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An analysis of the nurse internship program at Naval Medical Center San Diego

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THESIS

AN ANALYSIS OF THE NURSE INTERNSHIP PROGRAM AT NAVAL MEDICAL CENTER SAN DIEGO

by

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March 2003

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AN ANALYSIS OF THE NURSE INTERNSHIP PROGRAM AT NAVAL MEDICAL CENTER SAN DIEGO

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Submitted in partial fulfillment of the
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ABSTRACT

This thesis examines the implementation elements of the Nurse Internship Program (NIP) at Naval Medical Center San Diego. The NIP provides nurses with no or little nursing experience an opportunity to participate in professional development as United States Navy Nurse Corps officers. The resolution to implement a NIP requires resource allocation decisions and commitment from top leaders in the organization. A review of adult learning and teaching methods is presented as a foundation for the NIP. It emphasizes the Dreyfus skill acquisition model adapted to the nursing profession by Benner that depicts the "novice to expert" continuum. Next, an overview of nursing orientation framework as found in the civilian and military healthcare organizations focuses on the program implementation. A discussion of resource allocations made by organizations for a NIP or a nursing orientation program is then presented. Historical accessions data are examined to demonstrate the trend in new nurse appointments to the Navy. The NIP offers potential benefits to the organization and the nurse interns. Planning, evaluation, and leadership support are important drivers in the NIP framework. Recommendations are presented for further study based on the foundational aspects of this study.

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I. INTRODUCTION

A. BACKGROUND

The Nurse Internship Program (NIP) provides new nurses, that is a nurse with no or little nursing experience, an opportunity to participate in professional and career development as officers in the United States Navy Nurse Corps (USN NC). The web site at the Naval Medical Center, San Diego (NMC SD) describes the purpose of the NIP as follows: "to offer orientation to recent graduate nurses and registered nurses with minimal clinical experience to the generalized profession of nursing."[1] Training provides the new nurses with the opportunity to gain competency in various nursing skills.

New nurses, who join the Navy, have recently graduated from a college or university and received a bachelor's degree in nursing. They have the minimum amount of knowledge required to enter the profession. Some graduate nurses have their nursing license upon commissioning as officers. All nurses must attain nursing licensure, as it is the only proof that they have met the minimum requirements to enter the profession as per state regulations. However, the need for education and training does not end with the nursing license. All new nurses need to gain additional knowledge and skills to prepare them for their role as a nursing professional and as Naval officers.

Carol Bradley, Editor of the web based *NurseWeek* journal, states that while building a workforce, it is important that "new nurses are brought into the profession in a supportive and nurturing environment".[2] She adds that because nursing is a knowledge profession, educational support is key to new nurses as they start their careers.[3] Many healthcare organizations provide a six to eight week nursing orientation to the assigned workplace. During this period, the organization expects the nurse to become proficient at a set of nursing skills needed for the specific area. Civilian hospitals hire nurses for a specific nursing position within the organization such as a nursing position in the emergency department. Similarly, most Naval medical treatment facilities (MTF) assign

[1] Naval Medical Center, San Diego, Command Information: Nurse Internship Program, [http://159.71.170.20/SiteMaker/websitefiles/nmcsdpub/command_info.cfm?id=207].

[2] NurseWeek Bradley, Carol, Building a Workforce: Let's Roll Out the Red Carpet for New Graduates, Editor's Note, [http://www.nurseweek.com/ednote/00/041700.html].

[3] Ibid.

new nurses to a clinical position as soon as these new nurses arrive at the command. The clinical setting is usually a medical-surgical ward, but other clinical settings such as mental health, pediatrics, and obstetrics receive new nurses. After these new nurses complete the six to eight week orientation schedule, they assume full patient care and team leading responsibilities. Perhaps, during the orientation period they may have gained some of the skills needed for their job. The nurses may be prepared for one particular area, but may lack some of the skills necessary to feel comfortable in dealing with complex situations that may arise in the course of their work. Frustration and negative feelings about the job and the profession may arise as a result of insufficient training and lack of support given during their orientation. Therefore, role transitio n from student nurse to staff nurse requires time, practice, and guidance. [4]

The NIP fills this training void as it provides skill-building opportunities to these new nurses as they enter their respective assigned workplace. In contrast to a typical orientation, a NIP offers systematic guidance to the new nurses and establishes the value the organization places on training and professional development. It solidifies the organizational culture as one that emphasizes training and education at all levels. Organizations have different priorities in the quest to fulfill their mission and strategic goals. For the NMC, providing top quality health care to its beneficiaries is one of those strategic goals. The NIP is a method that prepares the new nurses so they are able to provide top quality care to their patients. In addition, the NIP assists in the socialization of the new nurses to the culture and values of the organization.

Healthcare organizations allocate the necessary resources to implement a NIP or a similar program as a result of strategic planning. Strategic planning targets the recruitment and retention issues that prevail in the nursing market, where the demand for nurses far outruns the supply. In addition, the organizational strategy identifies the importance of clinical skill acquisition by new nurses as they transition into the nursing role as vital to the organization. In this context, resource allocation is important for the success of programs generated from strategic planning. However, all organizations are

[4] Godinez, Gwendolyn, Schweiger, Janice, Gruver, Julie, Ryan, Polly, Role Transition from Graduate to Staff Nurse: A Qualitative Analysis, *Journal for Nurses in Staff Development*. v. 15(3), pp. 97-109, May/June 1999, p. 108.

faced with constraints. Consequently, professional development programs for new nurses differ from organization to organization.

Organizations decide what type of education and training programs they offer to attract employees. For, example, the Navy recruits many nurses through college programs that provide a monetary incentive to join the Navy. The investment by the Navy starts before the new nurses join military service. Usually these nurses sign a contract for obligated service of four to five years depending on the program and the Navy pays a full salary corresponding to the grade once these nurse are commissioned officers. Although the Navy has made an initial investment, in general, a contract guarantees that these nurses remain in the service for four to five years.

Traditionally, the Navy places great emphasis on the training of its service members. The Navy devotes resources to train officers in various communities prior to their respective assignment at a command. During the training, these officers receive full pay and benefits. In keeping with the policy, the Navy NIP is a training and education program that accelerates the education and professional development of the new nurses. The desired result is a nurse who is ready to face the challenges and expectations related to the clinical setting.

The benefits of the NIP are divided between the NMC and the individual nurse. The benefit to the NMC consists of the increased productivity gained as new nurses fulfill the workload requirements of a general nursing billet. The benefits to the new nurses include, as a minimum, the following: increased self-confidence, improved morale, increased knowledge, and a higher skill level. The organization makes an investment through the allocation of resources to ensure the success of the NIP.

This thesis investigates the structure and benefits of the NIPs in a civilian healthcare organization, and then, in the military health system, with an emphasis on the Navy's internship program for nurses.

B. OBJECTIVE OF THE RESEARCH

The purpose of the research is to determine the benefits obtained from the NIP as experienced in NMC SD that could be of interest to the USN NC. It explores how the

NIP benefits the NMC, USN NC, and the nurse interns. In addition, it addresses how the NIP influences resource allocation and constraints in the healthcare organization.

C. RESEARCH QUESTIONS

The following primary research questions provide a focus for the research:

- Based on the experience with the NIP at NMC San Diego, what are the potential benefits of the NIP for the Navy?
- How could unit-staffing concerns be addressed during the daily operations of a NIP?

The secondary research questions will further breakdown the primary research questions to assist in the analysis of the study.

- How are NIPs and other nursing orientation programs applied in the civilian healthcare settings?
- How are the nursing orientation programs implemented in the US Air Force and the US Army?
- How is the NIP implemented at NMC SD?
- In addition to the NIP at NMC SD, what are other orientation programs in the Navy for NC officers?
- What is the status of nurse interns while in the NIP in relation to the NMC SD nursing staff?
- In general, how could new nurses in the NIP impact over all staffing at NMC SD?

D. SCOPE AND LIMITATIONS OF THE STUDY

This research examines NIPs in civilian healthcare facilities to determine the benefits obtained from these programs and to identify the program implementation elements. Next, the thesis focuses on a detailed review of the NIP at NMC SD. It looks at potential benefits of the NIP for the new nurses, the NC, and the NMC. It addresses the issue of how new nurses impact the staffing of the facility through a review of nursing distribution relative to nursing positions at the NMC. The assumption is that the new nurses, who are assigned to the NMC to fill staff nursing positions, initially lack the experience and competency to fulfill the job requirements. The time period spent by the new nurses in training represents a resource allocation decision by the NMC. The new nurses, who are assigned to the NMC to fill nursing positions, participate instead in the NIP for a predetermined length of time. The expected outcomes from the human

resource allocation decision are the benefits gained by the NMC and by the new nurses as a result of the NIP.

E. METHODOLOGY

The thesis is mostly qualitative in nature as it seeks to answer the primary and subsidiary research questions. The scope includes: (1) a review of relevant literature about NIP in the civilian and in the military sector, (2) a review of the NIP at NMC San Diego, (3) an analysis of nurse accession data and nursing distribution data at NMC SD in relation to nursing billets filled by new nurses, (4) conduct individual interviews with program directors to gain insight into program implementation, (5) a review of other relevant documents.

F. DEFINITIONS

The following terms are used repeatedly throughout this thesis. Unless otherwise noted, the following definition is used for the term.

Competency – "the ability to meet or surpass prevailing standards of adequacy for a particular activity"[5]

Division Officer (DO) **–** similar to a nurse manager in the civilian healthcare sector, and they also have a key role in the guidance and evaluation of the nurse interns during the time they spent in that unit.

Ensign – Entry-level grade of military officers

Efficiency – "…the ability to do things right…"[6] – to do things well

Effective – "…the ability to get the right things done."[7]

Fiscal Year – In the Department of Defense it starts on October first of each year and ends on September thirtieth of the following year.

New Nurse—a nurse with no clinical experience or with less than six months of clinical experience.

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[5] Nurse Corps Web Site, [https://bumed.med.navy.mil/med00nc/Competencies/Navy%20NursingCoreCompetencies.doc], February 2003 quote obtained from Butler, F. C., The Concept of Competence: An Operational Definition , Education Technology , 7, pp. 7-18, January 1978.

[6] Drucker, Peter F., The Essential Drucker, 1st Ed, p. 191, HarperCollins Publisher, 2001.

[7] Ibid., p. 192.

Preceptor – a nurse experienced in the clinical setting who assists the new nurse in the acquisition of clinical skills required for nursing competence. It is a key element of nursing orientation programs and nurse internship programs.

G. ORGANIZATION OF THE THESIS

Chapter II provides background information on adult leaning theory, skill acquisition in nursing, and nursing orientation programs. Emphasis is placed on an in-depth review of literature pertaining to nursing orientation, including NIPs, in the civilian healthcare organizations and in the military health system. The focus is on program design and content; skill acquisition and competency of new nurses; evaluation of the new nurses; evaluation of the program; and, staffing concerns faced by the organization. Next, a summary of implementation alternatives described in the nursing literature is presented. The chapter concludes with an investigation of nurse accession by the Navy.

Chapter III provides a detailed description of the NIP program at NMC SD. In addition, brief descriptions of the internship programs at NMC Portsmouth and National Naval Medical Center (NNMC) Bethesda are described for relevancy to the implementation of the NIP in the Navy. The chapter ends with an inquiry into the distribution of nurses at NMC SD in order to examine the distribution of new nurses in the facility.

Finally, Chapter IV provides answers to the research questions, presents conclusions based on the review of the programs investigated, and the data obtained. Then, the chapter provides recommendations based on the findings. The chapter ends with recommendations for future studies linked to the potential organizational and employee implications of the NIP.

II. LITERATURE REVIEW

A. INTRODUCTION

This chapter provides an in-depth literature review about a variety of training/orientation models present in the nursing literature. The models range from orientation to competency-based orientation to NIP. The chapter begins with a discussion of adult learning theory, including experiential learning theory, as the basis for teaching and learning methods used in the education of graduate nurses once they enter the workplace. Next, the literature review provides background information about general nursing orientation for new nurses. It is followed by a comprehensive review of nursing orientation, including NIPs, in the civilian healthcare organizations and in the military health system. The focus is on program design and content, skill acquisition and competency of new nurses, evaluation of the new nurses, evaluation of the program, and, staffing concerns faced by the organization. Some of the programs discussed are directed at graduate nurses, while others are geared towards all nurses who may be unfamiliar with a specific nursing specialty such as critical care nursing. Next, alternative plans for implementing a NIP are presented. Finally, the chapter ends with an analysis of nurse accession by the Navy.

B. LEARNING THEORY AND LEARNING METHODS

1. Adult Learning Theories

Adult learning theory provides a set of concepts that guide educators in facilitating learning in adults. These concepts are based on an integration of a variety of learning theories such as humanist, social, behaviorist, and constructivist theories. For example, Knowles' adult learning theory concepts of andragogy are based on the humanistic assumptions of learning theories.[8] The humanist theory view of the learning process is that the adult acts to fulfill potential and the teacher's role is to facilitate the development of the whole person.[9] Knowles' andragogy model has six fundamental concepts. 1) the learner's need to know; 2) the learner's self concept leading to self-directed learning; 3) the role of the learner's experiences; 4) the learner's readiness to

[8] Merriam, Sharan B. and Caffarella, Rosemary, S., Learning In Adulthood: A Comprehensive Guide, 2nd ed., pp. 248-266, Jossey-Bass Publishers, 1999.

[9] Ibid.

learn; 5) the learner's life-centered orientation to learning; and 6) the learner's motivation to learn.[10] When graduate nurses enter the workplace, they may seek out learning opportunities because they realize they have a need to learn additional knowledge and skills that allow them to properly function in their workplace. Dunn's (1994) findings from a study of 22 critical care nursing orientees provide indication of self-direction in nursing orientees. She also suggests: "The orientee should be a fully participating member of the orientation team with input into orientation goals, timelines for achievement of these goals, and standards for evaluations."[11] Graduate nurses want to focus their learning on the knowledge and skills that will give them the ability to competently provide patient care as well as to become functioning members of the nursing profession.

Another concept in andragogy is the role of the learner's experiences, which produce a diverse background in learning styles, motivation needs, interest, and goals.[12] As nurses enter the workplace, they have different knowledge-based levels of nursing theories and nursing concepts. In addition, some nurses have previous work experience, which may include related healthcare fields, such as Emergency Medical Technician. Some of the learning methods that utilize the prior experiences of adults consist of: "discussions, simulation exercises, problem-solving, activities, case method, and laboratory methods".[13] Dunn (1994) suggests not only that a variety of orientation methods should be available for the new nurses, but also that the individual needs of these new nurses should be considered during the orientation process.[14]

Consequently, the fourth and fifth concepts, "readiness to learn" and "orientation to learning" respectively, define whether the adult learner is ready to learn when faced with real-life situations that indicate a learning need.[15] Additionally, Knowles et. al.

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[10] Knowles, Malcolm S., Holton, Elwood F. and Swanson, Richard A., The Adult Learner, 5th ed., pp. 64-69, 133-152, Gulf Publishing Company, 1998.

[11] Dunn, Sandra V. and Fought, Sharon G., Novice Critical Care Nurses' Affective Responses to Orientation, Journal of Nursing Staff Development, v. 10(5), pp. 257-261, September/October 1994, p. 261.

[12] Knowles, Malcolm S., Holton, Elwood F. and Swanson, Richard A., pp. 64-69, 133-152.

[13] Ibid., p. 66.

[14] Dunn, Sandra V. and Fought, Sharon G., pp. 257-261.

[15] Knowles, Malcolm S., Holton, Elwood F. and Swanson, Richard A., pp. 64-69, 133-152.

(1998) points out that adults learn "new knowledge, understandings, skills, values, and attitudes most effectively when they are presented in the context of applications to real-life situations."[16] Finally, he suggests, motivation to learn is important for adults.

Other learning theories also have adult learning applications. For instance, social context, modeling, and mentoring are emphasized as fundamental to adult learning by social learning theory.[17] Behavioral objectives, competency-based education, and skill development and training are based on behaviorist learning theories.[18] Experiential learning and reflection are grounded on the constructivist learning theory, which suggests that the learning process is constructed from obtaining "meaning from experiences".[19] Knowles et. al. (1998) describes how Kolb adds to the experiential theory with the development of the experiential learning model demonstrated in Figure 2.1. Kolb suggests that an individual first experiences a situation as a concrete event then, after reflecting on the event, develops abstracts concepts, generalizations, and theories.[20] Next, people will test these abstracts concepts and theories when encountering new situations. Although the model illustrates a cycle, people develop a preference for a learning style from a combination of different aspects in the model.

16 Ibid., p. 67.

17 Merriam, Sharan B., and Caffarella, Rosemary S., pp. 248-266.

18 Ibid.

19 ibid., p. 264.

20 Knowles, Malcolm S., Holton, Elwood F. and Swanson, Richard A., pp. 64-69, 133-152.

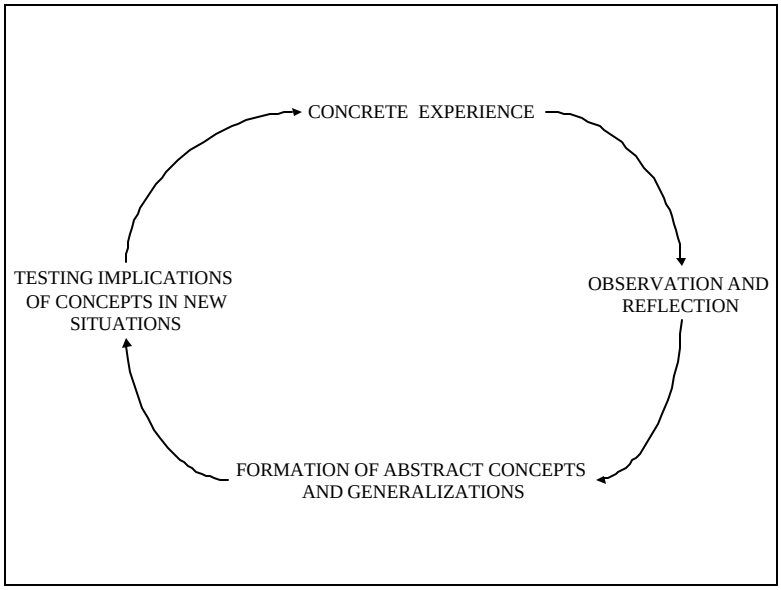

Figure 2.1. Kolb's Experiential Learning Model (From: Knowles, Holton, and Swanson, 1998)[21].

Table 2.1 illustrates how Knowles et. al. (1998) matched some of the learning and teaching strategies to Kolb's experiential model stages.

Table 2.1. Kolb's Model with Suggested Learning Strategies (From: Knowles, Holton, and Swanson, 1998)[22].

Kolb's Stage	**Example Learning/Teaching Strategy**
Concrete Experience	Simulation, Case Study, Field Trips, Real Experience, Demonstrations
Observe and Reflect	Discussion, Small Groups, Buzz Groups, Designated Observers
Abstract Conceptualization	Sharing Content
Active Experimentation	Laboratory experiences, On-the-Job Experience, Internships, Practice Sessions.

[21] Ibid,, p. 148.

[22] Ibid., p. 148.

In close agreement with these learning and teaching strategies in Table 2.1, Dunn's (1994) findings suggest the following methods for nursing education and practice: observation of procedures, skills labs, case study, individual study, group discussion including theoretical aspects of care, and opportunity to practice new skills.[23]

From the previous discussion, adult learning theories provide a solid foundation for educational programs geared towards professional development. Individuals lend their human capital, knowledge, skills, and abilities to the organization; therefore, employees want to have opportunities for continued personal growth and career development.[24] If an organizations desires to keep the best and the brightest, its organizational strategies for recruitment and retention should include the availability of educational opportunities for employees.[25] As one an organization's most valuable resources, knowledgeable workers may possibly give an organization a competitive advantage in industry.[26]

Adult learning theories open the door to the organization for establishing sound nursing orientation and training programs. These learning theories provide a framework for the development of programs that encourage new nurses to establish learning goals and seek out learning opportunities in a supportive environment. Orientation programs should foster the desire in new nurses to seek out learning opportunities, which include skill acquisition. A number of orientation models, with a base in adult leaning theory, provide examples of orientation programs for nurses, but most importantly for new nurses as they start their professional development.

2. Benner's Framework for Skill Development in Nurses

Benner (1984) searched for the knowledge embedded in nursing practice as she set out to describe a model, which could be used to identify "…the knowledge that accrues over time in the practice of an applied practice."[27] Benner's (1984) main goal

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[23] Dunn, Sandra V., and Fought, Sharon G., pp. 257-261.

[24] Mayo, Andrew, The Human Value of the Enterprise: Valuing PEOPLE As Assets Monitoring, Measuring, Managing, pp. 18-39, Nicholas Brealey Publishing, 2001.

[25] Ibid.

[26] Drucker, pp. 191-194.

[27] Benner, Patricia, From Novice to Expert: Excellence and Power in Clinical Nursing Practice, pp. 1-38, Menlo Park, CA: Addison-Wesley Publishing Company, Inc., 1984, p. 1.

was a desire to implement a method to systematically record observations based on what clinical nurses learn from their practice in the clinical setting.

Benner (1984) applied the Dreyfus skill acquisition model to the development and skill acquisition of clinical judgment and clinical interventions by nurses in the clinical setting.[28] The model is based on five levels: 1) novice, 2) advanced beginner, 3) competent, 4) proficient, and 5) expert.[29] Benner (1984) describes the characteristics and abilities that nurses demonstrate at each level, which are described in Table 2.2.

As graduate nurses enter the workplace, they come with a set of nursing theories, rules, and general knowledge about nursing practice learned in nursing school. Yet, they lack or possess little of the various specific skills required to identify priorities in order to achieve positive patient outcomes. Hence, graduate nurses are considered by Benner to be in the Advanced Beginner Stage where the behavior is governed by rules and it "…is extremely limited and inflexible".[30] In this stage "…they need support in the clinical setting since they operate on general rules and guidelines and it is at this stage that they are only beginning to see recurrent patterns as they gain clinical experience."[31] Benner exhorts that "Their nursing care of patients needs to be backed up by nurses who have reached at least the competent level of skill and performance, to ensure that important patient needs do not go unattended because the advanced beginner cannot yet sort out what is most important."[32] This idea asserts the importance of preceptors, who by Benner's description should be able to prioritize and manage nursing care in the clinical setting. Therefore, the interaction between the preceptor and the graduate nurse fosters the development and acquisition of judgment and intervention skills in the new nurse, such as critical thinking, technical skills, interpersonal communication, and patient care team management skills.

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[28] Ibid.

[29] Ibid.

[30] Ibid., p. 21

[31] Ibid., p. 24.

[32] Ibid., p. 25.

Table 2.2. Benner Application of the Dreyfus Model to Nurses (After: Benner, 1984).[33]

STAGE	GENERAL EXPERIENCE WITH SITUATION/BEHAVIOR	TEACHING/LEARNING METHODS
Novice	No experience in situation in which they are expected to perform / Rules guide performance	Rules, theory, procedural list of things to do.
Advanced Beginner	Recognize aspects (overall, global characteristics that can be identified only through prior experience) / Demonstrate marginally acceptable behavior	Guidelines for aspect recognition. Support in the clinical setting, priority setting
Competent	Conscious, deliberate planning helps achieve efficiency and organization. A plan dictates priorities. Lacks speed and flexibility of the next level, but has a feeling of mastery and ability to cope with and manage the many contingencies of clinical nursing. Plan is based on a conscious, abstract and analytical contemplation of the problem.	Decision making games, simulation: practice in planning, and coordinating multiple, complex patient care demands
Proficient	Holistic understanding, perceives situation as a whole, performance is guided by maxims.[34] Experienced-based ability to recognize whole situations, improved decision making by recognizing what is most important.	Challenging case studies that tax ability
Expert	Intuitive grasp of the situation, able to focus on the accurate area of the problem without wasteful consideration of a large range of unfruitful, alternatives	Clinical knowledge development. They benefit from recording and describing critical incidents from their practice that illustrate expertise or a breakdown in performance

In addition, Benner (1984) indicates the idea that a nurse, who might have prior experience in one nursing specialty, an may be considered a novice when entering another nursing specialty where they have little if any experience and the rules and tools

[33] Ibid., pp. 1-38

[34] Maxim – "Cryptic instructions that make sense only if the person already has a deep understanding of the situation." (Benner, p. 10) Maxims reflect nuances of the situation. (p. 29). Perceptual knowledge is hidden by maxims.

are new. It is important to note that the Dreyfus model is based on situational experience rather than on the traits or talents of a nurse. A nurse who is experienced in a nursing specialty may be considered competent in that nursing specialty. However, this nurse could move to the Novice or Advanced Beginner Stage when encountering a nursing specialty where the nurse lacks experience with the patient population found in the new practice setting. For example, a nurse who has worked with adults for the last five years has gained experience with nursing situations that deal with the adult patient population. If the same nurse is placed in a pediatric unit, that nurse may lack the skills necessary to provide safe, quality care. This concept normally applies to any person in any profession where technical skill acquisition is necessary. Through learning, support, guidance, and experience, the graduate nurse starts to acquire the level of competency required to provide quality patient care.[35]

C. THE ESSENTIALITY OF ORIENTATION

As graduate nurses enter the workplace, they start to make the transition from student to nurse. In nursing school, nurses obtain the theoretical framework and basic nursing concepts that are the fundamentals of the nursing profession. A nursing license is a requirement to practice but it represents the minimum requirements to enter the nursing field. Sometimes a nurse's first orientation experience is unstructured, and offers little guidance. The new nurse is faced with the reality of work and often the new nurse is overwhelmed and frustrated because of the inability to provide even adequate patient care. This may in turn lead to a dissatisfied new nurse, which may lead to morale issues leading to the turnover of the nurse.[36,37]

The efficiency and effectiveness of nursing orientations vary across hospitals. The graduate nurse not only has to adapt to nursing in a organization that is different from school, but also has to learn clinical skills, develop critical thinking skills, establish time management skills and patient care team leadership skills. As a basic rule, orientation programs should offer the new nurse an opportunity to learn and develop

[35] Ibid.

[36] Mathews, Joan J. and Nunley, Carolyn, Rejuvenating Orientation to Increase Nurse Satisfaction and Retention, Journal of Staff Development 8, no. 4, pp. 159-164, July/August 1992.

[37] Goldsberry, J. E., From Student To Professional, J. Nursing Administration, v. 7, p. 49, 1977, referenced in Roell, Shelagh M., Nurse-Intern Programs: How They're Working, Journal of Nursing Administration, pp. 33-36, October 1981.

skills that allow the nurse to feel proficient in the workplace. In return, such an orientation experience may increase the nurse's self-confidence and self-esteem as well as develop an organizational and professional commitment.[38].

