

Rural Case Study Report

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Rural Health Workforce Development Program: Providing On-the-Job Training for New Rural Nurses

INTRODUCTION

The U.S. faces a serious shortage of registered nurses (RNs) as nursing schools struggle to meet the growing need of an aging population and to keep pace with an aging RN workforce. Data from the Health Resources Services Administration (HRSA) predicts that by 2020 the state of Kansas will have a deficit of 5,900 RNs, while the population age 65 and older in the state is expected to grow by 46 percent.¹ In 2006 the Kansas legislature launched a \$30 million, 10-year program focusing on nurse education resulting in an increase in students admitted to nursing programs, expansion of full-time and part-time faculty persons, and the availability of nursing service scholarships. The program has been of particular importance to small, rural hospitals and Critical Access Hospitals (CAHs) that can have an especially difficult time finding and hiring health care professionals.

In 2010, the President's Budget created the new "Improving Rural Health Care Initiative," to re-organize the way rural programs are administered. Workforce recruitment and retention are a critical component of this initiative and as part of that effort, the HRSA Office of Rural Health Policy (ORHP) created the Rural Health Workforce Development Program (RHWDP).² The purpose of the RHWDP is to support the development of rural health networks that focus on activities that foster the recruitment and retention of primary and allied health

care providers in rural communities by establishing and sustaining network efforts to develop innovative community-based education and clinical health training programs. In 2010 the RHWDP provided grant support to 20 awardees selected through a competitive funding process.

This case study report describes the findings of a two-day site visit to one of the grantees, the Northwest Kansas Health Alliance (NWKHA), one of the largest rural health networks in the country, and its educational partner, the North Central Kansas Technical College. Funding was awarded to NWKHA to implement the Rural Northwest Kansas RN Residency Program. Hays Medical Center (HMC), the only source of tertiary care in the region, serves as the core support hospital for the network linking 23 CAHs that together serve a 23-county area over 20,518 miles of sparsely populated flat lands (6.5 persons per square mile). The North Central Kansas Technical College (Vo-Tech) offers programs of study leading to certification as a nurse assistant (CNA), one year certificate in Practical Nursing and a two year Associate degree preparing students for state exams to become either a Licensed Practical Nurse (LPN) or a Registered Nurse (RN). Face-to-face interviews were conducted with representatives from HMC (the Chief Nursing Officer, Clinical Nurse Specialist, Residency

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Program Coordinator, and the Network Grants Manager), Vo-Tech (Director of Nursing and Campus Dean), and each of four member CAHs (Director of Nursing or appointed representative, residency coaches, and facility administrators).

Hays Medical Center has served as the hub of the NWKHA since 1991. The network initially formed as part of the federal Essential Access Community Hospital and Rural Primary Care Hospital (EACH/RPCH) Kansas Demonstration program – the precursor to the current Medicare Rural Hospital Flexibility Program. HMC has historically worked closely with Vo-Tech by providing a rich clinical environment for hands-on training of Vo-Tech’s nursing students, while Vo-Tech has made its clinical simulation laboratory available to HMC for its nurses and nurse residents. Patient simulation labs provide a rich learning experience through repeated opportunities to practice clinical skills, develop critical thinking and teamwork skills, and gain exposure to clinical scenarios that students and new nurses might not otherwise be exposed to during their actual clinical training with patients.

HMC’s and the CAHs’ interest in establishing a residency program stems largely from a commitment to patient safety. As one network participant explained, “It is an issue that drives the need for the residency program – new graduates are coming out and you need to know that your patients are safe but the new grads don’t always have the clinical experience necessary to give us confidence in their practice on the floor solo.” A residency program provides a safe, structured, and monitored environment for graduate nurses to become accustomed to the clinical setting and gain confidence in their clinical skills. It also provides an opportunity for the hospital staff to evaluate their clinical core competencies and critical thinking skills while keeping patient safety and quality of care in the forefront of everyone’s mind.

