Using Monthly Support Groups to Increase Resilience and Decrease New Nurse Turnover

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Abstract

Poor retention of the newly licensed registered nurse (NLRN) can have deleterious effects on the nurse, unit, organization, and patient outcomes. This project examines the effect of a nurse residency program paired with monthly support groups that include resilience training on retention of the NLRN. Twenty NLRN participated and attended monthly NRP sessions and support group meetings over a 6-month period. The Connor-Davidson Resiliency Scale was used to measure resiliency pre-intervention and after 6 monthly support group sessions. The results demonstrated a slight increase in resiliency scores overall, and the retention rate increased from 83% to 90.5% from the previous year. While the results were going in the right direction, it is thought that a more significant impact may have been observed if Covid was not present.

Keywords: Newly licensed registered nurse; novice nurse; turnover; nurse residency programs; support group; and resilience.

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Entering the nursing profession can be both exciting and nerve racking for new nurses as they transition from a student to a professional. The first year can be trying for new nurses as they are navigating their new role and the expectations of being a nurse. As the newest generation of nurses are entering the workforce, there is a high turnover rate before they reach completion of the first year as a registered nurse (RN). According to the 2020 National Health Care Retention and RN staffing report, by Nursing Solutions Inc., "first year turnover continues to outpace all other tenure categories and makes up 58.9% of a hospital's turnover in the United States" (NSI Nursing Solutions, Inc., 2020). This turnover is contributing to a nursing shortage that is further compounded by the baby boomer generation aging, and many nurses are planning on entering retirement. A new generation of nurses is needed to fill the open positions that are being vacated by retirement and to care for this aging population.

Nurse residency programs (NRP) have been shown to increase retention rates along with an increased organizational commitment while decreasing the costs of turnover (Warren et al., 2018). NRP that include a support group component and resiliency training can also lower turnover intentions by allowing the newly licensed registered nurse (NLRN) a place to feel supported by a leader that is not on the unit and the use of resiliency training that will aid in decreasing stress (Irwin et al., 2020). The purpose of this DNP project is to examine the effect of a structured NRP with resiliency training and a monthly support group on the turnover rate of the NLRN.

Problem

This DNP project addresses the problem of high turnover of the NLRN. NLRN are described as "graduate RN's who have passed the National Council Licensure Exam for

Registered Nurses (NCLEX-RN) and are employed for the first time in the role as a professional nurse" (Concilio et al., 2019, p. 153). High turnover of NLRN is not only a problem that this DNP project site faces, but also is a national one. Nursing turnover can be reported inconsistently among organizations as that turnover can be either voluntary where the nurse decides to resign on their own, or involuntarily where the organization terminates the nurse. To complicate reporting further, not every organization conducts an exit interview to determine why the NLRN is leaving their organization. This DNP project hospital is one such organization that does not conduct exit interviews. Therefore, it is difficult to have a true understanding of why the NLRN decides to leave the organization.

Historical Perspective of the Nursing Shortage

High turnover of nurses is nothing new to the nursing profession and has been occurring for decades (Goodin, 2003). This phenomenon is cyclical and, in the US, has manifested itself throughout the decades as a roller coaster of alternating abundances and shortages of nurses. After World War II the growing population from the baby boom led to a shortage; in the 1970's and 1980's another shortage occurred due to nurses' dissatisfaction with working conditions and autonomy; and the latest current shortage is related to the growing aging population from the baby boom that occurred between 1946-1964 (Goodin, 2003). With this latest shortage of nurses, the NLRN are now a contributing factor more than ever. A disproportionate number of NLRN are starting in the position of a nurse and leaving not only their current position, but the profession altogether in a year or less (Edwards et al., 2015).

Recent Perspective of the Nursing Shortage

More recently, the Institute of Medicine (IOM) and the Robert Wood Johnson Foundation (RWJF) worked together for two years to evaluate the nursing profession and the

need to transform the nursing profession, so it is better able to meet the challenges of the health care system. The committee was tasked to evaluate the challenges of the nursing education system and to offer solutions to advance the nursing profession and to assist with the looming nursing shortage. There were four recommendations made to transform the nursing profession; (1) nurses should practice to the full extent of their education and training; (2) nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression; (3) nurses should be full partners, with physicians and other health professionals, on redesigning health care in the United States; and (4) effective workforce planning and policy making require better data collection and an improved information infrastructure (IOM, 2010).

Prevalence of Problem

The turnover rate of the NLRN at the 1-year mark outpaces all other tenure groups, including retirement, and is responsible for 58.9% of a hospital's turnover in the United States (NSI Nursing Solutions, Inc., 2020). Nursing turnover not only affects the United States; Meyer & Shatto (2018) share that the retention of nurses is a global issue. Canada has a 57% turnover of nurses within 2 years of hire; Taiwan's turnover is 28% within one year; and in the United Kingdom 18% of nurses left the profession within 3 years (Meyer & Shatto, 2018).

This DNP project site's healthcare organization is a system of six inpatient hospitals where NLRN are hired at five of the hospitals. The voluntary turnover rate for NLRN within their first year of employment at this organization has increased from 11.83% in 2016 to 14% in 2019 (See Appendix A). This trend is expected to continue to rise at this Midwest organization through 2020. Many leave the organization at the 6–9-month mark, which is the time when the

NLRN has completed their orientation and are on their own for approximately four months without the individualized support.

Within this healthcare organization, one of the inpatient units is noted to have a high turnover rate of NLRN leaving within one year of hire (See Appendix B). The unit employs a total of 60 RN, and the yearly turnover rate of the NLRN for years 2019 and 2020 displays a turnover of 12 and 11 NLRN per year, respectively. This turnover over the past 2 years has led to a unit that is staffed by 35% NLRN and 8.3% NLRN with 2 years of experience.

Why NLRN are Leaving the Profession

Nursing turnover of the NLRN population is concerning. NLRN give a variety of reasons for leaving the profession or the current organization that they are working. Reasons for leaving the profession such as: reality-shock; job and emotional stress from feeling underappreciated, feeling poorly supported, intimidated or bullied; staffing issues; not feeling included or valued; job dissatisfaction; an unclear understanding of the organizational goals and outcomes; and a lack of understanding of how decisions are made are reported in the literature by NLRN (Perron et al., 2019). Organizations must discover a way to address these issues and to support the NLRN, engaging them not only at the unit level, but also the organizational level in order to avoid leaving the profession in the first year of their career.

Lack of Meaning in Work

Many millennials (born between 1981 and 1997) are looking for a meaning and a purpose for the work that they do, and many will leave a job or position to find what they are looking for and need to feel accomplished. O'Hara & Burke (2019) describe many characteristic traits of the millennial generation: they communicate differently than other generations; they value commitment and compensation; they also expect to work in a flexible, safe and motivating

environment; and they prefer a coach to a boss. Millennials want to work in an environment where they learn from others, have healthy interpersonal relationships, self-efficacy, safety, open communication, autonomy and career development (O'Hara & Burke, 2019). If these needs are not met for the millennial, they will look for another position that will meet their needs.

Stressful Working Conditions

Many NLRN leave the profession because they are unhappy with working conditions, which leads to stress, anxiety, and poor job satisfaction. For example, many NLRN feel the pressure from the hospital setting "of a fast-paced work environment where nurses are confronted with high acuity of patients, shorter lengths of stay and high patient to nurse ratios, all of which puts increased pressure upon new graduate nurses" (Hawkins et al., 2019, p. 42). NLRN also report a lack of confidence in their role as a nurse for the first 12-18 months, and they need support and the ability to ask questions of more experienced nurses (Coyne et al., 2020).

Incongruent Expectations

Additionally, many NLRN are disillusioned due to the difference between their ideal working conditions and the actual working conditions. An ideal situation occurs when the NLRN has sufficient resources, is in a safe environment, has job satisfaction, works side by side with a trained preceptor and are supported and welcomed into the working environment. As the NLRN transitions from student to professional, they struggle with the reality shock of what the expectations are for being a professional nurse. As a student, the NLRN was generally only responsible for one patient and at times a second where they only had to complete minimal work and did not see the whole picture of what is needed to care for a patient. They are not prepared for the fast-paced, high acuity, complex and constantly changing patient care that they are

required to provide in a safe manner to four to six patients (Hawkins et al., 2019). Those NLRN who experience high levels of job stress, lack of a trained preceptor and do not feel supported by the team are likely to look for a new position.

Lacking Preparedness & Insecurities

Often a NLRN may show their insecurities and lack of confidence in the care that they are providing. With these insecurities the NLRN could be displaying that they have a lack of knowledge or they are unable to retain the information that the preceptor is sharing with them. This can lead to the NLRN asking the same questions over and over or have the same information explained to them repeatedly in order to complete a specific task. This has the potential to lead the preceptor and other coworkers to become frustrated and often leads to bullying of this vulnerable and insecure NLRN (Hawkins et al., 2019). Horizontal violence has been shown to cause the NLRN to have feelings of emotional distress, low self-esteem, anxiety, depression and disempowerment (Hawkins et al., 2019). This exposure to horizontal violence also affects job satisfaction, cynicism, burnout, and this horizontal violence can affect the NLRN and lead to the intention of the NLRN resigning from their position and potentially leaving the profession all together.

Lack of Resiliency

As NLRN are adapting to their new roles as a professional and facing adversity to the several new stressors that they are facing, the NLRN may turn to poor coping mechanisms when stressed (DuBois & Gonzalez, 2018). Thankfully, resilience can be acquired as it involves behaviors, thoughts, and actions that can be taught to the NLRN (DuBois & Gonzalez, 2018). DeBois & Gonzalez (2018) discuss rationale for why resiliency education is essential and needs to be taught in a way that promotes reflection and applications during residency programs and

work-integrated learning. Resilience is vital for NLRN as they adjust to their role of becoming a professional in the workplace (DuBois & Gonzalez, 2018).

Lack of Support with Transition from Student to RN

The academic-practice gap is well documented in the literature and has been occurring for decades (Hickerson et al., 2016). This gap becomes more evident as the NLRN enters the workforce and they are immediately aware of their deficiencies and lack of preparedness; as a result, they experience stress, frustration and become overwhelmed with their responsibilities (Hickerson et al., 2016). Without support from their preceptors and other coworkers, the NLRN is likely to leave the facility where they are working if not the profession altogether. Also, due to the academic-practice gap, a NLRN who does not have the competencies or critical thinking skills necessary to provide safe care, relies on the preceptor and other coworkers to help them accomplish and finish their work. If these NLRN do not have a strong preceptor to help guide them and to assist in gaining and fine tuning these skills, the NLRN has the potential to not be successful once on their own which can cause additional workload for co-workers. This leads to frustration of the other nurses and the potential to isolate the NLRN from the group.

A Midwest Hospital's NLRN Turnover Anecdotes

As mentioned earlier, the turnover rate at this project site is high and in need of repair. The following anecdotes at the DNP project site will exemplify this problem. Recently a NLRN resigned before the 6-week orientation was completed. There were many discussions with this NLRN that occurred during week three or four of orientation regarding how she was doing, her perceptions of not advancing or being where she thought she should be at this point, and the charting in the electronic documentation system. This NLRN believed that she was struggling and was not convinced that she would ever be able to do the job properly. Much support was

offered to the NLRN, such as reassurance that she is learning at the proper pace, an option for a longer orientation, separate support meetings with the educator, and a different preceptor. The NLRN agreed to all of the above yet called the manager the next day and resigned stating “this isn’t the right job for me”. Furthermore, there was a NLRN who worked one day on the unit; during that shift she was with a preceptor and did not have a responsibility to care for any of the patients on her own. That NLRN did not return the next day but called her manager and stated that this job was too much for her.

These anecdotes provide evidence to the project site administration, that many NLRN are not prepared for the fast paced, demanding healthcare environment, however administration also realizes that it is up to the units to provide a supportive NRP where the NLRN can thrive in their new chosen profession. The support from the NRP, the leader, and other participants, promotes professional socialization and offers a safe place where the NLRN does not feel belittled for their perceived insufficiencies. NRP offer a place where NLRN can practice and hone their skills, critical thinking can be practiced, organization and prioritization can be discussed and worked through, and communication can be reviewed. NLRN need education on resilience tools and a place where resilience tools can be discussed, evaluated for use, and practiced. NRP allows the NLRN a safe place to have the support needed to acclimate to their new role.

Significance of Problem

Constant turnover is costly, leads to nursing shortages, and impacts finances and quality of care (Hopson et al., 2018). The high turnover of the NLRN has many deleterious effects on the organization, the remaining working RNs, patients, and the profession of nursing. An additional significant ramification itself is for the NLRN, who likely paid thousands of dollars to enter a career that they will never reap the rewards.

High Cost to the Organization

Turnover of the NLRN is costly, averaging approximately $52,000 for one NLRN. A reported turnover rate of 17.2% in 2019 is estimated to cause an annual cost for a hospital of $5,700,000 (Asber, 2019, p. 430). Although NRP programs can be costly, the cost of turnover is costlier to organizations. Costs of recruitment and replacement are estimated to be between 75% and 125% of a nurse's salary and organizations can spend upward of $300,000 per every 1% of nursing turnover (Ackerson & Stiles, 2018). The NLRN turnover rate for the first 6 months of the 2020 fiscal year resulted in a cost of $7,361,704 to this organization. This total does not include the many other facets related to the costs of turnover such as advertising, interviewing, morale, commitment from others, and productivity. For the organization to recoup the cost of hiring and replacing a nurse it would require a NLRN to work "1,198 hours or 8.32 months at 36 hours per week in productive status to neutralize the cost of orientation" (Wolford et al., 2019, p. 47). So, after a six-week orientation, it would take a NLRN working full-time at 36 hours per week which is approximately nine months to pay back the cost of their orientation. As one can see that when a NLRN leaves the organization before the first year is over the organization suffers multiple losses.

Work Environment for Remaining Nurses

Turnover also leads to a stressful environment for those that remain; they are often asked to work above their committed hours which has the potential to add stress and the potential for burnout for these employees. The staff are asked to either run short with nursing staff or to run tight on the unit with a lack of available help, such as not having a patient care assistant, or the charge nurse is in an assignment also. This leads to a high stress environment which can lead to burn out and finally the potential to lead to more turnover on units. It is important to monitor

burnout which is “manifested by emotional exhaustion, cynicism, and a sense of inefficacy” (Dans & Lundmark, 2019, p. 7). This unresolved stress including increased workload demands along with limited resources leads to burnout and a decrease in job satisfaction for the remaining staff.

Patient Outcomes

Patient outcomes, length of stay, and quality of care are also affected by turnover (Vardaman et al., 2020). As the experienced nurses leave the bedside, the NLRN are there to take over. Those NLRN that are not adequately prepared, are at a higher risk for errors and potential patient harm. One report stated “75% of medication errors and 40% of patient falls” (Hickerson et al., 2016, p. 20) include involvement of the NLRN. As the NLRN tends to be more focused on completing tasks, they often do not see the patient as a whole picture. This leads to poor patient care and poor outcomes that are also associated with turnover (Hickerson et al., 2016).

