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Orientation Experience Tracking							
Communication	☐ SBAR	☐ Bedside hand-off	☐ shift huddle ☐ Calling Provider	☐ Verbal orders - including read back	☐ Text paging	☐ Critical Value Notification	**Other Experiences:**
Tubes/Drains	☐ Chest Tube ☐ Atrium Setup and Exchange	☐ NG/OG/NJ	O2 Devices ☐ NC/High flow NC ☐ Simple mask ☐ NRB mask	Urinary Catheter ☐ Indwelling ☐ In & Out			
Procedures	☐ Informed Consent ☐ Procedural Pause ☐ Moderate Sedation	Gastrointestinal ☐ Minnesota Tube	ETT ☐ Intubation ☐ Suctioning	Invasive Interventions ☐ Thoracentesis ☐ Paracentesis ☐ Lumbar Puncture	☐ Cardiac monitoring ☐ 12 Lead EKG ☐ CPAP ☐ BiPAP		
Care Transitions	Admissions ☐ General Care ☐ Direct Admit ☐ ICU/PCU	Dismissal to ☐ Home ☐ Skilled Facility ☐ CRU	☐ End-of-Life ☐ Bereavement Resources	☐ Pre-op/Pre-procedural			
Lines	☐ Vascular Access Protocol – Adult ☐ Peripheral IV insertion & site care	IVAD (Port) ☐ Site Care	Arterial Catheter ☐ Site Care ☐ Placement ☐ Waveform recognition				
Safety	Off-unit Transport ☐ Cart ☐ Safe patient handling equipment	☐ Isolation Precautions ☐ Emergency Equipment ☐ Hazardous Medication Precautions	☐ Barcode Scanning ☐ IV Pump Library Usage	Patient at Risk for: ☐ Intentional vs Unintentional Harm	Restraints ☐ Violent vs Nonviolent ☐ Seclusion ☐ Restraint chair ☐ Velcro restraints ☐ Cloth restraints	☐ Pre-cleaning and Equipment Transport ☐ MRI Safety (Where applicable)	
Medications/ Pumps	☐ IV Insulin ☐ IV Heparin	Alteplase ☐ Acute Stroke ☐ PE/DVT	☐ IV Pump	☐ Blood Products ☐ Crystalloids versus Colloids	Cardiac ☐ Inotropes ☐ Vasoactive ☐ Antiarrhythmic	☐ Sedation ☐ Paralytics	
Specialty Practice	Specialty Narrator ☐ Trauma ☐ Post Code/Priority ☐ STEMI ☐ Stroke	Patient Type ☐ Sepsis ☐ DKA or HHS ☐ STEMI ☐ Stroke ☐ Trauma ☐ Post Code	☐ Transcutaneous Pacing ☐ Cardioversion	☐ Rapid Infusor and/or Blood/fluid warmer	☐ Crutch training/ education ☐ C-collar	☐ Knee brace ☐ Shoulder immobilizer ☐ Sling	

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Resource Time: Immunizations	Name:

Objectives:

1. Review the resource notebook
2. Reflect on any situations that occurred during your floor time for areas of improvement, breakdowns, or critical incidents.
3. Update Orientation Record and other paperwork to reflect progress of orientation.
4. Analyze resources for immunizations and complete learning activities below.

Immunizations

Resource Finding:

- CDC Immunization Schedules
- Immunization Protocols
- Immunization Guidelines (age-based)
- Immunization Administration Guidelines

Discussion Points:

- Which immunizations can be given in your department?
- Who can give immunizations in your department (scope of practice)?
- Discuss nuances in your department (i.e. catchup sites, population specific, vaccine for children)
- How do you respond to ambivalence in pediatric and adult patients? (empathic communication, motivational interviewing, and education resources)

Learning Activities:

1) Find and print the most current vaccine information statement (VIS) for Tdap.

2) Your four-year-old patient is behind on immunizations because the parents were worried about too many immunizations at once. The following vaccines are behind schedule:

Rotavirus (one dose given at age 6 weeks)
Diphtheria, tetanus, and acellular pertussis (three doses given, last at age 18 months)
MMR (one dose given at 12 months).
The parents are consenting to catch up on immunizations. You are collaborating with the provider to determine what should be given today.

What do you use as a reference? Should the rotavirus vaccine be given today?
Should the Diphtheria, tetanus, and acellular pertussis be given today?
Should the MMR be given today?
When should the fifth dose of Diphtheria, tetanus, and acellular pertussis be given?

3) Your 26-year-old patient is going to be starting clinical rotations for school in 90 days. She needs documentation of immunity to chicken pox through a titer or completion of the vaccine series before she can start her clinical rotation. She never had chicken pox and has not received any doses of the vaccine yet. You look at her immunization record and confirm that she has not received the vaccine for chicken pox. You also notice that she is otherwise up to date with immunizations, including a live attenuated flu shot last week.

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What is the name of the vaccine she will need?
How many doses of the vaccine will she need?
Will you give her a dose of the vaccine today?
Will she have documentation of completion of the vaccine series before her clinical rotation starts?

4) Addison, your 13-year-old female patient, is in the office for a physical and is accompanied by her mom. She has not received the HPV vaccine yet. Addison looks scared and says she does not like shots. Her mom is uncertain and states it is up to Addison to decide. How should you respond to Addison and her mom?

5) Locate the Vaccine Adverse Event Reporting website. Walk through the steps for reporting an adverse reaction.

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Resource Time: Mechanical Ventilation, Multisystem, and CRRT	Name:

Objectives:

1. Review the resource notebook.
2. Reflect on any situations that occurred during your floor time for areas of improvement, breakdowns, or critical incidents.
3. Update Orientation Record and other paperwork to reflect progress of orientation.
4. Review ventilator and tracheostomy guidelines for progress care unit populations.
5. Review BIS monitoring and train of four.
6. Review chest tube guidelines for progress care unit population.
7. Demonstrate tracheostomy cares and suctioning.
8. Demonstrate chest tube assessment and dressing change.
9. Review intra-abdominal pressure monitoring.
10. Discuss liver failure and pancreatitis and nursing cares.
11. Review esophagectomy and significant nursing cares.
12. Review open abdomen and nursing cares.
13. Discuss CRRT and RN patient care role.
14. Differentiate between shock states (hypovolemic, distributive, cardiogenic, obstructive) and identify management strategies for each.

General Respiratory System

Resource Finding:

- Review the guidelines:
  - Bi-level positive airway pressure (BiPAP) use
  - Incentive spirometry
  - Chest physiotherapy using a vest

Discussion Points:

- Discuss OSA screening
  - Stop-Bang Questionnaire
- Discuss the respiratory patient
  - Pneumonia, COPD, RSV/influenza, respiratory distress, asthmatic
  - Discuss communication and collaboration with respiratory therapy
- Discuss bedside bronchoscopy
- Discuss cough assist

Learning Activities:

- Locate respiratory therapy resources and supplies

Ventilators & Tracheostomy

Resource Finding:

Locate and review the following guidelines:

- Mechanical ventilation, positive pressure
- Mechanical ventilation, positive pressure, setup, and application
- Endotracheal tube repositioning
- Endotracheal tube removal
- Tracheostomy tube cannula and stoma care
- Tracheostomy and ventilator speaking valve use
- Tracheostomy suctioning
- Manual proning
- Location of intubation supplies

Discussion Points:

- Discuss early mobility and how it relates to ICU patients

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- Discuss Ventilator Associated Events (VAE) and how it can lead to Ventilator Associated Pneumonia (VAP)
- Discuss nursing interventions to decrease VAE.
- Discuss mechanical ventilation orders and need for trach obturator
- Discuss with preceptor common respiratory diagnoses seen in unit patient population
- Respiratory therapist as a resource
- Discuss documentation related to ventilators
- Discuss the speaking valve and process to progression
- Discuss weaning trail process and documentation
- Discuss bedside percutaneous tracheostomy and RN role
- Discuss spontaneous awakening trials procedure and documentation needs

Learning Activities:

- Demonstrate the following:
  - Trach cares-tube cannula and stoma care, orders for changing dressing, etc
  - Suctioning: In-line versus open suctioning
  - Oral cares
- Review ABG laboratory values and their meaning
- Set up time to observe respiratory therapist if able, to review ventilators and settings, indications for modes
- Demonstrate documentation

Bispectral Index Monitoring & Peripheral Nerve Stimulation

Resource Finding:

Locate and review the following guidelines:

- Bispectral index monitoring
- Peripheral nerve stimulation

Discussion Points:

- Indications for BIS monitoring
- Equipment location, set up of monitoring system, and frequency of monitoring (Bedside monitor vs PNS unit)
- Discuss waveform and interpreting index values
- Discuss trouble shooting for BIS
- Discuss documentation for BIS
- Discuss peripheral nerve stimulation and train-of-four method
- Discuss train-of-four responses and interventions
- Discuss documentation requirements

Learning Activities:

- Locate BIS and PNS supplies on unit
- Identify 2 clinical indications for the utilization of Neuromuscular Blocking Agents (NMBAs) in the Critically ill patient
- Discuss 3 nursing responsibilities when caring for a patient receiving NMBAs
- Describe the process of proper Train-of-Four (TOF) stimulation using a Peripheral Nerve Stimulator. Correlate TOF (number of twitches) with approximate percent of blocked receptors

Chest Tubes

Resource Finding:

Locate and review the following guidelines:

- Chest tube insertion, assisting and chest tube monitoring and care
- Chest tube drainage system monitoring and care
- Chest tube insertion, assisting
- Chest tube removal, assisting
- Locate insertion supplies on the unit

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Discussion Points:

- Discuss common respiratory diagnoses seen with a chest tube
    - Speak to an operative note and knowing exactly type of procedure done and why this is important
- Discuss features of the chest tube
- Discuss how to assess an air leak
    - Air leak versus tidaling
- Discuss progression of chest tubes and suction options

Learning Activities:

- Demonstrate (discuss) assessment of chest tube system and patient assessment
    - Set up or exchange atrium
- Locate portable suction equipment and demonstrate use
- Verbalize complications and appropriate actions

Intra-Abdominal Pressure Monitoring

Resource Finding:

- Review the guideline:
    - Intra-abdominal pressure monitoring

Discussion Points:

- Discuss indication for IAP
- Discuss compartment syndrome
- Discuss abdominal perfusion pressure and how to calculate
- Discuss IAP set up and equipment

Learning Activities:

- Hands on with IAP set up

Pancreatitis & Liver Failure

Resource Finding:

Locate and review the following guidelines:

- Pain management and patient controlled analgesia (PCA)
- Locate PCA monitoring requirements

Discussion Points:

- Discuss pain management
- Discuss coagulopathies related to liver failure
- Discuss ammonia levels and other labs related to patient's condition
- Discuss paracentesis and RN's role during bedside procedure

Learning Activities:

- Review PCA orders and processes

Esophagectomy

Resource Finding:

- Locate and review the esophagectomy guideline
- Locate and review patient education materials for esophagectomy procedure

Discussion Points:

- Discuss various tubes/lines and usage (nasogastric not for feeding)
- Discuss importance of pulmonary function
- Discuss the nasogastric tube, use of nasal bridle, and reinsertion

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Open Abdomen

Discussion Points:

- Discuss the indications for leaving the abdomen open
- Discuss fluid shifting
- Discuss the use of wound vac therapy
- Discuss the need for sedation
- Discuss importance of pain control and not coughing with an open abdomen

Dialysis and CRRT

Resource Finding:

Locate and review the following guidelines:

- Hemodialysis catheters: blood draws, care and maintenance
- Continuous renal replacement therapy

Discussion Points:

- Discuss indications and contraindications
- Discuss CVVHD
- Discuss vascular access
- Discuss removal of dialysis catheters
- Discuss monitoring and management of patient receiving CRRT
- Discuss clotting in sepsis

Learning Activities:

- Locate CRRT resource guide on unit
- Locate CRRT machines and supplies

Shock States

Discussion Points:

- Discuss the hemodynamic parameters affecting normal perfusion.
- Discuss 2 compensatory mechanisms during states of hypoperfusion.
- Discuss 4 classifications of shock and goals of therapy for each.
- Discuss early warning signs of sepsis and septic shock and components of early goal directed therapy.

Learning Activities:

Case Study #1—
A man was involved in a motor vehicle accident and suffered blunt trauma to his abdomen. Upon admission to the ICU, his vital signs are: Temperature 100.9, pulse 120, respirations 20, blood pressure 90/54. His abdomen is firm with bruising around the umbilicus. He is alert and oriented but complains of dizziness when changing positions.

- The patient is admitted for management of what type of shock.
- The following orders are written for the patient:
    - Place two large bore IV's and infuse 0.9% normal saline at 125 cc/hr in each line
    - Obtain complete blood count, serum electrolytes
    - Oxygen at 2 liters/minute via nasal cannula
    - Type and cross for 4 units of blood
    - Flat plate of the abdomen stat
- Describe the pathophysiologic sequence of events seen with hypovolemic shock.
- What are the major goals of medical management in this patient?

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- What is the rationale for placing two large bore IV's?
- What is the rationale for placing the patient in a modified Trendelenburg position?

Case Study #2—
A 32-year-old man is admitted with severe pancreatitis. He has a long history of addiction to alcohol and was recently on a "drinking binge." The patient is agitated and exhibiting nervous behavior. His BP is 106/88, HR 126, RR 32, and he has not voided for the past 3 hours.

- Is the patient most likely experiencing withdrawal from alcohol or a type of shock?
- Describe the type of shock that poses the greatest risk for this patient.
- What interventions should the nurse anticipate preventing the progression of shock or development of MODS?
- Given the patient's history, what organ(s) is least likely to tolerate prolonged tissue hypoperfusion?
- What assessment data would you look at to monitor organ dysfunction in this patient?

Wound Care

Resource Finding:

- Locate and review wound and skin care resources
- Locate and review the below policies or procedures:
  - Pressure injury prevention and management
  - Skin Tear Prevention and Management
  - Wound assessment
  - Device-related pressure injury prevention and management

Discussion Points:

- Read the scenario and answer the questions below:

Scenario: It is a Saturday morning and your patient has a wound vac on their lower abdomen following a bowel resection that they were unable to close. As you are in the room for bedside report with the off going nurse, you notice the dressing has loosened around the edges of the wound and upon closer inspection the wound vac is showing a seal alarm. No alarm was heard.

  - What are your next steps?
  - What do you document for the wound and wound vac?

Learning Activities:

- Locate wound care resources, supplies, and equipment available at your organization and on your work unit

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TSAM® Orientation Record: RN Ambulatory

Preceptee

Preceptor is completely responsible for patient care, preceptee observes & questions.

Preceptee gradually takes on identified responsibilities. Preceptor supports preceptee & keeps remaining responsibilities.

Preceptee is responsible for all aspects of patient care (with preceptor support & increasing independence). Objectives are met through demonstration or verbalization with a high degree of accuracy.

