RESEARCH REPORT EXCERPT

The Experience-Complexity Gap

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IN FULL RESEARCH REPORT

Executive summary

A different-in-kind nursing shortage

Hospitals and health systems around the world are facing a new kind of shortage among the nursing workforce: a shortage of experience. As mass retirements continue, there is an exodus of experience leaving organizations across the country. With the quickly growing nursing workforce, leaders will need to rely on the influx of novice nurses to backfill vacant positions.

Rising care complexity creating a longer path to competence

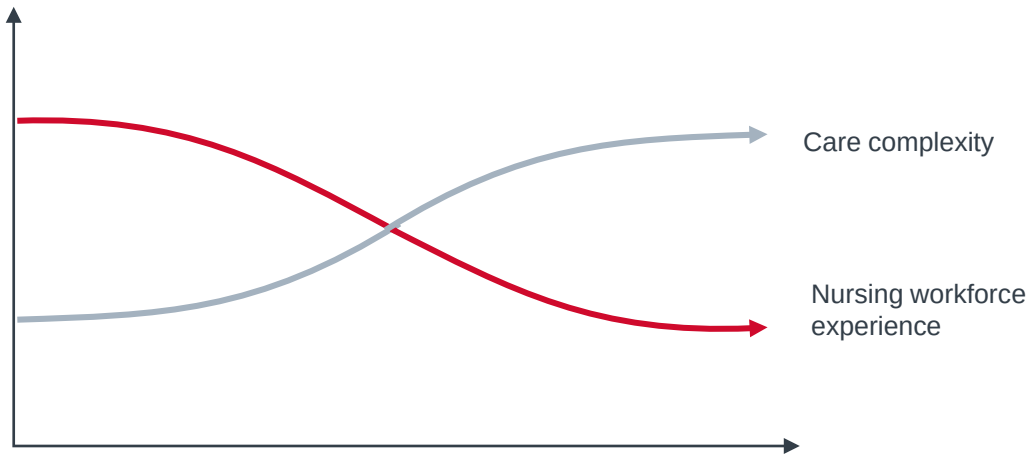
At the same time, care complexity is rising. On average, patients are older and have more chronic comorbidities. Care processes—including electronic documentation and more standardized protocols—are becoming more complex, while length of stay is getting shorter.

As a result of this rising complexity, it's more difficult for nurses to transition to practice, for at least three reasons. First, nurses have more to learn to be considered competent. They must have a richer understanding of pathophysiology, understand a wide range of treatment options, and be prepared to deliver highly complex care. Second, it's harder for nurses today to learn on the job. There are no more "easy" patients to assign to new graduates as low-stakes learning opportunities. And because there is more to do in less time, nurses have less time to focus and reflect on their own development. Finally, the shortage of experience means there are fewer expert nurses to mentor and provide feedback.

The emerging experience-complexity gap

As the collective experience of the workforce declines and care complexity rises, a new challenge is emerging, which the Nursing Executive Center has termed the "experience-complexity gap." This gap is projected to grow as nurses continue to retire. If unaddressed, the experience-complexity gap has the potential to result in increased adverse care outcomes and negatively impact care quality.

The "experience-complexity gap"



An executive approach to closing the experience-complexity gap

To close the experience-complexity gap, we recommend three paths. First, teach novice nurses more effectively by scoping their first 12 weeks and standardizing preceptor work. Second, redistribute experience across the organization by creating career pathways to select units and care sites. Third, differentiate practice for experienced nurses by positioning competent and proficient RNs “at-the-hip” and scaling the impact of expert RNs.

Read this report excerpt to get strategies that can help you:

- Maximize the impact of preceptors by standardizing preceptor materials and training.
- Utilize proficient and competent nurses to provide care oversight of novice nurses.

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The experience tipping point

National nursing shortage averted

While a handful of states may experience a moderate shortfall of RNs—as described by the factors below—the United States will likely avoid a nursing shortage in the coming years. At the regional level, the Health Resource and Services Administration projects that seven states will have a shortage of nurses by 2030: Alaska, California, Georgia, New Jersey, South Carolina, South Dakota, and Texas. These regional shortages are often caused by the factors listed below.

Key factors influencing regional variation in nursing supply, demand

Location, geography

Population density, demographics

Local nursing school capacity

Local job competition

Type of care site, specialty

As shown in the data here, the national nursing supply is projected to outpace growing demand, resulting in an excess of close to 300,000 nurses by 2030.

Breakdown of national nursing workforce projections, 2030

39%
Projected growth in **RN supply**

28%
Projected growth in **patient demand**

293,800
Projected **RN excess** by 2030

The overall growth of the nursing workforce is certainly welcome news—and it's crucial to avoiding another mass shortage. But it's also changing the workforce demographics, leading to a new and different shortage, which is described on the next page.

Source: "Supply and Demand Projections of the Nursing Workforce: 2014-2030," Health Resource and Services Administration, https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/NCHWA_HRSA_Nursing_Report.pdf; Nursing Executive Center interviews and analysis.

