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Nurse Residency Program: Best Practices for Optimizing Organizational Success

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Nurse Residency Program Best Practices

Nurse Residency Program: Best Practices for Optimizing Organizational Success

Almost40 years ago, Marlene Kramer's hallmark study (1974) of newly graduated nurses described the struggles that new nurses face and advanced the notion of the phenomenon of "reality shock" that puts new graduates in jeopardy for turnover. Reality shock continues to be a persistent occurrence; however, transition to practice or nurse residency programs (NRPs) are being implemented across the country in increasing numbers to address the difficulties that new graduates encounter as they enter the workplace. The burgeoning emergence of NRPs has been stimulated in part by the report published by the IOM (Institute of Medicine, 2010) that recommended implementation of residency programs following pre-licensure education. This same report advocated for the evaluation of NRPs' effectiveness, particularly their ability to enhance patient outcomes, nurse retention, and professional competency (pp. 11-12).

Evidence regarding the outcomes of residency programs is compelling and reveals that NRPs are associated with higher rates of new nurse retention, decreased nurse vacancy, cost-savings (Beecroft, Dorey, & Wenten, 2007; Halfer, 2007; Kowalski & Cross, 2010; Pine & Tart, 2007; Trepanier, Early, Ulrich, & Cherry, 2012; Williams, Goode, & Krsek, 2007), organizational commitment, improved patient safety, and decreased stress (Anderson & Linden, 2009; Bratt & Felzer, 2011, 2012; Goode, Lynn, Krsek, & Bednash, 2009; Fink, Krugman, Casey, & Goode, 2008; Romyn et al., 2009). Despite the growing body of research on residency program outcomes, best practices for implementation are still evolving. Therefore, this article presents best practice recommendations from the project team that created the Wisconsin Nurse Residency Program (WNRP) for a diverse group of healthcare organizations; the program was developed over seven years of implementation. Recommendations for NRP start up, planning, implementation, evaluation, and sustainability are outlined to guide organizations throughout all program phases from inception to measurement of outcomes. Furthermore, key findings and lessons learned by the project team will enable organizations, regardless of size, to be successful as they engage in the process of establishing a residency program.

Background

With the assistance of federal funding from the Health Resources and Services Administration (HRSA), the WNRP evolved from a partnership with an academic institution, six healthcare systems, five individual hospitals, and two rural hospital cooperatives, resulting in 13 geographically dispersed residency program sites. Participating hospitals were academic and regional medical centers located in large metropolitan cities, small to large independent community hospitals, and critical access hospitals in rural areas. The hospital-based nursing professional development educators from these diverse sites worked collaboratively across organizational boundaries to create a program structure that could be operationalized in each of their distinctive settings.

In 2005, the WNRP launched its first cohorts of nurse residents. The program was intended to augment existing newly licensed nurses' orientation programs in each participating hospital by offering an extensive two-phase transition to practice support system. The first phase (approximately 8-12 weeks) involved each hospital's standard new graduate orientation guided by preceptors that primarily focused on student to RN role transition, skill acquisition, and achievement of organization and unit-specific objectives. Phase two (approximately 12 months in length) followed completion of phase one and was comprised of education and psychosocial

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support provided by coaches/mentors with an emphasis on nursing role integration, formation of nurse residents' (NRs) professional identity, and advancement of their developmental plan. To this end, the WNRP provided preceptor training, monthly educational sessions to supplement ongoing clinical learning, and training of coaches/mentors (Bratt, 2009). Initially framed by the work of Kramer (1974) and Benner (1984), the overarching goals of the residency program were to ease newly licensed nurses' transition to practice and attain professional socialization outcomes, which included increased job satisfaction, decision-making, organizational retention, and competency to deliver care and to diminish stress (Bratt & Felzer, 2011, 2012).

Recommendation #1: Secure Stakeholder Buy-in at Program Inception

As the preliminary step, it is crucial to obtain program buy-in across organizational stakeholders including all levels of nursing leadership, nursing education/professional development, human resources, and staff nurses. A sense of mutual ownership of the NRP and dedication to its purpose and quality is requisite. To obtain widespread endorsement for the program, involve strategic administrators and educators throughout aspects of program development, implementation, and evaluation. Of particular importance is getting the front-line nurse managers committed from the onset to ensure that staff scheduling permits nurse residents (NRs) to take part in program components.

