How to create a skills intensive program for novice nurses

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Why leaders need to rethinking how they train novice nurses

Novice nurses have always developed their clinical skills and knowledge over time through organizational training, unit-based education, direct patient care, and nurse-to-nurse feedback. But as care complexity increases, novice nurses have a shorter ramp-up time because there are fewer "easy patients" to assign to them. Put another way, novice nurses have more to learn right away because they're often assigned patients with complex and diverse care needs.

"New RNs can’t start with easy patients anymore because they don’t exist."

Chief Nursing Officer

Source: Nursing Executive Center interviews and analysis.
In response to increasing care complexity, most organizations have expanded their support for new-graduate nurses during their first year of practice. The graphic below represents some of the commonly added supports in the last 10 years, which can be a sizeable investment of time and money.

First-year support for new nurses, 2009 versus 2019

These additional supports are often worth the investment. For example, completing a nurse residency program improves retention and helps new-graduate nurses feel more confident.

To make the case for a nurse residency program, Nursing Executive Center members can visit advisory.com/nec/FirstYearRetention.

Nurse residency programs improve retention, confidence

Findings indicated a new-graduate residency program was associated with a decrease in the 12-month turnover rate from 36.08% to 6.41%.

Residents’ perception of their ability to prioritize work, communicate, and provide clinical leadership showed statistically significant increases over the 12-month program.

One way organizations have tried to help novice nurses deliver more complex care is by adding more skills and competencies to new-graduate nurse orientation. While this was well intentioned, the growing number of skills and competencies new-graduate nurses are now required to learn in their first weeks can be overwhelming and difficult to absorb. Novice nurses often feel the list of skills and competencies they are learning is a “mile wide and an inch deep.”

Given the rising complexity of care delivery, leaders must ensure first-year support helps novice nurses develop clinical competence effectively and quickly.

Keep reading to learn how you help novice nurses focus on select skills and competencies in their first 12 weeks of practice and more effectively build their knowledge over time.

Source: Nursing Executive Center interviews and analysis.
How to create a targeted skills intensive

Practice in brief
Create a short, focused program in which a cohort of new nurses works with a dedicated preceptor to learn and practice select clinical skills prior to taking a patient assignment. The goal is to provide new nurses with hands-on repetition of specific skills before transitioning into independent practice.

Rationale
As a result of the growing list of skills and competencies novice nurses must learn today—and more diverse, complex patients—novice nurses often don’t have enough opportunities to practice each skill with enough repetition to become proficient for all types of patients. By carving out time for hands-on repetition of most critical competencies, novice nurses gain baseline skills before taking a patient assignment.

Implementation components

- **Component 1: Determine which competencies to teach during the targeted skills intensive.**
  Create a list of competencies and related skills that new nurses across all units must learn. Consider competencies that align with quality goals, are common patient care needs, or require hands-on practice. Allow nurse managers to add unit-specific competencies as needed. We recommend selecting no more than 10 total competencies.

- **Component 2: Assign new-graduate nurses to a cohort with a dedicated preceptor.**
  Group three to five new-graduate nurses working on similar units into a cohort with one dedicated preceptor. The nurse cohort and dedicated preceptor work together for the duration of the intensive.

- **Component 3: Equip dedicated preceptor to teach one competency per shift.**
  During each 8-hour shift, the dedicated preceptor teaches one competency and then supervises as the cohort practices associated skills with patients on the unit. The cohort and preceptor are excluded from patient assignment. Unit staff help the dedicated preceptor identify the right patients at the beginning and throughout the shift, as needed.

- **Component 4: Transition new nurses to their assigned unit.**
  Transition new nurses to their assigned unit after completing the intensive. The dedicated preceptor shares individual nurse performance with unit-based staff—such as the unit manager, individual preceptor, and unit-based educators—to ensure a smooth transition.

Practice assessment
This practice requires up-front investment to revamp the preceptor model and train unit staff on the change. In addition, there may be moderate ongoing staffing costs, as the dedicated preceptor must be removed from patient assignment. However, organizations may see a return on this investment through quality improvements and a reduction in early nurse turnover. While this practice can be implemented at most organizations, it is particularly beneficial for organizations that hire large cohorts of new nurses or those that do not have a nurse residency program.

