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Initial Competency Tool to Assist Preceptors in the Documentation of the New RN Competency

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INITIAL COMPETENCY TOOL TO ASSIST PRECEPTORS

IN THE DOCUMENTATION OF NEW RN COMPETENCY

DNP Project
Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Nursing Practice

St. Catherine University
St. Paul, Minnesota

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Mentor Approval Page

ST. CATHERINE UNIVERSITY
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This is to certify that I have examined this
Doctor of Nursing Practice DNP project manuscript
written by

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and have found that it is complete and satisfactory in all respects,
and that any and all revisions required by
the final examining committee have been made.

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April 27, 2020
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Date

DEPARTMENT OF NURSING

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Abstract

Health organizations rely on Registered Nurse (RN) preceptors to train and evaluate new RN's competence. A competency tool guides and documents a new RN's competency to adequately perform the skills needed for their position. This DNP project utilized preceptor input to optimize the competency tool to improve the preceptor's ease of use, clear expectations for each competency, and improved the preceptor to preceptor handoff. This quality improvement project involved surveying RN preceptors for their perception of the initial competency tool throughout its development and after implementation. Preceptors reported a dramatically improved preceptor perception of the initial competency tool. Survey results showed an increase in perceived ability to accurately document a new RN's competence, ease in transitioning a new hire RN from one preceptor to the next, and a clear understanding of what is expected for each competency.

Keywords: competency, preceptor input, competency tool

Initial Competency Tool to Assist Preceptors in the

Documentation of New RN Competency

Competency assessment is an essential process every organization must continually strengthen. Assuring new employees are competent is crucial for health organizations to assure patients are receiving competent, safe, and high-quality care. To be effective and productive members of the nursing staff, new nurses must achieve initial competency expectations. The initial competency period is a time of learning and application of knowledge and skill to practice. Failing to assess and document the competency of new employees adequately can result in catastrophic consequences for patients. The initial competency period requires thoughtful planning to make it successful for employees, the organization, and patients.

Background & Significance

The current initial competency practice at a midwestern, regional referral hospital needs improvement. The organizational definition of competency is "the application of knowledge, skills, and behaviors that are necessary to meet the requirements of the organization, department, and work setting requirements under the varied circumstances of the real world" (Wright, 2005, p. 7). Despite the clear definition, the hospital policy and practice blur the concepts of competency and education. For example, a staff member is deemed competent for restraints after attending an aggressive patient de-escalation class where they discuss restraints and view a restraint computer-based training module. Wright makes a clear distinction that education and competency are separate concepts and should not be confused (2005). Despite having a progressive and clear definition, the hospital needs to change to align the competency process with the definition.

The current hospital initial competency assessment process centers around a document called the Orientation Checklist (OC). The OC is an enormous list that is confusing, outdated, and cumbersome for preceptors and new nurses to use. Vague phrases describe competencies that are challenging for new RNs and preceptors to interpret, such as "Performance Improvement/Risk Event Reporting/Risk Management." These vague phrases do not tell a preceptor what knowledge, skill, or ability a new RN must have. There are OC items that do not meet the organizational definition of competency. Examples of unnecessary items that are not competencies include "value analysis" and "patient billing." Some items are outdated and have not been updated, despite policy changes renaming a process, such as "1:1" instead of the new term adopted by the organization "sitter." The outdated and unnecessary items result in a lengthy document that is not valued by preceptors and new RNs.

The organization recently adopted an orientation framework called "Tiered Skill Acquisition" (TSA). TSA is an orientation and competency framework grounded in Dreyfus' Model of Skill Acquisition and Benner's Model of Novice-Expert. The TSA model groups a set of orientation concepts into levels that were found to improve orientation by allowing new graduates to have 45% more patient exposure and decreased orientation length by 18% (Joswiak, 2018). For example, the first level of concepts is grouped into a category called "Assessment and Documentation." Once the new employee learns and attains competency with this level, the new employee moves to the level called "Medication and IV Therapy." The current OC document does not align with the levels of TSA and hinders preceptors from successfully implementing the new orientation model. Failing to integrate the new TSA model into the initial competency tool makes it challenging for the organization to enculturate the new framework fully.

Needs Assessment

The organization's current orientation competency tool is not meeting the needs of the organization, preceptors, or new RNs. The current tool is outdated, having not been updated for over ten years. The tool is lengthy and hard to interpret, which makes it very challenging for preceptors and new RNs to use effectively. The organization recently adopted a new orientation model, Tiered Skill Acquisition. The current orientation competency tool does not align with the levels of competence, creating barriers to successfully implementing the new model.

For preceptors to adequately assess and document a new RN's competency, a new tool is needed. This new tool must be developed with preceptor input. Involving preceptors in the design and content of the tool is integral to ensuring it is easy to use and understand. Aligning the competency tool with Tiered Skill Acquisition will enable preceptors to enculturate the new model successfully.

Goals and Objectives

The grand vision for this project is to spread a new orientation competency tool to nurses throughout the hospital and health system. There are three primary goals to achieve this vision. First, to integrate preceptor feedback on the current and revised orientation competency tool into a final product. To gather and integrate preceptor feedback, the same preceptor survey will be administered three times before and after the revision of the orientation competency tool. The survey results will inform the development and implementation of the tool.

The second goal for this project is to develop specific, measurable competency statements in alignment with the organization's orientation framework. A taskforce of preceptors and educators was gathered to develop competency outcomes. The outcome statements will be structured using the SMART format, in a statement that is specific, measurable, achievable,

relevant, and timely. The tool will also be reorganized by the taskforce to align with the Tiered

Skill Acquisition framework.

The last goal is to evaluate the preceptor experience and ease of use with the final

orientation competency tool. After the revision of the orientation competency tool, preceptors

who utilize the tool with new RNs will be surveyed. The results from this final survey will be

used to revise the orientation competency tool further and to evaluate the tool's effectiveness.

Problem Statement

Successful initial competency assessment and documentation are crucial to an

organization's competency program. The current process presents many barriers to success,

including a complex, confusing, and complicated competency tool. The current Orientation

Checklist tool is hard for preceptors to use as it lacks organization, measurable statements, and

alignment with the organization's orientation model.

Project Purpose and PICO Question

The purpose of this DNP project was to develop a new orientation competency tool using

measurable statements and based on a tiered orientation model and preceptor feedback. To direct

the literature search for this project a PICO question was designed. The PICO acronym stands

for problem, intervention, comparison, and outcome. The PICO question for this project was: for

preceptors of new RNs across the medical and surgical units at this facility, what is the effect of

a new initial competency tool on preceptor's satisfaction and ease of use?

Theoretical Framework

Intellectual capacity theory was used as the theoretical framework for this DNP project.