Sochalski (2002) published a study on the nursing shortage.[39] She exhorts healthcare organizations and the government to place an equal amount of emphasis on "supply-side strategies" at the workplace to retain nurses and, further, to replace those who leave by recruiting people to attend nursing school.[40] In her analysis, she used data from the 1992, 1996, and 2000 National Sample Survey of Registered Nurses.[41] The study method utilized population weighed data, except where it was noted, that used "…sampling weights created in each survey year to provide national estimates of the entire registered nurse (RN) population."[42] She found that in 2000 the number of new female nurses who were not working in nursing was 4.1 percent and 7.5 percent of new male nurses who were not working in nursing.[43] When compared to the 1996 survey, the percentage for females remained steady, but for men the percentage doubled.[44] The study also investigated the satisfaction nurses had with their current job. Sochalski found that new nurses were among the most satisfied, but warned that one might predict that this "new cohort of nurses may be destined to see their satisfaction levels sag over time, which, depending on market conditions, could influence their decisions to continue in their positions or to leave nursing entirely."[45] In conclusion, workplace initiatives that focus on the satisfaction of nurses with their jobs may be a step towards increasing the supply of nurses.

If the new nurses receive an orientation that helps prepare them to deal with job challenges as well as providing opportunities for career development, it might be a

38 Mathews, Joan J. and Nunley, Carolyn, pp. 159-164.

39 Sochalski, Julie, Nursing Shortage Redux: Turning the Corner On An Enduring Problem, Health Affairs, v. 21(3), pp. 157-164, September/October 2002.

40 Ibid., p. 163.

41 Total RN Sample (Unweighted): 1992--32,304; 1996—29,766 and 2000—35,358. The Total Registered Nurse Population: 1992-2,239, 816; 1996—2,558,874; 2000—2,696,540, Ibid, p. 158.

42 Ibid., p. 158.

43 Ibid,, percentages are from sample in footnote 41.

44 Ibid.

45 Ibid., p. 161.

retention incentive, encouraging more nurses to stay within an organization and in the nursing profession. It is important to note that a proficient orientation is not the only solution to this complex problem, but it opens the door to improved working conditions. For example, Domrose (2002) describes the events that caused a new nurse, recently out from nursing school, to lose the excitement and enthusiasm she had when she first entered the workplace. Within a few weeks after completing nursing school, the new nurse was placed on the night shift. However, within a few weeks, this new nurse found herself frightened, confused, miserable, and suffering from low self-confidence after a series of events where she was ridiculed for not knowing her job and for making one minor error.[46] After discussing the situation with the new nurse, the education specialist placed the nurse with a supportive preceptor and with a mentor. After definitive guidance and support from a mentor, this new nurse now excels in her job, and she is willing to remain in her nursing position.[47]. Ultimately, the retention goal was achieved.

Del Bueno (1994) has studied the level of knowledge and skills of recent nursing school graduates. The study evaluated 452 new graduate nurses who worked at fourteen hospitals. The Del Bueno (1994) study results identified deficiencies in the critical thinking and interpersonal skills of the new nurses.[48] Her research method consisted of presenting a video simulation of a patient problem to graduate nurses and rating their assessment of the situation. She utilized previously established criteria from a prior study to rank the answers, thus avoiding rater bias. The results indicated that from the 452 graduate nurses, 12-60 percent could not demonstrate acceptable entry-level abilities. The wide range was due to the individual variations and diversity that occurred within and among the fourteen hospitals investigated. In Del Bueno's summary, she admonishes nursing educators both in school and clinical settings to use adult "…active learning methods that enhance ability to synthesize data, choose among interventions for effective problem management, and differentiate the relative priority of patients' needs."[49] It is the

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[46] Domrose, Cathryn, A Guiding Hand, NurseWeek News, 11 February 2002, [http://www.nurseweek.com/news/features/02-02/mentor_print.html], January 2003.

[47] Ibid.

[48] Del Bueno, Dorothy J., Why Can't New Grads Think Like Nurses? Guest Editorial, Nurse Educator 19, no. 4, pp. 9-11, July/August 1994.

[49] Ibid., p. 11.

development of critical thinking skills that allows a nurse to problem solve and set priorities during patient care. As a result, an orientation program must factor in the development of critical thinking skills in new nurses.

An orientation program also serves the purpose of socializing nurses to the nursing profession and to the organization. In a study, by Bartlett (1980) concerning neophyte United States Air Force (USAF) Nurse Corps officers, the orientation program was one of the variables used to examine the orientation program's significance on the level of perceived stress experienced by these nurses at their workplace.[50] The sample consisted of 45 USAF nurses with up to twelve months of active duty and up to eighteen months of nursing experience. Using ANOVA methods, the study found a significant relationship between not attending the internship program and "staff-centered conflict", and not attending the internship program and "other" factors, both at the level of significance of $p < 0.01$.[51] Bartlett (1980) points out that the results agree with literature findings that socialization to the profession in some form alleviates stress, stressful situations, and reality shock.[52] She concludes with the ultimate goal of an education program as:

> …being lessened stress, smoother successful transitions into practice, lessened degrees of reality shock, and retention of this recently graduated nurse in the nursing profession rather than disillusionment and ultimately, exodus.[53]

Preparation is crucial to achieving the desired outcome of a self-confident and skilled professional who is able to cope with the stressful situations encountered in the workplace. Healthcare administrators and managers have the opportunity to provide an education program to assist in the transition process of graduate nurses into the nursing profession and the organization. Figure 2.2 shows a conceptual model that demonstrates the path a graduate nurse could potentially go through during the orientation process to produce the desired outcome. Each facility determines the resources utilized to

[50] Bartlett, Alayne L., Stressful Situations of Air Force Nurses Recently Graduated from Pre-Service Baccalaureate Programs in Nursing As Identified by Critical Incident Technique, A Master's Project, Saint Louis University, 1980.

[51] Ibid., ANOVA – Analysis of Variance.

[52] Ibid.

[53] Ibid., p. 127.

implement a type of educational program designed to assist the graduate nurse traverse the pathway from novice nurse to an experienced nurse. Organizations prefer the orientation outcome of nurses who are able to adapt to the reality of work and competently manage the work requirements. However, the actual outcome obtained may be very different from the desired outcome as it depends on the type of education program.

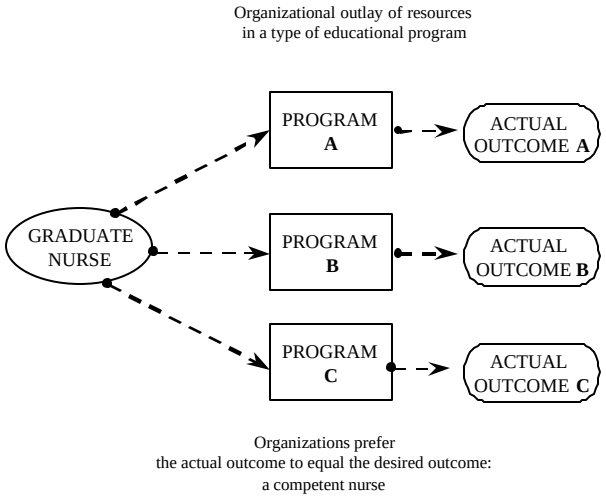

Figure 2.2. Nursing Orientation Programs: Actual and Desired Outcome.

Godinez et. al. (1999) proposed a dynamic model that describes the processes that occur in orientation programs as well as the components of an orientation program. The model illustrates a dynamic process that occurs between graduate nurses and the preceptor assigned to orient them. The study, behind the model development, consisted of a content analysis performed on a daily feedback sheet utilized by the orientees and the preceptor to communicate. The unit manager and nursing resource personnel also used the feedback sheets to evaluate the orientees' progress. The sample consisted of twenty - seven orientees and preceptors with a total of 299 feedback sheets. Figure 2.3 contains the model that describes the transition of a graduate nurse to staff nurse as a "dynamic and iterative process" that occurs between the orientees and the preceptor based on an

organizational setting.[54] Five themes emerged from the study: 1) "real" nurse work, 2) guidance, 3) transitional processes, 4) institutional context, and 5) interpersonal dynamics. Each circle in the model contains the factors that the orientees and preceptors found important in each theme as determined by the researchers. All of these factors interact to produce a change in the orientees as they grow in their orientation. It is an iterative process because the models suggests "that competence, combined with the preceptor's approval, leads to confidence" which in turn feeds the competence that leads the orientee and the preceptor to the next learning opportunity.[55]

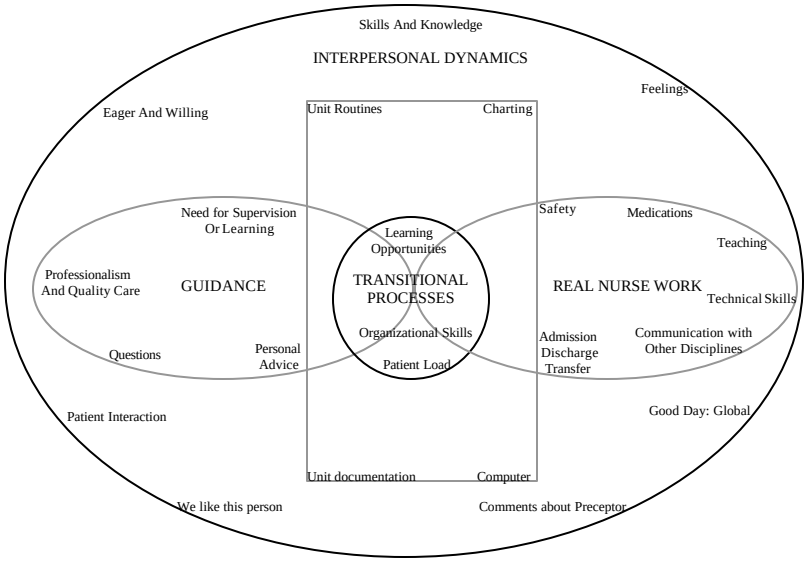

Figure 2.3. Model of the Process of Registered Nurse Role Transition (From: Godinez et. al., 1999)[56].

Lavoie-Tremblay et. al. (2002) identified key elements that ease the orientation.. These are:

- To offer a reassuring and warm welcome at the beginning of employment and to consider new nurses with compassion,

[54] Godinez, Gwendolyn, Schweiger, Janice, Gruver, Julie, and Ryan, Polly, Role, pp. 97 -109.

[55] Ibid,, p. 107.

[56] Ibid,, p.100.

- To offer complete and precise training from the onset,
- To train supervisors and to provide them with tools to measure the continuing progress of professional competence,
- To offer constant support for new nurses, and
- To evaluate the orientation program on a permanent basis.[57]

These elements may be basic determinants of the success of an orientation program for nurses, but even more significantly so for new nurses. The new nurses are transitioning between nursing school and "real" nursing work.

Mathew and Nunley (1992) describe the nursing department revision of the nursing orientation program at Foster G. McGaw Hospital, at Loyola University Chicago, Illinois. The department had to act because it faced a very high one-year turnover rate of 53 percent of orientees leaving the hospital within twelve months of employment.[58] This percent was unacceptably high. As it cost an average of $8,140 dollars to orient each nurse, the hospital considered the high level of turnover undesirably costly.[59] They decided to change the way they taught the clinical skills necessary for these nurses to be proficient and confident in their environment. Prior to the changes, classes and patient care had no direct link, resulting in frustration and dissatisfaction with the work setting. Often, the nurses felt that the orientation was insufficient to prepare them to work within a complex work setting such as a hospital. The change integrated the clinical portion of orientation with the classes. As nurses learned something in the classes, they were able to apply it to patients in a relatively short period of time.[60]

Another common goal is the socialization of nurses to the nursing profession as well as to the organization for which they are working. Another change the nursing department at Foster G. McGaw hospital implemented was the addition of socialization and induction processes to the clinical portion of the orientation program. The

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[57] Lavoie-Tremblay, Melanie, Viens, Chantal, Forcier, Marie, Labrosse, Nicole, Lafrance, Michelle, Laliberte, Denise and Lebeuf, Marie-Laure, How to Facilitate the Orientation of New Nurses into the Workplace, Journal For Nurses In Staff Development, v. 18(2), pp. 80-85, March/April 2002, Quote from p. 81.

[58] Mathews, Joan J. and Nunley, Carolyn, pp. 159-164.

[59] Ibid.

[60] Ibid.

socialization and induction process focused the orientee toward the organizational culture and values to generate loyalty to the organization.[61]

The other significant modification of the orientation process was the change in the role of various players in the orientation process. These players were the Clinical Nurse Specialist (CNA), the Nursing Staff Educators, and the clinical preceptors. The most significant change was the initiation of giving support to clinical preceptors. "Preceptors are required to attend quarterly workshops for continued training in adult learning theory, clinical teaching strategies, and materials preparation."[62]

New nursing orientees evaluated the nursing orientation program at Foster G. McGaw hospital after the changes occurred. The results demonstrated an overwhelmingly positive evaluation described as providing the following: "…clearer focus, better organization, and a more welcoming climate for new staff."[63] The underlying message to the orientees is that they are valuable members of the organization; thus, the organization demonstrates support and availability of the right resources for the new orientees to succeed in the organization. The achievement of these two main goals, development of clinical skills and organization integrations, should be considered important results of an orientation program.

D. EXAMPLES OF ORIENTATION PROGRAMS FOR NURSES

1. Competency-Based Orientation (CBO) Program

Another approach that has had a direct impact on the outcomes of nursing orientation is the development of competency-based orientation programs. As defined by Chaisson (1995), competency focuses on an individual's actual performance in a particular situation, while competence is an individual's potential to function in the situation.[64] A competency-based orientation (CBO) program was established at Charity Hospital and Medical Center of Louisiana in New Orleans in order to meet the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirement. A JCAHO requirement specifies that all nursing staff be competent in their job.

[61] Ibid.

[62] Ibid., p. 163.

[63] Ibid., pp. 163-164.

[64] Chaisson, Sandra, Role of the CNS in Developing a Competency-Based Orientation Program, Clinical Nurse Specialist, pp. 32-37, v. 9(1) 1995.

Additionally, CBO was developed with the goal of focusing on performance in addition to knowledge.[65] CBO is important to health care professionals, because it ensures that they demonstrate "clinical competency that includes both knowledge and technical skills."[66] Before CBO was implemented at this facility, the orientation of new nurses was fragmented, irregular, and costly as information given to the new nurses depended on what the particular unit or preceptor thought was important.[67] Such an unstructured orientation may fail to promote sound clinical skills and organizational commitment as learning occurs sporadically and is disjointed. CBO offers a structured environment to nursing orientation programs.

One of the main benefits of the CBO approach is that this program consolidated the orientation into general and unique components. The general components are orientation elements that are similar throughout the hospital. On the other hand, unique competencies are orientation elements that are applicable to a specific nursing unit such as pediatrics. At Charity Hospital, the elements of the general and unique orientation components include: measurable performance expectations, unit-specific skills, assessment tools, evaluation methods, and learning resources."[68] Other benefits for the organization and the educator include a decrease in orientation hours for experienced nurses and an increase in quality control by providing consistent information to each new nurse.[69]

Finally, the evaluation of the nurses in the CBO consisted of cognitive testing and evaluation of skills by using return demonstration, simulation, or role-playing.[70] This is an important step that clarifies for the new nurses what they still need to work on, and to define goals for advancement.

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65 Ibid.

66 Ibid., p. 37.

67 Ibid.

68 Ibid., p. 33.

69 O'Grady, T. and O'Brien, A., A Guide to Competency-Based Orientation, Journal of Nursing Staff Development, 8(3), 1992, pp. 128-133, Referenced in Chaisson, pp. 32-37.

70 Chaisson, Sandra, pp. 32-37.

2. Clinical Entry Nurse Residency Program

An orientation program based on a nurse residency idea was developed and piloted at Beth Israel Hospital of Boston in June of 1992. The residency positions are part of the existing nursing budget.[71] The Clinical Entry Nurse Residency program is a combination of orientation and career development for professional nurses directed at a baccalaureate degree for graduate nurses. The components are based on the Dreyfus' skill acquisitions model that Benner applied to nursing development as previously discussed. The main goal of the Nurse Residency Program is to have a nurse advance to the competent level by the end of the two-year program.[72] The residency program is divided into two parts. The first part is the original orientation schedule, which consists of a six-week competency-based orientation with a clinical preceptor. The second part adds a hands-on clinical teaching and sponsorship component that is linked with career planning over the two years of the residency programs.[73]

In order to accomplish the goal, the Clinical Entry Nurse Residency Program has five main objectives:

- Demonstrate the centrality of the professional nurse-patient-family relationship to clinical practice
- Demonstrate competence in providing quality, cost-effective nursing care
- Demonstrate leadership skills in all aspects of professional practice
- Formulate a plan for continued development and overall career goal
- Appreciate the larger context of the health care delivery system and how it affects clinical practice of nurses[74]

The program accomplishes its goals and objectives through the application of two main components. The first component is the use of an array of learning methods. The second is a well-orchestrated sponsorship program. The learning methods utilized provide the basis for expanding on previous knowledge, for appropriate management of

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[71] McHugh, Michele, Duprat, Laura J. and Clifford, Joyce C., Enhancing Support for the Graduate Nurse, American Journal of Nursing, v. 96(6), pp. 57-62, June 1996.

[72] Ibid.

[73] Ibid.

[74] Ibid., p. 57.

resources, for developing critical thinking, decision-making, and prioritization skills, improving oral and written communication, self-evaluation, and collaboration skills.[75]

In summary, the residency program socializes the nurse to the nursing profession as well as to the organization. The program not only expands the opportunities for nurses to acquire clinical skills, but also provides situations where verbal and written communications are enhanced. Communication skills are immeasurably important, as nurses are an integral part of the interdisciplinary patient care team. Nurses must learn to coordinate the different facets of patient care and communication skills are a necessity. Del Bueno (1995) summarized some of the problems with graduate nurses as often lacking the interpersonal, communication, and collaborative skills needed to adequately and efficiently handle patient care.[76] Therefore, the study indicated it is imperative to have learning methods that enhance communications skills in a non-threatening environment as part of an orientation system.

An interesting aspect of the Clinical Entry Nurse Residency Program is the attention given to those nurses who volunteer to be sponsors for the graduate nurses after the first six weeks of the residency program. The role of the sponsor is different from the role of the preceptor. While the preceptor works with the new nurse during the six weeks of clinical orientation, it is the sponsor who coaches and supports the nurse in the residency program after the first six weeks.[77] One must consider that the nurses, who choose to perform this extra duty, have to manage their own workload during their involvement with the graduate nurses. The authors of this residency program study emphasize the importance of the role of the sponsor in the success of the program and the successful outcomes for graduate nurse skill acquisition and especially in career development. Beth Hospital has established a support program for those nurses who volunteer to act as sponsors for nurses in the residency program. The support program consists of developmental programs that include: a development workshop,

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75 Ibid.

76 Del Bueno, Dorothy J., Ready, Willing, Able? Staff Competence in Workplace Redesign, Journal of Nursing Administration 25, no. 9, pp. 14-16, September 1995.

77 McHugh, Michele, Duprat, Laura J. and Clifford, Joyce C., pp. 57-62.

communication workshop and monthly sponsor support meetings.[78] The role of leadership in guiding, managing and supporting the sponsors solidifies the sponsor's interest and devotion to the development of the new nurse in an orientation program. The success of the program also depends on management's support and guidance of the sponsors in their role as a catalyst in the development of the new nurses.

An evaluation portion is the last, key piece of the residency program. Evaluation of the residents consists of three parts performed at six months, 12 to 18 months, and at the two-year mark. The first part consists of a review by the nurse manager of the objectives and learning methods as indicated by the nurse resident. The second part is a review of formal and written evaluation by the sponsor and nurse resident. The third part is a review of clinical narratives written by the nurse resident describing past achievement with clinical skills and professional development.[79]

Finally, the evaluation of the program is also important. As with any program, the desired outcome for a nurse after participating in the nurse residency program for two years is the attainment of the competency level. The outcome of the sponsor-resident relationship is that it "has provided experiences and support to individuals that allow them to grow, experiment and take risks, thus accelerating the learning process."[80]

3. Nurse Internship Programs

Detailed reviews of five NIP models, reflecting the literature in this area, are presented in the following section. The five NIPs describe a range of alternatives for internship programs, from general nursing to specific nursing specialties. At a fundamental level, the NIPs have similar goals and objectives. In addition, the NIP's design and content integrate many of the elements of the traditional orientation programs including CBO. Also, they are usually linked to the organizational strategy related to the recruitment and retention of nurses. The first example is a basic NIP model where the components may be applied to other programs in other healthcare organizations. Then, examples of four other NIPs geared at specific nursing specialties are presented. These nursing specialties include: operating room, emergency department, pediatric

78 Ibid.

79 Ibid.

80 Ibid., p. 62.

rehabilitation, and neuroscience. For each of these programs reviewed, a summary is presented in the following areas: nursing personnel issues in the specific healthcare organization, the program's goals and objectives, the application process for candidates, the program design and content, the evaluation of the nurse interns, the role and support of preceptor, the process for program evaluation, and, if available, resource allocation decisions by the organization.

a. Aspects of a Generic Nurse Internship Program

O'Friel (1993) describes the development and implementation of the internship program for nurses at Deaconess Hospital in Boston.[81] She describes critical elements that are important in the development and implementation of a NIP. These elements are found in Table 2.3 and they form the foundation for implementing the NIP at Deaconess Hospital in Boston.

Table 2.3. Recommendations for Nurse Internship Program as per Findings at Deaconess Hospital in Boston (After: O'Friel, 1993)[82].

Administrative Support	Nursing Staff Education
Advisory Committee	Preceptor Program
Evaluation System	Support Sessions
Computer System	Collaborative Relationship between Human Resources and Nursing
Retention Analysis	Communication/Feedback System
Base on Graduate Nurse Needs	Program Coordinator

The initiative for the internship program began with the collaborative efforts between administration and nursing services personnel. The hospital's Human Resources department acted as the liaison between the various departments. Publicity was a critical element in getting the program off the ground, which ranged from advertising in nursing journals and newspapers as well as going to job fairs and nursing schools.

[81] O'Friel, Jane A. Beaulieu, The Nurse Internship Experience: A Dynamic Learning Environment for the Novice, Journal of Nursing Staff Development, v.9(1), pp. 24-27, January/February 1993.

[82] Ibid.

Graduate nurses had to take several steps to apply to the NIP at Deaconess Hospital. The application steps consisted of: filling out a hospital employment application, submitting two references, submittal of a school transcript, completion of a nurse internship pre-assessment form, and participation in a one-hour interview with the Human Resources Nurse recruiter, and the Staff Development Specialist. The graduate nurses applied for four to ten positions available in the internship. The budget for the program was a limiting factor in the size of each class during the 12-week program. Other than the budget, O'Friel cited the need for personalized attention to the nurse interns as a driver for keeping the classes small.[83]

The design and content of the NIP at Deaconess Hospital are structured around the needs of the nurse intern. The Deaconess NIP is designed to last 12 weeks during which the nurse interns rotate through three different nursing units. Learning needs are assessed with a pre-employment skills inventory and validated in the first week of the NIP. During the first week, the abilities and experiences of the nurse interns are also assessed with a tool called the Performance Based Development System (PBDS). The information from this assessment tool as well as the results from an interview with each nurse candidate determines the program content. During the internship, six days consist of education directed at the learning needs identified by the nurse interns.[84]

O'Friel (1993) does not specify the evaluation tools used during the program to evaluate the progress of the nurse interns.

Another key aspect of a NIP is the role of the preceptor. O'Friel (1993) encourages the support and education of preceptors in the role and its responsibilities.[85]. In Deaconess Hospital, the preceptors apply for the opportunity to precept a nurse intern. Once accepted, the preceptors attend an 8-hour class to prepare them for the role and responsibilities as a preceptor, which O'Friel recommends, "should be based on each hospital's needs and on the turnover rate within the preceptor program."[86]

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[83] Ibid.

[84] Ibid.

[85] Ibid.

[86] Ibid., p. 26.

The final essential component of the NIP is an evaluation process to assess program effectiveness. O'Friel delineates several key personnel who evaluate the NIP and the time period when evaluation occurs:

- The nurse intern, at program completion and after six months have elapsed. It evaluates immediate and delayed benefits
- The preceptor every two years
- The nurse manager/assistance nurse manager evaluation is also every two years[87]

In support of the NIP at Deaconess, O'Friel (1993) mentions several benefits obtained by Deaconess Hospital after implementing the NIP. First, a higher quality of patient care delivery reflects the cost benefit measurement of the NIP. Another benefit is the understanding and application of organizational philosophy by the graduate nurses in their daily duties. There might be possible retention benefits as nurses choose to stay with Deaconess. Awareness of hospital and nursing resources by the graduate nurses as well as peer support from nurses working in different nursing units are some of the other benefits described by the author.[88]

O'Friel (1993) did not discuss cost of the NIP or resource allocation decisions by Deaconess Hospital. However, the author notes that further studies are needed to justify the cost of the program.

b. Operation Room Nurse Internship Program (OR NIP)

Strauss (1997) describes an operating room NIP whose main goal was the retention of operation room nurses at the author's healthcare organization.[89]

The OR NIP began in 1990 at a large southern teaching hospital. In addition to retention, the program's goal is to train "…new nurses to deliver intraoperative nursing care consistent with our department's policies and Association of Operation room nurses (AORN) standards, recommended practices, and guidelines."[90]

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87 Ibid., p. 26. (Initially the preceptor and the nurse manager evaluated the program six months after completion but it was changed to every two years due to repetitiveness. They are encouraged to provide input for program revision based on identified needs.)

88 Ibid.

89 Strauss, Judy, An OR Nurse Internship Program that Focuses on Retention, Association of Operating Room Nurses Journal, v. 66 (3), pp. 455 -463, September 1997.

90 Ibid,, p. 455.

The performance objectives are obtained from a collaborative effort between current operating room (OR) nursing staff, unit managers, and the program coordinator. These objectives are based on the knowledge, skills, and competencies necessary to provide patient care in the OR setting. Finally, the curriculum objectives and lessons plans are based on "behavioral terms" as described by AORN's standards called "*Patient Outcome: Standards of Perioperative Care*."[91] Strauss (1997) mentions the concept that these types of curriculum and lesson plans leads to accurate and unbiased evaluations as the objectives are in measurable, behavioral terms.[92]

Since the program is linked to the hospital's retention strategy, the applicants to the program are screened very carefully. The program accepts experienced nurses with no prior OR experience, as well as graduate nurses. The hospital prefers nurses with medical-surgical experience as they claim they have higher retention outcomes. They author points out that experienced nurses "bring valuable assessment and priority setting skills."[93] As part of the selection process, the interns submit a resume, two reference letters, answer questions in an interview and in a written questionnaire, and visit the OR. Once they are accepted into the program, the nursing intern signs a two-year agreement contract. During the first 12 months, $100 per month is withheld from the intern's base salary. If the intern remains during the second twelve months, the money is refunded.[94]

The OR NIP is designed to cover six weeks of classroom training and ten months of training in the OR where the intern is paired 50 percent of the time with a preceptor. During the second 12 months, the intern spends 90 percent of the time working independently and starts to precept new interns.[95]

Several teaching methods are utilized in this OR NIP. One method consists of the preceptor teaching one intern and that intern teaching another intern until the group has mastered basic skills. A second method utilizes a simulated environment

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[91] Ibid,, p. 456.

[92] Ibid.

[93] Ibid,, p. 456.

[94] Ibid.

