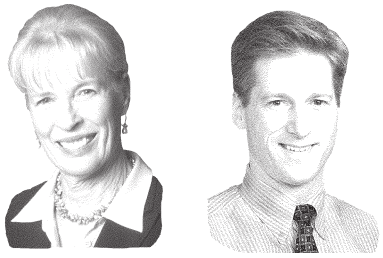
Editorial

Nurse Residency Programs: Preparing for the Next Shift

By Kathleen Dracup, RN, DNSc, and Peter E. Morris, MD



The *Wall Street Journal*, a newspaper usually filled with stories of business mergers and stock market summaries, recently ran an unusual first-person account.[1] The author, a journalist named John Blanton, had worked as a page-one editor for 15 years, but at 40 realized his career did not provide him with a sense of purpose. In 2002 he left his position at the newspaper, where his days were filled with deadlines and talk of the war on terror and Harry Potter. To the surprise of his fellow journalists, he enrolled in an accelerated bachelor of science in nursing (BSN) program.

This journalist's story is increasingly familiar. Accelerated nursing programs are popping up across the country like wildflowers after a spring rain. The new programs are fueled by 3 forces: state legislators' concern about the severity of the current and projected nursing shortage, the documented healthcare needs of an increasingly aged population, and generous media coverage about the opportunities available to nurses. Universities and colleges are expanding their nursing programs to increase the size of graduating classes to accommodate an applicant pool that continues to astound administrators.

The result of the sudden growth in nursing programs combined with nurse vacancy rates that are still in double digits in many parts of the country means a dramatic increase in the number of new RN graduates now coming to work in acute care settings. The number of licensed registered nurses in the United States grew by almost 8% between 2000 and 2004.[2] After a dramatic decrease in enrollments over the previous decade, registered nurses in the United States have climbed to a new high of 2.9 million. Since 2000, approximately 50 000 new nurses passed state board examinations each year; more than half obtained positions in hospitals as new graduates.[2]

This influx of new nurses is key to solving a workforce shortage that is predicted to become worse due to projected retirements. In a survey in 2004, 55% of respondents reported their intention to retire from nursing between 2011 and 2020.[2] This means that in little more than a decade we will see, at minimum, a 50% turnover in the nursing profession. This statistic is chilling in light of the number of new graduates who must be oriented and mentored into a healthcare system that has never been more complex, fragmented, or frustrating. It is even more chilling in light of the special challenges of critical care and the potential harm inadequately prepared and anxious new graduates might cause.

How Do New Nurses Cope?

Blanton, the midlife journalist-turned-nurse, eloquently summarizes his feelings as he assumed the role of a new intensive care unit nurse on the night shift in a busy 20-bed burn unit of a New York

> "In little more than a decade we will see, at minimum, a 50% turnover in the nursing profession."

hospital following graduation and a brief orientation. He lists the tasks involved in caring for 2 or often 3 burn patients each night and describes his feelings as he approached the unit to begin a 12-hour shift that would be filled with dozens, even hundreds of important patient care activities:

> ... I could handle these tasks, barely, so long as the night conformed to my expectations of a normal shift. It rarely did. And I operated in a state of continuous low-grade panic, punctuated by spikes of abject terror. The three or four nights a week when I walked toward the hospital to start my shift, I was gripped with a fear-induced nausea. My breathing quickened. Sweat slicked my palms.
>
> Please, don't let me hurt anyone tonight. Please.[1]

Thousands of new nurses across the country share his experience … and dread. These newly minted nurses graduate from programs in which they typically care for 1 or 2 patients with guidance and support from a faculty member or preceptor, but then they are catapulted into the breathless pace of real-life hospital care. Most nurses remember, decades later, the near-constant panic of those first few months. While they maintain the ideals that led them to the profession, they are overwhelmed by the sheer number of tasks required to care for an acutely ill patient and fearful they could inadvertently harm patients, perhaps seriously or, worst of all, mortally.

Further on in the article, Blanton describes the contrast between his expectations of how he would perform as a critical care nurse and the realities of his experience as a new graduate:

> I wanted to hover over my charges like a jealous hound, alert to the tiniest shifts in their biological function. I talked to my patients, to assess their mental status and their pain, to dispel their fears, to teach them about their conditions and treatments, and to learn details about their lives that might affect healing and recovery beyond the burn unit. But I felt hurried, with little time for the reassuring smile and comforting touch one sees on TV commercials that laud nursing as the caring profession. Most nights, unexpected contingencies unwound the tight choreography of the shift, diagrammed in hourly increments in the sprawling spreadsheets of patients' charts. I lurched from one task to the next, fulfilling all requirements, but little more.[1]

Blanton beautifully depicts the difficulty and level of skill needed in nursing and offers a sense of nurses' true contribution to every patient's care.