Intellectual capacity theory recognizes the value of nursing knowledge, which flows through an

organization. Nursing knowledge is a type of human capital that directly impacts nursing and

organizational performance. The organization does not own the nursing knowledge of its staff, and this resource can leave at any time. The organization must invest in nursing knowledge and skill of its nurses to achieve expected goals (Covell, 2008; Covell & Sidani, 2013).

This theory was chosen as it recognizes the challenge of measuring the impact of nursing knowledge. It provides structure to quantify the value and effect of knowledge as a type of resource, through organizational and nursing outcomes (Harris, 2016). Competency, as a type of nursing knowledge and skill, is a resource that the organization must assess, measure, and document. The competency tool at the center of this DNP project must recognize and value the nursing knowledge and skill needed to achieve competence.

Review of Literature

Search process

Using a systematic search strategy is invaluable. The search started with a definition of the population, intervention, outcome components, and time method (PICOT). The PICOT for this search was: P = nurse preceptors, I = initial competency tool, C =outdated competency tool, O = preceptor satisfaction, preceptor ease of use, and T = 2000 to 2019. Keywords included: "nurse preceptor," "preceptor," "initial competency tool," "orientation competency," "initial competency," "clinical competence," "satisfaction," "preceptor satisfaction," "ease of use," and "nurse engagement." A search was conducted using CINAHL, ProQuest, Academic Search Premier, PubMed, and Medline. The search was limited to the English language, peer-reviewed journals, between 2000 to 2019. A brief search was conducted between the years 1980 to 2000 to search for landmark studies, specifically Benner's novice-expert article. This search produced 1,562 articles, which was narrowed to 256 articles relevant to the topic of initial competency and competency tools. See Appendix A for an outline of the search strategy. An outline of the search

strategy and article selection is summarized in Appendix B. Twenty-three articles were critically appraised and summarized in an evidence table (see Appendix B).

Appraisal

The evidence is appraised using the John Hopkins Nursing Evidence-Based Practice (John Hopkins Center for Evidence-Based Practice, 2017). Level I of evidence is for experimental studies, randomized controlled trials (RCT), and systematic reviews of RCTs. Level II is for quasi-experimental studies and systematic reviews of RCTs and quasi-experimental studies. Level III is for non-experimental studies, qualitative studies, and systematic reviews of RCTs, quasi-experimental, and non-experimental studies. Expert opinion or nationally recognized experts are appraised as a Level IV. Level V is for experiential or non-research evidence, such as case studies, quality improvement, or program evaluations. Articles are then graded by the quality of the study, such as high quality (A), good quality (B), and low quality (C) (John Hopkins Center for Evidence-Based Practice, 2017).

Evidence was appraised using the John Hopkins Nursing Evidence-Based Practice guide as described above. A total of 23 articles were critically appraised, with ten articles rated as Level III and 13 articles as Level V. Of the Level III evidence, one article was appraised as A quality, eight articles as a B quality, and one article as C quality. Of the Level V evidence, one article was of A quality, eleven of B quality, and one of C quality.

Synthesis

Articles were classified into three key topics, including foundational competency evidence and competency tools. A review of each key topic will reveal the current knowledge and the need for more research on.

Foundational competency evidence

Benner. Possessing the knowledge to perform a skill and being able to perform said skill are different things. Assessing and verifying competency should be based in the real world (Khan & Ramachandran, 2012). Benner (1982) applied Dreyfus' model of skill acquisition to nursing. Benner postulates nurses begin as a novice and move through stages of skill acquisition to become advanced beginner, competent, proficient, and finally expert. New graduate nurses attain knowledge, skill, and abilities to move from novice to expert using reflective thinking and self-evaluation of practice (Oshvandi et al., 2016).

Competency and Organizational Outcomes. Effective competency and orientation processes can improve organizational outcomes. Del Bueno (2001) found that competencies are related to nurse satisfaction and engagement. Initial competencies are the foundation of nursing knowledge, skill, and ability within an organization and play a key role in career planning. Competency-based orientation can also improve nurse retention (Del Bueno, 2001). Documenting an employee's knowledge, skills, and abilities can reduce the cost of care by preventing mistakes and miscommunication (Levine & Johnson, 2014). Competency-based approaches also clarify expectations for new graduate nurses, which further adds to employee satisfaction and engagement.

Competency Tool Evidence

The literature search also yielded substantial evidence regarding best practice for the development of competency tools. Competency tools should not be "one-size-fits-all," meaning there is no one perfect tool that all facilities can utilize. An organization must tailor their competency tool to the values, work culture, and needs of the organization (Franklin & Melville, 2013). The competencies an organization chooses must align with the "real-life environment" of the nurses. Understanding what is important to organizational leaders, preceptors, and nurses are

important when determining what is meaningful to include on a competency tool (Brown &

Crookes, 2016). Utilizing the voices of internal stakeholders is crucial to preventing a

competency tool from becoming a lengthy checkbox, which is seen as a task or mundane activity

(Franklin & Melville, 2013). Using preceptors in the development of the tool is crucial to its

success, increasing the reliability and ease of use (Steffan & Goodin, 2010).

The design of a competency tool can impact the success of a new nurse. As is well

documented in the literature, feedback from preceptors is crucial to the development and success

of new nurses. Competency tools can be designed to facilitate performance conversations and

feedback between preceptor and new nurse (Lima, Jordan, Kinney, Hamilton, & Newall, 2015;

Steffan & Goodin, 2010). Feedback conversations can improve the preceptor-new nurse

relationships and expedite competency attainment, as well as nurse and preceptor satisfaction

and engagement (Wolfensperger-Bashford, Shaffer, & Young, 2012; Theisen & Saundau, 2013).

There are several validated and reliable self-assessment tools, but experts emphasize that

self-assessment should not be the only plan for competency assessment (Lima et al., 2016; Lima

et al., 2013; Wangensteen et al., 2012). Self-assessment tools, such as the Nurse Competence

Scale and Perceived Competence Scale, can be used to create an orientation competency plan or

to tailor competency attainment to the individual new nurse (Flinkman et al., 2016; Church,

2016; Nilsson et al., 2014).

Competency programs and tools are stronger when they align with the organization's

preceptor, orientation, and new graduate programs. The alignment of these programs strengthens

the overall experience of the new nurse and the organization's preceptors. When these programs

have similar values and goals, new nurses have a smoother transition into practice, with

improved competence and confidence (Parks & Jones, 2010; Theisen & Sandau, 2013).

Integration of the competency, preceptor, orientation, and new graduate programs strengthen the organization.