Preceptor/Evaluator signatures are required for all initials on this form			
Initials	Signature	Initials	Signature

Resource Time Activities		
Purpose: Use this valuable time for the in-depth conversations, teaching, and discovery of resources that you are not able to do during the busyness of a shift. Expectations: 1. The preceptee and preceptor will discuss patient care scenarios and work on Resource Time Activities that correlate with current Tier 2. The preceptee may engage in independent study during Resource Time		
Date	**Resource Time Activity**	**Preceptor Signature**
	Resource Time 1: Resource Finding	
	Resource Time 2: Release of Information	
	Resource Time 3: Emergency Management	
	Resource Time 4: Phone Triage/Scope of Practice	

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Resource Time Activities - continued		
Purpose: Use this valuable time for the in-depth conversations, teaching, and discovery of resources that you are not able to do during the busyness of a shift. Expectations: 1. The preceptee and preceptor will discuss patient care scenarios and work on Resource Time Activities that correlate with current Tier 2. The preceptee may engage in independent study during Resource Time		
Date	**Resource Time Activity**	**Preceptor Signature**
	Resource Time 5: Medication Management	
	Resource Time 6: Patient Education	
	Resource Time 7: Immunizations	
	Resource Time 8: Mental Health and Aggressive Patients	
	Resource Time 9: Pediatrics	
	Resource Time 10: Emergency Situations	

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TSAM® Orientation Record: Preceptee:

Tier 1					
Shift Date			If additional dates needed, notify NES		

Preceptee Responsibilities	**Objectives**	Objectives Met	
		Preceptor's initials	Date Completed MM/DD/YY
Guided Observation	Locates equipment and becomes familiar with resources, including emergency equipment, team member roles, huddles, patient flow, other departments interacting with the work unit.		
Recommended Activities	Observes preceptor's skills in time management, prioritization, and delegation while striving to meet the needs of the patients.		
	Observes preceptor's communication and collaboration with patients and other members of the patient care team, including verbal (i.e. phone call) and written communication.		
Tour of Department	Observes how the preceptor integrates best practices into patient situations: 2 identifiers, standard precautions, infection prevention, mutual respect, 5 Safe Behaviors.		
Resource Time: Resource Finding			
	Communication Box:		
	Signatures below indicate that the preceptee is ready to progress to the next tier. All tier objectives have been completed.		
	Preceptor / Date / Signature		
	Preceptee / Date / Signature		

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TSAM® Orientation Record: Preceptee:

Tier 2							
Shift Date						If additional dates needed, notify NES	

Preceptee Responsibilities Lab/Diagnostic/Vital Sign Trending Preparing for patient interaction Patient History EHR Navigation	**Objectives**	Objectives Met	
		Preceptor's initials	Date Completed MM/DD/YY
	Researches patient's EHR for pertinent information specific to encounter.		
	Identifies best practice or health maintenance recommendations (quality measures) involved in patient care, while preparing for patient encounters.		
	Trends labs, diagnostics, and vital signs in the EHR.		
Recommended Activities Resource Time: Release of Information Resource Time: Emergency Management Review Experience Tracker	Accesses resources and decision-making tools available to support evidence-based nursing (including protocols, telehealth resources).		
	Chooses communication route (i.e. letter, portal, phone) best suited for each patient situation.		
	Identifies patient using 2 identifiers 100% of the time in any interaction with patient and/or patient EHR.		
	Communication Box:		

Signatures below indicate that the preceptee is ready to progress to the next tier. All tier objectives have been completed.		
Preceptor	Date	Signature
Preceptee	Date	Signature

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TSAM® Orientation Record: Preceptee:

Tier 3						
Shift Date						
						If additional dates needed, notify NES

Preceptee Responsibilities Patient assessment Medication Review Order Management Documentation Results Management	**Objectives**	Objectives Met	
		Preceptor's initials	Date Completed MM/DD/YY
	Prioritizes incoming messages (online versus voicemail, etc.) based on acuity.		
	Navigates EHR to access pertinent patient information during and after patient encounter.		
Recommended Activities Resource Time: Phone Triage/Scope of Practice Resource Time: Medication Management Review Experience Tracker	Protects patient privacy by verifying that an *Authorization for Release of Information* been completed when speaking to someone other than the patient/guardian.		
	Reviews and updates medication list with patient per policy.		
	Verifies and updates allergies with patient.		
	Practices effective listening with attention paid to symptom, age, culture, and knowledge of the patient or caller.		
	Systematically assesses patient and addresses their needs; practices communication skills to elicit from patient pertinent information regarding situation and symptoms.		
	Utilizes appropriate pain management resources and scale to perform pain assessment/reassessment according to Pain Management Policy and appropriate Nursing Procedures.		
	Utilizes procedural guideline for medication refills. This may be accomplished through simulation.		
	Pends orders as appropriate for population/care area. This may be accomplished through simulation.		
	Communicates clearly and interacts with patients in a professional manner using AIDET.		

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TSAM® Orientation Record: Preceptee:

Tier 3 - continued

Objectives	Objectives Met	
	Preceptor's initials	Date Completed MM/DD/YY
Utilizes RN protocols (if applicable) to plan care for appropriate patient populations.		
Documents patient encounters according to the standard of care and department guidelines.		
Assesses patient for appropriate level of care, such as Express Care, Express Care Online, Clinic, Urgent Care, or Emergency Room. This may be accomplished through simulation.		
Communication Box:		

Signatures below indicate that the preceptee is ready to progress to the next tier. All tier objectives have been completed.

Preceptor	Date	Signature
Preceptee	Date	Signature

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TSAM® Orientation Record: Preceptee:

Tier 4						
Shift Date						If additional dates needed, notify NES

Preceptee Responsibilities Delegation Team communication Planning Patient Care	**Objectives**	Objectives Met: Preceptor's initials	Objectives Met: Date Completed MM/DD/YY
	Communicates with provider and other members of the patient care team using department templates and SBAR format incorporating any pertinent information.		
	Collaborates with the patient care team and delegates tasks appropriately.		
	Demonstrates leadership attributes of the professional nurse in the triage role through effective team communication & collaboration, delegation, and participation in team meetings.		
Recommended Activities Review Experience Tracker	Uses data collected and critical thinking to *plan* patient-centered interventions using evidence-based resources.		
	Engages interdisciplinary members of the care team to enhance the patient experience and efficiently meet patient needs.		
	Discusses scope of all team members; assign right task to right team member.		
	Utilizes EHR screening tools and prompts to guide data collection and meet quality performance measures.		
	Reviews immunization record and correlates immunization history with current recommendations from CDC and health maintenance best practices.		
	Communication Box:		
	Signatures below indicate that the preceptee is ready to progress to the next tier. All tier objectives have been completed.		

Preceptor	Date	Signature
Preceptee	Date	Signature

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TSAM® Orientation Record: Preceptee:

Tier 5						
Shift Date						If additional dates needed, notify NES

Preceptee Responsibilities	**Objectives**	Objectives Met	
		Preceptor's initials	Date Completed MM/DD/YY
Care Coordination Patient Education Wellness Promotion	Manages patient messages/needs with appropriate action including responding to patient, delegation and/or communicate to provider.		
	Identify the available resources for patient education related to patient care, treatment, and services and delivers it in an appropriate manner with regards to age, knowledge level, and readiness to learn.		
	Documentation of patient education is completed in a timely manner and meets organizational guidelines.		
Recommended Activities	Identify your role in reducing the likelihood of patient harm associated with the use of anticoagulation therapy. Including: patient/family education material, follow-up monitoring, compliance, drug-food interactions and potential for adverse drug reactions and interactions.		
Resource Time: Patient Education	Uses teach-back method for evaluating learning and/or plan of care.		
	Navigates patient to internal and external resources to increase patient participation in care planning.		
Resource Time: Immunizations	Engages in therapeutic conversation using compassion, caring and empathic communication skills appropriate for patient/caller developmental age and cognitive status.		
Resource Time: Mental Health and Aggressive Patients	Discuss nursing care of the patient with mental health/substance abuse or attempted suicide conditions.		
	Discuss resources for caring for aggressive/violent patients.		
Review Experience Tracker	Promotes preventive and wellness best practices by acting upon health maintenance recommendations.		
	Demonstrates ability to use technology (computer and phone system) to efficiently care for patient.		

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TSAM® Orientation Record: Preceptee:

Tier 5 - continued

Objectives	Objectives Met	
	Preceptor's initials	Date Completed MM/DD/YY

Communication Box:

Signatures below indicate that the preceptee is ready to progress to the next tier. All tier objectives have been completed.

Preceptor	Date	Signature
Preceptee	Date	Signature

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TSAM® Orientation Record: Preceptee:

Tier 6						
Shift Date						
		If additional dates are needed, contact NES				

Preceptee Responsibilities Procedures Medication Administration Immunization Administration	Objectives	Objectives Met	
		Preceptor's initials	Date Completed MM/DD/YY
	If required for visit, measures accurate vital signs, height and weight using equipment appropriate for patient's age and size.		
	Follows standard and isolation precautions and infection control principles 100% of the time before, during, and after each patient contact, i.e. recommended PPE, handwashing, cleaning of equipment, cleaning of exam room.		
	medication administration, medication reconciliation, medication event reporting, review of resources on medication compatibility and potential side effects per procedural guideline.		
Recommended Activities Resource Time: Pediatrics Review Experience Tracker	Identify when a medication or solution needs to be labeled in the work setting.		
	Demonstrates proper technique for frequently administered medications per procedural guideline.		
	Documents medication administration and procedures in a timely manner to meet organization guidelines using barcode scanning, if available.		
	Performs wrap-up processes inclusive of diagnoses and charge capture selection.		
	Independently locates and utilizes resources and protocols to guide evidence-based procedures and interventions.		
	Executes procedures according to procedural guidelines and the full nursing process: assess, plan, implement and evaluate.		
	Partners with patients in evaluating the effectiveness of procedure/intervention/medication administration and identify adverse reactions.		

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TSAM® Orientation Record: Preceptee:

Tier 6 - continued

Objectives	Objectives Met	
	Preceptor's initials	Date Completed MM/DD/YY
Screens patient for immunization inclusion and exclusion criteria per RN protocols.		
Administers and documents immunizations according to CDC and Immunization Action Coalition guidelines.		

Communication Box:

Signatures below indicate that the preceptee is ready to progress to the next tier. All tier objectives have been completed.

Preceptor	Date	Signature
Preceptee	Date	Signature

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TSAM® Orientation Record: Preceptee:

Tier 7						
Shift Date						
		If additional dates are needed, contact NES				

Preceptee Responsibilities Ownership of Role Preceptor Shadows Preceptee	**Objectives**	Objectives Met	
		Preceptor's initials	Date Completed MM/DD/YY
	Pays attention to detail, communicates clearly, and displays a questioning and receptive attitude to practice safely.		
	Adapts to changing workloads meeting the needs of the patient and department.		
	Contributes to team cohesiveness by offering assistance to team members and aligns individual work efforts to meet work unit and organizational goals.		
Recommended Activities Resource Time: Emergency Situations Review Experience Tracker	Demonstrates problem solving and critical thinking in the management of patient care through the application of the nursing process (assess, plan, implement, and evaluate).		
	Uses evidence-based resources to guide practice.		
	Operates as a team leader to manage, prioritize and individualize patient care.		
	Recognize when the situation requires delegation/communication to another role (to stay within scope of practice).		
	Communication Box:		

Signatures below indicate that the preceptee is ready to progress to the next tier. All tier objectives have been completed.		
Preceptor	Date	Signature
Preceptee	Date	Signature

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TSAM® Orientation Record: Preceptee:

Tier 8					
Shift Date				If additional dates are needed, notify NES	

Preceptee Responsibilities Ownership of Role Preceptor Resources Preceptee	**Objectives**	Objectives Met	
		Preceptor's initials	Date Completed MM/DD/YY
	Takes responsibility for own nursing practice and patient outcomes.		
	Interacts with patient in a professional manner using AIDET.		
	Independently functions as team leader.		
Recommended Activities Review Experience Tracker	Manages full workload with minimal assistance from preceptor.		
	Demonstrates problem solving by offering solutions when requesting assistance.		
	Communication Box:		

Signatures below indicate that the preceptee has met all objectives through demonstration and verbalization with high degree of accuracy and is ready to be off orientation.		
Preceptor	Date	Signature
Preceptee	Date	Signature

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TSAM® Orientation Record: General Care RN

Preceptee

Preceptor is completely responsible for patient care, preceptee observes & questions.

Preceptee gradually takes on identified responsibilities. Preceptor supports preceptee & keeps remaining responsibilities.

Preceptee is responsible for all aspects of patient care (with preceptor support & increasing independence). Objectives are met through demonstration or verbalization with a high degree of accuracy.

Preceptor/Evaluator signatures are required for all initials on this form			
Initials	Signature	Initials	Signature

Resource Time Activities

Purpose: Use this valuable time for the in-depth conversations, teaching, and discovery of resources that you are not able to do during the busyness of a shift.
Expectations:
1. The preceptee and preceptor will discuss patient care scenarios and work on Resource Time Activities that correlate with current Tier
2. The preceptee may engage in independent study during Resource Time

Date	Resource Time Activity	Preceptor Signature
	Resource Time 1	
	Resource Time 2	
	Resource Time 3	
	Resource Time 4	
	Resource Time 5	
	Resource Time 6	

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MAYO CLINIC

TSAM® Orientation Record: General Care RN Preceptee:

Tier 1						
Shift Date		If additional dates needed, notify NES				

Preceptee Responsibilities	**Objectives**	Objectives Met	
		Preceptor's initials	Date Completed MM/DD/YY
Shadow and Observe (First 4 hours ONLY, then move to Tier 2)	Observe how the professional nurse prioritizes and problem-solves, while striving to meet the needs of the patient through the application of the nursing process.		
	Observe how the professional nurse collaborates with the multidisciplinary team; placing the patient at the center of care.		
	Observe how the professional nurse communicates with patients and families with compassion and empathy through practices such as bedside handoff, intentional rounding, and narration of care.		
Activities	Performs infection prevention practices according to organizational expectations (handwashing, gloving, gowning, etc.).		
	Communication Box:		

Signatures below indicate that the preceptee is ready to progress to the next tier. All tier objectives have been completed.		
Preceptor	Date	Signature
Preceptee	Date	Signature

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MAYO CLINIC

TSAM® Orientation Record: General Care RN Preceptee:

Tier 2							
Shift Date						If additional dates needed, notify NES	

Preceptee Responsibilities	**Objectives**	Objectives Met	
		Preceptor's initials	Date Completed MM/DD/YY
Assessments and Documentation	Demonstrates individualized patient assessments based on patient diagnosis, co-morbidities, and/or provider orders.		
	Adjusts communication strategies, when gathering assessment data; i.e. hard of hearing, translation, aphasia, language barriers) to meet the needs of the patient.		
	Demonstrates use of technology when providing and documenting patient care.		
	Accurately documents patient assessment, interventions, medications/fluids, vital signs, and nursing cares in a timely manner to assure transparent patient classification.		
Activities	Accurately performs MEWS assessment, documentation and when to notify provider following MEWS algorithm.		
	Utilizes appropriate pain management resources and scale to perform pain assessment/reassessment according to policy and appropriate nursing procedures.		
	Demonstrates skin assessment and discusses resources for skin and wound management including pressure injury prevention and staging.		
	Demonstrates entering shift goal and documentation on care plans.		
	Correlates laboratory and diagnostic testing to patient condition.		
	Differentiates between abnormal and normal findings; Identifies exceptions to WDLs and documents in real time.		
	Demonstrates appropriate use of personal protective equipment (PPE) according to patient condition to maintain a safe clinical environment while patient is in their room or being transferred to another clinical area.		

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TSAM® Orientation Record: General Care RN Preceptee:

Tier 2 - continued

Objectives	Objectives Met	
	Preceptor's initials	Date Completed MM/DD/YY

Communication Box:

Signatures below indicate that the preceptee is ready to progress to the next tier. All tier objectives have been completed.

Preceptor	Date	Signature
Preceptee	Date	Signature

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TSAM® Orientation Record: General Care RN Preceptee:

Tier 3								
Shift Date							If additional dates needed, notify NES	

Preceptee Responsibilities Medication Management & Safety (all routes) Care Team Communication Orders Responding to Changes in Patient Condition	**Objectives**	Objectives Met	
		Preceptor's initials	Date Completed MM/DD/YY
	Demonstrate safe medication management that includes the following: 5 rights of medication administration, medication reconciliation, medication event reporting, and review of resources on medication compatibility and potential side effects.		
	Demonstrates use of barcode scanning and 2-patient identifiers 100% of the time, incorporating safe patient behaviors including paying attention to detail and having a questioning and receptive attitude.		
	Identify when a medication or solution needs to be labeled in your work setting.		
	Manages diabetes medications including using insulin pens, insulin syringes, sliding scale insulin, carbohydrate counting (actual or simulated).		
Activities	Identify your role in reducing the likelihood of patient harm associated with the use of anticoagulation therapy. Including: patient/family education material, follow-up monitoring, compliance, drug-food interactions, and potential for adverse drug reactions and interactions.		
	Demonstrates IV fluid/medication therapy via infusion pump, including selection of tubing, and correct connections with Y ports and secondary tubing (actual or simulated).		
	Describe appropriate management of patients on opioids (both acute and chronic) including screenings, patient education, use of guidelines, and location of resources.		
	Utilizes appropriate resources such as IV administration guidelines, high alert medications, pharmacy, etc. in the management of medication administration.		
	Completes focused re-assessments based on patient interventions and documentation in a timely manner per policy.		
	Demonstrate paying attention to detail by trending patient data, watching for subtle changes, and recognizing signs of patient deterioration.		

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TSAM® Orientation Record: General Care RN Preceptee:

Tier 3 - continued

Objectives	Objectives Met	
	Preceptor's initials	Date Completed MM/DD/YY
Demonstrate paying attention to detail by trending patient data, watching for subtle changes, and recognizing signs of patient deterioration.		
Articulate when and how to notify provider and/or emergency response team of findings.		
Acknowledges new orders and initiates RN protocols (if applicable); paying attention to details.		
Demonstrates communication with providers and the interdisciplinary care team, providing pertinent information utilizing the SBAR format; using questioning and receptive attitude.		
Communication Box:		

Signatures below indicate that the preceptee is ready to progress to the next tier. All tier objectives have been completed.

