NCSBN

Report of Findings from the

Post-Entry Competence Study

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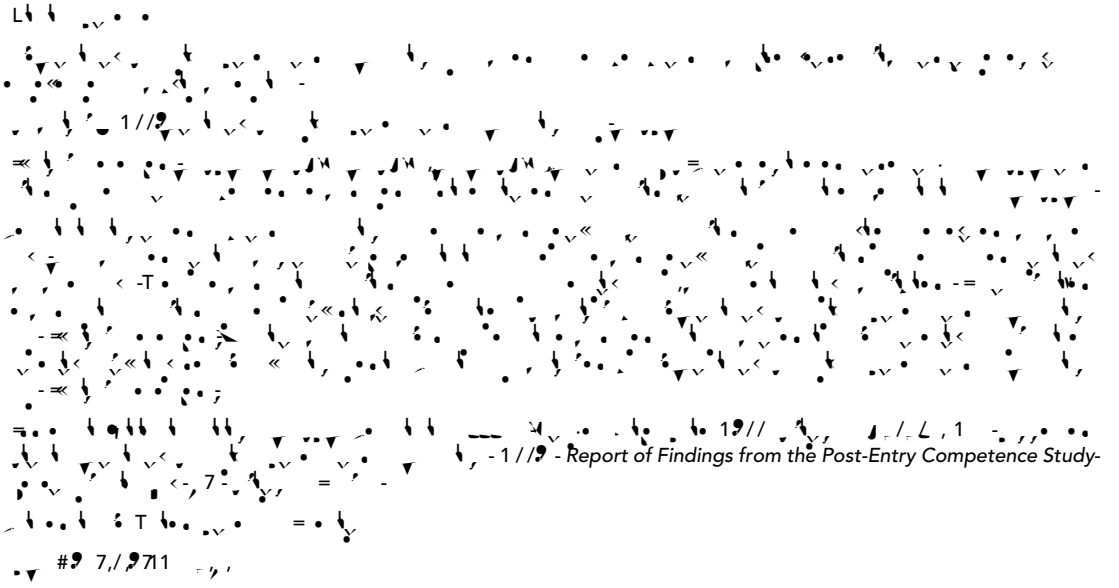
National Council of State Boards of Nursing, Inc. (NCSBN®)



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The Post-Entry Competence Study was a qualitative study designed by the National Council of State Boards of Nursing (NCSBN®) to explore the characteristics of registered and licensed practical/vocational nursing from entry through five years of practice. This study reported on a cohort of nurses who had been in practice for six to 18 months and were followed for a period of five years. The purpose of the Post-Entry Competence Study was to discover how nursing practice changed post-entry, when the changes occurred and the competencies needed by nurses with up to five years of experience.

An advisory panel composed of NCSBN members, at least one member of the regulatory commu-

METHODOLOGY

Data collection was accomplished through e-mail surveys, allowing investigators to interact quickly with participants to clarify and expand activity descriptions. The nurse participants who completed all four activity descriptions during the past year were paid a $100 yearly stipend.

Two sampling strategies were used for the study. First, data were collected from nurses to achieve a cross-sectional view of the characteristics of nursing practice. Eighteen groups were defined by two types of licenses, registered (RN) and licensed practical/vocational nurse (LPN/VN) and nine levels of nursing experience (6, 12, 18, 24, 30, 36, 42, 48, and 60 months of experience). Each cohort was sent a survey by e-mail at the beginning of the study. That survey collected several types of information, including demographic data, educational background, work setting information and self-assessment of proficiency within specific components of nursing practice.

The other sampling strategy consisted of following a group of nurses who had been employed six months or less through their first five years of practice, with each nurse providing data by e-mail at three month intervals. The questions that were asked at each time interval are included in Appendix A. Input from the advisory panel and SME Panel was used to modify the questions asked of the longitudinal nurse cohort to better answer the specific research questions. A total of 549 volunteered to participate in the longitudinal portion of the study.

The time frame for the longitudinal study was from August 2002 to June 2008. The reason the study encompassed more than the planned five years is because the first mailings to the longitudinal participants resulted in very low response rates. It was decided, therefore, to "accumulate cohorts over 12 months" until the desired numbers were reached. This process resulted in three groups of nurses who were mailed questions at different points in time. For example, Group 1 was mailed the first set of survey questions in August 2002, whereas Group 3 was mailed the same questions for the first time in July 2003. As a result, Group 1 received their last set of questions in 2007 and Group 3 received their last set in 2008. At study enrollment, participants could have been licensed for up to one year, so the first year of data actually reflected nurses with six to 18 months of experience.

Data were analyzed using a qualitative descriptive approach. Two original investigators independently read narratives supplied by a portion of the cross-sectional cohorts, noting changes in daily work and in performance of selected activities. Patterns of practice, issues related to patient safety and changes in perceptions across cohorts were to be examined. The principal investigators examined 315 of the 1,010 cross-sectional responses to identify the early themes and the delegation concerns from 2002 to 2004. Their preliminary findings are presented in Appendix B. While the remaining cross-sectional responses could serve as a resource for validation of the longitudinal findings, such an analysis would not have the benefit of the focused questions that were asked in the final surveys.

The main analysis encompassed all the longitudinal data, beginning in late 2006. A total of 2,081 e-mail responses (1,203 from RNs and 878 from LPN/VNs) from the longitudinal data collection were analyzed to look for changes in individuals' responses over time.

Some files were not usable because no longitudinal comparisons were possible due to missing tracking information or sporadic responses. The major limitation was attrition. There was a 50 percent drop-off from the original 549 responses over the first three months in the longitudinal group and fewer than 100 were participating by Year 3. By the end of Year 5, about 60 nurses were still submitting data and 49 provided sufficient data for analysis across the five years.

Given their unusual persistence in participating in the study over five years, these nurses clearly must be viewed as a self-selected and non-representative group. Nonetheless, they are diverse in terms of educational background and work settings and their responses are similar to those of their peers in the larger dataset. Their reports, totaling hundreds of pages of text, are a key source of the study findings.

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FINDINGS

Characteristics of Early Nursing Practice

Work Settings Over Time

Across the entire sample, the working conditions of newly licensed nurses were extremely diverse, ranging from intensive care units (ICUs) and emergency departments (EDs) to long-term care. The choice of setting did not seem to be related to RN/LPN/VN status or educational level, although the bachelor of science (BS) prepared nurses seemed to start in acute care more often and stay in acute care longer than the LPN/VNs or associate degree (ADN) and diploma nurses.