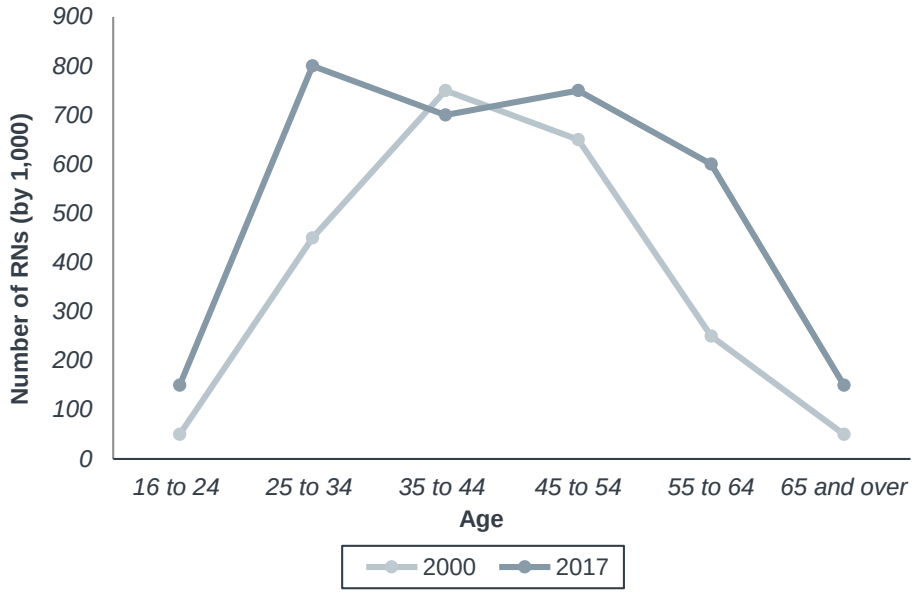
Short on nursing experience, not nurses

There is now a shortage of experience in the nursing workforce.

As shown below, the age distribution of the nursing workforce in 2017 is a bimodal curve. There are now more novice nurses and near-retirement nurses, as well as fewer mid-career nurses, than in 2000, when the age distribution produced a normal bell curve. Put simply, there is less experience across the nursing workforce.

This change in the demographic curve is due to two factors. First, the large generation of baby boomers is retiring. Since 2012, roughly 60,000 RNs exited the workforce each year. By 2020, more than 70,000 RNs will be retiring annually.[1] This means there is an exodus of experience leaving the nursing workforce. Second, the vast majority of vacant positions will be filled by new-graduate RNs. The nursing workforce is growing, with a large increase in the number of new nurses joining the workforce. For example, from 2000 to 2017, there was a 45% increase in employed nurses between the ages of 23 and 35.

Number of employed RNs by age group, 2000-2017[2]



1) According to a 2017 nursing supply and demand projection by the Health Resources and Services Administration.
2) Data approximated.

Source: "Median Age of Employed Registered Nurses Declines From 2011 to 2017," Staffing Industry Analysts, https://www2.staffingindustry.com/site/Editorial/Healthcare-Staffing-Report/March-8-2018/Median-age-of-employed-registered-nurses-declines-from-2011-to-2017; Nursing Executive Center interviews and analysis.

A more challenging road to competent

At the same time as the workforce is becoming less experienced, the care nurses must deliver continues to be more complex. For example, the average case mix index (CMI) and patients with comorbid conditions (including behavioral health diagnoses) are rising, while length of stay (LOS) is getting shorter. In addition, the increase in care protocols nurses are expected to know, coupled with the growing importance of electronic documentation, makes care processes more challenging.

Changes in care complexity

0.11

Average increase in CMI for non-ICU patients, 2012-2017[1]

0.15 days

Average decrease in LOS, 2014-2017

5 million

Number of ED visits with mental health as a primary diagnosis in 2014

As a result, it's taking longer for the large number of novice nurses entering the workforce to progress to competent. According to Patricia Benner's article in *The American Journal of Nursing,* "From Novice to Expert," nurses develop clinical competence through time and repeated practice providing the same type of care in similar situations before providing care in variable situations. While conducting this research, nursing leaders repeatedly shared that it is taking increasingly longer for nurses to reach competent, as described in the quotes below.

> "The days of your traditional, low-acuity med/surg patient no longer exist."
>
> *System Chief Nursing Officer*

> "Many of our patients are life-long patients with comorbidities and multiple medications."
>
> *Chief Nursing Officer*

An overview of Benner's stages of clinical competence is below. To access information on each stage, Nursing Executive Center members can visit advisory.com/nec/ExperienceComplexityGap.