Contributes to the Nursing Shortage

The high turnover of the NLRN is creating a perfect storm to impact the future nursing shortage even more than predicted. The academic-practice gap along with stress and reality shock the NLRN’s experience. Incongruent expectations of what nursing is, finding a purpose and meaning in what they do, and finding a way to be supported, are all factors that need to be addressed for the newest generation of NLRN. Baby boomer nurses are retiring and will need care, patients have a higher acuity, and the high turnover of the NLRN not staying in their position to replace those retiring is compounding the nursing shortage. The necessity to stop NLRN turnover is a necessity for the profession and for the people that will need the care from nurses in the future.

PICOT Question

Based on the high turnover rate of the NLRN and the need to support them in their transition into practice in today's high acuity health arena, the following question is posed to guide this EBP project. In newly licensed registered nurses (NLRN) with one year or less of experience (P), how does the current NRP along with monthly support group sessions with resiliency training (I) compared with the current NRP alone (C) affect the retention rate and resilience of NLRN (O) six months after starting the program (T)?

Review of Evidence

A search was conducted using the following databases CINHAL complete, Medline, EBCSO, Health Source Nursing/Academic Edition (EBSCO), Cochrane and Joanna Briggs. The search terms used were; *nurse residency program, new nurse intention to leave, nurse residency programs; turnover, new nurse organizational commitment, new nurse; support groups or self-help groups or group therapy, job embeddedness; nurse, novice nurse; job satisfaction; resilience; support group, and new nurse; turnover*.

Search Summary

A total of 2,042 articles were initially discovered in the search. Once duplicates were removed, the articles were reviewed using the inclusion criteria of: written in the English language and published between 2012-2020 in peer-reviewed journals. The criteria left 22 articles to be critically appraised and reviewed. Appendix C depicts the search strategy and the number of hits per the search terms.

Level of Evidence

The articles were examined for their level of evidence (LOE), which is determined by the type of design or research methodology that would answer the PICO question with the least

amount of error and provide the most reliable findings ((Melnyk & Fineout-Overholt, 2019). Evidence is ranked from level I to level VIII where LOE I is the strongest level of evidence that is generated from systematic reviews and LOE VIII is the lowest level based on opinions of experts. Appraising evidence involves reviewing all sources of information that assists in developing an understanding of the current knowledge that is available to aid in nursing research (Mick, 2017). Once all the 22 articles were appraised and assigned a level, they were calculated for the percentage per level. Of the 22 articles, 11 (50%) were appraised at LOE I. The articles searched have a strong support of the PICOT question. The articles that support the PICOT have a high LOE I, II, and III which equals 54.54% of the evidence available. (See Appendix D).

Synthesis of the Evidence

The evidence overwhelmingly shows that support is necessary for the NLRN. Strongest evidence was found in three areas to support the project: NRP, support groups, and resiliency training. A well-constructed NRP is vital to a positive transition from student to practice and retaining NLRN beyond the first year (Shatto & Lutz, 2017). NRP address ten main themes: (1) teamwork; (2) interpersonal relationships with other nurses; (3) physician interactions; (4) competency and confidence levels; (5) social support from others; (6) role and job stress; (7) commitment to the health care system; (8) job satisfaction; (9) evidence-based practice knowledge, attitudes, and practice; and (10) coping efficacy (Pelletier et al., 2019, p. 67).

The IOM Future of Nursing report of 2010 made recommendations to transform the nursing profession. Another recommendation focused on allowing nurses to practice to the full extent of their education and training. High turnover rates among the NLRN in nursing were discussed and the importance of NRP, “which help manage the transition from nursing school to

practice and help new graduates further develop the skills needed to deliver safe, quality care" (IOM, 2010, p.2) are recommended.

Evidence Supporting NRP Decrease Turnover

The Joint Commission recommended in 2002 that NRP need to be created to help provide the hands-on-experience for the NLRN. The evidence on the recommendation from Joint Commission was limited due to NRP were initially not widespread and there are several different NRP available with no specific curriculum. The IOM report (2010) does discuss that NRP have been shown to reduce turnover of the NLRN, reduce costs, increase stability in staffing, and help the NLRN develop critical competencies in clinical decisions and autonomy in providing patient care. The IOM recommendation of supporting NLRN through a NRP will assist in the transition process from student to professional and will help decrease the nursing shortage. Following the report from the Joint Commission in 2002 and the Future of Nursing report from the IOM in 2010, there has been much research and evidence to support the need to help the NLRN as they transition into practice.

Hickerson et al. (2016) evaluated 33 studies on the NLRN and found three common themes; preparation-practice gap is real; the gap is costly; and effective solutions like NRP are necessary. Van Camp & Chappy (2017) evaluated 22 studies and the retention rates from organizations that provided NRP. Those organizations that provided a program to the NLRN were able to demonstrate a retention rate after the first year of 84% to 94.6% with an estimated 22% increase in retention following NRP programs. Van Camp & Chappy (2017) also report NLRN that participate in NRP are more prepared to face the challenges in transitioning from student to professional.

NRP have many positive attributes including increasing engagement of the NLRN. Engagement has several positive consequences including commitment to the organization and a desire to stay within the organization (Wolford et al., 2019). Wolford et al. (2019) found that turnover for the NLRN decreased to 3.5% from 14% with initiation of NRP.

Asber (2019) performed an integrative review of 16 studies examining the effect of NRP on retention of NLRN. Many different NRP are available that are nationally used as well as organizationally based. It was found that those NRP associated with national programs have a higher retention rate of 74% to 100% of the NLRN, while retention of 74% to 98% occurs in organizational-based NRP. Thus, it is not the type of NRP that is the key to retention, but rather the usage of a formal program to orient NLRN.

Brook et al. (2019) performed a systematic review on the effectiveness of NRP. From the initial 11,656 studies 53 were evaluated and 10 of those showed a 18% decrease in turnover with NRP while 6 other studies had a 24% increase of retention. The most promising component of NRP and other interventions is teaching/training which increase knowledge, confidence and competence (Brook et al., 2019).

Ackerson & Stiles (2018) performed a systematic review regarding NRP implementation in acute care settings and their ability to retain nurses. From the initial 42 studies, 26 were evaluated and demonstrated a rate of NLRN turnover after initiation of NRP of 6.41% to 13%. Turnover was decreased by having “programs directly aimed at providing NLRN with additional skills and learning opportunities to decrease turnover” (Ackerson & Stiles, 2018, p. 284)

Edwards et al. (2015) performed a systematic review to determine the effectiveness of the main strategies to support the NLRN during their transition to the workplace and to evaluate the impact of these strategies on individuals and organizational outcomes. Of the initial 8,199

studies, 30 were evaluated and four main support strategies were identified: nurse internship/residency programs; graduate nurse orientation programs; mentorship/preceptorship; and simulation-based graduate programs (Edwards et al., 2015). All four of these support strategies are present and used in NRP that have evolved over the years and demonstrate a high retention rate between 73% and 94% at one year following implementation of support strategies (Edwards et al., 2015).

NRP can also be focused for specialty nursing practices. One such NRP focused on NLRN that worked in the psychiatric-mental health unit. Pelletier et al. (2019) performed a quantitative time-sequenced comparative study of several cohorts of NLRN thru the years 2010-2016 and included 34 NLRN. This focused NRP increased retention to 88.3% in the first year and 97.1% in the second year (Pelletier et al., 2019). While Smith et al. (2016) examined NRP in the pediatric setting, through a descriptive study. They emailed surveys to 316 pediatric hospitals to gather information on NRP with 81 return responses. There were several positive outcomes from the responses including a retention rate of 79.5% and an increase in professional role confidence by the NLRN of 77.5%, along with a peer support network that increased from 40% to 80%. Thus, it appears that regardless of the type of unit, NRP provide support to the NLRN and results in increased retention.

Evidence Supporting Monthly Support Groups to Retain NLRN

Supportive work environments are one of the top factors that assist NLRN in the transition from student to nurse (Shatto & Lutz, 2017). Support groups along with NRP have been shown to have the NLRN feel valued in the organization, promote resilience, helped to prevent burnout and therefore decrease intention to leave and lower turnover (Wolford et al., 2019).

Hawkins et al. (2019) performed an integrative review focused on NLRN and unsupportive work environments. Of the 247 studies found, 16 met the inclusion criteria. The incidence of the negative behavior varied from 0.3% -12% as a daily occurrence; 29.2% in the past month; 14.7%-24-6% within the past six months; 25.63% within the past year; and 57.1% experiencing sporadic negative behaviors. There was no difference in the reported percentage of those that experienced this behavior between those that participated in NRP and those that did not (Hawkins et al., 2019). Hawkins et al. (2019) share it is necessary for the NLRN to receive the support they require and to transform the 'civility norms' of the nursing profession.

Brook et al. (2019) performed a systematic review to evaluate successful interventions such as NRP and internships to promote retention and decrease turnover of the NLRN. Of the 11,656 studies, 53 met the inclusion criteria. Several studies evaluated turnover and found an average 18% decrease while retention had an average increase of 24% (Brook et al., 2019). Brook et al. (2019) discuss that it is clear for the NLRN to remain in their positions, support needs to be present to allow the NLRN to be more confident as they transition from student to nurse.

Many NLRN struggle when transitioning and peer support is necessary and needed, the opportunity for groups to have time to discuss interprofessional interactions and behaviors, and ways to cope with the stress and emotions with peer support and camaraderie is key (Ackerson & Stiles, 2018).

Resiliency Training

Resiliency is a newer concept that needs to be evaluated and a literature search based on resiliency education yields limited high level evidence (DuBois & Gonzalez, 2018). Resilience "is an innate energy or life force that can empower nurses to positively adapt to stressful

situations and use the experience as a learning practice" (Yu et al., 2019, p. 138). Yu et al. (2019) recommend several ways to increase coping skills, self-efficacy, and social support are to design evaluation programs, make facilitators available, and develop relevant workshops that can help increase and build resilience while reducing the nurses' emotional exhaustion and increase work engagement. A supportive work environment should be created for the NLRN to improve resilience that includes access to training, colleague support and performance feedback (Yu et al., 2019).

Irwin et al. (2020) examined the effect of support groups and resiliency training on NLRN in a community hospital. A pre/posttest design was used to measure resilience. The use of 10 resiliency tools were taught: journaling, reflection, huddling, best friend at work, joy in work, gratitude, positivity, turn on/turn off, self-care, and mindfulness. The introduction and use of these tools allowed the NLRN to identify and use the tools during challenging experiences. Among the 42 participants, there was a statistically significant increase in the mean resilience score from 73.38 to 77.64 ($p < .01$). Support groups allow the project leader the opportunity to ask the NLRN to discuss challenges they have experienced and how they coped with the experience and what resiliency tool they used (Irwin et al., 2020).

Concilio et al. (2019) performed an integrative review of 789 articles where 16 supported that resiliency must be fostered for NLRN to remain in their positions. NRP that specifically address the needs of the NLRN, positively affected resiliency and create resilient nurses who can receive information and act on it to safeguard patients and advocate for their needs. Concilio et al. (2019) discuss NLRN with resiliency have positive effects including: improved empathy towards patients, job engagement, teamwork, increased ability to perform tasks, increased confidence, adaptability, and improved clinical reasoning.

Yu & Lee (2018) surveyed 371 NLRN measuring resiliency and although resiliency did not have a direct effect ($B = 0.08$, $P = 0.253$), it has a negative, indirect effect ($B = -0.03$, $P = 0.003$). Those NLRN that have a resilient disposition may have protective elements or resources that enable the NLRN to reduce stress (Yu & Lee, 2018).

Resilience contributes to a NLRN control of negative emotions. Resilience has an important role in decreasing turnover intentions and finding ways to increase resiliency is an important concept that needs to be improved (Yu & Lee, 2018). NRP along with coworker support can be valuable in addressing the needs of the NLRN and increase resiliency. Resilience is increased with social support, group cohesion, well-prepared preceptors, relationship-based care practices, organizational support, and plentiful clinical support (Concilio et al., 2019). Those NLRN that have confidence in dealing with situations, will be more successful (Vardaman et al., 2020). Vardaman et al. (2020) believe onboarding and group-based socialization may help with strengthening self-efficacy which is a potential remedy to offset the negative feelings of change. Bringing resiliency training to the forefront of NRP may help healthcare organizations retain the NLRN (DuBois & Gonzalez, 2018).

Summary of Review of Evidence

Many NLRN are not prepared for the fast-paced practice they encounter with first jobs as an RN, and they struggle during the transition. The assistance of NRP that offer support and resiliency training are imperative to assist with this transition and to help decrease the turnover of the NLRN. Shatto & Lutz (2017) discuss that a well-constructed NRP is vital to a positive transition to practice which therefore decreases turnover.

Organizational support is also created in NRP that help those NLRN work through negative workplace behaviors (Hawkins et al., 2019). Many NLRN experience stress and a crisis

point at the 5 to 7 month point of practice. NRP with support groups and resiliency training have been shown to help decrease stress and turnover.

Project EBP Model and Theoretical Framework

EBP models available to assist in moving evidence into practice and following the steps of the model ensures that nothing is missed, and that the implementation is complete. Choosing a model that is user-friendly and conducive to a project will assist with a correct and timely implementation. Additionally, the use of a theoretical framework provides not only a structure for EBP but a way to justify the problem (Lederman & Lederman, 2015). Lederman & Lederman (2015) also discuss that a framework aids in answering the questions: What is the problem? and Why is your approach to solving the problem or answering the question feasible? For this project, the Stevens Star Model of Knowledge Transformation is the EBP practice model chosen to guide the implementation of this project, and the theory of organizational socialization by Van Maanen & Schein (1977) was chosen to support the intervention of this project.

EBP Model: Stevens Star Model of Knowledge Transformation

The preferred EBP model used by the Midwest healthcare organization and this DNP project is the Stevens Star Model of Knowledge Transformation. This model was initially created as a response to the EBP movement by Kathleen Stevens, a professor at the Academic Center for Evidence-Based Practice (ACE) at the University of Texas Health Science Center San Antonio in 2004. The model is star-shaped, and each point of the star describes a process in the five-step model: (a) discovery research, (b) evidence summary, (c) translation to guidelines, (d) practice integration, and (e) process, outcome evaluation. The use of the Stevens Star Model of Knowledge Transformation simplifies the evidence that already exists by summarizing

everything known on the topic for it to be applied and used for evidence-based recommendations (Appendix E).

The Stevens Star Model of Knowledge Transformation can be easily adapted for use by individuals and or organizations (Schaffer et al., 2012) and the model is also endorsed by the Institutional Research Board (IRB), which allows the model to be useful at the organizational, educational, and bedside level. The five steps of the model guide the user through the steps of translating evidence into practice. The model allows the user to easily advance from point to point as the steps are completed. Appendix E describes the Stevens Star Model of Knowledge Transformation as it applies to the project of support groups for the NLRN.

Discovery Research

The discovery phase for this project began while working with the NLRN in various aspects through their first year of working in the hospital setting. The voluntary turnover rate of the NLRN at this organization within their first year of employment raised from 11.83% in 2016 to 14% in 2019 (See Appendix A). The organization does not conduct exit interviews therefore it was not known why the NLRN are leaving. An evaluation of the current nurse residency program was conducted and was found to provide support to the NLRN. Although support is given in these sessions by the various educators that teach the sessions, there is not a consistent educator at each session and there is not a recommended discussion point during the session. Also, the NLRN do not consistently have the opportunity for support during these sessions since they may not see the specific educators that are teaching the session again. A systematic literature search was conducted for accompanying high level evidence that supports consistency and structure with support groups and what occurs during the support sessions.