During program start-up, organizations that experienced the most difficulty were those that did not have full support of unit-level managers. One-on-one dialogue with these managers proved most effective in obtaining their cooperation. The organizations that hardwired the NRP, establishing it as the standard onboarding program for all newly graduated RNs, were most successful. In these organizations it was a clear expectation that the residency program was part of the professional developmental journey for new RNs and all associate and baccalaureate-prepared nurses were enrolled in the program upon hire.

Recommendation #2: Allocate Sufficient and Appropriate Resources Capitalizing on Partnerships

Instituting the appropriate organizational infrastructure for an NRP is essential. Begin this step by engaging in an assessment of organizational resources to determine program feasibility. Sufficient resource allocation, both financial and human, at the outset is a prerequisite to establishing the residency program foundation. Essential to this activity is the designation of a planning team and residency coordinator who have clearly defined roles with specific responsibilities and accountability for program deliverables. The residency coordinator should be a skilled and respected nursing professional development educator who is a strong advocate for advancing newly licensed nurses' professional transition. Most of the organizations adopted a model of a dedicated residency program coordinator that ranged from a 0.2 – 1.0 FTE, depending on the number of nurse residents in each cohort and number of cohorts offered per year. Adding the NRP coordination responsibility on top of the full-time responsibilities of nursing professional development educators created considerable workload challenges; for that reason, this practice should be avoided.

In organizations that had limited resources, such as rural hospitals, existing partnerships and informal networks were capitalized on to build an NRP site comprised of multiple hospitals. Alliances were also created with larger healthcare systems and hospitals within a regional area. The hospitals also collaborated with their academic affiliates to obtain access to learning technologies including simulation labs, equipment, and task trainers. However, for most of the program sites, rental of academic simulation labs was cost-prohibitive resulting in the purchase

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of a portable high-fidelity simulator that could be rotated among sites, which proved to be an effective alternative.

Academe and practice share the same goal of preparing nurses for their professional role. Just as practice partners are essential to assisting academe to prepare students for work entry, academic partners can be instrumental in assisting organizations to continue the professional socialization of new graduates post-hire. For this reason, invite a college/university faculty member to be on the program advisory board or the planning team. This individual can provide valuable insight regarding program design, curriculum construction, training of preceptors and educators, use of appropriate pedagogies, and program evaluation methods.

Leading the program was an academic partner who procured continuous external funding and provided extensive university resources over the seven-year WNRP project. Throughout the duration of the project, with academe and practice collaborating, all partners realized significant personal and organizational benefits. The success of this partnership resulted from the common desire to promote the professional socialization of new nurses and enable them to excel in the delivery of quality care (Bratt, 2009).

Recommendation #3: Build the Program Based on Best Evidence

Once the infrastructure is in place, the residency program model should be based on evidence from multiple sources including internal organizational perspectives, recommendations from national policymakers, and findings from existing programs as conveyed in the literature. To accomplish this, a thorough review of research studies, theories of professional socialization, and other reliable evidence should be carefully analyzed and used to shape decisions regarding NRP structure and outcomes. This appraisal of the literature should be an ongoing function of the program team to keep abreast of emerging knowledge, which will inform the process of continuous program improvements once the residency program has launched.

As a starting point, theories regarding professional role transition need to be examined. An understanding of new graduates' contextual experience throughout the first year of practice is necessary to formulate the conceptual basis of the residency program. For this activity, the seminal work of Kramer's Reality Shock (1974), Benner's Novice to Expert theory (1984) and Duchscher's Process of Becoming (2008) along with transition to practice models advanced by Schoessler and Waldo (2006) and Scott, Engelke, and Swanson (2008) provide noteworthy theoretical perspectives that can help formulate appropriate program elements. Originally, the team did not fully appreciate the importance of this knowledge base. Six to nine months into the launch of the first cohorts, NRs verbalized being overwhelmed, discouraged, and questioned their choice of nursing as a vocation. Initially, this was interpreted as NRs' dissatisfaction with the NRP and program failure, which was demoralizing for the team. However, after a re-examination of transition to practice theories, the team realized that the NRs' behaviors were demonstrative of the reality shock phase that they were experiencing.

Presently, the work being undertaken by the National Council of State Boards of Nursing (NCSBN) toward creating a standardized transition to practice (TTP) model implemented through regulation (NCSBN, 2009a; Spector & Li, 2007) is also valuable to examine. This conceptual model is undergoing multi-site testing to determine its influence on patient safety and quality outcomes. Additionally, the NCSBN Post-Entry Competence Study (2009b), which presents qualitative data regarding entry-level nurses' longitudinal professional development and methodological suggestions for transition to practice programs, is most informative.