Benner's stages of clinical competence

1	2	3	4	5
Novice	Advanced beginner	Competent	Proficient	Expert

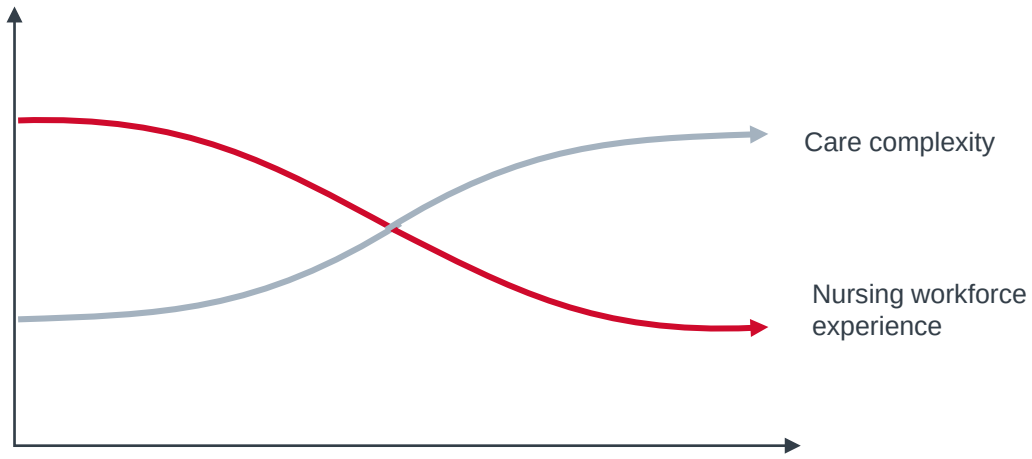
Source: "Hospital Compare datasets," Medicare, https://data.medicare.gov/data/hospital-compare; Rui P, Kang K, "National Hospital Ambulatory Medical Care Survey: 2014 Emergency Department Summary Tables," Centers for Disease Control and Prevention, https://www.cdc.gov/nchs/data/nhamcs/web_tables/2014_ed_web_tables.pdf; Benner P, "From Novice to Expert," *The American Journal of Nursing*, 82, no. 3 (1982): 402-407; The Hospital Benchmark Generator, Health Care Advisory Board; Nursing Executive Center interviews and analysis.

1) Calculated from the average MS-DRG weights of all non-ICU claims in a year.

The experience-complexity gap

The last several pages described a new nursing workforce challenge. Specifically, health care organizations must find a way for a more novice workforce to safely deliver more complex care. Put another way, leaders must close the "experience-complexity gap." This gap is expected to widen in coming years as more baby boomers retire and the nursing workforce continues to grow.

The "experience-complexity gap"



The next page explains why closing experience-complexity gap should be a key priority for nursing leaders.

Source: Nursing Executive Center interviews and analysis.

Early signs of impact on quality

Organizations must close the experience-complexity gap to maintain care quality. Novice nurses caring for patients with higher care complexity can result in adverse quality outcomes. Below, supporting data demonstrates that having a novice workforce negatively impacts quality metrics. Medication errors, missing signs of life-threatening conditions, and hospital-acquired conditions, are all more likely with less experienced nurses.

Sample quality outcomes by RN experience level

40%

Of new-graduate RNs report making medication errors

50%

Of novice RNs who report missing signs of life-threatening conditions

1.9%

Decrease in pressure ulcers for each additional year of RN experience on a unit

The next page outlines two potential ways to close the experience-complexity gap.

Source: del Bueno D, "A crisis in critical thinking.," *Nursing Education Perspective*, 26, no. 5 (2005): 278-82; Hill, K, "Improving Quality and Patient Safety by Retaining Nursing Expertise," *The Online Journal of Issues in Nursing*, Vol. 15, 3 (2010): https://bit.ly/2BEY1ez; Nursing Executive Center interviews and analysis.

Two ways to close the experience-complexity gap

There are two ways nurse leaders can close the experience-complexity gap.

The first is to accelerate the transition from novice to competent more quickly. Nursing leaders are already heavily investing in support for new-graduate onboarding, engagement, and retention. However, there's an opportunity to refine this process across the first year and accelerate progression.

The second is to leverage the existing skills, expertise, and experience of current nurses. Organizations must deploy experience strategically to address the experience-complexity gap, not ask experienced nurses to do more work.

On the next page, we present three paths to accelerate the transition from novice to competent and better leverage existing experience.

Source: Nursing Executive Center interviews and analysis.

Closing the experience-complexity gap

Our recommendations for closing the experience-complexity gap are outlined below.

The first path is to teach novice nurses more effectively by fiercely scoping new nurses' first 12 weeks and standardizing preceptor work.

The second path is to redistribute experience across the organization by creating career pathways to select units and care sites.

The third path is to differentiate practice for experienced nurses by positioning competent and proficient nurses "at-the-hip" of new nurses and scaling the impact of expert nurses.

Best practices to close the experience-complexity gap

Accelerate the transition from **novice to competent**

Better leverage **existing experience**

1

Teach novice nurses more effectively

Fiercely scope weeks 1-12

1. Streamlined RN orientation
2. Targeted skills intensive
3. Unit-based learning intervals

Standardize preceptor work

4. The preceptor's ready-to-use teaching kit
5. Standardized preceptor boot camp

2

Redistribute experience across the organization

Create career pathways to select units and care sites

6. Targeted role transitions
7. Direct-to-ambulatory program

3

Differentiate practice for experienced nurses

Position competent and proficient RNs "at-the-hip"

8. RN partner rounds
9. Role-based team nursing

Scale the impact of expert RNs

10. Tiered precepting model
11. Expert-led care team

The remainder of this report provides further details and guidance on these strategies and best practices.

Source: Nursing Executive Center interviews and analysis.

EXCERPT

Teach novice nurses more effectively

Fiercely scope weeks 1-12

- Practice 1: Streamlined nurse orientation
- Practice 2: Targeted skills intensive
- Practice 3: Unit-based learning intervals

Standardize preceptor work

- Practice 4: The preceptor's ready-to-use teaching kit
- Practice 5: Standardized preceptor boot camp

How to teach novice nurses more effectively

The first path to close the experience-complexity gap is to teach novice nurses more effectively. We've identified two strategies for doing this: fiercely scope the first 12 weeks for new nurses, and standardize preceptor work.