Evidence Summary

During the evidence summary star point, "the synthesis of all available knowledge is compiled into a single harmonious statement, such as a systematic review" (Melnyk & Fineout-Overholt, 2019, p. 470). A formal summary of the evidence was completed and yielded 22 articles. Of the 22 articles, eleven were appraised at LOE I which is the strongest evidence available (Appendix D). The articles support the need for the NLRN to be supported and to participate in a support group with a consistent person. This evidence was shared with the management team on the DNP project site unit and permission was given to continue with the proposed project.

Translation to Guidelines

Translation to Guidelines serves "to inform action, often referred to as evidence-based clinical practice guidelines, combining the evidential base and expertise to extend recommendations" (Melnyk & Fineout-Overholt, 2019, p. 470). Translation helps to decipher what the literature is sharing. The literature supports NRP, resilience training and support groups for support of the NLRN.

Practice changes that occurred from the evidence review included a 6-month NRP with support group focusing on developing resiliency for the NLRN on the DNP project site unit. NRP have been shown to increase retention rates and organizational commitment and decrease the cost of turnover. NRP that also include a support group component can lower turnover intentions by allowing the NLRN a place to feel supported by a leader.

Support groups do work for the NLRN when led consistently with the same leader and with a scheduled topic to be reviewed at each of the separate group meetings. Consistency is the key for the NLRN to feel supported and have a safe place to discuss their concerns and worries.

From the evidence, support for the NLRN is important and necessary for retention. With the proper support provided, the NLRN would feel more confident during their transition from student to professional. This support and confidence will provide the NLRN the desire to stay in the position and organization that they began their career in.

Practice Integration

During the practice integration point on the star, "evidence-in-action, in which practice and clinical making are aligned to reflect best evidence" (Melnyk & Fineout-Overholt, 2019, p. 470). This step occurred at the project site as the NLRN attended the monthly NRP session, resiliency training, and support group sessions. In addition to the monthly support group, NLRN had a 3-hour clinical information session following the current NRP curriculum.

It is critical to understand that the NLRN needs support as they transition from student to professional, due to feelings of being overwhelmed, being the recipient of incivility, feeling undervalued, and experiencing a lack of support (Cochran, 2017). The NLRN is looking for assurance, a sense of relaxation and security, lifting spirits through encouragement, and emotional belonging and involvement (Ebrahimi et al., 2016), all of which are available in support groups. Each of the monthly support group sessions will have a planned topic to guide the conversation and to provide the support that the NLRN is looking for.

Process and Outcome Evaluation

The process and outcome evaluation star point "is an inclusive view of the impact that EBP has on patient health outcomes, satisfaction, efficacy and efficiency of care, and health policy" (Melnyk & Fineout-Overholt, 2019, p. 470). Research has shown that a decrease in turnover leads to better patient outcomes and a better understanding of the policies of the organization from the consistency with the staff and their knowledge on the proper procedures

for care. There were two outcomes measured that indirectly affected patient outcomes. First the voluntary turnover rate of the NLRN going through this new NRP plus monthly resiliency training and support groups was compared to the voluntary turnover rate of NLRN during the same months the previous year. Secondly resiliency was measured pre and post intervention.

Theoretical Framework: Theory of Organizational Socialization

Two professors at Massachusetts Institute of Technology (MIT) Sloan School of Management, John Van Maanen and Edgar Schein, created the theory of organizational socialization which will be used to support the intervention in this project. This theory can be applied to a wide range of areas since every job has some form of socialization (MIT Management, 2020a). Organizational socialization is the "process by which an individual acquires the social knowledge and skills necessary to assume an organizational role" (Van Maanen & Schein, 1977, p. 3). Through the years there have been many additional definitions for organizational socialization and a more recent definition "is a process where a new employee learns the processes and rules of a particular role, thereby acquiring the necessary knowledge and skills to function in that role" (Phillips et al., 2015, p. 120). It is necessary for the NLRN to be properly socialized into the organization for the transition to be successful.

Van Maanen & Schein (1977) propose that there are six socialization processes and six socialization counter processes that can be used by an organization to structure the socialization for the new employee into the organization. The processes and their counter processes include: (a) collective vs individual, (b) formal vs informal, (c) sequential vs random steps, (d) fixed vs variable, (e) serial vs disjunctive, and (f) investiture vs divestiture (Van Maanen & Schein, 1977, p. 37). Van Maanen & Schein initially described these processes to be independent of each other with the first process the preferred way to socialize a new employee into an organization.

Tuttle (2002) proposes the processes are continuums where each possible socialization process and their counter processes represent the extreme possible socialization process on each end of the spectrum; on one end of the spectrum, organizational socialization is represented, while individualized socialization is at the other end. Tuttle (2002) also shares that the number of possible process combinations are infinite with combinations that can be used to successfully socialize a NLRN into an organization. It is necessary to use both processes for the NLRN to have a successful socialization to the organization. The NLRN is not only being socialized into the organization, but also individually socialized to each specific area where they work. Those organizations that can blend both ends of the spectrum of the socialization processes, will create a welcoming environment that will allow the NLRN to navigate easily through the expectations of the acute care organization and to successfully socialize themselves into both the organization and their individualized units (Appendix F).

Collective vs Individual Socialization

The first continuum process of collective versus individual socialization refers to the way the NLRN are being either grouped together for common socialization experiences or isolated from one another to be paired with a preceptor or more seasoned nurse for their socialization experience. “Collective socialization refers to the tactic of taking a group of recruits who are facing a given boundary passage and putting them through a common set of experiences together” (Van Maanen & Schein, 1977, p. 38). While “individual socialization refers to the tactic of processing recruits singly and in isolation from one another through a more or less unique set of experiences” (Van Maanen & Schein, 1977, p. 38). Both processes of collective and individual socialization are especially important for the NLRN.

Currently as the NLRN are hired they may not see the other NLRN that they initially began their journey with from initial corporate orientation again. Following the collective process, it is important that NLRN are grouped together and that they experience common experiences. This can be completed by taking a group of NLRN to acclimate through NRP resiliency training and support groups which allows the NLRN to collectively go through experiences together.

It is also imperative for the NLRN to have individual socialization which occurs on the separate units they were hired to. The NLRN are isolated from other NLRN where they each experience socialization to their specific units and the culture of those individual units. Individual socialization allows the NLRN to successfully acclimate to their new coworkers and to the units' culture.

Formal vs Informal Socialization

The NLRN needs to participate in both formal and informal socialization during orientation. Formal socialization "refers to those processes in which a newcomer is more or less segregated from regular organizational members while being put through a set of experiences tailored explicitly for the newcomer" (Van Maanen & Schein, 1977, p. 43). While "informal socialization process does not distinguish the newcomer's role specifically nor is there an effort made in such programs to rigidly differentiate the recruit from other more experienced organizational members" (Van Maanen & Schein, 1977, p. 44).

During formal socialization, the NLRN is away from their unit coworkers and they are participating in clearly defined activities and training. This socialization occurs in separate areas such as classrooms, simulation, skills sessions or computer labs away from the unit. It is important for the NLRN to participate in formal socialization via participation in NRP and

support groups where they are having shared experiences and able to openly discuss any positive experiences or difficulties they are having, along with the use of resilience tools.

During informal socialization, the NLRN are participating in experiences on their units where they are blended into the team on the unit. With informal socialization the NLRN is not identified as a newcomer but as a part of the team. This often occurs through the daily assignments and workflow that the NLRN is participating it. Informal socialization includes socializing during lunch, get togethers outside of work, random chit-chat at the nursing station and other informal non-work-related conversations that allows others to get to know each other on a personal level.

Sequential vs Random Steps Socialization

Socialization and orientation for the NLRN has both components for sequential and random socialization. Sequential socialization "refers to the degree to which the organization or occupation specifies a given sequence of discrete and identifiable steps leading to the target role" (Van Maanen & Schein, 1977, p. 51). While random socialization occurs "when the sequence of steps leading to the target role is unknown, ambiguous, or continually changing" (Van Maanen & Schein, 1977, p. 51).

Sequential socialization occurs when the organization specifies a sequence where the goal is identified, and the steps get the NLRN to that goal. For sequential socialization, the final goal is for the NLRN to care safely for an assignment of four-six patients by the end of orientation. This is done through a variety of steps, where more and more responsibilities are given to the NLRN. The NLRN is also attending sequential monthly meetings as part of the NRP.

Random socialization occurs as one is going through the steps to reach the final goal. The steps are random and not in a sequential order and because things are consistently changing based on the individual nurse, preceptor, unit and patient population. Each unit and preceptor function independently with the NLRN, therefore each experience is different for the NLRN.

Fixed vs Variable Socialization

Fixed and variable socialization are both necessary for the NLRN to experience as not everyone learns at the same pace nor do they have the same experiences on their individualized units. Fixed socialization "processes provide a recruit with the precise knowledge of the time it will take to complete a given passage" (Van Maanen & Schein, 1977, p. 55). While a variable socialization "process give a recruit few clues as to when to expect a given boundary passage" (Van Maanen & Schein, 1977, p. 55).

During fixed socialization, the NLRN is aware of the timetable of their orientation. The NLRN is aware of the expectations to adjust to their new role within a specific timeframe. This timetable varies per department but on inpatient units, orientation is generally six weeks long with the availability to add additional time if needed. The NLRN will also participate in an NRP and a support group that lasts one year.

During variable socialization, there is not a timeline associated with reaching the final goal of becoming a novice to advanced beginner nurse by the end of orientation. Variable socialization allows the NLRN to transition from a student to a novice nurse or advanced beginner at their own pace.

Serial vs Disjunctive Socialization

It is ideal for a NLRN to only experience serial socialization and not disjunctive. Serial socialization "process is one on which experienced members of the organization groom

newcomers who are about to assume similar kinds of positions in the organization" (Van Maanen & Schein, 1977, p. 59). Serial socialization occurs when an experienced nurse of the organization educates a newcomer to the organization. This is done through orientation where the experienced nurse educates and orients the NLRN to the unit and in their new position. This grooming and education by an experienced role model allow the NLRN to understand what is being asked of them in the new position.

Disjunctive socialization occurs when socialization for the NLRN is not ideal. When "newcomers are not following the footsteps of immediate or recent predecessors, and when no role models are available to recruits to inform them as to how they are to proceed in the new role, is a disjunctive socialization process" (Van Maanen & Schein, 1977, p. 60). This socialization can occur when the NLRN is trained by a preceptor that may not be an expert in the current position. Disjunctive socialization occurs when the nursing team has a high turnover and the preceptors for the NLRN have less than two years of experience themselves. Yet, these preceptors are expected to assist in training and socializing the NLRN into the organization as they are still acclimating themselves.

Investiture vs Divestiture Socialization

Investiture versus divestiture socialization represents the degree to which the organization supports or attempts to break away from the NLRN prior socialization experiences and identity. Investiture processes "ratify and document for recruits the viability and usefulness of those personal characteristics they bring with them to the organization" (Van Maanen & Schein, 1977, p. 64). In contrast the divestiture socialization process "seeks to deny and strip away certain personal characteristics of a recruit" (Van Maanen & Schein, 1977, p. 64).

Investiture socialization encourages the newcomer to bring their own personalities and ideas into the organization to assist in the process of trying to fit into the organization. This socialization also uses the NLRN skills, experiences and knowledge and would use those to build upon the foundation that is already there.

Divestiture socialization wants the newcomer to only behave a specific way and to conform to specific rules and regulations. This divestiture socialization attempts to breakdown old patterns and assumptions that the NLRN brought with them into the new setting in order to "rebuild the individual's self-image based on new assumptions" (Van Maanen & Schein, 1977, p. 69). Organizations that use investiture socialization welcomes the NLRN with open arms and welcomes their ideas and fresh perspective on things, while the divestiture socialization uses negative feedback in attempts to break down the NLRN in order to assimilate them into the culture of the organization.

Socialization of NLRN

For many NLRN, their first jobs are in a hospital setting as a bedside nurse and it is necessary for the socialization to be positive as these initial experiences are the foundation for retention, job satisfaction, and role identification (Feng & Tsai, 2012). Many NLRN struggle with the transition from student to professional and they often voice concerns about the discrepancy between what the NLRN envisions the nursing job to be versus the realities of the clinical areas (Feng & Tsai, 2012). Applying the organizational socialization theory can assist with the transition and can encourage a positive transition that will increase satisfaction and ensure that the NLRN are socialized into the organization along with its structure and expectations. Although the theory describes both an ideal process and an opposite one, many of the processes need to be blended to be successful. This is due to the fact that socialization occurs

at both the organizational level and the individualized unit level for the NLRN. The NLRN is not only hired to work on a specific unit, but they also have the expectations to honor the expectations of the organization also.

DNP Project Proposal

This DNP project was created to evaluate the effects of an NRP and a support group that includes resiliency training on turnover of the NLRN for this Midwest organization. The goal is that the initiation of an NRP with support group and resiliency training conducted by a consistent leader, will allow the NLRN to feel supported and will increase job satisfaction, resilience and decrease turnover.

Population

Participants of this project are determined by the organization and meet the following criteria: 1) is a newly graduated nurse or has been a nurse less than one year; and 2) is hired to work on the 39-bed unit where the project will be implemented. All NLRN hired into this organization on the 39-bed telemetry unit were required to attend the NRP and support group sessions and thus participate in this project. An unexpected twist on hiring is related to the state's allowance to hire newly graduated nurses who have not yet taken NCLEX due the COVID-19 pandemic. These nurses were enrolled in the NRP, resiliency training and support groups.

The project site hired 20 NLRN that participated in the project. All 20 participants were female; 17 identified as white, two as black or African American, one as Asian/Pacific Islander. Their ages varied with 14 between ages 20-25, three aged 26-30, two aged 31-35, and one over age 50. Education included eight with a Bachelor of Science in Nursing (BSN) degree and 12 with an associate degree (AD). All 20 were hired into a fulltime position with nine hired to straight day shift and 11 were hired to work straight nightshift. Nineteen reported being single

and one is divorced. Nine live with a spouse/partner, four live with their parents, three live with friends, three live alone, and one lives with their child.

Due to COVID-19 not every NLRN was able to participate in a role transition during their last semester in school; twelve did complete role transition, four completed a modified role transition, and four did not have a role transition. COVID-19 also allowed for graduate nurses to begin working as a nurse with a temporary license before they sat for the NCLEX exam. Twelve NLRN began working prior to taking the NCLEX while eight began their career after passing the NCLEX exam. Prior experience in healthcare also varied prior to becoming a NLRN, one was an LPN (licensed practical nurse), one was a personal assistant, four did not work in healthcare prior to this position, and fourteen worked as a personal care assistant (PCA) in the hospital.

Setting

NLRN participating in this project were employed in one of the five hospitals that are part of this large healthcare organization in the Midwest. The hospitals are urban, suburban, and rurally located, and provide adult, pediatric, and obstetric services; hospitals vary on the types of services they provide. The number of beds range from 32- 460 adult beds; additionally, there are 60-130 newborn beds, and some pediatric. The NLRN for this project will be hired for the healthcare system urban location on a 39-bed unit.