Methodology

For this DNP project, data was collected using three surveys to gather preceptor input on the identified pilot departments. The pilot departments for this project are the six medical and surgical care units at the organization. Each department's leadership structure was engaged in the implementation of the new orientation model, Tiered Skills Acquisition. In each department, the supervisor or educator selected the RN preceptors who would be the sample for this project. Of the approximately 263 RNs on these departments, 91 RN preceptors were selected to survey.

The surveys were designed by the DNP student to evaluate preceptor impressions of the competency tool. The survey questions were reviewed for validity by experts at the organization and by the project's DNP faculty advisor. The organization's Nursing Research Review Board (NRRB) and the Institutional Review Board (IRB) approval was granted by St. Catherine University and the organization.

The survey was developed using the web-based software, Survey Gizmo, and consisted of Likert-type and open-ended questions (see Appendix C for Survey). The survey consisted of 14 items. Two items were demographic questions determining department and years of precepting. This demographic information was designed to gather only the necessary information to inform the results and would not expose the identity of any participants. There were ten Likert scale items about the preceptor's assessment of the competency tool. The Likert scale statements gathered information about a preceptor's perception on ease of use of the competency tool, whether it contained clear and unambiguous language with clear description of competencies, and if the competencies noted on the tool were meaningful to daily nursing

practice. Other Likert scale statements included preceptor perception of how the tool assists with

the transition from one preceptor to another, the ease in making a plan and providing feedback, if

it was organized logically, accurately documents new nurse's competence, and if it was

perceived as useful to the respondent. Finally, two open-ended questions asked the nurse

preceptors what they liked about the tool and suggestions for improvement.

The survey was administered three times to Registered Nurses (RN) who were identified

by their supervisors or unit-based educators as preceptors. This convenience sample included 91

RNs preceptors on the project pilot units, the six medical and surgical units of the organization.

The survey was administered initially to gather baseline preceptor assessment of the

organization's current orientation competency tool. Preceptor involvement in this DNP project

was anonymous and voluntary. Responses to each DNP survey were recorded anonymously by

Survey Gizmo, and at no time did any person have access to personal identification or unique

identifiers. Data, without any descriptors, were accumulated and analyzed. No compensation

was offered for participation.

Informed consent was developed and approved by St. Catherine University and the

organization. Informed consent (see Appendix D) was delivered via email inviting preceptors to

take the survey and in the introduction in the survey software.

Baseline Survey

The baseline survey was intended to collect RN preceptor's opinion and perception of the

organization's current orientation competency tool. The baseline survey was distributed to 91

RN preceptors at the organization. The survey was completed by 27 RNs (29%). This

convenience sample for the baseline survey is made up of mostly the medical units. Those who

have precepted more than five years also comprise most of the respondents.

The baseline survey results are summarized in Appendix E. The survey revealed

preceptors were largely undecided about the clarity of the tool's language, the continuity the tool

supports between preceptors, nor the ease of use. The open-ended questions revealed the

preceptors liked that the tool prompted them to review things they may have forgotten to cover

during orientation. However, the subjective feedback also revealed preceptor's dissatisfaction

with the number of items that are not competency, the outdated terms used, and the desire for

more detail about what is expected.

Competency Tool Development

Following the baseline survey, a task force made up of pilot department clinical RN

preceptors, educators, and supervisors gathered. The task force reviewed the baseline survey

trends. The group then developed a new orientation competency tool to meet the needs of clinical

preceptors. The tool provided additional clarification to preceptors about the expectations of each

competency, specifically what outcome the new hire is expected to achieve. Outcome statements

for each competency were developed using SMART sentences. SMART stands for Specific,

Measurable, Attainable, Realistic, and Timely, and is meant to provide clear and concise

expectations for each competency. For example, with the competency for "Handoff

Communication," the SMART outcome statement the group developed was "the RN will

demonstrate accurate and timely handoff communication, utilizing IPASSON communication

tool for bedside report and SBAR for just-in-time provider or staff communication." The clarity

of the outcome statement gives the preceptor guidance on what to assess before documenting

competency achievement for a new RN.

The task force sought to align the tool with the organization's Tiered Skill Acquisition

model. Competencies were grouped into levels of competency, as guided by the organization's

application of the model. The organization has six levels of competence: Core Competencies, Assessment and Documentation, Medication and IV Therapy, Communication and Teamwork, Quality and Safety, and Workload Management/Continuum of Care. For example, the level "Assessment and Documentation" includes competencies such as "Head-to-Toe Assessment," "Focused Assessment," "Clinical Documentation," "Patient Identification," "Pain Assessment and Management," "Skin," and "Outcome Standards of Care." The task force identified the competencies appropriate for the departments and grouped them into the appropriate levels of competence in the organization's Tiered Skill Acquisition model.

The taskforce collaborated with a variety of stakeholders on the development of the tool. The organization's regulatory specialist worked closely with the task force to review and assure that the tool met regulatory requirements. The Joint Commission guidelines were comprehensively reviewed with the regulatory specialist to verify the needed competencies were included. Human resources personnel were also invited to give input into the tool design to align with other performance management processes. The organization's senior and executive nursing leadership were also kept informed of the status and progress of the task force and the project.

Pre-implementation Survey

After the task force drafted the tool, it was shared with the pilot preceptors who received the baseline survey. The tool was sent with the pre-implementation survey (see Appendix F) to collect the RN preceptor's opinion and perception of the revised orientation competency tool. The pre-survey was distributed to the same 91 RN preceptors who received the baseline survey. The survey was completed by 25 RN preceptors (27%), an equitable percentage of medical and surgical RNs. Identifiers were not used on the survey, and it is impossible to determine whether the same respondents took both the baseline and the pre-implementation survey.

The survey revealed preceptors had an agreeable response to the new tool's clarity of language, the continuity between preceptors, and the ease of use. When compared to the baseline survey, all survey items improved from the baseline to the pre-implementation survey. The open-ended questions revealed some preceptors appreciated the groups of competencies, the clear expectations for each competency, and found the competencies were more applicable to daily practice. The respondents also suggested that some larger concepts be broken into separate competencies, and there be more space on the tool to note feedback from the preceptor to the new RN. The task force reviewed the pre-implementation survey and made changes based on the feedback. Some competencies which had multiple outcome statements were divided into separate items. For example, the competency item "Care of the Suicidal Patient" originally included outcome statements that covered suicide screening, interventions, sitter observation, and 72-hour hold. Based on the feedback on the survey, these outcome statements were divided into "Suicide assessment and intervention," "Sitter Observation," and "72 hour holds". Separating these items helps preceptors accurately document the new RN's specific competence.