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As part of the process to create the TTP model, the NCSBN (2009c) compiled an extensive evidence grid regarding residency programs, which can be used to familiarize the planning team with some of the existing findings regarding NRPs. This document describes national and international transition-to-practice projects and highlights associated research studies and best practices from these projects. Construction of an evidence table by the NRP planning team is an informative exercise and can be a valuable mechanism to build consensus related to residency program format and components.

In 2009 the American Association of Colleges of Nursing (AACN) Commission on Collegiate Nursing Education (CCNE) launched the accreditation of post-baccalaureate nurse residency programs based on identified standards (CCNE, 2008). These standards are extremely helpful and provide specific guidelines including faculty and organizational resources, designing curriculum, and ensuring quality through effective program evaluation, which can assist educators who are developing a residency program for baccalaureate-prepared nurses.

Since the original program creation almost a decade ago, the number of published articles about residency programs has expanded dramatically. A research study undertaken by Kramer and colleagues (Kramer et al., 2012; Kramer, Maguire, Halfer, Brewer, & Schmalenberg, 2013) provided one of the most recent critical appraisals of NRPs and identified strategic program features that best promote new nurses' professional transition. A significant finding from this study was that residency programs that were one year in length provided the best transition experience for newly graduated nurses. Evidence from established residency programs such as the University HealthSystem Consortium (UHC)/AACN Residency Program (Fink et al., 2008; Williams et al., 2007), Versant (Ulrich et al., 2010), and Wisconsin Nurse Residency Program (Bratt, 2009; Bratt, Baernholdt, & Pryzinski, 2012; Bratt & Felzer, 2011, 2012) should also be reviewed.

Additional sources of data can be generated from within the organization. Hosting internal focus groups with nurse managers, past new graduates, and preceptors can generate qualitative data regarding perceptions of new graduates' role transition and how to best support new nurses throughout transition. Involving these various groups also increases buy-in among those who will be directly interfacing with the program and can help it thrive.

Even in light of best evidence, there is no one program structure that fits every organization. The residency program was rolled out in a wide variety of hospitals in both urban and rural settings, which required some modifications in implementation. However, it was possible to retain consistent elements and overall delivery methods while still customizing the program according to each organization's structure, number and type of nurse residents, and available resources.

Since full program development takes time to evolve, begin the first cohort with a manageable number of NRs or a pilot group since it will allow processes to be established and implementation obstacles typically associated with program startups can be handled. Beginning with a large first cohort will only magnify any problems and may lead to program demise. Typically, after three successive cohorts, the program becomes well-tuned and entrenched within the culture of the organization.

Recommendation #4: Provide a Multi-staged Program Providing Long-term Support

Preceptors and Clinical Coaches

A residency program needs to be a staged and multi-faceted approach comprised of an educational and psychosocial support system that fosters the new graduate's professional

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socialization over 15-18 months. During the first stage, called "becoming," (Duchscher, 2008) or "transitioning," (Kramer et al., 2012), the new graduate is undergoing rapid skill acquisition and is guided to function in practice. Pairing NRs with effectively trained preceptors should be the initial facet of this staged approach. A multitude of studies (Baggot, Hensinger, Parry,Valdes, & Zaim, 2005; Baltimore, 2004; Casey, Fink, Krugman, & Propst, 2004; Paton, Thompson-Isherwood, & Thirsk, 2009) underscored the importance of preceptors for providing professional role models and building new graduates' clinical competence. Preceptorship programs also have importance since they have been linked to patient safety, quality, and improved patient outcomes (Latham, Hogan, & Ringl, 2008; Lee, Tzeng, Lin, & Yeh, 2009) and are critical to new graduates' success (Sandau & Halm, 2010).

In order for preceptors to be effective, they need sufficient education to enable them to fully enact their role (Park & Jones, 2010). Preceptors involved in the WNRP had access to a two-day face-to-face training workshop that provided them with practical skills to function as professional role models who guide the socialization process, facilitate learning, and evaluate the performance of new nurses. As an alternative modality, to increase accessibility to preceptor training, the team also created an online course comprised of eight self-paced modules. These modules were bundled separately allowing nursing professional development educators to tailor their use. Some hospitals required preceptors to complete all modules; others assigned specific modules based on preceptors' level of experience or used a blended approach with preceptors completing certain online modules as a preface to a face-to-face workshop. All these educational approaches used active learning strategies to allow preceptors to practice techniques learned during the training, which proved to be the most valuable feature of preceptor education.