[95] Ibid.

where skills and techniques are practiced in a low stress setting. A third method is didactic teaching of concepts in the morning followed by application of these concepts in the OR setting in the afternoon. This sequence allows the interns to integrate what they have learned by applying it the same day that it is learned.[96] It avoids the possible frustration that results from learning something that is never applied or is applied too long after the lesson has been presented.

During the internship, the nurse interns are rigorously evaluated on goal achievement and performance. A weekly two-hour meeting with the program coordinator provides a supportive environment where the evaluation of progress occurs, lectures are presented or relevant issues are discussed.[97] It also gives the program coordinator an opportunity to set goals with the interns. At the end of the internship, the nurses are classified as clinically competent "through performance evaluations and by passing the Certified Nursing Operating Room examination."[98]

Preceptors receive a one-day course where they are informed about adult learning principles, communication, and clinical evaluation skills.[99] Nurse interns begin to work with the preceptors during the seventh week of the internship. In general, the nurse interns have attained enough clinical experience so that the interns are able to perform some of the OR jobs independently by this time. Skill development and experience are gained through the observation of the specific skills followed by a demonstration of the observed skill. Once the skill is successfully performed, the preceptor allows the nurse intern to proceed without supervision with the learned skill. Strauss (1997) encourages management support of the preceptor component of the program by having adequate staffing levels so preceptors are available for interns.[100]

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96 Ibid.

97 Ibid.

98 Ibid,, p. 456.

99 Ibid.

100 Ibid.

A collaborative team revises the knowledge, skills, and competencies checklist to maintain the program current. Retention statistics of OR nurses are also a basis for program evaluation.[101]

Strauss (1997) claims that, in addition to the retention of OR nurses, the hospital benefits because the program produces nurses who are well rounded in all aspects of OR nursing, which results in having fewer personnel covering weekend duties. She strongly provides direct guidelines to encourage management to provide a supportive environment. These are:

- Provide a budget for teaching materials
- Exclude nurse interns and the program coordinator from the staffing levels for the period of the internship
- Provide adequate OR staffing to have preceptors available
- Maintain high department morale to serve as an example to nurse interns[102]

The first three guidelines have a direct impact on the hospital's budget. The last one reflects a mixture of leadership and budgetary demands.

c. Emergency Department Nurse Internship Program (ED NIP)

Alban, Coburn, and May (1999) describe the inception of an internship program geared towards enhancing the number of emergency room nurses in the suburbs of Washington D.C.[103]

The NIP for nurses in the emergency department (ED) is based at two hospitals operated by the Adventist Health Care System in the suburbs of Washington D.C. The NIP is a strategic initiative designed to decrease the vacancy rate of up to 30 percent in one of the two hospitals. Although agency nurses meet the staffing shortage, it proves costly for the organization. Even worse, the pool of nursing applicants with ED experience was almost non-existent at the time of the program initiation. The smaller hospital had instituted an internship program in 1996 directed at those nurses who lacked ED experience, but were willing to work in the ED. The larger hospital decided to follow

[101] Ibid.

[102] Ibid., p. 463.

[103] Alban, Anne, Coburn, Mary and May, Christine, Addressing the Emergency Nursing Staffing Shortage: Implementing an Internship Using a Nursing School Instructor Model, Journal of Emergency Nursing, v. 25, pp. 509-513, 1999.

suit, and in 1998, starts a collaborative internship program between the two facilities that targets nurses who desire to work in the ED.[104]

Input to start the program was obtained from feedback from the staff, preceptors, nurse managers, educators, and the "Center for Organizational Learning".[105] The ED internship program is intended for nurses with prior nursing experience, but lack ED experience. The authors do not mention new graduate nurses. Although goals and objectives are not expressly specified in this article, the authors do mention recruitment and retention of new staff as the reason for starting the program. The nurse manager interviews the applicants to the program and makes the selections. Selected nurses sign a commitment to work for the organization for 18 months following the completion of the internship. Initially, they have to pay $150.00 for teaching materials. While in the NIP, their pay is based on basic nursing pay, but once they successfully complete the internship program, they receive the ED pay differential common for nurses who work in a specialty area. If they renege on their commitment, they must pay a fee of $350.00.[106]

The program coordinators base the NIP on the Benner framework using the novice to expert levels, as it is aimed at nurses who have prior nursing experience but not in emergency nursing. "Nurses new to the specialty must integrate the special aspects of emergency nursing with their prior knowledge and experience."[107] Furthermore, program coordinators use the Benner model as a guide to base the internship on a nursing school model. Consequently, the preceptors are defined as instructors. As instructors, they have two or three interns in contrast to the typical 1:1 preceptor to nurse intern model seen in other internship programs. The nurses in the internship are defined as interns to clearly identify them as part of the internship program. In addition, the intern designation distinguishes them from nurses in the ED orientation, which is designed for nurses with prior ED nursing experience.

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[104] Ibid.

[105] The Center for Organizational Learning is responsible for staff development at both of the hospitals. Ibid., p. 509.

[106] Ibid.

[107] Ibid., p. 510.

The educational design of the internship program consists of the following aspects:

- Lectures
- Self-directed learning modules
- Selected observation experiences
- Extended orientation to practice in the emergency department[108]

The six months internship is divided into the first three months, which consists of classes and observational experiences. The second three months consists of individualized teaching based on the intern's progress.[109]

The content of the program consists of department-specific procedures, various certifications, and clinical experiences gained by working in the various sections of the ED. The time partitions of the NIP are 170 hours of classroom time, 85 hours of structured observation opportunities outside of the ED, and 600 hours in the ED. [110]

Evaluation of the interns consists of three parts. One part is composed of a self-evaluation at the beginning, midway, and near the completion of the program. The second part is composed of progress evaluations, which the instructors complete on a regular basis. The last part consists of a test derived from the Emergency Nursing Association program. The program's flexibility allows each intern to identify his or her learning needs throughout the internship. Based on this self-evaluation, the interns are allowed to shorten the internship, stay with the initial six months program, or prolong the internship.[111]

The instructors are responsible for training two to three interns in the first three months. Staff nurses volunteer to assume the role of instructors to the new nurses. Initially, the Clinical Nurse Specialist had to extensively coach each instructor to help them work with the 1:3 ratio versus the typical 1:1 ratio utilized in their previous orientation format. Initially, instructors received only a manual. However, after a few

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[108] Ibid., p. 509.

[109] Ibid.

[110] Ibid.

[111] Ibid.

program iterations, a four-hour class is currently available to prepare the preceptors for their role.[112]

Various components of the program are evaluated for content, relevance, and validity using a variety of assessment tools. The components evaluated include lectures, speakers, class format, length of each program component, and clinical experiences. Program coordinators incorporate input from these evaluations to refine the program. The rationale for preferring the "school" model is that more nurses can be trained concurrently, and that in the long run, the program is cost effective as it develops strong clinical nurses with a shorter adjustment time.[113]

Alban et. al. (1999) provides a detailed discussion about the hardships of instituting the internship program in the organization. Initially, staff acceptance by all of the staff did not occur due to the longer training period. The major sticking point was that the instructors and the interns were not counted as part of the staffing numbers. Changes were made along the way to accommodate the staffing needs of the ED. However, staffing changes were made at points where interns felt they could afford to take action that is more independent. The results yielded a compromise. The instructor and one to two interns are counted as 1.0 full-time equivalent (FTE) in the last half of the program, versus the initial exclusion from staffing numbers during the entire internship.[114]

Other changes that occurred to deal with some of the scheduling challenges encountered in the internship are as follow:

- Pre-scheduling observations experiences
- Balancing time on and off the unit
- Restricting scheduling changes during the first three month of the internship, to help avoid staffing errors
- Increased communication with the staff about intern and instructors location[115]

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[112] Ibid.

[113] Ibid., p. 513.

[114] Ibid.

[115] Ibid., p. 512.

d. Pediatric Rehabilitation Nurse Internship Program (PR NIP)

Diehl and Dorsey (1994) describe the implementation and outcome of the Pediatric Rehabilitation Nurse Internship Program at Mount Washington Pediatric Hospital in Baltimore, Maryland during its first year.[116]

Pediatrics is a nursing specialty that encompasses a whole set of new rules. The field covers the range of infants to teenagers. Therefore, a nurse who works with adults will feel uncomfortable when pediatrics is introduced. Pediatric rehabilitation is a further specialization of pediatrics and the nurses need further training even with prior pediatric experience. In the mid 1990s, Mount Washington Pediatric Hospital implemented the PR NIP to combat staffing difficulties due to the limited number of nurses with experience in the pediatric rehabilitation nursing field.[117] The program was grounded on the organization strategy of recruitment and retention of nurses in a field in which it is difficult to find employees.

The collaboration of a nursing education representative and unit-based clinical nurse specialists forged the program.[118] "The goal is to allow the intern to achieve clinical competence in pediatrics rehabilitative nursing."[119] Program objectives deal with providing an in-depth theory related to the pediatric rehabilitation as well as obtaining clinical exposure through a close working relationship with a preceptor.[120]

Graduate nurses as well as registered nurses without pediatric experience enter the program in response to an extensive advertising campaign ranging from health fairs to nursing schools. The selection of interns takes place through a joint interview by staff from the nurse recruiter and education departments. In this program, the nurse only has to agree to complete the program as it is intended. These nurses do not have to sign a contract because the program is partially funded by a grant from the Health Services Cost Review Commission in the State of Maryland. Employment would be offered after

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116 Diehl, Beth C. and Dorsey, Louella K., A Comprehensive Pediatric Rehabilitation Nurse Internship Program, Rehabilitation Nursing, pp. 211-213, 218, v. 19(4) July/August 1994.

117 Ibid., p. 211

118 Ibid.

119 Ibid., p. 211.

120 Ibid.

completion of the program.[121] The authors do not mention if the interns receive a salary during the internship.

The program's design consists of a twelve-week schedule. Interns attend a one-week facility orientation prior to the start of the internship. This allows for organizational information to be disseminated to the interns prior to their clinical exposure. The design of the internship consisted of a Monday through Friday schedule with didactic and clinical experiences during the week. The didactic content and clinical experience include basic rehabilitation principles, general pediatric knowledge, and hospital-specific clinical programs.[122] During the first six weeks, the interns receive exposure to the infant-toddler unit. In the second six-weeks, the interns work on the pediatric rehabilitation floor. After each six-week period, the nurse manager and the director of nursing education perform a formal evaluation with the intern using input from the preceptor. In addition, weekly informal evaluations take place during the internship and include a review of clinical progress as evidenced by a skills checklist. The skills checklist includes "…unit specific and addressed assessments protocols, documentation standards, use of adaptive equipment, participation in team activities, and parent education."[123] Additional clinical experiences consist of attending a variety of interdisciplinary team and nursing pediatric rehabilitation forums.[124]

In order to complete the program, the nurse interns complete a 150-question exam and make a presentation about a relevant clinical topic. The nurse interns present the topics to nursing staff in the units.[125]

Experienced nurses fulfill the role of preceptors and are paired up with interns in a 1:1 ratio. Although preceptors are not given a monetary incentive to perform as preceptors, at Mount Washington Pediatric Hospital, it is part of the clinical ladder[126].

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[121] Ibid.

[122] Ibid.

[123] Ibid,, p. 213.

[124] Ibid.

[125] Ibid.

[126] Clinical ladder –presents an opportunity for nurses to advance in their nursing career in their organization.

Preceptors attend a one-day workshop where they receive relevant information about their role and discuss relevant issues in a supportive environment.[127]

The program evaluation protocol consists of the evaluation by interns of the content found in the various program components including lectures, speakers, and clinical sessions. The program coordinators use the intern's input for program revision and modification.

The results of the first group's evaluation results demonstrated that the program achieved the desired goal. Consequently, the success of the program is verified by the high clinical competency of the nurses who complete the program. The program met its strategic goals of recruitment and retention. In regards to the retention objective, those nurses who completed the internship remained at their job two years later. Additionally, the recruitment objective was also met, as the nurse recruiter received numerous internship applications the following year.[128]

Alban et. al. (1999) do not provide specific costs or tradeoffs, but they noted the "…program requires considerable financial investment."[129] Therefore, the grant money was pursued prior to initiating the internship to partially fund the program.

e. Neuroscience Nurse Internship Program (NNIP)

At the National Institutes of Health (NIH) in Bethesda, Maryland, an internship program is in place to train nurses in the nursing field of neuroscience. Price, DiIorian and Becker (2000) described the program in the Journal of Neuroscience Nursing.[130]

The nursing specialty of neuroscience addresses the patient care of persons with nervous system disorders. In an attempt to recruit and retain nurses with this nursing specialty, a NNIP was started in 1988 at the NIH Clinical Center.[131] It is an

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[127] Ibid.

[128] Ibid.

[129] Ibid., p. 212.

[130] Price, Mary Elizabeth, DiIorio, Colleen and Becker, Jody K., The Neuroscience Nurse Internship Program: The Description, Journal of Neuroscience Nursing, pp. 318-323, v. 32(6), December 2002.

[131] Ibid.

ongoing internship program at NIH.[132] The basic problem inspiring the NNIP was NIH inability to attract nurses with knowledge in neuroscience and the clinical skill necessary to provide care to people with nervous system disorders such as strokes, traumatic spinal and neck injuries, or Parkinson's disease. However, the root cause is the lack of neuroscience nursing curricula in the education arena. The curriculum for the internship program was developed and tested during the four years prior to the start of the internship program. Therefore, by the start of the NNIP, the curriculum was comprehensive and expected to meet the learning needs of the nurses in the NNIP.[133]

The goals and objectives of the NNIP are:

- To provide nurses with a basic knowledge and understanding of the theory and practice of neuroscience nursing
- To prepare nurses to deliver clinically competent care to patients with neurological disorders
- To prepare nurses as clinical generalists in neuroscience nursing
- To increase the recruitment and retention of nurses in the field of neuroscience nursing
- To increase the number of clinically competent nurse practicing neuroscience nursing in the healthcare community
- To prepare nurse to function as members of the biomedical research team at the Clinical Center[134]

New nurses or nurses who have recent clinical experience, but not in neuroscience nursing, can apply to the program. To be considered for a position in the program, nurses have to submit a letter of interest, references, the nursing school curriculum, and undergraduate grades. In addition, nurses need to have a nursing license prior to commencing the internship in the fall. Consequently, graduate nurses have to pass the nursing licensure exam during the preceding summer, if they hope to stay in the program. Applications are blinded and ranked according to curriculum, undergraduate grades, experience, letter of interest, and references. Selected nurses proceed to an

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[132] National Institute of Health, Nursing at the NIH Clinical Center, Website [http://www.cc.nih.gov/nursingnew/profopp/educationtraining.shtml], 27 February 2003.

[133] Price, Mary Elizabeth, DiIorio, Colleen and Becker, Jody K., pp. 318-323.

[134] Ibid., p. 319.

interview composed of a team of nurses consisting of the nurse manager and the program coordinator, but the nurse manager selects the nurse interns.[135]

The NNIP is designed to cover a six-month period and is composed of two major components. The first component is the didactic portion, which consists of lectures and informal seminars. A multidisciplinary team composed of nurses, physicians, social workers, nutritionists, and various types of therapists, presents lectures on the various topics relevant to neuroscience nursing. Lectures are usually one and a half to three hours in length and are scheduled two to three times per week. The teaching methods utilize multimedia, case studies, role-playing, handling models, and problem solving activities.[136]

The clinical component is the second major part of the NNIP design. At this point, the nurse provides direct patient care under the supervision of the preceptor. Observational experiences are an important teaching method consisting of several steps and may include the simulation of the desired skill. First, the preceptor demonstrates a procedure. Second, the intern demonstrates and verbalizes the procedure. If successfully completed, the nurse intern is allowed to perform the procedure in the unit under direct supervision. Finally, a nurse intern who successfully performs the procedure can then proceed independently.[137]

The NNIP nurse intern evaluation methods are designed to assess and evaluate several outcomes and changes in the participants. The knowledge base of the nurse interns is evaluated by two methods. The first evaluative component is a set of written tests given every for weeks, which are designed to assess the understanding of the material by the nurse interns. The second evaluation component is a set of nursing care plans formulated by the nurse interns. The care plans provide a detailed description of the nurse interns' plans to care for a patient based on identified patient needs ranging from physical, psychological, social, and spiritual needs. Concomitantly, preceptors evaluate the progress of the interns based on the goals and objectives.[138]

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[135] Ibid.

[136] Ibid.

[137] Ibid.

[138] Ibid.

Preceptors in the NNIP are chosen based on their knowledge and demonstrated clinical skills in neuroscience nursing. Once selected, they are matched to the intern based on "teaching and learning styles, common interests, schedule preferences, and interpersonal skills."[139] The role of the preceptor in preparing the nurse in the neuroscience field is paramount. They guide the nurse intern in the acquisition of knowledge and procedural skills as well as the prioritization of patient care.

The NNIP is thoroughly evaluated on four levels: process, content, outcome, and impact. Since the program has been in place for thirteen years at the date the article was published, DiIorio, Price and Becker (2001) present the results of ten years of evaluations in a second study.[140] The study focused on the evaluation of the program's process, content, and outcome. Content and process evaluations demonstrated that nursing interns were generally satisfied with the quality of instructions and content of the lectures. Additionally, the NNIP accomplished the targeted goal of increasing the knowledge of the nursing interns in neuroscience nursing as proven by "a dramatic increase in knowledge scores for all classes (and all nurse-interns) by the end of the program."[141]

The outcome evaluations, which focused on behavioral changes as a result of attending the NNIP, were also encouraging. The results not only indicated the interns increased their level of knowledge, but also demonstrated an increase in confidence, collaboration, mutual support, resourcefulness, and ability to practice independently in complex situations. Outcome evaluations also assessed the attitudes of nurse administrators and physicians, who gave high marks on the quality of patient care NNIP participants provided their patients. They also positively noted their level of knowledge, enthusiasm, comfort level with the patients, search for learning opportunities, and motivation to work in an interdisciplinary team. A limitation of the study voiced by the

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[139] Ibid., p. 320.

[140] DiIorio, Collen, Price, Mary E. and Becker, Jody K., Evaluation of the Neuroscience Nurse Internship Program: The First Decade, Journal of Neuroscience Nursing, v. 33(1), pp. 42-49, February 2001.

[141] Ibid., p. 45

authors is the lack of a control group. In addition, impact evaluations dealing with the impact on patient status is not a regular evaluation tool as it is limited by cost.[142]

Currently, during the time period that nurse interns are in the NNIP, they are employees of NIH. They are expected to perform accordingly by meeting the rules and regulations of the workplace including attendance at the designated place of duty. The authors do not mention how the nurses and preceptors are counted in the staffing number. However, they do mention that budget oversight is the responsibility of the nurse manager and the clinical nurse specialist for the Neuroscience Program of Care, one of three patient care divisions within the Clinical Center Nursing Department. Finally, as of 2000, during the thirteen years since the program's inception, three to five nurses have been accepted into each class.[143] The small number of nurse candidates every year might indicate budgetary constraints for the organization, since the nursing interns are paid as employees, but are not fully productive as staff nurses. On the other hand, NIH might only need relatively few nursing interns to staff the neuroscience nursing units.

E. EXAMPLES OF ORIENTATION PROGRAMS FOR NURSES IN THE U.S. MILITARY

In this section an overview of three orientation programs for nurses in the Military Health System are presented. First, a summary of the orientation program for nurses at the Naval Hospital Bremerton in Washington is presented. Second, the Nurse Transition Program (NTP) of the U.S. Air Force (USAF) is summarized. Third, the Preceptorship Program of the U.S. Army for nurses is noted. Each facility has to decide where to allocate limited resources so as to receive the maximum benefit. In the case of education for its nurses, benefits take the form of more skilled employees.

1. Naval Hospital Bremerton, Washington

Naval Hospital Bremerton is part of Tricare[144] region 11 with medical services responsibility encompassing an area that covers about 60,000 beneficiaries. In addition, the hospital sponsors a Family Medicine Residency Program and is the base home to

142 Ibid.

143 Ibid.

144 Tricare is a comprehensive military healthcare program for active duty military members and designated beneficiaries, [http://tricare.osd.mil/TAAGBrochure/index.html], 22 March 2003.

Fleet Hospital Bremerton (FH5). FH5 is a 500 - bed medical surgical unit required to stand up within ten days notice anywhere in the world. The FH5 requirement puts an "increased emphasis on training and the medical and personnel readiness of assigned personnel."[145] FH5 is the mobilization unit for assigned military members during military deployments. Also, the FH5 training site on the hospital campus serves as additional beds in the event of disaster. The hospital serves the community with an inpatient medical-surgical ward, an intensive care unit, an obstetrics unit with a postpartum section as well as comprehensive outpatient ambulatory clinics.

Nursing orientation consists of three major components, which are command orientation, patient care orientation, and unit based competency orientation. Information provided in the command orientation delineates organizational attributes that familiarize a new employee with safety procedures, employee services, business guidelines, and Navy required training. This orientation is geared toward all hospital employees, military, and civilian. Military personnel also receive training on FH 5. The second component, Patient Care Orientation, is for all hospital personnel who provide patient care. It consists of training mandated by JCAHO[146]. The content of this orientation consists of risk management/process improvement, patient safety, age-specific awareness, pain management, medical immobilization, and restraints.[147]

The final component of the nursing orientation is the unit based competency orientation. These competencies consist of unit specific orientation and clinical skills the individual has to learn and demonstrate prior to working independently in the unit. Once the nurse who is orienting to the unit successfully demonstrates the clinical skill, the preceptor signs the competency. New nurses, who do not have prior experience, will need to complete the required competencies. However, if an experienced nurse has documented competencies, the hospital has reciprocity so the nurse avoids having to repeat them. All steps in a competency must be signed and dated before the nurse can independently perform the specific skills delineated in the competency.

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[145] Facts about Naval Hospital Bremerton, [http://nh_bremerton.med.navy.mil/Default.aspx?Pageid=287], March 2003.

[146] Joint Commission on Accreditation of Healthcare Organizations.

[147] E-Mail Correspondence from LCDR Lake L., Clinical Nurse Specialist, Naval Hospital Bremerton and the author, 10 January 2003.

Learning methods consist of self-study, classroom instruction, and on the job training (OJT). Many of the competencies are partially completed through a self-study. Others, such as the medication administration competency, require two additional components. First, the new nurses have to demonstrate to the preceptor how to administer medications on three separate workdays. Second, the new nurses have to take and pass a written medication administration test. Another example is the age specific competencies,[148] which require a test for each patient age group served by the unit. Additionally, demonstration of specific skills with each age population is required to achieve competency in the skill. Another learning opportunity new nurses can utilize for some of the competencies is to attend classes given by the Hospital Corps Staff Basic Skills Program.[149] The classes cover the following four competencies: Medication Administration, Venipuncture, Intravenous Therapy, and Primary and Secondary Physical Assessments. The last learning method is OJT and it consists of six weeks during which the new nurse works with a preceptor. A preceptor is assigned to each new nurse. While this is the intent of the program, sometimes another preceptor works with the new nurse. In addition to the preceptor, a clinical nurse specialist is available in ICU/Medical Surgical units to provide oversight of hospitalized patients such as individuals with cardiac problems.[150] Finally, it is the preceptor who signs and initials the steps after a successful return demonstration by the new nurse.

The last aspect of the orientation program consists of evaluations. The division officer (DO) evaluates the new nurse and sets the evaluation schedule. The new nurse's role in the evaluation consists of weekly input on their progress and a preceptor/orientation evaluation. The frequency of the evaluations is set by unit specific

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148 Age specific competencies – refers to the ability of the nurse to provide nursing care to patients within a set range of age. Infants (birth to one year), Children (13 months to 12 years), Adolescents (12 years to 18 years), Adults (19 years to 65 years), Geriatrics (greater than 65 years). Naval Hospital Bremerton, Command Age Specific Competency.

149 Ibid. BUMED mandates five competencies that every hospital Corps staff must have. These five competencies are Medication Administration, Intravenous Therapy, Primary and Secondary Assessment, Venipuncture and Suturing. Hospital Corps staff are a unique component of Navy medicine. They are taught to function in a variety of healthcare settings as well as provide health care in ships, in the field, and in submarines.

150 E-Mail Correspondence from LCDR Lake L., Clinical Nurse Specialist, Naval Hospital Bremerton and the Author, 10 January 2003.

policy. Depending on the progress status of the new nurse, the DO either terminates the orientation at the end of six weeks or extends it.[151]

2. United States Air Force Nurse Transition Program

The USAF offers a ten-week training program for new nurses called the Nurse Transition Program (NTP). All new nurses in the USAF are called transition nurses and they attend the program at designated USAF training sites for the NTP. Guidance and direction comes from a centrally located program manager at Sheppard Air Force Base. The USAF considers these new nurses to be in a training status while they participate in the NTP. The Air Education and Training Command (AETC) provides funding for the NTP.[152] The goal of the program is "to mentor AF officer as well as bridge the gap between the educational and practice settings."[153] The program's philosophy states, "that nurses who are trained and educated to care for acutely ill patients are better prepared for managing actual wartime injuries."[154] The program allows the new nurse to develop as a professional nurse and also as an officer.

The NTP's design consists of didactic lectures and clinical rotations. The didactic portion consists of lesson plans designated to provide information on both the nursing and officer roles. The clinical rotations are divided into two portions. The first part includes 144 hours designated for skill acquisition. The second rotation is for clinical practicum consisting of 238 hours.[155]

During the first week of the course, the didactic portion takes up to fourteen hours. During this time period, seminars cover topics on safety, medication, patient care assignment, documentation, and simulated patient care scenarios. These lesson plans and the corresponding progress checks, or tests, are utilized for mandatory classes at all NTP training sites. After the initial week, the NTP coordinators are responsible for setting up classes, which may contain clinical and military officer role information. After the first

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151 Ibid.

152 E-Mail Correspondence from A. Program Manager NTP/Phase II, Nurse Transition Program (NTP), Captain Bartlett, Katie, to the Author, 21 February 2003.

153 Air Force, New Graduates (46N1's), [http://afas.afpc.randolph.af.mil/medical/Nurse_Corps/NewgradsWeb.rtf], February 2003.