Preceptor	Date	Signature
Preceptee	Date	Signature

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TSAM® Orientation Record: General Care RN Preceptee:

Tier 4								
Shift Date							If additional dates needed, notify NES	

Preceptee Responsibilities Patient Management, Delegation Patient Education Care Planning Admission, Discharge, Transfers, Referrals	**Objectives**	Objectives Met	
		Preceptor's initials	Date Completed MM/DD/YY
	Complete Purposeful Intentional Rounding.		
	Support a minimal lift culture to reduce hazards of injury for employees and patients by demonstrating safe patient handling equipment competencies (lift, transfer, reposition, ambulation, etc.) using the assistive devices used in the work area, along with role modeling best practice and speaking up if risky behavior is observed.		
	Perform Bedside Handoff in the patient's room, involving the patient and/or family members in the handoff process.		
	Identify the available resources for patient education related to patient care, treatment, and services.		
Activities	Demonstrate appropriate delegation to team members, including follow-up.		
	Respond to changing patient needs by reprioritizing care activities.		
	Individualize and update patient care plans in a timely manner with minimal assistance.		
	Functions in the role of the teacher by individualizing and documenting patient education based on diagnoses and relevant co-morbidities.		
	Review/demonstrate the process for transfer of patients from unit to unit.		
	Demonstrate documentation of all admission criteria in the electronic health record.		
	Assess patient safety and well-being by identifying and utilizing all appropriate screening tools, to include, but not limited to: behavioral health, fall risk, abuse indicators, etc.		

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TSAM® Orientation Record: General Care RN Preceptee:

Tier 4 - continued

Objectives	Objectives Met	
	Preceptor's initials	Date Completed MM/DD/YY
Discharge patients with minimal assistance per policy/ procedure.		
Discuss differences in discharge requirements and identify discharge resources related to patients' post-hospitalization needs.		

Communication Box:

Signatures below indicate that the preceptee is ready to progress to the next tier. All tier objectives have been completed.

Preceptor	Date	Signature
Preceptee	Date	Signature

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MAYO CLINIC

TSAM® Orientation Record: General Care RN Preceptee:

Tier 5							
Shift Date						If additional dates needed, notify NES	

Preceptee Responsibilities	Objectives	Objectives Met	
		Preceptor's initials	Date Completed MM/DD/YY
Resource Management and Critical Thinking	Discuss the risk of ligature points in the patient care setting and identify resources for risk- reduction nursing interventions. (i.e. suicide risk assessment, potential for self-harm).		
	Articulate the process for required reporting. This includes patient events (including near misses), employee incident reporting (e.g. injury or exposures), role and responsibilities as a mandated reporter, and reporting equipment needing repair.		
	Discuss the RN role in end-of-life care, including care for the patient's family. Identify bereavement resources.		
	Articulate the role of the CNS and how they can assist with complex patient care.		
Activities	Employs critical thinking in evaluating the effectiveness of procedures and interventions and initiates appropriate follow-up actions.		
	Partners with professionals on the multidisciplinary team to identify resources related to dismissal planning.		
	Recognize violent behavior warning signs/signals and make efforts to de-escalate an intensifying situation.		
	Discuss nursing care of the patient with mental health/substance abuse or attempted suicide conditions.		
	Discuss resources for aggressive/violent patients.		
	Demonstrate components of alarm management for which nursing staff is responsible including purpose of alarm, alarm limits, and ability to change alarm limits based on patient condition.		
	Independently locate and utilize resources to guide evidence-based practice.		

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TSAM® Orientation Record: General Care RN Preceptee:

Tier 5 - continued

Objectives	Objectives Met	
	Preceptor's initials	Date Completed MM/DD/YY
Performs procedures according to guidelines and the full nursing process: assess, plan, implement and evaluate.		

Communication Box:

Signatures below indicate that the preceptee is ready to progress to the next tier. All tier objectives have been completed.

Preceptor	Date	Signature
Preceptee	Date	Signature

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TSAM® Orientation Record: General Care RN Preceptee:

Tier 6						
Shift Date					If additional dates needed, notify NES	

Preceptee Responsibilities Ownership of All Cares Preceptor Shadows and Resources Preceptee	**Objectives**	Objectives Met	
		Preceptor's initials	Date Completed MM/DD/YY
	Successfully navigate a patient assignment throughout the day as evidenced by demonstration of prioritization and time management.		
	Demonstrate providing care to high acuity patients.		
	Competently manage full patient load with minimal assistance from preceptor.		
	Takes responsibility for own nursing practice and patient outcomes.		
Activities	Demonstrates mastery of appropriate delegation and follow-up to team members.		
	Communication Box:		

Signatures below indicate that the preceptee has met all objectives through demonstration or verbalization with a high degree of accuracy and is ready to be off orientation.		
Preceptor	Date	Signature
Preceptee	Date	Signature

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TSAM® Orientation Toolkit Template

Instructions to Preceptors: Review the items in this toolkit with the preceptee. Distinguish preceptee's specific learning needs based on their past patient care experience. Use the toolkit to develop a teaching plan individualized to the preceptee's needs and your patient care area's needs. Contact your nursing education specialist if additional assistance is needed while working through this toolkit.

Learning Modules or Education Resources	• Insert link(s) to education resource(s) • List name of learning module(s) if located in an internal learning management system
Organization Policies or Procedural Guidelines	• List key points of policy • Insert link(s) to organization policies • Insert link(s) to procedural guidelines
Quality Measures or Accreditation Requirements	• Review internal quality resources-insert link(s) • Discuss quality measure including required education or documentation in electronic health record • Discuss accreditation requirement including education or documentation in electronic health record

Additional Resources:

❑ Patient Education

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TSAM®

Change Management Worksheet

Current State:

Anticipate Obstacles in Organizational Culture:

Inputs	**Outputs**		**Outcomes -- Impact**		
	Activities	*Participation*	*Short*	*Medium*	*Long*
Resources required: **Leader Stakeholders** **Additional Stakeholders**	*What we will do:* **Elicit Perspectives**	*Who we will reach:* ***Scope***	*E.G. preceptor, preceptee, educator, manager reaction, satisfaction with new model*	*E.G. Increase in desirable behaviors such as time management*	*E.G. Retention, Cost*

Sponsorship Team Members:

Resources:

TSAM® definition: An evidence-based process for orienting and precepting nurses based on increasing skills from simple to complex while having a full assignment with the preceptor. Our organization's focus of TSAM® is to (fill in your goals) Examples: develop critical thinking skills, improve time management and prioritization, or increase retention.

Key components of TSAM® are **simple to complex tier objectives, continuous partnership, and resource time**.

Answer these questions to assess your readiness for change to the TSAM® model in your unit and complete for the whole unit or fill out one for each group including nurse leadership team, preceptors, preceptees, charge nurse/house supervisor, all staff, or other key stakeholders (including physicians) in your unit.

Use a change management model to guide your team.

	Assess the need for change	In your own words, what is your current understanding of TSAM®? What is your awareness of the need to change to TSAM®? Why is this change necessary? Why is this change happening now? What is wrong with what we are doing today? If not much wrong, how could we do better? What will happen if we don't change? In other words, what is the risk of not changing? What is the nature using the TSAM® model for orientation and how does that align with our vision and success for our unit? How will this impact our unit? What is in it for me? (from each perspective of Manager, Supervisor, Lead, Nursing Professional Development Practitioner, Preceptor, Staff member without preceptee (could include Providers), and the Preceptee) Have we considered the multiple (five) factors that influence how readily our colleagues recognize the need for change? Have we crafted responses to address the needs our colleagues discovered in exploring these five factors? (Think time management, prioritization, critical thinking and other current weaknesses or benefits of TSAM® implementation) What is the risk of not changing or improving?	Review these reasons and ask yourself the degree to which your unit understands all the reasons for this change– Rank on a 1-5 scale with 5 being the best. Rank

	Support and participation level for this change	Think about encouraging and supportive factors. What are the motivating factors in support of this change – What would cause someone to support this change? Think about resistance to change and being prepared to manage this resistance. Consider the commitment to key elements of TSAM® as well as a quick review of what you discovered in the awareness assessment as you ask the following questions: Identify groups impacted and whether it is an opportunity or a threat for each: Manager/Supervisor – opportunity or threat Lead- opportunity or threat Nursing Professional Practitioner- opportunity or threat Preceptor- opportunity or threat Staff member without orientee (could include providers)- opportunity or threat Preceptee- opportunity or threat Is the change to TSAM® an opportunity or a threat for each group in your unit? Are there differences between the groups that could provide an excuse to resist the change to TSAM®? Do you anticipate support or resistance to this change and why? What is our unit's track record for change? Consider how much change is going on, reinforcement for past changes absent or not, is there good follow through here, do we have a track record of allowing some groups to opt-out of change – these precedents weigh on the willingness of employees to engage in the change of TSAM® and should be part of this assessment and will need to be considered later as part of the plan. Is the preceptor (individual) you are considering for their first TSAM® experience in a "good place" for change personally and professionally – is this change important to them? Because the individual preceptor considered has a high impact on the outcome, this assessment is of their capacity to change. What is the motivation or personal expectation to be successful in TSAM®? Consider all groups listed above and discuss each. Does the NLT and preceptor group currently agree on the initial competencies essential for the role? How will you ensure agreement? The question to examine at this point is "If I understand the need for change and I am willing to change, can I reasonably expect that the change will happen?"	Consider these factors, including your unit's conviction in these areas. Assess and ask yourself the degree to which your unit supports the change. Rank on a 1-5 scale. Rank

Knowledge gap for implementing the change	What is your nurse leadership team's current understanding of the difference between competency evaluation, facilitating learning and facilitating experiences? Why is this important in TSAM®? What is the current knowledge base of our preceptors? (? Already have required knowledge? Ability?) What is the capacity of the preceptor(s)? Is there any fundamental training or practice skills needed by the preceptors in your unit to shift to fundamentals of TSAM®: • Facilitate learning and experiences? (such as asking questions to facilitate thinking, providing experiences and using teach-back – show back) • Evaluate competency? (such as asking questions to determine if critical thinking is present, using documented procedures (standards for care) to assess whether the person is doing it correctly) What is the capacity of the preceptor to gain additional training or practice? What resources are available for additional training or practice? What access is available for additional training or practice? Is there detailed information on how processes, workflows, or tools (paperwork) will change - the "How to change" for TSAM®? (The answer at this initial point is "no" – but will need to be clearly planned and written this out for our unit as the Nursing Professional Development Practitioners will be primary designers of the Tiers and Resource Time.) New for TSAM® is carving out Resource Time – what might that look like and how could we do that? Consider centralized scheduling impacts. New for TSAM® is commitment to a continuous partnership (working together as one) – what might that look like and how could we do that? Think competency evaluation, facilitating learning and facilitating experiences	Do you have a clear understanding of the required skills and knowledge needed to be successful? Have your unit members received training or information in TSAM® orientation model? Rank on a 1-5 scale. Rank
Ability to achieve desired performance or training needed	Key principle = Knowing how to do something and being able to do something is not the same thing. Knowledge versus Competence Do you have preceptors? Are they developed? Do they have the desired skills and behavior for the change to using a TSAM® model? Are there any psychological blocks that prevent the preceptor from being successful in TSAM® roles expectations of facilitating learning or assessing competency? (TSAM® key elements) – Example; maybe the preceptor is not able to give effective feedback because of a fear of conflict or hurting someone's feelings. "I just can't do that, I avoid it") Are there strong intellectual abilities in the preceptors (such as problem-solving, analyzing competency)? Need development/practice/ assessment of the preceptor(s) for these abilities? Is there time needed to do this development? What is the availability of resources to support the preceptor during this developmental or initial implementation period? Do the preceptors have a solid structure for paperwork/documentation, resource time, clear about what is expected and when? Is the nurse leadership team ready to commitment to key elements of the Model? What barriers do you anticipate? How might you address barriers? • Maintaining the continuous partnership • Planning for resource time • Commitment (all members of the unit or dept.) to staying in current tier until all objectives are met	Review these factors and ask yourself the degree to which your unit has the skills to implement or is training needed. Rank on a 1-5 scale. Rank

	Maintain and sustain the change	Do you have the commitment to support the TSAM® model and key elements? If not why? Do you have the commitment to address barriers related to the TSAM® model and its key elements? If not why? Does both the Nurse Manager/Supervisor and Nursing Professional Development Practitioner together hold preceptors & new hires accountable (backsliding/tier hopping/skipping) for key elements? Identify where you are at in the following factors: Is there valuable recognition or rewards to all unit members to sustain the change to TSAM®? Who is the person (s) that needs to do the recognition (preceptor appreciates the recognition coming from whom? Do you anticipate any negative consequences for behaviors that follow the key elements of the TSAM® model? (Peer pressure, opposing behaviors that are key such as taking time for continuous partnership state, feedback, carved out time for resource time away from patient care) What accountability is in place for continued performance in following the TSAM® model? (What does your unit historically do? Does it work? Job performance measures for TSAM®?) What will you do if people go back to the old behaviors and habits? (No continuous partnership/honor resource time/skip around tiers and paperwork) Ongoing role in monitoring key elements	To what degree can the change be maintained. Rank on a 1-5 scale.

Take time to review your scores.
Highlight those areas that scored **3 or less** and identify which is the first area with a score of 3 or less. This first area will be your primary focus.

Leadership and preceptor buy in, plus collaboration from the beginning is essential.

Meet early and often with the Unit- based Nursing Leadership Team (NLT) through the entire design process.

Readiness Assessment

What is your readiness for this change? Using a model for change will provide you with a framework that helps leaders to realize change to using TSAM® for orientation more quickly and completely. Those who did not use a model for change indicated they wished they would have done this step before they began; now spending more time catching up on what was missed and it is taking longer than if they would have thought it through using a change model first. Use of a change model will help to assess your unit's readiness for change and will drive your plans to get a solid TSAM® program in place.

In addition, using a model of change and following the chosen change model resource, you as a change leader together with your team, will accomplish learning about use of a tool for change management!

Planning for Implementation

After completing a thorough readiness assessment, it is time to work with your NLT to plan for implementation and customize the plan to address what you uncovered in your readiness assessment. Use the questions below to assist you and your leadership team in the planning phase.

How will the NLT commit to supporting preceptors to contribute to developing the orientation record and resource time?

How will the NLT approach scheduling resource time? What will have the best chance of working in your area?

How will the NLT commit to the preceptee and their need for resource time when it may be the path of least resistance or easier to pull the preceptor away from the preceptee to meet staffing needs? Will the preceptor be pulled to patient care as the first option? What impact would that have on the preceptee's development and progress? Is there alternate guidance that could be implemented, so the preceptor is not the first choice, but rather reserved in the event there are no other options? Is there a place away from the clinical unit that may help 'protect' resource time?

How will the NLT commit to having a dedicated preceptor for each preceptee? What barrier(s) do you foresee and how could you implement a plan to minimize disruption with multiple preceptors?

How will the NLT commit to holding preceptors and the preceptees accountable to:

- Continuous partnership
- Resource time quality
- Staying in current tier until all objectives are met and refraining from 'tier jumping'

How will the NLT approach 'backsliding' from the new model to the old way. An example is divide and conquer mentality. Or the Charge Nurse asking the preceptor to leave the new hire and help someone else, or take an additional patient because the new hire is almost done and doing so well.

What evaluation metrics are the NLT interested in monitoring? How could the NLT monitor and capture evaluation metrics?

How will you prepare preceptors for TSAM® implementation including engagement in developing the model, meeting time to commit to learning activities provided by a preceptor workgroup, and development of enduring resources provided by the TSAM® group? Will you develop them all at once or over a period of time?

How will you mentor preceptors during implementation to ensure they change their practice to incorporate key TSAM® practices of continuous partnership, appropriate progression through tiers and the quality of resource time?

Lastly, are you confident you have a complete readiness assessment and good starting plan for implementation?

Sample SBAR Communication

Situation: The TSAM® model is a preceptor/preceptee paired model for clinical orientation. Show video.

Background: TSAM® is a trademark product of the Mayo Clinic. It has been closely studied with favorable outcomes since 2015. Outcomes have been published in the Journal for Nurses in Professional Development.

The TSAM® model has been successfully implemented in nursing units and non-nursing units across all Mayo Clinic sites located in five states. Mayo Clinic has consulted with outside organizations to successfully implement TSAM® also.

Assessment: This model is strongly rooted in evidence and adult learning theory.

Resource time is well designed to target gaps in critical thinking evaluation.

TSAM® is an opportunity to improve upon current clinical orientation. There is more structure and direction for preceptors and preceptees.

There is strong evidence to indicate TSAM® improves transition from preceptee to independent practice, appears cost neutral to possibly cost saving, and no reason to conclude it would be harmful.

Recommendations:

Nursing leaders take opportunity to move on this now, collaborate with clinical leaders and preceptors and thoughtfully plan for implementation unit by unit.

Target General Medical and Primary Care units first.

Target Registered Nurses first.

