. Residents received a badge pin indicating their program affiliation and graduate nurse status; attending class sessions facilitated group bonding and fostered organizational “belonging” beyond a unit- or division-based identity (Shermont & Krepecio, 2006).

During this role transition stage, the graduate nurse focuses on “doing,” or behaviorally adapting to the nursing role. At this stage, the primary interest is receiving the skills and knowledge to be successful at the most visible aspects of their practice, which is often misperceived as task orientation (Duchscher, 2008; Williams, 1999). Nursing orientation involved six division “tracks” (Fig. 3). The weekly graduate NRP class sessions provided clinically focused didactic content, such as respiratory management, central line care, care of dialysis patients, and laboratory practice with limited exposure skills, such as chest tubes, tracheostomy care, and blood administration. A couple of facilitated debriefing sessions helped to mitigate the initial transition shock (Duchscher, 2009).

Precepted time on the home unit provided the graduate nurses with experiential learning opportunities to increase their clinical reasoning, allowed socialization to the role and unit, and improved professional and clinical skills. Nurse managers selected the unit preceptors and ensured that they attended a 1-day training course through staff development. Preceptors usually had 2 or more years of experience, provided quality nursing care, and adhered to the organization’s standards of behavior.

Alternate unit experiences provided the residents with precepted exposure to affiliated unit workflow variations, enabled empathy for the patient’s experience, and fostered collaboration between units. One resident indicated that this learning opportunity in the emergency department was very important because “it is not always understood how the flow works and why it is so important to get the patient admitted ASAP.” Another resident who was going from an intensive care unit to a step-down unit noted, “It was nice to get a feel [for the unit] prior to being floated there one day.”

The length of the orientation phase varied based on individual needs, shift, and division track, but generally included 350 precepted hours during 12 to 20 weeks. The resident completed weekly reflections and received written evaluations from the preceptor; the NRP leader and nurse manager provided feedback as well. The nurse manager, NRP leader, preceptor, unit educator, and graduate nurse collectively determined practice readiness during an end-date huddle that served as a marker event to usher in the next role development phase (Bridges, 2009; Hansen, 2011), as well as a summative evaluation opportunity. After the graduate nurses completed the orientation phase and entered staffing, they were switched to the “home unit” cost center.

Phase 2: Transition

For the first time, the graduate nurse is “being” the nurse, trying to cognitively adapt to role expectations (Duchscher, 2008; Williams, 1999). Between the fourth and the ninth month of hire, the graduate nurse exists in a crisis state that often results in physical, emotional, and spiritual exhaustion as the nurse attempts to determine whether to “stay or go.” At approximately the sixth month, the graduate nurse often experiences a crisis of confidence or defining moment (Fig. 2). The authors often observed this event as a two-sided coin. For example, a resident’s first patient code might be the crisis. On reflection, these experiences can transform into role-defining moments as graduate nurses realize that they know what to do and whom to call.

Each month, the transition phase residents attended a required class encompassing a facilitated debriefing
session and didactic content. Topics included transition management, communication, delegation, and time management. Facility-specific training on materials distribution, pharmacy updates, and case management continued to provide more of the “big picture.” Each resident identified a staff nurse mentor for informal monthly meetings during this stage.

Nursing leadership agreed on a “protected status” for these residents. Nurse managers and house supervisors ensured that the residents would not float for at least 3 months after orientation. Overtime was strongly discouraged; for stress reduction, leadership expected the residents to take a vacation approximately 6 months after hire. Preferably, residents were not to precept new hires or to be in charge during the first year. Transition education for nurse leaders facilitated their ability to anticipate, recognize, and effectively support the critical turning point. The second phase ended on completion of the transition sessions at approximately the ninth month of hire.

Phase 3: Transformation

In the “knowing” phase, the graduate nurse usually begins to recover, experiencing renewed energy, enthusiasm, and comfort in the role (Duchscher, 2008; Williams, 1999). One resident wrote, “Knowing that I’m part of a team, and they’re there for me no matter what, gives me the courage to face any situation at hand.” The transformation monthly classes included a debriefing, additional role development, and leadership-oriented didactic content. Nurse leaders presented expectations for organizational and unit-level involvement, introduced the clinical ladder, and emphasized the importance of lifelong learning and professional contributions. The residents often began to seek out more recent graduates to mentor, which enabled employee engagement and leadership development opportunities. Completion of the mandatory phased program educational requirements in the first year opened the door to the voluntary fourth phase.

Phase 4: Exploration

During the second year of hire, the NRP provided quarterly meetings that included a debriefing and free continuing education classes. Participation in facility events and specialty-specific organizations encouraged employee engagement and satisfaction. Regarding facility committee involvement, a resident stated, “It helps you gain a more global view of what we do every day [and] gets you out of your unit bubble. [It] helps things make sense!” Nurse leaders led by example and championed these expectations. Completion of the second year signaled fulfillment of the contract requirements and officially marked the end of the residency experience.

PROGRAM EVALUATION

Program outcomes for a successful transition to professional practice, socialization to the role, and development of leadership skills were measured through stakeholder satisfaction, further evidenced by employee retention and engagement. Safe delivery of care evaluation involved quality measures; however, data were limited.

Stakeholder Satisfaction

The program’s stakeholders included the residents, patients, preceptors, and nurse leaders. During each phase, residents received an anonymous online survey to allow them to provide feedback on job and program satisfaction. Overall, resident satisfaction remained high (>94%) throughout implementation of the program. The extended clinical orientation, specialty education, and ongoing support were among the most highly rated factors.