HOW DID THE PROGRAM GET STARTED AND WHAT IS ITS STRUCTURE?

Although many hospitals, including the CAHs in the NWKHA, provide some form of nurse orientation program, many only have resources to offer a few weeks before nurses are needed for floor duty. One Director of Nursing for a network CAH noted that although they hoped new nurses would get a month of working closely with a more experienced nurse, the facility often did not have the resources to do so. A staff nurse would check in

on the new nurse, but typically was unable to really stay with him or her. A nurse coach noted that “we would try to point things out to the new nurse, but we were busy.” Another commented that many times they would set their new nurses on their own after around six weeks of orientation and “hope they did okay.” People were doing what they could with the resources they had, but clearly hoped for a better way to do it.

The former Vice President for Regional Planning and the Chief Nursing Officer at HMC had witnessed the value of HMC’s residency program and had been grappling with the nurse workforce issues facing the network CAHs. Using an approach like HMC’s 18-week residency was not feasible at the smaller facilities, because of staffing ratios and distances from educational sites. However, the Rural Health Workforce Development Program provided an opportunity to implement a similar program. When grant support was awarded in the fall of 2010, a project was developed that bridged the academic and clinical settings in a way that strengthened clinical nurse competencies and critical thinking skills in new Registered Nurses but also offered a way to introduce new approaches and knowledge to the CAHs’ existing nursing staff. Funds are being used to support a residency program coordinator to work with the CAHs in recruiting and training graduate nurses and to be a liaison between the clinical and academic arenas. Grant funds are also being used to offset some of the staffing costs participating CAHs incur as they assign floor staff to work with the nurse residents.

Patient safety “is an issue that drives the need for the residency program”

– network participant

The Rural Northwest Kansas RN Residency Program accepts graduate Registered Nurses for a 12-week orientation and training sequence that has been tailored to meet the specific needs of the network’s CAHs. For example, sim lab sessions can require residents to make quick clinical decisions without the help and support of staff who may not be available during their shift or even at their facility (e.g., lab and respiratory specialists, or urologists). With the support of the HMC nursing staff, the residency coordinator designed the program to feature situations and conditions typical for CAHs.

The new 12-week program contains 144 hours of classroom instruction and 336 hours of clinical training. The first six weeks includes 96 didactic hours (12 days) and 144 supervised clinical hours, while the second six weeks

involves 48 didactic hours (10 days) and 192 supervised clinical hours. Supervision is provided by an experienced staff nurse with training in coaching new residents. A little over half of the curriculum focuses on patient-centered care including diagnosis-related assessment and crisis management, death/dying, cultural competence, critical thinking, time management and ethical decision making. A little under 20 percent of the curriculum is devoted to quality improvement (e.g., fall prevention, wound management, medication administration, etc.), while another 15 percent covers communication, team building and professionalism.

The first cohort of residents, which started in June 2011, included 14 nurses from eight of the network CAHs. At the time of the site visit in December, the second residency cohort was engaged in the program, including three nurse residents representing three of the network CAHs.

To date, 22 of the 23 network CAHs signed a memorandum of agreement (MOA) to participate in the residency program. For most of the CAHs it was not a difficult choice to become part of the new program. Although the NWKHA did not mandate participation, the residency program was highly promoted because of its inherent value in terms of staff competencies, patient safety and use as a recruiting tool. Several of the CAHs included in the site visit had been looking for ways to improve their orientation processes before the grant program, as well as ways to improve the competencies of their existing staff. Some had been able to take advantage of the state nursing service scholarship and other resources to gradually begin developing a nursing cadre from within their own personnel rosters – supporting and encouraging staff to build skills from a CNA to LPN and RN. For most, recruiting a new nurse graduate was a major challenge, especially people from outside the local community. As one NWKHA member put it, “When new grads look at the possible settings, they usually scratch the small towns off the list right away.” Probably the greatest single incentive for participation in the program was the availability of grant funds to help offset expenses and therefore help jump-start local recruiting and training (e.g., gas for resident travel from their CAH to HMC and extra staffing costs for resident coaches). Grant funds were used to cover six of the twelve weeks of residency and the CAHs covered the other six weeks.