The second stage of professional socialization is "professional integration," which involves new graduates assuming the roles and identity of a professional nurse (Kramer et al., 2012). Since this phase can last 12-18 months, coaches or mentors should be designated to continue the new graduate's socialization process (Boyer, 2008; Bratt, 2009; Latham et al., 2008; Thomka, 2007). Coaches and mentors function in an advisory role and are important to advancing the NRs' professional development and assimilation into the professional nursing role, which takes place over an extended time (Kramer et al., 2012). The team selected a coaching model to promote the goals of role integration, and coaches focused primarily on advancing the NRs' professional development plan (Bratt, 2009). This approach was most appropriate since coaches were assigned rather than selected by the NRs and the coach-NR relationship was time-limited, which is contrary to mentoring relationships (Thomka, 2007).

The roles, responsibilities, and competencies of preceptors and coaches/mentors need to be clearly defined. Once the role has been carefully articulated, care needs to be taken to actively recruit the best candidates and effectively train, reward, and sustain their engagement. In this program, coaches attended a one-day training session that taught coaching strategies to foster NRs' achievement of professional goals. Ways in which the organizations found to reward coaches were to provide financial incentives, a special pin, lab coat, gift certificates, or hosting a celebration in their honor. Engagement of WNRP preceptors and coaches was sustained through circulation of educational newsletters and regular meetings with the program coordinator.

Despite these efforts, maintaining the long-term commitment of coaches was one of the most problematic components of the WNRP. Participating organizations either integrated clinical coaches as an element of the professional nursing practice model or did not enact the role at all. In the hospitals that upheld the coaching role, the coaches provided powerful examples such as

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through their sustained guidance a "nurse resident was saved" and prevented from leaving the organization. Workloads, inability to schedule regular meetings with the assigned resident, and lack of commitment were the obstacles encountered by WNRP coaches.

Education Sessions

Continuing education during the transition and integration periods should be a component of a multi-staged NRP, since it serves to augment new nurses' successful movement toward professional role assumption. Regularly scheduled educational sessions, with a focus on addressing NRs' specific learning within the context of their expanding roles and responsibilities, are important. A pedagogical approach based on theories of learning from practice (Argyris & Schon, 1974; Boyd & Fales, 1983) and the action-reflection cycle advanced by Marks-Maran and Rose (1997) were effective since it helped NRs build understanding through reflection to derive meaning and arrive at solutions for the daily challenges they faced. A 6 to 8-hour session once per month delivered over one year was deemed to be the best format. However, when education budgets became tight, several organizations decreased these sessions to four hours.

Education session content was based on new graduates' identified knowledge gaps and underdeveloped skills, such as clinical judgment. Examples of session content included reviews of core clinical topics including management of hypoxia and alterations in blood pressure, which NRs found helpful since they commonly verbalized that nursing school "seemed like a blur." Additionally, sessions concentrated on helping NRs learn how to access resources, use clinical practice guidelines, become knowledge synthesizers, be empowered to recognize rapidly changing conditions to avoid failure to rescue, and know when and how to call physicians. Evidence-based practice, conflict resolution, quality and safety, communication skills, team work, and delegation were also included (Bratt, 2009).

Following a careful analysis of evaluation data from multiple education sessions, the team came to understand that it was not *what* was taught, but *how* it was taught that was most important. This analysis also resulted in redirecting priorities to role modeling and teaching NRs to think critically and act like professional nurses, which was an important cognitive shift for the team (Bratt, 2009). Nurse residents frequently verbalized that "we do not want to feel like we are in school." Keeping this in mind, strategies that were most effective included active learning techniques that engaged learners, avoidance of formal PowerPoint lectures, moving from teacher-driven to learner-driven models, organizing sessions around the NRs' personal learning needs, using methods that fostered clinical judgment and clinical reasoning, role plays, games, case studies, reflection on practice stories, and debriefing in small groups. Using a high fidelity simulator to increase NRs' competency to address emergent health problems, such as sepsis and acute heart failure, was also highly successful. Support for these methods has been advocated for by Benner and colleagues (2010), the Institute of Medicine (2009), and the NCSBN (2009a).