Many RNs and LPN/VNs changed their work settings within the first year, often because of untenable working conditions in acute care. Some became travel nurses and adapted to as many as three settings within their first year as an RN. Some went from one acute care setting to another seeking a better work climate or lighter caseloads. A fair number, perhaps more often LPN/VNs and AD-prepared RNs than BSNs (Bachelor of Science in Nursing), left

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I am responsible for assessments incl ding ital sign monitoring, medication administration, patient ed cation regarding care and medications, patient safet , and reporting of patient condition to necessar disciplines. [LPN/VN, Year 1]

There are t o n rses in o r of ce. M self and a RN. There are also t o s rgeons in the of ce. We as the n rses bring patients back to the e am rooms and

the N rse Practice Act. I cannot nd an part that sa s that the LPN/VN cannot perform IV therap . I ha e read that the LPN/VN ma perform IV therap

kno abo t that on't h rt her. I ask them to help o t as needed. If there is a problem ith patient care I am e pected to inform the charge n rse. I ha e not had to do that et. The CNA has al a s responded to m req ests. I feel that o r CNAs are great. As a ne n rse, I appreciate the e perienced CNAs inp t. [LPN/VN, Year 2]

O r hospital has t o oors, one being the medical and the other the s rgical oor. There is al a s one RN that e ork nder and there are s all t o to fo r LPN/VNs on the oor. Sometimes, there ill be t o RNs on the oor depending on sched ling. The LPN/VNs do a beginning shift assessment of each of their patients: hang IV id;, start IVs; pass meds; pro ide doc mentation; dress o nds; monitor blood transf sions; gi e baths; empt bedpans; p t in fole s; change sheets; discharge a patient after the RN assesses them; monitor ent patients; p t in NG t be; and gi e enemas. We ha e an RN ho is on d t if e need them and the ill check on s from time to time to see if e need help. We do all of the aides' d ties hen necessar . We s all ha e one, if not t o aides to help s. I report to the RN if I am going to do an in asi e proced re or if I ha e a ne patient coming to the oor, if I ha e a patient discharged hen there is a problem, or if I need ad ice or a second opinion abo t a patient or sit ation. The n rsing assistants assist patients hen amb latin;, assist to the bathroom or bedside commode; pass meal tra s; empt bedpans and clean patient;, gi e bath;, ma gi e enemas; and takes ital signs hen ordered. I am responsible for m patients' needs and it is p to me to make s re the aides do their d ties for m patients. [LPN/VN, Year 1]

I'm an LPN/VN at a n rsing home. I'm responsible for passing medications doing treatments, s ch as dressing changes and appl ing creams. I'm responsible for charting an changes the residents ha e, Medicare and topic charting. I'm responsible for taking blood s gars and gi ing ins lin and other shots, s ch as in en a and manto . I'm also responsible for the n rsing assistants and medication aides ho ork nder me. I'm responsible for making s re the residents get the care the need. We ha e a eekend s per isor ho is there and I report to her for an important e ents or changes that happen. I also report things to an RN that is orking on m station beca se the are an RN and I'm onl an LPN/VN. The n rsing assistants do all of the ADLs for the residents. I o ersee hat the do and the RNs o ersee hat I do. The RNs as ell as I decide hat parts each of s do for the residents. [LPN/VN, Year 1]

On m shift, there are t o n rses ho are LPN/VNs. We ha e a s per isor for the hole b ilding ho is an RN. I do the charting, passing meds and treatments. Sho ld an one fall, e need to call o r s per isor to come do n and assess. If someone's temperat re sho ld go o er 102, e report that to the s per isor. The CNAs do all the hands on care, s ch as toileting, sho ers, etc. I am responsible for the care that the CNAs do. [LPN/VN, Year 2]

M nderstanding is that I ork nder the charge n rse's license. I can do e er thing at ork that an RN can do, e cept hen it comes to IVs I ha e to either ask the RN do n the hall to hang m medicated IVs or else track do n the charge and ask her to do it for me . I am responsible for the care pro ided b CNAs. I don't ha e an a thorit o er

it o ld be eas for it to become o t of control fast. It's her critical thinking skills that make her one of the best n rses I kno . ..We had a code recentl and it asn't going er ell. People ere frantic and it as slopp and norgani ed. There as no real leader" of the code so I chose that e needed to sa e this life and the c rrent path asn't going to ha e that o tcome at its end. I elled o t lo d to stop and e er one take a breath and let's start again. The did stop and the took a breath and e started again. This time there as a leader and the code ent m ch better. We ere able to bring the man back and he comes to o r nit e er no and again to sho his thanks. If he onl kne ... [LPN/VN, Year 5]

The competent n rse q ickl con erts a p rposeless gro p of people into a foc sed team. To do this o need to identif priorities. Team members ill feel a sense of relief as o task them o t to help sa e the patient. The e perienced n rse's moti ation for this is not to deri e a feeling of dominance or a po er trip. The n rse ill feel satisfaction in seeing the bene t the patient recei es. [LPN/VN, Year 5]

The n rse I think of has e perience, is able to criticall think q ickl on her feet and is gen inel caring. Being highl organi ed and competent in technical skills are also hat make her competent . I had an OB patient that came in earl one morning ith no doctor in ho se I q ickl made decisions to call in e tra help and a respirator therapist. I set p for a dif c lt deli er since the bab as breech, the patient as a smoker and had minimal prenatal care. I contin ed calling the doctor ho as not comfortable coming in. I as er adamant and contin ed calling important people that I needed no . In the end, e had one doctor and t o n rses to do the deli er , b t e maintained o r calm and deli ered a health bab . The sit ation sho ed me that e en in a crisis sit ation, I as able to make appropriate decisions and sta calm. [RN, Year 5]

Equally important was the ability to listen well and treat all staff and participants as valued people in a warm, respectful manner.

The n rse that trained me d ring m earl time on the oor is a n rse I still highl respect. She is e tremel compassionate and respectf l to ards the patients, e en hen the are not al a s kind to the staff. She is not prone to gossip and acts professionall to ard other n rses. [LPN/VN, Year 5]

Competenc , I belie e, is meas red not onl b clinical kno ledge, b t also abilit to interact ell ith those o ork ith and those hom o care for. The abilit to criticall think is also in al able. Dedication to the job is also er important. [RN, Year 5]

Being in p blic health, competenc isn't meas red b clinical skills, b t being able to connect ith people and make an impact on their decision making process. M colleag e is al a s researching the ne est trends in child de elopment and is al a s illing to lend a hand to others. She doesn't al a s kno the ans ers b t ill ans er to the best of her abilit and get back to the person ith the ans er after she's had a chance to research it. She is er forthcoming ith things and has a great a of dealing ith people. She is er sincere and it sho s to her clients and the respect and enjo ha ing her isit. She has the ama ing abilit to come p ith other alternati es and ingenio s a s of sol ing problems. She helps the families problem sol e and come p ith

o feel as if she cares as m ch abo t o as she does the patients. She is dependable, on time, is professional, neat in appearance, and does not speak nkindl of others. [LPN/VN, Year 5]

M colleag e has been a n rse manager for man ears and is close to retirement. I belie e that the characteristics that stand o t ith her are her abilit to al a s listen more than she speaks and she is fair. She al a s bears on the side of the emplo ee and orks hard to train them to policies. She q ickl remo es lo performers from o r staff in order to make it the best. She is er professional and respects e er one. She is also not afraid to get her hands dirt like some managers are. [LPN/VN, Year 5]

Knowing How to Work the System

Knowing how to obtain little-known or otherwise inaccessible consultation, resources and services for patients was valued and admired, a common example selected by experienced respondents to demonstrate how they addressed an unmet need. This skill was necessarily founded on a deep familiarity with the channels of communication, resources, and authorization strategies across the health care agency and the geographic region. This, coupled with an ongoing working relationship with key staff in positions of influence outside the home unit, a high level of self-confidence in negotiating on behalf of patients and families, diagnostic certainty about patients' needs, creativity in perceiving solutions to patients' needs, and a strong commitment to the good of the patient and family underpins going to unusual lengths on their behalf. This type of competence represents a capstone of expertise as it draws on a wide range of knowledge and skills.