Implementation

The revised tool was implemented with five new RNs who were hired and started during the project period on the pilot departments. Four of the new RNs were hired on the medical units, two on Medical Unit 2, one on Medical Unit 1, and one on Medical & Oncology. One new RN hired on Surgical Care Unit 1. Each RN preceptor responsible for the orientation of the new RNs were instructed on the use of the revised orientation tool by the DNP student and the department educator. Department educators frequently met with the new RN and preceptor to answer questions and address any barriers to success. Following orientation, preceptors were sent the post-implementation survey.

Post-implementation Survey

Of the 18 preceptors sent the survey, 15 participants responded. The respondents were

primarily from the medical units, as a majority of new RNs were hired on the medical units

during the implementation period. Identifiers were not used on the survey, and it is impossible to

determine whether the same respondents took the baseline, the pre-implementation survey, and

the post-implementation survey.

The post-implementation survey revealed an agreeable response to the updated tool.

Every question was responded with a more satisfactory response than previous survey

respondents. The most significant increases in satisfactory responses were to the statements:

"The competency tool provides a clear description of what is required in each competency;" "the

competency tool helps me understand the new nurse orientee's progress as s/he works with

different preceptors;" "the competency tool allows me to accurately document a new nurse

orientee's competence;" and "the competency tool is useful to me as a preceptor." A summary

of the post-implementation survey is in Appendix G.

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Discussion

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Results

The PICO question for this DNP project was, for preceptors of new RNs across the

medical and surgical units at this facility, what is the effect of a new initial competency tool on

preceptor's satisfaction and ease of use? The null hypothesis for the question is the preceptors

would find the revised tool more satisfying and easier to use. The three surveys contained

identical questions that allow for comparison across the three surveys. The mean comparisons

were generated from Likert questions that asked preceptors for their perception of the

competency tools. Using a comparison of mean scores (see Appendix H) to determine changes in

preceptor's opinions, the null hypothesis was retained. All items on the survey increased from baseline to the pre-implementation survey. All items on the survey increased further from the pre-implementation to the post-implementation survey. The data did not meet the assumptions needed for a t-test. Descriptive comments were compared. The individual comments to the open-ended questions were organized, tabulated to determine the most frequent response, and summarized in Appendix I.

Strengths

The three surveys were identical, making the comparison between baseline, pre-implementation, and post-implementation possible. Preceptor feedback was able to be compared and analyzed to craft and revise a meaningful competency tool. Feedback from the surveys identified self-perceived barriers and advantages to the competency tool so it could be customized to the needs of the organization.

The competency tool was developed using the input and active participation of the main users, RN preceptors. Direct involvement from RN preceptors in the development of the tool and gathering the input of RN preceptors contributed to the success of the initial competency tool at the organization. Understanding the perception of RN preceptors helped the taskforce shape and refine the tool to meet the needs of RN preceptors.

Limitations

The cohort surveyed included 67 preceptors. The baseline survey was completed by 27 RN preceptors; the pre-implementation survey was completed by 25 RN preceptors; the post-implementation survey was completed by 15 RN preceptors. The anonymous nature of the survey made it impossible to know if the same RN preceptors responded to all three surveys. The anonymity of the survey makes statistical analysis difficult.

The limited timeframe for the DNP project was another limitation of this project. The project was implemented during a point of low hire, and only five RNs were hired and started at the organization during the pilot period. Thus, only 18 preceptors were involved in the orientation of these five RNs, leading to low sample size for the post-implementation survey.

This quality improvement project only sought input from the RN preceptors involved in the assessment and documentation of competence. This project failed to include an assessment of the new hire RN's perspective. Their satisfaction and engagement in the process of competency assessment could provide valuable insight.

Social Justice Implications

An organization's competency plan is correlated to positive patient and organizational outcomes. A poor competency program has been linked to increased patient mortality (WHO, 2018). Failing to assess and document the competence of its staff adequately can directly impact patients. Inadequate competency programs can also create segments in care and weaken population health efforts of an organization (Bleich, 2018). The organization's strategy must standardize competency assessment process yet allow for some variation in the tool between departments and entities within the organization. In the AACN Essentials, DNP-prepared nurses are accountable for quality and safe patient care (AACN, 2006). An integral part of quality and safe care is a thorough and comprehensive competency program.

Contributions to Nursing Practice Knowledge

This DNP project contributes to overall nursing knowledge. Initial competency tools are not one-size-fits-all (Franklin & Melville, 2013). An organization must shape and develop a tool that meets the needs of its competency assessment program. This project provided the DNP student with the opportunity to collaborate with RN preceptors, educators, and leaders within the

organization to develop a competency tool framework that can be used across the health system. The new initial competency tool meets the needs of RN preceptors and enables them to more effectively and efficiently assess and document a new RN's competence.

The tool developed during this project has spread beyond the scope of this DNP project. The orientation competency tool structure created by the DNP project allowed for applied to other nursing departments within the hospital and health system. The tool's structure allows for departments to customize and tailor the content on the orientation competency tool to the needs of their department. Clinical preceptors are involved as significant stakeholders in the implementation of the orientation competency tool on each department. The voices of the preceptor are integrated into the system change across the hospital and health system.

Significance for Future Study

This quality improvement project suggests further study is needed. Initial competence remains a difficult topic that is often implemented inconsistently in practice. Given the recent changes to the orientation and competency programs, including the adoption of Tiered Skill Acquisition and the revised initial competency tool, a study about the long-term outcomes of these programs would be valuable to determine their effectiveness. Further study would also be valuable to determine whether the revised competency tool contributes to a change in retention rates or employee engagement of the preceptors or new nurses.

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Conclusions

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The nurses who precept new nurses in the organization play a vital role in the success of the new staff, the department, and the organization. Failing to invest in the accurate assessment and documentation of new nurses would result in poor quality or unsafe care. The new initial competency tool provides preceptors with a detailed understanding of the competency

expectations of new nurses and allows for a smoother transition between preceptors. The new tool was developed with the direct input and participation of preceptors, and preceptor feedback was obtained through anonymous surveys. The baseline, pre-implementation, and post-implementation surveys showed consistent improvement with each successive survey. Further research should be directed to measure the long-term impact of the new competency tool on retention, and engagement of both the preceptor and new nurse. The successful systems change at this organization has improved nurse preceptor's ability to assess and document new RN competence.