Key Benefits

Cost neutral / Cost avoidance	Increase in new employees confidence and ability to manage full assignment
Retention	Higher speed to competency, prioritizing and time management
Decrease in number of failed orientations	Nurse Manager reports new employee confidence in skills is improved

Strategic Communication Worksheet

What is the need for change?	
What matters most to this stakeholder group (E.G. Executives)	
Credible sources I'll use	
Describe the personally relevant benefit(s)	
Validate their concern(s) while acknowledging TSAM® cannot resolve all issues	
What isn't changing	

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EDITORS' PICK

Transforming Orientation Through a Tiered Skills Acquisition Model

M. Ellen Joswiak, DNP, RN, RN-BC

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The tiered skills acquisition model (TSAM) is an effective method for structuring the clinical unit orientation. The orientee gradually assumes increased responsibilities based on advancing through tiers of skills from simple to complex. This article focuses on TSAM implemented at a teaching hospital with 188 newly licensed registered nurses. TSAM has increased nurses' confidence, role satisfaction, retention, reduced overall length of orientation by 18%, and increased the number of patient experiences by 45%.

The transition from academia to the practice setting can be challenging for newly licensed registered nurses (NLRNs). Despite having knowledge in essential nursing concepts, becoming competent in basic clinical skills, and passing the National Council of State Boards of Nursing Licensure Examination (NCLEX-RN), there are numerous experiences a new nurse can find challenging. Caring for acutely ill patients, mastering an extensive range of technology, and working with a culturally diverse workforce are a few characteristics of the complex settings in which nurses' practice. NLRNs need support during the critical transition from the role of student to that of a staff nurse in any setting (Boychuk-Duchscher, 2012). A lack of support contributes to turnover of new nursing staff. Kovner, Brewer, Fatehi, and Jun (2014) found that 17.5% of NLRNs leave their first nursing job within the first year of starting, and 33.5% leave within 2 years, thus increasing costs to healthcare organizations and potentially decreasing the quality of patient care. Historically orientation of NLRNs at this large Midwest teaching hospital consisted of having one patient then increasing numbers of patients (incremental productivity model) while completing all cares and interventions. NLRNs frequently stated they desired more practice with time management, delegation, prioritizing, and critical thinking. Competence in these foundational skills was difficult to achieve in the incremental productivity model. Providing a robust clinical orientation with preceptors trained to work specifically with NLRNs provides the opportunity for retaining new nurses and developing a competent nursing staff.

The tiered skills acquisition model (TSAM) is an innovative process designed for orienting and precepting NLRNs. The TSAM is based on increasing nursing intervention skills from simple to complex during the orientation period while having a full assignment with the preceptor. The TSAM process was designed, implemented, and evaluated on eight inpatient clinical units that included general and progressive care at a teaching hospital with 188 NLRNs. Outcomes of that evaluation will be discussed. To maintain clarity, the term *orientee* will refer to the nurse who is a *new graduate* to a clinical environment and is currently in orientation, and the term *preceptor* will refer to the professional nurse who is working alongside the new nurse and facilitating his or her orientation.

BACKGROUND

The orientation process for NLRNs is a significant time in their professional careers. All the education and training prior to their first professional role is part of their repertoire of skills as they enter the professional practice environment. The structured support and organized, systematic approach to learning one's role responsibilities during orientation is integral to the success of a new nurse in the practice setting (Bullock, Groff Paris, & Terhaar, 2011; Figueroa, Bulos, Forges, & Judkins-Cohn, 2013; Rivera, Shedenhelm, & Gibbs, 2015). Structured orientation enhances critical thinking, clinical judgment, time management, and the organizational skills of the new nurse. Working closely with a supportive preceptor provides opportunities to develop skills and confidence. New nurses need this consistent support from the preceptor in order to gain comfort in the clinical setting. Knowledgeable preceptors committed to their role of teaching, role modeling, and providing feedback assist in the orientation process (Cotter & Dienemann, 2016; Gueorguieva et al., 2016). Developing competence and confidence in the clinical setting also leads to improved role satisfaction and retention.

LITERATURE REVIEW

In *The Future of Nursing, Leading Change, Advancing Health*, the Institute of Medicine, (2010) offered recommendations

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related to nurses practicing to the full extent of their education and training. There is recognition that high turnover rates among new nurses are a concern for many stakeholders, including hospitals, physicians, nurses, patients, and families. Supporting nurses as they transition from academia to practice with emphasis on further development of skills is needed to deliver safe, quality care (Institute of Medicine, 2010). A significant body of literature is available today, which informs nursing professional development (NPD) practitioners about orientation processes and preceptor development tools and the need for transition support for NLRNs from preceptors and other nursing colleagues.

The NLRNs' transition into the practice environment has remained a priority of healthcare institutions for several decades. Dr. Marlene Kramer (1974) first coined the term "reality shock" to describe the gap between what is taught in school versus the reality of what is experienced in practice. Considerable work has been done to study the effects of role transition from student nurse to professional nurse. Recent research by Dr. Boychuk-Duchscher (2012) described how this role transition affects the nurse's whole being and is not just related to his or her professional role. Qualitative research on the phenomena of new nurse transition illustrates the challenges NLRNs face in the workplace. These challenges include the emotional aspects of caring for complex patients, intense periods of learning, professional acculturation, a sense of being nurtured, preceptor variability, and development of professional role responsibilities (Martin & Wilson, 2011; Pinchera, 2012; Spiva et al., 2013).

Preceptors have an integral role in the development and support of new staff through modeling professionalism, teaching nurses how to navigate the healthcare system, and bridging the gap between concepts learned in school and meaningful application in practice (Roth, Figueroa, & Swihart, 2014; Windey et al., 2015). Preceptors who are trained to work with NLRNs provide a sense of support and guidance to the new nurse during the orientation period. The preceptor role models professional behaviors that the orientee can observe and replicate. Creating a safe practice environment where the NLRN is continuously supported and provided with meaningful feedback is essential to successful completion of orientation and the development of comfort and confidence in the clinical environment. An important role for the NPD practitioner is to support preceptors in their work with new nurses through developing strategies for teaching and learning. Innovative strategies to enhance critical thinking, clinical problem recognition, and timely responses to patient deterioration are priorities to support an environment of patient safety.

ORIENTATION GAP IDENTIFIED

Based on the literature review, feedback from new nurses, and discussions with preceptors and nurse managers, a gap was identified between the current method of clinical unit orientation and the needs of both NLRNs and preceptors. Thus, an opportunity to improve the orientation process was identified, and a revision to the clinical unit orientation within eight inpatient units at a large Midwest teaching hospital was deemed a priority.

Traditionally, the clinical unit orientation at this institution consisted of an orientee and a preceptor assignment based on an incremental productivity model. The orientee-and-preceptor pair would have one patient for a certain number of shifts, then increase numbers of patients all while completing total care for each patient. It was during the last portion of orientation that the pair would have one full assignment and be 100% productive. Nurses new to the practice area frequently stated they wanted more experiences with a full patient assignment earlier in their orientation to enhance their time management, prioritization, delegation, and clinical decision-making skills. This repetition of skills with multiple patients and watching the professional practice of the preceptor allows for concepts to be observed then practiced repeatedly; therefore, orientees gain confidence and competence in practice.

METHODS: TSAM DESIGN

With Benner's (1984) novice to expert model as the framework, the NPD practitioner and a group of preceptors proceeded to develop tiers of skills that moved from simple nursing activities to more complex nursing interventions. A proposal was developed that included objectives, implementation strategies, measurable outcomes, a timeline, and a process for revising the project based on stakeholder feedback. This proposal was shared with the nurse managers on eight inpatient clinical units at one organization; the nurse managers supported using a tiered skills acquisition approach to orientation and precepting.

Tiered or phased orientation models have been shown to provide support and facilitate the translation of knowledge into practice, thus preparing NLRNs to provide safe patient care (Figueroa et al., 2013; Rivera et al., 2015). In TSAM, movement through the tiers is guided by demonstrating competency in mastering specific skills and objectives, not by the time it takes to master all skills for a single patient. The NPD practitioner and a core group of preceptors created the tiers of skills based on experiences of working with new nurses. Several flip charts were placed around the meeting room labeled "simple skills," "medium level skills," and "complex skills." Preceptors used their knowledge and clinical experiences to write skills on the flip charts that they felt were associated with that particular level of skill. For example, on the "simple skills" flip chart preceptors included vital signs, intake and output measurements, and documentation. In addition, each tier has specific learning objectives. These objectives must be demonstrated in order to move to the

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next tier. The orientee only performs specific skills, for example, in Tier 1 vital signs, intake and output measurements, and documentation, all higher-level skills and interventions for the patients are completed by the preceptor with the orientee watching and observing. Once the orientee has mastered a tier he or she moves to the next tier, always continuing the skills from the previous tiers.

The orientee was paired with the preceptor for the entire orientation period following the schedule of the preceptor. The orientee gradually assumed increased role responsibilities based on their demonstrated level of competence. The orientee and preceptor were assigned a patient assignment that would be typical in that specific care environment. There were a targeted number of days of orientation per tier outlined in the orientation; however, the preceptor had the ability to move the orientee through the tiers faster or slower, depending on demonstrated competence. This model worked well for experienced RNs transferring into an unfamiliar clinical unit, as it was individualized and movement through the tiers was based on a nurse's abilities and the preceptor's assessment. Having a consistent preceptor was important to the NLRN related to receiving feedback and assessing the orientees' progress and ability to move to the next tier. If there was a specific learning objective within the tier that the orientee was having difficulty achieving, the NPD practitioner, preceptor, and orientee developed an action plan in order to support the orientee in demonstrating the required level of competence in that tier.

A critical element to the success of the TSAM was having structured resource time for the orientee and preceptor to devote to teaching and learning. Resource time was placed in both the orientee and preceptor's schedule using a special scheduling code. This code alerted charge nurses that the orientee and preceptor would be "off the unit" during this designated time for teaching and learning. The resource time, typically 2–4 hours away from the clinical unit and patient responsibilities, occurred approximately every 2 weeks during orientation. The orientee and preceptor did not work over time or come in extra to accomplish the resource time activities. This structured time was used to improve critical thinking, practice technical skills, review case scenarios, access online learning modules, and debrief clinical situations that occurred during the previous shifts. This time to provide guidance, support, and feedback was valued by both the orientee and preceptor.

OUTCOMES

Qualitative Data

Orientees, preceptors, and charge nurses completed surveys to elicit feedback related to the TSAM for orientation and precepting. The orientees completed the survey within 2 weeks of orientation completion. The preceptors and charge nurses completed surveys at 6 months and 1 year following the redesign of the orientation process. Nurse manager data were collected via group discussion. Based on qualitative data from the surveys, preceptors and orientees rated the TSAM orientation experience as positive; having goals and objectives identified for each tier was rated as especially meaningful and made progression of orientation clear and transparent. Charge nurses reported that orientees were more confident and prepared. They noted that orientees were more independent, open, flexible, and willing to adapt. Nurse managers commented during leadership group discussions with the NPD practitioner on the positive impact of the increase in patient encounters had on the orientee, as demonstrated by the orientee having a higher level of confidence in their skills.

Number of Patient Experiences in Orientation

The number of patient experiences in the TSAM orientation increased by approximately 45% when compared with the incremental productivity orientation model. The TSAM orientation allowed the preceptor and orientee to have one full patient assignment during the entire orientation, which allowed the pair together to have multiple patient experiences. With increased numbers of patient experiences, there is an increased level of comfort and proficiency that the orientee described as extremely important to their growth, confidence, and role satisfaction.

Length of Orientation

The length of orientation time in the TSAM decreased by 18% compared to the previous incremental productivity model of orientation. The TSAM allowed the preceptor and orientee to customize orientation to fit the specific learning needs of the orientee. The pair could then focus on pertinent areas of need rather than focusing on increasing numbers of patients. Overall, the TSAM helped NLRNs and preceptors to organize skill acquisition and objectives so orientation became more efficient.

The implementation of the TSAM provided the opportunity for the preceptors and NPD practitioner to identify earlier in the orientation process when an orientee was not meeting role expectations. Orientees were not moved into the progressive tiers until all objectives in the current tier were met. This system helped to identify and correct areas of concern more quickly than in the previous incremental productivity orientation model. The clear expectations for meeting the goals and objectives in one tier focused the preceptor and orientee on skills needing improvement before moving to the goals and objectives in the next tier, resulting in enhanced competence with specific skills.

RN Retention

RN retention is a metric that also has been positively influenced. This institution has historically had acceptable

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retention rates; using the TSAM has demonstrated a continued success with retention.

Analysis of Cost Avoidance

Although the TSAM was developed to improve the overall quality and efficiency of the orientation experience, a secondary benefit of the model has been cost avoidance with using this framework. When using the previous incremental productivity method for orientation, the preceptor/orientee were less productive (only taking one to two patients between the two of them to start) on the unit, and therefore, additional nurses were needed to care for patients. In the TSAM, the preceptor/orientee pair was fully productive with one full assignment from Day 1. The new model avoided the cost of additional nurses to care for patients; therefore, less staffing has been required to support orientation. In addition, the TSAM outcomes included a reduction of overall length of orientation by 18%; this was a positive cost metric in that the orientees could take an independent assignment sooner than in the previous incremental productivity orientation. The TSAM did incorporate resource time, the off-unit time for strengthening critical thinking and practicing skills; however, even with this time factored into the overall cost, TSAM has demonstrated significant overall cost avoidance.

IMPLICATIONS FOR NPD PRACTITIONERS

A successful orientation that supports NLRNs in their practice environment is beneficial for multiple stakeholders, including NLRN orientees, preceptors, and NPDs. The orientee that is supported with an organized approach to the role responsibilities and clinical expectations and guided by a supportive preceptor is more likely to be a successful, productive employee and to continue practicing nursing. A challenge associated with using TSAM as the framework for orientation included preceptors trying to continue to precept using methods from the previous incremental productivity model. This was a challenge because preceptors wanted to continue to talk through many care experiences instead of actually role modeling the care with a full patient assignment. Considerations that are critical to any change in orientation are supporting preceptors in their role. Continuous preceptor development is important when making enhancements to an orientation program. Partnering with preceptors to develop, implement, and revise the new orientation process is vital. This partnership with preceptors and nurse managers proved to be integral to the success of TSAM. Continually evaluating the change in orientation was also an important factor. With data from orientee and preceptor evaluations, improvements to the orientation process occurred frequently. For example, in the early stages of TSAM, communicating with providers was in Tier 4. The preceptors believed this skill needed to be in an earlier tier; therefore, an adjustment was made to move this skill up within the tiers based on preceptor feedback. Flexibility and adaptability were also very important to the success of this model.

Supporting preceptors through the change in the orientation process was especially important when transitioning from an incremental productivity model to a tiered skills model. The NPD practitioner and preceptors met several times to refine the tiers and resource time activities. Allowing the preceptors to take an active role in the development, implementation, and revision of the process increased the ownership of TSAM by the preceptors and was pivotal to having a successful outcome. The TSAM will provide NPD practitioners another innovative approach to orientation of NLRNs. As the individuals responsible for orientation, competency training, and continuing professional education programs, NPD practitioners are important to the adoption and success of new orientation models.

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Task-Layered Clinical Orientation for New Graduate Registered Nurses

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New nurse residency programs focus on the professional transition from student nurse to clinical nurse. In some facilities, the way in which new graduate nurses are oriented to the fast-paced clinical setting is based on tradition rather than theory, research, or available evidence. This article offers a theory-based approach to clinical practice orientation of new graduate nurses termed *task-layered clinical orientation* and offers an innovative approach for consideration.

Nurse residency programs have proven to be successful in the professional transition and retention of nurses in various institutions. Although much is known about the value of new graduate nurse/residency programs, how best to deliver the clinical precepting of these new nurses has been less of a focus in the literature. The healthcare environment changes rapidly, which may require a look at business as usual for clinical orientation of new graduate nurses. Is the traditional approach to clinical orientation really "tried and true"? This question led to an examination of the traditional clinical orientation and the need and desire to consider alternative approaches to clinical orientation in a new graduate program. The task-layered clinical orientation has been successful in the authors' work as new graduate nurse coordinators and reflects the tenets of cognitive load theory (CLT). Examples of how a task-layered approach to clinical orientation within a new graduate residency program has been successful and a description of this theoretical perspective to support its use are provided in the following discussion.

BACKGROUND

Graduate nurses have dealt with feelings of being overwhelmed and unsure of where to begin patient care when stepping out on their own in the clinical role of registered nurse (RN). Author experience with student clinical groups in various settings, including both academic and hospital environments, provided an understanding of the success that could be achieved using a more targeted learning approach, that developed skill with repetition of tasks, real-time feedback, and a layered approach to increased responsibility. The application of these concepts to the existing nurse residency clinical orientation in two different hospital settings has allowed for more focused and directed learning for new graduate nurses. Because of the anecdotal success of the task-layered orientation approach, the authors are in the process of collecting longitudinal research data to add to the existing literature regarding the use of a task-layered approach to clinical orientation. In lieu of a publication forthcoming on this research, it was apparent that use of a task-layered orientation model for new graduate nurses was not well known and in need of defining.