When I rst started n rsing I didn't kno the s stem, I didn't kno if I as the one ho needed to address the patients needs. Pl s I as also intimidated to talk to doctors, cm's, etc. I as so concerned abo t gi ing meds on time, looking for changes that the

and forge new approaches to increasingly complex patient care needs.

One ho seeks o t a s to impro e their da to da practice. One ho seeks o t and keeps p on ne info concerning n rsing practices. A person ho does not get st ck in the da to da , b t stri es to make the n rsing profession better and is a ad ocate for the practice. A leader. [LPN/VN, Year 5]

I think there are t o characteristics that re ect a person's competence. The rst trait is that a competent n rse is ne er satis ed ith their le el of kno ledge I feel that a second trait that highl competent n rses e hibit is con dence, or coolness nder press re Finall I o ld emphasi e that in an emergenc sit ation or e en j st a tr ing sit ation, the n rse needs to demonstrate calmness and con dence to gain the tr st of the general p blic as ell as their fello n rses. [LPN/VN, Year 5]

Not afraid to sa the don't kno , b t ill seek o t the ans er. Takes the time to research and st d information and data before ans ering an q estions. Is er kno ledgeable in hat the are certain the kno . Wants to see different perspecti es and other ie s to enlighten themsel es. [LPN/VN, Year 5]

M c rrent manager is e perienced and kno ledgeable Se eral characteristics that come to mind are her eagerness to al a s be learning more and researching hat she doesn't ha e a clear nderstanding of. O erall, in m e periences I belie e an eagerness to learn more and e perience itself are hat de elop and and ho5e8eonstr1.316 T3O Q belie e an

bed of m patient, eri ed the MAR for the ne t da , charted in the comp ter m itals, I&Os, ritten on the o sheet a narrati e, incl ding assessments and m plan of care for that shift. I print a lab histor , replace electrol tes per orders, and prepared to gi e report to the ne t n rse. I generall am a bit behind and nish p tting in m q4h itals into the comp ter j st after report (that's m Achilles heel still tr ing hard to get o t on time). [RN, ICU, Year 1]

I don't think I o ld ha e had eno gh con dence in m teaching or in the patients learning of diabetes to be effecti e hen I rst became a n rse. I probabl o ld not ha e spent so m ch time ed cating and I kno I o ld not ha e kno n ho to reall listen to m patients and be able to read hat as going on ith them. I o ld ha e tho ght this partic lar patient o ld ha e been nteachable. I o ld not ha e had the con dence to teach the patient to se the lancet and injecting the ins lin. I belie e I no ha e more e perience, nderstanding, and patience to spend the time needed ith them. M time management skills ha e also impro ed greatl , so I ha e the time to sit and isit, listen, ed cate, and obser e. M nderstanding of Diabetes is better than it as altho gh I still ha e a lot to learn. [LPN/VN, Year 5]

In the rst si months of practice, I as er task oriented. I co ldn't seem to see past the tasks that needed to be done, s. the critical thinking and actions that come ith more e perience in n rsing. When I as a ne n rse, I don't think that I o ld ha e seen some of the s btle changes that ere occ rring, altho gh I ma ha e sensed something as rong, o ld not necessaril been able to p t the hole pict re together. This comes ith e perience. When looking back at m rst ear as a licensed n rse, I belie e it is rather scar that e are o t there, fort natel the pr dent n rse ill al a s talk to her colleag es hen something doesn't seem right, or she can't p t her nger on the iss e, in order to tr to get a different perspecti e of hat ma be transpiring. In m earl da s of n rsing, I o ld go to the e perienced n rse, and still do toda for inp t if something j st doesn't seem q ite right, and other n rses come to me for m opinion. [LPN/VN, Year 5]

Within this striving for efficiency, the focus for many new nurses was on physiologic needs and hands-on skills above thoroughness and sensitivity to patients' psychosocial needs. Some expressed regret, but a few described knowingly ignoring emotional distress because they saw physiologic issues as more pressing.

I as er ner o s in m rst si months of practice. I don't think I as a are that m patients ere real people. I as more concerned ith the proced re than the person. I as more foc sed on learning the job than on caring for the patient. [No] I nderstand the importance of treating m patients ith dignit and respect. I look at the hole pict re and tr and foc s on hat is rong ith m patients rather than placing m hole foc s on proced res. [LPN/VN, Year 5]

Initiall , I fo nd it er dif c lt to manage m time ef cientl . I al a s felt as tho gh I as r nning from patient to patient and ne er ha ing an time to act - all spend ith the patient. M organi ational skills ha e impro ed signi cantl and I feel as tho gh I am able to foc s more attention on the needs of each indi id al. [RN, Year 3]

Because they were focused on completing assessments and procedures, and identifying and responding to physiologic needs, when asked to describe a situation of a patient'sort t18eindivid-9(for)Tjindivi

the room aro nd the same time. Calming inter entions ere sed to rela the patient. The MD as noti ed b an RN. Patient as hooked p to p lse o machine. Patient as 68% on t o liters, 52% on RA, portable chest -ra as done b -ra tech. An emergenc room MD asked BS for an assistance needed. Patient as p t on non-rebreather mask to assist ith rise in O2 sats. CNA and BS performing VS e er 10 min tes. Patient stabili ed. Paramedics and BS to transfer patient to larger facilit per MD order. Patient again reass red things ere going to be OK. Consent for transfer signed b patient. Lab and BS dra ing blood. Final ABG done before transfer. Assist paramedics in loading patient in amb lance. Within ho rs, the facilit here the patient as transferred called to tell s he had thro n a p lmonar embolism to the l ng b t as stable at this time and done ne. [LPN/VN, Year 1]

A patient recentl had a er high temp hich I fo nd d ring m ital signs check. I called the doctor for an order for med for temp, administered it hen pharmac sent it p to oor and contin ed to check temp freq entl . Temp decreased some hat b t remained ele ated for all of shift. Ga e med q 4 ho rs as ordered and passed this information on to the ne t shift. [RN, Year 1]

Pro iding care to kidne transplant post op, da three, second transplant, so the patient as recei ing Th mo pon shift change. Vital signs ere ho rl . Assessing the patient and looking at all the itals noticed that the BP as rising. Asked the patient if she had an s mptoms; she stated she had bl rr ision. BP at this time as aro nd 180/111. Decided to notif the Renal primar doc (not resi-

n rsing. It as too slight a change. I'm not s re I o ld ha e noticed the change had it happened on the rst da of the three da s I cared for him, b t the three da s histor made me a are of his condition. This as a real God da for him and for me. [RN, Year 4]

Differences in Responses Based on Educational Level

The narratives in Year 1 from BSNs were much more verbose and detailed than ADNs and LPN/VNs, the exception was foreign-trained BSNs for whom English was a second language. BSNs seemed more comfortable in this form of self-expression and usually engaged in more self-examination and insight.

However, the BS-prepared nurses were no less likely than the others to describe instances of poor judgment. The self-report form of data did not reliably reveal safety issues, but a small proportion of newly licensed LPN/VNs and RNs at all educational levels did share stories that raised questions about appropriateness of their responses to apparent downturns or patient needs. The difference was that the BSNs were more likely to analyze the situations and identify areas for self-improvement. ADNs working on their BS degrees showed more insight and commitment than ADNs who did not enroll in further education. RNs from second degree BS programs were especially insightful and motivated to do better for their patients. There were exceptions, however; education did not reliably predict this.