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Appendix A

Search Strategy

Total results from search
n=1,562

Articles excluded:
Non-English
Articles about cultural
competency
n=606

Results
n=956

Articles not in full text
through St. Kate Library
n=700

Full text results reviewed
n=256

Articles excluded based on
relevance to practice
problem:
n=233

Total results from search
n=23
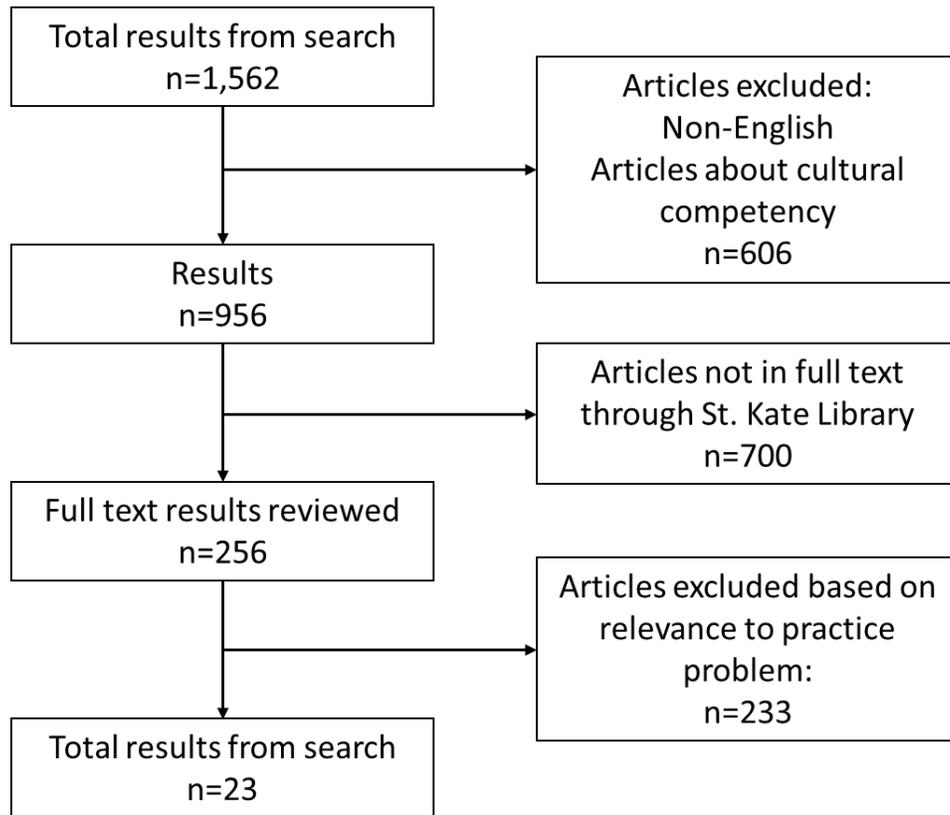
Appendix B

Literature Search

Article #	Author & Date	Evidence Type	Sample, Size & Setting	Study findings that help answer the EBP question	Limitations	Evidence Level & Quality
Foundational evidence						
1	Benner (1982)	Qualitative	6 different hospitals, 51 nurse clinicians, 11 new graduates, 5 senior nursing students in six different hospitals	• Development of novice to expert theory which builds on the Dreyfus model of skill acquisition • Novice: taught about tasks, rules, unable to use discretionary judgment • Advanced beginner: has had enough situations to see situational aspects; need help setting priorities • Competent: can see how their actions achieve long term goals; can identify what information is important and what is not; still lack flexibility and speed • Proficient: able to know what is expected in a given situation and can modify plans; has a holistic understanding • Expert: no longer needs rules or guidelines to understand situations or take appropriate actions; a deeper understanding	Older evidence Small sample size	Level III, A Quality
2	Cusack & Smith (2010)	Qualitative study	Not described	• There is a perceived power imbalance between manager and staff • Managers can positively influence competency assessment through good leadership • Assessments force nurses to open themselves up to be vulnerable	No detail of many aspects of the qualitative study (i.e., # of participants,	Level III, C Quality

				• Competency program must be developed to strengthen relationships between the new hire and preceptor	protection of participants, the process used to determine themes)	
3	Del Bueno (2001)	Expert opinion	NA	• Competencies fall in three categories (critical thinking, technical, and interpersonal skills) • Failing to assess initial competency can be costly to an organization and risk patient safety and quality • New grads who meet competency expectations are more likely to stay within the organization • Ongoing competency assessment can help in retaining current employees	Non-experimental Expert opinion	Level V A Quality
4	Khan & Ramachandran (2012)	Expert opinion	NA	• Competency is a skill • Competence is the attribute of a person • Performance is affected by several factors – some are easy to learn and others are not. • It is easy for a person to learn: knowledge, psychomotor ability, decision making, teamwork, and attitude • It is NOT easy to learn: the environment of the workplace, emotional state, physical state, and personality traits. • Authors postulate Dreyfus model should have a level below novice (incompetent) and the level above expert (master). An individual grows through the Dreyfus levels through training and deliberate practice. • Competency assessment should be based on performance and real-world assessment of action ("does" or "shows how", NOT "knows")	Expert opinion Theoretical, no evidence to support opinions	Level V, B quality

| 5 | Levine & Johnson (2014) | Non-experimental Expert opinion | One health system. No description of size or location | • Competency assessment is an effective approach to quality and performance improvement.
• Competency-based orientation helps improve nurse satisfaction and engagement by clearly communicating expectations
• Levels of competence:
  1.Level 1: what individual "knows" based on knowledge
  2.Level 2: individuals "knows how" to act measured by competence
  3.Level 3: individual "shows how" to act measured by performance
  4.Level 4: what individual "does" as measured by action
• International criteria for continuing nursing competence are that RNs should be responsible for assessing own practice and individual nurse's competence is grounded in their specialty
• Wright defines three competency periods: pre-hire, initial competency, and ongoing competency
• Five opportunities for competency validation: corporate orientation, core nursing orientation, unit-specific nursing orientation, ongoing evaluation, and specialized evaluation.
• The organization must develop a competency-based performance model which outlines initial and annual competency methods of assessment, validation, and evaluation. Nurses in Nursing Professional Development (NPD) should lead implementation team to oversee this model.
• Competency model must align with organization's nursing values and culture. | Theory-based evidence from one health system's experiences No outcome measures to support model | Level V B Quality |

6	Oshvandi, Moghadam, Khatiban, Cheraghi, Borzu, & Moradi (2016)	Systematic review of non-experimental studies	31 studies reviewed	• Application of Benner's novice-to-expert theory on pharmacy, nursing, and medical competencies • Novice-to-expert promotes reflective thinking, classifying nursing expertise, and standardized evaluation of nursing performance	Non-experimental studies included in systematic review	Level III, B Quality
				Competency Tools		

