Clinical Support for the Off-Shift Nurse and the Graduate Nurse: The Clinical Rock Stars

Tracy Gemberling, Nancy Tretter-Long, Lori Reiner, Mary Jean Potylycki, and Carolyn L. Davidson

In November 2005, Lehigh Valley Health Network (LVHN), a 988-bed acute care, academic, Magnet®-designated health network (Allentown, PA), was immersed in change. The organization’s size was increasing steadily. Due to construction of a new patient care tower with expected completion at the end of 2007, a large influx of new employees, especially graduate nurses (GNs), was expected, and a human capacity constraint existed with regard to the education and integration of new staff. Extensive orientation needs were anticipated because GNs came from a mix of educational backgrounds. A plan was needed to assure the educational needs of all staff, especially the graduate nurses, would be met in a way that was compatible with organizational goals, values, and mission.

Recruitment and retention efforts were paramount. In 2005, critical care areas in the network experienced a 6% turnover rate, while medical-surgical areas faced an alarming 18% turnover rate. Overall clinical service RN turnover (including inpatient, home care, hospice, and perioperative areas) in fiscal year 2006 was 13.36% (C. Pifer, personal communication, April 17, 2009). Depending on the specialty, estimated replacement costs for an RN were $42,000-$64,000 (Strachota, Normandin, O’Brien, Clary, & Krukow, 2003). A more recent report, which adjusted baseline nurse turnover costs for inflation, identified per-RN turnover costs as $62,000-$67,000 (Jones, 2008). To assure local financial and quality outcomes, leaders in the network had to develop and assess retention initiatives constantly for medical-surgical RNs.

Literature Review

Job satisfaction has a major impact on the retention of graduate nurses and is influenced by several factors (Bowles & Candela, 2005). New nurses left their first jobs because they experienced stress related to patient acuity, believed patient care was unsafe, perceived they were given too much responsibility, or lacked guidance and support on the job. Additional stressors faced by GNs include lack of experience and organizational skills, unfamiliar patient situations, limited clinical skills, and generalized fear of causing harm to a patient (Christmas, 2008). Many skills required for safe patient care, such as critical thinking, prioritization, and judgments related to patient care, are learned over time through exposure and repeated experience. They have not been acquired by the new graduate just beginning her or his professional nursing practice (Duchscher, 2008).

According to Benner’s skill acquisition model, 2-3 years of practice are needed for the new nurse to achieve competence, confidence, and comfort in managing the many tasks and skills that are part of safe, efficient nursing practice (Benner, 1984).

New nurses often describe feeling “unsupported, overwhelmed, and hung out to dry” as they embark upon their new careers (Christmas, 2008, p. 317). The many stressors encountered by graduate nurses reveal a challenging, frustrating, and anxiety-provoking work environment during a vulnerable time in their new profession. According to Kramer (1974), such feelings and experiences are a natural, expected part of new nurses’ transition process that appropriately are called reality shock. During this time, new nurses experience personal conflict and a difficult transition from the sheltered, structured, knowledge-based environment of nursing school to the fast-paced, chaotic reality of clinical practice.

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nursing practice. Winfield, Melo, and Myrick (2009) suggested reality shock occurs “when new nurses realize there is a gap in what they feel prepared for in practice and what they actually find to be their experience in the workplace” (p. E7). Without supportive orientation programs to ease transition, turnover is often the result. The turnover rate among graduate nurses is much higher than that of more experienced nurses; nearly one-third of new graduates leave employment within the first 6 months, and as many as 57% depart by the end of their first year (Mills & Mullins, 2008). With such high attrition within the first year of employment, graduate nurses leave their first jobs before they have fully transitioned to their new professional roles (Schoessler & Waldo, 2006). Unfortunately, many graduates who leave their jobs also choose to leave the nursing profession entirely (Christmas, 2008). These data, coupled with the costs involved in training new employees, make recruitment and retention an economic priority for every health care organization.