One early difference based on education and license was seen in use of psychosocial interventions. A few new nurses, mostly BSNs, who resisted pressure to speed up for efficiency's sake and did make time to get to know their patients were proud to report their success at solving complex problems with psychosocial origins. Fewer ADNs or LPN/VNs focused on psychosocial complexities or depicted *therape tic se of self* to get to know patients and families, and discover hidden causes of difficulties or non-adherence. Those who did spend

more comprehensive care. LPN/VNs were highly likely to be enrolled in RN programs at or soon after

patients and families based on insights they might not have had in Year 1, and were more aware of and able to address families' distress and needs.

We had a er long term patient in o r medical/s rgical ICU ho as ith s from earl October ntil Jan ar 1 hen he died. He had ALS and a er aggressi e, ntreatable cancer, b t he and his famil ere not illing to accept his diagnosis, th s kept him as a F ll Code. His mind as intact ntil the last fe da s hen he de eloped renal fail re. His ife as er dif c lt, constantl critici ing o r care, constantl checking him o er'' looking for a sheet crease or something to pin his deterioration on. She as so dif c lt, that most ga e p tr ing to e en talk to her. I spoke ith m manager, ho challenged me to nderstand her and to ha e her nderstand s and his prognosis. (I remember telling m manager that I didn't need an more challenges, b t I ended p taking it on!) I spoke ith all his doctors, e en those ho had checked off'' the case to nderstand their positions, sed the Social Serices and Case Management teams of n rses/social orkers and nall spoke ith him alone to see hat his end of life decisions ere and then I spoke ith her alone in the conference room. He and she both anted to maintain the F ll Code stat s, so then e disc ssed his probable co rse. It took man conferences ith her b t she came to tr st me and e ent all called me his fa orite n rse''. It ta ght me that patience is cr cial, and that as nothing I tho ght I had in m arsenal! His room had a small indo , b t he hadn't been o tside in man months other than his transfer from the amb lance from his rehab center to o r hospital in October. The respirator therapist and I decided to take him o tside for some s n. We cleared it ith the doctors, the charge n rse and nall ith the patient. He as terri ed and I e plained e'd bag him hile he as o tside and then he co ld see the life o tside. He agreed. It as a major ndertaking, b t he smiled in the slightl o ercast da . We b ndled him in arm blankets and he as o t there for abo t 15 min tes, ith the ind blo ing his hair and he beamed. His ife as thrilled and asked if e co ld do it again, so e repeated the ad ent re the follo ing da ith her and that da as s nn , so e sta ed o t longer. We had fo r to e trips o tside o er the ne t t o eeks. His deterioration as s bstantial after Christmas; his code stat s as changed to No Code and she asked for a priest to come to gi e him a nal blessing. E ent all , she agreed, on Jan ar 1, to take him o tside, off the entilator and allo him to go in peace in the s n here he had enjo ed some last pleasant da s. It as a rain da , b t the s n came o t for an ho r and a half. He breathed for 45 min tes and had his famil (real famil and hospital famil of RNs and his'' respirator therapist, ho had been ith me on o r rst ent re o tside) aro nd him hen he nall passed a a . It as one of the most bea tif l e periences of m life and one I' e learned a lot from! [RN, Year 3]

They drew on community services and resources outside the institution and were more skilled at working the system on their patients' behalf.

No that I ha e gained kno ledge and e periences I feel that I ha e more to offer m families. I also feel more con dent in famil ad ocac . I kno m role better and I kno hat reso rces and opport nities are o t there so I kno ho to ad ocate for them no . I sed to think that being a n rse I as the ke person for medical inter entions b t no I see that I am j st one of man people. It reall helps for e er one to ork together and dra on indi id al e periences to promote the health of o r children e ser e. [RN, Year 3]

When the nurses were asked how their skills had changed over time, confidence in speaking to physicians and advocating for one's patients was a commonly reported area of growth.

When I as a ne RN, there as a lot of an iet e er time I go to ork Being raised nder the Filipino c lt re, e ere ta ght not to ans er back or q estion others speciall those ho are older or s perior than s in an effort to maintain a smooth interpersonal relationship (hich b the a is not stress free). This kind of thinking can be a great hindrance hen it comes to health care, patient safet and ass ring a q alit ser ice to the clients. As a ne RN, I as not sed to carr ing a beeper and a cellphone so that I ma easil talk ith m patient's pro ider or that an bod else co ld easil reach me. Talking to m patient's doctor scared me at rst speciall after hearing stories from other staff members abo t hat doctors do and sa to n rses .Most

Nine months later: I o ld tell potential f t re n rses the tr th abo t n rsing. The pa and ho rs are lo s . Yo ill get no respect. Yo ill be constantl e posed to dangero s sit ations, s ch as potential for needle sticks, iolent patients, back strain, mandator o ertime, etc. I ill remind st dents that n rses are still considered to be handmaids of doctors and patients nd them to be c te'' caregi ers and are not taken serio sl as professionals. I o ld ad ise all omen to sta o t of positions that are stereot picall female, s ch as n rsing. I o ld tell them the ill st d hard for fo r ears at college to get this degree, onl for co ntless people to ask them if the had to go to college to become a n rse. I o ld remind n rses that there is a lot of changing diapers, bed pans, and dirt sheets in n rsing. O erall I feel betra ed and disappointed b m brief career as a n rse. I as for the most part ineffect al at making an real change is peoples' li es (m patients). I missed co ntless famil and

orders and let patients o t and, ans er the phone, etc. Witho t a secretar , a n rse m st be posted at the desk for eight ho rs hich left onl one n rse on the oor at all times (pl s me gi ing meds aro nd here and there). To sol e this problem e ran o r tails off and had a l ck shift. No one fell or killed themsel es hich is fort nate. The charge n rse sat at the desk, the oor n rse ran aro nd, and I ga e meds (p and do n the hall) The da I make eno gh mone to b a to nho se in m other f ll time, non n rsing job, I am soooo o t of n rsing.

Three months later, nal s bmission: Since I onl ork PRN, I am not at the hospital er often (onl three shifts a month). I can't think of a partic lar nmet client need since the last s r e . I can onl sa the hospital has needs, beca se there is a lo cens s and I get cancelled a lot. The ha e gone thro gh director after director and no one sta s and no one es the problems in o r department. I choose to ignore this sinking ship beca se the other times I tried to get in ol ed (s ch as hen I spoke o t against peer re ie or protested not getting a raise), I got b rned. I ill sta o t of hospital politics and collect m $30/ ho r and keep m mo th sh t.

It is difficult to determine which is more frightening about this story: the fact that this individual continued to practice nursing or the possibility that the care was as substandard as she described. Although objective examples of unsafe care could not reliably be identified in these self-reports, the attitudinal problems displayed by this individual clearly would contribute to substandard care in a mental health setting.

Do Nurses Believe their Basic and Continuing Education Enhances Competence?

Looking Back on their Nursing Education

The most common wish for their basic education, from both LPN/VNs and RNs, regardless of educational level, was for more clinical experience. The overall message was that book learning was only somewhat useful and much of nursing could only be learned on the job. Those with nursing assistant or emergency medical technician (EMT) experience described it as invaluable.