7	Brown, & Crookes (2016)	Non-experimental Delphi case study	Initial Delphi with 495 nurses, including clinical nurses, academic nursing, clinical nurse educators, and new graduate coordinators in urban area of Australia	• Study aimed to determine what experienced nurses expect for competency of new graduate nurses immediately upon exiting nursing school
				• Highest rated items (meaning new grads should be independent in) include:
				  1. Privacy and dignity (n=244)
				  2. Demonstrates behavior conducive to learning (n=221)
				  3. Personal care (n=201)
				  4. Efficient and effective communication (n=192)
				  5. Communication and documentation (n=183)
				  6. Professional nursing behaviors (n=184)
				  7. Therapeutic nursing behaviors (n=176)
				• Lowest rated items (meaning new grads are not expected to be independent) include:
				  1. Case manager (n=18)
				  2. Leadership skills (n=36)
				  3. Supervisory skills (n=42)
				  4. Mental health nursing care (n=57)
				  5. Dealing with emotional and bereaved people (n=61)
					Non experimental
					Some nurses surveyed had left the profession
					No statistics or demographic information shared beyond percentages in total demographic, no analysis of whether there were trends amongst
						Level V, B Quality

				6. Acting as a resource (n=65)	demographic groups	
8	Chen, Chien, Kuo, Li, Chiang & Liu (2017)	Non-experimental Cross-sectional study	Post-graduate nurses and their preceptors in Taiwan academic medical center. 307 New Graduates, 31 preceptors	• New graduates and preceptors had no significant difference in perceived competence in areas of clinical care, research awareness, professional growth, or overall competence. • New graduates self-assessed higher competence than their preceptors in communication, patient education, and management. • Preceptors with more years of experience had more discrepancies than their new graduate orientees.	One setting No documentation of the amount of time preceptor and orientee spent together	Level V, B Quality

9	Church (2016)	Literature review	38 articles	• Competence is directly related to the quality of patient care
				• Transition to practice programs greatly assist in competence attainment in new grads
				• Alignment of transition to practice program and competency is valuable
				• Similar concepts amongst literature on competence. Competence depends on the following things:
				  1. Access to and understanding knowledge base
				  2. Exhibiting mastery of discipline skills
				  3. Ability to utilize sound professional judgment
				  4. Exhibiting respect for and adherence to professional standards
				  5. Maintaining positive interpersonal relationships
				  6. Ability to identify the situational application of skills and knowledge
					Excluded specific unit orientation, specialized orientation programs Non-experimental	Level V, B Quality

				7. Evaluates success by outcome measurements against standards • Of all competence scales, the Nurse Competence Scale and Perceived Competence Scale have highest content validity		
10	Flinkman, Leino-Kilpi, Numminen, Jeon, Kuokkanen, & Meretoja (2016)	Systematic review of quasi-experimental and non-experimental studies	30 studies included in systematic review	• Most new graduate nurses self-assessed their competence as "moderate" across several countries. Over year in practice, competence raises to consistently "good". • NCS is used most frequently in European countries • NCS is applicable in most practice settings • Nurse managers typically assess competence higher in new grads than new grads self-assess	PRISMA used in review Antecedents of high levels of competence was not addressed	Level III, B Quality
11	Franklin & Melville (2013)	Expert opinion	NA	• Competency assessment tools should avoid being a "tick box" checklist which leads new nurses and preceptors to see the tool as a task or a mundane activity • Tools are not "one-size-fits-all" • Consider using self-assessment and preceptor assessment of competence • Competency tool must reflect the "real-life" environment in which new nurses will be working • Competency tool should consider the range of novice-advanced beginner nurse and those who come as competent-proficient-expert	Expert opinion Theoretical, no evidence to support opinions	Level V, B Quality
12	Kavanagh, & Szweda (2017)	Quality improvement	5,000 new graduate nurses (from 140 nursing programs in 31 states)	• Organization used the Performance Based Development System competency system • Graduates were underprepared upon hire – only 23% of new grads demonstrate entry-level competencies	Single medical center Lack of concrete data about those who	Level V, C quality

			hired at one large medical center between 2012 – 2015	• Those who did not achieve entry-level competencies were put into intensive immersion program which had a 99% success rate	didn't achieve entry-level competencie s No data breakdown by department/ specialty	
13	Lima, Jordan, Kinney, Hamilton , & Newall (2015)	Qualitative	21 graduate nurses interviewed metropolita n pediatric hospital in Australia	• Framework for developing competence was developed by asking questions, guidance, exposure to new things, to inform competence. Competence is often heavily influenced by the local leadership (i.e., nurse manager, preceptors) • Transition to practice programs must guide new grads towards competencies	Single pediatric hospital	Level III B Quality
14	Lima, Jordan, Kinney, Hamilton & Newall (2015)	Mixed method	21 new graduate nurses in qualitative interviews. 47 new graduates surveyed in quantitative survey	• Unit leadership, including the nurse manager, have the largest influence on development of competence. • Departments which had a positive work culture, in the opinion of the new grad, had greater success achieving competence and had a higher self-competence • Another major aspect of attaining competence is asking questions and being asked questions • Other aspects of attaining competence include: providing support and challenge, providing feedback and mentoring.	Small sample size for quantitative study Single pediatric hospital	Level III B quality
15	Lima, Newall, Jordan, Kinney,	Qualitative aspect of mixed-method study	21 graduate nurses from metropolita n pediatric	• New grad nurses self-assessed their overall competence as very well. • Self-assessed highest domains in ensuring quality and teaching-coaching.	Small sample size	Level III, B Quality

	Hamilton (2013)	described in 15	hospital in Australia		Single pediatric hospital	
16	Lima, Newall, Jordan, Hamilton, & Kinney (2016)	Quantitative aspect of mixed-method study described in 15	47 graduate nurses from metropolitan pediatric hospital in Australia	• Significant increase in self-assessed level of competence of new grad in first 6 months. Stable rates of competence from 6months – 1 year. • Authors felt this study validated Nightingale's claim (1860): "The most important practical lesson that can be given to nurses is to teach them what to observe, how to observe, what symptoms indicate improvement, what the reverse, which are of importance, and which are of none".	Small sample size Single pediatric hospital	Level III B Quality
17	Nilsson, Johansson, Egmar. Florin, Leksell, Lepp ... Gardulf (2014)	Non-experimental	1086 newly graduated nurses from 11 universities across Sweden	• Study described the development and testing of the Nurse Competence Scale (NCS) • The 88-item questionnaire was found to have sufficient face validity and reliability. • Statements changed to questions for self-competence (ex: "a nurse should be able to follow up on patients' status after investigations and treatment" to a question: "do you perceive you have the ability to follow up on patients' status after investigations and treatments?" to achieve better reliability	Long tool Non-experimental	Level V B Quality
18	Park & Jones (2010)	Systematic review of non-experimental studies	17 studies	• Review of orientation programs that aimed to improve confidence and competence, and retention. • Transition to practice programs and internships dramatically improve competence and confidence. • Structured orientation programs reported new grad retention rates between 76-92%.	No competency models discussed Non-experimental studies discussed	Level III B Quality