This first strategy, fiercely scope weeks 1-12, includes best practices that revamp existing support to more effectively teach new-graduate nurses. Practice 1 streamlines skills and competencies taught to new graduates, practice 2 enables repetition of practice on key competencies, and practice 3 breaks down competencies into manageable pieces.

The second strategy, standardize preceptor work, includes best practices that equip leaders to overcome the limitations of early-tenure preceptors and benefit from their strengths. Practice 4 equips preceptors with the correct guidance on what to teach, and practice 5 aims to help preceptors teach more effectively.

Two strategies to teach novice nurses more effectively

Fiercely scope weeks 1-12

Streamline the list of skills and competencies that novice nurses are expected to learn during their first 12 weeks of practice.

Standardize preceptor work

Maximize the impact of preceptors to train novice nurses by standardizing preceptor materials and training.

A promising opportunity for collaboration

Our research suggests there is a meaningful opportunity for hospitals to work with local nursing schools to develop key competencies during student clinical rotations. Best practice institutions are now complementing their post-hire efforts with collaborative, pre-hire initiatives to ensure new graduates are "practice ready" as early in their careers as possible.

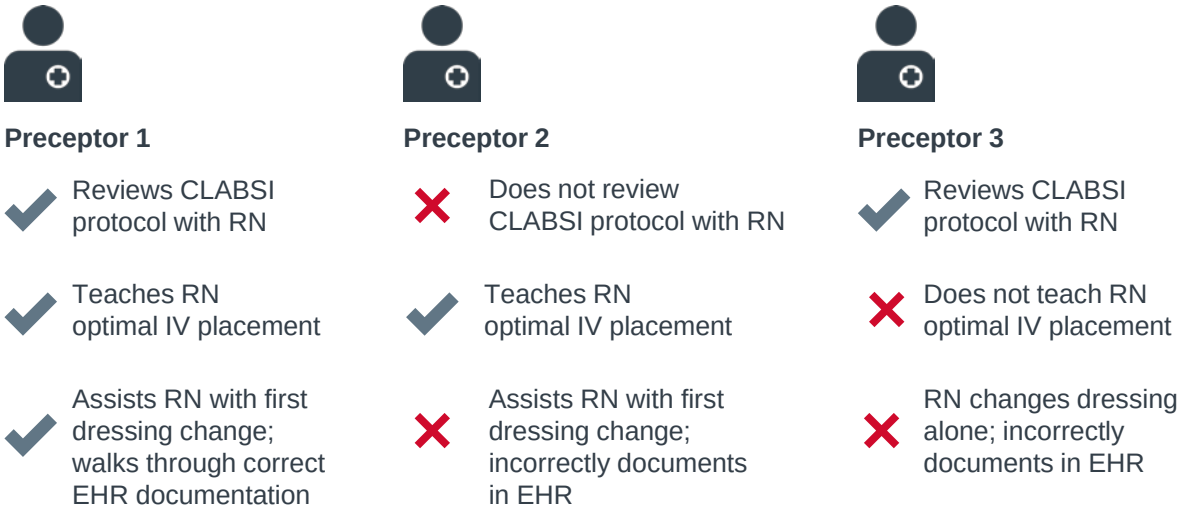
For strategies to enhance preparation before students graduate from nursing school, Nursing Executive Center members can access *Bridging the Preparation-Practice Gap volumes 1 and 2*, at **advisory.com/nec/publications.**

Source: Nursing Executive Center interviews and analysis.

Preceptors are key to effectively teaching novice nurses

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

Representation of preceptor variation, CLABSI protocol



24% Of surveyed new RNs[1] reported seeing preceptors contradict best practice

1) n = 276 new nurses surveyed.

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

Preceptors are often early-tenure nurses

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

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

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

Limitations of early-tenure preceptors

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

Strengths of early-tenure preceptors

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

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

Source: Nursing Executive Center interviews and analysis.

Practice 4: The preceptor's ready-to-use teaching kit

Practice in brief

Assemble "grab and go" kits that contain all the supplies preceptors need to teach a specific clinical competency. The goal is to help preceptors teach clinical competencies correctly without disrupting their workflow.

Rationale

Preceptors are responsible for teaching many competencies to new nurses. But they often receive insufficient guidance about how to teach each competency or what the most up-to-date protocol is. Without adequate guidance and supplies needed in the moment, preceptors may delay teaching competencies or find a workaround. By creating teaching kits that are easily accessible and include all the supplies necessary to teach a specific clinical competency, leaders make it easy for preceptors to teach correctly.

Implementation components

Component 1: Prioritize units with a high proportion of novice nurses.

Prioritize creating teaching kits for units with a high proportion of new-graduate nurses or novice preceptors.

Component 2: Determine the right competencies to target.

For each selected unit, assign no more than 10 clinical competencies that will receive a teaching kit. Use our list of checklist on page 44 to pick which competencies should have a teaching kit. Consider consulting unit managers, educators, and preceptors to weigh in.

Component 3: Create two or more teaching kits for each competency.

Gather the supplies needed to teach each competency and place them in individual bags. Examples of materials to include: a printed copy of the policy or procedure, a step-by-step teaching guide for the preceptor, and necessary supplies or equipment.