Parallels From History

The projection that critical care as a specialty is facing a 50% turnover of nursing staff within the next 10 years may seem daunting until we remember other professions that have faced a sudden infusion of new professionals. One example comes from the airline industry. On August 3, 1981, almost 13 000 members of the Professional Air Traffic Controllers Organization walked off the job after unsuccessful contract negotiations. In response, President Reagan asserted that the strike was a peril to national safety and that the controllers were in violation of a law banning government workers from striking. The controllers were told that if they did not report to work in 48 hours, their jobs would be terminated. Most believed that concern for the safety of the flying public would stop Reagan from carrying out his threat.

To everyone's amazement, however, the striking air-traffic controllers were fired on August 5. More than 11 000 strikers received their pink slips. Twelve hundred of these returned to work within a week and joined the approximately 3000 supervisors, 2000 nonstriking controllers, and 900 military controllers who continued manning airport towers.[3]

How did the Federal Aviation Administration (FAA) respond to losing more than 70% of its licensed and experienced air-traffic controllers? It ordered airlines at major airports to reduce scheduled

About the Authors
Kathleen Dracup is nurse coeditor of the *American Journal of Critical Care*. She is dean of the School of Nursing at the University of California, San Francisco. **Peter E. Morris** is physician coeditor of the *American Journal of Critical Care*. He is an associate professor in the pulmonary, critical care, allergy, and immunologic diseases section of the Department of Medicine at the Wake University School of Medicine, Winston Salem, North Carolina.

> "No planes perished because of the influx of new air-traffic controllers in the field. We must plan so that no patient perishes because of the influx of new nurse graduates."

flights by 50% during peak hours. Nearly 60 small airports had their towers shut down indefinitely. The FAA's Oklahoma City training school, which normally produced 3000 graduates per year, doubled its class sizes. On August 17, 1981, the FAA began accepting applications for new air-traffic controllers (45 000 people applied within 4 weeks of the strike's onset) and the orientation of a new generation of workers in the industry began.[3]

What are the lessons for hospitals and universities related to nursing? Although many aspects of healthcare will continue to move to the outpatient setting, reducing intensive care unit beds is probably not possible. Small hospitals will continue to struggle with the nursing shortage and some may be forced to close their doors, as did small airports. But the major response will be, as it was with the FAA, the education and orientation of a new generation of nurses.

Approaches to Incorporating the Next Generation

How will we ensure that our patients remain safe while inexperienced new graduates perfect their craft? How will we incorporate novices into a complex intensive care environment and support them as they gain experience? How will we prevent burnout? For an increasing number of hospitals, the answer is a residency program that goes beyond the typical new graduate orientation program.

Residency programs are not a new idea. They have been tried over the years, but usually abandoned as soon as hospitals have the luxury of hiring only experienced nurses. Recognizing that this nursing shortage is unique and that the solution lies in preparing thousands (even millions) of new nurses, the University HealthSystem Consortium joined with the American Association of Colleges of Nursing 4 years ago to formalize a new residency program with a curriculum shared by many hospitals.[4] It includes a year-long residency program in the participating clinical settings that takes the novice learner from new graduate to more competent provider.

The results of the evaluation of the first 2 cohorts to "graduate" from the year-long program reflected a marked improvement in the residents' perceptions of their competence, ability to communicate, and satisfaction with their work as acute care–based professional nurses. One of the most important outcomes documented was the retention rate of participants: 89%. This compares to commonly reported turnover rates of 40% to 50% in the first year of employment.[4]

Unfortunately, transition programs are expensive. Unlike medical residency programs that are supported, in part, by Medicare funds, the cost of nurse transition programs must be borne solely by the hospital. In this age of declining reimbursements and higher costs, hospitals often are loath to support the cost of a new graduate residency program. But we believe that hospitals soon will not have a choice. Given considerations of patient safety and the financial cost of high turnover rates, residency programs may be our best answer to the challenge experienced by the airline industry more than 25 years ago. No planes perished because of the influx of new air-traffic controllers in the field. We must plan so that no patient perishes because of the influx of new nurse graduates.

We hope that professional organizations and hospital administrators will lobby to have residency programs such as those developed by the University HealthSystem Consortium supported by Medicare funds. The future of critical care may depend on how we solve this problem. Ask John Blanton: he left nursing and is now back working at the *Wall Street Journal*.

The statements and opinions contained in this editorial are solely those of the coeditors.

FINANCIAL DISCLOSURES
None reported.

REFERENCES
1. Blanton J. Editor finds care, chaos on the night nursing shift. *Wall Street Journal Online*. http://www.careerjournal.com/columnists/perspective/20070426-fmp.html. Accessed April 24, 2007.
2. *The Registered Nurse Population: Findings From the 2004 National Sample Survey of Registered Nurses.* http://bhpr.hrsa.gov/healthworkforce/rnsurvey04. Accessed May 26, 2007.
3. Pels R. The pressures of PATCO: strikes and stress in the 1980s. *Essays in History*. Vol 37. University of Virginia Corcoran Department of History; 1995.
4. *The Registered Nurse Population: Findings From the 2004 National Sample Survey of Registered Nurses.* http://www.aacn.nche.edu/Education/nurseresidency.htm. Accessed May 26, 2007.