Nursing Executive Center grades:
Practice impact: A
Ease of implementation: B
Limited opportunities to master key skills

With more diverse and complex patients, new-graduate nurses have limited opportunities to practice their emerging clinical skills with enough repetition to become proficient for all types of patients. As a result, nurses often learn a skill the first time with one type of patient, but have limited practice before applying that skill on different, and potentially much more complex patients. See the representative scenario below.

**Representation of new RN learning patient ambulation over six weeks**

<table>
<thead>
<tr>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Week 5</th>
<th>Week 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preceptor models ambulation with a 65-year-old post-op patient</td>
<td>RN ambulates a 45-year-old cardiac patient independently</td>
<td>RN ambulates 88-year-old medical patient and preceptor observes</td>
<td>RN ambulates 32-year-old post-op patient independently</td>
<td>RN incorrectly ambulates 77-year-old stroke patient, resulting in a fall</td>
</tr>
</tbody>
</table>

To address this problem, Indiana University Health Methodist and University Hospitals, a 1,256-bed hospital, created a short, focused program in which a cohort of new nurses works with a dedicated preceptor to learn and practice select clinical skills prior to taking a patient assignment. This targeted skills intensive provides new nurses with hands-on repetition of specific skills before transitioning into independent practice.

The components of this practice are detailed on the following pages.

Source: Nursing Executive Center interviews and analysis.
Component 1: Determine what to teach during the targeted skills intensive.

First, determine which competencies to teach during the targeted skills intensive. To do this, create a list of competencies that new nurses across all units must learn, and allow nurse managers to add unit-specific competencies as needed.

Consider competencies that align with quality goals, address common patient care needs, or require hands-on practice. We recommend no more than 10 total competencies. If needed, use the questions below to narrow the list.

- What competencies are you teaching most frequently?
- What competencies do novices nurses find most challenging?
- What competencies are related to your priority quality metrics?

At Indiana University Health, leaders identified six organization-wide competencies to include in the intensive, shown below. In addition, nurse managers had the option to add unit-specific competencies. As shown here, some managers added unit-based competencies while other managers did not.

Sample competencies for three inpatient units at Indiana University Health

<table>
<thead>
<tr>
<th>Intensive care unit</th>
<th>Progressive care unit</th>
<th>Medical/surgical unit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organization-wide competencies</strong></td>
<td><strong>Organization-wide competencies</strong></td>
<td><strong>Organization-wide competencies</strong></td>
</tr>
<tr>
<td>- Patient safety</td>
<td>- Patient safety</td>
<td>- Patient safety</td>
</tr>
<tr>
<td>- Medication and blood administration</td>
<td>- Medication and blood administration</td>
<td>- Medication and blood administration</td>
</tr>
<tr>
<td>- IV, phlebotomy, CLABSI</td>
<td>- IV, phlebotomy, CLABSI</td>
<td>- IV, phlebotomy, CLABSI</td>
</tr>
<tr>
<td>- Respiratory care</td>
<td>- Respiratory care</td>
<td>- Respiratory care</td>
</tr>
<tr>
<td>- Glucose management</td>
<td>- Glucose management</td>
<td>- Glucose management</td>
</tr>
<tr>
<td>- CAUTI/skin</td>
<td>- CAUTI/skin</td>
<td>- CAUTI/skin</td>
</tr>
<tr>
<td><strong>Unit-specific competencies</strong></td>
<td><strong>Unit-specific competencies</strong></td>
<td><strong>Unit-specific competencies</strong></td>
</tr>
<tr>
<td>- ECG interpretation</td>
<td>- ECG interpretation</td>
<td>- ECG interpretation</td>
</tr>
<tr>
<td>- Advanced safety and emergency care</td>
<td>- Trachea care</td>
<td></td>
</tr>
<tr>
<td>- Unit-specific population</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The next page shares a representative sample list of associated skills that Indiana University Health uses to teach their competencies.
Once you have identified the competencies to teach during the targeted skills intensive, create a list of associated skills to teach. For example, at Indiana University Health, the IV, phlebotomy, and CLABSI competency includes seven related-skill, which are outlined here.