PATIENT-LAYERED VERSUS TASK-LAYERED

Much of a new graduate nursing residency is focused on orientation to the clinical world of registered nursing. Traditionally, the model for this orientation of new RNs has been a patient-layered clinical approach. Patient-layered orientation involves the new RN working with a seasoned nurse preceptor who shares an assignment for a specific number of patients during the nursing shift. Assume a scenario in which nurses working on an adult inpatient medical-surgical units or acute-care units in the hospital are typically assigned around five or six patients. In a patient-layered orientation model, the new graduate RN may begin the orientation by providing care for two or three of these patients with the careful oversight and guidance of the preceptor. The new graduate RN is expected to provide full nursing care for the patients assigned to them by their preceptor. The preceptor oversees the graduate RN as well as takes care of the additional two or three patients assigned for that particular shift. As the graduate RN gains more competency and experience, the number of patients that they are responsible for progressively increases. The ultimate goal in this clinical preceptorship model is for the new graduate nurse to take responsibility for a full patient load with minimal assistance or oversight from the RN preceptor by the end of their clinical orientation.

In contrast, the task-layered clinical orientation for graduate RNs is a less established clinical orientation strategy

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that emphasizes layering of specific patient care tasks over the number of patients assigned for care. For example, the new graduate would first focus on completing the skills of assessments and documentation for all patients assigned for two to three shifts. The preceptor would be assigned the same patients as the new RN. Once the preceptor deemed that the new graduate had achieved competency in their ability to complete and chart a thorough physical assessment, the next task would be assigned. This next task may be administration of oral medications, which would then be added to (or layered with) the established skill of assessment and documentation for the entire patient assignment. Over the course of the 10–12 weeks of orientation with the preceptor, the new graduate progressively layers and masters additional key nursing tasks to culminate in completion of all nursing care for a full patient assignment. Figure 1 provides a sample of information from the task-layered orientation curriculum used in the authors' institution. The task-layered clinical orientation structure used by the authors allows graduate RNs the chance to master core nursing skills and allows flexibility for preceptors to introduce population-specific skills as the opportunities present themselves.

REVIEW OF LITERATURE

Joswaik (2018) introduced the tiered skills acquisition model (TSAM) to the literature as an effective method for structuring clinical unit orientation for nurses. Described as an innovative process, the TSAM was based on increasing nursing intervention skills from simple to more complex during the orientation period while having a full assignment with the preceptor. TSAM was designed, implemented, and evaluated on eight inpatient clinical units at a teaching hospital with 188 newly licensed RNs (new graduate nurses). Joswiak found through qualitative surveys that TSAM was a positive experience and that charge nurses reported that their orientees seemed to be more confident and prepared. Length of orientation was decreased by 18% when compared to previous orientation methods.

In a scoping review of new graduate orientation best practice literature, Leflamme and Hyrkas, 2020) examined 14 articles and 7 websites, most from which were from the United States (86%). This collective work described the goal of the new graduate orientation to be practicing within the advanced beginner stage of Benner's novice-to-expert model. The word "competency" was regularly used to describe organization or specialty-specific skills that were defined by each organization to determine learning process and evaluation. Many programs incorporated Quality and Safety Education for Nurses (n.d.) in both curriculum and evaluation of competency for new graduate nurses. Others used debriefing, testing, and the American Academy of Colleges of Nursing synergy model for patient care in the initial and ongoing steps of evaluation. Competency was most often assessed on more than one occasion with the use of a skills checklist that was specific to the unit and organization of hire. The scoping review (Leflamme & Hyrkas, 2020) also discussed tools used for monitoring the progression of orientation, such as the Lasater Clinical Judgment Rubric. This tool proposes to evaluate a nurse's ability to make quality clinical judgments that maximize patient safety. In the conclusion, Leflamme and Hyrkas encouraged the use of frameworks and standardized evaluation and progression tools in an effort to use evidence-based, standardized processes in the orientation of new graduate nurses.

In order to streamline competency assessment documentation for new graduation nurses, Beamer et al. (2020) developed a three-phase TSAM for clinical orientation.

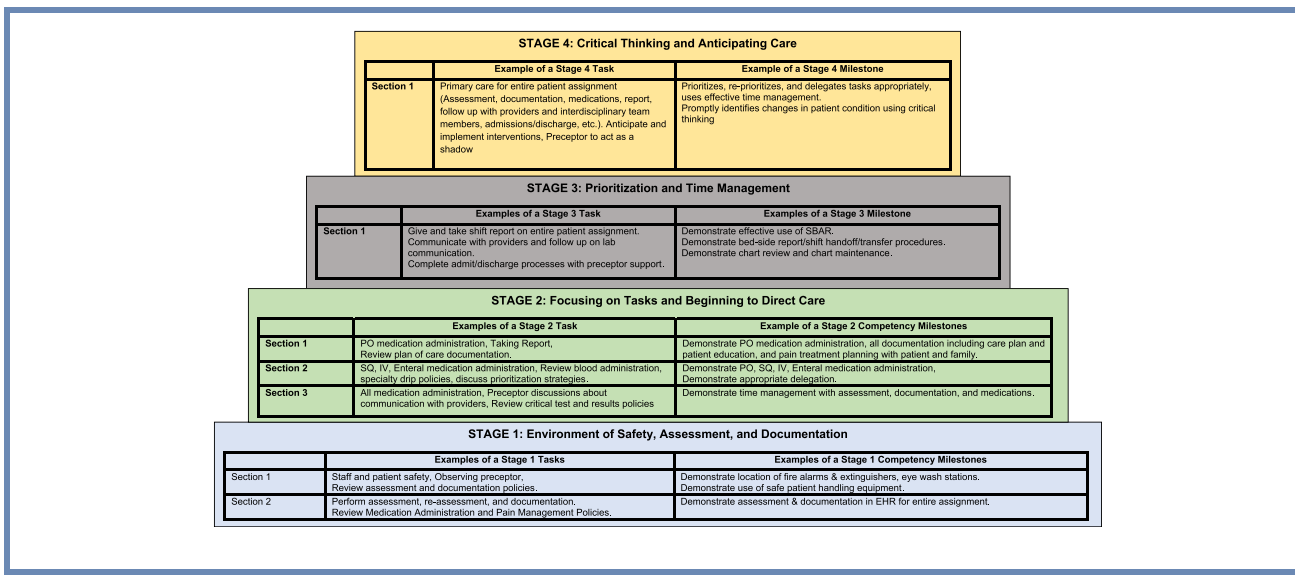

FIGURE 1. The figure is a schematic to show a sample of the task-layered clinical curriculum. This figure is available in color online (www.jnpdonline.com).

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The skills were layered in five levels: Level 1, assessment and documentation; Level 2, medication, communication, and teamwork; Level 3, safety and quality; Level 4, continuum of care; and Level 5, workload management. Although not a research-based article, the authors did report a reduction in orientation weeks, cost savings, time management improvement, and more developed and intentional goal setting among the new employees and preceptors.

Finding poor preceptor satisfaction and a high rate of graduate nurse turnover, Bullock et al. (2011) developed an outcome-focused orientation model. Rather than using time and budget, progression of new nurses through the clinical orientation was verified by accomplishment of strategic outcomes. Utilizing Edwin Locke's goal-setting theory, which proports that performance and motivation are improved by obtainable goals and objectives, a revised orientation was created where collective responsibility was taken by preceptors, managers, and the entire nursing staff to orient new RNs. The orientation process was structured into seven phases, each focusing on a set of outcomes to move the learner toward effective professional practice goals. Unit-specific checklists were developed to further individualize the goals of each orientee. This work clearly parallels the task-layered orientation approach discussed in this article; however, the traditional approach of patient-layered orientation was used. The researchers found that new graduate nurse turnover decreased each year since implementation of the revised orientation program; the first 2 years decreased by 50%, and the third year had a zero turnover rate.

Cohen et al. (2015) implemented an innovative clinical orientation and learning strategy within the nursing specialty of midwifery, finding that pairing two clinical students with one preceptor led to advantages in student accountability, enhanced socialization to the profession, improvement in learning, and decreased teaching burden of preceptors. Students appreciated peer support and the opportunity to both be mentored and be a mentor within the clinical environment. Some students were concerned that sharing clinical experiences was a barrier to their learning and the decision of which student was able to have the actual clinical experience was not always straightforward. Preceptors found advantages such as shared learning and less repetition between teaching moments but also found negotiating the sharing of student space and clinical experiences to be a challenge. In terms of new graduate nursing programs, placing two new graduate nurses with one clinical preceptor would present similar challenges. Although this clinical innovation was successful in the profession of midwifery, it would be more difficult to incorporate into a new graduate residency clinical orientation.

Loy et al. (2017) utilized the layered learning practice model to train pharmacy residents. In this model, pharmacy residents had layered topics of orientation in four steps, including orientation to the layered learning practice model, pre-experience planning, implementation, and post-experience evaluation. Although this example does not layer clinical skills or tasks, it does speak to the layered nature of clinical orientation, incorporating individualized experience to augment the organization and speed at which pharmacy residents are able to complete their training.

Current literature has mentioned the clinical orientation of new graduate nurses and offered some alternatives showing promise. The works that most align with the task-layered approach to clinical orientation are that of Beamer et al. (2020) and Joswiak (2018), both focusing on versions of a TSAM. Adding a theoretical framework as a basis for implementation of a new clinical orientation model can assist in explaining the purpose for such an innovation. Theory can also be a guide for development, implementation, and management of various challenges that can arise with a new approach to clinical orientation of new graduate nurses.

THEORETICAL SUPPORT FOR TASK-LAYERED ORIENTATION

One may not see much of a difference in the traditional orientation method compared to the task-layered orientation approach. However, theoretical perspectives in adult learning and brain architecture point out some key advantages to a task-layered clinical orientation approach that may not have been previously discussed. Those from the world of nursing academia may see a parallel between concept-based curriculum approach to nursing education and the task-layered orientation described here. Use of adult learning theory has been instrumental in the successful implementation of concept-based curriculum in favor of the more traditional systems-based curricular approach (Hendricks & Wangerin, 2017). Adult learning theories are rich in their ability to provide a framework for understanding how adult learners put together information that results in a learning outcome being met. To that end, an introduction to CLT and its application to the task-layered clinical orientation approach will be explored.

CLT is one theory that can assist nurse residency program coordinators in their approach to orienting and teaching new nurses the complex role of patient care in the new graduate time frame. CLT defines *learning* as the accumulation of knowledge, which results in a change in one's long-term memory (Sweller et al., 1998). Long-term memory change (learning) is limited by existing boundaries of human memory capacity. Atkinson and Shiffrin (1968), Broadbent (1981), Lockhart and Craik (1990), and others have explained that information processing theory explains how information moves through the stages of one's memory and how learning subsequently occurs. Information is stored in the brain in a specific way. Short-term memory is the first to process any new information, but new information does not stay available in the brain

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for a long time. If information is not used again or categorized as important information, it will be lost quickly. In a theoretical sense, learning actually "happens" when information moves into one's long-term memory. Items in the long-term memory are stored for later recall when they are needed by the brain.

Beyond this explanation, short-term memory contains both sensory memory and working memory. This is where the learner selects content for processing. *Sensory memory* is limited to approximately 20 seconds of attention capability and allows a learner to filter and categorize elements as necessary. Historical work completed by Peterson and Peterson (1959) furthers this understanding, identifying that without repetition of elements to be learned, content will be lost after 20 seconds. Once the sensory memory categorizes an element to be learned as necessary, it moves on to the *working memory*.

In seminal work about processing information in the human brain, Miller (1956) discovered that the adult *working memory* can process and hold, on average, seven data elements (± 2) at one time. The term cognitive load is aptly described by Miller's findings, helping with the understanding that the brain does not have limitless capacity to manage multiple pieces of information at one time. Knowing this fact, a new graduate nurse can only process five to nine elements at the most at one time. The complex clinical environment of nursing is likely to bring more than five to nine learning elements at one point in time to one learning the bedside work a nurse does on a daily basis.

Long-term memory is unlimited in its capacity for both storage and recall of information necessary to learn and complete tasks accordingly (Peterson & Peterson, 1959; Tarnow, 2003). Long-term memory is key in its role of storing and encoding information for later recall when needed (Baddeley, 1966). Such categorization has been termed *schema construction*. Schema construction is the term to describe how the brain uses something familiar or known and builds new information onto that original idea. New information is then more easily and quickly stored into the long-term memory. For example, suppose the orienting nurse has learned about sterile technique and has those major processes solid within the long-term memory. When learning about new procedures, such as catheterization, which require sterile technique, the nurse can pull from their existing knowledge of sterile technique and scaffold the steps of catheterization within existing knowledge. Why are schemas even mentioned in CLT? A schema can make learning happen more swiftly and easily because of the ability to understand the basic concepts or ideas of the content that needs to be learned. Similarly, chunking of information into groups of information assists the brain in remembering these items and can recall them more readily when they are needed. In a task-layered clinical orientation, novice nurses are more able to use both schemas and chunking of information as they are presented with mastering one task at a time. The alternative approach of accepting full care for a patient load progressively is much more likely to produce unmanageable cognitive load that inhibits both learning and mastery of skills.

CLT Concepts

Using the basics of cognitive architecture as described above, John Sweller was the first to develop the concepts of CLT. CLT considers how learning occurs in the brain, with an effort to develop learning experiences that augment learning ability. Sweller (2003) described the long-term memory in cognition in a similar way that we understand the genetic code. The long-term memory can be likened to a hard drive, storing information for quick recall. Each person stores information in the long-term memory in their own unique manner, making schema construction an individualized process.

Although clinical precepting has been done similarly over the years, one could argue that, from the perspective of CLT, nurse residency programs could be doing more to help new nurses in the clinical realm. Preceptors can orient new nurses to the busy clinical environment in a way that either supplements or obstructs their learning ability. Remember that for learning to actually occur, CLT states that information must be processed by short-term memory and then moved into long-term memory. If a new nurse is given too many elements to learn at one time, it is a real possibility that this makes it harder for learning to occur. More difficult learning typically equates to more time to accomplish mastery of any given task, which in turn could translate to a longer orientation time at the bedside. The complexity of what needs to be learned (intrinsic load) contributes to the total cognitive load. The way new graduate nurses are clinically orientated can contribute to extraneous cognitive load (Sweller et al., 1998). Intrinsic cognitive load cannot be changed. Nursing is a profession that carries with it a very heavy intrinsic cognitive load. The work done by nurses requires critical thinking of many elements at one time, all connected to the safe and effective care of their many patients. The good news is that, according to CLT, the way in which the material is presented to the orienting nurses (extraneous cognitive load) can be altered to make their learning during orientation easier. The total cognitive load is determined by adding the intrinsic and extrinsic cognitive load together. Therefore, it can be easily understood that nursing, having a high intrinsic cognitive load, should have an extraneous cognitive load that allows for learning to balance the total CLT experienced. Task-layered clinical orientation provides a perfect example of a reduction in extraneous cognitive load to counteract the heavy intrinsic load necessary to learn the art and science of nursing at the bedside.

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Application of CLT to Clinical Orientation Model

Chunking of data points and schema building are two important ways that individuals organize and learn information. Chunking is a technique that preceptors can use to assist the orienting nurse in schema formation and the process of learning. It is important to chunk information in small elements first and then move on to the analysis and schema formation of those elements. The task-layered clinical orientation strategy provides a practical example of using chunking to master core nursing tasks (e.g., assessment, documentation, and medication administration) with repetitive experiences that build more and more experiential knowledge into the long-term memory. In this manner, knowledge can build and become more efficient as recall of existing knowledge and scaffolding comes from the long-term memory.

As previously discussed, schemas are developed individually by the learner and are the search engine for human cognition. When a schema is constructed, the learner organizes the information and transfers it to their long-term memory for later recall. For example, each new graduate nurse may create an acronym to assist in learning blood gases or elements of a white blood cell count that makes more sense to them individually. As each learner is introduced to additional information, their schemas become more individualized, better defined, and intricate, and they are more easily accessed from long-term memory for immediate use. The task-layered clinical orientation approach allows for learning one task at a time rather than juggling several learning tasks all at once. Doing so allows for the brain to learn singular tasks that can be used for scaffolding within individual schema. Herein lies one of the main tenets of CLT, that too much information at one time equates to lower rates of learning and retention.

In turn, giving time for schemas to develop can be helpful in expanding the capacity of working memory, which can be extended by pulling different schemas together and treating them as interacting elements. When this occurs, one experiences automation within the brain. With task-layered clinical orientation, the nursing tasks are being introduced one at a time in order to decrease the overall cognitive load for the orienting nurse. Similarly, this approach allows for schema building, which has the potential to greatly increase the long-term memory capacity, recall, and learning for the nurse. A decrease of cognitive load in this manner has the potential to improve understanding, decrease frustration, decrease orientation fatigue and burnout, and result in a shorter amount of time necessary for clinical orientation of new graduate nurses.