During these education sessions, NRs have to be motivated to learn. If they do not perceive the need to learn what is being taught or the relevancy to their practice area, they will be dispassionate learners. This can be challenging since cohorts can be comprised of NRs working in a variety of specialty units. To address this, at the conclusion of each session, the NRs' specific learning needs about the proposed topics for the next month were solicited and then incorporated into the next session agenda. Additionally, the curriculum addressed pervasive patient health problems, like pain management, which had wider application across specialty areas. Session speakers would then draw links between these global concepts and the NRs'

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experiences with specific patient populations, which enabled NRs to see the value of the content no matter what unit they worked on.

Education Session Speakers

Carefully select the speakers for these educational sessions. It is optimum to use existing in-house experts since it creates opportunities for these individuals to build their own teaching expertise and it introduces the NRs to the various specialists and resources that they can access. These individuals should be clinically-based, relative experts in the area, dynamic, and confident using a dialectical approach rather than a structured formal presentation. Consequently, speakers need clear guidelines about their role in these sessions and the desired learning goals. They also need training to use methods that actively engage the NRs and foster application of theory to practice. Unskilled educators and deployment of ineffective teaching strategies can result in learner dissatisfaction and poor program outcomes; therefore, investment in training is absolutely essential. As a result, WNRP session speakers were provided with a curriculum guide that outlined the learning objectives, topics to be covered, references, and suggested teaching methods. Speakers would use this guide to construct their individual presentation that could be tailored to their specific expertise and style. Session speakers were also supplied with a detailed manual that described the WNRP and successful teaching techniques including how to create an attention-grabbing presentation that engages learners in learning. Teaching effectiveness workshops were also developed to provide speakers with direct assistance in constructing and delivering their presentations.

For many hospital educators who served as faculty for the WNRP, this required a shift in teaching style, which was a significant divergence from the techniques they frequently used for competency-based training. For example, in a session that addressed cardiac arrest, educators needed to be dissuaded from simply explaining the equipment and drugs administered and demonstrating all the crucial resuscitation steps. Rather, educators were coached to also actively involve the NRs and facilitate dialogue about how to address other issues related to resuscitation such as team communication, family presence, and dealing with poor patient outcomes. To promote adoption of new teaching techniques speakers benefited from one-on-one coaching, attending teaching workshops, role modeling, and receiving feedback from the residency program coordinator.

Recommendation #5: Construct and Implement a Comprehensive Evaluation Plan and Measure Outcomes

Measuring the effectiveness of a NRP can generate valuable data relative to cost-benefits and provide impetus for continued backing by leadership and allocation of resources. Therefore, a clear program evaluation plan needs to be in place to provide tangible evidence related to achievement of program goals and outcomes and to compel ongoing program improvements. Again, involving stakeholders in the plan construction and connecting the evaluation component to other organizational outcome assessments is a worthwhile investment of time.

The evaluation plan needs to encompass not only program outcomes but also process and long-term impact on practice. A useful framework for this process is the Kirkpatrick four-step evaluation model (Kirkpatrick & Kirkpatrick, 2006). It includes learners' reaction or satisfaction with the program (reaction), what changed in the learner's knowledge, attitudes, or skills (learning), changes in job behavior or performance as a result of the program (behavior), and final outcomes that occurred from participating in the program (results). When creating the WNRP evaluation plan, the team found it valuable to start with the end in mind and concentrate

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on program results. This required identification of end-point program outcomes, methods of data generation, and concrete indicators of success, which were outlined in a document.

Nurse residents' perceptions of learning sessions (reaction) were measured using a questionnaire with forced and open-ended responses administered at the conclusion of each session (formative evaluation) and at the conclusion of the entire program (summative evaluation). Preceptors and coaches' perceptions of their training were measured by an instrument generated by the team. NRs' changes in knowledge, attitudes, or skills (learning) were assessed through activities such as role-playing, qualitative analysis of nurse residents' journaling (Schweitzer, 2009), focus groups, and pre-post program changes related to residents' perceptions of job satisfaction and stress (Bratt & Felzer, 2011, 2012). Preceptors' and coaches' learning was assessed during the training workshop through a variety of role playing activities and assignments, such as creating a learning plan or conducting a coaching session. Changes in NRs' job performance (behavior) were measured by pre- and post-performance appraisals using standardized competency assessment tools, by noting indicators of NRs' professional development such as upward movement on a clinical ladder or progress on personal professional goals, surveying managers or peers, and through standardized instruments that measured nursing performance and decision-making ability (Bratt & Felzer, 2011, 2012). Preceptors' and coaches' change in behavior was assessed using instruments that were generated by the academic team member. These instruments included behavioral statements associated with aspects of the coaches' and preceptors' role and were administered pre-post training workshop.