Skills taught during IV, phlebotomy, and CLABSI shift at Indiana University Health

<table>
<thead>
<tr>
<th>Organization-wide competencies</th>
<th>IV, phlebotomy, CLABSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient safety</td>
<td>• CLABSI rounds</td>
</tr>
<tr>
<td>• Medication and blood</td>
<td>• Central line dressing changes</td>
</tr>
<tr>
<td>administration</td>
<td>• IV infusion pump</td>
</tr>
<tr>
<td>• IV, phlebotomy, and CLABSI</td>
<td>• Blood draws</td>
</tr>
<tr>
<td>• Respiratory care</td>
<td>• IV start</td>
</tr>
<tr>
<td>• Glucose management</td>
<td>• IV priming and tubing changes</td>
</tr>
<tr>
<td>• CAUTI/skin</td>
<td>• Documentation of completed tasks</td>
</tr>
</tbody>
</table>

Indiana University Health’s other curriculums are also available online at advisory.com/nec/ExperienceComplexityGap.
Create cohorts to maximize preceptor impact

Component 2: Assign new-graduate nurses to a cohort with a dedicated preceptor.

Next, assign a small group of new-graduate nurses working on similar units to a cohort with one dedicated preceptor. The nurse cohort and dedicated preceptor work together for the duration of the intensive.

At Indiana University Health, each cohort includes three to five new-graduate nurses led by one unit preceptor, depicted in the graphic. Every cohort works together for one or two weeks, depending on the type of unit, while they learn select core competences. The length of the intensive varies across units because it is based on the total number of competencies. For example, at Indiana University Health, the ICU intensive runs nine days while the medical/surgical intensive is only six days.
Component 3: Equip dedicated preceptor to teach one competency per shift.

Each preceptor should teach one competency and the related skills during an eight-hour shift. The dedicated intensive preceptor teaches one competency and then supervises as the cohort practices associated skills with patients on the unit.

To make this happen, the cohort and preceptor are excluded from patient assignment. The cohort is covered by orientation hours, while the preceptor’s time comes out of the unit budget. In addition, unit staff help the preceptor identify the right patients at the beginning and throughout the shift, as needed. Use the guidance below to help coordinate communication and collaboration between unit staff.

At Indiana University Health, preceptors and managers alert unit nurses to each daily competency during morning huddles. To provide a visual reminder of the competency of the day, managers also post flyers on the unit. In return, nurses notify preceptors when they encounter patient care related to the competency so the cohort can practice providing that care.

### How preceptors and unit RNs coordinate on targeted skills intensive days

<table>
<thead>
<tr>
<th>Unit RNs alerted to competency of the day by preceptor and manager</th>
<th>RNs notify preceptor when patient care is related to competency of the day</th>
<th>RN cohort provides patient care related to competency of the day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preceptor posts flyers with competency of the day at beginning of shift; manager announces at morning huddle</td>
<td>Preceptor notified at morning huddle and available via cell phone during shift</td>
<td>New RNs and preceptor complete patient care activities and communicate any additional care needs to RN</td>
</tr>
</tbody>
</table>

At Indiana University Health, once patients are identified, preceptors ask for patient permission and explain that this is a teaching moment before bringing the new-graduate in to provide care. Patients have been receptive to this model. Finally, to prevent any lapses in care, the new graduates and their preceptor communicate any additional care needs back to the nurse assigned to each patient.
Component 4: Transition new nurses to their assigned unit.

After completing the training skills intensive, new nurses transition to their assigned units. There are two elements that facilitate a warm hand-off to the unit preceptor, shown here.

Key elements of warm hand off to unit preceptor

- **Ongoing check-ins with intensive preceptor, unit manager and educator**

  Intensive preceptor, unit educator, and manager check in every other week during the intensive to discuss RNs' progress.

- **Smooth transition from intensive preceptor to unit-based preceptor**

  Unit manager or educator meets with unit preceptor prior to hand off and discusses intensive performance, individual development areas.

To help preceptors effectively transition new graduates to their assigned units, leaders at Indiana University Health created a preceptor hand off tool. Preceptors rate each new-graduate on a scale of 1 to 5, indicating their independence on each set of skills taught. The purpose of this tool is to share clear and standardized feedback with both new graduates and their unit-based staff.

Indiana University Health’s full preceptor hand off tool and other program materials are available online at advisory.com/nec/ExperienceComplexityGap.