CONCLUSION—THEORY IN PRACTICE

In nursing and many other professions, it is arguable that the more experience a person has within the profession, the more of an expert that person will become. Most nurses are familiar with this approach as the Dreyfus model, which has been adapted for nursing by Benner (2001). It makes sense that the more a nurse is subjected to a variety of conditions in the clinical environment, the more comfortable and knowledgeable they will become. Sweller (1988) recognized that preexisting brain architecture could be the key to how one develops from a novice into an expert. When assessing the difference between a novice and an expert chess player, Sweller found that the number of stored schemas from the experience of playing many games of chess made any player more likely to win the game. One may not be surprised by this due to learning our lessons through experiential learning from any number of examples. In this sense, the intelligence of one person over another may have some factor in the winning, but, ultimately, Sweller believed an expert to be crafted by layered, experiential learning and schema formation. Theoretically, the more exposure a novice nurse has to the clinical environment, the more likely they are to move the professional needle to the mark of an expert. Similarly, the more the novice is able to layer important, essential patient care tasks associated with work within the field of nursing, the more quickly one can move toward competency and, eventually, be an expert.

With the precedent information at hand, one could argue that experts accumulate knowledge through experiencing events and/or doing tasks over and over. These experiences form an automatic processing that largely bypasses working memory all together. A nurse who has been in an emergent situation and finds themselves moving swiftly through life-saving measures may appreciate this automation of processes. Clearly, simulations and other practice-based environments used for preparation of emergent situations use repetition of steps to achieve automation during a real-life emergency. Many of the nurses precepting new graduate nurses have adequate experience and knowledge to lead the next generation in clinical orientation. What was once difficult for the nurse preceptor over time and with day-to-day repetition is moved into long-term memory for easy and quick recall. The task-layered clinical orientation approach has potential to augment new graduate orientation in such a way that time for orientation could be minimized and production of RN time be maximized.

As with any change, implementation of the task-layered orientation model did meet some resistance with preceptors and leaders. Learning a new approach takes time and effort, so some resistance to a change was anticipated. The nurse preceptor council within the institution was used as a platform for explanation of the proposed change. Those who precept on a regular basis attend the council meetings and work collectively on solutions to common challenges faced when completing the clinical orientation for new employees and new graduate residency nurses. Once the theory behind the method was described more fully, the resistance of preceptors was softened, and

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acceptance of a new approach was implemented. A 2-year research study is currently in progress to provide outcomes data for the task-layered orientation model. This work will further define the effectiveness of the model and provide outcomes for decisions on implementation on a larger scale in new graduate nurse residency programs.

More research and quality improvement studies are needed to test these theories in the real world of new graduate nurse residency orientation. As research adds to the current state of the literature on the topic, it will begin to provide answers to these questions more definitively and make a place for innovative, emerging models of clinical orientation to successfully challenge the status quo in new graduate nursing programs everywhere. Until then, reflection upon learning theory as it applies to the clinical education of new graduate nurses can, at the very least, inform current and future practices. To this end, the challenge is to look upon traditional practices with a new focus on best practices and application of learning theory, rather than practice as usual.

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JNPD Preceptorship
Column Editor: Jennifer Bodine, DNP, FNP-BC, NPD-BC, CEN

Empowering Preceptors

Implementation of an Orientation Record



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Successful onboarding of new nurses prepares them to provide competent, safe, and high-quality patient care (Strauss et al., 2016). High-quality nursing orientation programs are cost-effective and structured with clear, consistent, and measurable competency expectations (McNamara et al., 2016). Preceptors contribute significantly to an effective orientation process as they evaluate a preceptee's progress in obtaining key competencies and determine when they are ready for independent practice (Powers et al., 2019). Currently, there is a lack of evidence in the literature regarding best practices for consistently evaluating orientation progress and determining when new graduate registered nurses (NGRNs) are ready to move from orientation to independent practice (Laflamme & Hyrkas, 2020).

Nursing professional development (NPD) practitioners can set preceptors up for success by providing tools that empower them to effectively individualize, evaluate, track, and communicate the progress of a preceptee (McNamera et al., 2016). This article will share how two NPD practitioners supporting four inpatient general care units at a large Midwestern teaching hospital developed an innovative *Orientation Record* (Nelson & Zimmerman, 2015) that empowers a preceptor to evaluate, document, and individualize each orientation. This Orientation Record provides preceptors with a structured orientation plan, specific objectives to evaluate, and a flexible timeline. The use of this tool ensures that the preceptee demonstrates all standard goals and objectives and empowers the preceptor to evaluate progress and provide specific coaching and feedback. Implementation of this tool resulted in decreased length of orientation, increased satisfaction of preceptees and preceptors, and ultimately contributed to enhanced retention and cost savings for the organization.

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BACKGROUND

Clinical orientation surveys for 47 orientations from 1 year in the general care specialty were completed by preceptees and preceptors. These surveys, along with the outcomes of these orientations, were analyzed to evaluate and improve the orientation process at our organization. The synthesis of evaluation results revealed that there were three common gaps in quality: (a) unclear expectations; (b) length of orientation; and (c) preceptor assessment of competence, feedback, and communication.

Unclear Expectations

For preceptees to be successful, there must be a clear understanding of expectations and goals for adequate progression. Feedback and survey results revealed that current resources and tools did not afford the preceptee a clear understanding of what their full job expectations and competencies were at the beginning of their orientation. This lack of understanding often created situations where there was a mismatch between preceptee confidence and preceptor perception of readiness for independent practice.

Length of Orientation

The standard length of clinical orientation in this specialty was planned for 12 weeks, with the goal of individualization based on the preceptee's demonstration of skill acquisition. However, the length of the planned orientation was rarely perfect. Many NGRN preceptees struggled with effective time management and prioritization. These challenges often resulted in extensions of orientation. In situations where the preceptee was successfully progressing and had demonstrated required competencies, they were still hesitant to end orientation early, as they lacked overall confidence in their skills.

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Preceptor Assessment of Competence, Feedback, and Communication

Processes were missing for preceptors to consistently assess competence, track progress, and communicate with stakeholders about the preceptee's progression. These missing processes became particularly problematic when multiple preceptors were supporting the same preceptee. Preceptors struggled to objectively articulate expectations for preceptees throughout their clinical orientation, leaving preceptees with an unclear understanding of what was expected of them and desiring more feedback. Common statements preceptors made about struggling preceptees included the following: "they are just not ready to be off orientation," "they need to work on time management," "they need to work on critical thinking skills," and "they are too slow." These statements are very general and were not helpful to the preceptees who needed more specific direction.

TIERED SKILLS ACQUISITION MODEL

During this same time, two surgical inpatient units were piloting a new, innovative orientation model, called the Tiered Skills Acquisition Model (TSAM). This model's premise is to break orientation down into tiers of skills that are ordered from simple to complex (Joswiak, 2018). The preceptor and the preceptee are paired together for each shift with a full clinical assignment. In the beginning, the preceptor is completely responsible for the assignment, and the preceptee observes. The preceptee learns much about time management, prioritization, and managing a full patient assignment simply by observing the preceptor role model these skills. As the preceptee progresses through each tier, they gradually assume more responsibility.

As depicted in Figure 1, in Tier 1, the preceptee is responsible for completing vital signs, assessments, and documentation on all patients. The preceptor remains responsible for medications, orders, admissions, dismissals, complex care planning, and so forth. As the preceptee progresses through the tiers, they gradually assume more responsibility. By the end of the orientation, the preceptee has successfully demonstrated their competence in each tier of job responsibilities, can manage a full patient assignment, and is ready to be independent in their practice. This model has proved to be effective in addressing the development of critical thinking, prioritization, and time management.

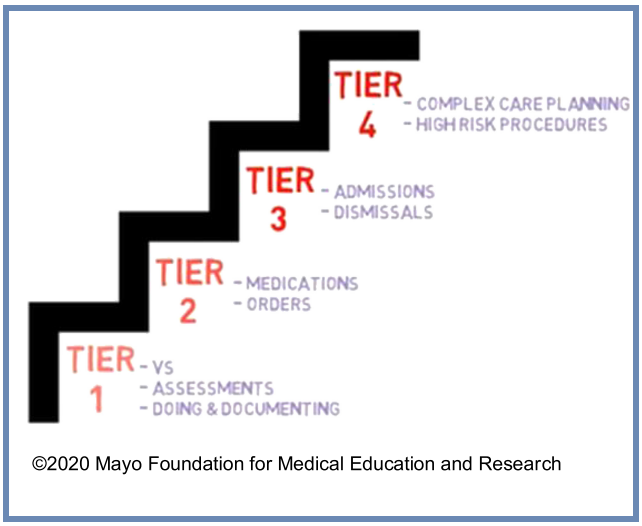

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FIGURE 1. Tiers of skills. This figure is available in color online (www.jnpdonline.com).

QUALITY IMPROVEMENT

Wanting to build off of the successes of the TSAM pilot and close the identified gaps in our orientation program using quality improvement strategies, a team of key stakeholders was assembled, which included two NPD practitioners, a preceptor from each clinical unit (four in total), and a nurse manager. The team's first step was to appraise the TSAM model and determine if it could be translated to the general care specialty. Overall, members of the workgroup were very excited about the strengths of the TSAM methodology and felt that it could be easily translated to any work setting. However, implementation of the model alone would not fully address the three quality gaps of unclear expectations; length of orientation; and lack of preceptor assessment of competence, feedback, and communication. Workgroup members conducted a literature review and performed external benchmarking. Upon conclusion of that work, it was decided that there was a need to develop an original tool that could help guide clinical orientation using the TSAM model while providing clear objectives for preceptors to evaluate to determine preceptee competence. To be effective, the tool would need to address the following:

- provide objectives for each shift;
- align objectives with the tiers of the TSAM model;
- provide structure, yet exhibit flexibility, for the amount of time in each tier and overall length of orientation;
- support feedback both from preceptor to preceptee and from preceptor to preceptor; and
- be easily replicated for other roles, including unlicensed personnel.

Developing the Orientation Record

A draft of a tool called the Orientation Record was completed by a workgroup (see Figure 2). Tiers of skills had already been identified by the surgical units that first piloted the TSAM. However, preceptors still needed guidance to consistently assess the competence of preceptees' demonstration of these skills. In order to accomplish this, specific objectives were identified to align with each tier of skills. The objectives clearly outlined what the preceptee needed to demonstrate to be deemed competent with that tier of

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	Shift Date	Preceptee Responsibilities	Objectives	Objectives Met	
				Preceptor's Initial	Date Completed
Tier 3	Date				
	Date				
	Date				
	Date				
	Date				
	Date				
	Date				
	Additional Shift Dates PRN				
	Communication Box:				
	Signatures below indicate that the Preceptee is ready to progress to the next tier. All tier objectives have been completed.				
	Preceptor	Date	Signature		
	Preceptee	Date	Signature		

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FIGURE 2. Orientation Record template. This figure is available in color online (www.jnpdonline.com).

skills. For example, within the tier for the skills of "assessment and documentation," objectives might include "accurately documents patient assessment in a timely manner according to policy," "demonstrates skin assessment and discusses resources for skin and wound management including pressure injury prevention and staging," and "correlates laboratory and diagnostic testing to the patient condition" among other objectives.

To address the need to allow for a flexible orientation length, the team determined the number of shifts expected for the typical NGRN preceptee to complete each tier. Date boxes corresponding to the expected number of shifts needed for a preceptee to demonstrate competence of each tier's skills were added to the Orientation Record. The preceptee writes the date of each shift they work within a date box for the appropriate tier on the Orientation Record. If the preceptee needs more shifts than available date boxes to complete the tier, these additional dates are added to the "Additional Shift Dates" section. These additions allow the preceptor and NPD practitioner to easily identify when a preceptee is taking longer than expected to complete a tier, allowing for early interventions when a preceptee might be struggling. If a preceptee meets the objectives within a tier before filling in all of the date boxes, the tier is signed off as complete and the preceptee moves to the next tier. This flexibility prevents unnecessarily delaying orientation because of a predetermined orientation length. Using these date boxes, a preceptor is empowered to move a preceptee through orientation at an individualized pace based on their demonstrated competence while acknowledging their abilities and prior experiences. This individualization is particularly helpful for experienced preceptees transferring to the work unit because the orientation length can be determined by actual learning needs rather than a best guess of the appropriate orientation length.

Implementation Plan

Once the Orientation Record was complete, an implementation plan was developed. Buy-in from unit leadership was obtained, and preceptor workshops were held for training. It is important to note that the workshops were a crucial step in the implementation process, as they informed preceptors about the Orientation Record and how to use it and preceptor suggestions were collected for how to enhance the tool to make it easy to use and relevant to practice. Workshops also focused on the following

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key principles for assessing competence and knowing when to appropriately sign off objectives:

- Use organizational policies, procedures, and guidelines as the measuring stick against which to measure preceptee performance.
- Require the preceptee to demonstrate the objective consistently and competently without needing prompting or reminders. One demonstration of an identified skill is not enough to determine competence.
- Apply appropriate evaluation methods for the objective. For example, when evaluating a technical-based objective, the best evaluation method may be return demonstration. If evaluating a critical thinking-based objective, the preceptor may use critical thinking scenarios to evaluate competence.
- Maintain realistic expectations. It is expected that, at the completion of orientation, the preceptee is practicing at the "advanced beginner" level of Benner's (1984) novice to expert model. This level means that the preceptee should be demonstrating safe and competent care, but they may not be as efficient as an experienced nurse working at the "expert" level.

EVALUATIONS AND OUTCOMES

After implementing the Orientation Record, the workgroup met every 2 months to evaluate the orientation process and make enhancements to the tool. Preceptors reported that certain skills needed to be moved to an earlier or later tier. For example, initially, skills related to vital signs, assessments, and documentation were all included in the same tier. However, preceptors identified that this tier was overwhelming and taking too long to master. In addition to vital signs, it was important to focus on intake and output during this early tier. Assessments and documentation were then moved to a separate tier following the vital signs/intake and output tier. This move allowed preceptees to master the critical vital sign/intake and output skills before moving on to assessments and documentation, which were often hard to master because of our complex electronic health record. Preceptors also gave input on the wording of specific objectives, as sometimes the wording of the objective left the preceptor unclear about exactly what they were evaluating. The number of date boxes associated with each tier was also adjusted based on preceptor feedback.

During the first year of use, preceptors and preceptees evaluated 57 orientations using original electronic preceptor and preceptee surveys. The preceptor survey was composed of questions related to preceptor confidence with providing feedback, the preceptee's ability to perform a variety of skills and prioritize and manage time at completion of orientation, as well as the appropriateness of orientation length, types of patient assignments, and overall comments regarding the orientation model and improvements needed. The preceptee survey was composed of questions related to the preceptor's ability to provide timely feedback and promote critical thinking, the preceptee's confidence with managing a full patient assignment independently, appropriateness of length of orientation, and variety of patient experiences as well as overall comments about the orientation experience. Results were compared to the previous years' 47 orientations. Three themes emerged from the analysis of the implementation of the Orientation Record: (a) enhanced communication, (b) increased satisfaction, and (c) decreased length of orientation.

Enhanced Communication

The Orientation Record provided an objective roadmap for a preceptee's orientation plan. This roadmap ensured that all key stakeholders in the orientation process, including nurse managers, NPD practitioners, charge nurses, preceptors, and the preceptee, always knew how the orientation was progressing. This roadmap was essential in being able to quickly identify learning needs and barriers to success. In addition, preceptees were expected to review their Orientation Record with their preceptor at the beginning and end of each shift. This review allowed the pair to identify what objectives the preceptee needed to work on, set goals and role responsibilities, and evaluate progress toward meeting objectives for the shift. This process encouraged preceptees to have accountability for their orientation progression and was particularly helpful whenever a preceptee had multiple preceptors. As the workgroup worked through the rapid cycle Plan-Do-Study-Act process, a communication box was added to each tier of the Orientation Record to enhance preceptor-to-preceptor communication.

Increased Satisfaction

One hundred percent of preceptees using the Orientation Record were satisfied or very satisfied with their orientation, resulting from a process and tool that allows for customization. Both preceptors and preceptees reported that they appreciated the structure of the Orientation Record. Preceptees reported it being helpful to know exactly what they were being evaluated on each shift and preceptors reported benefits in knowing specifically what objectives for which they should be providing feedback. In years past, preceptees have consistently shared that increased feedback from preceptors improved their orientation experience. With the implementation of the Orientation Record, preceptees reported their preceptors' ability to provide timely feedback as "excellent" 87% of the time, an improvement from 60% preimplementation. Similarly, preceptors ranked their confidence in providing feedback

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as "confident" or "very confident" 99% of the time, compared to 78% preimplementation.