19	Schanne, Stern, Hand, Collins, Kirk, Kweeder, Brody, Hughes LaPorta, & Meehan (2016)	Non-experimental Quality improvement	5 hospital in one health system	• Implementing competency model is a challenge to get full engagement • Stakeholder input is essential to success • Outcome measurement should align with QI data • Needs of each unit must be individualized so competencies are meaningful for the unit staff • First-year competencies should focus on core competencies of communication, patient satisfaction, and patient safety.	Single health system	Level V, B Quality
20	Steffan & Goodin (2010)	Non-experimental, descriptive study	Convenience sample of 81 preceptors 3 hospitals in one health system	• Evaluated preceptor's assessment of orientation competency tool: "RN Weekly Performance Summary" • 75% preceptors thought tool was easy to use. • 24% participants thought the preceptors would not use the tool the same way.	Sample size low One health system	Level V, B Quality
21	Theisen & Sandau (2013)	Systematic review of qualitative, quasi-experimental, non-experimental, and meta-analysis	26 studies including qualitative, quasi-experimental, nonexperimental, and meta-analysis	• Competencies that are important for new graduates include communication, leadership, organization, critical thinking, specific situations (such as end of life care, emergency situations), and stress management • Integrate competencies into new graduate residency program and curricula. • Improve preceptor relationships and align preceptor program with new graduate competencies • Competency tools from various studies reviewed (Casey-Fink, Nurse Resident's Readiness for Entry into Practice, Performance Based	Excluded specific unit orientation, specialized orientation programs	Level III B Quality

				Development System Assessment, California Critical Thinking Skills Test, Basic Knowledge Assessment Tool, Nurse Competence Scale).		
22	Wangensteen, Johansson, Bjorkstrom, & Nordstrom (2012)	Non-experimental, Cross-sectional	730 graduate nurses who graduated from all Norway universities in 2006	• Critical thinking was the most prominent predictor of self-perception of competence. • Self-assessed most competent with "ethical" and "individualized nursing care"	Focus on academics, not clinical practice competence	Level V, B Quality
23	Wolfensperger-Bashford, Shaffer, & Young (2012)	Mixed method study	31 RNs at one hospital	• Competency-based assessment tool was helpful (87%) • Helped preceptor develop goals with new graduate nurse (73%) • Preceptor input to tool helps with its use	Sample size low One hospital	Level V, B Quality

Appendix C

Survey

1. Select your department:
   - Medical Unit 1
   - Medical Unit 2
   - Medical & Oncology
   - Surgical Care Unit 1
   - Surgical Care Unit 2
   - Observation
2. How many years have you precepted?
   - Less than 1 year
   - 1 – 2 years
   - 3 – 4 years
   - 5 – 10 years
   - 10+ years
3. The competency tool provides a clear description of what is required in each competency.
   - Strongly Agree (5)
   - Agree (4)
   - Undecided (3)
   - Disagree (2)
   - Strongly Disagree (1)
4. The competency tool includes language that is clear and unambiguous.
   - Strongly Agree (5)
   - Agree (4)
   - Undecided (3)
   - Disagree (2)
   - Strongly Disagree (1)
5. The competency tool includes competencies that are meaningful to daily nursing practice in my practice area.
   - Strongly Agree (5)
   - Agree (4)
   - Undecided (3)
   - Disagree (2)
   - Strongly Disagree (1)
6. The competency tool is structured in a way that facilitates transition from one nurse preceptor to another.
   - Strongly Agree (5)
   - Agree (4)
   - Undecided (3)
   - Disagree (2)
   - Strongly Disagree (1)
7. The competency tool helps me understand the new nurse orientee's progress as s/he works with different preceptors.

- Strongly Agree (5)
- Agree (4)
- Undecided (3)
- Disagree (2)
- Strongly Disagree (1)

8. The competency tool helps me make a plan for learning with my nurse orientee.
   - Strongly Agree (5)
   - Agree (4)
   - Undecided (3)
   - Disagree (2)
   - Strongly Disagree (1)

9. The competency tool helps me give feedback to my nurse orientee about her/his development and areas of opportunity.
   - Strongly Agree (5)
   - Agree (4)
   - Undecided (3)
   - Disagree (2)
   - Strongly Disagree (1)

10. The competency tool is organized in a logical manner.
    - Strongly Agree (5)
    - Agree (4)
    - Undecided (3)
    - Disagree (2)
    - Strongly Disagree (1)

11. The competency tool allows me to accurately document a new nurse orientee's competence.
    - Strongly Agree (5)
    - Agree (4)
    - Undecided (3)
    - Disagree (2)
    - Strongly Disagree (1)

12. The competency tool is useful to me as a preceptor.
    - Strongly Agree (5)
    - Agree (4)
    - Undecided (3)
    - Disagree (2)
    - Strongly Disagree (1)

13. What do you like best about the competency tool?
14. What suggestions do you have to improve the competency tool?

Appendix D

Informed Consent

You are invited to participate in this quality improvement project because you have been

identified as a preceptor on a medical or surgical care unit. This project is being conducted by

Katie Schulz, a Doctor of Nursing Practice student at St. Catherine University. The purpose of

this survey is to gather preceptor feedback on the orientation competency tool (currently called

the Orientation Checklist). The survey includes items about new hire competency and the ease of

use of the competency tool. The data that we collect from this survey will be used to guide

revisions to the orientation competency tool. You will be surveyed before changing the

orientation competency tool, after changing the orientation competency tool, and after using the

new orientation competency tool with new hire RNs. It will take approximately 10 minutes to

complete.

Your responses to this survey will be anonymous and results will be presented in a way that no

one will be identifiable. Confidentiality will be maintained to the degree permitted by the survey

technology used, Survey Gizmo. Specifically, no guarantees can be made regarding the

interception of data sent via the Internet by any third parties.

Your participation is voluntary and your decision whether or not to participate will not affect

your relationships with the researchers or St. Catherine University. If you decide to stop at any

time you may do so. You may also skip any item that you do not want to answer. If you have any

questions about this project, please contact Katie Schulz at kaschulz006@stkate.edu or 320-293-

7431 or the Institutional Reviewer Board Chair: John Schmitt, PT, PhD, 651.690.7739;

jsschmitt@stkate.edu. By responding to items on this survey you are giving us your consent to

allow us to use your responses for quality improvement and educational purposes.