The last step in evaluation, results, is perhaps the most challenging. Improved new nurse retention with resultant decreased overtime and dependence on contract labor are frequently cited outcomes of NRPs, which have considerable financial implications for organizations (Pine & Tart, 2007; Trepanier et al., 2012). To capture retention data, enlist the assistance of the Human Resources Department so that new graduates can be earmarked within the employee database and their movement tracked within the organization. Alternately, assign this recordkeeping responsibility to the residency program coordinator. It is optimum to have pre-program new graduate retention rates and compare them to post-program implementation. Improved new nurse retention rates are extremely powerful statistics and influential with administrators.

Similar to NRs, retaining preceptors and coaches in their role is also a desired outcome, particularly if there has been a financial investment in their training. These data can be collected directly or through the use of a survey such as that proposed by Dibert and Goldenberg (1995) that measures preceptors' role commitment. This instrument was originally designed for use with preceptors but has the potential to be modified for use with coaches or mentors.

Other potential measureable program outcomes include incidence of error on units, perceptions of patient safety climate, and the practice environment (Baernholdt, Jennings, Merwin, & Thornlow, 2010). Most critically, use the results from the evaluation process to engage in continuous program improvements. Results from assessment of NRs, preceptors, and coaches'/mentors' reactions to the educational sessions and the resultant learning are vital to determining whether the content, methods, and speakers are meeting the needs of these groups. Analysis of outcome data will reveal whether targets have been reached and lead to appropriate program revisions.

Evidence regarding the efficacy of nurse residency programs is slowly developing. Therefore, by creating a program evaluation research study on outcome data can contribute to the growing body of knowledge regarding residency programs. With this in mind, obtain

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institutional review board (IRB) approval prior to the launching of the program. Even if outcome data are not published, it is better to have IRB approval in advance rather than try to obtain it post-hoc. Recruiting an academic partner to fulfill the role of the study primary investigator can provide a wealth of research support, particularly in the area of study design and data analysis, and facilitate dissemination of results. Academic partners can also provide valuable assistance in proposal writing to fund evaluation research and acquire items such as clinical simulation equipment.

Recommendation #6: Sustain Program through Strategic Planning, Communication of Outcomes/Cost-Benefit, and Continued Collaboration

Program sustainability starts at the moment of program conception. Keeping organizational leaders informed throughout all phases of the program, from planning to evaluation, is imperative. To accomplish this, a comprehensive communication plan that included the communication objective, message focus, stakeholder for message receipt, vehicle for message delivery, timing and frequency of the message, and accountability was created. This document was helpful to keep the right communication targeted to the right audience. As part of this plan, it was worthwhile to provide reports for administrators that summarized the WNRP progress and results. Additionally, at scheduled leadership and nursing professional development meetings, NRP coordinators provided regular program highlights and updates. A residency program newsletter featuring individual residents and showcasing what they were learning proved to be another effective mechanism to maintain engagement. A preceptor/coach newsletter showcasing personal success stories and providing helpful hints was circulated among the hospitals. One of the most dramatic displays of support was when a participating hospital advertised the WNRP and displayed pictures of the NRs on an outdoor billboard adjacent to the hospital's entrance.

Across the organizations, the average cost for a cohort of ten NRs was $60,000, which approximated the cost of replacing one nurse who left. Using a cost-benefit approach, the team members built a compelling case that if the WNRP prevented turnover of just one nurse resident the program was cost-neutral. Sharing this cost-benefit analysis with administrators proved to be a powerful mechanism to stimulate continued dedication of resources to the program. This resulted in most of the hospitals establishing a separate cost center to cover NRs' non-productive time thereby protecting unit-based budgets, which was extremely important to assure sustainability of the program.

As a funding-requirement, the WNRP had to have an identified sustainability plan, which became a fundamental aspect of the work plan throughout the project duration. Participating organizations were aware of this obligation at the outset and actively engaged in devising internal tactics and resource procurement to maintain the residency program upon funding expiration. An important aspect was the philosophical stance of the project director, which was to provide the hospital partners with the skills and tools to administer the program and empower them to *own* the program from the very beginning.