I o ld pro ide more hands on training ith machiner . I o ld incorporate a clinical eek to ork ith the ard clerk I think e need more clinical da s orking ith the phlebotomist. We spent so m ch time gi ing baths and doing linen changes in clinicals that e missed so man opport nities for other skills beca se e ere b s ith baths I think o need abo t one eek of complete re ie after o ha e nished all of o r ork and clinicals, j st before o test o t, to refresh o r memor and practice skills (like starting an IV or dra ing blood). It o ld ha e gi en me more con dence. [LPN/VN, Year 3]

I got basics. I kno ho to rite a care plan (hich no one does, beca se e ha e comp ters to do that) I o ld SIGNIFICANTLY increase the amo nt of clinical e perience in the hospital and especiall , for me, in the critical care area. I o ld ha e critical care theor classes at the same time as the clinical time. I o ld ha e an ad anced pathoph siolog class and an ad anced pharmacolog class that might coincide ith the critical care clinical time. There's j st too m ch I did NOT kno hen I began. [RN, Year 2]

Two kinds of specific experience were sought: specialty practice expertise to prepare for the nurse's current choice of field, including the knowledge and skills unique to that specialty; and real-world multi-patient assignments with practice in time management and communication with physicians. Both RNs and LPN/VNs suggested an internship or extended precepted experience in which they would shadow a nurse who is carrying a full assignment,

rather than caring for one or two patients using skills, such as care plan development, that were seen as unrealistic or irrelevant in current practice. Some LPN/VNs wished for more acute care experience and regretted following the expected path into less acute care settings.

I think ne n rses co ld reall bene t from eekl classes to re ie skills and eq ipment. In the past ear, I ha e ne er had an opport nit to ork ith a CPM machine, perform an EKG, a chest t be ith or itho t s ction, start an IV on a pediatric and others. I ha e onl once remo ed a central line, a NG t be and checked resid al on an NG t be. We no ha e the ne IV catheters and e do not like them at all. I ha e been nable to s ccessf ll start an IV ith them. This greatl adds to m fr stration and lack of con dence. Also, as a ne n rse, I do not feel con dent that I o ld kno hat to do in an emergenc sit ation. I feel like a ne n rse sho ld ha e to go thro gh a er long orientation (ma be a ear). I feel like the need to ork side-b -side ith another n rse in ICU, the ED, OB, and all areas for a hile. As ne n rses, e need to ha e more hands on emergenc sit ations ith close g idance and s per ision. I think ne n rses are r shed into the eld. Honestl , the more I learn, the more fearf l and less con dent I become. I am afraid of making a mistake that ill not onl endanger someone, b t ill ca se me to lose m license and I am tr ing as hard as I can. I hope to begin school in Jan ar to obtain m RN license. I am looking for ard to the schooling part. I hope to learn and nderstand more so that m con dence ill ret rn and m skills ill be greatl impro ed. [LPN/VN, Year 1]

If I had to start m career o er kno ing hat I kno no , I o ld start o t on a medical/s rgical oor at the hospital. I feel that I lost a lot of m skills b going directl into Dial sis from school. I ha e noticed changes in m e perience as a n rse, ho e er not as m ch as I o ld like. I regret not going to ork at a hospital hen I grad ated from LPN/VNs school. [LPN/VN, Year 4]

Nurses emphasized the need for experience with the interpersonal interactions involved in clinical care.

I o ld onl tr to add more hands on and being able to kno ho to comm nicate to the doctor better. That as the onl thing I belie e I learned once I as o t of school. [RN, Year 2]

I as reall ell prepared from a book-learning standpoint, b t there is reall no a to prepare for all the real- orld iss es o enco nter. I as strong in medication administration - simple fol-

departments and services within and outside the agency and the individuals who staff them. These person-to-person contacts are often the mainstay of effective collaboration ranging from emergency responses to discharge planning. Insight into how the unit relates to other units, how nurses relate to other care providers and therapists, and how the hospital relates to the community can be intentionally fostered, rather than acquired serendipitously over time.

1 - - Nurses felt unable to begin to provide care and especially unable to respond effectively to physician communications without an understanding of the disease processes and principles of the treatment approaches that were ordered. Relying on basic education to provide specialty-level knowledge is clearly insufficient. The type of classroom orientation most often seen for critical care units is probably warranted for today's acute care specialty units as well.

- - The extreme diversity of RN practice settings and the extreme acuity of the hospital settings, both far beyond the clinical experiences offered in basic nursing education, suggest a clear need for site-specific orientation followed by some form of preceptorship that continues throughout the first year and possibly beyond. New nurses have deep confidence in and respect for their experienced colleagues and are reluctant to go to any other source of help with complex patient needs.

Year 1 data suggest that some nurses may have been hampered in their ability to progress in their development by the lack of a designated resource nurse to guide them beyond the basic skills of care and into the judgments and sophisticated assessenced in the system would have enabled some to acquire these skills more rapidly.

- - The narratives from recently licensed nurses demonstrate a real need to revisit actions and decisions and reflect on alternative pathways. Those nurses, mainly BSNs, who spontaneously did so in their written accounts did identify better approaches and depict more skilled care in their narratives. This was rarely seen in LPN/VN narratives and only occasionally in ADN narratives, suggesting that these programs may not be teaching reflective practice.

Nurses would benefit from reflection not only on the actual care they delivered, but on how they used their time. Some nurses reported insisting on taking an hour for lunch regardless of conditions on the unit, and others reported never taking a break and eating standing at the medication cart or while delivering care to patients. Some focused on routine assessments over responding to acute needs.

Guided debriefing in a safe environment may help those nurses who have not been exposed to practices of self-appraisal and insight. A talk-aloud method might be useful, possibly in conjunction with simulation training, in which nurses presented with a simulated patient downturn, either physiologic or psychosocial, could reflect as they went along in gathering information and addressing the problem, and then receive coaching on their responses.

- = - New RNs were very uncritical of the different ways LPN/VNs were used. They seemed to delegate or let go of what is traditionally thought of as RN responsibility for assessment and care planning for patients. Certainly in shortage conditions, LPN/VNs were relied on to do whatever they could to relieve RN workload, but the level of supervision by RNs was often minimal or absent.

This was even more the case for PCAs, who despite questionable training and accountability, were often relied on to be the eyes and ears of RNs and LPN/VNs. Although some respondents reported they valued PCAs and could not function without them, both RNs and LPN/VNs described PCAs as of varying help depending on their willingness to work. Inconsistent understanding of how their duties were

determined and variations in PCA responsibilities and reporting relationships would make teaching on delegation and supervision skills difficult, either in basic or continuing nursing education. Yet all nurses, with or without perceived authority over the PCAs as workers, cited themselves as accountable for the care PCAs delivered. It is clear why new RNs were dismayed and frustrated.

At the time of orientation to the facility, health systems must clarify the roles and accountability of each level of provider, with specific rules and examples of responsibilities of each staff role conveyed at a level understandable to all involved and follow through at the charge nurse level to insure that the legal scope of practice is adhered to. State laws on scope of practice warrant national-level attention. NCSBN's work toward standardizing LPN/VN roles is extremely important here.