Decreased Length of Orientation

The Orientation Record is designed to incorporate adult learning principles and empower the preceptee to be self-directed. One hundred percent of preceptees using the Orientation Record reported that the length of their orientation was "just right." The year before implementation, a total of 33 shifts were added to the planned orientations. Through the implementation of TSAM and the Orientation Record, we canceled 166 planned orientation shifts, resulting in a decrease of planned orientation by 2 weeks the following year, a 20% reduction in time and resources. The following statements reflect the thoughts of preceptees regarding the ability to individualize the length of their orientation.

- "I felt very empowered by my preceptors. When I was able to prove I could perform a skill, they would give me more and more independence."
- "Having the freedom to set my own pace was beneficial. Having so many different preceptors forced me to be more proactive in establishing my comfort level with each day's tasks. I like building up my tasks and responsibilities slowly."

An additional benefit of the Orientation Record was that it allowed for early identification when a preceptee was struggling. If the preceptee was requiring many more shift dates in a particular tier than was expected, this was a clear indicator to the preceptor to involve the NPD practitioner, allowing for strategies to be put into place that refocused the preceptee and promoted their progression. Early identification of barriers and intervention with targeted learning strategies are crucial to preventing an extended orientation (Mathen & Hoke, 2020).

IMPLICATIONS FOR NPD PRACTITIONERS

The literature recommends that organizations develop or purchase evidence-based tools that serve as roadmaps to track orientation progress and to assist with determining when a preceptee is ready for independent practice (McNamara et al., 2016). A literature review completed by Laflamme and Hyrkas (2020) identified a lack of evidence for best practices for evaluating preceptees during orientation. This Orientation Record effectively addresses this gap. The strategies used and the tool developed build off the current state of evidence available in the literature. It can easily be translated to both large and small work areas across the nation. Since the original pilot, the Orientation Record has been replicated and translated to various other healthcare roles, including licensed practical nurses, patient care assistants, health unit coordinators, and technician roles. In addition, the use of this tool has been disseminated to all nursing units at our healthcare organization and successfully adopted at several external organizations.

CONCLUSION

In conclusion, it is important to ensure that preceptors have the necessary tools to consistently evaluate preceptee progress and readiness to practice independently. Orientation records similar to the one described in this article can be easily developed using the methods outlined. As teams look to replicate this work, it is essential to identify and engage key stakeholders from the initial conceptual development through the ongoing evaluation process. Approaching the implementation of the Orientation Record using evidence-based quality improvement methodologies promotes overall success.

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JNPD Preceptorship
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Preceptor Teaching Tools to Support Consistency While Training Novice Nurses

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As experienced nurses leave the profession and new graduate registered nurses (NGRNs) enter the field, there is a potential shortage of nurses with the appropriate level of skills and knowledge to safely care for patients. Simultaneously, the nursing practice environment is becoming increasingly complex, creating new challenges for those entering the profession (Hoffler & Thomas, 2016). NGRNs are now taking longer to transition from novice to competent nurse. In a recent Association for Nursing Professional Development webinar (Boston-Fleischhauer, 2020), this phenomenon is defined as the "experience–complexity" gap. Boston-Fleischhauer identifies a focus on preceptorship as one strategy to address this gap and recommends that nursing professional development (NPD) practitioners prepare preceptors to be competent teachers and equip them with "teaching kits" to ensure that they correctly and consistently teach essential competencies. Many preceptors are still novices in their practice, and experienced nurses are often incorrectly assumed to know how to teach (L'ecuyer et al., 2018). Thus, both experienced and novice nurse preceptors can benefit from teaching tools.

BACKGROUND

The Tiered Skills Acquisition Model is a framework for orientation and precepting that was designed, implemented, and evaluated within our organization in 2016 (Joswiak, 2018). The foundation of this orientation process involves a strategic approach to moving a preceptee through tiers that are based on Benner's Stages of Clinical Competence, moving from simple skills to more complex interventions (Benner, 1984). A preceptor is partnered with the preceptee during the clinical experience and functions as a guide and evaluator of clinical practice. During the orientation process, the preceptor and preceptee are provided resource time, which is dedicated time away from the clinical unit to enhance technical skills, clinical judgment, and critical thinking. During resource time, the preceptor uses adult teaching/learning methods designed in collaboration with the NPD practitioner. This structured approach to supporting the preceptor during resource time is twofold. First, there is consistency in training because preceptors are working through concepts in an organized format. Second, even if the preceptor is a novice in their role, they have the teaching tools and strategies to provide the essential concepts to the preceptee in a systematic, logical way.

During resource time, a preceptor guides the preceptee through review and debrief of clinical scenarios and hands-on practice of technical skills. The resource time is individualized to meet the preceptee's specific learning needs. Engaging activities make teaching and learning more effective and fun. From our experience, some computer-based training is acceptable; however, having preceptees spend multiple hours during the same day completing computer-based training has not been an effective method for concept comprehension or translating those concepts into clinical practice. Promoting critical thinking through activities to stimulate clinical decision-making has been an effective method to support novice nurses during their orientation. A preceptor cannot simply "talk" through every detail of a specific patient case and assume the preceptee will have the recall and ability to appropriately care for that patient type in the future. Preceptor teaching tools can be customized to be used in many clinical settings.

ORIENTATION TOOLKITS

Orientation toolkits were developed to ensure essential competencies are taught using standardized and appropriate resources. Each *orientation toolkit* focuses on a specific topic

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that a preceptee needs to master. A standardized guide of key concepts and activities are covered related to the topic. For example, an orientation toolkit on the topic of patient assessment guides the preceptor with specific concepts to teach and activities for the preceptee to complete related to the patient assessment topic. Toolkit instructions direct the preceptor to assess the learning needs of the preceptee, to select activities from the toolkit that will best meet their individualized needs, and to validate that the preceptee has learned and can apply key concepts appropriately. Two types of toolkits were developed. Departmental toolkits focus on topics that every nurse in the Department of Nursing should learn (e.g., medication administration, diabetes, fall injury prevention, skin integrity, and sepsis). Specialty toolkits focus on topics pertinent to specific specialties (e.g., telehealth, oncological emergencies, and pediatric growth and development). The toolkits are stored on a webpage easily accessible by preceptors. These toolkits were developed by NPD practitioners in collaboration with nurse managers, clinical nurse specialists, and a broad representation of preceptors.

An *orientation toolkit* template was designed to provide a consistent structure for toolkits (see Figure 1). The components of the template are intended to ensure that key concepts of the topic are taught in a standardized logical way as well as provide an opportunity for application of concepts learned. The layout of a toolkit includes a "review of resources" section, which contains elements such as organizational policies, procedures and guidelines, accreditation standards of practice, and patient education resources. The Discussion section prompts the preceptor to highlight important discussion points related to the topic. The Documentation section ensures that the preceptor teaches the preceptee documentation requirements related to the topic and often prompts practicing this documentation using a test patient. The Activities section contains a variety of activities for the preceptee to complete, such as case scenarios, situation, background, assessment, and recommendation (SBAR) communication, resource location and bookmarking, patient education practice, and skills practice. These activities vary based on the topic of the toolkit. The preceptor can select whatever activities they think will be most beneficial to complete based on the preceptee's learning needs and the clinical practice environment. The bottom of the template includes a section for "additional resources," which includes resources that can be used for additional review if needed or desired. The inclusion of this section allows the content within the toolkit to focus on key components without overwhelming preceptees with too much information. A "resource location assistance" section was added to the toolkit template in response to preceptors' feedback that locating resources was often challenging. This section gives directions on how to search for policies, web pages, documentation, and quick reference guides and also provides instruction on how to locate and use a "test" patient for documentation practice.

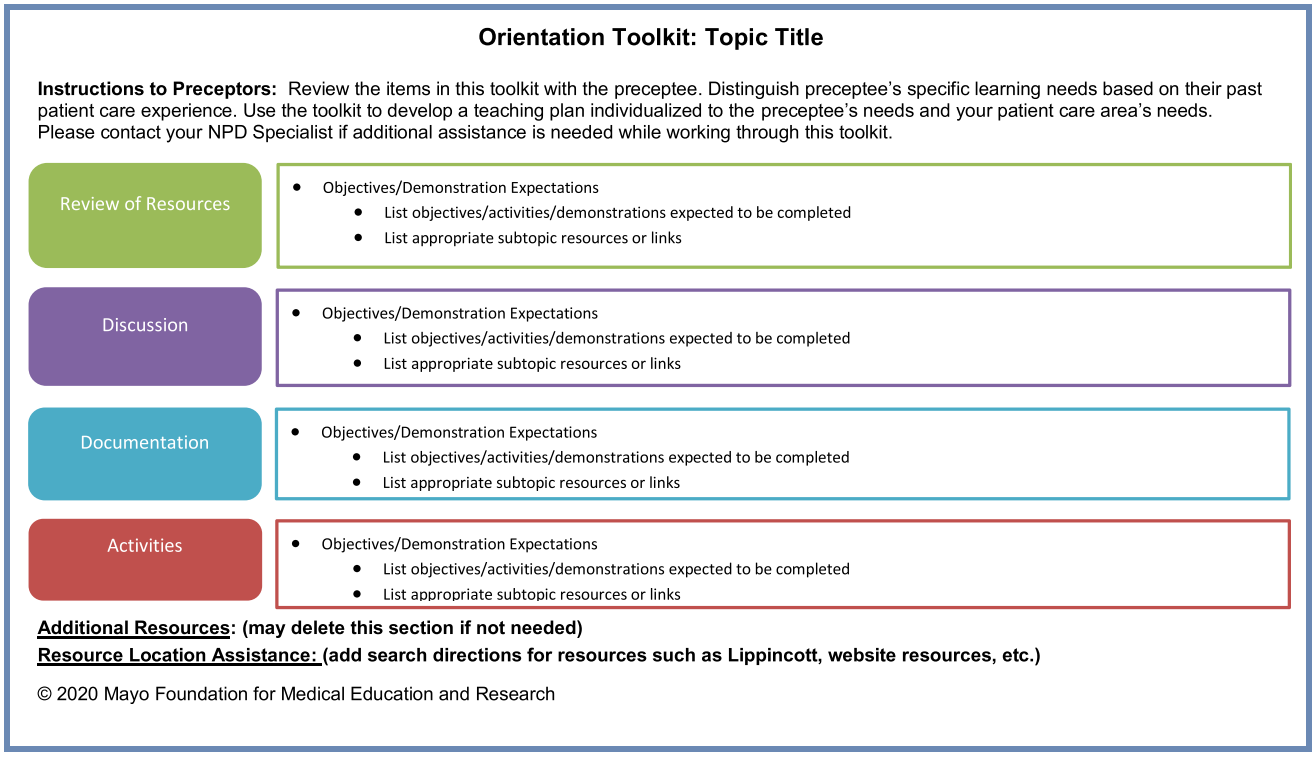

FIGURE 1. Orientation toolkit template. This figure is available in color online (www.jnpdonline.com).

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Once essential competency topics are identified, content experts build toolkits for each topic using the template. Content experts are selected based on the topic. For example, an NPD practitioner may collaborate with the Diabetes Clinical Nurse Specialist and a group of preceptors from a clinical area with a high volume of diabetic patients to develop the *Diabetes Orientation Toolkit*. A group of preceptors from a variety of patient care settings then reviews completed toolkits and provides input on the usability and comprehensiveness of the toolkit. This step in toolkit development is an important part of the process not only to gain preceptor "buy-in" but also to ensure the toolkits are user friendly and can be used effectively by preceptors. The final version of the toolkit is then uploaded to the *orientation toolkit* webpage. The NPD practitioner who oversees the preceptor program ensures orientation toolkits are reviewed and updated annually or as needed with practice changes.

The pain management toolkit is one example of an orientation toolkit. This toolkit includes the following.

Review of Resources

- Organizational policies, procedures, and guidelines related to pain management
- Micromedex
- Patient education pamphlets related to pain management, including required pain education components
- Alternative pain management resources (e.g., Integrative Medication and Health and Holistic Nursing resources)

Discussion

- Nursing responsibilities with pain management, assessment, and reassessment
- Identify five appropriate pain interventions for your patient population
- Use of pain scales as appropriate to your patient population (e.g., 0–1 Numeric Pain Intensity Scale, Adult Behavioral Pain Scale, Faces Pain Scale)
- Appropriate wasting of narcotics
- The role responsibilities of hospital pain service providers

Documentation

- Demonstrate and discuss the following pain documentation pieces
- Pain assessment including pain scale
- Pain reassessment (discuss appropriate timeline)
- Documentation related to pain reassessment when patient is "asleep" (must document respiratory rate and pattern, etc.)
- Documentation of pain medications and infusions

Activities

- Demonstrate safe use of medication infusion therapies based on organizational procedures and guidelines
- Patient Controlled Analgesia (PCA) pump
- Epidural pump
- Locate and view video resources related to use of pain infusion pumps
- Complete one to two pain management case scenarios (linked to toolkit)

Additional Resources (note that this section is available for additional learning related to this topic but not essential)

- Explore the Complementary and Integrative Therapies website and patient education materials
- User manuals for each pump
- Medication diversion webpage

SIMPLE PRECEPTOR TEACHING TOOLS

The NPD practitioner, in collaboration with clinical preceptors, developed simple teaching tools and activities that are used with the *orientation toolkits* to provide an organized approach to resource times. Active learning strategies include *think it out talk it out cards* (Nelson et al., 2012), *critical thinking worksheets* (Carlson, 2015), *medication scenarios* (Joswiak, 2016), and *search it find it cards* (Joswiak, 2016).

Think It Out Talk It Out Cards

Think it out talk it out cards emphasize clinical concepts and promote discussion of appropriate and safe actions. The clinical concept is written on one side of a card, and an appropriate response/answer/resource is written on the other side of the card. The preceptee selects a card from the "deck" and talks through what they would do in that situation. The preceptor guides the discussion and makes sure the preceptee is analyzing and processing correct actions based on the information. The preceptee then selects another card and continues this activity. The "deck" has multiple cards, and the ability to customize this activity based on clinical specialty and level of care is easy. Examples of *think it out talk it out* cards are as follows:

- "What if you are caring for a 90-year-old female with a series of strokes? You assess she is at high risk for skin breakdown. What nursing interventions are appropriate for this patient?"
- "What if you are caring for a 36-year-old patient with asthma? She complains of chest tightness and wheezing. What nursing interventions are appropriate?"
- "The nursing assistant has recorded a blood pressure reading of 144/92 for an obese adult patient. The usual readings for this patient have been 120–130/70–80. You checked that a proper-sized cuff was used. What more can be done to assess the accuracy of this reading?"
- "While administering medications to an 86-year-old receiving heparin therapy, you notice blood oozing around the venipuncture site. What are your concerns in this situation? What actions must you take?"

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- "You are caring for a 65-year-old male who was admitted for a right pneumothorax. His chest tube is at 20 cm low continuous suction. The provider has ordered it to be on water seal. Approximately 1 hour after you put the chest tube to water seal, the patient complains of chest pain and shortness of breath. His respirations are 36 and labored, and his oxygen saturation is 85% on room air. What immediate actions should you take?"

Critical Thinking Worksheets

Critical thinking worksheets are based on general situations that could arise anywhere in the clinical setting. The preceptee reads through a situation, such as "You enter the patient room to find him diaphoretic, confused, and experiencing slight tremors" or "You are caring for a patient whose vital signs indicate a sudden drop in blood pressure." The next portion of the worksheet asks, "What are three possible causes of this situation?" The preceptee needs to think through the situation and write down or state the possible causes. In addition, based on the cause the preceptee identified, they would need to describe what they would see if this was the cause and what actions they would take. For example, with the diaphoretic, confused, tremor situation, if the preceptee stated hypoglycemia as the cause, they would need to indicate what they would assess, see, and do. If they indicated fever/sepsis as the cause, they would need to indicate what they would assess and appropriate interventions to initiate. Finally, on the worksheet, the preceptee completes a communication section using SBAR. This part of the worksheet has been extremely helpful because many preceptees are confident or state they are confident in SBAR for communication. However, when asked to write the SBAR down, some have difficulty demonstrating this skill. Practicing SBAR using the situation on the worksheet has been a valuable teaching method.