To access the Nursing Executive Center’s ready-to-use hand off tool, visit advisory.com/nec/preceptortoolkit.
Indiana University Health’s targeted skills intensive has been a successful strategy to accelerate novice nurses’ path to competent by dedicating time to master basic, but essential, skills. Despite onboarding nearly 700 nurses in 2017 and 2018, Indiana University Health simultaneously had a 49% decrease in harm events. Additionally, this program has attracted more new-graduate nurses to apply for jobs at the system. The results shown below emphasize the value of this program.

**DATA SPOTLIGHT**

**Continued quality gains with an influx of new-graduate RNs**

<table>
<thead>
<tr>
<th>Number of new-graduate RNs on boarded through the targeted skills intensive</th>
<th>Decrease in harm events at Indiana University Health despite influx of new RNs</th>
</tr>
</thead>
<tbody>
<tr>
<td>700</td>
<td>49%</td>
</tr>
</tbody>
</table>

**Benefits of the targeted skills intensive**

- New RNs more prepared to deliver patient care during unit orientation
- Fewer unit orientation extensions after implementing intensive
- New RNs able to care for higher acuity patients in less time
- Increased number of new-graduate RN applicants after implementing the intensive

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2. From 2015-2017; decrease in harm events attributed to multiple interventions within IU Health.
3. According to preceptor feedback.

Source: Nursing Executive Center interviews and analysis.

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Practice 3: Unit-based learning intervals

Practice in brief
New-graduate nurses learn sets of related competencies by rotating through intervals of education and clinical practice. The goal is to break down learning into smaller components to help new nurses focus on and master related clinical competencies.

Rationale
New-graduate nurses often care for many types of patients when they transition to practice. As a result, they must learn a large number of diverse clinical competencies at one time. Because there is a limited amount of information any individual can effectively learn at once, nurses may struggle to retain key information. By breaking down large amounts of clinical information into smaller learning intervals, leaders can help new-graduate nurses master subsets of competencies and effectively build competency over time.

Implementation components

- **Component 1: Create competency bundles.**
  Prioritize the most common patient conditions seen on a unit and determine the clinical competencies required to care for each patient group.

- **Component 2: Use orientation hours to teach one competency bundle.**
  Teach new nurses the competencies in one bundle before moving to the next. Education should include: didactic sessions reviewing relevant protocols or procedures and unit-based work with a preceptor. New nurses should remain out of staffing assignment, using orientation hours to cover the time.

- **Component 3: Rotate new nurses to clinical practice with associated patient group.**
  Assign new nurses patients who are associated with one competency bundle. New nurses should work with the patient group for at least 2 weeks to allow sufficient time to practice new competencies. Unit managers track new nurse performance, adjusting the interval timeline for maximum exposure and clinical practice as needed.

- **Component 4: Unit managers flag when new nurses are ready to move to the next competency bundle.**
  Unit managers determine when new nurses are ready to begin the next competency bundle. New nurses then rotate back to orientation hours and repeat components 2 and 3. This process continues until the nurse completes all competency bundles for the unit.

Practice assessment
This practice is an effective way to help new nurses master competencies faster. It is best for organizations that onboard small cohorts of nurses at one time, because unit leaders need to track individual competency development to effectively rotate nurses through the learning intervals. This practice can also be applied to experienced nurses transferring to a new unit.

Source: Nursing Executive Center interviews and analysis.
Breaking up information into bite-sized pieces improves novice nurses’ comprehension of material and ability to retain information. This is substantiated by research conducted by George Miller, a psychology professor at Harvard. He proposed two relevant theories, shown here. First, cognitive load theory indicates that an average person can retain seven pieces of information at a time. Second, “chunking theory” proposes that breaking information into bite-sized pieces allows individuals to retain more than seven pieces of information while improving comprehension and long-term retention.

**Learning theories in brief**

**Cognitive load theory**
There is a limit to the amount of information that individuals can comprehend and convert to long-term knowledge.

**“Chunking” theory**
Breaking information into bite-sized pieces helps increase the amount of information that can be comprehended and converted to long-term knowledge.

Novice nurses often care for many types of patients when they transition to practice. As a result, they must learn a large number of diverse clinical competencies at one time. Because there is a limited amount of information any individual can effectively learn at once, nurses may struggle to retain key information. The following pages provide guidance on how to break down large amounts of clinical information into smaller learning intervals so novice nurses master subsets of competencies and build competency over time.

1. According to George Miller’s 1956 paper, “The Magical Number Seven, Plus or Minus Two: Some Limits on Our Capacity for Processing Information.”