Since the predominant financial costs of the WNRP were generated during the planning phases, organizations determined strategies to maintain the program including reallocation of nursing professional development educators' job responsibilities, securing internal foundation monetary support, and cost-savings from reduction in turnover and bolstered new nurse recruitment. Organizations also continued to collaborate, share resources, and offer joint

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programs, which was possible because of the strength of the relationships that were built throughout the project.

Summary

Establishing a successful residency program takes time, patience, and focus on the end results. Devoting time to build a cohesive NRP team, solidify the program support network and engage in deliberate planning is time well spent. The recommendations and best practice strategies in Table 1 will assist organizational leaders and nursing professional development educators to avoid obstacles and navigate NRP development, implementation, evaluation, and sustainability.

Nurse residency programs have the potential to build capacity within an organization and can ultimately build cultures of nurse retention and enhance quality of care. Furthermore, residency programs can positively transform work environments, interpersonal relationships, and professional practice and mitigate the reality shock that can paralyze new nurses. All these factors warrant dedication of organizational resources to provide a well-conceptualized and administered nurse residency program for every newly licensed nurse.

Acknowledgment

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TABLE 1: Summary of Nurse Residency Program Recommendations and Best Practice Strategies	
Recommendations	**Best Practice Strategies**
Secure Stakeholder Buy-in at Program Inception	• Solicit program buy-in across organizational stakeholders including nursing leaders, nursing education/professional development, human resources, and staff nurses. • Involve strategic administrators, front-line nurse managers, and educators throughout program creation, implementation, and evaluation. • Hard-wire the nurse residency program (NRP), establishing it as the organizational standard for all newly graduated s registered nurses (RNs).
Allocate Sufficient and Appropriate Resources Capitalizing on Partnerships	• Designate a residency program planning team with representatives across levels of the organizations. • Formalize the position of residency program coordinator with clearly defined role responsibilities and accountability for program oversight and deliverables. • Collaborate with academic affiliates to provide program development support and access to additional teaching and learning resources. • Capitalize on existing partnerships and/or create informal networks to build an NRP site comprised of multiple hospitals.
Build the Program Based on Best Evidence	• Review existing NRP research and recommendations from national policy-makers (Institute of Medicine), accreditation (Commission on Collegiate Nursing Education), regulatory bodies (National Council of State Boards of Nursing), and successful NRPs. • Use a conceptual framework/transition to practice model advanced by noted experts. • Construct an evidence table to provide the underpinnings for program structure and components. • Seek input regarding program elements from internal stakeholders through focus groups of nurse managers, recently graduated nurses, and preceptors.
Create a Multi-staged Program Providing Long-term Support	• Create a program that spans 12-18 months and includes guidance by preceptors, coaches/mentors, and continuing education. • Actively recruit, train, and reward preceptors and coaches/mentors and put into place strategies to sustain their engagement and commitment to the role. • Foster nurse residents' (NRs) practice knowledge, attitude, and skill development through ongoing learning sessions focused on recognition of rapidly changing patient condition, access to resources, and development of clinical judgment to enable them to "think and act like a professional nurse." • Deploy pedagogical strategies that resonate with adult learners and promote learning within the context of nursing practice such as

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	reflection and story-telling; avoid PowerPoint-based lectures. • Empower educational session presenters to use a dialectical approach and use interactive methods through specialized training, mentoring, and feedback.
Construct and Implement a Comprehensive Evaluation Plan and Measure Outcomes	• Conduct a formal, comprehensive program evaluation that includes assessing learners' reaction, learning, and changes in behavior and NRs' professional socialization outcomes; use evaluation data to engage in continuous program improvement. • Disseminate outcomes to organizational stakeholders. • Partner with an academic liaison to conduct the program evaluation /research project and procure additional resources.
Sustain Program through Strategic Planning, Communication of Outcomes/ Cost-Benefit and Continued Collaboration	• Implement an ongoing communication plan that informs key constituents regarding progress and outcomes. • Convey the cost-benefits of the NRP and changes in new nurse retention resulting from the program to nurse administrators. • Incorporate the NRP into the strategic plan for the organization/nursing professional development department. • Collaborate with other hospitals/organizations to offer joint programs if resources are limited.

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