Teaching Methods to Promote Competence Development After Licensure

Examinations are unlikely to capture the forms of competence depicted in these study findings. Even sophisticated simulations and vignettes are unlikely to capture the nuanced graded distinctions involved in highly skilled nursing diagnostic judgments and interactions. Unless the profession can agree on standardized priorities and order of procedures in patient care and time management, such as the sequence of actions used in CPR training, standardized exams are unlikely to tap even the most basic of these components of competence. Other approaches to assessment and intervention to promote competence are needed.

- One of the simpler strategies would be to build times for reflection and debriefing into acute care practice. The goal would be to develop an expectation that this is part of minimal safety standards, as is done in physicians' case reviews, or in psychiatric or counseling practices, where supervision sessions are considered mandatory, even for experts.

1 - Preceptors are clearly pivotal to the competence development process and as resources to nurses who are not

METHODOLOGICAL NOTES: APPROACH TO DATA MANAGEMENT AND ANALYSIS

Each file was de-identified and reformatted to remove line break characters and other extraneous content for readability, and entered into Atlas-ti™. Each of the approximately 2,000 e-mail responses from the first four years was then coded, using basic descriptors of the kinds of clinical anecdotes they choose to tell, the actions they take, whether they intervened on their own or through others, what kind of interventions they used, their educational preparation and other basic labels for the text.

The analysis focused on the subsample of 49 nurses, 24 RN respondents and 25 LPN/VNs, who had consistently returned data at least once a year over the full course of the study. This subset formed a suitable sample size for an in-depth qualitative analysis, although the entire longitudinal dataset of about 2,100 e-mails contributed to the analytic conclusions. The core subsample was individually profiled and their responses coded and interpreted to produce the main findings presented in this report.

LESSONS LEARNED FROM THE E-MAIL METHODOLOGY

This five year study yielded a great deal of anecdotal data about the daily lives of newly licensed nurses. It provided a one-of-a-kind window into the perspectives of nurses beginning their practice in the highly challenging period from 2002 to 2006. The anecdotes that were elicited revealed the complexity of patients in acute care today; the burden of large patient assignments carried by many new nurses; the intensity of pathophysiological and medical treatment knowledge they were expected to bring to their practice; and their ongoing challenges in communicating with members of their own and other professions on behalf of their patients and themselves in a high-pressure environment. Some heartwarming and inspiring stories were told of truly ingenious nursing responses to extremely difficult patient care situations. It also revealed how soon many nurses, almost half of the highly diligent and persistent subsample that stayed in the study five years, left acute or critical care for less intense practice settings. These verbatim snapshots of the experience of contemporary nursing practice can yield many additional insights for future analysts.

The self-report e-mail format also revealed the diversity of education and writing skill of nurses joining the profession today, ranging from articulate insights and skilled reflection to poorly written or procedural communications, revealing serious literacy challenges (excerpts printed here were edited to correct punctuation and spelling) and shallow, routinized approaches to nursing practice. The self-report format was ideal for eliciting personal opinions and recollections, and uncovering how those changed over time. It also was a means of tracking changes in practice venue and, if volunteered, reasons for these changes.

This approach was not well suited to documenting growth in competence in terms of safe practice or performance and how it changes over time. The goal of identifying which factors influence the evolution of a nurse's practice was also overly optimistic. If self-reported influences were judged of interest, some of these goals might have been

personnel and the cessation of analysis for its middle years, it was not possible to achieve this goal.

SUMMARY OF POINTS FOR FURTHER EXPLORATION

The main contribution of this analysis is the qualitative depiction of an insider experience of high-level competence. Some aspects of competence depicted here are familiar, but others are less commonly described. These include the interpersonal characteristics seen as reflecting competence and the deep single-site experience with local personalities, processes and agencies that undergirds the expert's ability to work the system on behalf of patients.

The second salient finding is less positive, namely the contrast of the competence development seen in complex care environments to the narrowly-focused, lower-acuity and sometimes truly non-nursing roles taken by many nurses, particularly those less well-educated, within the first five years of practice.

The question to be pursued, if appropriate methodology can be determined, is whether these nurses' departure from acute care is a good or bad thing. Are there in-house supports that might enable some of these nurses to build both competence and coping skills? Or are some licensed nurses not capable of sustaining successful practice in acute care, regardless of orientation and mentoring? Does providing alternate career paths for those who are less intellectually or temperamentally equipped for high-acuity environments promote safety or simply prolong the nursing shortage?

In an ideal world, specialty-specific learning opportunities covering pathophysiology and common treatments would be provided on joining a unit staff, and booster sessions would be regularly offered based on staff's self-identified learning needs. Structures of authority, responsibility and delegation would be uniform for levels of licensure across similar practice sites, enabling delegation and teamwork skills to be transferable across settings. All new nurses would have extended supervision and precepting by a seasoned and expert peer, accompanied by structured time for self-reflection, feedback and skill development planning. Both interpersonal and communication skills, including communication with physicians, and patient care approaches and techniques would be reviewed. These skill development approaches may enable less-prepared nurses to develop and sustain competence in today's complex care environments.

APPENDIX A: POST-ENTRY STUDY QUESTIONS

SURVEY 1

1. Question: What type of basic nursing education program did you attend, i.e., associate degree, baccalaureate degree, diploma, or other?

2. Are you currently enrolled in any educational program or have you attained any educational degrees (nursing or non-nursing) since graduating from your nursing education program?

3. Question: What nursing license do you hold, i.e., LPN or RN or both?

4. Question: If you are currently an RN, were you previously an LPN; and how long were you an LPN?

5. Question: How many months or years have you held your LPN or RN license?

6. Question: How many nursing positions have you held? Please list in chronologic order (starting with your first position and ending with your current position) the type of positions you held, the type of facility they were in and the length of time you held the positions.

SURVEY 2

1. Please describe the levels of nursing personnel who provide patient/client care in your work setting. Specifically, what parts of the care (the parts that you are responsible for) do you do? Is there a supervisor/manager/charge nurse to whom you report during the shift? What types of information do you report to that person and how often? What parts of the care are done by nursing assistive personnel? Who decides which parts of the care will be done by assistive personnel? Are you responsible for the care provided by assistive personnel or practical (or vocational) nurses?

2. Think back to your last typical workday. Consider the care you provided to one specific client and describe how you identified one (or more) need(s) your client had. How did you know about the need(s)? Please describe how you proceeded to address the need(s) (including any referrals you made, any resources you used, any help you sought, etc.). Include your thoughts and actions and communications with others as pertinent. What were the outcomes of your action?

3. In the situation you described for question # 2:
   a. How did you determine the "truth" about what was going on?
   b. What did you hope would be the result of the action you took?
   c. Did you discuss this situation with anyone else?
   d. Could you have done something differently?

SURVEY 3

1. Please describe the levels of nursing personnel who provide patient/client care in your work setting. Specifically, what parts of the care (the parts that you are responsible for) do you do? Is there a supervisor/manager/charge nurse to whom you report during the shift? What types of information do you report to that person and how often? What parts of the care are done by nursing assistive personnel? Who decides which parts of the care will be done by assistive personnel? Are you responsible for the care provided by assistive personnel or practical (or vocational) nurses?

2. Think back to your last typical workday. Consider the care you provided to one specific client and describe how you identified one (or more) need(s) your client had. How did you know about the need(s)? Please describe how you proceeded to address the need(s) (including any referrals you made, any resources you used, any help you sought, etc.). Include your thoughts and actions and communications with others as pertinent. What were the outcomes of your action?