Most hospitals currently have orientation programs to help new nurses transition from their roles as students to professional roles upon the start of employment; programs vary in length and intensity from organization to organization (Scott, Engelke, & Swanson, 2008). However, after completing orientation, new nurses often lack support from their peers (Guhde, 2005). Although LVHN already had a 12-week orientation program for newly hired nurses, feedback from GNs within the organization indicated additional resources were needed to continue to support their transition to the professional role on their shifts of hire.

Medical-surgical RN turnover at LVHN was distressing to leaders and costly to the organization. Surveys of newly hired graduate nurses emphasized the frustrations they experienced: “I sometimes feel overwhelmed…” “It is too busy for me to get everything done…” “It’s not all from being a new nurse, because nurses who are here a long time have the same problems.” “I’m finding that even now – after orientation – I am in situations where I don’t know what to do.” These comments were directed to two new hire liaisons whose job was to assist GNs with integration into their units, problem solving, and adjustment into the RN role. This relationship lasted for 1 year. These new hire liaisons reported many GNs wished they had a resource on evening and night shifts. One GN stated, “It’s hard to be a new nurse and have that support (unit-based educator and director) and communication abruptly end as soon as you’re off orientation.”

Planning

Within this organizational milieu, a multidisciplinary team prepared a proposal to improve the orientation and continuing education process for new and current nursing staff. The result was the establishment of a new role, the clinical resource specialist (CRS). The main responsibility of the CRS was to support RNs, especially GNs and RNs on the evening and night shifts. The reporting structure, qualifications, job description, and budget for this role were delineated. See Table 1 for characteristics included in the CRS job description.

**Implementation**

Clinical resource specialist positions were posted so applications could be sought. Work hours were 7:00 p.m. to 7:00 a.m. The largest hospital campus in the network sought three CRSs, the community-based campus two, and the smallest, inner-city campus one. Interviews were accomplished by nursing administrators and a group of patient care specialists (PCSs) who serve as unit-based educators. Positions were filled in December 2006, and the group began orientation in mid-January 2007.

The 3-month CRS orientation program was developed by a core group of PCSs throughout the network. The first week, several classes provided by the hospital’s division of education centralized educators covered the following topics: preceptor update; review of the orientation process; transition into a new role; critical thinking strategies; and the goal-setting process. A CRS orientation booklet contained a helpful skills inventory checklist. Using the checklist, CRSs could identify and communicate their weaknesses and concerns in areas involving patient care. This checklist also allowed mentors to devise a plan to meet the educational needs of the CRSs.

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**TABLE 1. Clinical Resource Specialist (CRS) Characteristics**

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<th>The CRS must:</th>
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<td>1. Be a graduate of an accredited school of nursing and hold a current RN license.</td>
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<td>2. Be BLS and ACLS certified.</td>
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<td>3. Have a BSN, or be pursuing a BSN or a degree in a health care field; hold a specially nursing certification.</td>
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<td>4. Demonstrate strong initiative and be able to function independently.</td>
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<td>5. Demonstrate the ability to accept and adapt appropriately to change; demonstrate appropriate time management and organizational skills.</td>
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<td>6. Have a strong commitment to recognizing and accepting differences among individuals.</td>
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To facilitate socialization, CRSs met with all the PCSs at a mid-morning brunch and were assigned to PCS mentors. The next several weeks of orientation involved working closely with mentors, shadowing daily activities, and observing unit workflow. Various workshops and educational sessions were arranged based on the skills checklist to assure individual goals could be attained.

At the beginning of the second month of orientation, CRSs began their scheduled shifts. They introduced themselves, publicized their cell phone numbers, and explained their role to staff. Of paramount importance was emphasizing their role in offering guidance and education to enhance the staff’s professional growth and assure quality patient care.

Clinical resource specialists are required to coach, mentor, and support staff in order to facilitate exceptional care by utilizing professional, evidenced-based practice. Serving as resource nurses for night and evening shifts, they utilize effective communication skills with patients, significant others, visitors, staff, and professional colleagues. They exhibit effective leadership and team building skills, and encourage their development among staff. CRSs function as important team members to support network and unit goals and objectives. They collaborate with the unit leaders and supervisors to maximize individual development, as well as to provide global education to staff on night and evening shifts. CRSs encourage staff development and empowerment by promoting teamwork and professional practice. CRSs also participate in research, and encourage staff to participate in and apply research in practice (see Table 2 for CRS activities during a typical 12-hour shift). CRSs’ workflow on any shift depends upon the needs of the nursing staff. When not involved in routine rounds or assisting staff nurses, CRSs conduct in-services or are involved in quality improvement activities. CRSs also support staff with decedent care, documentation, and post-fall debriefing activities.