Component 4: Ensure easy access to teaching kits.

Ensure each teaching kit is clearly labeled and store them in a location convenient to preceptors, such as a unit's supply room. Designate one person to regularly stock the teaching kits.

Practice assessment

We recommend this practice for all organizations as a quick and easy way to help preceptors correctly teach select competencies to new nurses. The work required to create the teaching kits is minimal and requires little to no investment.

Nursing Executive Center grades:

Practice impact: B+

Ease of implementation: A

Source: Nursing Executive Center interviews and analysis.

Right equipment overcomes teaching roadblocks

Preceptors take on an important responsibility in educating new nurses. But there are often roadblocks that prevent preceptors from teaching correctly. First, preceptors don't always know how to best teach competencies. Second, preceptors don't always know when or how care standards have changed. Third, the right equipment isn't always available to teach standards. The result is that competencies aren't always taught correctly.

Sample roadblocks to effective preceptor teaching

Unsure how to teach

Preceptors often have many competencies to teach and don't know how to best teach them all.

New care standards

Protocols change, and preceptors don't always know when they're teaching the wrong way.

Inaccessible supplies

Necessary equipment and protocols aren't always easy to find in a teaching moment.

Cobalt Memorial, a pseudonym for a midsized pediatric hospital in the United States, designed ready-to-use teaching kits to overcome these challenges in 2014. The key components of this practice are described on the following pages.

Source: Nursing Executive Center interviews and analysis.

Teaching kits overcome educational shortcomings

Component 1: Prioritize units with a high proportion of novice nurses.

Use the two questions in step 1 below to determine which units to prioritize when creating teaching kits.

Component 2: Determine the right competencies to target.

For each unit selected, create a list of no more than 10 clinical competencies. Consider asking unit managers, educators, and preceptors to weigh in on the questions below in step 2.

Key considerations for developing ready-to-use teaching kits

Step 1: Prioritize select units

Use the following questions to identify the unit(s) that will benefit the most from kits

- Which units have the most new-graduate RNs?
- Which units have a high concentration of novice preceptors?

Step 2: Prioritize specific competencies

Use the following questions to decide which competencies to include in the kits

- Which competencies are taught most frequently?
- Which competencies do new RNs struggle the most to learn?
- Which competencies require the most supplies to teach?
- Which competencies are most critical to patient outcomes?
- Are there new care standards all RNs need to learn?

For a more structured approach, Cobalt Memorial hosted staff focus groups to identify gaps in novice nurse preparation and preceptor adherence to care standards. During this process, they identified the most important competencies to target based on potential risk when they are not done correctly and how often they are taught inaccurately.

Source: Nursing Executive Center interviews and analysis.

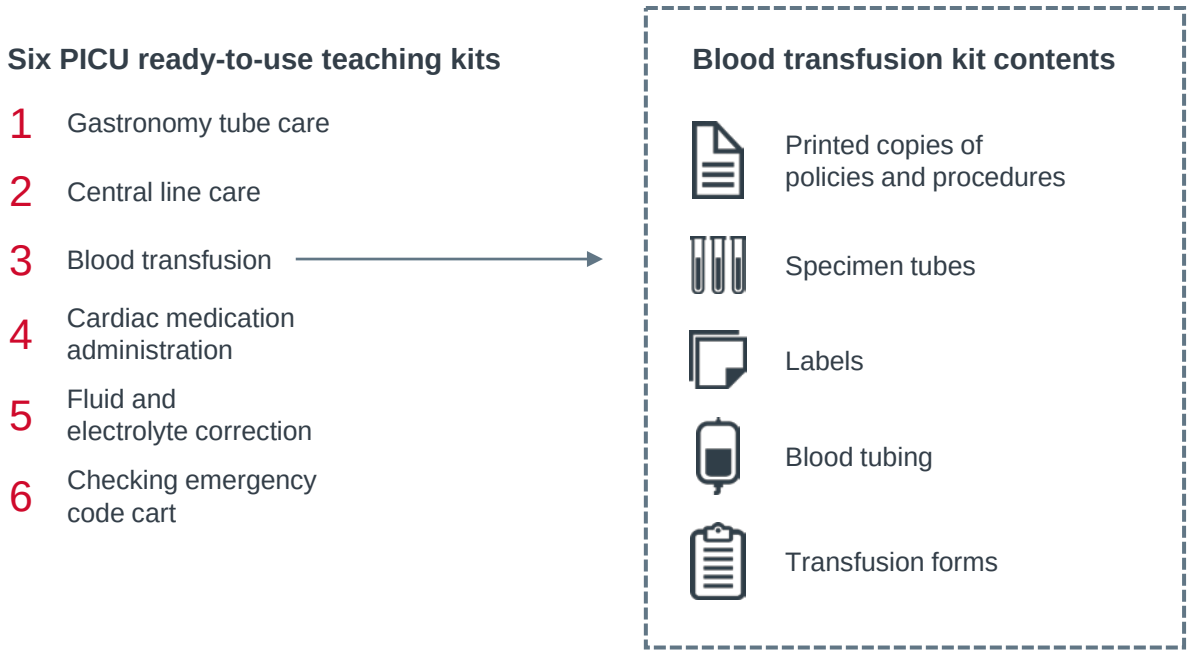
A closer look inside the teaching kits

Component 3: Create two or more teaching kits for each competency.