3. In the situation you described for question # 2:
   a. How did you determine the "truth" about what was going on?
   b. What did you hope would be the result of the action you took?
   c. Did you discuss this situation with anyone else?
   d. Could you have done something differently?

SURVEY 4

1. Describe a recent challenging situation involving a client (or clients) with an unmet need. Please include the way you identified the problem or need, including the information you collected, and what occurred after you identified it. I

What, if anything, would you have done differently than the nurse in this case?

3. The following is a case study reflecting a real-life nursing situation. Passages identifying assessment data, actions, conclusions and outcomes have been numbered. After the case study you will be asked a set of questions, some of which will ask you to select appropriate passages. Please read each question carefully and select the numbers of only those passages that pertain to the question. You will also be asked to write an answer to a question, please write your answer legibly in the space provided.

The nurse, working in a rehabilitation facility, [1] entered a patient's room at midnight and found the pt. nearly unresponsive. The [2] pt. was a 57-year-old male client [3] recovering from a multi-vessel coronary artery bypass graph surgery (he was 14 days post-op) and he [4] had been diagnosed with adult-onset diabetes at the age of 30 and was insulin-dependent. The [5] pt. was drooling, and he [6] responded with incoherent answers when the nurse asked questions to see if he was oriented. He was [7] lying slumped down on the bed with his feet hanging over the end. [8] He had sweat beads on his face and was cold to the touch. [9] The nurse thought his blood sugar might be too low as she [10] noticed an HS snack untouched on his bedside table. [11] The nurse got the accucheck machine and [12] his blood sugar was 27. [13] The nurse then called the Lab tech for a stat recheck and [14] notified the doctor. The [15] nurse gave the pt. the ordered stat infusion of high dose glucose and [16] that brought his sugar up to a normal level. [17] As a follow-up to the situation, the nurse passed along to day shift nurses how fast this patient can drop and to keep an eye on him.

Following are the numbers of passages describing actions taken by the nurse. Please circle the number(s) of the passages of actions you believe were correct based on the information in the case study.

11 13 14 15 17

For each of the actions (11, 13, 14, 15, 17) please record the numbers of one to three of the passages that support your decision that the action either was or was not the correct action within the circumstances. Passage numbers may be used to support your decisions about multiple actions.

Action number 11 _____ _____ _____

Action number 13 _____ _____ _____

Action number 14 _____ _____ _____

Action number 15 _____ _____ _____

Action number 17 _____ _____ _____

The following passages describe circumstances possibly influencing the patient's condition or the outcome of the situation. Rank the following passages according to potential or actual impact on the patient's safety by placing a 1 beside the circumstance with the most influence on the patient's safety, a 2 beside the next most influential, etc.

1 _____ 4 _____

2 _____ 10 _____

3 _____ 12 _____

What, if anything, would you have done differently than the nurse in this case?

4. The following is a case study reflecting a real-life nursing situation. Passages identifying assessment data, actions, conclusions, and outcomes have been numbered. After the case study you will be asked a set of questions, some of which will ask you to select appropriate passages. Please read each question carefully and select the numbers of only those passages that pertain to the question. You will also be asked to write an answer to a question, please write your answer legibly in the space provided.

Pt. is a [1] 10 year old [2] child that had suffered a severe brain injury at 3 years of age. [3] The pt. had been admitted to the hospital's pediatric unit 10 days ago with a mild case of pneumonia. The night RN reported [4] pt. had had several instances of bleeding from old gastric tube (GT) site during the night. [5] First thing in the morning the pt.'s mother removed the wound dressing and called the nurse. The nurse observed quite a bit of blood present (1/2 saturated abdominal pad and wet-to-dry dressing). [6] Minutes later with nurse still in the room the pt. began coughing, turned pale and failed to regain color once the mucus plug cleared. [7] The nurse concluded the patient was pale due to low red blood cells from the bleeding. [8] The patient continued to cough and the [9] nurse gave a PRN dose of cough suppressant [10] fearing continued coughing would increase the bleeding. [11] The nurse called the doctor for assessment and to get a hemotacrit (HCT) order. The doctor arrived 15 minutes later as the [12] nurse was setting up monitoring equipment for O2 sat and respirations/heart rate. [13] The doctor ordered a HCT that came back at 19.8. [14] The patient's O2 sat was 85. The doctor ordered, and the [15] nurse transfused, one unit of packed red blood cells (PRBC). [16] The doctors used silver nitrate sticks to cauterize edges of wound. [17] The nurse repacked the wet-dry dressing tightly. [18] A repeat CBC was drawn once infusion of PRBCs was complete and showed a HCT in the mid-20s.

Following are the numbers of passages describing actions taken by the nurse. Please circle the number(s) of the passages of actions you believe were correct based on the information in the case study.

9 11 12 15 17

For each of the actions (9, 11, 12, 15, 17) please record the numbers of one to three of the passages that support your decision that the action <u>either was or was not</u> the correct action within the circumstances. Passage numbers may be used to support your decisions about multiple actions.

Action number 9 _____ _____ _____

Action number 11 _____ _____ _____

Action number 12 _____ _____ _____

Action number 15 _____ _____ _____

Action number 17 _____ _____ _____

The following passages describe circumstances possibly influencing the patient's condition or the outcome of the situation. Rank the following passages according to potential or actual impact on the patient's safety by placing a 1 beside the circumstance with the most influence on the patient's safety, a 2 beside the next most influential, etc.

3 _____ 13 _____

5 _____ 14 _____

8 _____ 16 _____

What, if anything, would you have done differently than the nurse in this case?

5. The following is a case study reflecting a real-life nursing situation. Passages identifying assessment data, actions, conclusions, and outcomes have been numbered. After the case study you will be asked a set of questions, some of which will ask you to select appropriate passages. Please read each question carefully and select the numbers of only those passages that pertain to the question. You will also be asked to write an answer to a question, please write your answer legibly in the space provided.

When making a home visit to a [1] 72 year old pt. with a [2] diagnosis of coronary artery disease (CAD) and congestive heart failure (CHF) the nurse found the [3] pt. complaining of being nauseated and slightly dizzy for the past 24 hours. [4] Her skin and mucous members were dry, she [5] reported passing very little dark-colored urine and her [6] ankles were swollen due to being in a dependent position. [7] The pt. was afebrile. [8] The nurse called and got an order for an anti-emetic and made sure the pt. had a dose and then [9] encouraged her to increase her fluid intake. [10] The nurse then called the pt.'s daughter and asked her to look in on her mother several times that day. [11] About five hours later the pt.'s daughter called the nurse reporting that her mother had become short of breath while sitting and that her legs were now swollen up to her knees. The nurse returned to assess the pt. and [12] found her with a high pulse rate and crackles in her lungs. [13] The nurse concluded the pt.'s flu-type virus must have exacerbated her CHF and [14] arranged for the pt. to be taken to the ER.

Following are the numbers of passages describing actions taken by the nurse. Please circle the number(s) of the passages of actions you believe were correct based on the information in the case study.

8 9 10 14

For each of the actions (8, 9, 10, 14) please record the numbers of one to three of the passages that support your decision that the action either was or was not the correct action within the circumstances. Passage numbers may be used to support your decisions about multiple actions.