The NRP sessions will occur at two of hospitals with the urban hospital location being the main site. This location has several classroom and computer labs available, and the classroom can be converted into a skills lab. The classroom settings at the urban location can hold anywhere from five to one hundred people in the room and is ideal to hold the sessions. The other location that will be used for the NRP and support groups is the simulation lab at the

suburban hospital. The simulation lab has four old inpatient rooms that have been converted to hold both simulation and skills labs.

The support group portion and resiliency training for the NLRN will occur at the same two locations discussed and will allow for the discussions to remain within the cohort group. Although the simulation lab does have the capability to record and send a live feed of discussions from specific rooms to a viewing room, the discussions will not occur in the rooms capable to record. This will be communicated to the NLRN who are participating.

The NLRN for this project will be employed at the urban location on a 39-bed private room telemetry unit. The unit is currently returning seven of the rooms to semi-private and the unit will be a 46-bed unit. The patient population includes heart failure, chest pain, chronic obstructive pulmonary disease, irregular heart rhythms, those with endocarditis needing antibiotics, and any surgical patient that develops heart rhythm/ irregular heart rate changes from surgery. This unit is also a COVID-19 unit and cares for patients with high oxygen demands on BIPAP and Optiflow. The unit is shaped like the letter H and that leads the unit to often function as two separate units with one charge nurse managing the admissions and assignments for all the beds. The manager is new to the organization and has been in her position for one year and the assistant nurse manager was a staff nurse on the unit and has in her position for approximately nine months. There is also an educator and has worked on the unit for 24 years as a staff RN and has been the educator for the past seven years. The unit is staffed with approximately 60 nurses, with ages ranging from 20-65; most of the nursing staff has less than 1 year of experience. Of those nurses working on this unit, 35% have less than one-year experience, 8.3% have between one to two years, 23% have between two to five years of experience, 1.67% have five to ten

years, 5% have 10-15 years, 6.67% have over 20 years, 1.67% over 30 years and 3.33% have over 40 years nursing experience.

Data Collection Tools

Three tools will be used to collect data for this DNP project: a demographic form, a resiliency survey, and a recording form of monthly turnover pre- and post-intervention. These forms are described below and are included in the appendices.

Demographic Form

Upon entering the NRP program, each participant completed a demographic information form. This form inquired about factors such as age, gender, race, education, licensure status and so forth. Participants entered a unique code on this form, as well as the resilience survey, that will allow data to be anonymous and able to match for a longitudinal comparison. This demographic form can be found in Appendix G.

Conner-Davidson Resilience Scale

The Conner-Davidson Resilience Scale (CD-RISC) (2003) (Appendix H) was used to evaluate the resiliency of the NLRN in the NRP. Permission was granted to use the tool by Jonathan R. T. Davidson, M.D. (Appendix I). This survey was created by doctors Conner and Davidson as a "brief self-rated assessment to help quantify resilience and as a clinical measure to assess treatment response" (Conner & Davidson, 2003, p. 77). This tool is reliable with a Cronbach's alpha of 0.93 (Conner & Davidson, 2003).

CD-RISC is a 25-question survey that was administered at session one and session six of the support group sessions. The survey was administered by the coordinator in paper form and took approximately 10 minutes to complete. The same unique code was used on this survey as

the demographic form. The completed forms were placed in an envelope and returned to the coordinator and were completed prior to leaving the support group session.

The survey questions measure different aspects of resiliency which is an individual trait that enables one to thrive in the face of adversity (Conner & Davidson, 2003). Hardiness, coping, adaptability/flexibility, meaningfulness/purpose, optimism, regulation of emotion and cognition and self-efficacy are all evaluated by the CD-RISC-25. The score can also change and increase over time with self-help or other interventions. The CD-RISC has 25 questions that are answered on a 5-point Likert scale (0) not true at all, (1) rarely true, (2) sometimes true, (3) often true, and (4) true nearly all the time. The ratings from all 25 items were totaled and resulted in a resiliency score between 0-100. The higher the score, the higher the individual perceives their resilience to cope with things that can add stress.

Record of Turnover by Month

Turnover of NLRN was recorded monthly on this student-made form (Appendix K). Data from September 2019 thru February 2020 compared to September 2020 thru February 2021. Turnover was recorded from September 2020 through February 2021 by DNP student.

Intervention

The intervention in this project is twofold. It consists of the currently used, home grown NRP program and a newly added support group that includes resiliency training. The NRP is a six-month program, with monthly meetings lasting four hours, held either in a classroom or simulation lab. The program follows a specific curriculum focusing on different topics each month and occasionally using expert guest speakers. Each of the monthly sessions began with a reflection, a YouTube video or a clip to help inspire the participants to be glad that they are a nurse, help make the sessions fun, and inspire a questioning attitude and learning. (See Appendix

L for summary of monthly sessions). NLRN were assigned to cohort group of four to six nurses; small groups are more conducive to learning and sharing of ideas.

The second part of the intervention involves a one-hour support group meeting that provides an opportunity for the NLRN to focus more on their emotional handling of making the transition from student to professional nurse. Support is a "mutually, interpersonal and context-dependent process that makes people feel respected" (Ebrahimi et al., 2016, p. 12). The support groups provide positive interactions that address clinical skills and self-esteem (Ebrahimi et al., 2016). Resiliency training is part of this support group intervention.

Through resiliency training, NLRN can learn how to care for themselves by learning to replenish their minds, bodies, and souls. Resilience contributes to NLRN having control of negative emotions and reducing burnout while playing a role in promoting job satisfaction which lowers turnover intention (Yu & Lee, 2018). Yu & Lee (2018) also believe those NLRN with a resilient deposition have protective elements and resources that help enable to lower stress. Allowing time for NLRN to discuss stressful issues and providing them with tools for resiliency and lowering stress was the major focus of these support group sessions. The sections following outline the monthly NRP curriculum and the monthly support group foci.

Month One

During the first month the NLRN is adjusting to their role and beginning the journey of transforming from student to professional. At this point in the NLRN career, they are beginning to assume care of a 2-3 patient assignment and they are learning the routines and roles of their coworkers and the culture of the unit. The NLRN are also delegating care to others and are discovering what is permissible to delegate and what cannot be delegated. It is also necessary for

the NLRN to understand that this organization management team gives feedback frequently and that it is to help them grow and it is not a punitive thing.

NRP. This session occurred in the classroom and included introductions, program expectations and confidentiality, stress management and self-care. There was a PowerPoint presentation and handouts that reviewed common documentation needs along with quality measures that everyone needs to be aware of. The participants also received an article "Give the gift of feedback" that shared why feedback is important and to give them a better understanding of the feedback they will be receiving often from the managers, educator and charge nurses. The NLRN needs to learn early on how and what to delegate. Many NLRN struggle with asking for help much less asking or telling an unlicensed care assistant what they need them to do. This session allowed the NLRN to share and discuss their concerns with delegation and teamwork and allowed for role playing and for the coordinator to share tips and ideas for the NLRN to be successful.

Support Group. In this support group, the groundwork was laid regarding rules for participation and confidentiality. Support is needed to help NLRN address the multitude of emotions that they are experiencing. A place where the NLRN can feel safe and know that they are not alone experiencing several emotions such as "anxiety, fear, depression, emotional exhaustion, helplessness, feeling of immense time pressures and despair" was needed (Ebrahimi et al., 2016, p. 11). NLRN met monthly for 1 hour with the project leader for a support session that followed the NRP session. Each session began after a short break from the NRP to separate the two different sessions. Ground rules were explained at the first session, posted in view at every session, and include:

1) Everything talked about in the group, stays in the group, and remains confidential.

2) Agreement to not disclose to anyone outside the group any information that may help to identify another group member.
3) Group leader promise to maintain confidentiality unless, of course, there is a concern of harm to self or to others.
4) Acknowledgement of safe place to share triumphs and challenges.

The session will open and/or close with an inspirational reflection related to the topic of the month, this helped inspire and guide the conversation. Next, an open-ended question such as "What is your biggest challenge on the unit thus far?" was asked. Once the discussion began, the facilitator listened and ask others in the group about their experiences, if they have any advice to share, and role playing if appropriate for situations for the group to understand ways to deal with situations that may frustrate them. To allow the group to be more conversational, there will be snacks such as chips, cookies, and candy for the group during the sessions. Small gifts will be given to the participants as listed in the resiliency training section.

Resiliency training began, and ten resiliency tools were explained in this first support group and participants were asked to choose 3 tools they will use over the next month. These tools include journaling, reflection, huddling, best friend at work, joy in work, gratitude, positivity, turn on/turn off, self-care and mindfulness (Irwin et al., 2020). As a gift, a photo box will be given to the NLRN, this box is referred to as the "Happy Box". Often nurses receive thank you and kudos from families, managers and co-workers and the happy box is a place to begin to store all the mementos from the beginning of their career. The first item in the box is the list of the three items the NLRN will be using. Those that choose the journaling option will be given a journal and a pen to use so they can begin journaling as soon as the first session is complete. Handouts were also given to everyone that are from the American Nurses Foundation

that suggests tips, apps and tools that are all free to use. The second handout from American Nurses Foundation is a checklist for the end of the shift to decompress before going home (Appendix M).

Month Two

The NLRN is thought to be becoming slightly more confident with the care that they are providing. Also, they are becoming more familiar with the other staff on the unit and the routines for the care of patients. They are finishing orientation and beginning to provide care on their own to their own patient assignment. NLRN may experience anxiety and feel unsure of the care that they are providing due to inexperience and being on their own. NLRN may also have questions on some of the care that is provided often but that they may not have had experience with during orientation.

NRP. During this monthly session prevention of falls, infections, and intravenous infiltrations were discussed. Also, restraint use, blood administration and properly donning and doffing of personal protective equipment (PPE) were discussed in this monthly session. The participants were able to demonstrate tying the several different restraints and related protocols; proper use of chair, bed and lap belt alarms; how to properly scan and document blood; proper placement and infection prevention measures for foley catheters; the preventative measures for patients with central lines; and demonstrated properly donning and doffing PPE. A member from the unit's shared leadership committee (SLC) also attended, explained what SLC is and invited the NLRN to participate in the next SLC meeting to help encourage engagement in the unit and the organization.

Support Group. Support for the NLRN included discussions that involved their interactions and interprofessional communication with other members of the healthcare team. At

this point the NLRN should be forming some relationships with other members of the healthcare team who also care for their patients. NLRN should be communicating daily with physicians, therapists, social workers, nutritionists, pharmacists, transportation technicians and care coordinators. Discussions and sharing tips and discussions will help the NLRN navigate the interprofessional team and discussions that need to occur to provide the best care for the patient. The chain of command was also discussed due to the number of resident doctors that are also in training at this Midwest healthcare organization. The NLRN will need to understand if they have concerns regarding the care or the orders from the resident doctors, they can call another doctor that has more training to clarify the orders or the care that is ordered.

The group leader led a discussion on how the resiliency tools worked that were chosen last month? How often did you use them? Did you like using one the best? Why or why not? Which one did you not like to use or was not what you thought it would be? After this discussion, resiliency training focused on self-care, mindfulness and turn on/turn off.

Self-care and mindfulness discussion focused on the use of mobile applications. These applications are often free of charge and allows the participant to set their own personal goals for what they want for self-care: such as sleep, mindfulness, exercise, nutrition, meditation and mood. The concept of turn on/turn off helps to create a mind for the day at work and when it is time to go home. This concept allows the NLRN to prepare to mentally let go of the day at work and to prepare for home (Irwin et al., 2020). Everyone was encouraged to try these techniques for the month.

Month Three

The NLRN is typically out of orientation for two to three weeks at this point and is working on their own, managing the care of patient assignments consisting of three to six,

depending on the shift that they are working. They often feel timid and fearful with asking questions and with asking for help from other more experienced staff.

NRP. This session occurred in the simulation center of the urban hospital and focused on code readiness. Prior to the simulation session there was a classroom portion that was conducted by the simulation specialist. During this session, the NLRN were aware that this is a practice session, that there is no judgement, that the session is to facilitate learning in a safe environment, and the manager will not be aware of what was discussed or happens during the simulation session. The NLRN had an opportunity to familiarize themselves with the crash cart, documentation, and the mannequin along with the events that typically happen in the first 15 minutes of a code situation. During the high-fidelity simulation, the simulated patient experienced an event that needed the NLRN to call for assistance from the charge nurse, a physician and eventually calling the code team. The NLRN was not alone in this situation. All the participants in the cohort were together for this experience. Debriefing occurred with the group of NLRN after the simulation portion is complete. The debriefing discussion included: "What went well?"; "What were the signs and symptoms of the simulated patient?"; "What tests are you expecting to have ordered?"; "Who did you notify for assistance and who else could be notified?"

During the debriefing of an emergent situation, another topic that was discussed was care of the dying patient and post-mortem care. NLRN have received end of life (EOL) care education during nursing school but enter the nursing profession without witnessing the death of a patient (Cadavero et al., 2020). Cadavero et al. (2020) also discovered NLRN feel unprepared and anxious when they experience a death which has the potential to lead to "emotional exhaustion, cynicism, and burnout which may ultimately lead to job turnover" (Cadavero et al.,

2020, p. 267). Learning to care for the dying can be challenging for the NLRN and learning this care early in one's career will assist with the topic and how difficult it can be.

Support group Once the simulation portion was completed, questions were posed to the group based on how they are doing with time-management, such as: "Are you leaving on time?"; "Are you eating lunch?"; "Are you taking breaks to go to the restroom?" Time-management does not come instantly and takes months to discover a workflow that works best for the NLRN. Time management is a tricky skill for the NLRN however, it does develop with experience and time and there are certain strategies that can assist with time management (Leis & Anderson, 2020). Leis & Anderson (2020) suggest getting to work on time and being prepared to start your shift; use tracking tools such as standardized report sheets; get a meaningful report such as bedside shift report; routinely review charts for new orders, lab results and to have a better understanding of the patient; check on patients early, a quick round to check on each of your patients before you begin the time consuming task of medication administration; learn about common medications that are routinely given on your unit; anticipate physician rounds and do your best to participate asking questions for both yourself and the patient; keep track of any ordered tests and trips off of the unit; facilitate meal time and plan ahead for anything the patient may need; and prepare for handoff at the end of the shift. Other suggestions to assist with time management include, taking breaks to reset your mind; chart in real time; conduct purposeful hourly rounding; assist others; and be prepared for the unexpected (Leis & Anderson, 2020). Discussions that reviewed what is working and what is not, where the NLRN is struggling and succeeding and ways to work through not leaving on time and feeling behind in their work will be initiated.

Resiliency training began with a review of how the use of resiliency tools were working and what the NLRN likes and dislikes about the tools they used. The focus for resiliency training this month was positivity and journaling. There are a multitude of free applications for phones available that provide positive quotes, pictures and phrases. These were discussed and the NLRN in the group will be encouraged to download one onto their phone. There are also different options for journaling, such as pen and paper, typing into a journal and free applications and websites available for journaling. These were discussed and the NLRN will be encouraged to choose one that works best for them. For those who would rather write in their own journal, one was provided at this session. There may be times where the NLRN is struggling, and the tools did not provide the support that is needed. Should this occur the NLRN will have information on ways to reach out for help and to speak with someone, and they are always encouraged to reach out to the coordinator or unit managers.