154 Ibid.

155 Bartlett, Katie A, 21 February 2003.

week, an eight-hour seminar is presented every other week. Thus, the didactic portion intertwines lectures with clinical rotations.[156]

The first rotation in the program concentrates on acquiring and developing technical skills and learning patient care procedures. These skills are summarized in the USAF NC Competency Verification Records utilized at all NTP training sites. These competencies contain topics typically found in medical-surgical units. For example, the transition nurses learn technical skills such as medication administration, emergency procedures, and pre-operative and post-operative care.[157]

During the second rotation component of the program, the focus is shifted towards team management. The transition nurse manages a team, which contains at least four patients with higher levels of illness, that is, higher patient acuity. This system allows the transition nurse to further develop and apply such skills as delegation, critical thinking in decision making, and patient care prioritization. As time progresses, the transition nurse gains experience not only in technical skills but also in the realm of team management.[158]

During the clinical rotation each nurses acquires knowledge and skills while working under the supervision of a preceptor. Each preceptor works with two transition nurses during a shift. The transition nurses are not part of the nursing staff at the training healthcare facility. Consequently, these nurses do not count in the staffing number of the unit where they are training. However, in general, the preceptor counts as part of the unit staff and he or she carries a patient load. Initially, an optimal patient assignment for the preceptor is four patients. Hence, each transition nurse is then able to take care of two patients under the supervision of the preceptor. This may cause other nurses in the unit to assume a greater workload. The reality is that sometimes the preceptor has more than four patients in addition to supervising the two transition nurses; but as time progresses the transition nurses are able to manage more patients. Hence, the impact on workload depends upon the transition nurses' training stage. As the transition nurses assume patient care for a greater number of patients towards the end of the rotation, the total

156 Ibid.

157 Ibid.

158 Ibid.

number of patients cared for by the transition nurses may be a higher number than the preceptor's regular workload.[159]

The preceptor evaluates and provides feedback to the new nurse during the clinical rotation. Feedback on performance occurs every workday as the transition nurses learn new skills and apply these skills. A progression checklist provides the means for feedback. The preceptor uses the checklist to document assessment of skills and competency. Another evaluation occurs every two weeks when the preceptor and the transition nurse review upcoming goals. At this time the preceptor comments on the transition nurse's performance in the clinical setting and in the officer role. The systematic evaluation provides a feedback mechanism so that the transition nurse is able to develop individual learning goals based on performance and learning needs.[160]

Evaluation processes are an integral component of the NTP. The NTP receives overall guidance from the program manager who performs program evaluation every two years. These evaluations are used to provide assistance in aligning, if needed, the program with NTP guidelines and requirement. The visit from the program manager helps in preparation for the USAF standard and evaluation personnel who evaluate the program for administrative consistency with NTP requirements. This visit also occurs every two years but on alternate years from the program manager's visit. These two evaluative visits provide a systematic procedure that leads the NTP to function according to centrally establish guidelines.[161]

Once the USAF nurses complete the NTP, they proceed to their permanent duty stations, which is where they are assigned to fill a nursing vacancy. Their assignment might be at the training site where they attended the NTP or it might be at another site. The vacancy could be at an AF hospital or at a large clinic. The assignment and distribution is based on the individual preference, AF vacancies, and possible other special needs considerations. In conclusion, once they arrive at their final assignment they then count towards staffing numbers. If they stay at their training site, they will

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159 Ibid.

160 E-Mail Correspondence from Program Manager NTP/Phase II, Nurse Transition Program (NTP), Captain Bartlett, Katie to the Author, 03 March 2003.

161 Ibid.

have about a month of orientation at their permanent unit assignment. Similarly, if the transition nurse transfers to a new facility, he or she will need an orientation at their facility.[162] Overall, the new nurses will arrive at their designated duty assignments with basic patient care experience.

3. United States Army Preceptorship Program

The early beginnings of the Army Nurse Corps (ANC) Preceptorship Program date back to the early 1980's.[163] The program was designed to help new nurses during their transition to clinical practice. Initially, the program was implemented by each Army medical treatment facility. However, in 1988, a framework for an ANC-wide Preceptorship Program was developed. The current framework guidelines are broad enough that they not only assist the transition of new nurses in to the ANC, but also assist the transition of enlisted soldiers in Army healthcare fields. Thus, the purpose of the program is "to facilitate the transition of new graduates of healthcare programs into practice in a military environment."[164] However, the focus here is on how the programs assist new nurses in assuming the role of professional nurses in the ANC.

The goals and objectives of the preceptorship program establish the direction for each program at each MTF. The goals and objectives are to utilize competency-based standards for technical skill acquisition, to assist new nurses in the transition into the professional healthcare role and the healthcare environment, and to foster the development of leadership skills.[165]

The program consists of at least six weeks didactic training combined with clinical rotations in which the new nurse works under the supervision of a preceptor. The ratio of preceptor to preceptee is one-to-one. The guidelines exhort the adoption of a work schedule for the preceptor and for the new nurse that is designed to cover all shifts

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[162] Telephone Conversation Between NTP Program Coordinator at Wilford Hall Medical Center, Major Stewart, and the Author, 05 February 2003.

[163] Bartz, Claudia, and Srsie-Stoehr, Kathleen M., Nurses' Views on Preceptorship Programs and Preceptor and Preceptee Experiences, Journal of Nursing Staff Development, v. 10 (3), pp. 153-158, May/June, 1994.

[164] AMEDD Preceptorship Program, [http://armynursecorps.amedd.army.mil/Preceptorship%2001.doc], February 2003.

[165] Ibid.

in the unit. During this time, the nurse is able to work at skill acquisition under the direct supervision of an experienced nurse.[166]

The program design and content are based on adult learning principles and related teaching methods. Guidelines for learning assessments, and learning and teaching strategies are part of the preceptorship framework. Learning objectives are based on the individual needs of the new nurse and are reviewed by the preceptor as well as the charge nurse. In order to achieve congruence between the new nurse's learning goals and objectives and the guidance provided by the preceptor, two assessment tools are utilized. One tool is an interview between the preceptor and the new nurse. The second tool is a self-assessment by the new nurse of the terminal learning objectives identified for the unit or work environment.[167] With the use of the two assessment tools, the learning objectives are individualized to the needs of the new Army nurse. Learning and teaching strategies used to meet the new nurses learning objectives consist of didactic, discussions, practicum, case studies, and independent study. An integrated model consisting of learning assessments, and learning and teaching methods is used for the new nurses as they work on transitioning to the Army nurse role.[168]

Also, the framework lists responsibilities for all personnel who participate in the learning experience of the new nurse. It is a combined effort between the preceptor, the charge nurse, unit personnel, and the new nurse that makes all of the elements of the program work together.[169]

The preceptorship program evaluation component covers three aspects: 1) the learner, 2) the program structure, and 3) the program process. First, the learner's evaluation consists of a weekly performance review by the preceptor, supervising officer, and new nurse. This joint evaluation offers constructive feedback and develops learning goals. Embedded in the preceptorship program is the idea that the preceptor's guidance establishes a feedback loop that the new nurse may use to assess daily progress of

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166 Ibid.

167 Ibid, Definition for Terminal Learning Objective –"A Description of Task Performance in Training. It is Stated in Terms of Actions, Conditions, and Standards of Task Performance."

168 Ibid.

169 Ibid.

performance objectives. The next two aspects of the evaluation system, program structure and program process, are evaluated at the end of the preceptorship. Both the preceptor and the new nurse fill out the program evaluation at this time providing valuable feedback to the program coordinators.[170]

It is the responsibility of the supervisor to choose the preceptors. As per the Preceptorship Program guidelines, the preceptors should attend a Preceptor Development course and they are encouraged to attend quarterly preceptor workshops. Basic to the course is the objective to learn how to perform in the preceptor role. Preceptors are recognized through annual luncheons and "thank-you-grams" sent at the conclusion of the Army preceptorship program.[171]

In conclusion, the format for each of the three nursing education programs examined in this section is designed to assist new nurses as they transition into the professional nursing role and the officer role. Each organization establishes the resources available to implement their specific education program. However, constraints, such as time, budget, and human resources, may place limits on how resources are utilized in the organization. Each organization determines its needs and implements an action plan to obtain the desired outcomes from their professional development program. The desired outcome is to produce skilled nursing professionals who are self-confident and competent in the delivery of patient care. In the pursuit of this outcome, organizations allocate resources to produce alternative methods for assisting the transition of the new nurse into the professional nursing role.

F. ALTERNATIVE IMPLEMENTATION PLANS

Healthcare facilities are faced with limited resources while at the same time pursuing quality patient care and the benefits associated with trained employees. One of the choices organizations have to make is the choice between the costs of recruiting as a result of a high turnover rate or the cost of training and education programs. As healthcare organizations face the current nursing shortage, many of these organizations have to deal with hiring and training new nurses to fill job vacancies. Different types of orientation methods abound, but the general outcome desired is for the employee to be

[170] Ibid.

[171] Ibid.

productive. Alternative strategies may be generalized into several issues such as retention and turnover, utilization of human resources in educational programs, length of education program, and staffing concerns. Health care facilities have to decide how they will allocate resources to meet the action steps in their educational plans. A review of alternative decisions made about implementing orientation and training program for new nurses and the associated benefits are presented in the following section.

A comprehensive orientation program may be a benefit, especially when the program is linked to the organizational strategies. One organizational strategy revolves around the issues pertaining to the retention of talented employees. Recruiting, training, and turnover are a cost to the organization. Once the investments are made, the organization hopes to gain the benefits obtained through increased employee productivity. As the employee's length of employment with the organization increases, the organization may recoup orientation costs and may benefit from the increased productivity of an experienced employee.[172] The benefits can only be realized through higher retention rates as employees stay with the organization. As Mathews and Nunley (1992) assert:

> One indicator of the success of an orientation program should be its effect on nurse turnover. Nurses who perceive themselves as assets to the organization and as members of a collegial team and who are confident in their job performance are likely to stay.[173]

In economic theory, employers prefer to hire experienced employees as their output is higher than related hiring costs. Healthcare organizations would prefer to hire experienced nurses who have the knowledge, skills, and abilities to be productive at work. Experienced nurses will produce a higher return on investment because they can be productive with minimal orientation cost. They have the experience needed to provide competent patient care in their assigned work centers. Consequently, a brief orientation provides experienced nurses with the knowledge necessary to become acquainted with organizational processes so as to be able to function within the facility. The orientation

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[172] Ehrenberg, Ronald G. and Smith, Robert S., Modern Labor Economics: Theory and Public Policy, 7th edition, Addison Wesley Longman, Inc., 2000.

[173] Mathews, Joan J. and Nunley, Carolyn, p. 164.

costs for experienced nurses are minimal and the nurses' productivity is expected to be high. Therefore, an employer will prefer to hire an experienced nurse.

Still, supply and demand determines the job market for nurses. In markets where a low demand for nurses exists, healthcare facilities have a greater opportunity to hire nurses with experience. However, when nursing demand is high and the nursing supply is low, organizations may run into problems with recruiting experienced nurses. Currently, the demand for nurses is high and the supply is very limited. Many organizations have to resort to hiring graduate nurses and training them in order to fill job vacancies.

In the Navy, as well as in the Army and Air Force, an internal labor market exists. This type of labor market is defined as "When a formal set of rules and procedures guides and constraints the employment relationship within a firm."[174] In general, nurses enter military service at the entry-grade level with no or little nursing experience. Promotion to the higher grades is based, at a minimum, on time in service, achievements, and yearly performance evaluations. In general, the Navy as an internal labor market does not hire experienced nurses. Hence, the Navy relies on the available pool of nurses that have chosen to remain in the service to fill positions in the higher grades. Once nurses make the decision to remain in the Navy, the organization benefits from the increased productivity of experienced nurses.

Healthcare organizations benefit when experienced nurses stay with the organization as they can avoid the expense of training new nurses. Hiring new nurses leads to a higher orientation cost for the organization because of the longer length of time needed for orientation and the increased use of resources to orient new nurses. However, a successful orientation for new nurses can influence their decision to stay with the organization. The organization wins because they recoup training costs once productivity increases due to well-trained and confident nurses. However, the opposite is also true. If a program is unsuccessful, some nurses may not feel comfortable in the clinical setting and may lack self-confidence in their skills. They may choose to quit the organization. These nurses may even go a step further and leave the nursing profession completely.

[174] Ehrenberg, Ronald G. and Smith, Robert S., p. 26.

To help account for and manage orientation costs, one Florida hospital implemented an orientation matrix based on productivity and length of orientation. Messmer et. al. (1995) described the orientation matrix developed to control costs.[175] Financial analysis indicated a range of three to nine months devoted to orientation and varying orientation cost across different types of work centers. The orientation matrix divided nursing employee types by experience level, which included graduate nurses. A systematic reorganization of the orientation program was associated with the cost matrix development, which consolidated the length of orientation assigned to the different types of units.

Each type of orientee was assigned a number of expected days for orientation. It also attached a productivity schedule to the time period, allowing improved tracking of costs. For example, a medical-surgical graduate nurse orientee would be expected to be in orientation a total of 67 days.[176] Productivity was expected to be zero percent for the first two weeks, 50 percent during orientation, and 100 percent by the end of orientation. Dividing the productivity in percentages through out the orientation period provided an improved cost measure for orientation cost as pay could be linked with amount of workload. Most importantly, because units were held accountable, the unit manager, preceptor, and nurse educator paid closer attention to the orientee's progression through orientation. [177]

The end result was a cost savings for the hospital due to lower orientation costs. Also, a positive consequence developed as the program orientees felt greater satisfaction with their orientation progress as more attention was directed towards their individual goals and learning needs. Individual attention also included determination of a longer or shorter orientation period. A goal for cutting costs was achieved and it resulted in an improved orientation system.

Another organization strategy that can lead to cost savings is a focus on the retention of nurses. When talented employees are retained in the organization, a potential

[175] Messmer, Patricia R., Abelleira, Alina and Erb, Pamela S., Code 50: An Orientation Matrix to Track Orientation Cost, Journal of Nursing Staff Development, v.11(5), pp. 261-264, September/October 1995.

[176] Ibid, "Schedule is based on five workdays per week and excluding hospital holidays." p. 262.

[177] Ibid.

for savings occurs in recruiting and orientations costs. Currie et. al. (2000) describes an example of increased retention of nurses for an Illinois hospital. Once intended for acute care new graduate nurses, the internship program at the hospital expanded to cover the medical-surgical and operative unit due to the benefits obtained from the program. Currie et. al. (2000) reports that the hospital strategy for nursing recruitment and retention consisted of developing a nurse internship program.[178] The hospital compared the money spent to gain 50 full-time equivalent (FTE) through the program against the money they would spend to recruit the same number of nurses. The financial outlay for recruiting alone would be three to four times higher than the amount spent in the internship program. Other costs that were calculated into the cost of recruiting the nurses consisted of: "… continued nurse turnover, employee dissatisfaction, and ultimately patient satisfaction."[179] The program's extreme success resulted in the inclusion of other nursing units in the internship program. The obvious benefit of the internship program is the output of well-trained nurses who are likely to remain in the organization and be highly productive.

Other approaches to retention use contracts to ensure the organization obtains a return on its education investment. Some facilities have a contract for nurse interns to agree to stay at the facility for a specified period of time. In the late 1960s, a San Francisco hospital initiated a clinical nurse intern program designed to bridge "…the gap between theory and practice."[180] This hospital offered the nurse interns jobs after they completed the program only if they agreed to stay for a year. In the OR nurse internship program (Section D. 3. b), nurse interns signed a two-year commitment to remain with the hospital once they were hired.[181] The military services have a contract ranging from three to five years of active duty service depending on the incentives chosen by the nurses prior to joining the military. The contract is one method organizations may use to obtain the employees' commitment.

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178 Currie, Donna L., Vierke, Judith and Greer, Kimberly, Making a Nurse Intern Program Pay off, Nursing Management, v. 31(6), pp. 12-13, June 2000.

179 Ibid., p. 13.

180 Archbold, Carl R., Our Nurse-Interns are a Sound Investment, RN, v. 40(9), pp. 105-112, (Non-Contiguous Pages), September 1977.

181 Strauss, Judy, pp. 455-463.

Another cost saving benefit related to the orientation format deals with the new nurses' awareness of the organizational culture, values, available resources, and support. Sometimes, new nurses are hastily oriented to the skills necessary to work on the nursing unit for which they were hired. The new nurses might not learn about the resources available in the facility that help them provide efficient patient care. For example, a new nurse might not learn about the availability of an educational video for patients, so he or she will not offer the patient the media resource. The end result is that the nurse may not have all the knowledge necessary to function well in her or his work center, resulting in a potential cost to the organization. Archbold (1977) describes an internship program as a tool for nurses to learn how to work consistently with the hospital's standards and procedures.[182] O'Friel (1993) states that the new graduates' understanding of the hospitals mission and philosophy directly impacts the quality of patient care delivered.[183]

Human resource allocation during an orientation program is another method that healthcare organizations utilize to control costs and minimize impact on workload. The concern lies in the cost of the program, the impact on productivity or workload incurred by the use of preceptors, CNS and CE, and the time allotted to the new nurse for orientation. Alternative methods are used by healthcare facilities to budget and allocate staff resources in order to provide orientation programs for new nurses.

The military health system utilizes the Joint Healthcare Manpower Standards (JHMS) to determine the manpower needs of its healthcare facilities. The JHMS contains staffing standards. Staffing standards show the quantity and quality of manpower required to perform a specific function and include a range from the lowest to the highest workload values.[184]. The standards quantify the manpower required to perform tasks described in a specific work center description.

These standards consist of a set of man-hour equations based on workload factors specific to each type of work center. For example, one of the workload factors for a

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[182] Archbold, pp. 105-112.

[183] O'Friel, pp. 24-27.

[184] Cherry, Paige, BUMED Manpower Requirements Determination Team, Navy Medical Manpower Management Conference 2002, 22 – 24 September 2002, Slide 24. [http://www.changearchitect.com/manpower/WorkshopPresentations/SMRDIICOMBINED.ppt], 15 January 2003.

Medical-Surgical Nursing Work Center is defined as "the average monthly number of Medical-Surgical Inpatients accruing Category I critical indicator points (1-12 points)"[185]. This corresponds to a patient with an acuity level of I. The other workload factors are matched to a patient acuity level that range from II to VI. The higher the acuity of the patient the more work is required.[186] Each of the manpower standards has a work center description that describes the functions and tasks required of the work center.

The work center description lists the required functions and tasks that unit staff must perform in order to function with the type of patient population that determines the workload. In this case, the workload factors are the acuity levels assigned to patients in that unit. Whenever a nurse is assigned to this unit, he or she must have the skills necessary to provide patient care to this particular patient population. Consequently, the number of nurses and paraprofessional are determined from these staffing standards.

The USAF has included in the JHMS model an additive number to account for the use of preceptors in the inpatient nursing units in the facilities that sponsor the NTP. The model adds a predetermined number to the staffing standards equations used to determine the total manpower requirements for the unit. The added number is called a variance. The variance is added to USAF medical treatment facilities that have a NTP in a peacetime environment.[187] The functional statement associated with this variance relates to the duties and responsibilities of the preceptor who orients the new USAF nurses. Therefore, the Air Force has included in its manpower determination process a rule that may result in a higher number of nurses in the unit, in contrast to a lower number of nurses needed for a unit without the NTP.

Preceptors are a valuable human capital resource utilized in the education programs for nurses. Healthcare facilities entrust preceptors with the development of the new nurses. A consequence that may be overlooked at times is the burden imposed on preceptors who already have a taxing workload. As preceptors, these nurses have

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185 Department of Defense (DoD), Joint Healthcare Manpower Standard, Directive 6300, p. A-6300-2, 08 March 1993. The published source for determining acuity levels is Office of the Assistant Secretary of Defense (Health Affairs) Workload Management System for Nursing Reference Manual, dated June 15, 1989. Note: during the research for this thesis, the staffing standards were being revised.

186 Ibid.

187 Air Force Manpower Standard, Medical/Surgical Inpatient Nursing, AFMS 5219, 03 July 1997.

additional work as they assume a teaching role in addition to their work responsibilities. Therefore, preceptors may become overwhelmed, overworked, and underpaid.[188] In one Illinois healthcare institution, the use of critical pathways adapted to the nursing orientation allowed for a decrease in the preceptor's workload as the nurse interns gained experience.[189]

Other organizations make the financial investment to allow the nurse interns to prioritize attendance to the educational component of the program over staffing issues. Golub (1971) describes a three-month nurse internship program at the University of Chicago Hospitals and Clinics. The program's main objective was to assist new nurses in adjusting to their new role as a staff nurse as well as gain awareness about the facilities' resources and processes. The hospital hired the nurse interns as hospital employees who receive the same wages as other new graduates but did not chose to participate in the program. The interns were hired to fill a nursing vacancy in a specific unit. As part of the unit, the interns were part of the staff and were supervised by the unit manager. Although workload is not mentioned, the nurse intern followed the internship program schedule, which took precedence over staffing schedules.[190]

Ambivalence about an internship program may also be an intangible cost that affects morale due to the resources, time, and effort spent in the internship program at the facility. Fleming et. al. (1975) described some of the ambivalent emotions during discussions regarding the internship program at that time at the Medical College of Virginia (MCV) hospitals. The main purpose of the program was to attract new graduates to the MCV healthcare facilities and ultimately "…improve the nurse-patient ratio"[191]. Nursing administration determined the internship would serve as a tool to

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188 Byrd, Carol Y., Hood, Lucy, and Youtsey, Neoma, Student and Preceptor Perceptions of Factors in a Successful Learning Partnership, Journal of Professional Nursing, v. 13(6), pp. 344-351, November-December 1997.

189 Francis, Richard J. and Batsie, Catherine, Critical Pathways: Not Just for Patients Anymore, Nursing Management, v. 29(10), pp. 46-48, October 1998.

190 Golub, Judith C., A Nurse-Internship Program: Helping to Bridge the Gap, Hospital, v.45(16), pp. 73-78, 16 August 1971.

191 Fleming, Barbara W., Woodcock, Audrey G. and Boyd, Beverly T., From Student to Staff Nurse: A Nurse Internship Program, American Journal of Nursing, v.75(4), pp. 595-599, April 1975.

increase the interns' functional effectiveness and smooth the transition into professional nursing. However, only selected new graduates attended the internship.[192]

The nurse interns held staff positions and were paid accordingly. Also, unit managers supervised the nurse interns and were responsible for orienting the nurse interns to the unit during the unit rotation. Since the program length was for one year, interns could rotate to another unit when the reason was justified and the change could be accommodated. Unit rotations were mostly four to six months depending on the type of unit. Head nurses and other unit staff were frustrated when nurse interns rotated to another unit since time and effort were spent to get them oriented to the unit.[193] Therefore, some ambivalence about the program evolved and had to be dealt with directly.

In conclusion, this section has examined several alternative methods used by healthcare organizations to manage resource allocation for nurse internship programs while allocating resources. Healthcare facilities want to have competent nurses who are satisfied, who cope with the challenges faced in the work setting, and who regard the work setting as a rewarding experience. However, depending on the methods utilized to help the nurse transition into the work setting, the general outcome may generate mixed feelings regarding the work setting and support from the organization. Healthcare facilities need to assess their resource limitations and then make the choices that accomplish the desired outcomes based on the vision of the organization.[194]

G. NURSE ACCESSIONS PROGRAMS

1. Introduction

Nurse accessions for the last eleven years are analyzed in this section to obtain an estimate of the number of nurses that could potentially benefit from the NIP in the future, if the accessioning trend continues to be the same. The USN NC gains the majority of nurses at the entry level when they are commissioned with the officer grade of Ensign. Some nurses join the Navy with a certain amount of nursing experience, but the majority

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192 Ibid.

193 Ibid.

194 Zuckerman, Alan M., Healthcare Strategic Planning, Health Administration Press, Chicago, IL, 1998.

of nurses enter the Navy without nursing experience. For example, some of the accession programs require nurses to enter the Navy as soon as they complete their baccalaureate degree. As graduate nurses start a career in the nursing profession and in the Navy, they will need to acquire and develop the knowledge, skills, and abilities to successfully transition into the nursing profession and the Navy. Finally, all nurses accessed will need to adjust to the leadership role of a Naval officer.

2. Methodology

The analysis of accession data containing accession program information for eleven fiscal years, 1992-2002, is presented in this section. The analysis includes two parts. First, an overview of the number of nurses gained from each accession program is presented. Second, an overview of accession programs demonstrating the total number and the percentage of nurses who are commissioned as Ensigns is explained. The data sets were obtained from the Bureau of Medicine and Surgery (BUMED), medical information systems II (BUMIS II). The premise underlying this analysis is the assumption that nurses who enter the Navy immediately finishing nursing school have no nursing experience in the workplace.

3. Nurse Accessions into the United States Navy Nurse Corps

In order to recruit nurses, the USN utilizes different accession programs each with a contract to serve on active duty in the Navy for a number of years. Appendix A describes the different USN nurse accession programs for nurses. Table 2.4 indicates the total number of nurses gained per accession program. The NROTC, NCP, and MECP accession programs provide monetary funding to obtain a nursing degree. As graduate nurses complete their nursing degree from their designated college or university they are commissioned as Ensigns in the USN. A program similar to the last three programs mentioned, the BDCP, stopped accepting students into the program after fiscal year 1995. However, a substantial number of nurses entered the Navy through this program in the early 1990s.

The nurses from the aforementioned college programs have a contract for active duty service in the Navy for four or five year depending on the accession program. The other accession programs, Direct with bonus and without a bonus, and Recall, bring nurses into the Navy who may have some nursing experience, but they all must have their

nursing license prior to joining. The Direct accession program offers a monetary bonus for a four-year contract. However, if the nurse does not take a bonus, then the contract length is three years for active duty. The IST nurses have prior nursing experience as they are transferring from one of the other military services. The TNWOP also gained experienced nurses, as these nurses were initially accepted into the military with an associate degree in nursing and served as warrant officers. They opted to obtain their baccalaureate nursing degree and remain in the Navy as commissioned officers.

Table 2.4. Number of Nurse Accessions per Program, 1992-2002.

Program	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
NROTC	**7**	**9**	**20**	**63**	**87**	**99**	**81**	**62**	**49**	**54**	**52**
Direct No Bonus	44	20	6	16	10	6	3	89	15	29	8
Recall	9	11	2	15	13	11	5	15	18	13	14
IST	0	0	1	1	0	0	0	0	2	0	1
TNWOP	1	3	1	6	16	19	10	6	0	0	0
BDCP	**290**	**175**	**128**	**50**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Direct Bonus	66	22	39	157	73	68	23	14	74	55	68
NCP	**0**	**21**	**28**	**44**	**44**	**45**	**50**	**34**	**39**	**58**	**62**
FTOST	16	6	0	0	0	0	0	0	0	0	0
MECP	**50**	**53**	**50**	**47**	**51**	**55**	**51**	**48**	**45**	**66**	**41**
Total	483	320	275	399	294	303	223	268	242	275	246

(Note: The bold programs indicate the college accession programs for nurses. See Appendix A for acronym definitions. Data source is BUMIS II, M13)

Table 2.5 provides a summary of the total number of nurses gained through all the accession programs for fiscal years 1992-2002. Nurses receive an officer grade upon commissioning into the Navy, and for the most part, these nurses receive the entry-level grade of Ensign. The percentage of gains that are Ensigns ranges from a minimum of 87 percent to a maximum of 98 percent (column D). If all Ensigns entered the Navy as soon as they completed college, column D would indicate the percentage of nurses who entered the Navy without prior nursing experience. However, a distinction in experience level cannot be made for Ensigns who came into the Navy through the Direct, bonus or no bonus, accession programs. Hence, the nurses entering the Navy through the NROTC, BDCP, NCP, and MECP programs may be considered to provide an estimate of the minimum number of nurses who entered the Navy without prior nursing experience.

Column E of Table 2.5 lists the total number of nurses who joined the USN through the four college programs as a subset of the total number of nurses who were gained each year. In addition, the Direct accession programs may also contain a number of nurses with minimal if any prior nursing experience.