Action number 8 _____ _____ _____

Action number 9 _____ _____ _____

Action number 10 _____ _____ _____

Action number 14 _____ _____ _____

The following passages describe circumstances possibly influencing the patient's condition or the outcome of the situation. Rank the following passages according to potential or actual impact on the patient's safety by placing a 1 beside the circumstance with the most influence on the patient's safety, a 2 beside the next most influential, etc.

2 _____ 6 _____ 12 _____

3 _____ 7 _____

4 _____ 11 _____

What, if anything, would you have done differently than the nurse in this case?

6. T

and select the numbers of only those passages that pertain to the question. You will also be asked to write an answer to a question please write your answer legibly in the space provided.

A Certified Nursing Assistant [1] (CNA) told the charge nurse that one of the relatives was asking if the had a change in medication. [2] The nurse went to speak with the relative and told her that she was not aware of any change in meds, but that she would check the Medication Administration Record/chart to see for sure. [3] But first the nurse performed a head to toe assessment of the [4] The nurse found the resident very clammy and pale with increased confusion. [5] There was new edema in ankles, [6] pulse was up and irregular, respirations were 24-26 with some difficulty, [7] lung sounds were wet and crackles were heard in all lobes. [8] resident was unable to stand. [9] The nurse put the head of the bed down so she could check his skin for any breakdown, bruises, cuts, etc and listen to his B/S. [10] The was flat for approximately minutes when he began to aspirate on his own fluid. [11] The nurse called for help from the other nurses, called EMS MD and hospital and gave report on condition, filled out transfer forms and collected all needed info.

Following are the numbers of passages describing actions taken by the nurse. Please circle the number(s) of the passages of actions you believe were correct based on the information in the case study.

2 3 9 11

For each of the actions (2, 3, 9, 11) please record the numbers of one to three of the passages that support your decision that the action either was or was not the correct action within the circumstances. Passage numbers may be used to support your decisions about multiple actions.

Action number 2 _____ _____ _____

Action number 3 _____ _____ _____

Action number 9 _____ _____ _____

Action number 11 _____ _____ _____

The following passages describe circumstances possibly influencing the patient's condition or the outcome of the situation. Rank the following passages according to potential or actual impact on the patient's safety by placing a 1 beside the circumstance with the most influence on the patient's safety, a 2 beside the next most influential, etc.

4 _____ 7 _____

5_____ 8 _____

6 _____ 10 _____

What, if anything, would you have done differently than the nurse in this case?

SURVEY 8

1. Describe a recent challenging situation involving a client (or clients) with an unmet need. Please include the way you identified the problem or need, including the information you collected, what occurred after you identified it including what you did to resolve the need. Include all your thoughts and actions, communications with others, care planning and any equipment or other resources used (including assistance from others) as pertinent. What were the outcomes of your actions?

SURVEY 12

1. Describe a recent challenging situation involving a client (or clients) with an unmet need. Please include the way you identified the problem or need, including the information you collected, what occurred after you identified it including what you did to resolve the need. Include all your thoughts and actions, communications with others, care planning and any equipment or other resources used (including assistance from others) as pertinent. What were the outcomes of your actions?

2. Think about the client situation you described in Question 1. Can you see any effect of the nursing shortage on what happened in that particular situation? Do you feel an effect of the shortage in your work in general? If changes in nursing staffing levels have affected you, please give some examples of the impact on the care you are able to provide.

SURVEY 13

1. Describe a recent challenging situation involving a client (or clients) with an unmet need. Please include the way you identified the problem or need, including the information you collected, what occurred after you identified it including what you did to resolve the need. Include all your thoughts and actions, communications with others, care planning and any equipment or other resources used (including assistance from others) as pertinent. What were the outcomes of your actions?

2. In the situation above, where did you feel your greatest lack of knowledge or skill? Many experienced RNs still feel a need for continued learning or insight in one area or another. Can you identify a topic or kind of situation you would like to know more about and where you might gain that additional knowledge or experience?

SURVEY 14

1. Describe a recent challenging situation involving a client (or clients) with an unmet need. Please include the way you identified the problem or need, including the information you collected, what occurred after you identified it including what you did to resolve the need. Include all your thoughts and actions, communications with others, care planning and any equipment or other resources used (including assistance from others) as pertinent. What were the outcomes of your actions?

2. In the situation above, what was your thinking about being part of a team to deliver health care? Did you pull in members of your own nursing team or other professions, or decide not to do so? Have you noticed any changes in your experiences of teamwork over your time as a professional nurse?

SURVEY 15

1. Describe a recent challenging situation involving a client (or clients) with an unmet need. Please include the way you identified the problem or need, including the information you collected, what occurred after you identified it including what you did to resolve the need. Include all your thoughts and actions, communications with others, care planning and any equipment or other resources used (including assistance from others) as pertinent. What were the outcomes of your actions?

SURVEY 19

1. Please think of yourself or a colleague whom you consider to be a highly competent nurse. What characteristics or behaviors come to mind that show this person to be highly competent?

2. Please give one or two examples of recent situations that showed your competence as an experienced nurse.

3. As you move ahead in your career, what knowledge or skills who you like to improve?

4. If you foresee a change in job or career in the next few years, what would that be?

SURVEY 20

1. What changes have you personally observed in the U.S. health care system since your nursing licensure?

2. What kinds of new skills or competencies, if any, will nurses need over the next 5 years?

3. What do you see as your most important skills or competencies as a nurse? Please give an example or two of patient care situations that showed these skills.

4. What kind of role or work setting would you like to be in 5 years from now, and why?

APPENDIX B: POST ENTRY STUDY INTERIM FINDINGS 2002-2004

Interim Findings: Delegation

As cross sectional data have been analyzed, delegation has been identified as a key area to study because of the frequency of responses relating incidences or issues and because of the potential of unsafe care described in the narratives. The themes that have emerged in the area of delegation include:

Nurses do not feel accountable for the care provided by others;

Tasks are assigned instead of delegated to assistive personnel; and

Newly licensed nurses are not prepared to manage assistive personnel.

Examples of narratives that support these findings follow:

The charge n rse is the one ho assigns patients to the n rsing assistants and e di ide p the patients to chart on.

The charge n rse assigns most d ties, b t e are generall one big team that tries to help each other o t hene er and here er possible. The To[(he t-93(1he o24p)18(e)ichar) hat happene on her shift, b t each of s p ts o r license to scr tin , no matter hat the task or ho it p.

The charge n rse in some deg[decides the care assisti e personnel ill gi e]. Assisti e personnel also ol nteer on their o n accord to help compromised patients.

The facilit has a man al that states hat the can and cannot do.

The staff n rse delegates d ties that do not req ire critical thinking.

The doctors and n rses are the ones ho decide hich care is done b hat personnel.

The LPN/VNs ha e set tasks the perform and do so itho t direction nless additional req ests b the RN are made.

When I rst came to m present job, I had se eral fr strations ith some of the assisti e personnel; ma be beca se I e pected them to do their job and be ants to meet the patients needs at the soonest time possible. I co ld not tolerate seeing them j st sitting and not ans ering call lights promptl . For some time, I ha e felt like nothing can be done to those of them ho o ld t rn patients hapha ardl , sometimes p lling o t IV lines.

It seems to be er dif c lt to keep track of hat the do. The n rse managers ha e a hard time s per ising