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Education in intervals facilitates learning

Component 1: Create competency bundles

The first part of teaching in competency bundles is to determine what should be in each bundle. At Hospital Sisters Health System (HSHS) Eastern Wisconsin Division1, unit managers have the flexibility to create intervals that best fit their units. They do this in two steps.

First, HSHS categorizes patients on the unit by primary care need. For units with diverse patient populations, such as medical/surgical units, they prioritize the most common patient conditions. Second, HSHS determines the clinical competencies required to care for each patient group.

Examples of clinical intervals at HSHS in four areas are shown below.

Sample clinical intervals

<table>
<thead>
<tr>
<th>Emergency</th>
<th>Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Urgent</td>
<td>• Vascular</td>
</tr>
<tr>
<td>• Non-urgent</td>
<td>• Hip and knee</td>
</tr>
<tr>
<td>• Critical</td>
<td>• General</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Med/surg</th>
<th>Woman/infant</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cardiac</td>
<td>• Postpartum</td>
</tr>
<tr>
<td>• Post-procedural</td>
<td>• Labor</td>
</tr>
<tr>
<td>• Oncology</td>
<td>• Delivery</td>
</tr>
</tbody>
</table>

1. Four hospitals within the Hospital Sisters Health System in Wisconsin.

Source: Nursing Executive Center interviews and analysis.
Putting clinical intervals into action

The next three components describe how to execute learning-based intervals across nurse onboarding.

Component 2: Use orientation hours to teach one competency bundle.

HSHS uses dedicated and existing orientation hours to train nurses during the onset of each interval. New nurses receive didactic instruction and unit orientation on key competencies prior to longer periods of related clinical practice. Managers do not staff new nurses while they receive training during dedicated orientation hours.

Education options include didactic sessions reviewing relevant protocols or procedures, as well as unit-based work with a preceptor.

Component 3: Rotate new nurses to clinical practice with associated patient group.

Next, HSHS assigns new nurses to patients whose care is associated with a competency bundle. New nurses should work with the patient group for at least 2 weeks to allow sufficient time to practice new competencies. Unit managers track new nurse performance, adjusting the timeline for maximum exposure and clinical practice as needed.

Component 4: Unit managers flag when new nurses are ready to move to the next competency bundle.

At HSHS, managers have discretion over when new nurses are ready to progress. Once their manager signs off, new nurses rotate back to orientation hours to learn the next competency bundle. This process continues until the nurse completes all competency bundles for the unit.

The graphic below depicts how HSHS puts this practice together. For example, on the women and infants unit, a novice nurse begins with a day of postpartum didactic instruction, spends two weeks with a postpartum preceptor, and finishes the interval working exclusively with postpartum patients for three weeks. After managers sign off, novice nurses move to labor before ending in delivery.

Representative RN onboarding to women and infant unit at HSHS Eastern Wisconsin

The next page describes key considerations for developing unit-based learning intervals.

Source: Nursing Executive Center interviews and analysis.
This practice is an effective way to help novice nurses master competencies quickly, but it requires flexibility in three areas.

The first is flexibility with which competencies to target. To drive skill mastery, managers should have the flexibility to tailor the competencies to a nurse’s knowledge base and the patient populations most commonly seen on the unit.

The second is having flexible timelines for movement across intervals. Managers decide when novice nurses are ready to move to their next interval or competency. This decision is based on both individual performance and whether nurses have seen the right type of patients to master key skills. Managers can extend interval times for individual nurses if needed.

The third is flexible utilization of orientation hours. Orientation hours are spread out across all intervals. The preliminary orientation is short, and remaining orientation hours are used with preceptors at the beginning of each interval.

Key considerations for development of Unit-Based Learning Intervals

- **Scoped core competencies**: Managers select specific competencies and related patient assignments to support nurse in mastering competency.
- **Flexible timelines based on RN needs**: Managers decide when a new RN is ready to move on to the next phase based on individual performance.
- **Budgeted orientation and staffing hours**: New RNs use orientation hours on days spent with a preceptor, so as not to negatively impact productivity.1

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1. Total orientation hours used per new RN remain consistent with previous orientation model.

Source: Nursing Executive Center interviews and analysis.
Intervals foster holistic learning, critical thinking

HSHS has received positive feedback from preceptors and new graduates about the program’s impact on skill development, confidence, and critical thinking. Here is a selection of feedback HSHS has received.