The percentage of nurses that have no prior nursing experience upon accessioning is consistently greater than the percent of experienced nurses throughout the period of analysis. For example, in 2002, only 33 nurses (246 minus 213) or thirteen percent of the nurses accessed into the Navy were given the grade of Lieutenant Junior Grade or above, an indication of prior nursing experience. On the other hand, in the same fiscal year, 2002, 87 percent (213/246) of the nurses accessed into the Navy were Ensigns, mostly inexperienced nurses. About 63 percent (155/246) of the total number of nurse accessions for 2002, entered the Navy from a college accessions program (Column F) . All of these recent college graduates were new to nursing.

Overall analysis of the nurse accession data identifies a mean value of 91 percent for the percentage of nurses that were commissioned as Ensigns from all programs over all the years. Likewise, the percentage of nurses who entered the USN through college accession programs had a mean value of 66 percent over all the years (Column F). Column E provides the minimum number of nurses that needed to gain nursing experience to function in the clinical setting. All nurses needed orientation to their role as a Naval officer, except perhaps some of the nurses gained through the recall program who may have had prior military experience.

Table 2.5. Summary of Accession Programs Demonstrating the Total Number and the Percentage of Nurses Commissioned as Ensigns, 1992-2002.

A	B	C*	D*	E*	F*
Fiscal Year	Total Number of Nurses Gained, All Programs	Total Number of Ensigns gained from all programs	Percent of Ensigns from all Accession Programs (C/B)	Total gain from four Colleges accession Programs Only	Percent of nurses From college accession programs (All are ENS) (E/B)
1992	483	430	0.89	347	0.72
1993	320	298	0.93	258	0.81
1994	275	269	0.98	226	0.82
1995	399	373	0.93	204	0.51
1996	294	274	0.93	182	0.62
1997	303	287	0.95	199	0.66
1998	223	202	0.91	182	0.82
1999	268	234	0.87	144	0.54
2000	242	210	0.87	133	0.55
2001	275	253	0.92	178	0.65
2002	246	213	0.87	155	0.63
Total	**3328**	**3043**	**0.91**	**2208**	**0.66**

(Data source: BUMIS II, M13)
*Column C, D, E, and F are subsets of column B

4. Conclusion

In conclusion, a majority of the nurses who come into the USN NC will need to develop and acquire the knowledge, skills, and abilities that will enable them to function in their new roles as nurses and Naval officers. The NROTC, NCP, and MECP accession numbers provide the minimum number of inexperienced nurses. However, the other accession programs may also gain inexperienced nurses. These inexperienced nurses are the new nurses described in this thesis. These new nurses will need a comprehensive transitional program to open the portal into skill acquisition and continuous learning. The time and resources spent in such programs may influence the perception of these new nurses as they transition into their new roles. Early perceptions mold these nurses' views of the organization. How well the Navy provides an opportunity for these nurses to transition into the professional nursing and the Naval officer role will shape the nurses' views about organizational commitment to professional development.

H. DUAL ROLE OF U.S. NAVY NURSE CORPS OFFICER

1. Description of the Role and Development of USN NC Officers

The fundamental role of the USN NC is to provide healthcare support to the USN and U.S. Marine Corps during peacetime, wartime, and humanitarian operations. Nurse

Corps officers have a dual role consisting of the professional nursing role and the Naval officer role. As dictated by these roles, development and fostering of professional growth and leadership skills are essential components of career progression. Lifelong learning defines a NC officer, as they are expected to be nursing and military leaders.[195] These dual roles allow NC officers to fill a variety of jobs in the Navy.

In general, once nurses are commissioned into the Navy, they attend Officer Indoctrination School (OIS) in Newport, Rhode Island. OIS prepares the nurse corps officers "… to carry out the duties and responsibilities of a Naval officer."[196] For six weeks, the training covers a variety of topics dealing with military information such as Navy rules and regulations, uniform regulations, physical fitness, safety, professional responsibilities, Navy medicine's healthcare management issues and the Basic Officer Leadership Course. OIS provides basic training that forms the foundation to support the start of a successful Naval career. It gives participants the fundamental knowledge necessary to assume their new role in the Navy. Through guidance and mentoring during the NC officers' career, participants further advance their experience to perform successfully as a Naval officer.

After spending six weeks in OIS, the nurses proceed to their assigned command. Some of the newly commissioned nurses arrive at their first duty station as graduate nurses, meaning they do not have their nursing licenses. The new nurses are starting the basic phase of a Navy Nursing Career path. It is during this phase that nurses acquire and refine their clinical skills so as to provide the nursing care required of them in both peacetime and wartime operations. The premise of the basic phase of the career path is based on the time period when nurses obtain additional knowledge, hone their technical skills, and develop leadership abilities.[197] The initiation of the basic phase occurs at their first duty station where they are expected to fulfill the role of a professional nurse and Naval officer.

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195 Nurse Corps Strategic Plan, Navy Nursing Scope of Practice, [https://bumed.med.navy.mil/med00nc/StrategicPlanning/strategic_planning.htm], 16 January 2003.

196 Officer Indoctrination School (OIS), [http://nshs.med.navy.mil/eme2/navycourses/asp#OIS], March 2003.

197 U.S. Navy Nurse Corps Web Page: A Navy Nursing Career…Today and Tomorrow, [https://bumed.med.navy.mil/med00nc/StrategicPlanning/strategic_planning.htm], 16 January 2003.

New nurses arrive at their new command to fill a staff nurse requirement. The description for a staff nurse in the Navy is 0944 under the Navy Officer Billet Classification (NOBC) Code. It describes the position as a person who:

> …assesses, plans, and implements direct nursing care of patients on assigned unit. Supervises and trains nursing personnel. Assumes charge nurse responsibilities on a relief basis.[198]

In general, new nurses fill the 0944 NOBC billet (position) when they arrive at a naval treatment facility. New nurses receive the 1900E subspecialty code upon commissioning into the Navy. According to the NOBC manual, officers who have the 1900E are fully credentialed and actively practicing in the professional nursing role as a primary duty. These nurse corps officers have a baccalaureate degree in nursing required to fulfill the duties associated with this specialty.

In addition to the staff nurse position requirements, the Navy Nursing core competencies (Appendix B) provide a foundation that guides skill acquisition.[199] The Navy Nursing core competencies consists of the following main headings: emergency response and safety; patient assessment and plan of care; performance and documentation of patient care; patient and family education; professional development; leadership, management, and information management; missions, performance improvement, and operational readiness; and, managed care/population health.[200] These core competencies are intended to demonstrate the path towards acquisition of new knowledge and skills in clinical operational, leadership, and managed care.

The above core competencies form a stable foundation on which to base unit competencies, class curriculum, and other teaching methods. The USN NC expects nurses to complete the core competencies in three years from the time nurses enter active duty. Therefore, commands are exhorted to integrate the core competencies into the development of tools such as "…internships, orientations, and leveling systems" so as

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198 Navy Manpower Analysis Center, Manual of Navy Officer Manpower and Personnel Classifications, p. C-17, [http://www.navmac.navy.mil/main/html], March 2003. .

199 U.S. Navy Nurse Corps Web Site, Navy Nursing Core Competencies, [https://bumed.med.navy.mil/med00nc/Competencies/home.html], February 2003.

200 Ibid.

new nurses arrive at a command, they start with a solid foundation on which to base role expectations.[201]

2. Distribution and Assignment of Navy Nurses

The mission of the distribution process has three parts.

- To assign the best qualified officers to meet the needs of the Navy as defined by approved officer billet files
- To assign officers to billets which develop their professional expertise, thereby ensuring individual career needs match leadership, technical and managerial skills necessary to meet the Navy Mission and
- To assign officers sensitively and fairly to meet their continued professional motivation and dedication to the Navy.[202]

Allocation, placement, and assignment are sub-processes of the distribution process. The allocation process ensures that each command receives a fair share of the number of available nurses. The placement process serves each command based on its staffing interests, requests, and concerns. On the other hand, the assignment process works to assign each nurse to a job while taking into account each nurse's request. The person who communicates with the nurse is the detailer who processes and issues the orders for the nurse. Ultimately, detailers try to maintain a balance between the individual's wishes and the nursing requirements of the commands.

In Appendix C, the distribution of nurses from college accession programs to a particular command is presented. The command will need to provide training and development opportunities for these new nurses to gain necessary knowledge and skills.

3. Conclusion

In conclusion, USN NC officers have a dual role: the professional nursing role and the Naval officer role. Basic training for the officer role occurs at OIS before the nurse arrives at his or her first duty station. The new nurses receive the subspecialty code 1900E, which describes them as professional nurses. When the new nurses arrive at their first duty station, they will generally fill the staff nurse positions in the MTFs. To fill a staff nursing position, the new nurses must acquire clinical skills in order to successfully

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[201] Ibid.

[202] Breier, David, and Thomas, Clarence, Presenter, Medical Placement Overview, Notes, Navy Medical Manpower Management Conference 2002, 22 – 24 September 2002, Slide 1, [http://www.changearchitect.com/manpower/WorkshopPresentations/DistributionandPlacement(Officers).ppt]. 15 January 2003.

perform in the position. Consequently, the Navy nursing core competencies describe the general competencies a NC officer needs to acquire in their first duty station. These core competencies provide a foundation for the development of comprehensive clinical competency requirements, and class curriculums. The development of clinical skill competency is a crucial goal for the new nurses.

The nurses' skills are one set of the drivers for the distribution and assignment process in the Navy that allocates nurses to vacant nursing positions in the MTF. The objectives of the process are to match the skill of a nurse with a vacant position in the MTF. However, new nurses lack the skills needed to perform in the clinical setting when they arrive at the MTF. Hence, the orientation program utilized in the facility needs to provide the opportunities for skill acquisition necessary to successfully perform in the staff nursing position.

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III. NURSE INTERNSHIP PROGRAM, NAVAL MEDICAL CENTER, SAN DIEGO

A. INTRODUCTION

Chapter III provides a descriptive, focused overview of the NIP as implemented at NMC SD. This facility implemented the first NIP for nurses in a Naval MTF in January of 2001. Researchers at NMC SD evaluated the outcomes of the NIP and summarized their findings in an as yet unpublished paper.[203] Their general findings include increased level of self-confidence, increased flexibility in job assignment, increased self-direction, increased management satisfaction with performance of new nurses, and increased fit with organizational culture and values as outcomes of the NIP.[204]

The internship program was monitored for this thesis from November 2002 to February 2003. The elements of implementation are described in this chapter. First, a brief description of NMC SD is provided as background information relevant to the NIP. Second, the reasons for implementing the internship are reviewed in the context of strategic planning, and the NIP's goals and objectives. Third, in-depth descriptions of the program's design, content, and the role of key personnel are provided. Fourth, a summary of the evaluation systems for both the nurse interns as well as for the program are presented. Fifth, the role of the preceptors in the internship program is explored due to its important connection to the experiential learning method used by the nurse interns. Sixth, a review of the support available to the nurse interns is described. Seventh, an overview of the NIPs at Naval Medical Center Portsmouth (NMCP) and National Naval Medical Center (NNMC) Bethesda are described depicting only general variances from the NIP at NMC SD. Finally, the chapter concludes by examining the distribution of nurses at NMC SD with emphasis on the distribution of new nurses.

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[203] Blanzola, Cherie, Lindeman, Roslyn M. and King, M. L., Nurse Internship – Pathway to Clinical Comfort, Confidence and Competency, August 2002.

[204] Ibid., Evaluation of Nurse Interns.

B. NIP IMPLEMENTATION FRAMEWORK

1. Naval Medical Center, San Diego

NMC SD is located in southern California and provides medical services to the Tricare Region 9 area, which serves military eligible beneficiaries. It is one of three large naval medical treatment facilities in the United States. It is a tertiary medical care center providing full-service medical care to eligible beneficiaries. NMC SD plays a significant role in medical education, training, and research. In addition, NMC SD provides medical care at the operational level through mobilization units to support operational settings in "…disaster relief, humanitarian aid, peacekeeping, and war fighting."[205]

The NMC SD mission and vision statements establish the direction of the organization towards excellence in access to health care, patient care, education, research, professional growth, and job satisfaction. The NMC SD mission statements are:

- Deliver quality health care services in support of the Armed Forces and maintain medical readiness
- Advance military medicine through education, training and research as the tertiary referral center for Tricare region 9[206]

One of the roles of leadership is to exhort and support the organization's employees, both military and civilian, in the pursuit of excellence through education, training and professional growth. The vision statements embody the pursuit of education, training, and professional growth, and are as follows:

- Be fully trained and ready to provide the highest level of operational support
- Be regarded as a Department of Defense center for excellence in medical education, research, and professional growth.
- Provide an information management system that maximizes our efficiency
- Reward achievement which supports our values and promotes job satisfaction
- Be preferred by patients for our personalized and compassionate care[207]

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[205] Naval Medical Center, San Diego, Command Information: Commander's Guidance, [http://159.71.170.20/SiteMaker/websitefiles/nmcsdpub/command_info.cfm?id=8], 15 January 2003.

[206] Ibid,. Mission Statement, Tricare Region 9 consists of Southern California and the Yuma area of Arizona.

[207] Ibid., Vision Statement.

Likewise, direct guidance from the commanding officer (CO) of NMC SD offers support and encouragement to the hospital staff for continuing education and training among its twenty guidance points.[208] In summary, the CO's guidance presents the expectations of the commander for the staff's behavior grounded in the Navy's core values of honor, courage, and commitment. A supportive climate for the NIP is present at NMC SD. The NIP offers education, training, and profes sional growth to new nurses who are either new to the nursing profession, to the Navy, or to both.

2. Reasons for Implementing the NIP

The NIP was implemented at NMC SC for several reasons. First, the organizational environment allowed such a program to take place. Second, the U.S. Navy *Nurse Corps Strategic Plan* set the direction towards the development of the NIP in the Navy for the education and professional development of new nurses. One of the goals in the NC Strategic Plan deals with the Professional Nursing Practice.[209] The goal states: "We will optimize the capabilities of Nurse Corps Officers to provide quality care across the entire healthcare continuum."[210] Under this goal, objective number two directs: "Novice nurses will be transformed into competent Navy Nurse Corps Officers, as indicated by completion of basic core competencies."[211] It spells out the strategies as follows:

- Identify a list of core competencies of the novice nurse
- Research possibilities for developing an internship program for the novice nurse based on established core competencies
- Pilot the internship program or provide internship guidelines
- Evaluate the effectiveness of the internship programs[212]

These strategies established the direction and provided guidance from top leadership that led to the start of the NIP at NMC SD.

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208 Ibid., Commander's Guidance,

209 U.S. Navy Nurse Corps Website, Nurse Corps Strategic Plan, January 2002, [https: //bumend.med.navy.mil/med00nc/StrategicPlanning/strategic_planning.htm].

210 Ibid.

211 Ibid.

212 Ibid.

Another major driver behind the implementation of the NIP at NMC SD was the outcome observed by staff nurses on the ward and by the nursing leadership at the medical center. For example, Blanzola et. al. states: "Staff nurses at our facility felt that new nurses were being placed in clinical situations that they were ill prepared to manage because of an inadequate orientation program in terms of both length and content."[213] The previous orientation program was only six weeks long, a very short period in which the new nurse was expected to transition into the organization, adjust to new quarters, and gain necessary clinical skills to provide patient care.[214] Another reason for establishing the NIP was the large influx of new nurse accessions through the NROTC and NCP as well as new nurses who arrived at the command without their nursing license.[215]

As a result of the strategic plan and the established need for a NIP, a working group convened in the summer of 2000 to research, develop, and initiate the internship program for new nurses at NMC SD.[216] The working group was composed of division officers (DO), clinical nursing educators, nursing administration personnel, and some nurse practitioners. The staff came from the various nursing units including the operating room, intensive care unit, emergency department, medical–surgical unit, maternal-child unit, and pediatrics. An extensive literature review provided the fundamentals for the working group to start developing the internship program. The group also obtained input from the U.S. Medical Corps, as they have an inveterate model for the physician internship and residency programs. Also, the group sought input from the Medical Service Corps (MSC) at NMC SD who had a business plan for training newly accessed MSC officers without experience in Navy medicine.

As a result of the working group's effort, the NIP's purpose is to "strengthen the nursing workforce by providing clinical skills and experiences needed for the new nurse to be a competent health care delivery team member and develop leadership skills expected of a Naval officer."[217] The main goal of the NIP is "to provide a pathway to

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213 Blanzola, Cherie, Lindeman, Roslyn M. and King, M. L., August 2002.

214 Ibid.

215 Telephone Conversation Between LCDR Blanzola, C. and the Author, 27 January 2003.

216 Ibid.

217 Blanzola, Cherie, Lindeman, Roslyn M. and King, M. L., August 2002.

clinical comfort, confidence and competence."[218] The four objectives of the NIP are described below:

- To provide ongoing support and meaningful experiences for the novice nurse
- To provide the novice nurse with the knowledge, training, and tools necessary for a smooth transition into the role of Ensign and registered nurse
- To provide mentorship and guided orientation in conjunction with "clinical expertise" supported with unit and didactic experiences
- To provide a program that addresses the issue of preparation, sustainability and retention.[219]

3. The NIP's Design and Content

To implement the NIP, the working group had to overcome some organizational and logistical challenges. Resistance to organizational change was one of the challenges. Resistance emanated as a result of the potential staff vacancies that would be created while the new nurses would be participating in the internship program. Some of the other obstacles dealt with the implementation of the multiple program components. First, scheduling the number of interns in the different nursing units was one challenge that had to be met. Initially, all unit managers wanted the interns to come to their unit even if it was a critical care unit. A second logistical challenge dealt with scheduling the interns to attend the required program classes. Many of the classes were open to the hospital nursing staff. Thus, if the nurse interns filled all the seats available, then the opportunity to attend the class was significantly reduced for other hospital nursing staff members. In summary, planning and implementing the NIP is succinctly described by one of the co-leaders, "…it was like putting a puzzle together…you had many pieces."[220]

Presently, in addition to managing the logistics of multiple program components, the program has to integrate new nurses into an internship rotation as they arrive at NMC SD at different times throughout the year. Different factors affect the arrival of these nurses to the command. Some possible examples include college graduation date,

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[218] Blanzola, Cheri, Internship Overview, Nurse Internship Program Guide, NMC SD, January 2001.

[219] Ibid.

[220] Telephone Conversation Between LCDR Blanzola, C., and the Author, 27 January 2003, LCDR Blanzola was one of the leaders of the working group, which planned the implementation of the NIP at NMC SD.

accession contract specifications, assignment by detailers, and time of OIS attendance. Therefore, due to the different intern arrival dates, the internship rotations are scheduled on an ongoing basis throughout the year. New nurses who arrive at close intervals to each other may constitute an intern rotation group. However, as other Ensigns arrive at the command, they join the current internship rotation and participate in a flexible orientation plan until the next internship rotation begins. This is in contrast to the civilian internship examples found in the literature review, in which each class was limited in the number of candidates and the number of internship groups offered in a year. As a result, the NIP at NMC SD is an ongoing dynamic process with nurses rotating in and out as they enter and complete the program.[221]

New nurses fall under the Director of Nursing Services (DNS) Nursing Administration Directorate while participating in the NIP. This type of staff classification provides an advantage as potential conflicts between training and staff requirements of a unit may be limited or possibly eliminated. In contrast, in the previous orientation program, new nurses went directly to clinical spaces to fill nursing vacancies and were under the direct supervision of the DO. The NIP director and the NIP coordinator[222], provides direction to the nurse interns.

NC officers constitute the greatest portion of the internship with an average of thirteen nurses per rotation, but rotations may have up to thirty nurses depending on seasonal fluctuations.[223] The program is also open to civilian nurses who are hired to fill nursing positions designated for civilian employment at NMC SD. Qualifications for program participation consist of having graduated from an accredited school of nursing and having less than six months of clinical nursing experience.[224]

The new nurses participate in the NIP for a period of sixteen weeks of skill acquisition. Program components include classroom lectures, bi-monthly group

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[221] Telephone Conversation Between NIP Director at NMC SD, Lindeman, Roslyn, and the Author, 12 February 2003.

[222] The NIP Coordinator manages the Clinical Education division under the Staff Education and Training department.

[223] E-Mail Correspondence from NIP Director at NMC SD, Lindeman, Roslyn, to the Author 14 January 2003.

[224] Blanzola, Cheri, Eligibility, Nurse Internship Program Guide, NMC SD, January 2001.

seminars, clinical experience in a direct patient care setting, group presentations, and patient care conferences.[225] Each of these components has a direct link to skills the new nurse will need to learn and eventually apply in the patient care setting. Classroom time is devoted to at least 20 hours of lecture material consisting of a variety of topics directly linked to patient care. The NIP coordinator oversees the class content presented in the lectures. According to the NIP coordinator at NMC SD "the classes the interns take vary depending on what classes are offered during the time they are in the program."[226] Appendix D contains the required courses and other classes that may be taken as schedules and time permits. In summary, the classes offer the knowledge necessary to provide patient care.

As a critical and balancing component of the program, the clinical rotation yields a rich environment where the nurse intern experiences a variety of inpatient care settings. The interns rotate between medical-surgical floors, pediatric, obstetrics, and a critical care or other specialty area. Table 3.1 displays the rotation areas and the length of time a nurse intern spends in each area. Depending on the number of nurse interns in a rotation, a psychiatric unit rotation may be part of the clinical rotation. At least 100 hours per month are devoted to the clinical experience. An objective of the clinical experience is to integrate the content of the classroom lectures with actual clinical situations. This integrated schedule provides the nurse intern with a direct and concrete application of the material discussed in the classroom to a patient setting. Thus, topics such as physical assessment, pathophysiology, diagnosis, treatment, nursing interventions, and patient evaluation are learned in class and then applied in the clinical setting.[227] Appendix E provides a sample of the "Unit Clinical Plan" that provides guidance to the intern, preceptor, and DO during the clinical rotation. Weekly goals, patient assignment, and responsibilities are outlined in the plan. The plan is only offers guidelines for the program participants, as the clinical rotation is adapted to meet the individual learning needs of each nurse intern.

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[225] Lindeman, Roslyn, and Blanzola, C., LCDR, Nurse Internship Program (NIP): The "Pathway" to Clinical Comfort, Confidence, and Competence, Slide Presentation, Slide 5.

[226] E-Mail Correspondence from NIP Coordinator, LCDR Stensrud, to the Author, 03 February 2003.

[227] Lindeman, Roslyn and Blanzola, C., LCDR, Slide Presentation, Slide 6.

Table 3.1. Nursing Areas and Length of Rotation (From: Nurse Internship Program Guide)[228].

Rotating Areas	Length of Rotation
Medical Surgical Nursing	Four Weeks
Medical Surgical Nursing II	Four Weeks
Pediatric Nursing	Two Weeks
Obstetrical Nursing	Two Weeks
Specialty Nursing/Critical Care Nursing	One Week

The clinical rotation schedule in the unit consists of 12-hour day shifts and includes weekends. The maximum number of nurse interns per rotation is six per unit. They are divided into three interns per unit per day since the units operate under 12-hour rotating shifts.[229] However, as explained by the program director, four interns per group is a more manageable situation at the unit level, since there will be two interns per unit per day. It is the number of interns in the program at any one time that determines the number of intern rotating through the units at any one time.

As classes have teaching objectives, the clinical experiences also have objectives designed to assist the nurse interns in learning and applying clinical skills. Table 3.2 contains the clinical experiences linked to a learning objective or an experience that nurse interns learn or obtain when they rotate through a specific unit. Inherent in the clinical content of the program is the nurse intern's participation in all facets of patient care. "This includes patient assessment, prioritization, delivery, and evaluation of nursing care for one or a group of patients."[230] These skills are essential components of the program. Del Bueno (1994) warns of the lack of prioritization, and critical thinking skills that new

228 Blanzola, Nurse Internship Program Guide, NMC SD, Rotations, January 2001.

229 E-Mail Correspondence from NIP Coordinator at NMC SD, Lindeman, Roslyn, to the Author, 14 January 2003.

230 Naval Medical Center San Diego, Nurse Internship Program – Specifics, [http://www.nmcsd.med.navy.mil/SiteMaker/websitefiles/nmcsdpub/command_info.cfm?id=208], February 2003.

nurses exhibit.[231] Benner (1984) also identified, by means of the Dreyfus skill acquisition model, the need for new nurses to learn prioritization skills when faced with a barrage of information. Therefore, priority setting is an essential component of the clinical experience.[232] The contents of the NIP are designed to offer a balanced clinical experience that provides the opportunity for new nurses to acquire the skills necessary to transition confidently to the role of healthcare provider on the unit.

Table 3.2. Clinical Experiences Learning Objectives (After: Nurse Internship Program Guide)[233].

Clinic Experiences	**Learning objective**
Command Orientation and Clinical Orientation	Safety, confidentiality, infection control, universal precautions
Surgical Experience	Intern follows a patient through preoperative teaching, day of surgery, post-operative report, and care of patient post operatively. Operating room is optional and is scheduled on a case-by-case basis.
Nurse Mentorship Experience	Mentorship with an experienced clinical nurse leader to gain a better understanding of the roles and responsibilities of DO
Outpatient Clinic Rotation	One day rotation in a specific outpatient clinic allows intern to observe patient care in an outpatient setting and gain an awareness of activities in the clinic.
Special or Critical Care Area Rotation [234]	One or two days spent rotating through the corresponding critical or specialty are while intern is assigned to a rotation (i.e. Pediatrics linked with a one or two day rotation in the Pediatric Intensive Care Unit
Intern Grand Rounds – 20 minute presentation of a case study on a patient to the intern group at the end of the internship program	Incorporates knowledge and skills learned through the Medical Surgical Nursing Rotations.

[231] Del Bueno, pp. 9-11.

[232] Benner, pp. 1-38.

[233] Blanzola, Cheri, Rotations, Nurse Internship Program Guide, NMC SD, January 2001.

[234] The specialty care areas include the intensive care unit, cardiac care unit, pediatric intensive care unit, Neonatal Intensive care unit, Emergency Department, Post anesthesia Care Unit, Mental Health, Operating Room, Outpatient clinics, 5 West, 5 North, 5 East, 4 West, 4 North – Same Day Surgery, 3 East, 3 West, Labor and Delivery, 2 East. Command Information, NIP – Specialty Care Area Choices, On Line:

During each of the clinical rotations, the constant interactions between the program director, key unit nursing personnel, and the nurse interns are the catalyst in the nurse interns' skill acquisition. These interactions between the program participants promote a learning environment. One key role is that of the program coordinator. This person has a proactive role in the program, matching up teaching opportunities in the hospital with the learning needs of each nurse intern. A second key role is that of the Clinical Nurse Specialist (CNS) or clinical educator (CE)[235] as they are able to provide education and knowledge about patients in the clinical setting. The division officer (DO) may substitute for the CNS when they are not available as they also have experience in providing nursing care to the unit's patient population. Finally, the third key player is the clinical preceptor who, along with the CNS or DO, offers direct guidance to the nurse intern while providing direct patient care. Finally, it is a combined effort between all key members, including the nurse interns that ensures the clinical experiences are integrated with each nurse intern's learning goals and objectives.

4. Competency and Skill Level Assessment

A fundamental element of the clinical rotation in the internship program is the competency-based clinical performance assessment checklist.[236] This competency checklist is a critical component of the program as it not only provides a guide for learning and teaching but also for evaluating and documenting the level of clinical performance in "…core nursing skills, knowledge and tasks."[237] Appendix F presents excerpts of the clinical performance program package. Both the nurse intern and the preceptor utilize the checklist while in the clinical setting to document the level of skill proficiency.