Medication Scenarios

Medication scenarios is an activity based on analyzing medication orders and discussing/demonstrating appropriate actions and reassessments for each situation. Examples of medication scenarios include the following:

- Provider orders: 0.9 normal saline + 20 mEq K at 50 ml/hour continuously. Zosyn 100 mgq 6 hours due now, patient is nauseated and is NPO, patient has order for Zofran, patient has low magnesium and provider has just ordered 1 g magnesium, and patient also has low urine output and provider has ordered 500 ml fluid bolus. The patient has one intravenous line. Talk through with your preceptor what you will do to accomplish completing these orders and keeping the patient safe.
- If your patient's electrolyte level was this: Mg 1.8 mg/dl, K^+ 2.7 mg/dl, and Ca^+ 3.8 mg/dl, what treatment would you expect to occur?
- 0.45 NS + 20 mEq K^+ @60 ml/hr continuously, K^+ 60 mEq IV @ 100 ml each over 1 hour (six potassium riders in total). Patient complains of pain in arm with intravenous therapy (IV) and is complaining of nausea. There is an order for Zofran 4 mg IV once. What actions do you take for this patient?

An important element of this activity is for the preceptor to facilitate questions that prompt the preceptee to critically analyze the appropriate actions that need to occur. The guided support of the preceptor enables the preceptee to discover why certain actions are needed first rather than other actions (prioritization). There is also time to review medication administration guidelines and access compatibility data as well as apply technical skills with medication scenarios, including setting up infusion pumps, programming correct dosages of medications ordered, and practicing with intravenous tubing and connectors. During the discussions and practice time, preceptors have discovered that preceptees gain improved confidence with their decision-making and technical skills.

Search It Find It Cards

Search it find it cards are designed to assist the preceptee in using electronic resources effectively. This activity is also played with a "deck" of cards. The preceptee selects five cards, reads the activity on the card, and then demonstrates how to navigate to the appropriate electronic resource. In addition, the preceptee can "bookmark" the resource for future use. This strategy can also be played with more than one preceptee, each selecting cards and then timing them on finding the resources. Instead of having preceptors talk through where to find resources, this activity involves the learner in the process of navigation. Examples of *search it find it* cards include the following:

- "Locate in the electronic record where to find medications administered in the Emergency Department."
- "Demonstrate how to find the policy for moderate sedation."
- "Navigate to register for an upcoming education offering."
- "Identify how to locate interpreter services."
- "Find the quality dashboard for your clinical unit."

OUTCOMES

The reaction to the active teaching tools described has been overwhelmingly positive from both preceptor and preceptee perspectives. Using adult teaching methods to engage the learner in the process and individualizing the teaching to meet the needs of the learner has elevated the role of the preceptor. Confidence in being able to teach concepts consistently allows the preceptor to promote preceptee

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learning effectively. Preceptor surveys completed during the past year indicate 87% of preceptors are confident with their ability to locate and use orientation teaching tools and enhance preceptee critical thinking skills. Preceptor comments included the following: "*Orientation toolkits* helped keep me on track about what I should be teaching"; "*Think it out talk it out* cards are fun and easy to use"; "*Search it find it* cards even helped me find resources that I could not locate before." Preceptee surveys completed during the past year indicate 94% of preceptees felt that activities completed during resource time enhanced their practice. Preceptee comments included the following: "I liked orientation toolkits a lot because they explained everything and made sure that you hit all the appropriate points in orientation"; "The scenarios challenged me and helped prepare me for real-life situations"; and "I like the *think it out talk it out* cards; resource time was a safe place for me to figure out how to handle situations."

LESSONS LEARNED

Feedback from users of the teaching tools identified areas for improvement. With regard to the *orientation toolkits*, keeping the toolkits simple and providing direction are essential. If too much information is included in the toolkit, the user is not sure where to place their focus. For example, rather than directing the preceptee to review the diabetes webpage, which contains an overwhelming amount of information, it is more helpful to give them specific items to find and discuss on that webpage. Providing a few suggestions for activities and discussion points is more helpful than providing so many that the preceptor is overwhelmed with choices. When directing preceptees to find online resources, it is helpful to provide them with navigation and/or search directions rather than link directly to the resource. Links often "break," and using a link does not teach the preceptee to find the resource on their own. In regard to the simple teaching tools, it was discovered that the tools are the most helpful to preceptees if they are designed with input from preceptors so that the topics covered are relevant to actual practice. Some preceptors reported not being aware of the teaching tools available to them. Thus, a component of the initial preceptor training course was added to provide preceptors the opportunity to locate and explore various teaching tools and practice using them. Resource time

Resource Time Checklist #1	Date	Preceptor Initials
☐ Review preceptee notebook: Preceptee is to lead conversations and ask questions about clinical experiences utilizing their notebook.		
☐ Department of Nursing Toolkits: Use these toolkits as a resource. ☐ Medication Management ☐ Infusion Pump ☐ Assessment ☐ Documentation ☐ Safe Patient Handling ☐ Required Reporting		
☐ Unit Specific Toolkits: ☐ Warfarin ☐ Lovenox		
☐ Review 3-5 Search it Find it cards. Preceptee should utilize the computer to demonstrate finding resources.		
☐ Review 2 Medication Scenarios. Discuss issues relevant with each scenario.		
☐ Think it Out Talk it Out cards. Complete 5-6 cards, discuss correct interventions.		
☐ Locate and review 2-3 Lippincott Procedures and bookmark. ☐ List guidelines reviewed here: _____ _____ _____		

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FIGURE 2. Resource time checklist example.

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checklists (see Figure 2) have been developed to guide preceptors in suggested activities to complete with preceptees during resource time. In the case that dedicated resource time is not available, these activities can be completed during patient care downtime.

CONCLUSION

Preceptors play an important role in the successful transition to practice of NGRNs (Powers et al., 2019), and a structured approach to assist preceptors in teaching specific concepts is necessary to ensure preceptor consistency and accuracy with teaching. Providing a variety of teaching tools is one way NPD practitioners can empower preceptors to teach critical concepts while integrating adult learning principles and active learning. These tools have been demonstrated to be fun and effective in assisting novice nurses in learning and applying concepts to practice, thereby promoting the quality and safety of patient care.

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JNPD Preceptorship
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"Just in Time" Training for Novice Preceptors

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Preceptors play an integral role in support of new clinical staff members. Development of preceptors through education and training to function effectively in the role is essential. A primary role of the nursing professional development (NPD) practitioner is individualizing the training of a novice preceptor in order to support them while working with a new nurse. Some organizations have structured, planned courses offered periodically throughout the year to train novice preceptors in their role. This centralized approach to preceptor development is a good strategy to support preceptors; however, there are times when a novice preceptor is needed to orient a new staff member, and the timing of the centralized preceptor course does not coincide with the need for a preceptor.

BACKGROUND

The success of newly licensed registered nurses (NLRNs) in navigating the transition to the practice setting is linked to adequate preceptor development and support (Shinners, Africa, Deasy, & Franqueiro, 2018). Preceptors role model professional behaviors and have a unique opportunity to further develop NLRNs while they are working closely together during the orientation period (Joswiak, 2018). Preceptors also assist in creating a safe clinical practice environment for the NLRN that encourages questions, curiosity, and discovery. However, one of the main barriers to having effective preceptors is inadequate preparation and support (Panzavecchia & Pearce, 2014). Thus, the need to identify strategies to support the training and development of novice preceptors is essential for successful NLRN orientations and preceptors' confidence in their role. The needs of novice preceptors may vary depending on clinical experiences, ability to provide direction and feedback to NLRNs, using concepts of adult teaching and learning, and the skill of evaluation of clinical practice. A critical factor in preceptors' engagement in the role is direction and support from nursing leadership (Bodine, 2018).

Clinical preceptor feedback at a large Midwestern teaching organization identified a gap related to the flexibility and content of the centralized preceptor orientation course offered to teach novice preceptors the skills necessary to be successful in their role. The purpose of this quality improvement initiative was to develop and evaluate a clinical-based orientation to the role of preceptor, which could also be used as "Just in Time" training for novice preceptors.

METHODS

A workgroup of key stakeholders was convened consisting of clinical preceptors, two NPD practitioners, and one nurse manager with a goal of working collaboratively to design and evaluate an innovative option to train novice preceptors. This clinical-based preceptor orientation was used to develop new preceptors when the formal, centralized course was not available. The tools created for this clinical-based preceptor orientation were also used for "Just in Time" training when needed by novice preceptors.

The first step in this quality improvement initiative was to examine the gaps that existed in the centralized preceptor orientation course. This course was not always available when new preceptors needed to be trained. "Just in Time" training was needed for use by novice preceptors whenever they identified a gap in their knowledge or skills related to the preceptor role. The centralized course taught

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the following broad concepts: organizational orientation overview, use of orientation forms, giving and receiving feedback, and evaluation of orientee performance. However, the specifics of clinical-based preceptor requirements and expectations were not included in the centralized course, supporting the need for a clinical-based preceptor orientation. Based on the identified gaps, it was determined that the clinical-based preceptor orientation option would be flexible. Content would be specific to the clinical area, giving the novice preceptor the nuts and bolts of what they need to know to be effective in their role.

Additional skill development could be achieved when the scheduled centralized course was available. Participants found more meaning in the centralized course after having experience as a preceptor on the clinical unit. Preceptors were able to use knowledge gained from their experience precepting and apply it to the concepts included in the centralized course. For instance, during the giving and receiving feedback portion of the centralized course, preceptors were able to use examples from actual interactions where they provided feedback to NLRNs in the practice setting.

The second step in this quality improvement initiative was to develop the content for the clinical-based preceptor orientation. The workgroup reviewed evaluations of current preceptors and orientees to determine where preceptors had gaps in knowledge and skills related to their role. Additionally, the group reviewed the content of the centralized preceptor orientation course, the components of the clinical-based orientation process, and available online resources. A checklist of knowledge and skills that a novice preceptor would need to work in the role effectively was created. The checklist included items related to the clinical-based orientation process and items identified as gaps from preceptor surveys. For example, many preceptors indicated that they had difficulty finding online tools and resources related to clinical orientation. Thus, an item was included on the checklist directing the novice preceptor to explore resources on the organization's preceptor and orientation web pages. Additional items on the checklist included reviewing the orientation paperwork, practicing critical thinking skills, and exploring what to do on the first and last day of clinical orientation. A large group of preceptors reviewed the checklist, and nurse managers provided feedback on the usability and content. Finally, the completed "Preceptor Orientation Checklist" (Figure 1) was added to the clinical unit web page where it could be easily accessed.

The third step was to develop activities and resources to teach the items on the checklist. Workgroup members were paired and assigned a checklist item to develop. Once all items were developed, the entire group reviewed and refined the checklist and supporting activities. For example, one item on the checklist was to review "First Day" activities. On the first day of clinical orientation, the orientee and preceptor review the role expectations required for orientation. During this time, they also review the process for clinical orientation using the tiered skills acquisition model (TSAM; Joswiak, 2018). Short video vignettes that identify key principles to expect during orientation were created to support the preceptor's and the orientee's understanding of TSAM. The preceptor and orientee watch the videos and debrief any questions the orientee may have. The videos include the following:

1. Precepting: The Tiered Skills Acquisition Model–TSAM (4 minutes 44 seconds)
2. TSAM: Preceptor and Orientee Partnership (1 minute 45 seconds)
3. TSAM: Preceptor Role With the Orientation Record (3 minutes 13 seconds)
4. TSAM: Resource Time (1 minute 30 seconds)

The "Preceptor Orientation Checklist" was used to guide the clinical-based preceptor orientation using a variety of formats. Ideally, the novice preceptor met with the preceptor committee chairperson of the clinical unit or the NPD practitioner to go through the concepts on the list. However, if there was no opportunity to do this before the novice preceptors needing to precept, pertinent items on the checklist were completed independently. For example, if a unit assigned a novice preceptor on the day that an orientee was to administer medications for the first time, the novice preceptor could review the contents of the "Grab and Go" tote for teaching medication administration. A "Grab and Go" tote is a small collection of teaching tools with equipment, case scenarios, and critical thinking exercises that the preceptor uses to guide the orientee through specific skills and clinical practice concepts. The items on the preceptor orientation checklist also worked well to provide "Just in Time" training of novice preceptors. The novice preceptor could refer to the checklist, identify items they needed to know, and review those items in the moment.

The final step for the workgroup was to develop a method for providing ongoing support and evaluation of the process used to train novice preceptors upon completion of the clinical-based preceptor orientation. The NPD practitioner accomplished this by frequently checking in with novice preceptors to provide support and coaching. Additionally, the workgroup identified that it was important to have a formalized checkpoint 4–6 months after the novice preceptor started working in the role. A meeting with the NPD practitioner or the preceptor chairperson or both was scheduled to accomplish this checkpoint. A "novice preceptor follow-up form" (Figure 2) was developed by the work group to guide the discussion. The "novice preceptor follow-up form" provided structure and discussion points for the follow-up meeting. This meeting allowed the novice preceptor an opportunity to share successes,

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Preceptor Orientation Checklist

☐ View "Precepting: The Tiered Skills Acquisition Model- TSAM" video
☐ View "TSAM: Preceptor and Orientee Partnership" video
☐ View "TSAM: Preceptor Role with the Orientation Record" video
☐ View "TSAM: Resource Time" video
☐ Review Orientation FAQ Document
☐ Review and become familiar with contents of sample orientation packet
☐ Discuss resource time expectations and resources
☐ Review "First Day" activities checklist
☐ Review "Wrap up Day" activities checklist
☐ Practice critical thinking and learning activities that can be utilized during resource time
☐ Explore "resource room" and/or "Grab and Go" totes
☐ Become familiar with Department of Nursing online resources
☐ Become familiar with clinical unit orientation webpage
☐ Review Core Curriculum and Nurse Residency webpages
☐ Explain process for evaluating preceptor role

- Seek feedback from peers
- Be accountable to have another preceptor observe you in the preceptor role and provide feedback to you
- Preceptor chair will follow-up with an "orientation follow-up" meeting approximately 4 to 6 months after you become a preceptor

_____ has completed the clinical unit based preceptor orientation and has successfully demonstrated achievement of above listed objectives.

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FIGURE 1. Preceptor orientation checklist.

debrief difficult situations, and discuss challenges as well as potential strategies and solutions.

OUTCOMES

Novice preceptors self-reported increased confidence and competence with their role following "Just in Time" training. One hundred percent of novice preceptors surveyed reported satisfaction with the training. The preceptors' use of online resources increased posttraining, and their ability to translate this knowledge to the NLRN improved the overall experience for both as indicated on postorientation surveys. Additionally, there was great value in the touch point meetings and discussions, as it gave the novice preceptor the opportunity for dedicated time to process through role responsibilities and challenges of precepting after gaining four to six months of experience in the role.

LESSONS LEARNED

The process for clinical-based preceptor orientation and "Just in Time" training for novice preceptors was successful. Having a structured approach to training new preceptors related to their role responsibilities and clinical unit-specific training was important for preceptor development and overall success. As with many new initiatives, there were areas identified to improve the process.

A challenge for the novice preceptor was having secured meeting time with the preceptor chair or NPD practitioner to complete the "Preceptor Orientation Checklist." One solution to this challenge was for the NPD practitioner to work closely with the unit scheduler to proactively schedule this meeting. Group training sessions were added as another option to complete the "Just in Time" training. These meetings proved to be efficient and valuable and maximized the number of novice preceptors that can be trained and debriefed.

Identifying a core group of experienced preceptors to lead the program guaranteed information covered was consistent. Partnering with preceptors to develop and evaluate this process was critical to the success of the novice clinical-based preceptor orientation program. The NPD practitioner guided preceptors through the development of content for the program. The practical experience of current preceptors ensured that the content was relevant to the learning needs of the novice preceptor.

CONCLUSION

Clinical-based preceptor training demonstrated success in efficiently preparing novice preceptors for the role.

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Novice Preceptor Follow-up Form

This time is designated to have open and candid conversations between new RN preceptors and the chair of the preceptor committee. The goal is to discuss progress as the new preceptors navigate through the first few months in the preceptor role. This should be completed 4 to 6 months after initial preceptor orientation.

- What is going well as a preceptor?
- What do you think could be improved in the orientation process?
- What are three of your strengths as a preceptor?
- What are three areas you hope to improve upon as a preceptor?
- Describe your most challenging situation in the preceptor role.
    - How did you handle this?
    - How would you handle this differently in the future?
- Describe your most positive/meaningful experience as a preceptor.
- Review preceptor tips and resources.

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FIGURE 2. Novice preceptor follow-up form.

Although there is great value in a centralized preceptor course, clinical-based content provides the novice preceptor with unit-specific knowledge and skills to train NLRNs to be successful. Preceptors who are confident and competent can provide the support and guidance NLRNs need for successful orientation outcomes. Cost-effective, quality care is the result of having a competent and stable workforce, which is impacted by the implementation of formal preceptor training programs (Senyk & Staffileno, 2017). The NPD practitioner plays an important role in developing a unit-based preceptor program, educating experienced preceptors to lead the program, and evaluating the program to verify it is meeting the needs of the novice preceptors and NLRNs. If there are any questions, please reach out to Dawn M. Nelson at nelson.dawn3@mayo.edu.

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