Being a member of the NWKHA and participating in the residency program also provides a recruitment advantage. The word has been spreading from former residents and through Google searches; new nurse

graduates have heard about the program and are interested in becoming involved. When the residency coordinator began recruiting for the current workforce project, the nurse graduates asked if the hospitals were in the network. “They had heard about the twelve-week training course and the horror stories of getting six-week orientations and then being on their own – they wanted no part of that.”

Classroom instruction is delivered primarily by remote telecast (ITV) and an online servicing program, which allows each hospital to customize the educational programs to meet its specific needs. While ITV was initially used to soften the hardship of residents travelling to Hays – half of the first cohort of residents was located more than two hours one-way from Hays – some of the residents commented that it was isolating and their coaches noted that they seemed bored. These concerns were addressed. The evaluation of the first cohort brought to light the fact that the residents would like to have more hands-on experience. Discussions with the residents during the evaluation also revealed a number of knowledge gaps. “The nurses were coming from different nursing schools and some would breeze over some stuff and some over other [stuff] but not all the same.” Some community colleges had simulators but did not use them much or at all because the colleges did not know how. That underutilization, coupled with limited clinical exposure, did not adequately prepare the nursing students for work on a hospital floor – some had not even completed half of the critical skills checklist. To address residents’ request for more hands-on experience and to catch up on important skill sets, the second cohort is getting greater hands-on experience through the sim lab.

There is no way to get around the need for residents to put in time in the sim lab. Lab time was not only an opportunity for assessing clinical skills performance; it is also an important tool in revisiting the case studies presented in class instruction to build core competencies. With the lab it is possible to create a scenario with a hospital wing with patients of different age groups with different diagnoses and to simulate the need to handle critical decisions for several patients at a time. However, since sim lab time is such a critical component of the instruction, the residents needed to spend time in Hays. This presented an additional hardship for those residents living hours away. HMC worked closely with Vo-Tech to coordinate lab availability with its nursing program to accommodate back-to-back lab sessions for the nurse residents and minimize the number of round trips they had to make over the 12-week program.

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Clinical instruction forms the bulk of the training, with 336 hours provided largely at each resident's hospital and in partnership with a clinical coach. Ideally, nurse residents should have the same nurse as their coach throughout the 12-week period. Experience has shown that the best coaches have been on the floor for no more than a couple of years; nurses who have been there for 30 years may not be as attuned to the challenges facing new nurses. Personality is the key to being a successful coach. "You need somebody that remembers the learning process – what it was like in those negative things that you went through because a coach did not help you when you asked questions." It can be counterproductive and very discouraging for the resident if questions and hesitations are met with less than supportive responses.

In selecting coaches "you need somebody that remembers the learning process."

– network participant

The grant program provides training for resident coaches, although not all of the CAHs have been able to send a nurse to training in Hays. A six-hour training program was developed for resident coaches touching on issues such as the mentoring role, coach responsibilities, workplace culture, motivation, generational differences, critical thinking in the clinical setting, conflict resolution, and transition to practice. The most popular component was discussion of generational differences. It was new to most of the nurse coaches because coming from small facilities some had not experienced meeting new hires for a long time.

Discussions with several coaches provided interesting insights into how they were able to operationalize the coaching training. At one facility, the new nurse followed the staff nurses around just observing for a couple of days. Then "I would let her get her hands wet and we would stand back. We would just observe her and helpfully make suggestions about different techniques or things we had developed through the years. I would point out, this works for me; you might want to think about it." When asked about the qualities or characteristics of a coach that can make a difference, another coach commented "you need to allow them to do things... [Residents] need to get hands-on experience rather than just (being told) this is the way we do it." She noted that you have to be conscious of how you approach things: "they may be RNs, but they are wide-eyed RNs." A Director of Nursing pointed out that she had a couple of nurses that she could tell would make good coaches but she had one who was problematic. "She didn't have

that softness to her; she would rather throw them out there to themselves." The Director of Nursing then described how she allowed the harder nurse to observe the others and learn by watching how they coached. "Softness is being supportive and promoting them and pushing them rather than just doing it for them and having them watch."