The first section, *Administrative and General Requirements Checklist*, provides a path for the nurse interns to learn the administrative and safety routines of each unit attended during the clinical rotation. Also, the educational requirements are contained within the first section. The second section contains the *Clinical Competency Checklist*,

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235 The CNS and the CE may be available during the clinical rotation in a unit or only one may be available.

236 U.S. Navy Nurse Corps Web Site, Nurse Internship Program: Clinical Performance, Navy Nursing Competencies, [https://bumed.med.navy.mil.med00nc/Competencies/home.html], February 2003.

237 Ibid.

in which the nurse intern and the preceptor have the opportunity to jointly assess the intern's nursing skills. The clinical requirements consist of "…a systems-based tool" containing elements that describe a competency statement and criteria (performance element) on which the intern's level of knowledge, skill or task demonstrated is documented.[238] For example, one of the competency statements relates to basic nursing care for performing and documenting a basic health assessment. Accordingly, the corresponding criteria include the patient's health history, physical assessment, vital signs, and other pertinent aspects of the patient's health assessment. Lastly, among the clinical requirements are competency statements identified as the skills necessary for operational contingencies. This is an important distinction in the competency checklist as the NIP provides the nurse interns the ability to develop operational skills essential in the operational environment as well as in the hospital setting.

The competency assessment range begins at Level One for *Novice*, which describes a nurse intern possessing no knowledge or skill in the given competency or criteria. At Level Two, *Advanced Beginner*, the nurse interns has some knowledge or skill but needs practice under supervision or may need additional training or education to master the element. Finally, Level Three corresponds to the *Competent* level. At this level, the nurse intern has sufficient knowledge to work independently and performs the indicated element in a consistent and safe manner. The documentation substantiates the learning progress of the nurse interns as they learn knowledge and skills as well as gain experience in a patient care setting.

The *Equipment Competency Checklist* constitutes the third section and it specifies the equipment utilized in the clinical nursing units for patient care. The fourth section consists of a *Checklist of Types of Patient* for the nurse intern to document the types of patients he or she has provided patient care for during the clinical rotations in a given unit. Finally, the fifth and sixth sections consist of the *Signature List* and the *Reference Key Legend*, respectively. The signature list contains the preceptor's name, while the reference key contains a list of nursing manuals and nursing books used as learning resources.[239]

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[238] Ibid.

[239] Ibid. The Signature List and the Reference Key are not shown in Appendix F.

5. Evaluation Processes

As the Clinical Performance packet provides a mechanism to assess the nurse intern's competency and skill levels, the NIP, as a program, also contains an ongoing evaluation process. Embedded in the design of the NIP are various evaluation tools. These tools are utilized at points throughout the nurse interns' progression in the NIP, such as during the entry point, after each rotation, and at program completion.[240] Additionally, evaluations not only assess the performance of the nurse intern, but also assess the preceptor and the program. Table 3.3 describes each of the evaluation tools used in the NIP at NMC SD as well as the frequency of the evaluations.

a. Nurse Intern Evaluation

The first evaluation tool used is the Performance Based Development System (PBDS). It is a system of multimedia assessment tools that classifies the nurse on the novice to expert continuum and assesses critical thinking and interpersonal skills. The PBDS tool is also used at the completion of the program and six months after completion of the NIP. This allows for a thorough assessment of the nurse's clinical skills at various points early in the nurse's career.

The second evaluation tool is the PEERS™ and it is utilized throughout the internship program to evaluate the intern. Nurse interns receive feedback as they advance in the program and at program completion through an individual competency model based on seven criteria.

[240] E-Mail Correspondence from NIP Director at NMC SD, Lindeman, Roslyn to the Author, 14 January 2003.

Table 3.3. Intern Evaluation Tools (After: Nurse Internship Program Guide)[241].

Intern Evaluation Tool	Description	Frequency And Evaluator
Performance Based Development System (PBDS)	"…a competency-based performance development system used as part of clinical orientation and ongoing competency assessment of registered nurses."[242]	During the first week after the nurse interns' arrive at the command for an initial clinical assessment. A focused PBDS assessment is also given at the end of the NIP and at six months after unit assignment
Personal Enrichment and Reward System (PEERS™)[243]	Systematically assesses, monitors and evaluates professional growth, comfort, confidence, competency and performance of nurse interns based on input from first level observers	Baseline self-assessment at program entry and during the program by nurse intern. Also, an ongoing assessment of the nurse intern's performance by staff working directly with the nurse intern. Tool completed at end of each clinical rotation. Evaluation system provides a model that is divided into five scores: individual intern, group, self-evaluation, and overall scores for the individual intern and for the group.
Program Evaluation	Intern evaluation of goal and objective achievement, unit support, and educational opportunities and preceptor interactions	At the end of unit rotation by nurse intern
Military Fitness Report (FITREP) for Navy Nurse corps officers; PARS – Performance Appraisal/Evaluation for civilians employees	Organization wide evaluation systems for military and civilian employees, respectively.	Each year by the DO.

The seven criteria are: 1) clinical knowledge and performance; 2) performs and/or assists patients with various patient care elements; 3) performs core

241 Ibid., and from the Nurse Internship Program Guide.

242 Blanzola, Cheri, Evaluation, Nurse Internship Program Guide, NMC SD, January 2001.

243 Lindeman, Roslyn, Designed Evaluation Tool, PEERS™, 1982.

nursing skills; 4) equality and fairness; 5) teamwork; 6) initiative; 7) communication.[244] The system supports a model that is a composite of the evaluator's assessment scores, group score, and a self-assessment score, which are then compared to an overall individual and group score. Anywhere from five to eight observers, such as the clinical preceptors, the DO, CNS, and CE, evaluate the nurse interns using the Personal Enrichment and Reward System (PEERS™) criteria. The comments reflect strengths and weaknesses with suggestions for improvement in the areas identified by the evaluators. Another score reflects the self-evaluation by the nurse intern that contains the self reported strengths and weaknesses. The weak areas are linked to a training strategy identified by the nurse intern. However, the program coordinator also provides comments to the nurse intern, reflecting a collaborative effort. The PEERS™ evaluation model allows a nurse intern to receive comments from different nurses involved in the clinical experience.

b. Program Evaluation

Nurse interns and evaluators also provide valuable feedback used for improving the NIP through the rotation evaluation as described in Table 3.3. A thorough evaluation of the unit rotation stems from the rating of rotation objectives, support, and education of the nurse intern. To evaluate the rotation objectives, the nurse interns appraise if goals and objectives with specific unit responsibilities were clarified during the rotation. Evaluation of support allows the nurse intern to provide feedback on the teaching, facilitation, and overall performance of the clinical preceptor, clinical educator, and if available, the CNS. Each nurse intern also evaluates the teaching and learning methods. Finally, an opportunity is provided for the nurse intern to suggest changes to the unit rotation. This is important to the program as changes to the NIP may occur based on the feedback received. For example, initially the program was designed to cover six months. However, after feedback from nurse interns and evaluators, the program was re-designed to its current length of four months. Another program evaluation occurs when nurse interns evaluate the usefulness of the PEERS™ process in identifying learning needs. This evaluation is done midway through the program and upon completion of the

[244] Ibid.

program. In summary, the evaluation system is designed to measure different facets of the NIP including communication from all program participants.

The FITREP and PARS are part of the general organization evaluation tools for all employees. Likewise, these evaluation documents are also used for evaluating new nurses.

c. Nurse Intern's Journal

Although not formally a program evaluation tool, the requirement for a weekly journal is another method for learning and self-evaluation by the nurse interns. Goals are divided into short and long-term goals and may apply to a diversity of issues either at the professional or personal level.[245] Entry anonymity is encouraged, as it is a learning and evaluation tool exclusively for the intern. Nurse interns may use it to record their thoughts and conclude the week with the most useful learning experiences. Writing in a journal helps guide the interns in the transition towards professional nursing as they annotate their goals, experiences, and reflections.

6. The Preceptor

Among the program participants, the preceptor has a critical role as one of the program participants who works closely with the nurse intern and provides guidance throughout the clinical rotation. The preceptor has a key role in the development, molding, and support of the nurse intern. Each preceptor offers guidance in the unit, not only about the nursing role, but also about the nurse's leadership role in the unit. The NIP guide exhorts each preceptor to assist with the development of the nurse intern while working on the specific goals and objectives of each intern.[246] It is the responsibility of the DO to assign a preceptor to each nurse intern who begins a rotation on the unit that they manage with a one-to-one ratio of preceptor to nurse intern. The DO matches working schedules of the preceptor with the nurse intern scheduled as much as possible. However, during the intern's unit rotation, sometimes they will join with more than one preceptor, but at most, it is usually two according to the program director.[247] The

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245 Blanzola, Cheri, Weekly Journal Rules, Nurse Internship Program Guide, NMC SD, January 2001.

246 Blanzola, Cheri, Clinical Nurse Leader (CNL) and Preceptor Responsibilities Nurse Internship Program Guide, NMC SD, January 2001.

247 Telephone Conversation Between NIP Director at NMC SD, Lindeman, Roslyn and the Author, 14 January 2003.

program director adds that this is sometimes helpful in providing a different view for the intern, which is corroborated by the evaluations of the preceptors and their working relationships of the nurse interns.[248]

Currently, preceptors are usually nurses who have already completed the internship program at NMC SD. They have worked on their assigned units for more than six months, and some for a year or more. They understand the steps that need to be taken to successfully complete the program. According to the program coordinator, these preceptors are able to form a connection and understanding with the new nurses coming into the program as they once were in the same position as the interns.[249] The preceptors understand the goals and are supportive, while guiding the nurse interns to achieve the program and individual goals.

One element for a successful preceptor is the support provided by the leadership in the organization. The support for preceptors at NMC SD comes from two different areas. One is the opportunity for preceptors to attend a two-day preceptor course offered through the command's Staff Education and Training Department. The preceptor course is designed to charter the path from staff nurse to preceptor. Objectives include the following: how to identify the specifics of the role of a preceptor; how to learn and apply adult learning principles; how to assist orientees identify learning needs; how to plan learning experiences and to implement the learning plan; and, how to evaluate the orientees and to resolve conflicts. Various teaching methods are used in the preceptor course, such as role-playing, group discussion, and didactic presentation of material.[250]

Potential preceptors are given a list of criteria defining their responsibility as preceptor. Most importantly, the criteria denote the expectation that the preceptors must have demonstrated appropriate nursing competency in their workplace. Nurses who aspire to be preceptors must be able to competently perform not only the technical skills while providing patient care, but also demonstrate interpersonal communication skills, and critical thinking skills. These criteria are part of the preceptor's responsibility, as the

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248 Ibid.

249 Ibid.

250 NMC SD, Nursing Preceptor Development Workshop: Participant Objectives, Staff Education and Training, February 1999.

preceptor will model these skills while interacting with the nurse intern.[251] To have nurses learn how to be an efficient and effective preceptor as well as understand their responsibilities are the desired outcomes of the course.

Personal recognition is the second type of support given to preceptors, through a "Preceptor of the Quarter" award. Input for the award is received from the nurse interns when they submit evaluations of the preceptors. The preceptor with the most accolades by name in a quarter is presented the award. Recognition of the preceptor is an important organizational incentive to motivate the preceptors to excel.

Instruction and recognition are at least two methods the leadership acknowledges as important for the role. The command has demonstrated support for preceptors and encouraged the development of preceptors to assume a role linked closely to the professional development of other nurses. The leadership deems it important to prepare nurses in the preceptor role, so preceptors feel comfortable, and prepared to function effectively in this role. Leadership support is fundamental to providing credence to the preceptor role.

7. Other Supportive Strategies for the Nurse Intern

The desired outcome the of the NIP is the growth of nurse interns in the nursing profession as confident, highly skilled nursing professionals who demonstrate top NC officer qualities. The chain of command provides a clear mechanism for communication and support not only for clinical needs but also for personal issues that may arise during the internship. The program coordinator handles all military concerns that may arise during the internship. On the other hand, if the issues involve clinical issues, then the nurse interns go through the chain of command as indicated in Figure 3.1.[252]

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[251] Blanzola, Cheri, Clinical Nurse Leader (CNL) and Preceptor Responsibilities Nurse Internship Program Guide, NMC SD, January 2001

[252] E-Mail Correspondence from NIP Director at NMC SD, Lindeman, Roslyn, to the Author 14 January 2003.

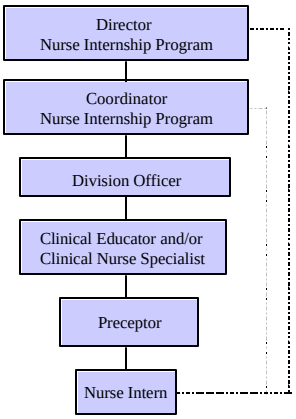

Figure 3.1. Chain of Command (After: NIP Guide)[253].

In addition to the clinical components reviewed in this thesis, the program offers a supportive environment in several different manners. One is that the program provides a nursing licensing examination review course for those nurses who need to obtain their nursing license. The review course coincides and intertwines with the internship program to allow the nurse to prepare for the examination. This course reinforces a supportive environment as the nursing leadership demonstrates s upport for the interns who otherwise would have to review for the test on their own time while dealing with a new command and a new job.

Another area of support is the allowance made for leave (vacation time) during the internship for personal time as needed. Nurse interns are allowed to take five days of leave during the sixteen weeks of the NIP. Interns must schedule leave days so that the requested leave days do not coincide with the scheduled classes.

The program director and coordinator also report the development of a strong peer support network for the nurse intern, during and after the NIP. Finally, the NIP helps the transition of interns into the community by allowing time for finding and moving into

[253] Nurse Internship Program Slide Presentation in NIP Guide at NMC SD.

living quarters, as nurse interns are from different areas of the United States and must relocate to the San Diego area. [254]

8. Conclusion

In conclusion, the emphasis of the NIP is on the professional development of nurse interns as they begin their careers. Although the internship focus is on the acquisition of clinical skills, the program also acknowledges the personal side of each individual by providing a clear chain of command for communicating clinical, military, and personal issues. In order to assist the new nurse in starting a nursing career, the NIP consists of comprehensive and systematic elements that are critical to the program goal and objectives. These elements are didactic instruction, clinical rotations, seminars, feedback and evaluation, and support for the intern. The program provides a process for new nurses to transition into the nursing professional, and Naval officer roles. The desired outcome is professional growth through the acquisition of clinical and leadership skills. The outcome is expected to be evident in the increased self-confidence that the nurse interns will display once they begin to work in the clinical setting and through involvement in the hospital mission and operational settings.

C. IMPLEMENTATION AT OTHER NAVAL MEDICAL CENTERS

Since the NIP was implemented at NMC SD, other NIPs have started at NMCP and NNMC Bethesda. The implementation at these two sites also follows the objective of the USN NC strategic plan. The information for this section was obtained from the program directors at NMCP and NNMC Bethesda and from the Internship Program Guides of each location. A brief summary is provided indicating how each program was adapted to each MTF and thus slightly differs from the NIP at NMC SD. Other minor variations may exist which are not covered in this section as a comprehensive review of the NIPs at NMCP and NNMC Bethesda are not within the scope of this thesis. However, the fundamental goals and objectives, and program design and content remain the same.

1. Naval Medical Center Portsmouth (NMCP), VA

The NIP at NMCP was implemented in May of 2002 as part of the Nurse Corps strategic goal to have internship available to all new nurses entering Naval service. The

[254] Interview Between NIP Director at NMC SD, Lindeman, Roslyn, and the Author, 18 November 2002.

NIP at NMCP is similar to the program at NMC SD. However, there are some minor differences such as length of program, rotation, candidates, and evaluation.

NMCP's mission statement reads "Support readiness through quality healthcare for our beneficiaries, and education and training for our staff."[255] As an education and training program, the NIP is aligned with the command's mission statement as well as to the USN NC strategic plan. This alignment is vital to the implementation of a NIP. The established linkage promotes resource allocation to the program and survival of the program.

The targeted audience is USN NC officers with less than six months of nursing experience. NMCP hires experienced civilian nurses only. Consequently, civilian nurses do not participate in the NIP. The participants spend twelve weeks in the NIP.[256] The program elements are classroom lectures, weekly seminars, clinical rotation and if needed, NCLEX preparation and remediation.[257] There are five rotation areas and the schedule is described in Table 3.4. In addition to the clinical rotations, a general command orientation and a Nursing Orientation are included in the twelve weeks.[258]

Table 3.4. NMC Portsmouth, NIP Rotation Schedule (From: Nurse Internship Program NMCP Guidebook, 2002)[259]

Rotating Areas	Length of Rotation
Surgical Nursing	Four Weeks
Medical Nursing	Four Weeks
Pediatric Nursing	One Weeks
Obstetric Nursing	One Weeks
Specialty Nursing	Two Week

255 NMCP PowerPoint Presentation, Nurse Corps Video Teleconference (VTC) Presentation, 25 February 2003, [https://bumed.med.navy.mil/med00nc/Resources/25%20FEB%20VTC%20SLIDES.html], March 2003.

256 E-Mail Correspondence from NIP Coordinator at NMCP, LCDR Forbus, S., and the Author, 03 February 2003.

257 NMCP Initiatives PowerPoint Presentation, Nurse Corps VTC, Presentation, 25 February 2003, [https://bumed.med.navy.mil/med00nc/Resources/25%20FEB%20VTC%20SLIDES.html], March 2003.

258 All nurses, new nurses and experienced nurses, take the command orientation and the Nursing orientation. These two components are not exclusive to the NIP. E-Mail Correspondence from NIP Coordinator at NMCP, LCDR Forbus, S., and the Author, 03 February 2003.

259 Nurse Internship Program NMCP Guidebook, 2002.

The NMCP internship follows the same evaluation pattern as NMC SD. However, NMCP uses two long-term data collection tools in addition to the PEERS™ evaluation system. The *Nurse Satisfaction Questionnaire* and the *Intent to Stay Scale* are the two additional tools utilized at NMCP. These are completed at six months and at one year after completion of the NIP for research analysis.[260] The qualitative data gathered so far shows the following findings:

- Interns are highly satisfied with the NIP
- Nursing Leadership note remarkable differences in competency and development of Nurse Interns compared to new orientees under the prior orientation program.[261]

The NIP at NMCP seems to be producing the desired outcome of professional development for new nurses.

2. National Naval Medical Center (NNMC) Bethesda, MD

The NIP at NNMC Bethesda was implemented on May 2001. The NIP has similar implementation elements as those at NMC SD and NMCP. Yet, small adaptations of the program to the organization are present. The goals and objectives are parallel to those of the NMCs reviewed in previous sections. These goals and objectives guide the focus of the NIP during the 12 weeks of the program. The NIP incorporates didactic instruction, clinical experiences and bi-monthly seminars that support learning of clinical skills, critical thinking and prioritization.[262]

Eligible nurses are USN NC officers with less than one year of medical surgical experience. However, nurses with more than one year may participate in the program after an assessment by the program director.[263] This is a clear distinction in the internship programs at NMC SD and NMCP. Once eligibility is established, the nurse interns begin the program with ten days of didactic instruction followed by the clinical rotations. The nurse interns rotate through three clinical areas: an internal medicine unit

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[260] NMCP Guidebook, 2002.

[261] NMCP Initiatives PowerPoint Presentation, [https://bumed.med.navy.mil/med0 0nc/Resources/25%20FEB%20VTC%20SLIDES.html], March 2003.

[262] NNMC Bethesda, RN Internship Program Guide, May 2001.

[263] Telephone Conversation Between Program Director at NNMC Bethesda, CDR Thomas-Rogers and the Author, 03 March 2003.

for four weeks; a surgical unit for four weeks; and, a cardiovascular unit for two week. A competency-based orientation packet is used in the rotations for skill competency assessment.[264]

In addition, during the twelve weeks, the nurse interns participate in learning opportunities through observation method in these areas: one day of surgical experience by following one patient through the surgical process, one day with a charge nurse, two days at a specialty clinical area, and attendance at interdisciplinary team rounds. To develop communication and organizational skills, nurse interns discuss a patient case in a seminar presented to nurses and corps staff.[265] Hence, nurses with minimal experience are able to acquire the clinical skills, critical thinking and interpersonal skills necessary to transition into the nursing role.

To guide the acquisition of skills, an evaluation process is embedded in the NIP as with the NIP in NMC SD an NMCP. At NNMC Bethesda, the CE, in addition to the preceptors and the nurse interns, make up an integral part of the evaluation process. The nurse interns obtain an evaluation every two weeks from the preceptor and the CE. The CE is in nurse intern's direct chain of command. Finally, a competency based orientation (CBO) packet is used to follow the nurses' advancement through the clinical rotation. Finally, the evaluation process continues as the nurse interns use the CBO three and six months after completing the NIP.[266]

NNMC Bethesda implemented the NIP in accordance with USN NC strategic plan with similar components to the internship program in the other two NMC. The goals and objectives are also aligned with the other two programs to obtain the desired outcome of a nurse who has gained the clinical skills necessary to start the nursing role.[267]

In conclusion, although some program variances exist depending on location, the implementation of the NIP at each of the three large MTFs is aligned with the strategic direction of the USN NC. The desired outcomes of the program at each medical center

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264 NNMC Bethesda RN Internship Program Guide, May 2001.

265 Ibid.

266 Ibid.

267 Ibid.

are the same. Each program offers guidance and learning opportunities to help the nurse interns gain the knowledge and skills needed to start in a nursing clinical position.

D. USN NURSE CORPS OFFICER DISTRIBUTION AT NMC SD

1. Introduction

Nurse corps officers at NMC SD are distributed throughout the hospital's inpatient and outpatient settings, including outlying clinics and a Tricare service center. In addition, NC officers may also have an assignment to a deployable unit such as a hospital ship, fleet hospital, or CRTS[268]. Nursing specialty, nursing vacancies, time of arrival at the command, and grade are variables that contribute to a job assignment at the NMC.

2. Methodology

In this section, data sets from the Military Human Resources Office (MHRO) and the Medical Mobilization Planning Office (MMPO) at NMC SD are used to examine the NC officer distribution at NMC. The analysis in this section includes five parts. First, a general distribution by grade is presented. Second, a distribution by year group[269] (1990-2002) is analyzed as year group may be used as a proxy for experience, if the nurse entered military service after finishing nursing school. Third, NC officer vacancy positions are examined. Fourth, the distribution of assignments for Ensigns (ENS) is reviewed. Finally, the number of nurse interns at one point in time is compared to the distribution of other nurses at the command.

3. Distribution of USN NC Officers at NMC SD by Grade

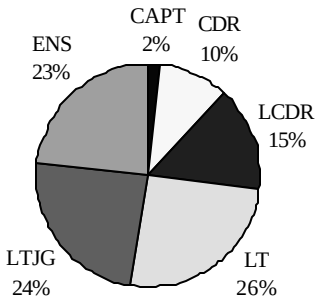
The expected grade structure in the USN NC consists of a higher number of junior officers that tapers as grade increases. The first three grades, ENS, Lieutenant Junior Grade (LTJG), and Lieutenant (LT), constitute 73 percent (294/397) of the military nursing population at NMC SD (See Figure 3.2). Length of service for this population ranges from nurses who just entered the military to those serving for at least 10 years. Within the first three grades, two general groups of nurses, differentiated by their nursing experience, are found in the nursing population at NMC SD. One group includes the nurses who come into the Navy immediately after completing their respective nursing

[268] CRTS – Casualty Receiving and Treatment Ship.

[269] year group — Year group is determined by the year the nurse entered the Navy and is commissioned as an officer.

schools. This group of nurses is both inexperienced in nursing and in the officer role when they arrive at their first command. The second group of nurses is made up of nurses who are credited with time in service due to nursing experience prior to joining the military. Nevertheless, this second group of nurses also needs to obtain experience within the Navy Medicine organizational framework and in the officer role.

The distribution of the next three higher grades, Lieutenant Commander (LCDR), Commander (CDR), and Captain, is also identified in Figure 3.2. At the NMC SD, these nurses, in general, have at least ten years of experience. These nurses mostly fill the roles of nurse practitioner, division officer, nurse educators, clinical nurse specialists, and top leadership positions at NMC SD. The top three grades consist of those nurses who have clinical, administrative, and organizational experience.



Grade	Frequency
CAPT	7
CDR	40
LCDR	60
LT	101
LTJG	96
ENS	93

Figure 3.2. Distribution of Grade Percentage of USN NC Officers at NMC SD, 30 September 2002, N= 397.

Another distinctive characteristic of the NC population at NMC SD is the distribution of officers by year group, which is delineated in Figure 3.3. Only year groups 1990 through 2002 are displayed, due to very low numbers in previous year

groups. In general, the earlier year groups have longer years of nursing experience, while those nurses in the later year groups have, in general, less nursing experience. The data set shows that 44 new nurses (ENS) were commissioned in fiscal year 2002. All of these nurses (44) had less than one year of experience as of 30 September 2002 and participated or were in the NIP in 2002.

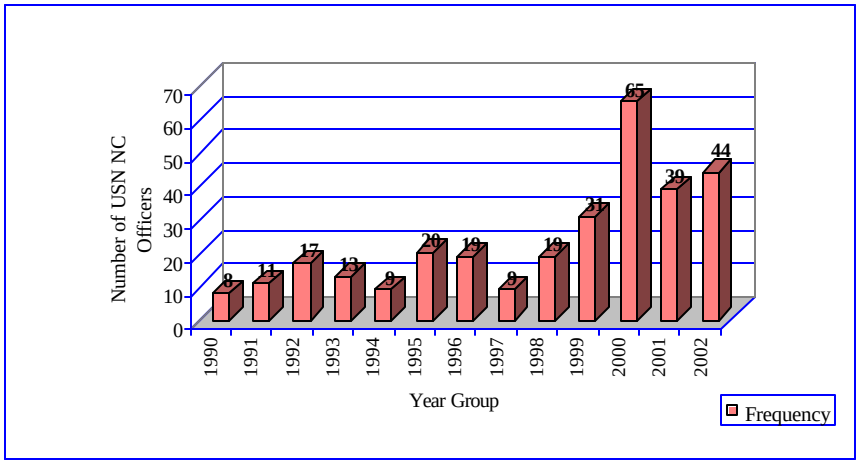


Figure 3.3. Distribution of USN NC Officers at NMC SD By Year Groups 1990 – 2002, 30 September 2002.

Figure 3.4 shows the distribution of NC officers by grade and further divides ENS into year groups. Hence, those nurses who arrived in 2002 have, in general, one year or less of nursing experience. Those ensigns who arrived in 2001 have between one and two years of nursing experience. Finally, nurses in the 2000 fiscal year group have at least two years of nursing experience. However, promotion procedures generally advance ensigns to LTJG at the two-year commissioning date. The one percent of ENS might be due to a lag time in updating the data set or these ENS may not have been promoted.