Month Four

The NLRN has been on their own for approximately six weeks. They are forming a base of practical knowledge on a variety of cases and are having success with some decisions. With the common diagnoses that they see most commonly, the NLRN is beginning to use critical thinking skills with more ease with these patients.

NRP. This session took place in the simulation center of the hospital and focuses on how to manage the changing condition of patients. The NLRN had one of the two high-fidelity simulation scenarios: one a patient with chest pain and the second a patient who is becoming septic. During the simulation portion, half of the participants in the cohort participated in the simulation while the other half watched the scenario from another room. The group is split in half to help conduce learning in different ways. The group that does not enter the simulation,

observed those in the simulation via a video feed. This group had all of the same information as those participating in the high-fidelity simulation and had a leader in the room with them to assist in facilitation of discussions. Once the high-fidelity simulation is completed, the groups met for debriefing. The groups switched, and the next high-fidelity simulation session began, and the same process was repeated.

Support Group. Discussion continued and allowed the NLRN the opportunity to share emergency situations that they have been involved in. The NLRN shared their experiences with the code team and how they felt during the situation.

Feedback for the use of the positivity applications and journaling were sought. The discussion then led to huddling, reflection and gratitude. Huddling is best described as an "effective method of overcoming adversity in an occupational environment in which new nurses are required to use appropriate coping mechanisms to deal with job stress and job-related problems that are often caused by the lack of working experience" (Im et al., 2016, p. 1379). Huddling was encouraged to happen while at work when needed. It is encouraged for those working to huddle if an incident occurs on the unit, such as a death, a fall or an emergency. This allowed everyone the opportunity to share how they were feeling at that moment and to know that they are not alone while providing support, protection and encouragement in real time.

Reflection was also important during those high stress situations. This provided the NLRN the opportunity to review what happened, by either writing about it, discussing it with someone or simply thinking about the situation. Finally, gratitude was discussed. Gratitude is defined "as a generalized tendency to recognize and respond with grateful emotion to the roles of other people's benevolence in the positive experiences and outcomes that one obtains" (Davis et al., 2016, p. 20). Davis et al. (2016) discussed common strategies for promoting gratitude by

engaging in brief activities such as listing five things that they are grateful for. This can be accomplished by listing five things that occurred at the end of every shift that the NLRN was thankful for or that the NLRN can take a moment and write a quick thank you to someone who helped them during their shift. Everyone appreciates when someone recognizes them for doing something kind or positive. The unit has a bulletin board where Extra Kindness Grams (EKG) are written by the team members on the unit. Taking a quick moment to thank someone during the shift not only allowed the NLRN to end their shift on a positive note and helped to create a culture of gratitude and appreciation.

Month Five

The NLRN has had good and bad shifts at this point and how they handle those shifts impact their emotions. The next several months are critical for the NLRN. Cochran (2017) shares that months five through seven are critical and many NLRN reach a crisis point and quit. This struggle can be due to the NLRN not perceiving a progress or growth in critical thinking or in the care they are providing. Most colleges have a 16-week semester and the NLRN is used to receiving feedback on how well they are doing at this point. The NLRN are in their first professional position and are looking for the feedback that they are used to receiving on how they are doing.

NRP. This monthly session was in the classroom setting where patient outcomes, wound care, pain management, medication administration and errors were discussed. There was a guest speaker who shared and discussed the medication error that she made and the resulting outcomes. The NLRN then had the opportunity to set up a patient control analgesia pump (PCA) and discuss what patient population this pain management is best for. There were opportunities to discuss the importance of pain management, when it is appropriate to discuss with the doctor

changing pain medication from intravenous to oral, how to give medications per the pain scale properly and the orders, and when to call or discuss with the doctor how the patient is responding to the pain regime. Wound care was also discussed including properly staging a wound, what products to use on incontinent patients and negative pressure wound therapy. There was a guest speaker from wound care who discussed care with the NLRN and was available for questions.

Support Group. Discussions focused on administering pain medications and dealing with pain control for patients. Medication errors were also discussed including near misses or actual events. Ideas on ways to prevent errors and near misses were role played.

The group shared how gratitude, huddling and reflection resiliency tools are working. The discussion led to having joy in work and a best friend at work. An assumption is that by this point everyone connects with one or more special coworker. This is encouraged and allows the NLRN to have someone to talk about their day with who truly understands. This friendly relationship can be positive and lead to joy in work. If this friend at work relationship has not already happened naturally, the NLRN was encouraged to make those friends.

Month Six

NLRN they still struggle with their level of confidence and many believe they should be further along than they are. Many are less timid as they are working permanent shifts, have found their support people who they trust and often ask questions and they are continuing to develop a work and social system.

NRP. This session occurred in the classroom setting and covered the suicidal and alcohol or drug addicted patient including withdrawal and included dealing with difficult families and patients. There were opportunities to role play within the group and ways to discuss: Why was

the patient difficult? What led the family to be difficult? Was there anything that could be done differently?

Support Group. Feedback and role play on dealing with difficult patients and families were done. The NLRN were able to share experiences and the way the situations were handled and what worked well and what could have gone better.

During this month, all ten of the resiliency items were reviewed and the NLRN were asked to discuss; What was your favorite? What will you continue to use? Did you find another tool to use that you can share? There are many positive outcomes from resiliency training including: improved empathy towards patients, work engagement, teamwork, increased confidence, adaptability, increased ability to perform tasks and increase in clinical reasoning (Concilio et al., 2019). The results from the CD-RISC survey will hopefully display that the resiliency training was helpful to assist the NLRN with their transition.

Strategic Planning

Strategic planning is "a deliberative, disciplined effort to produce fundamental decisions and actions that shape and guide what an organization (or other entity) is, what it does, and why" (Kools & George, 2020, p. 1). The success of EBP depends on methodical planning and considerations of many things, from personnel, too organizational and too available resources. Following a strategic plan with a NRP can lead to a higher return on investment and retention rate of the NLRN who participates in the NRP.

Ethical Considerations

Safety is always the number one priority for anyone who participates in the NRP and support group programs. CITI training was completed by the project leader (Appendix N) to assure an understanding of concern for human subjects. The project was submitted to the Mount

St. Joseph University Institutional Review Board (IRB) and it was determined “not to be research” (see Appendix O). The project was also submitted to the project hospital site IRB and was also determined “not to be research” (see Appendix P). Support group sessions that occurred at the Midwest urban hospital simulation center were not recorded nor had the ability to have a live feed transfer into another room. This ensured that privacy was maintained for the NLRN participants. Additionally, all participants were instructed to maintain the confidentiality of any content discussed in the support sessions. A signature was required by the NLRN and the coordinator for the support group promising confidentiality and privacy from the support group participation (see Appendix Q).

Key Stakeholders

Stakeholders are defined as “groups or individuals who benefit from or are harmed by, and whose rights are violated or respected by corporate actions” (Werhane, 2000, p. 4). These include but are not limited to program managers and staff; local, state and regional coalitions; advocacy partners; state education agencies, schools, and other educational groups; universities and educational institutions; local government, state legislators, and state governors; privately owned businesses and business associations; healthcare systems and the medical community; religious organizations; community organizations; and private citizens (Walston, 2018, p. 127). For the purpose of this DNP project, not all the above will be explained. A stakeholder “is any individual or group whose role relationships with an organization: (a) help to define the organization, its mission, purpose, or its goals, and/or (b) are vital to the survival and success [or well-being] of the corporation, and (c) are most affected by the organization and its activities” (Werhane, 2000, p. 5).

Nurse Managers

It is essential for the nurse manager to see the value in allowing their NLRN to attend the NRP along with resilience training and support group sessions. It is imperative for the managers to allow the NLRN to have the scheduled time off to attend sessions and not change the NLRN schedules for them to work on the unit and unable to attend. The programs do affect the budget and the staffing on the unit; however, these are short term issues that have the potential to be corrected with the programs. The ultimate goal is retention and allowing participation in the program will lead to a decrease in turnover and a more stable staff on the nursing units for the managers. This in turn stabilizes the budget and staffing on the individual nursing units.

NLRN

NLRN are looking for a place to feel valued and where they can make a difference. They also want support as they transition from student to professional. Organizations that offer an NRP with resiliency training and support to the NLRN are the organizations that NLRN are looking for. This will lead to a reduction in turnover and a place where the NLRN will want to stay and grow within an organization.

Patients as Consumers

Potential patients now have access to data and information on how healthcare organizations are doing. This allows patients to “shop around” for what they believe is the best place to receive high quality and safe care. Healthcare organizations that have high patient satisfaction scores, low infection rates and low fall rates are organizations that patients want to go. NLRN that participate in an NRP gain knowledge on how the organization works, and the skills to support their growth, which leads to a decrease in errors and infections and a higher patient satisfaction. These NRP have been found to “reduce turnover, resulting in a more stable

workforce that is comfortable with the policies of the hospital, and thus positioned to deliver safer care" (Perron et al., 2020, p. 51).

Community

Communities want to be associated with successful businesses and organizations. A healthcare organization that supports its employees and provides a stable environment with a low turnover and good patient outcomes is an organization that a community will be proud of and want to be a part of. Many who live in a community want to stay in the same community for their healthcare needs.

Accreditation Agencies

Accreditation is "a process of review that allows healthcare organizations to demonstrate their ability to meet regulatory requirements and standards established by a recognized accreditation organization such as ACHC" (Accreditation Commission for Health Care [ACHC], 2020). This Midwest organization has many disease specific and generalized accreditations from the Joint Commission and is also a Magnet recognized organization. Achieving "accreditation demonstrates a commitment to continuous improvement in patient care" (The Joint Commission, 2020) and providing an NRP that is accredited will continue in the tradition of providing the best patient care available.

Driving and Restraining Forces

Psychologist Kurt Lewin is considered a pioneer of social, organizational and applied psychology and he developed the change theory where major concepts of driving forces and restraining forces are discussed. Lewin describes driving forces as "corresponding, for instance, to ambition, goals, needs, or fears are forces toward something or forces away from something" (Lewin, 1997, p. 322). These driving forces tend to bring about changes. While Lewin describes

"a restraining force is not in itself equivalent to a tendency to change; it merely opposes driving forces" (Lewin, 1997, p. 323). These forces, both, work together as changes occur.

Driving Forces

There are a multitude of driving forces to move this DNP project forward for the organization, decreasing turnover, stabilizing the nursing staff, creating a safer nursing team, and saving money for the organization. A main driving force is a desired decrease in turnover, and with a decrease in turnover, the nursing staff becomes more stable and safer (Perron et al., 2020). The NLRN who participates in an NRP with resiliency training and a support program will have a better understanding of policies and procedures of the organization which will allow the NLRN to provide safer care to the patients. Another driving force is saving money for the organization by decreasing turnover. Organizations that provide NRP with resiliency training and support groups have the potential to save money by keeping the NLRN in the organization, beyond the expensive orientation period. The average turnover cost of a bedside nurse is $52,100. With the average annual loss of $5, 700,000 for an organization with a turnover rate of 17.2% (Asber, 2019), the ability to decrease NLRN turnover is a necessity for all organizations.

Restraining Forces

There are also many restraining forces that have the capability of affecting this DNP project such as when a NLRN misses a session or more or does not participate in sessions. The NLRN will be required to attend a four-hour session that is away from the units where they work. While it rarely happens, the unit manager could pull the NLRN from attending a session to work on the floor if patient acuity/census deems it necessary; most managers plan in advance for the NLRN to be absent from the floor for these four hours.

If the NLRN misses a session, the NLRN will miss the opportunity to grow, learn resiliency tools, and have support; this will continue to lead to turnover. There are a variety of reasons the NLRN may miss NRP sessions, such as leaving the unit short for the day while the NLRN attends the session, or they may not see a value in the NRP resiliency training and support group. This restraining force has the potential for the NLRN to not see a value or importance in the program and could miss other session or to not participate in the sessions if the NLRN does attend. The restraining forces are troublesome for any project and can lead to the NLRN continuing the cycle of turnover. Attendance is taken in each session so that future connections can be made between a nurse resigning and poor attendance.

Another restraining force that must be considered is the COVID-19 pandemic. Many healthcare organizations have faced financial hardships and have restructured their organizations. This restructuring has affected the budget, the number of positions that are being approved and the hiring of NLRN prior to them sitting for the NCLEX exam. The Ohio Board of Nursing released a new law on March 27, 2020 which allows nursing applicants who have successfully completed their nursing programs to be granted a license to practice in the hospital setting without passing the NCLEX-RN. This law also gives the applicants the opportunity to take the NCLEX-RN at a later date. Currently the later date is 90 days after December 1, 2020 or 90 days after the state of emergency is declared over (Ohio Board of Nursing, 2020).

Budget

The manager and the director of the 39-bed telemetry unit are aware of the turnover rate on this unit, and they are allowing the NRP and support group along with resilience training to occur. Costs include class time for the hourly NLRN, paper copies, notepads, folders, incentives/tokens, and random supplies (Appendix R).

Timeline

This DNP project will span 15 months from January 2020 to April 2021. Implementation of the interventions of the NRP resiliency training and support groups will span a six-month period beginning in September of 2020 and ending February of 2021. See Appendix S for a milestone timeline.

Evaluation

This DNP project will serve to evaluate two outcomes: retention rate of NLRN and resiliency of NLRN. The goal is that the NLRN will learn resiliency strategies, be able to cope with the stressors on the job, and thus will want to stay at the organization, increasing the retention rate.

Retention Rate

All pre-turnover data was obtained from the organizations' human resources business intelligence developer/analyst for all 12 months in 2019 and for the first 8 months of 2020 (Appendix B). The data for September 2020 through February 2021 was obtained from the DNP student. The retention rate during the 6-months of the project will be compared to the 6-month retention rate at the organization during the same 6-month period of the previous year. (Appendix T)

During the 6-month period of September 2019-February 2020 two NLRN resigned from the organization. Both NLRN did attend the organizations NRP and attended three of the four sessions prior to resigning. The first resignation occurred at 9 months into the position and per the NLRN that it was not a good fit for what they wanted from their career. The second resignation at 10 months was due to a visa issue, forcing the nurse to choose between employment or school.

During the 6-month period of September 2020 through February 2021 two NLRN resigned from the organization. The first NLRN resigned at 6 months after attending three NRP sessions, resiliency training and support groups. The NLRN was uncomfortable caring for COVID-19 patients and resigned to accept a position at another organization in an outpatient setting. The second NLRN resigned at 8 months. This NLRN had anxiety caring for the units' normal population, believed it was easier to care for the COVID-19 population as their care was very routine with the medications, oxygen and daily care that was needed. This NLRN attended three NRP sessions, resiliency training, support groups in addition to having several conversations with the project leader and nursing manager prior to making the ultimate decision to resign.

While the number of NLRN who left post-intervention remained the same at two, it is more accurate to compare the percentage of retention pre and post intervention. Pre-intervention, 10/12 NLRN remained with an 83% retention rate; post-intervention 19/21 NLRN remained with a 90.5% retention rate. Thus overall, the NRP and support groups with resiliency training did have a positive impact on retaining NLRN on the project unit.