Appendix E

Baseline Survey Results (n=27)

Question	n (%)
1. Select your department:	
• Medical Unit 1	6 (22%)
• Medical Unit 2	7 (26%)
• Medical & Oncology	8 (30%)
• Surgical Care Unit 1	1 (4%)
• Surgical Care Unit 2	4 (15%)
• Observation	1 (4%)
2. How many years have you precepted?	
• Less than 1 year	0 (0%)
• 1 – 2 years	8 (30%)
• 3 – 4 years	2 (7%)
• 5 – 10 years	10 (37%)
• 10+ years	7 (26%)
	Mean
3. The competency tool provides a clear description of what is required in each competency.	3.29
4. The competency tool includes language that is clear and unambiguous.	3.63
5. The competency tool includes competencies that are meaningful to daily nursing practice in my practice area.	3.61
6. The competency tool is structured in a way that facilitates transition from one nurse preceptor to another.	3.29
7. The competency tool helps me understand the new nurse orientee's progress as s/he works with different preceptors.	3.00
8. The competency tool helps me make a plan for learning with my nurse orientee.	3.17
9. The competency tool helps me give feedback to my nurse orientee about her/his development and areas of opportunity.	3.17
10. The competency tool is organized in a logical manner.	3.42
11. The competency tool allows me to accurately document a new nurse orientee's competence.	3.17
12. The competency tool is useful to me as a preceptor.	3.29

Appendix F

Pre-Implementation Survey (n=25)

Question	n (%)
1. Select your department:	
• Medical Unit 1	6 (24%)
• Medical Unit 2	5 (20%)
• Medical & Oncology	2 (8%)
• Surgical Care Unit 1	5 (20%)
• Surgical Care Unit 2	6 (24%)
• Observation	1 (4%)
2. How many years have you precepted?	
• Less than 1 year	3 (12%)
• 1 – 2 years	5 (20%)
• 3 – 4 years	7 (28%)
• 5 – 10 years	4 (16%)
• 10+ years	6 (24%)
	Mean
3. The competency tool provides a clear description of what is required in each competency.	3.74
4. The competency tool includes language that is clear and unambiguous.	3.96
5. The competency tool includes competencies that are meaningful to daily nursing practice in my practice area.	4.04
6. The competency tool is structured in a way that facilitates transition from one nurse preceptor to another.	3.74
7. The competency tool helps me understand the new nurse orientee's progress as s/he works with different preceptors.	3.57
8. The competency tool helps me make a plan for learning with my nurse orientee.	3.70
9. The competency tool helps me give feedback to my nurse orientee about her/his development and areas of opportunity.	3.78
10. The competency tool is organized in a logical manner.	3.70
11. The competency tool allows me to accurately document a new nurse orientee's competence.	3.74
12. The competency tool is useful to me as a preceptor.	3.83

Appendix G

Post-Implementation Survey (n=XX)

Question	n=15
1. Select your department:	
• Medical Unit 1	2 (13%)
• Medical Unit 2	8 (53%)
• Medical & Oncology	4 (27%)
• Surgical Care Unit 1	1 (7%)
• Surgical Care Unit 2	0
• Observation	0
2. How many years have you precepted?	
• Less than 1 year	1 (7%)
• 1 – 2 years	3 (20%)
• 3 – 4 years	6 (40%)
• 5 – 10 years	5 (33%)
• 10+ years	0
	Mean
3. The competency tool provides a clear description of what is required in each competency.	4.40
4. The competency tool includes language that is clear and unambiguous.	4.40
5. The competency tool includes competencies that are meaningful to daily nursing practice in my practice area.	4.27
6. The competency tool is structured in a way that facilitates transition from one nurse preceptor to another.	4.27
7. The competency tool helps me understand the new nurse orientee's progress as s/he works with different preceptors.	4.13
8. The competency tool helps me make a plan for learning with my nurse orientee.	4.13
9. The competency tool helps me give feedback to my nurse orientee about her/his development and areas of opportunity.	4.20
10. The competency tool is organized in a logical manner.	4.13
11. The competency tool allows me to accurately document a new nurse orientee's competence.	4.27
12. The competency tool is useful to me as a preceptor.	4.33

Appendix H

Comparison of Means

Preceptor Survey

	Provides a clear description of what is required in each competency.	Includes language that is clear and unambiguous.	Includes competencies that are meaningful to daily nursing practice in my practice area.	Is structured in a way that facilitates transition from one nurse preceptor to another.	Helps me understand the new nurse orientee's progress as s/he works with different preceptors.	Helps me make a plan for learning with my nurse orientee.	Helps me give feedback to my nurse orientee about her/his development and areas of opportunity.	Is organized in a logical manner.	Allows me to accurately document a new nurse orientee's competence.	Is useful to me as a preceptor.
■ Baseline	3.29	3.63	3.61	3.29	3.00	3.17	3.17	3.42	3.17	3.29
■ Pre-Implementation	3.74	3.96	4.04	3.74	3.57	3.70	3.78	3.70	3.74	3.83
■ Post-Implementation	4.4	4.4	4.27	4.27	4.13	4.13	4.2	4.13	4.27	4.33

Appendix I

Summary of Open-Ended Questions

RN preceptors were asked to respond to the following two questions. Comments are categorized into themes outlined below in a bulleted list.

What do you like best about the competency tool?

Baseline Survey:
- It is organized well, clear, and is easy to use
- The multiple area that are addressed within the competency tool
- Tool is universal
- Option to verbalize vs observe some competencies

Pre-implementation Survey:
- More clear and direct than the previous one. Clear expectation and explanation of each competency.
- Competencies more applicable to daily nursing practice
- The groupings of competencies into levels are easy to navigate
- Easy to pass new orientee from preceptor to preceptor

Post-implementation Survey:
- Clear, concise competencies and objectives
- Provides progression to orientation and handoff between preceptors
- Updated, pertinent, relevant competencies to daily practice

What suggestions do you have to improve the competency tool?

Baseline Survey:
- The tool does not help with continuity between preceptors
- Competencies are not applicable to current nursing practice. Outdated terms
- Tool is not often seen until the end of each shift, making it hard to use it to plan orientation
- Having more areas to comment and communicate between preceptors
- Request more detail on expectations for each competency
- Lengthy tool and takes lots of time to complete
- Transition in it from written form to online

Pre-implementation Survey:
- Room for subjective observations for constructive feedback and props to the new RN
- There are some "boxes" of competencies with multiple tasks. A preceptor may touch on one point but not others. It would be helpful to be able to score each bullet point.
- Some larger competencies should be broken out into multiple items
- Tool is still lengthy

- Some items are still not applicable to daily practice, but are more regulatory in nature

Post-implementation Survey:
- Desire for more unit-specific competencies
- Hard to change to tiered skill acquisition model