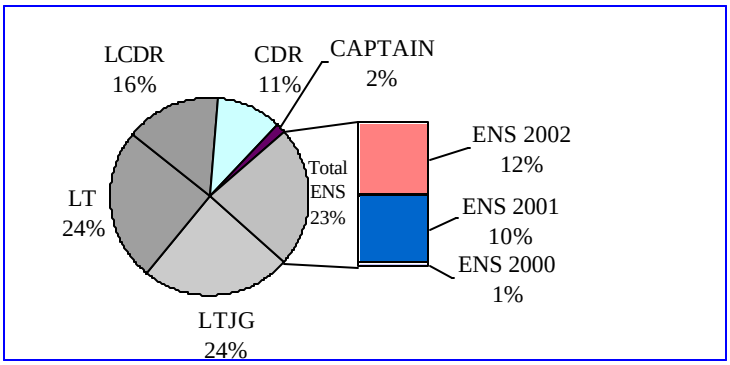


Figure 3.4. Distribution by Grade with Percent Division of Ensign by Year Group, 30 September 2002, N=379[270]

4. Authorized Positions

An internal process of the manpower management process in the USN is the authorization of positions at each Naval MTF including ambulatory care clinics. The resource sponsor, the Surgeon General of the Navy, funds manpower requirement each fiscal year. Consequently, it is up to the claimant, BUMED to chose specific requirements to fund. These requirements become authorized positions. When these authorized requirements are linked to a portion of end strength, it becomes a billet. End strength is the total number of personnel in the Navy on the last day of the fiscal year (30 September) as approved by Congress for each fiscal year. Furthermore, billets are reflected in the Activity Manning Document (AMD) for the facility. The AMD is defined as follows: "the qualitative and quantitative expression of manpower requirements and authorizations allocated to a Naval activity to perform the assigned mission, functions and tasks"[271]. This document is "the single official statement of funded and unfunded requirements (manpower requirements and billets authorized)."[272] The AMD is a dynamic document that describes the number and type of billets present at a Naval shore facility. In summary, the number of positions at NMC SD is determined through a systematic and controlled process linked to financial constraints.

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[270] Original data set N = 397. However, 18 missing due to year group omission. Number missing equals 7-ENS, 3-LTjg, 7-LT, 1-LCDR.

[271] Hatch, Bill CDR, Class Notes, Manpower, Personnel and Training, MN 2112, Naval Postgraduate School, Slides 52, 53, Fall 2001.

[272] Ibid, Slide 53.

It is the financial constraints that determine resource allocation including valuable human resources to perform the required mission. Due to the economic constraints imposed on the system, the number of billets is not always equal to the number of requirements, as a certain percentage may go unfilled. Figure 3.5 illustrates the distribution of billets filled and the percent of vacancies present at NMC SD in September 2002. The data shows a thirteen percent (59/450) vacancy representing the number of billets that are not filled. This situation is not unique to NMC SD. Unfilled billets are found throughout other Naval Healthcare Facilities and Naval installations. The Navy distribution system works at assigning a fair share of nurses to each Naval facility, recognizing that each will be staffed at less than the level of requirements.

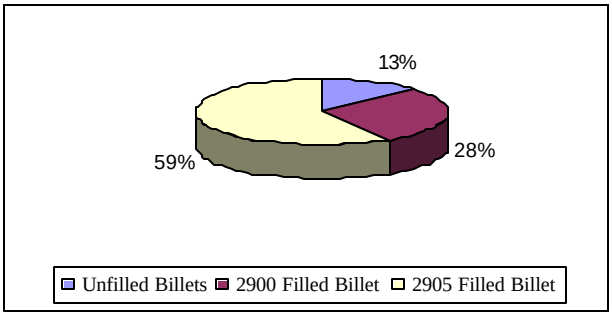

Figure 3.5. Distribution of USN NC Officer Billets at NMC SD, September 2002, N=450 Total Billets[273].

It must be noted that Naval treatment facilities have civilian nurses who augment the total number of military nurses at the facility. The civilian nurses were not included in the data analysis, indicating a limitation of this thesis. However, civilian nurses also need to have the skills necessary to perform in the organization and so they are also participants in the NIP at NMC SD. The desired outcome is to have nursing professionals who provide medical support to those who are reliant on the military health system for their medical care.[274]

[273] 2900 – Designator for an officer in the regular Navy; 2905 Designator for an officer of the Naval Reserve.

[274] MHS Strategic Plan: Balanced Scorecard Overview, [http://www.ha.osd.mil/strat_plan/default.cfm], February 2003.

a. Peacetime Mission and Operational Needs

An integral part of the NMC SD function is the dual requirement to link the nursing positions during the peacetime mission with the operational nursing positions. Although, the nurses work on a regular basis in the NMC, a portion of these nurses are assigned to an operational platform that deploys during wartime, humanitarian missions, and other assignments where nursing skills are needed. New nurses arriving at the command may also be assigned to operational units.

Figure 3.6 shows the distribution of Ensigns who are assigned to operational platform. Fifty-two percent (47/90) of the ensigns are assigned to NMC SD and the other 48 percent (43/90) of ensigns are assigned to operational platforms. As previously observed in Figure 3.4, some of these nurses have less than one year of military service; therefore most nurses will need to gain the skills necessary not only to function in a hospital setting, but also to function in the operational environment. Since new nurses are within the deployable groups, they must also obtain the knowledge, skills, and tools corresponding to operational capability. The NIP is designed to offer the new nurses the opportunity to learn the nursing skills applicable to the operational field.

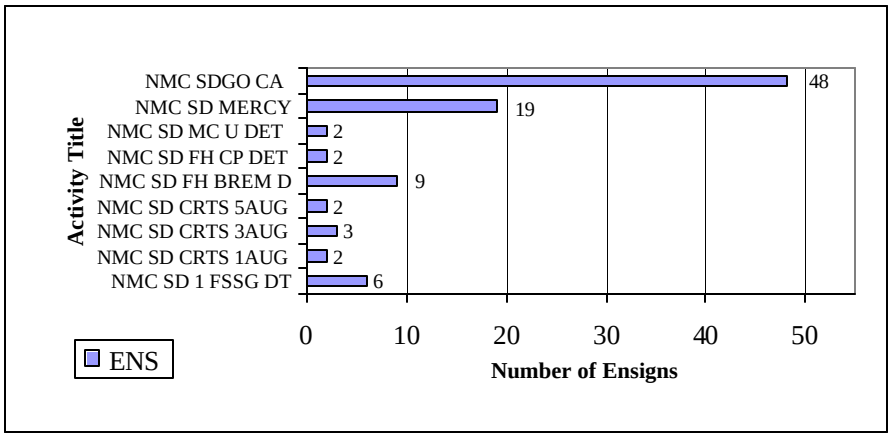

Figure 3.6. Distribution of Ensigns, Including Operational Assignments, September 2002, ENS = 93

5. Distribution of New Nurses in the NIP Compared to Job Assignments

The nurse interns are part of the Director of Nursing Services (DNS), Administrative Department during the sixteen weeks of the NIP. The arrival of new nurses to NMC SD occurs every month, so the number of nurse interns change from month to month. Figure 3.7 shows that there were 26 nurse interns on 09 September 2002. The number of interns is compared to the distribution of nurses assigned to different departments at the NMC SD. The 26 nurse interns will eventually fill clinical positions in the inpatient units; but while the new nurses are in the NIP, they are not part of the nursing staff in the inpatient unit. The nursing staff in the inpatient units provides nursing care to hospitalized patients.

The nurse interns are counted in the total NMC's nursing workforce; but as long as they are in the NIP, they do not fill vacancies in the unit's work schedules. As Figure 3.7 shows, 89 percent of the Ensigns in the NMC (77/87, excluding nurse interns) occupy nursing positions in the DNS clinical areas. When the new nurses arrive at the NMC to fill nursing positions, they are counted as part of the resources of the various departments even though they are not contributing to patient care as staff nurses. This inaccurate classification penalizes the clinical units by giving the appearance to an outsider that the units have more nurses available for patient care than is actually the case.

6. Conclusion

All NC officers, including Ensigns, fill a vacancy at the NMC that has been identified as a requirement. Junior officers at NMC SD comprise the majority of military nurses. In general, Ensigns make up the portion of nurses with two or fewer years of nursing experience. Ensigns not only work in the clinical setting of the NMC but also may function in an operational unit. As Ensigns arrive at the NMC, they participate in the NIP and are assigned to the DNS administrative directorate. The nurse interns do not fill a clinical position while participating in the NIP. Consequently, there may be a potential for tension to develop between the need to fill staff vacancies and the need to train the new nurses. The potential tension between the two needs is an aspect of the NIP implementation that needs to be carefully monitored and managed.

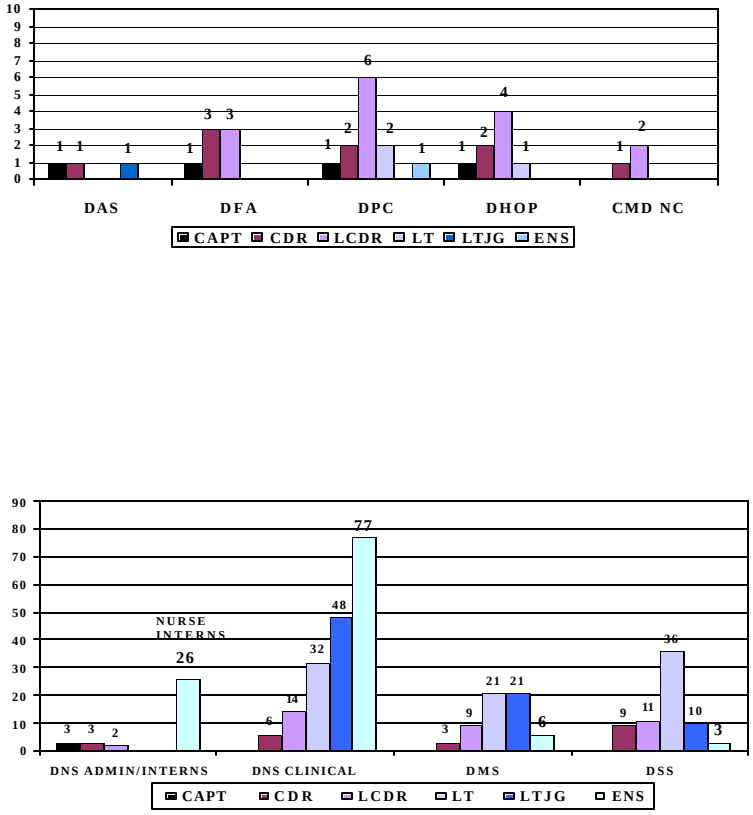

Figure 3.7. Directorate Distribution by Grade, 09 September 2002 (From: DNS Administration Department, NMC SD)[275].

[275] Graphs made by the DNS Administration Department at NMC SD, NIP Director, Lindeman, R., obtained on 18 November 2002. Acronym definition: DAS - Director of Ancillary Services; DFA - Director for Administration; DPC – Director Primary Care; DHOP - Director Health Operations and Planning; CMD NC - Command, Nurse Corps; DNS Admin - Director of Nursing Services, Administration; DNS Clinical – inpatient units; DMS - Director of Medical Services; DSS - Director of Surgical Services.

IV. CONCLUSION AND RECOMMENDATIONS

A. INTRODUCTION

This thesis examines the orientation of new nurses in different types of healthcare organizations. The focus is on the implementation elements of nursing orientation programs with an emphasis on Nurse Internship Programs (NIP). It includes a review of the key elements of the NIP program at NMC SD. In addition, the thesis assesses the number of NC officers who would benefit from the NIP and reviews of the resource allocation decisions made during the implementation of a NIP.

The research questions are answered in part II. In part III, conclusions made as a result of the analysis are presented. Part IV offers a list of recommendations. The chapter closes with recommendations for future research.

B. SUMMARY

This section outlines answers to the research questions in a summary format. First, answers to the secondary research questions are presented. These questions lead in and are used to support the primary research questions.

1. Secondary Research Questions

- **How are NIPs and other nursing orientation programs applied in the civilian healthcare settings?**

In the civilian healthcare setting, nursing orientation for new nurses includes a variety of different configurations. The civilian orientation programs examined encompass competency based orientation, a clinical entry nurse residency program, and, NIPs. The types of NIPs reviewed consisted of operation room nurse internship, emergency room NIP, pediatric rehabilitation NIP, and, neuroscience NIP. Key program elements were commonly used in the application of the programs in each of the healthcare settings examined. These elements were support from top organizational leadership, a program based on adult learning principles and teaching methods, preceptor–preceptee interaction that focused on skill acquisition based on competencies needed for job performance, evaluation of the nurse interns, and, evaluation of program components. The programs applied mostly to new nurses, but some also applied to

experienced nurses who lacked skills in a specific nursing field such as neuroscience nursing.

- **How are the nursing orientation programs implemented in the US Air Force and the US Army?**

In addition to civilian healthcare organizations, examples from the USAF and the Army nursing training programs were also examined. The USAF offers the Nurse Transition Program (NTP) to new nurses at the beginning of their Air Force nursing career. The USAF sends nurses to specific training sites at AF medical centers. After ten weeks of didactic and clinical practicum, the nurses proceed to their job assignment. During the NTP, the nurses in the program, called transition nurses, dedicate their time to acquiring the skills necessary to transition into the workplace.

The Army implements a nursing orientation program based on the Preceptorship course framework. The framework offers guidelines on how to apply the program in each Army healthcare setting to assist new nurses in their transition into the professional nursing and military roles. The preceptorship is six weeks long and the design offers both classes and clinical rotations.

- **How is the NIP implemented at NMC SD?**

The key implementation elements of the NIP at NMC SD are:

- Strategic guidance and top leadership support
- Didactic portion based on adult learning theory and teaching methods
- Clinical rotations in five clinical settings
- Competency based clinical performance assessment checklist
- Evaluation of interns learning needs and performance
- Continuous program evaluation process
- Logistical scheduling of nurse interns in a dynamic program

The action plan for implementation evolved from the USN NC strategic planning process. A working group, composed of middle managers, developed the action plan for the NIP under the auspices of top NC leadership, who provided direction and support.

The NIP didactic and clinical elements appear to be consistent with goals and objectives of the NC. They are designed to produce highly skilled, competent nurses to function in peacetime and wartime mission. The didactic and clinical rotations elements

are integrated to form a cyclic learning experience based on adult learning principles. Trained preceptors, knowledgeable in adult learning and teaching methods, guide the interns in their clinical rotations. In addition, the emphasis of the program relies on a joint effort by the preceptor, DO, and, if available in the unit, the CNS and CE to offer the nurse interns a successful learning experience.

Another two crucial implementation elements are the evaluation of the nurse interns and the program. First, the evaluation of the nurse interns occurs as a continuous process containing a feedback loop and embedded in a supportive environment. As a critical aspect, the evaluation focus is directed at identifying the learning needs of each nurse intern. In addition, evaluations of the program components are also an ongoing process. The preceptors, unit management, CNS, CE, didactic component, and the clinical rotation are evaluated as part of the program evaluation.

Planning and scheduling logistics are critical elements in the implementation process of the NIP. At a minimum, the logistics involve finding available space for classes and discussion groups, utilizing technical equipment and supplies, scheduling nurse interns in both the clinical rotation and didactic component, and, managing a variable number of nurse interns each month.

- **In addition, to the NIP at NMC SD, what are other orientation programs in the Navy for NC officers?**

Currently, the NIP has been implemented at three Naval Medical Centers. In addition to NMC SD, internship programs exist at NMCP and NNMC Bethesda. Each has its own variances defined by organizational characteristics and limitations. On the other hand, a unit-based competency orientation program was briefly examined at Naval Hospital Bremerton. The program focuses on unit specific training and averaged about six weeks of orientation for new nurses.

- **What is the status of nurse interns while in the NIP in relation to the NMC SD nursing staff?**

New nurses are assigned to NMC SD to fill a nursing staff position. However, during the 16 weeks of the NIP, the new nurses are assigned to the DNS, Administrative Department. While in the NIP, nurse interns are not part of the nursing workforce that may be utilized to staff the inpatient units. During the internship, nurse interns work with

preceptors and assume limited patient care responsibilities under the supervision of the preceptors.

- **In general, how could new nurses in the NIP impact overall staffing at NMC SD?**

There are at least two potential manners in which the nurse interns may impact the staffing plans. First, the number of nurse interns in the program may impose a human resources strain on inpatient nursing units, if positions are vacant. As a result, there may be fewer nurses in the unit during the time the nurse interns are in the NIP. A second impact is the effect on the preceptor's productivity. The preceptor's productivity is divided into providing guidance to the nurse interns and providing patient care. As the nurse interns spend more time in the units, they assume increased patient responsibility. However, nurse interns still need the supervision of the preceptors.

2. Primary Research Questions

With the answers provided to the secondary questions, the primary questions can be addressed in a summarized format.

- **Based on the experience with the NIP at NMC San Diego, what are the potential benefits of the NIP for the Navy?**

The NIP provides a number of potential benefits to the NMC, the USN NC and Navy Medicine. The benefits are:

- Dissemination of similar information to each nurse intern due to a systematic program design
- Individualization of learning based on personal goals and needs
- Acquisition of self-confident and skilled nursing professionals
- Development of nurses with strong leadership and interpersonal communication skills
- Potential for an increase in patient satisfaction based on care received
- Utilization of the NIP as a recruitment tool
- Possible beneficial impact on retention in the long run
- Supporting and strengthening a culture that values learning
- Increased employee satisfaction
- Development of peer support network as nurse interns transition into regular staff positions

- **How could unit-staffing concerns be addressed during the daily operations of a NIP?**

As with any implementation plan, constraints within the system place limitations on the final format of a program. Human resource constraints generate concerns in the implementation and management of a NIP. Several alternatives for addressing staffing concerns were found in the literature reviewed. The alternatives are:

- Maintain the current state. The nurse interns continue to be a part of the total nursing workforce (fill a billet), but do not count in the staffing numbers used to provide nursing care in the unit.
- Apply an incremental approach to including the nurse intern as a percent of an FTE as they gain competence. For example, initially the intern is considered zero percent of an FTE. As interns progress, they are included as fraction of one FTE, such as 25-50 percent half way through the program. Finally, the intern counts as 100 percent of an FTE at the end of the program.
- Designate the intern under a training position budgeted by an education and training component of the overarching organizational structure, such as Naval Education and Training Command (CNET). In the context of a training position, the nurse interns are not part of the nursing staff at the MTF. For example, the transition nurses in the NTP are in a training status. As a result, they are not part of the nursing staff at the training site, little or no tension develops between program schedule and nursing staff needs of the units.
- Count the preceptor and the nurse intern as one FTE in staffing numbers at the MTF.
- Add a business rule that accounts for the nurse interns and the preceptor when determining the staffing requirements of an inpatient unit. For example, the system used for determining manpower requirements includes a staffing standard variance related to training functions of the work center.

C. CONCLUSION

The NIP is a product of the USN NC strategy plan and it is closely linked to the strategy plan of the NMC SD. This in turn provides a system that fits within the organizational goals and objectives. The NIP is a systematic and dynamic program designed to help transition new nurses into the professional nursing and the officer roles.

The nurse interns have access to tools that enable them to acquire the knowledge, and skills necessary for confident and competent patient care. The preceptors provide guidance as the nurse interns acquire the knowledge, skills, and tools necessary to attain

competency. The competency checklist guides the learning goals of the in terns to acquire the knowledge, skills, and abilities for the clinical and operational setting. In addition, the competencies checklist is an adaptable tool that helps guide the new nurses as they progress in different clinical settings. As per evaluatio ns from program coordinators, the NIP seems to be successfully assisting the new nurses transition into the nursing profession and their Naval career.

The success of the program seems to depend on the seamless integration of program elements, resource allocation, and organizational flexibility. All of these components are key to the implementation of the NIP at NMC SD. These elements appear to fit together because of the continual effort of program coordinators, staff support, and top leadership support.

In the past, nurse accessions into the Navy included a majority of nurses with little or no nursing experience. This trend is likely to continue as the Navy is based on an internal labor market that, in general, brings people at the lower grade levels and promotes from within. As it appears that new nurses will continue to be the majority of nurses who enter the Navy, a comprehensive and systematic professional development program will not only benefit the nurse but also the organization. Already the NIP has expanded from NMC SD to the other two large MTF, NMCP and NNMC Bethesda. All new nurses who are assigned to these three Naval facilities go through the NIP. However not all new nurses who enter the Navy, go directly to these medical treatment fac ilities. Therefore, at this time, some new nurses do not participate in the NIP.

Human resource allocation is a significant investment in the nurse internship program. The NIP as implemented seems to be producing the desired outcome at the larger MTFs. The allocation of resources appears to be a critical implementation element in the success of the NIP.

In conclusion, the Navy gains from the NIP as a tool used to enhance human capital. The results of enhancing the knowledge and skills of new nurses ma y be evident in patient satisfaction from the care received, employee satisfaction, and organizational mission achievement.

D. RECOMMENDATIONS

Based on the findings of this thesis, the following recommendations are made to ensure the continued success of the NIP in the Navy and future implementation at other commands:

- Utilize the same short and long-term evaluation tools at all facilities with a NIP. This action will permit future research regarding benefits and unintended consequences of the NIP.
- Establish and develop a contingency plan for the absence of the program director/coordinators, as the program requires careful logistical planning and management to run smoothly.
- Exhort attendance of potential preceptors to a preceptor class to learn about adult leaning theory and teaching methods. Also, consider having a support group for preceptors.
- Include mentorship guidelines as part of the NIP so the intern and the mentor know the general areas of responsibilities while they participate in this role.
- Examine alternative staffing plans for nurse interns at the MTFs.
- Ensure adequate resource allocation and budgeting to maintain and improve the NIP. These actions will prevent the program from weakening due to a lack of resources. If the program is expanded to cover the smaller MTFs, careful consideration to staffing concerns needs to be addressed so as not to dilute the intent of the current design and content of the NIP.
- Implement resource sharing between larger and the smaller MTFs through the use of technology (if the NIP is expanded to all MTFs). VTC may be used to link smaller naval facilities with larger facilities to share instruction about general classes that are not specific to the facility. Additional resource sharing occurs through an expanded selection of on-line courses.
- Sustain support for the NIP by ensuring alignment of the program with the organizational mission, culture, and values. The NIP must be kept in congruence with organizational mission, values, philosophy, and culture for the desired outcomes to be achieved.

E. AREAS FOR FUTURE RESEARCH

This thesis examined the implementation of the NIP at NMC SD. It builds a foundation for further research into a wide array of qualitative and quantitative topics surrounding the NIP. Although, plentiful data exist in the civilian market for a nursing internship program, the Navy's program is in its early years. Eventually, after the collection of evaluation results and surveys, and quantitative analysis will be valuable for

the assessment of the NIP. Perhaps, the influence of the NIP on patient outcomes could also be investigated. The following list recommends areas for future research:

- Qualitative study to determine the impact of NIP on patient satisfaction
- Qualitative study to determine staff satisfaction
- Qualitative study to determine nurse intern satisfaction with the NIP
- Study to determine the effect of the NIP on retention and recruiting
- Perceptions of healthcare workers, such as experienced nurses, physicians, pharmacists, respiratory therapists and others in relation to the NIP
- Feasibility of implementing a NIP at a smaller naval treatment facility
- Development of a survey to assess the quality of life of the nurse interns during and after the program
- Cost benefit analysis of the NIP

APPENDIX A. UNITED STATES NAVY NURSE CORPS ACCESSION PROGRAMS

Program	Age Requirement	Education	Prof. Qual.	Service Obligation	Special Notes
NROTC (004) - Naval Reserve Officer Training Corps	Commission before age 27, unless prior AD; Waiv to 30	Selected by CNET. GPA. Must be 3.0 overall & "C" average in related sciences; Varsity change with 4 yr p+g	High School graduate (Pre-Education)	4 yrs AD; Total of 8 yrs mil service (SELRES or IRR)	Tuition (up to 4 years) plus books, Subsistence of $150/mon. Not to exceed 4 years of scholarship/mon of 40 academic months. Summers are training periods. Counts as NROTC undergrad time while in school. Commissioned at time of graduation. May request voluntary delay for AD up to 12 months. Does not attend OCS.
Direct - no bonus (018)	Complete 20 years active commissioned service by age 55. Waivers for graded specialties only.	Graduate from an accredited U.S. bachelor's or master's nursing program. Prior to FY90, accepted Diploma (108 weeks) and Associates Degree with BS in related field (Chemistry, Biology,etc)	Must be a currently licensed registered nurse.	3 years active duty.	Entry grade credit for experience. Appt as ENS, LTjg, LT
IST - Interservice Transfer (036)			Must be a currently licensed registered nurse.	4 years of active duty minimum, retain commission for a minimum of 8 years.	Accepts active duty officers from the other uniform services. Application from an active duty officer must arrive nine months before the desired transfer date.
Recall (029)	Must be able to complete 20 years by age 55.	Graduate from an accredited U.S. bachelor's or master's nursing program.	Must be a currently licensed registered nurse.		
2005 (Direct) (091)	Complete 20 years active commissioned service by age 55. Waivers for graded specialties only.	Graduate from an accredited U.S. bachelor's or master's nursing program. Prior to FY90, accepted Diploma (108 weeks) and Associates Degree with BS in related field (Chemistry, Biology,etc)	Must be a currently licensed registered nurse.	If accepts accession bonus, obligation is 4 years.	$5,000 accession bonus. Entry grade credit for experience. Appt as ENS, LTjg, LT
NCP- Nurse Candidate Program (092)	Complete 20 yrs active commissioned service by age 55. Must report to OCS before 35th birthday.	Must have completed 2nd yr of accredited BSN prog. GPA must be 3.0/4.0 scale.	High school graduate (Pre-Education)	1 yr school - 4 yrs ACS 2 yrs school - 3 yrs ACS Total 8 yrs mil service (SELRES or IRR)	$5000 access bonus, monthly stipend of $500/mon. No basic or fees. Max of 24 months. Not eligible 6 months from graduation. Counts as active reserve and enough, commissioned (graduate) at graduation.
MECP - Medical Enlisted Commissioning Program (103)	Commission prior to 35th birthday	Graduate from an accredited U.S. bachelor's or master's nursing program.	High school graduate, Complete 30 semester credit hours of undergraduate courses to transfer; 2.5 GPA for undergraduate courses.	4 yrs AD; Total of 8 yrs mil service (SELRES or IRR)	Program is open to all AD Navy Enlisted Ratings. Receive full pay and allowances for their enlisted pay grades. Eligible for advancement. Student pays tuition, fees, and books. Required to complete bachelor in 36 months. May obtain masters degree within this time period.
Historical Accession Programs: Programs no longer offered					
ENWOP-Technical Nurse Warrant Officer Program (069)	Appointed prior to 42nd birthday (waiverable)	Graduated from an accredited AA nursing program. Licensed RN in good standing.	see education.	3 yrs AD; Total 8 yrs mil service (balance serve in IRR)	Technical Nurse - phased out in the early nineties; given the opportunity to complete a baccalaureate nursing degree and receive an appointment as a Navy Corps officer-Ensign.
BDCP - Bachelors Degree Completion Program (090)	Commission prior to 35th birthday	Graduate from an accredited U.S. bachelor's nursing program.	Enrolled or accepted to upper division college or university.	4 yrs AD; Total of 8 yrs mil service (SELRES or IRR)	Baccalaureate degree requirements required to be completed within 24 months. Receive full pay and allowances. Student pays tuition, fees, and books. Entered as E-3 in an active status in the reserves. FY95 was the last yr BDCP accepted students.
FTOST - Full Time Outservice Training (093)					In the early 1990s there was difficulty recruiting to specific specialties (CRNAs and Family Nurse Practitioners). This was a result of the late 1980's nursing shortage. Began in FY91. 10 - CRNAs and 4 - Family NPs; FY92: 5 - CRNAs; FY93: 1 - CRNA. FY93 was the last yr for FTOST.