Resiliency

Resiliency results were evaluated and reported following the scoring and interpretation guidelines from Conner-Davidson (see Appendix U). Possible scores range from 1-100 and the ideal score is greater than 80. This high score correlates to lower levels of stress and vulnerability with a higher resiliency and thus can be viewed as a measure of successful stress-coping abilities (Conner & Davidson, 2003).

Resiliency was measured using the CD-RISC 25 survey, comparing the results from the baseline survey at month one to those results at the 6-month mark of the program. Twenty

NLRN completed both resiliency surveys, while one was not able to complete the post resiliency survey (see Appendix T for pre and post resiliency scores). A paired t-test was planned to examine whether the mean difference between the pre and post resiliency scores was greater than zero. The paired t-test requires that two assumptions be met related to the distribution of data: Normality and Homogeneity of variances. A Shapiro-Wilk test found that the assumption of normality was met ($W=0.93$, $p=0.171$) and the Levene's test found that the assumption of homogeneity of variances was met ($F(1,38)=0.33$, $p=0.570$). Therefore, the paired t-test was appropriate to run. There is no statistically significant difference between pre-resiliency scores ($M=77.90$, $SD=8.25$) and post-resiliency scores ($M=80.15$, $SD=8.80$), $t(19) = -1.14$, $p=0.269$.

The scores for the NLRN were also examined by age. The NRLN aged 20-25 were 67% of the participants and their resiliency score increased from 78 to 78.3. Those aged 26-30 were 19% of the participants and resiliency increased from 80 to 84.6. The NLRN aged 31-35 were 10% of the participants and increased their resiliency score from 75.5-81.5. The NLRN >50 was 5% of the participants and increased their resiliency score from 89-90. As a person ages, their life experiences generally lead them to have a higher resiliency score. The pre and post surveys did report an increase in resiliency for 13 of the NLRN, while one did not change their resiliency score, and six NLRN reported a decrease in resiliency (Appendix T).

The combined pre-intervention resiliency score of the two NLRN who left the organization was 150. While the combined post resiliency score was 144. This decrease in resiliency scores support the need for deliberate resiliency training and support for the NLRN.

Resiliency Anecdotes

The NLRN had many fun anecdotes to share with the use of the resiliency tools. Thirteen of them reported having a best friend at work was the way to go. Comments included "I love my

work friends and like looking for advice from someone I trust." "Friends helped me reflect and discuss with others who have has similar situations." "Work friends offer all of the SUPPORT." "I love my work sisters." "I couldn't make it through my shifts without the support of my best friends at work." "Talking about things with my work besties gave me the most relief."

Many stated that they did not like journaling for a variety of reasons. "I'm not good at it and it is too time consuming." "I do not like journaling." "I never read them." "I do not have time to journal." "I am not a fan of writing." One NLRN reported that journaling "Helps me think through my thoughts and helps me lay them out." Another NLRN shared that "after a tough shift journaling about the shift was helpful, then I tore it up and threw it away. It was my way of closing the issue."

Huddling was difficult for many of the NLRN. Each shift on the unit begins with a daily huddle where important information is discussed. The huddles can be up to 15 minutes long and at times may not always be positive. The teams are also encouraged to huddle on the unit with the team when incidents happen such as an emergency or a fall. One NLRN reported "huddling was difficult because there wasn't always someone to huddle with." Another NLRN reported "I like huddling and the fact that the whole team can come together and talk about what's going on and how things can become better."

Many NLRN report that self-care was particularly important to them especially orienting during a pandemic. Comments include "Taking time for myself is rewarding to me." "It made me take time away from all of the stress going on and to focus on myself." "Finding and doing things I enjoyed helped my stress." One reported between work and school "I do not have time for self-care."

Reflection was also helpful for the NLRN. “Reflecting helps me learn from my mistakes.” “I like reflection it helps me reflect to figure out what could have been done differently in that situation.” One NLRN reported gratitude and positivity as their favorite; “Staying positive keeps me going and keeps me hopeful that things will change to the best.” One NLRN shared that turn on/turn off was important “I feel the best when I’m able to enjoy myself outside of work. I can turn off the thoughts and remember I am more than a nurse.”

Significance and Implications

The increase in resiliency scores is significant for patient care safety. Those NLRN that have a high resiliency score are gaining confidence in the care that they are providing. They are becoming more confident with the routine of the unit and the patients that they care for. Many of the NLRN are reaching out for assistance and asking the appropriate questions to critically think and work through situations.

Thirteen of the twenty-one NLRN all reported a higher resiliency score ranging from an increase of 1 to 25 points from the post surveys following resiliency training and support groups. All thirteen NLRN remained employed on the project unit thus the results/project is significant.

Project Goals

The goal of this project was twofold: 1) for the NLRN to feel supported and learn to be resilient; and 2) to increase the retention of the NLRN through participation in an NRP and monthly support groups. Project goals were met on time and within the budget. While retention increased, resiliency did increase for the NLRN. A future evaluation regarding the project goals will be to examine if the NLRN who completed the NRP with support groups remain at the organization for a significant length of time. Due to the scope of this project, retention was only able to be evaluated 6 months into the program, however the goal is to retain this NLRN for

years to come. It would also be beneficial to reexamine resiliency scores at the one-year mark to evaluate a continued increase in resiliency.

Satisfaction level of Stakeholders

The NLRN that participated in the NRP, support group and resiliency training had positive feedback for this DNP student. They enjoyed the NRP sessions, the resiliency training, support group sessions, and the one-on-one communication and individualized support with this DNP student. The management team was satisfied with the amount of turnover that has occurred. The managers believe that with the pandemic and the stress of the unit and patient population that the turnover would have been greater without the support groups. Managers credit the project, resiliency training, and the time spent supporting the NLRN as a stabilizing factor.

Project Considerations

Several factors need to be considered, should this project become part of the organization's NRP on a permanent basis, including: 1) content and structure of the support groups; 2) choice and number of units to conduct the groups; and 3) determining the best way to deal with NLRN hired at various times throughout the year.

Content and Structure of Support Groups

To recreate this project, several considerations must be made. The length of the NRP sessions needs to be limited to three hours of education while allowing the fourth hour for the support group to occur. The sizes of the groups were appropriate with four to six per group. It would be beneficial to occasionally have a few of the groups meet and share their insights and perspectives with each other at various times throughout the NRP and support groups. Hiring at the DNP project site varies for each unit, it would be beneficial to have the NLRN hired at the same time in the same group as the NLRN are having similar experiences close to the same time.

Meeting monthly was the appropriate time frame for the NLRN to use the resiliency tools and to use the NRP information as they cared for patients. The monthly NRP allowed the NLRN time to use the education and to build upon it on the monthly basis. The NLRN did evaluate each NRP session, and it would also be beneficial to have an additional evaluation form to evaluate the resiliency tools and how the support group helped or did not help on a monthly basis. It would also be beneficial for the group leader to have training in running a support group and on the resiliency tools. This training would benefit both the NLRN and the group leader with support and advice on the tools.

Future Units for Project Implementation

The DNP project occurred on a 39-bed telemetry unit. This unit was appropriate for the project and the concept of resiliency training and support groups could be used on any unit that hires NLRN. The NRP also could be used on any unit however, an emergency department or an intensive care unit would benefit from a more robust NRP or internship.

Dealing with Sporadic Hires

Ideally, this intervention would work the best with a cohort of NLRN, hired at the same time, and consistently meeting in the same groups. This would facilitate trust within the group, and all NLRN would be at the same level of experience. In this current project, NLRN were hired at different times, had different numbers of group sessions, and thus did not have the opportunity to develop that strong sense of camaraderie. While they were supportive of each other, using a cohort model for these groups would enhance understanding, empathy, and caring in this group.

Future of Project

The DNP project site recently purchased a NRP and hired a coordinator for the program. Resiliency training could be suggested to the coordinator and added into the NRP. This addition to the NRP could help the NLRN with resilience as they are transitioning from student to professional. Resiliency training could be an additional tool for the NLRN to use and to assist during transition. The NLRN hired onto this project unit will continue to be educated on resiliency tools by this project leader to assist with their transition.

Future work

This DNP project highlighted that resiliency training needs to be introduced and incorporated early on in ones' career. Many of these concepts could be helpful to nursing students as they are navigating the complex training and education of healthcare. It will be proposed to the project sites NRP coordinator to add the resiliency education into the NRP to further support the NLRN and assist with their success. There are several other tools that could be considered for resiliency training such as music, song, yoga and tia chi.

Dissemination

This project has many facets and would be appropriate to disseminate to hospital administrators, academic nurse educators, as well as unit nurses responsible for orienting the NLRN. To this end, three nursing journals present appropriate vehicles for dissemination. First, *The Journal of Nursing Administration* would provide a venue to educate administrators on the importance of resilience training and support for the NLRN. NRP and support groups are costly; administrative support is needed to offer this important service to the NLRN. Secondly, *The Journal of Nursing Education* is a widely read journal in nursing academia and would provide a medium to educate prelicensure faculty about the importance of resilience. Too often

prelicensure curriculums focus on caring for patients, rather than the nurse caring for themselves. Lastly, publishing this project in *The Journal for Nurses in Professional Development* would reach the audience of those nurses who would be working with NLRN. They would gain knowledge on the struggles of the NLRN and how best to help them. Furthermore, given the content of this project is relevant to nurses in administration, academia, and patient care, dissemination at nursing conferences via poster or podium, would also be appropriate.

Conclusion

High turnover of the NLRN is not only a problem that this DNP project sited faces, but also is a global one. The first year can be trying for new nurses as they are navigating their new role and the expectations of being a nurse. As the newest generation of nurses are entering the workforce, there is a high turnover rate before they reach completion of the first year as a RN. The turnover rate of the NLRN at the 1-year mark outpaces all other tenure groups, including retirement, and is responsible for 58.9% of a hospital's turnover in the United States (NSI Nursing Solutions, Inc., 2020). The purpose of the project was retaining NLRN via NRP and support groups with resiliency training, which was strongly supported in the literature. The results were significant for decreasing turnover from 16% to 9.5% with the intervention. Resiliency also increased for many of the participants. Although the mean was not statistically significant at the 6-month mark, it would be worthwhile to have the participants fill out another survey at the one-year mark to evaluate resilience. The literature supports that those NLRN that remain within an organization for extended periods of time, have a positive link to patient outcomes. A decrease in turnover leads to better patient outcomes. Those NLRN that remain in an organization understand the policies, procedures, and the best care to provide to the patients.

They understand the standards of care that the patients need to provide the best care and to improve patient outcomes.

References

Accreditation Commission for Health Care. (2020). *About accrediation*. ACHC for Providers, by Providers. https://www.achc.org/about-accreditation.html

Ackerson, K., & Stiles, K. (2018). Value of nurse residency programs in retaining new graduate nurses and their potential effect on the nursing shortage. *The Journal of Continuing Education in Nursing*, *49*(6), 282–288. https://doi.org/10.3928/00220124-20180517-09

Asber, S. R. (2019). Retention outcomes of new graduate nurse residency programs: An integrative review. *The Journal of Nursing Administration*, *49*(9), 430–435. https://doi.org/10.1097/NNA.0000000000000780

Brook, J., Aitken, L., Webb, R., MacLaren, J., & Salmon, D. (2019). Characteristics of successful interventions to reduce turnover and increase retention of early career nurses: A systematic review. *International Journal of Nursing Studies*, *91*, 47–59. https://doi.org/10.1016/j.ijnurstu.2018.11.003

Buerhaus, P. I., Auerbach, D. I., & Staiger, D. O. (2020). Older clinicians and the surge in novel coronavirus disease 2019 (COVID-19). *JAMA*, *323*(18), 1777–1778. https://doi.org/10.1001/jama.2020.4978

Cadavero, A., Sharts-Hopko, N., & Granger, B. (2020). Nurse graduates' perceived educational after the death of a patient: A descriptive qualitative research study. *The Journal of Continuing Education in Nursing*, *51*(6), 267–273. https://doi.org/:10.3928/00220124-20200514-06

Cochran, C. (2017). Effectiveness and best practice of nurse residency programs: A literature review. *MEDSURG Nursing*, *26*(1), 53–63.

Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institure of Medicine. (2010). *The future of nursing: Leading change, advancing health*. National Academies Press . https://nacns.org/wp-content/uploads/2016/11/5-IOM-Report.pdf

Concilio, L., Lockhart, J. S., Oermann, M. H., Kronk, R., & Schreiber, J. B. (2019). Newly licensed nurse resiliency and interventions to promote resiliency in the first year of hire: An integrative review. *The Journal of Continuing Education in Nursing*, *50*(4), 153–161. https://doi.org/10.3928/00220124-20190319-05

Conner, K. M., & Davidson, J. R. (2003). Development of a new resilience scale: The Conner-Davidson resilience scale (CD-RISC). *Depression and Anxiety*, *18*, 76–82. https://doi.org/10.1002/da.10113

Coyne, D., Tuer, A., & Nair, J. (2020). Novice nurse support group: A pilot study. *Journal for Nurses in Professional Development*, *36*(1), 12–32. https://doi.org/10.1097/NND.0000000000000601

Dans, M., & Lundmark, V. (2019). The effects of positive practice environments: Leadership must-knows. *Nursing Management*, *50*(10), 7–10. https://doi.org/10.1097/01.NUMA.0000580624.53251.29

Davis, D., Choe, E., Meyers, J., Varjas, K., Gifford, A., Quinn, A., & Van Tongeren, D. (2016). Thankful for the little things: A meta-analysis of gratitude interventions. *Journal of Counseling Psychology*, *63*(1), 20–31. https://doi.org/10.1037/cou0000107

Dechawatanapaisal, D. (2018). Nurses' turnover intention: The impact of leader-member exchange, organizational identification and job embeddedness. *Journal of Advanced Nursing*, *74*(6), 1380–1391. https://doi.org/10.1111/jan.13552

DuBois, C., & Gonzalez, J. (2018). Implementing a resilience-promoting education program for new nursing graduates. *Journal for Nurses in Professional Development*, *35*(5), 263–269. https://doi.org/10.1097/NND.0000000000000484

Ebrahimi, H., Hassankhani, H., Negarandeh, R., Gillespie, M., & Azizi, A. (2016). Emotional support for new graduated nurses in clinical setting: A qualitative study. *Journal of Caring Sciences*, *5*(1), 11–21. https://doi.org/10.15171/jcs.2016.002

Edwards, D., Hawker, C., Carrier, J., & Rees, C. (2015). A systematic review of the effectiveness of strategies and interventions to improve the transition from student to newly qualified nurse. *International Journal of Nursing Studies*, *52*(7), 1254–1268. https://doi.org/10.1016/j.ijnurstu.2015.03.007

Feng, R., & Tsai, Y. (2012). Socialisation of new graduate nurses to practising nurses. *Journal of Clinical Nursing*, *21*(13), 2064–2071. https://doi.org/10.1111/j.1365-2702.2011.03992.x

Goodin, H. J. (2003). The nursing shortage in the United States of America: An integrative review of the literature. *Journal of Advanced Nursing*, *43*(3), 335–350. https://doi.org/10.1046/J.1365-2648.2003.02722_1.X

Hawkins, N., Jeong, S., & Smith, T. (2019). New graduate registered nurses' exposure to negative workplace behaviour in the acute care setting: An integrative reveiw. *International Journal of Nursing Studies*, *93*(1), 41–54. https://doi.org/10.1016/j.ijnurstu.2018.09.020

Hickerson, K. A., Taylor, L. A., & Terhaar, M. F. (2016). The preparation-practice gap: An integrative literature review. *The Journal of Continuing Education in Nursing*, *47*(1), 17–23. https://doi.org/10.3928/00220124-20151230-06

Hopson, M., Petri, L., & Kufera, J. (2018). A new perspective on nursing retention: Job embeddedness in acute care nurses. *Journal for Nurses in Professional Development*, *34*(1), 31–37. https://doi.org/10.1097/NND.0000000000000420

Im, S., Cho, M., Kim, S., & Heo, M. (2016). The huddling programme: Effects on empowerment, organizational commitment and ego-resilience in clinical nurses - a randomized trial. *Journal of Clinical Nursing*, *25*(9), 1377–1387. https://doi.org/10.11111/jocn.13228

Indra, V. (2018). A review on models of evidence-based practice. *Asian Journal of Nursing Eduation and Research*, *8*(4), 549–552. https://doi.org/10.5958/2349-2996.2018.00115.5

Institute of Medicine (IOM) (US) Roundtable on Evidence-Based Medicine. (2009). *Leadership commitments to improve value in healthcare: Finding common ground: Workshop Summary*. Washington DC: National Academies Press (US).