Next, gather the supplies needed to teach each competency and place them in individual bags, to create “grab and go” teaching kits.

The six ready-to-use kits Cobalt Memorial uses on the pediatric intensive care unit (PICU) and the contents of a blood transfusion kit are shown here. The stocking and creation of each bag is inexpensive. The canvas bags cost less than $20 and the equipment inside is covered in the supplies budget.

Sample kit materials include a printed copy of the policy or procedure, a step-by-step teaching guide for the preceptor, and necessary supplies or equipment. Create at least two teaching kits per competency, based on the number of new-graduate nurses on the unit.



Component 4: Ensure easy access to teaching kits.

Finally, ensure that preceptors can easily access the kits when needed. Each teaching kit at Cobalt Memorial is clearly labeled and stored in a convenient location, such as a unit’s supply room. Work study students regularly stock the teaching kits, saving time for busy managers.

Source: Nursing Executive Center interviews and analysis.

Standardized teaching improves nurse competence

Cobalt Memorial's teaching kits were created as part of a comprehensive preceptor program. Three key elements of the program are shown here.

The first element of the preceptor program is the ready-to-use teaching kits. To ensure the kits were easy to "grab and go," leaders decided not to track teaching kit utilization. Preceptors anecdotally report that the kits have helped improve their ability to be more thorough when teaching novice nurses.

The second element is online preceptor support, which Cobalt embedded in an internal SharePoint site. This includes a section to ask questions or share input, tutorial videos, and evidence-based best practice resources. Cobalt tracks preceptor usage of the site and found that it's heavily utilized, with about 1,400 site visits each month.

The third element is an online novice nurse competency passport to manage and track development areas. This is a real-time log designed by clinical nurse specialists. As novice nurses progress, preceptors log their success across skills, competencies, and information novice nurses are accountable for mastering during their 20-week orientation. The passport is used as a discussion guide to structure weekly check-ins between novice nurses and their preceptor.

Since implementing this program, the mean Basic Knowledge Assessment Tool (BKAT) score for new RNs increased by 10%.

Elements of Cobalt Memorial's holistic preceptor program

Ready-to-use teaching kits

Canvas bags with supplies to teach high-priority skills

Online preceptor support

Internal website with preceptor tools and resources

Online competency passport

Easy-to-use template to record RN progress in real time

Improved RN competence

10% Increase in mean novice RN BKAT scores after implementing the preceptor program

Source: Nursing Executive Center interviews and analysis.

EXCERPT

Differentiate practice for experienced nurses

Position competent and proficient nurses "at-the-hip"

- Practice 8: RN partner rounds
- Practice 9: Role-based team nursing

Scale the impact of expert RNs

- Practice 10: Tiered precepting model
- Practice 11: Expert-led care team

How to differentiate practice for experienced nurses

The third path to close the experience-complexity gap is to differentiate practice for experienced nurses. There are two strategies to do so: position competent and proficient RNs “at-the-hip” of new nurses and scale the impact of expert RNs.

This first strategy, position competent and proficient RNs “at-the-hip,” includes best practices that equip leaders to tap into the skills of competent and proficient nurses. Practice 8 leverages competent and proficient nurses as peer coaches during rounds, while practice 9 shows you how to use a team-based staffing model to increase the experience of the care team.

The second strategy, scale the impact of expert RNs, includes best practices that equip leaders to differentiate roles of experienced RNs to maximize their expert status. Practice 10 aims to ensure expert preceptors are performing top-of-license work, while practice 11 elevates the role of expert nurses on care teams.

Two strategies to differentiate practice for experienced nurses

Position competent and proficient RNs “at-the-hip”

Utilize proficient and competent nurses to provide care oversight of novice nurses.

Scale the impact of expert RNs

Maximize the impact of expert RNs by differentiating their role on the unit to reflect their skills as an expert RN.

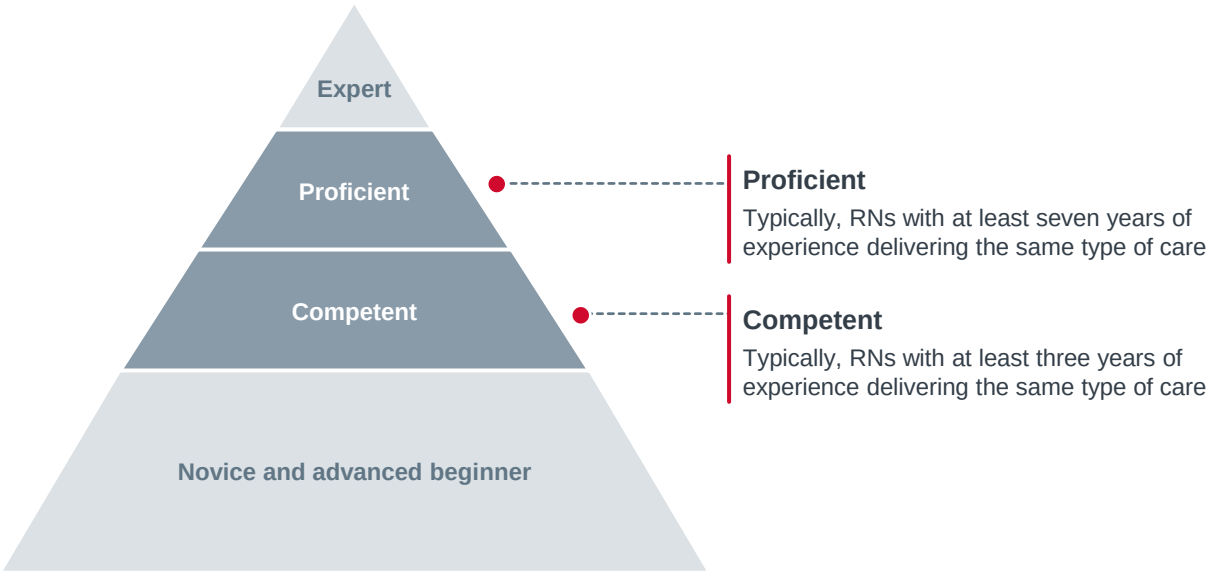
Source: Nursing Executive Center interviews and analysis.