Date: a/o 07 May 02 (After: LCDR E. McDonald, NC Personnel Plan Analyst, M131NC, BUMED)

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APPENDIX B. NAVY NURSING CORE COMPETENCIES (FROM: USN NC WEBSITE, 2002)

The Navy Nursing Core Competencies describe the general categories of skill competencies. The core competencies are designed to serve as a guide in skill acquisition for NC officers.

EMERGENCY RESPONSE AND SAFETY

- Accesses emergency response systems.
- Responds appropriately to emergency codes.
- Locates fire alarm(s) and fire extinguisher(s) in the assigned work area. Verbalizes appropriate emergency actions.
- Locates and verbalizes the appropriate use of oxygen cutoff valve in the assigned work area.
- Utilizes universal precautions and isolation procedures, techniques, and resources required for airborne, droplet, and contact modes of transmission.
- Utilizes appropriate devices to aid in the transfer, moving, support, and evacuation of patients.
- Identifies and describes appropriate interventions for patients at risk for skin breakdown.
- Identifies and describes appropriate interventions for patients at risk for nosocomial infections.
- Identifies and describes appropriate interventions for patients at risk for falls. Demonstrates appropriate use of Fall Risk Protocol.
- Identifies and describes appropriate interventions for use and application of supportive devices and restraints.
- Utilizes effective body mechanics when lifting, pushing, pulling, reaching, and sitting.
- Identifies and initiates risk management tools.
- Demonstrates appropriate technique in handling sharps and infectious/biohazardous waste.

PATIENT ASSESSMENT AND PLAN OF CARE

- Performs data collection through a comprehensive nursing assessment. Assessment includes physical, psychosocial, cultural, ethnic, spiritual or age specific needs and communication barriers.
- Identifies diagnoses consistent with information obtained during nursing assessment.
- Recognizes patient status changes and need for interventions.
- Formulates and implements an individualized plan of care.

- Institutes nursing interventions based on established protocols and standards.
- Identifies need for support services and appropriately generates referrals.
- Evaluates patient outcomes and measures the effectiveness of nursing care. Revises plan of care as needed.
- Participates in multidisciplinary discharge planning.

PERFORMANCE & DOCUMENTATION OF PATIENT CARE

- Applies knowledge and skills to provide comprehensive patient care.
- Demonstrates proficiency in basic nursing interventions and technical skills as identified in unit specific skills list.
- Completes qualifications for IV therapy, Medication Administration, and Blood and Blood Component Administration.
- Administers medication according to established standards.
- Performs venipuncture and IV therapy according to established standards.
- Accurately transcribes and implements provider orders.
- Utilizes technology appropriately to monitor patients.
- Provides patient care in a manner that is respectful of and protects the patient/family's privacy.
- Demonstrates compliance with organizational policy for Advance Directives.
- Medical Records Documentation reflects:
    - Nursing process (assessment, plan, implementation, and evaluation). Assessment documentation includes physical, psychosocial, cultural, ethnic, spiritual, and age specific needs, and communication barriers.
    - Use of appropriate terminology and abbreviations.
    - Legibility, brevity, and relevancy to patient's condition
    - Transfer/discharge notes include patient status, disposition, and patient education.

PATIENT AND FAMILY EDUCATION

- Performs physical, psychosocial, and educational needs assessment to include primary language, ability to read, method of learning, barriers, and limitations to learning.
- Determines content of instruction required for acute, chronic, and preventive health maintenance.
- Determines teaching method(s) most appropriate to age, assessed barriers, abilities, and limitations.
- Provides instructions(s) and/or demonstrations(s) required for learning.
- Evaluates outcome of educational process and provides for follow-up instruction as needed.
- Identifies appropriate community resources.

- Coordinates patient and family education with other disciplines as appropriate.
- Documents patient and family education in appropriate patient record(s).

PROFESSIONAL DEVELOPMENT

- Maintains licensure and certifications as required.
- Trains Hospital Corpsmen.
- Participates in continuing education and professional organizations.
- Identifies educational resources for self and others.
- Utilizes research to evaluate practice and delivery of patient care.
- Sets realistic goals and develops a plan of action for professional growth and career development.

LEADERSHIP, MANAGEMENT, AND INFORMATION MANAGEMENT

- Supervises and directs subordinates in the delivery of patient care.
- Recognizes limitations and seeks appropriate assistance/guidance when needed.
- Demonstrates understanding of and ability to manage administrative tasks related to care delivery.
- Assigns patient care based on acuity, workload, and caregiver's competencies.
- Demonstrates constructive problem-solving behavior by:
  - Discussing interpersonal concerns with the individuals involved.
  - Forwarding concerns that cannot be handled on a person-to-person basis up the chain of command.
  - Identifying alternative solutions to problems or conflicts.
- Provides accurate, timely, and concise transfer of patient information.
- Utilizes electronic information systems appropriately.
- Maintains security of patient and personnel information and understands implications of the Privacy Act of 1974.

MISSION, PERFORMANCE IMPROVEMENT, AND OPERATIONAL READINESS

- Articulates Command mission.
- Knows scope of service for assigned area.
- Describes application of and participates in Performance Improvement activities.
- Identifies operational platform assignment and maintains readiness requirements.

MANAGED CARE/POPULATION HEALTH

- Verbalizes knowledge of existing and emerging health care systems.
- Articulates the basic concepts of the economics and financing of health care in the context of the Military Health System (MHS).
- Understands each of the components of the Population Health Improvement (PHI) Policy (standardized enrollment, demand forecasting, capacity management, demand management, condition management, community involvement and outcomes analysis).

APPENDIX C. DISTRIBUTION OF NEW NURSES FROM THREE ACCESSION PROGRAMS[276][277]

The next three tables demonstrate the distribution of new nurses to the different duty stations for fiscal years, 2000, 2001, and 2002. Only nurse accessions from the NROTC, NCP, and MECP are annotated, since the nurse from these accession program make up the minimum number of nurses that enter the Navy with no nursing experience.

New nurses are assigned to an operational unit (a unit that mobilizes for wartime, humanitarian and other missions dictated by the Navy) or to a Medical Treatment Facility. However, the new nurses will work in an MTF for most the majority of the time. Under mobilization orders, the nurses detach with their respective units. In conclusion, new nurses need to obtain training not only for the Clinical setting but also for the operational missions.

Fiscal year 2000		**Name of UIC**	**Frequency**
Accession Program	Frequency	NH BREM FH BREM DET	7
NROTC	49	NH CHPOINT FH CLEJUN DET	1
NCP	39	NH CLEJUN FH CLEJUN DET	4
MECP	45	NH CPEN FH CPEN DET	5
		NH GLAKES 2 FSSG DET	3
Name of UIC	Frequency	NH GLAKES CRTS 9 AUG	1
NATNAVMEDCEN BETHESDA	15	NH JAX FH JAX DET	4
NAVHOSP CAMP PENDLETON CA	1	NH LEMOORE FH CP PEN DET	1
NAVHOSP GREAT LAKES IL	3	NH PCOLA FH PCOLA DET	4
NAVHOSP JACKSONVILLE FL	8	NMC PORTS FH JAX DET	1
NAVHOSP NAPLES IT	1	NMC PORTS FH PORTS DET	1
NAVHOSP OKINAWA JA	2	NMC PORTSMOUTH FH PCOLA DET	2
NAVHOSP PENSACOLA FL	2	NMC SD CRTS 1 AUG	1
NAVHOSP ROTA	1	NMC SD CRTS 3 AUG	2
NAVHOSP YOKOSUKA JA	1	NMC SD CRTS 5 AUG	3
NAVMEDCEN PORTSMOUTH VA	15	NMC SD MERCY DET	11
NAVMEDCEN SAN DIEGO CA	29	NNMC BETH COMFORT DET	2
NH BEAU FH PCOLA DET	2	**Total**	133

276 Data obtained from Bureau of Medicine and Surgery (BUMED) Medical Information Systems II (BUMIS II). M131. Acronym Definitions after last table of Appendix C.

277 In fiscal years 2001 and 2002, the shaded fields indicate an area that was not updated at the time the data set from BUMIS II was analyzed.

Fiscal year 2001	
Accession Program	Frequency
NROTC	54
NCP	58
MECP	66
Name of UIC	Frequency
NATNAVMEDCEN BETHESDA	9
NAVAL HOSPITAL SIGONELLA IT	1
NAVHOSP 29 PALMS	3
NAVHOSP CAMP LEJEUNE NC	1
NAVHOSP CAMP PENDLETON CA	2
NAVHOSP GREAT LAKES IL	2
NAVHOSP GUAM MI	5
NAVHOSP JACKSONVILLE FL	5
NAVHOSP KEFLAVIK IC	1
NAVHOSP OKINAWA JA	2
NAVMEDCEN PORTSMOUTH VA	12
NAVMEDCEN SAN DIEGO CA	16
NH BEAU FH PCOLA DET	1
NH BREM 3D FSSG DET	1
NH BREM FH BREM DET	5
NH CHPOINT FH CLEJUN DET	1
NH CLEJUN 2 FSSG DET	1
NH CLEJUN FH CLEJUN DET	2

Name of UIC	Frequency
NH CPEN FH CPEN DET	11
NH CPLEJ 3D FSSG DET	1
NH GLAKES CRTS 9 AUG	1
NH JAX 2 FSSG DET	1
NH JAX FH JAX DET	7
NH PCOLA FH PCOLA DET	2
NMC PORTS FH JAX DET	4
NMC PORTS FH PORTS DET	16
NMC PORTSMOUTH FH PCOLA DET	2
NMC SD 1 FSSG DET	1
NMC SD CRTS 1 AUG	1
NMC SD CRTS 3 AUG	1
NMC SD FH BREM DET	2
NMC SD MERCY DET	3
NNMC BETH COMFORT DET	8
NNMC BETH CRTS 10 AUG	2
NNMC BETH CRTS FWD DET	2
NROTC PENN ST UNIV	1
NROTCU HAMPTON ROADS NORFOLK	5
PENDING NAVY GAIN	8
STU MECP U AL SCH NURSING	2
STU NAVLEAD TRNG UNIT LCRK	2
STU NETC NEWPORT	25
Total	178

Fiscal year 2002	
Accession Program	Frequency
NROTC	52
NCP	62
MECP	41
Name of UIC	Frequency
CNATRA	1
NATNAVMEDCEN BETHESDA	7
NAVHOSP 29 PALMS	1
NAVHOSP GREAT LAKES IL	1
NAVHOSP JACKSONVILLE FL	4
NAVHOSP OKINAWA JA	1
NAVMEDCEN PORTSMOUTH VA	13
NAVMEDCEN SAN DIEGO CA	21
NH BEAU FH PCOLA DET	1
NH BREM FH BREM DET	3
NH CLEJUN FH CLEJUN DET	1
NH CPEN 1 FSSG DET	2
NH CPEN FH CPEN DET	1
NH GLAKES CRTS 7 AUG	2
NH GLAKES CRTS 9 AUG	1
NH GLAKES OCONUS AUG DET	1
NH JAX FH JAX DET	1

Name of UIC	Frequency
NH PCOLA FH PCOLA DET	6
NMC PORTS 2 FSSG DET	1
NMC PORTS CRTS 4 AUG	1
NMC PORTS CRTS 6 AUG	1
NMC PORTS FH JAX DET	2
NMC PORTS FH PORTS DET	11
NMC SD FH BREM DET	4
NMC SD MERCY DET	9
NNMC BETH COMFORT DET	8
NNMC BETH CRTS FWD DET	1
NROTC CARNEGIE MELLON UNIV	2
NROTC UNIV NORTH CAROLINA	1
NROTC UNIV NOTRE DAME	1
NROTC UNIV SOUTH CAROLINA	1
NROTC UNIV VIRGINIA	1
NROTC VILLANOVA UNIV	1
NROTCU HAMPTON ROADS NORFOLK	2
PENDING NAVY GAIN	14
STU MECP COMNAVDIST WASH DC	1
STU MED DEPT OST UNIV NFLA	1
STU NETC NEWPORT	23
TRI SERVICE TRAUMA TRAINING	1
Total	155

Acronym definition:

BEAU	Beaufort	JAX	Jacksonville
BETH	Bethesda	MECP	Medical Enlisted Commissioning Program
BREM	Bremerton	NAVHOSP or NH	Naval Hospital
CHPOINT	Cherry Point	NAVMEDCENT or NMC	Naval Medical Center
CLEJUN	Camp Lejeune	NATNAVMEDCET or NNMC	National Naval Medical Center
CPEN	Camp Pendleton	NCP	Nurse Candidate Program
CRTS	Casualty Receiving and Treatment Ship	NROTC	Naval Reserve Officer Training Corps
DET	Detachment	PCOLA	Pensacola
FH	Fleet Hospital	PORTS	Portsmouth
FSSG	Force Service Support Group	SD	San Diego
GLAKES	Great Lakes		

APPENDIX D. EDUCATIONAL OPPORTUNITIES (AFTER: NURSE INTERNSHIP PROGRAM GUIDE NMC SD, JANUARY 2001)

Required courses	**Other Available Courses Taken When Offered At The Command**
Classroom	Vascular Access Devices
Welcome Aboard	Medical-Surgical Course I
Customer Relations	Medical-Surgical Course II
CLINICOMP	Medical-Surgical Course III
CHCS	Medical-Surgical Course IV
Clinical Nursing Orientation	Communication/Team Building Workshop
	Interpretation of Basic Cardiac Rhythms (EKG)
On-line courses	Advances Cardiac Life Support
Blood Transfusion	Pediatric Advanced Life Support
Pain Management	Pediatric Course
Restraint	Breast Feeding Course
Health Insurance Portability and Accountability Act	Newborn Course
Bio-terrorism	Basic Fetal Monitoring Course
Self-Directed Learning (SDL)	**Other Self-Directed learning Packets Available for Nurse Interns**
Medication Administration	Family/Domestic Violence
Age Specific Competencies	IVP
Medical-Surgical Home Studies Courses	Arterial Blood Gases
Advanced Directives	Drug Culture Language

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APPENDIX E. UNIT CLINICAL PLAN (FROM: NURSE INTERNSHIP PROGRAM GUIDE NMC SD, JANUARY 2001)

Note: The Unit Clinical Plan shows the progression of nurse interns in the units. The plan may be modified to fit individual learning needs and goals.

GOALS	PATIENT ASSIGNMENT	CNS/PRECEPTOR RESPONSIBILITY	INTERN RESPONSIBILITY
Week 1 Become responsible for direct patient care. Focus nursing care on the pulmonary and cardiac systems.	• Two or three stable medical-surgical* patients. • Medication administration. • Unit specific equipment review.	• Review patient charts and nursing notes. • Assist intern with cardiac and pulmonary assessments. • Assist with interpreting lab results. • Assist with end of shift report.	• Ask questions! • Inform preceptor/DO of your clinical needs. • Practice pulmonary and cardiac assessment. • Administer medications. • Give end of shift report. • Document: vs, pt assessments…etc. • Assist with ADL's (activities of Daily Living)
Week 2 Continue to be responsible for direct patient care. Focus nursing care on t he gastrointestinal (GI) and genitourinary (GU) systems.	• Three or four complicated and stable medical-surgical patients. • Take patient admission. • Observe physician rounds.	• Continue to review patient charts and nursing notes. • Assist intern with GI and GU assessments. • Encourage NC and corps staff interaction.	• Ask questions! • Inform preceptor/DO of your clinical needs. • Practice GI and GU assessment. • Practice utilizing corps staff. • Admit patient.
Week 3 Become comfortable with direct patient care.	• Team lead half of a full team with team leader.	• Assist intern with neurological and integumentary assessments.	• Ask questions! • Inform preceptor/DO of your clinical needs. • Practice neurological

GOALS	PATIENT ASSIGNMENT	CNS/PRECEPTOR RESPONSIBILITY	INTERN RESPONSIBILITY
Become responsible to care for team of patients. Focus nursing care on the neurological and integumentary systems	• Do patient teaching and patient discharge. • Transport patient to special studies or ICU • Participate with physician rounds.	• Assist with organizing care for five or more patients. • Encourage Nurse Corps/Medical Corps interaction. • Give feedback and direction regarding organizational skills.	and integumentary assessment. • Report changes in patient's condition. • Increase physician interaction.
Week 4 Continue to be responsible for direct patient care. Continue to be responsible for a team of patients. Focus nursing care on the psychosocial aspects and unit specific complications.	• Team lead a full team with MINIMAL team leader assistance. • Begin functioning as unit staff.	• Assist intern with psychosocial and unit specific complications. • Observe organization of care to a full team of patients. • Assure dissemination of Intern evaluations to preceptor/DO/CNS (at least 4-5 evaluators per intern, please!)	• Ask questions! • Inform preceptor/DO of your clinical needs. • Practice psychosocial aspects and unit specific complications assessment. • Complete Rotation Evaluation. • Complete Self Evaluation

* please substitute patient type with corresponding area (i.e., pediatrics, ob, critical care, etc.)

APPENDIX F. NURSE INTERNSHIP PROGRAM: CLINICAL PERFORMANCE (FROM: NURSE INTERNSHIP PROGRAM NMCSD)[278]

(Note: Appendix F Provides excerpts from the clinical Performance Program Packet at NMC SD.)

Purpose of the Nurse Internship Clinical Program:

- To provide the opportunity for the nurse intern to be exposed to core nursing skills, knowledge, and tasks in order to facilitate their educational pathway and establish the foundation for clinical practice.

Guidelines When Assigning Clinical Areas :

- Review the pre-internship self assessment as well as other assessment tools (PBDS) and assign intern according to their clinical learning needs.
- A day will be scheduled in the clinic when the intern rotates to each clinical area to allow ambulatory/clinic experience.
- Due to unforeseen circumstances, it might not be feasible to obtain competency (or experience) to every element. Elements not covered in the internship program may be completed upon assignment to their permanent workplace.
- Medications may be administered by the nurse intern using the unit-specific medication certification process.

Components of the Clinical Performance Program Packet:

1. Administrative and General Requirements Checklist
2. Clinical Competency Checklist
3. Equipment Competency Checklist
4. Checklist of Types of Patients
5. Signature List
6. Reference Key Legend

[278] U.S. Navy Nurse Corps Web Site, Nurse Internship Program: Clinical Performance, Navy Nursing Competencies, [https://bumedmed.navy.mil.med00nc/Competencies/home.html], February 2003.

Administrative and General Requirements Checklist

Directions:

1. Write the specific name of the area (ward/unit) on the line in the space provided if applicable.
2. The preceptor will place their initials in the column next to the assigned area when the element has been completed for that area. If the element is not pertinent to the area, place NA (not applicable) in the column.

General Requirements	I Medical/Surgical	II Medical/Surgical	Pediatric	Obstetrics	Specialty Care	
Chain of Command						
Characteristics of Unit: Type of unit & unit tour Patient population Scope of practice Capacity of unit Treasure hunt/scavenger list Page System Call bell/Call light system						

Educational Competency Checklist

Educational Requirements	SCHEDULED	COMPLETED
Course Offerings: Welcome Aboard		
Customer Relations		
CLINICOMP		

Clinical Competency Checklist

Purpose of the Clinical and Equipment Competency Checklists :

- These checklists represent a systems -based tool used to validate the nurse intern's level of knowledge and skill while rotating through the internship program. Each element contains a competency statement and criteria (performance element) on which to evaluate the knowledge, skill, or task demonstrated by the intern. Although the intern may demonstrate competence in a particular element, competency in a particular ward/unit will occur when the intern has been permanently assigned.
- The checklist includes:
  - Reference to locate the specific source (such as the policy, procedure, instruction, etc.) related to the specific performance element.
  - Pre-internship self-assessment to be completed by the intern prior to the beginning of the clinical program.
  - Method of teaching and learning used for each performance element.
  - Validation by the preceptor and intern to determine the level of competency after training has been done.
  - Document the level of competence after the completion of the specific element and also at the end of the rotation to demonstrate progress of learning.
- Legend for the Method of Teaching and Learning:
  - C = Course/Class/Inservice completion
  - D = Demonstration of the knowledge, skill, task by intern
  - Q = Question(s) asked by the preceptor and answered by the intern
  - R = Return demonstration
  - T = Test/Assessment/Worksheet
  - W = Observation of Work
- Legend of Levels of Learning:
  - Level 1 = *Novice*: No knowledge or skill; needs additional training, education, or practice.
  - Level 2 = *Advanced Beginner*: Some knowledge or skill; needs to practice under the supervision or needs additional training, education, to master the element.
  - Level 3 = *Competent*: Sufficient knowledge and skill to work independently; able to perform the element in a consistent and safe manner.

Directions:

1. The nurse intern will compete the self-assessment prior to the clinical experience marking either yes or no and placing the date in the appropriate column.
2. The preceptor will provide teaching on the criteria and document the teaching/learning method (if not already done), and place the date in the appropriate column.
3. The preceptor and nurse intern will determine the level of competency and place the date and initials of the preceptor in the appropriate column. The nurse intern may obtain additional experience when assigned to other areas - thus subsequent preceptors may validate a higher level of competence and document this in the appropriate column.
4. Starred (*) criteria represent criteria from the Basic Operational Clinical Competencies. When the nurse intern completes these criteria during their internship program, they can transfer them directly to the Operational Checklist if desired.
5. When there are more than one criterion listed, circle the ones that were completed.

Clinical Requirements: Competency Statement and Criteria	Ref Key #	Self-Assessment by Nurse Intern: Are You Competent?			Method Of Teaching and Learning		Competency Assessment Level & Validation		
	Refer to List	Yes	No	Date	Type	Date	Level **1** Date/ Initials	Level **2** Date/ Initials	Level **3** Date/ Initials
Demonstrates Basic Nursing Care: Performs &/or Assists with Rest & Comfort									
▸ Aquathermia Pad (K-pad)									
▸ Heat Therapy Moist Dry Hot Pack Warm Compresses Commercial Hot Pack									
▸ Cold Therapy Ice Bag/Collar/Glove Moist Compresses Commercial Cold Pack									
▸ Sitz Bath									
▸ Assesses for & Manages Pain Oral/IM Medications PCA Epidural Comfort Measures/Therapeutic Techniques Documentation									
Other:									
Demonstrates Basic Nursing Care: Performs &/or Assists with Oxygenation									
▸ Chest Tube Care & Maintenance (PleuorVac) Patency Water Seal Pressure Bubbles Drainage Dressing Suction									
▸ Oxygen Therapy Nasal Cannula Simple Mask Venturi Mask Non-rebreather Rebreather Tracheostomy Collar									
Airway Adjuncts:* Oral & Nasopharyngeal									
Suctioning:* Oral & Nasal									
▸ Incentive Spirometer/Deep Breath & Cough									
▸ Tracheostomy Care* Suctioning Dressing/Tie Change Cleaning Cuff Management									
Other:									

Other headings

- Performs Administrative Nursing Functions
- Demonstrates Basic Nursing Care: Performs & Documents Basic Health Assessment
- Demonstrates Basic Nursing Care: Performs &/or Assists with Hygiene Care
- Demonstrates Basic Nursing Care: Performs &/or Assists with Nutrition & Fluid
- Demonstrates Basic Nursing Care: Performs &/or Assists with Elimination
- Demonstrates Basic Nursing Care: Performs &/or Assists with Activity & Mobility
- Demonstrates Basic Nursing Care: Performs &/or Assists with Safety Needs/Concerns
- Demonstrates Basic Nursing Care: Spiritual & Terminal Care
- Demonstrates Basic Nursing Care: Emotional and Psychosocial
- Performs Basic Pre-Operative Care
- Performs Basic Post-Operative Care
- Performs/Assists With Core Laboratory and Radiologic Tests
- Performs Core Nursing Skills
- Cares for Patient with Integumentary Conditions and/or Compromise (Skin)
- Cares for Patient With Genitourinary/Renal Conditions and/or Compromise (Kidneys, Ureters, Bladder, Urethra, Male & Female Reproductive)
- Cares for Patient With Pulmonary Condition and/or Compromise (Nose, Mouth, Pharynx, Larynx, Trachea, Bronchi, Lungs
- Cares for Patient With Psychosocial Conditions and/or Compromise
- Cares for Patient With Musculoskeletal Conditions and/or Compromise (Muscles, Tendons & Ligaments, Bones, Joints)
- Cares for Patient With Neurologic Conditions and/or Compromise (Brain, Spinal Cord, Nerves)
- Cares for Patient With Gastrointestinal Conditions and/or Compromise (Mouth, Esophagus, Stomach, Small & Large Intestines, Liver, Gall Bladder, Pancreas)
- Cares for Patient With Immunologic and Hematologic Conditions and/or Compromise (Blood Cells, Bone Marrow, Plasma, Spleen, Thymus, Lymph Nodes, Lymphatic Vessels)
- Cares for Patient With Endocrinologic Conditions and/or Compromise (Thyroid, Parathyroid, Adrenals, Pancreas(Insulin-specific)
- Cares for Patient With Cardiovascular Conditions and/or Compromise (Heart, Blood Vessels)

Equipment Competency Checklist

(Not Inclusive)

Competency Statement: Demonstrate the correct and safe use of equipment used for patient care.

For each piece of equipment the nurse intern will be able to:

Criteria: Locate the operator's manual.
Verify the equipment is working properly.
Indicate who is responsible for maintaining the equipment.
Demonstrate use per manufacturer's guidelines and standard operating procedure (SOP).
Describe the basic repair of the equipment.
State potential risks of malfunctioning equipment.
Know the risk(s) to the patient or operator if equipment is improperly used.
Know the procedure if equipment has harmed a patient or operator (non-emergent/emergent).

Name of Equipment	Ref Key	Self-Assessment by Nurse Intern: Are You Competent?			Method Of Teaching and Learning		Competency Assessment Level & Validation		
							Level 1	Level 2	Level 3
		Yes	No	Date	Type	Date	Date/ Initials	Date/ Initials	Date/ Initials
Genius First Temp Tympanic	SOP								
IVAC Rectal/Oral Thermometer	SOP								
IVAC 4200 Vital Check	SOP								
IVAC Infusion Pump	SOP								
Alaris Signature IV Pump	SOP								
Ohmeda Wall Suction	SOP								
HP Code Master XL	SOP								
Flowtron Excel Prophylactic DVT	SOP								

Checklist of Types of Patients Cared For by their Medical Diagnoses or Surgical Procedure

Directions: After the nurse intern has had exposure with, assisted with, and/or has performed care for the patients in a particular area, the patient's medical diagnosis or surgical procedure will be documented in the table below.

Medical Diagnosis/Surgical Procedure	Medical Diagnosis/Surgical Procedure
1.	41.
2.	42.
3.	43.
4.	44.
5.	45.
6.	46.

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