Several coaches also pointed out that they had learned a few new things from the nurse residents. "It is part of being a coach to notice when she has a good idea and to reinforce them and follow through with it." Another said that it was important to make sure to give the residents opportunities to share their ideas and thoughts. "You want them to open up to you." One coach explained, "If you have a situation where you are thrown onto the floor very quickly and have to fend for yourself, which is not a good way to get a person to feel like they want to come back to work. When you come to work and learn under circumstances where you are not completely alone and afraid of making a mistake, it is a way to build confidence and they come back more often and feel better about themselves." Another said, "We have all been through the gauntlet, I don't think anybody ever thought it really worked best that way. It was just what we had to do."

"Softness [for coaches] is being supportive and promoting [residents] and pushing them rather than just doing it for them and having them watch."

– network participant

One of the challenges of being a resident at a small facility, like a CAH, is the variation in clinical experiences. It may take some time before residents can cover all the skills on their competency check list. Some coaches made a special effort to alert their residents (e.g., call them when it was their day off) if a procedure was coming up that they had not had a chance to experience (e.g., hanging blood, mock codes, or changing dressings). In the past, new nurses were frequently placed on the night shift after only a few weeks orientation. While it might be the hardest shift to staff, placing new nurses on the night shift is a real handicap as there is little going on and there is little or no opportunity to get to know the medical staff. One said, "I made sure she was a day shifter. That's what I would do with all of them, that is where the true education occurs... where things flow from one department to another."

One obstacle mentioned by several program participants is scheduling. Although efforts were made to not have

a resident scheduled for a night shift when there was a scheduled ITV instruction the following day, nurses noted that it was difficult making the adjustment over a short period of time – “so I was tired a lot because it’s difficult for my body to adjust to the time changes.” Another noted that sometimes she worked up to eight nights in a row “so a day before really didn’t make a big difference ... getting up for classes the next day was pretty difficult.”

Discussions with several of the rural residents revealed that their decisions to practice at these hospitals were very functional and practical. One had a Board of Regents Scholarship for two years in the town where the CAH was located. She had worked there before as a CNA and, as a newly graduated nurse working at the CAH, was required to take part in the residency program. Another also had worked at the CAH as an LPN; she became familiar with new RNs who were taking part in the residency program and decided she wanted to take the next step to become an RN and eventually took part in the residency program. Another was living just a short distance from the town in which the CAH was located and knew a nurse who had gone through the program. One had selected the CAH because of its scope of services (especially obstetrics).

The residents commented on how the coaches helped them push their comfort zone in the various departments like the emergency room or the delivery room. In order to gain as much experience as possible, one resident noted that she had several coaches because she wanted to observe as many OB cases as she could. Discussions with the Directors of Nursing made it clear that the most desirable strategy was to have a number of staff nurses trained as coaches to provide as much flexibility as possible for both the residents and their shift nurses (e.g., to minimize any confusion about who should take responsibility for the resident).

WHAT CHALLENGES HAS THE PROGRAM FACED AND WHAT LESSONS HAVE BEEN LEARNED?