Irwin, K. M., Saathoff, A., Janz, D. A., & Long, C. (2020). Resiliency programs for new graduate nurses. *Journal for Nurses in Professional Development*, *37*(1), 1–5. https://doi.org/10.1097/nnd.0000000000000678

Kools, M., & George, B. (2020). Debate: The learning organization- a key construct linking strategic planning and strategic management. *Public Money & Mangement*, 1–4. https://doi.org/g and strategic management, Public Money & Management, DOI: 10.1080/09540962.2020.1727112

Lederman, N. G., & Lederman, J. S. (2015). What is a theoretical framework? A practical answer. *Journal of Science Teacher Education*, *26*, 593–597. https://doi.org/10.1007/s10972-015-9443-2

Leis, S., & Anderson, A. (2020). Time management strategies for new nurses. *Transition to Practice, 120*(12), 63–66. https://doi.org/10.1097/01.naj.0000724260.01363.a3

Lewin, K. (1997). *Resolving social conflicts and field theory in social science*. American Psychological Association. https://doi.org/10.1037/10269-000

Melnyk, B. M., & Fineout-Overholt, E. (2019). *Evidence-based practice in nursing and healthcare: A guide to best practice* (4th ed.). Wolters Kluwer.

Meyer, G., & Shatto, B. (2018). Resilience and transition to practice in direct entry nursing graduates. *Nurse Education in Practice, 28*, 276–279. https://doi.org/10.1016/j.nepr.2017.10.008

Mick, J. (2017). Funneling evidence into practice. *Nursing Management*, *48*(7), 27–34. https://doi.org/10.1097/01.NUMA.0000520719.70926.79

MIT Management. (2020a). *Edgar H. Schein*. MIT Management Sloan School. mit.edu/faculty/directory/edgar-h-schein

MIT Management. (2020b). *John Van Maanen*. MIT Management Sloan School. https://mitsloan.mit.edu/faculty/directory

NSI Nursing Solutions, Inc. (2020). *2020 National healthcare retention and RN staffing report*. NSI Nursing Solutions, Inc.. https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf

O'Hara, M. A., & Burke, D. (2019). Assessment of millennial nurses' job satisfaction and professional practice environment. *The Journal of Nursing Administration*, *49*(9), 411–417. https://doi.org/10.31097/NNA.0000000000000777

Ohio Board of Nursing. (2020). *Ohio Board of Nursing*. https://nursing.ohio.gov/

Pelletier, L. R., Vincent, C., Woods, L., Odell, C., & Stichler, J. F. (2019). Effectiveness of a psychiatric-mental health nurse residency program on retention. *Journal of the American Psychiatric Nurse Association*, *25*(1), 66–75. https://doi.org/10.1177/1078390318807968

Perron, T., Gascoyne, M., Kallakavumkal, T., Kelly, M., & Demagistris, N. (2020). Effectiveness of nurse residency programs. *Journal of Nursing Practice Applications & Reviews of Research*, *10*(1), 48–52. https://doi.org/10.13178/jnparr.2019.09.02.0908

Phillips, C., Esterman, A., & Kenny. (2015). The theory of organisational socialisation and its potential for improving transition experiences for new graduate nurses. *Nurse Education Today*, *35*(1), 118–124. https://doi.org/10.1016/j.nedt.2014.07.011

Reinhart, R. J. (2020, January 6). *Nurses continue to rate highest in honesty, ethics*. Gallup. https://news.gallup.com/poll/274673/nurses-continue-rate-highest-honesty-ethics.aspx

Rosseter, R. (2019, April 1). *Nursing fact sheet*. American Association of Colleges of Nursing. https://www.aacnnursing.org/News-Information/Fact-Sheets/Nursing-Fact-Sheet

Rush, K. L., Janke, R., Duchscher, J. E., Phillips, R., & Kaur, S. (2019). Best practices of formal new graduate transition programs: An integrative review. *International Journal of Nursing Studies*, *94*, 139–158. https://doi.org/10.1016/j.ijnurstu.2019.02.010

Schaffer, M. A., Sandau, K. E., & Diedrick, L. (2012). Evidence-based practice models for organizational change: Overview and practical applications. *Journal of Advanced Nursing*, *69*(5), 1197–1209. https://doi.org/10.1111/j.1365-2648.2012.06122.x

Shatto, B., & Lutz, L. M. (2017). Transition from education to practice for new nursing graduates: A literature review. *Creative Nursing*, *23*(4), 248–254. https://doi.org/10.1891/1078-4535.23.4.248

Smith, J. B., Rubinson, D., Echtenkamp, D., Brostoff, M., & McCarthy, A. M. (2016). Exploring the structure and content of hospital-based pediatric nurse residency programs. *Journal of Pediatric Nursing*, *31*(2), 187–195. https://doi.org/10.1016/j.pedn.2015.10.010

Stetler, C. B., Ritchie, J., Rycroft-Malone, J., Schultz, A., & Charns, M. (2007). Improving quality of care through routine, successful implementaiton of evidence-based practice at the bedside: An organizational case study protocol using Pettigrew and Whipp model of strategic change. *Implementation Science*, *2*(3), 1–13. https://doi.org/10.1186/1748-5908-2-3

The Joint Commission. (2020). *What is accreditation?* https://www.jointcommission.org/en/accreditation-and-certification/become-accredited/what-is-accreditation/

Tuttle, M. (2002). A review and critique of Van Maanen and Schein's "toward a theory of organizational socialization" and implications for human resource development. *Human Resource Development Review*, *1*(1), 66–90. https://doi.org/10.1177/1534484302011004

Tyndall, D. E., Jones, L. R., Scott, E. S., & Cook, K. J. (2019). Changing new graduate nurse profiles and retention recommendations for nurse leaders. *The Journal of Nursing Administration*, *49*(2), 93–98. https://doi.org/10.1097/NNA.0000000000000716

United Nations. (2015). *United Nations*. United Nations, Department of Economic Affiars, Popluation Division. https://www.un.org/en/development/desa/population/publications/pdf/ageing/PopulationAgeingAndDevelopment2015.pdf

Van Camp, J., & Chappy, S. (2017). The effectiveness of nurse residency programs on retention: A systematic review. *AORN*, *106*(2), 128–144. https://doi.org/10.1016/j.aorn.2017.06.003

Van Maanen, J., & Schein, E. H. (1977). *Toward a theory of organizational socialization*. JIP Press. https://dspace.mit.edu/bitstream/handle/1721.1/1934/?sequence=1

Vardaman, J. M., Rogers, B. L., & Marler, L. E. (2020). Retaining nurses in a changing health care environment: The role of job embeddedness and self-efficacy. *Health Care Management Review*, *45*(1), 52–59. https://doi.org/10.1097/HMR.0000000000000202

Walston, S. L. (2018). *Strategic healthcare management: Planning and execution* (2nd ed.). Health Administration Press.

Warren, J. I., Perkins, S., & Greene, M. A. (2018). Advancing new nurse graduate education through implementation of statewide, standardized nurse residency programs. *Journal of Nursing Regulation*, *8*(4), 14–21. https://doi.org/10.1016/S2155-8256(17)30177-1

Werhane, P. H. (2000). Business ethics, stakeholder theory, and the ethics of healthcare organizations. *Cambridge Quarterly of Healthcare Ethics*, *9*(2), 169–181. https://doi.org/10.1017/S0963180100902044

Wolford, J., Hampton, D., Tharp-Barre, K., & Goss, C. (2019). Establishing a nurse residency program to boost new graduate nurse retention. *Nursing Management*, *50*(3), 43–49. https://doi.org/10.1097/01.NUMA.0000553497.40156.4e

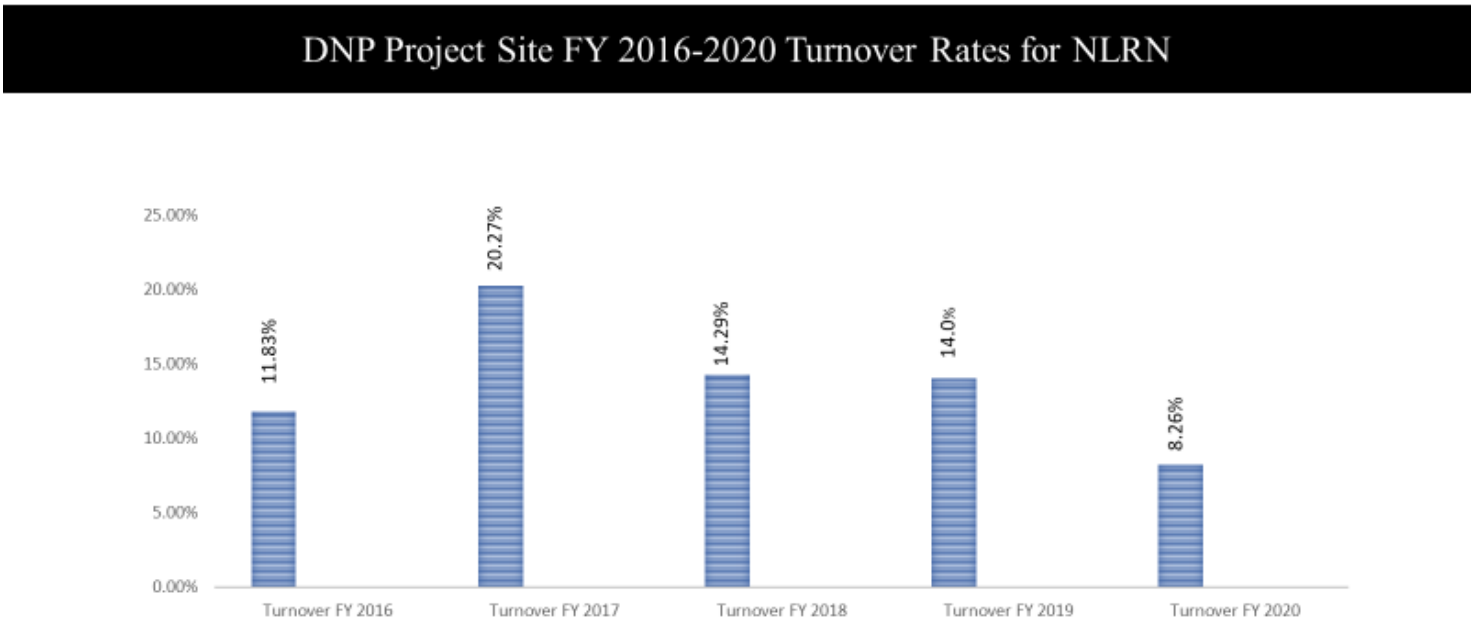
World Health Organization. (2013, November 11). *World health organization (WHO)*. Global health workforce shortage to reach 12.9 million in coming decades. https://www.who.int/mediacentre/news/releases/2013/health-workforce-shortage/en/

Yu, F., Raphael, D., Mackay, L., Smith, M., & King, A. (2019). Personal and work-related factors associated with nurse resilience: A systematic review. *International Journal of Nursing Studies*, *93*, 129–140. https://doi.org/10.1016/j.ijnurstu.2019.02.014

Yu, M., & Lee, H. (2018). Impact of resilience and job involvement on turnover intention of new graduate nurses using structural equation modeling. *Japan Journal of Nursing Science*, *15*(4), 351–361. https://doi.org/10.1111/jjns.12210

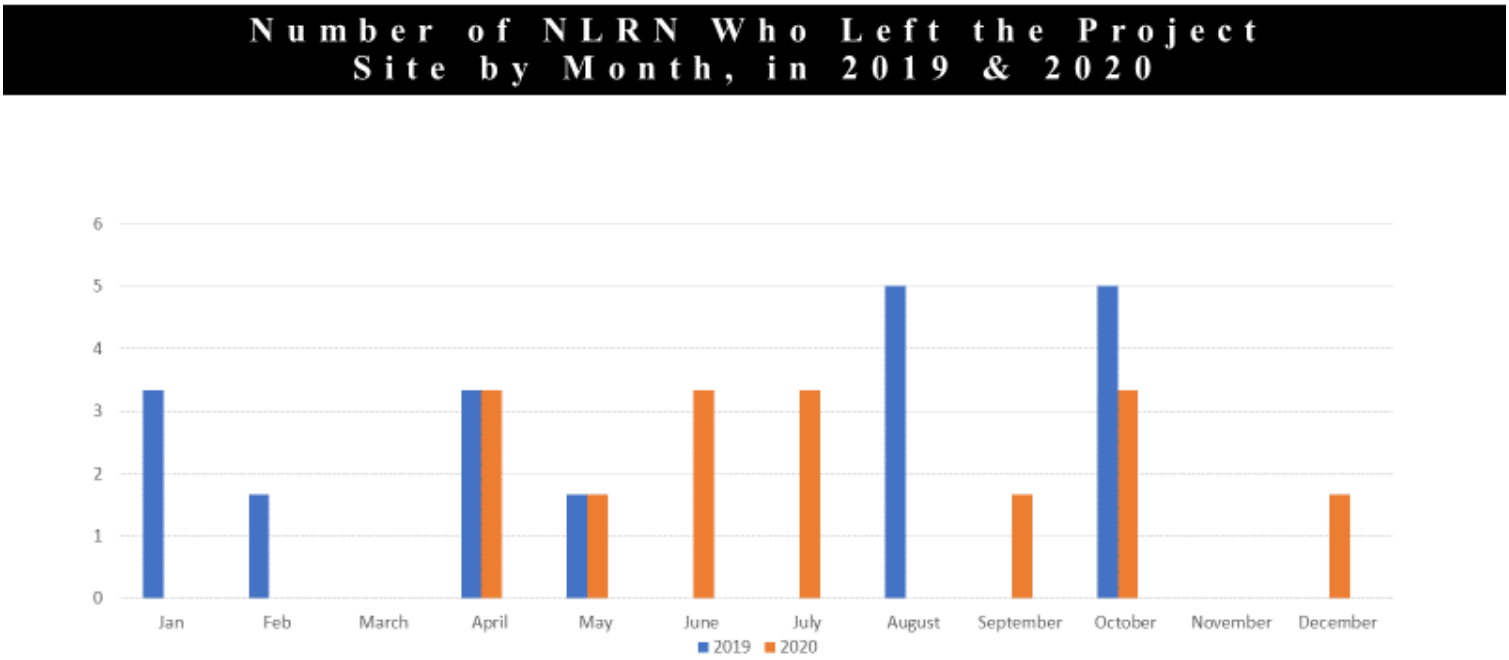
Appendix A

DNP Project Site FY 2016 – 2020 Turnover Rates for NLRN



Appendix B

Number of NLRN Who Left the DNP Project Site, by Month, in 2019 & 2020



Appendix C

Search Strategy Table

Search Term(s) **Years 2012-2020**	**CINAHL Complete**	**Medline**	**EBSCO Consumer Health Complete**	**Cochrane**	**Health Source Nursing/ Academic Edition (EBSCO)**	**Joanna Briggs**
Nurse Residency Program	251	193	87	14	91	4
New Nurse; Intention to leave	32	23	11	0	10	2
Nurse Residency Programs; Turnover	48	34	15	0	15	5
New Nurse; Organizational commitment	17	14	6	0	5	0
New Nurse; Support groups or self-help groups or group therapy	43	19	10	7	12	0
Job Embeddedness; nurse	36	18	13	1	9	2
Novice Nurse; Support Group	4	4	1	4	1	0
New Nurse; Turnover	277	147	66	73	66	2
New nurse; resiliency	72	19	14	1	14	1
Resilience; tools or techniques or strategies; new nurse	32	19	10	3	14	151
Totals for all Databases and Search Terms= 2042	Total number of relevant hits = 22					