An underleveraged resource

Many organizations position experienced nurses in the same roles as novice nurses. As a result, organizations are not leveraging the experience they already have.

Collectively, competent and proficient nurses make up a sizeable part of an organization’s workforce. While the exact proportion varies from one organization to the next, both groups are a valuable yet often underleveraged resource. They are clinically competent and have developed specific skills, including prioritization, patient communication, and critical thinking.

Representation of RN workforce by experience level



To better leverage competent and proficient nurses, leaders should differentiate their practice by positioning them “at-the-hip” of more novice staff. This leverages these experienced nurses in a more valuable way, raising the experience level on the unit.

Source: Nursing Executive Center interviews and analysis.

Practice 8: RN partner rounds

Practice in brief

Formally partner proficient or competent nurses with novice nurses to round on patients together several times per shift. The goal is to utilize more experienced nurses to catch missed care in the moment, and provide at-the-hip support and actionable feedback to novice nurses.

Rationale

Novice nurses don’t always know all needed care steps during hourly rounding, which can result in missed care. Proficient or competent nurses can partner with novice nurses to provide in-the-moment supervision, support, feedback, and mentorship during hourly rounds. In addition, proficient and competent nurses themselves benefit from this practice because it provides an opportunity to develop and hone their teaching and mentoring skills.

Implementation components

Component 1: Partner each novice nurse with a proficient or competent nurse at the beginning of each shift.

Before the shift begins, managers assign a proficient or competent partner to each novice nurse. Depending on unit staffing, managers can consider alternative pairings, such as: prioritizing experienced partners for the most novice staff, pairing nurses who are close in tenure, or grouping three to four nurses with one experienced nurse.

Component 2: Partners round together on both of their patient assignments.

Throughout the shift, partners round on select patients in their assignments together. Managers decide how many patients the partners should round on—prioritizing the most complex patients—as well as the frequency of rounds for each patient.

Component 3: Provide in-the-moment and follow-up coaching to novice nurses.

Proficient or competent nurse partners provide clinical support and coaching on soft skills to novice nurses—both at the point of care and during a debriefing that follows each rounding session. Examples of in-the-moment support include checking work and flagging missed care. If there are serious clinical concerns, the proficient or competent nurse partner elevates them to the manager who intervenes to provide support.

Practice assessment

We recommend this practice for all organizations as an effective way to provide at-the-hip coaching to novice nurses. The work required to implement this practice is minimal and requires little to no financial investment. This practice is most effective when proficient and competent nurse partners have the training and support to operate as effective peer coaches.

Nursing Executive Center grades:

Practice impact: B

Ease of implementation: A-

Source: Nursing Executive Center interviews and analysis.

Rounding primed for “at-the-hip” support

A key opportunity for positioning competent and proficient nurses “at-the-hip” for novice nurses is during hourly rounding. The three reasons why are shown here. First, most organizations already have hourly rounding in place. Second, rounding is an opportune time to catch missed care by reviewing care plans and observing patients together. Third, rounding facilitates an opportunity for in-the-moment and after-the-fact, actionable feedback.

Three reasons

Modifies existing best practice

Hourly rounding is already embedded in RN workflow, occurs during most shifts.

Creates opportunity to catch missed care

Rounding with a partner provides a routine moment to review care plans and identify gaps in care.

Embeds routine teaching opportunities

More tenured RN can give novice RNs regular, actionable feedback on clinical and soft skills.

Bairnsdale Regional Health Service, a 72-bed hospital located in Bairnsdale, Victoria, Australia, implemented nurse partner rounds during hourly rounding to improve patient care and support a disproportionately novice workforce. The next few pages provide more detail about the components of this practice.