Survey comments and personal anecdotes about feeling supported, understanding the nurse role, experiencing a heightened sense of clinical confidence and competence, and “fitting in” on the unit supported achievement of the program’s outcomes. Managers provided qualitative evidence of the organizational effect of the program through quality patient care experiences, increased unit committee involvement, and selection for leadership roles, such as charge nurse, preceptor, mentor, and unit educator. Within the 2009 cohort, continuing education contributed to an increase in baccalaureate-prepared nurses from 30% to 50% by 2011.

Nurse leader rounds and patient satisfaction surveys showed that residents frequently were described as providing “outstanding” patient care. Written comments included “best nurse during my stay,” “made me feel at home,” and “going above and beyond.” During the second implementation year, preceptors received an online survey to determine their support for the program. Monthly nursing leadership and clinical nurse manager meetings provided the NRP leader opportunities to present program updates and receive feedback. Each year, the nurse managers responded to a survey on the program’s effectiveness. Flexible structures, leadership support, and ongoing feedback and collaboration for process improvement enabled the NRP leader to make improvements to the program.

Organizational Retention

Organizational evaluation involved retention statistics and quality outcomes. Significant variation in gradu-
ate nurse program vernacular and outcome evaluation is found in the literature (Spector & Echternacht, 2010). The NRP task force defined retention as full- or part-time employment at either facility for the length of the 2-year program contract. Organizational policy did not allow transfers of new hires until 6 months of employment; within the program, transfer was discouraged during the first year. Rare exceptions occurred based on a collaborative decision that another unit might be a better “fit.”

Within the phased program, the first-year turnover rate averaged 5%. The second-year cohort turnover rate varied from zero to 9%. After completion of the 2-year contract, the facility turnover rate increased to 24%, with almost half remaining in the network (Fig. 4). The residents who left the organization took positions in non-acute care settings, such as hospice, extended care, and outpatient dialysis. Each year, a graduate nurse departed during the transition crisis window, despite support and early intervention.

**Patient Safety and Quality**

Work environment, academic preparation, and nursing experience affect patient outcomes; positive outcomes reflect excellent nursing care (Aiken, Clark, Sloane, Lake, & Cheney, 2008). Because of the existing reporting system, direct tracking and trending between specific resident practice and quality measures, such as medication errors, pressure sores, and failure to rescue, was not possible. Unit managers occasionally notified the NRP leader of near-miss and incident reports involving residents. Clinical rounding provided the greatest opportunity to receive accounts from residents and preceptors regarding medication errors, falls, and the use of rapid response teams. Nursing leadership used these reports for program and facility-specific quality improvements.

**CONSIDERATIONS**

Pre-existing conditions greatly facilitated the successful implementation of the phased program. Nursing leadership was already in agreement. Approximately 30% of the current preceptors emerged from previous residency designs. The existing NRP budget covered expenses incurred through the extended orientation as well as ongoing support. Collaboration among nurse leaders, preceptors, and residents was an established expectation. Professional and personal life experiences, combined with academic preparation, enabled the NRP leader to contribute to the program’s success. Regarding cost-effectiveness, replacing a nurse can cost up to 1.3 full-time equivalents (Jones, 2008). Leadership calculated the program cost for each graduate nurse, based on participant wages, instructor and program leader salaries, materials, and other associated expenses. Preceptors received no financial compensation and worked their regular schedules. Because of the decrease in graduate nurse turnover costs and the notable positive outcomes for both the participants and the organization over the implementation period, leadership determined that the program provided an excellent return on expectations (Hansen, 2011). Efficiency was achieved by remaining within the current orientation processes, using a designated coordinator, and capitalizing on existing resources.

The authors acknowledged that other factors, such as the program contract, the economy, and limited job opportunities for graduate nurses, may have contributed to high retention rates. However, high post-contract retention rates suggested that the contract was not the main factor. Although the economy and limited job opportunities are considerations, former and current residents actively recruited peers. Survey results identified the NRP, the opportunity to pursue an area of interest, positive coworker relationships, and a supportive work environment as primary retaining factors, reflective of the findings of Beecroft et al. (2008).

**CHALLENGES**

The recruitment and on-boarding process was lengthy, occasionally resulting in the loss of outstanding candidates who joined other organizations. Because all graduate nurses were required to participate, the program contract served as a deterrent for a small number of candidates. The human resources department offered an employee referral bonus that provided an additional
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1. Graduate nurses desperately need a supportive organizational culture during their transition to professional practice as well as leadership willing to invest in their future.

2. As the evidence regarding these programs' effectiveness grows, nurse leaders feel the pressure to establish high-quality, yet cost-effective, graduate nurse transition programs.

3. Residency programs should provide support tailored to the unique needs of each of the role transition stages of the newly graduated registered nurse.

4. Transition theory, research results, stakeholder input, and national agency recommendations are essential elements of graduate nurse residency program design.

Validated evaluation tools were not used during the initial implementation of the phased program. Reflections written by residents and feedback from preceptors were manually reviewed by the NRP leader. Program success was predominantly gauged by retention and stakeholder satisfaction; quality reporting systems were not conducive to isolating the effect of the resident program. Access to graduate nurse retention and satisfaction data before 2009 was limited, and variations in program structure made comparative outcome analysis difficult.

CONCLUSION

Both GVMC and SVMC transformed into competitive places of employment. The NRP, along with an opportunity to work within an area of interest, facilitated the recruitment and retention of exceptional graduate nurses. Stakeholder involvement increased support for the program across the organization. The success of the phased program occurred because of a hospital culture supportive of education, visionary leadership, and nurse advocates committed to a positive transition to practice experience.

REFERENCES