Preceptor and new RN feedback on unit-based learning intervals

“Intervals foster holistic learning, critical thinking. As a preceptor, I feel this process is beneficial to new nurses so they can focus on clinical judgment and critical thinking, not just skill development.”

Preceptor

“This is a great way to orient a new nurse. Rather than orienting on a wide variety of patients and skills, we can dedicate our time to specific skills and really learn about the patients on our unit.”

Preceptor

“I like the continual learning and building on experiences. I became ‘good’ at some things before moving on to new patients.”

New-graduate RN

“The process worked well for me to focus on a particular patient population. It made my orientation a good experience. I became confident in my nursing skills sooner.”

New-graduate RN

Source: Nursing Executive Center interviews and analysis.
Preceptors are key to effectively teaching novice nurses

Preceptors play a critical role in nursing clinical education. They assess a new nurses’ ability to manage a patient assignment, provide direct supervision and coaching, and offer timely feedback. Yet few organizations have revisited their preceptor program to account for two emerging challenges. The first challenge when it comes to teaching novice nurses is that there is wide variation in the way that preceptors teach standards. The graphic below shows how differently preceptors teach CLABSI protocol. As a result, it’s harder for novice nurses to learn standards correctly—which can delay their progression to competent.

Representation of preceptor variation, CLABSI protocol

Preceptor 1
- Reviews CLABSI protocol with RN
- Teaches RN optimal IV placement
- Assists RN with first dressing change; walks through correct EHR documentation

Preceptor 2
- Does not review CLABSI protocol with RN
- Teaches RN optimal IV placement
- Assists RN with first dressing change; incorrectly documents in EHR

Preceptor 3
- Reviews CLABSI protocol with RN
- Does not teach RN optimal IV placement
- RN changes dressing alone; incorrectly documents in EHR

24% Of surveyed new RNs¹ reported seeing preceptors contradict best practice

¹ n = 276 new nurses surveyed.

Source: Krautscheid L. "Moral Distress and Associated Factors among Baccalaureate Nursing Students: A Multi-Site Descriptive Study," Nursing Education Perspectives, 38, no. 6 (2017): 313-319; Nursing Executive Center interviews and analysis.
Preceptors are often early-tenure nurses

The second challenge when it comes to teaching novice nurses is that preceptors are often new to the job themselves. This is because so many novice nurses are entering the workforce that early-tenure nurses need to act as preceptors.

The limitations of early-tenure preceptors are shown on the left in this graphic. They have finite knowledge, little experience themselves, and are often still refining their own skills. These limitations may account for some of the variation, gaps, and inconsistencies in preceptor teaching.

The good news is there are benefits to having early-tenure preceptors. As shown on the right, they were recently new nurses themselves and can easily remember the novice nurse mind set. As a result, early-tenure preceptors can often breakdown information because they recently learned care delivery steps. This also means the nurses they teach may find them more relatable and approachable than more tenured preceptors.

Limitations of early-tenure preceptors

- Not as knowledgeable about complex care delivery
- Less experienced at evaluating new-graduate competency
- Still refining soft skills, such as patient communication

Strengths of early-tenure preceptors

- More easily relate to the novice RN mind-set
- Similar communication style and norms to novice RNs
- Effective at breaking down care into teachable steps

“Increasingly, our preceptors are younger, with only a few years of experience. We’re losing that pool of that 15-year or 20-year nurse preceptors that we had in the past.”

Director of Clinical Education

Source: Nursing Executive Center interviews and analysis.
Advisors to our work

We are grateful to the individuals and organizations that shared their insights, analysis, and time with us. We would especially like to recognize the following individuals for being particularly generous with their time and expertise.

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Our member CNOs tell us one of their biggest difficulties in overcoming these challenges is bridging the gap between strategy and execution. On one side, some try to just go it alone—and struggle to pick the right solutions for their organization. On the other, cost-prohibitive consulting results in disenfranchised staff, unsustainable results, and low ROI. We fill the need in between by providing multiple levels of support backed by 40 years of best practice research trusted by 1,800 health care organizations. Find out how we help CNOs and nurse leaders drive strategy and get quicker results through customizable, vetted solutions.

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Want to speak with one our experts about how to more effectively teach new-graduate nurses? Contact us at programinquries@advisory.com
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