**Evaluation/Impact**

After 2 years of role implementation, with numerous unsolicited anecdotal accounts from the staff, organizational leaders desired quantifiable information to establish the efficacy of the CRS role. An electronic survey was conducted in March 2009 to evaluate the CRS role from the staff nurse perspective. Nurses (N=950) working a shift after 7:00 p.m. were invited to participate. Respondents (n=415) primarily worked on a medical-surgical unit (n=169) or in a critical care setting (n=112). Most respondents (37.6%, n=156) had more than 6 years of experience.

The survey had 27 questions; 12 questions specifically asked respondents to quantify their utilization of the CRS (once to more than four times) in defined clinical situations. Figure 1 indicates the percentage of respondents who called at least once for 10 defined clinical situations or processes. The survey also included 10 questions using a 4-point Likert scale to identify staff nurses’ perceived value of the CRSs. These questions addressed the responsiveness of the CRS, the effect of CRS intervention on staff RN comfort and anxiety level, and potential error prevention. Overall, respondents scored the CRS above 3.25 in the areas of value. Specifically, the question, “knowing that this hospital has a CRS available on the off-shift has decreased my anxiety as a new RN,” was scored at 3.75. The question, “CRSs have helped me prevent potential errors,” was scored as agree moderately or agree strongly by 95% of the respondents. The CRS provides phone advice when appropriate, and respondents found this support appropriate and useful in select situations. The overall value of the CRS on a 1-10 scale was 8 or greater for 81% (n=338) of respondents.

Three open-ended questions led to 80% of respondents providing
written feedback regarding the CRS role. Remarks included the following:

- “Without the CRS, I would have quit my job as a new RN.”
- “The CRS role has helped me and others so much over the last 2 years. They are one of the main reasons I came to LVHN and one of the many reasons I stay.”
- “They are a great resource and help improve patient care and reduce medication and procedure errors.”
- “As a critical care RN, code nurse, and RRT nurse, the CRS role is critical in my practice. Having another set of well-educated hands and their knowledge and experience is invaluable. Their intervention has helped staff avert bad situations and has helped get patients the level of care they need faster.”
- “Knowing that the CRSs are here overnight allows me the opportunity to breathe; knowing that a helpful hand is only a phone call away...the CRSs are a light in the dark. They are an invaluable asset to LVH.”
- “They...ROCK!!”

Survey feedback clearly shows the CRS role is valued highly by staff, and the organization continues to support the off-shift resource. To further validate the role’s efficacy, the CRSs collect data on every unit visit or phone call. Data include unit of service, day of week, time of shift, nurse experience, and type of assistance requested (whether an error could have occurred without their intervention and support).

Conclusion

The CRS provides expert clinical knowledge and guidance to nurses at all levels regardless of their individual experience. In particular, new nurses benefit from the one-on-one interaction with the CRS. Unfamiliar clinical situations and skills become invaluable learning experiences when the CRS is present. The CRS is a mentor for the nurse during these learning opportunities, providing recognition and positive feedback on skills the nurse already possesses, as well as instruction and encouragement when the nurse encounters uncharted territory.

According to Bowles and Candela (as cited in Pine and Tart, 2007), “The gap between new graduate employee’s preparedness and their professional readiness is a documented stress and is perhaps one of the most influential variables that affect graduate nurse retention” (p. 13). If an employer desires to increase retention and decrease GN turnover, the organization must bridge the gap by providing resources to help ease the GN’s transition into the role of professional nurse. Nurses who feel supported during the transition process report higher job satisfaction and consequently are less likely to leave their current jobs for positions outside the organization (Pine & Tart, 2007).

REFERENCES