One of the biggest challenges facing a program like the rural residency program is the need to maximize opportunities for residents to gain confidence in the wide range of skills they will be called upon to use on the floor of a CAH. Taking residents and putting them on the night shift after a short while on the day shift works counter to that goal. There are not enough opportunities for the residents to gain confidence

working with physicians; there are not as many clinical exposures to build and strengthen the resident’s skill set; and there are seldom sufficient opportunities to gauge nurses’ competency level to assure that they are ready to take to the floor on their own. Some coaches have been adamant about the need to take extraordinary measures to assure their residents have such opportunities but it is not a position expressed universally. Given the financial circumstances and staffing challenges facing most small hospitals, this is a challenge that will likely remain. Providing a greater amount of hands-on experience through the simulation lab provides some resolution by expanding nurses’ clinical exposure. In addition, Vo-Tech has expressed the desire to expand its simulation capacity in Hays as well as to develop, at some point in the future, a mobile capacity to provide sim lab services to the more remote hospitals in the region.

Another issue raised by the resident coaches was the importance of maintaining the professional image of the residents. There is a fine balance between providing a degree a safety for the residents and at the same time encouraging them to take more responsibility in clinically challenging situations. Because they have a coach who accompanies them over the 12-week period, it can be natural to view the residents as students and not licensed providers. This can occur in subtle ways. For example, leaving the new nurse’s name off the assignment/shift board and only listing the staff nurse who is coaching the resident can be a simple mistake. If hospital staff come to view the residents as students, it runs the risk of undermining one of the important objectives of the program – to give new nurses the confidence to step up to assume clinical responsibilities. As one of the coaches noted, “You say this is your resident, this is your partner. It sets up a totally different relationship.” HMC has developed a convention such that if an individual is working with a student, he or she is a preceptor; whereas those staff members who are working with residents are coaches. “If you are a preceptor, you better ask them about everything they are doing before you let them do it and if you are a coach you need to be asking questions that you would of a respected licensed professional.”

An issue that typically accompanies initial efforts to address unmet needs is the inevitable request to address further needs. In the case of the rural residency program, it has been the request of hospital Directors of Nursing that the program meet the advanced cardiac life support and trauma training needs of their staff. Program developers are struggling with how they could

meet these important needs. Do you fold the training into the residency program? Do you fold the concepts in so that the training can occur after the residency program is complete?

WHAT ADVICE WOULD PROGRAM PARTICIPANTS OFFER?

When asked what advice they would have for other networks considering adopting a program like the rural residency program, a clear lesson was that facilities will appreciate it when they are not being forced to adopt a program. It is important that CAHs hear that the network director understands and appreciates that there is something unique to them and their facility. It is also important to have a qualified person – with both clinical and curriculum-development expertise – to develop and launch the program. The coaches, to be effective, need to be individuals who remember the learning process, who remember what it was like to not have all the answers and not have someone supporting them along the way.

Coaches also offered advice about coaching. One resident coach pointed out that good coaches are people who themselves are confident in what they are doing. They have to be flexible because they can get busy and still need to take time to teach. Another coach provided advice for hospitals considering participating in a similar program: “you can’t really count on the resident being a whole person (staffing wise), you need to take into consideration that for the coach it requires you to think more and slows you down some.” A new nurse who had been expected to be on his/her own after a couple of weeks now is not totally available until the end of 12 weeks; however, several coaches noted that some residents were ready earlier.

A Director of Nursing pointed out the “you just make sure that your front office is on board.” At least for the CAHs that were included in the site visit, the front office was either directly on board or totally trusted the advice offered by their Directors of Nursing to participate. All were pleased with the outcomes both in terms of the way their staff were functioning and the implications for patient care (e.g., learning experiences for existing staff, increased confidence on the part of the residents to work on their own, reduced risk of medication errors, reduced patient falls and other incidents that could happen if the caregiver is not fully trained and competent). In addition, one noted that pairing a new nurse with a more experienced one might lead to better care: “Having two pairs of eyes looking at stuff for 12 weeks can catch a lot of stuff.”

References

1. The Kansas Nursing Initiative Annual Report, State of Kansas Board of Regents, 2008
2. Rural Health Workforce Development Program Funding Opportunity Announcement, Announcement Number HRSA-10-193, CFDA No. 93.912, Fiscal Year 2010 (March 2010)