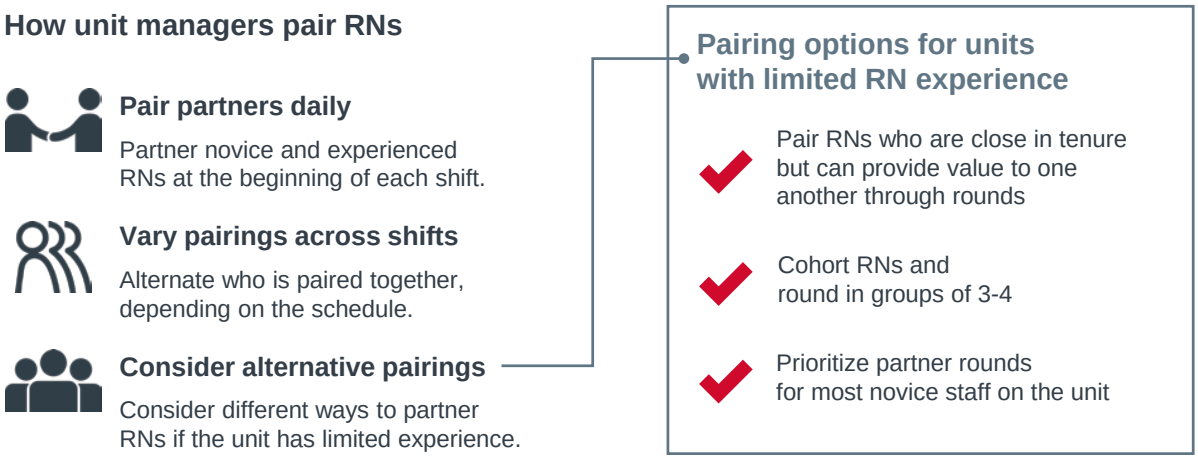
Source: Nursing Executive Center interviews and analysis.

Managers set partner rounds up for success

Component 1: Partner each novice nurse with a proficient or competent nurse at the beginning of each shift.

At Bairnsdale, managers follow three steps for pairing nurses. First, they partner nurses daily. Second, they vary partner assignments based on the mix of nurse competence staffed on that shift and the acuity of patients on the unit.

Third, when units or shifts are staffed with limited nurse experience, or when a one-to-one pairing is not feasible, managers assign alternative pairings. To do so, they select from the three options, shown below. Bairnsdale recommends partnering the most experienced staff with the most novice nurses or pairing nurses who are similar in tenure when necessary.



Component 2: Partners round together on both of their patient assignments.

As partners round together, they focus on the most complex patients.

At Bairnsdale, partners round together approximately six times per shift. They have some flexibility and can decide not to round together for every round, as long as they fulfill the number of joint rounds determined by the manager. Instead of doing every round together, they can choose to round on a subgroup of patients instead. Partners select which patients to round on by identifying the most complex patients on the unit during the shift.

Source: Nursing Executive Center interviews and analysis.

Peer coaches catch missed care and provide ongoing support

Component 3: Provide in-the-moment and follow-up coaching to novice nurses.

Proficient or competent nurse partners provide clinical support and coaching on soft skills to novice nurses—both at the point of care and during a debriefing session following the interaction with the patient. Examples of in-the-moment support include checking the novice nurses’ work, prompting them when a step is being missed, asking questions to prompt critical thinking, and looking for missed care.

At the end of each rounding session, coaches debrief with their partner and share actionable feedback to aid in skill development. Examples of coaching responsibilities are shown here.

Examples of clinical coaching responsibilities

In-the-moment coaching

- Identify missed care
- Weigh in on care plans
- Double-check nurse work

Feedback after-the-fact

- Provide feedback on soft skills including communication and prioritization
- Identify development opportunities

At Bairnsdale, managers are also involved in facilitating and responding to feedback in two ways. First, they conduct rounds on patients to gather feedback to share with nurses. Second, they personally coach novice nurses if a partner elevates a serious concern.

Additional unit manager responsibilities

Hold partners accountable

Managers round on patients once a day asking for feedback on partner rounds. Managers share feedback with RNs.

Follow up with direct coaching

If needed, managers step in to give novice RNs additional coaching on care delivery or other concerns elevated by rounding partner.

The next page provides additional resources to develop peer coaching skills.

Source: Nursing Executive Center interviews and analysis.

Resources to build peer coaching skills

Nursing Executive Center members can use the additional resources and tips shown here to develop peer coaching skills among frontline nurses. For example, if the feedback novice nurses receive is too general, they may not know how to act on it. Or worse—if the feedback they receive is too negative, they may feel overwhelmed or frustrated. As a result, they can lose confidence. The Guide to Delivering Actionable Feedback aims to equip coaches to provide feedback to new nurses in a way that pinpoints specific improvement opportunities while at the same time, bolsters their confidence as new clinicians. The resources below are available on advisory.com.

Source	Tool name	Description
Building Peer Accountability	In-the-moment communication scripting	Enable frontline RNs to clearly and comprehensively deliver in-the-moment feedback to their peers
	Just-in-time feedback opportunity assessment	Teach frontline RNs to identify when it is prudent to deliver just-in-time feedback to peers
	Just-in-time feedback scripting	Equip frontline RNs to clearly and comprehensively deliver after-the-fact feedback
First-Year Nurse Retention Toolkit	Guide to delivering actionable feedback	Equip preceptors, managers, and peer coaches to provide feedback to new RNs in a way that pinpoints specific improvement opportunities and bolsters their confidence as new clinicians

Three tips to develop peer coaching skills

Provide training and tools to develop coaching skills

Practice coaching with role-playing exercises

Give peer coaches ongoing feedback

Source: Nursing Executive Center interviews and analysis.

This is an Advisory Board publication, one of the many resources available to members.

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Advisors to our work

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