Appendix D

Summary of Levels of Evidence Support

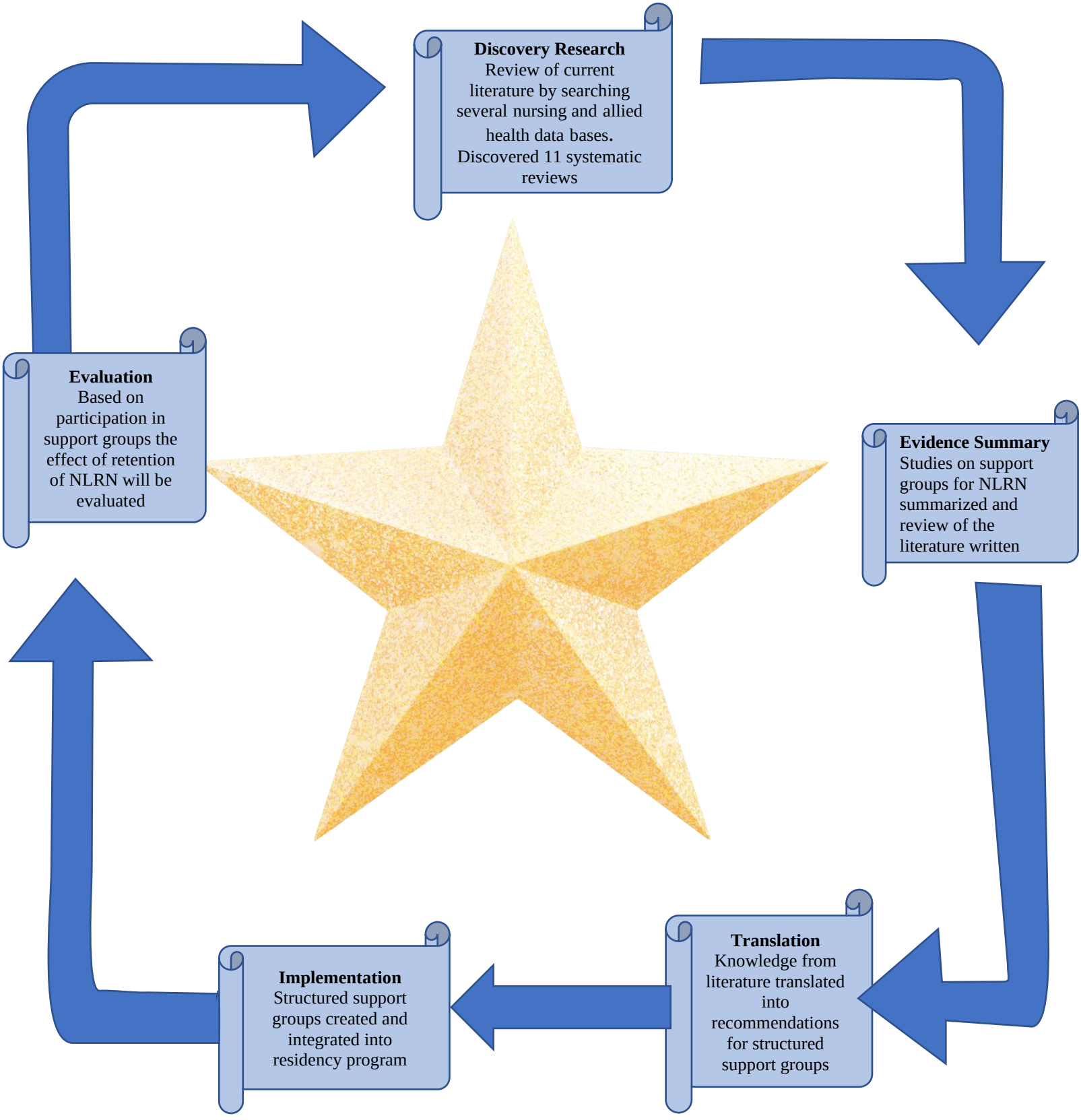
Type of Evidence	**Level of Evidence**	**Number of Articles per Level (N=22) ***	**Percentage Articles per Level (N=22) ***
Systematic Review	I	11	50%
Single Randomized Control Trial	II	1	4.54%
Single Non-Randomized Trail	III	0	0%
Single Prospective/Cohort Study	IV	4	18.2%
Single Case-Control Study	V	1	4.54%
Single Cross-Sectional Study (e.g. survey)	VI	3	13.64%
Single In-Depth Qualitative Study	VII	0	0%
Expert Opinion Case Reports, etc.	VIII	2	9.1%

*N is the total number of articles used.

Polit, D. F., & Beck, C.T. (2017). *Nursing research: Generating and assessing evidence for nursing practice,* (10th ed.). Wolters Kluwer.

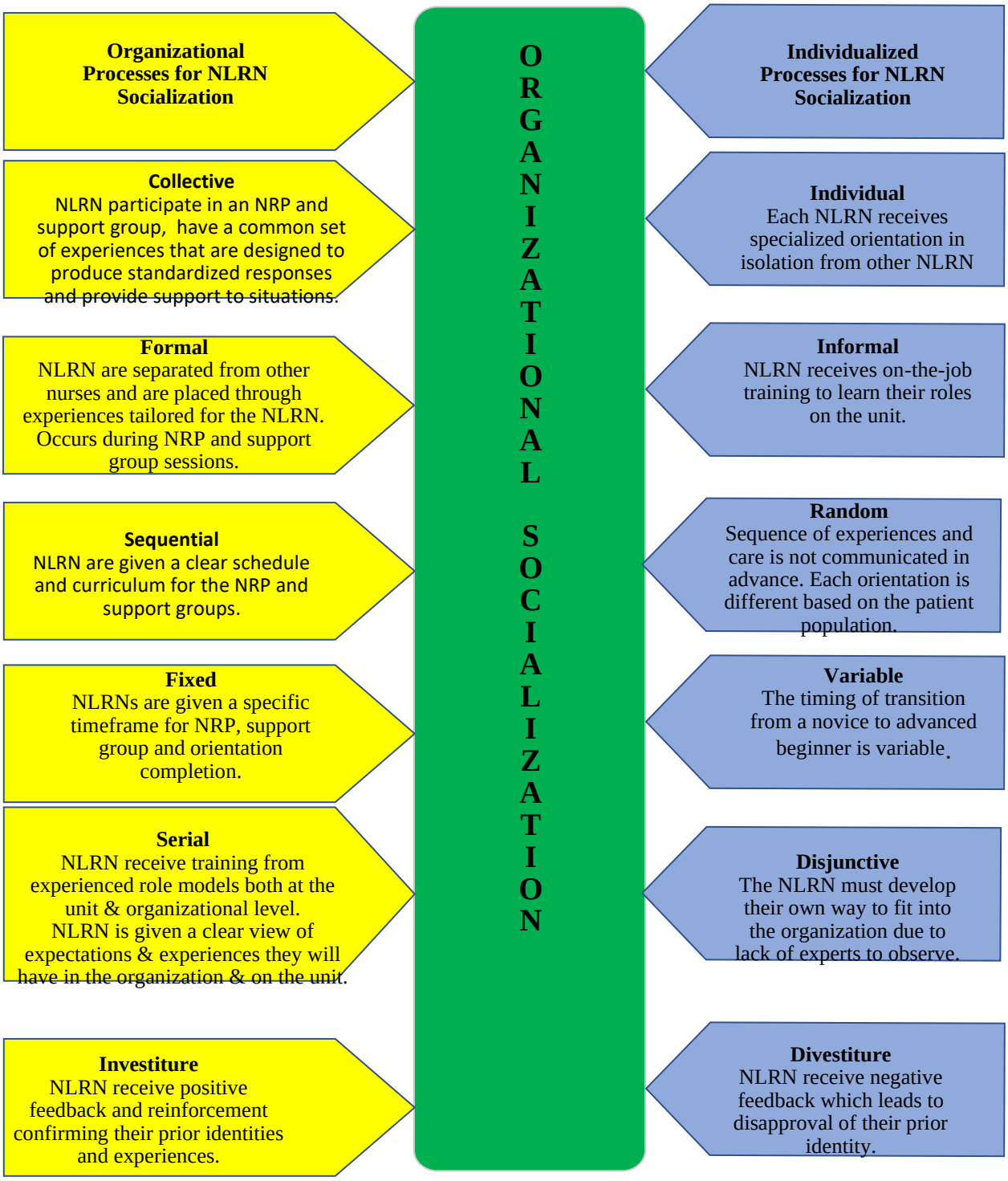
Appendix E

Steven's Star Model of Knowledge Transformation



Appendix F

Application of Organizational Socialization Theory to DNP Project



Appendix G

Demographic Questions

_____

First 3 letters of your mother's maiden name and the numerical month and day of your birthday. For example: MAU0113

Age

- 20-25 years old
- 26-30 years old
- 31-35 years old
- 36-40 years old
- 41-45 years old
- 46-50 years old
- >50 years old

Gender

- Male
- Female
- Other (please specify) _____
- Prefer not to answer

Ethnicity

- White
- Hispanic or Latino
- Black or African American
- Native American or American Indian
- Asian/Pacific Islander
- Other

Highest Educational Degree Completed

- AD
- BSN
- MSN
- DNP
- Other (please specify) _____

Employment Status

- Full time
- Part time

Shift most often worked

- Straight day shift
- Straight night shift
- Weekend Option

Do you live with anyone?

- With parents
- With friends
- With spouse/partner
- Other (please specify) _____

Marital Status

- Single (never married)
- Married
- In a domestic partnership
- Divorced
- Widowed
- Prefer not to answer

Did you have Role Transition prior to graduation?

- Yes, I completed a role transition
- Yes, I completed a modified or shortened role transition
- No, I did not participate in a role transition

Did you begin working before you sat for the NCLEX exam?

- Yes
- No, I already passed the NCLEX prior to orientation

If you answered Yes above, have you sat for the NCLEX exam?

- Yes
- No

If you answered No above, do you have a date to take NCLEX prior to March 1, 2021?

- Yes
- No

Do you have prior health care experience?

- LPN
- PCA (healthcare assistant)
- Other (please specify) _____

Appendix H

Conner-Davidson Resilience Scale Survey

Connor-Davidson Resilience Scale 25 (CD-RISC-25) ©

*For each item, please mark an "**x**" in the box below that best indicates how much you agree with the following statements as they apply to you over the last **month**. If a particular situation has not occurred recently, answer according to how you think you would have felt.*

		not true at all (0)	rarely true (1)	sometimes true (2)	often true (3)	true nearly all the time (4)
1.	I am able to adapt when changes occur.	☐	☐	☐	☐	☐
2.	I have at least one close and secure relationship that helps me when I am stressed.	☐	☐	☐	☐	☐
3.	When there are no clear solutions to my problems, sometimes fate or God can help.	☐	☐	☐	☐	☐
4.	I can deal with whatever comes my way.	☐	☐	☐	☐	☐
5.	Past successes give me confidence in dealing with new challenges and difficulties.	☐	☐	☐	☐	☐
6.	I try to see the humorous side of things when I am faced with problems.	☐	☐	☐	☐	☐
7.	Having to cope with stress can make me stronger.	☐	☐	☐	☐	☐
8.	I tend to bounce back after illness, injury, or other hardships.	☐	☐	☐	☐	☐
9.	Good or bad, I believe that most things happen for a reason.	☐	☐	☐	☐	☐
10.	I give my best effort no matter what the outcome may be.	☐	☐	☐	☐	☐
11.	I believe I can achieve my goals, even if there are obstacles.	☐	☐	☐	☐	☐
12.	Even when things look hopeless, I don't give up.	☐	☐	☐	☐	☐
13.	During times of stress/crisis, I know where to turn for help.	☐	☐	☐	☐	☐
14.	Under pressure, I stay focused and think clearly.	☐	☐	☐	☐	☐
15.	I prefer to take the lead in solving problems rather than letting others make all the decisions.	☐	☐	☐	☐	☐

16. I am not easily discouraged by failure.	☐	☐	☐	☐	☐
17. I think of myself as a strong person when dealing with life's challenges and difficulties.	☐	☐	☐	☐	☐
18. I can make unpopular or difficult decisions that affect other people, if it is necessary.	☐	☐	☐	☐	☐
19. I am able to handle unpleasant or painful feelings like sadness, fear, and anger.	☐	☐	☐	☐	☐
20. In dealing with life's problems, sometimes you have to act on a hunch without knowing why.	☐	☐	☐	☐	☐
21. I have a strong sense of purpose in life.	☐	☐	☐	☐	☐
22. I feel in control of my life.	☐	☐	☐	☐	☐
23. I like challenges.	☐	☐	☐	☐	☐
24. I work to attain my goals no matter what roadblocks I encounter along the way.	☐	☐	☐	☐	☐
25. I take pride in my achievements.	☐	☐	☐	☐	☐
Add up your score for each column	0 + ____	+ ____	+ ____	+ ____	

Add each of the column totals to obtain CD-RISC score = _____

01-01-20

Appendix I

Conner-Davidson Resilience Scale Survey Permission

CD-RISC © Intended Use of the Scale

Please complete each item clearly and email this form to Jonathan Davidson at mail@cd-risc.com.

With the information given, it will be possible to quote a use fee and prepare a user agreement.

Name of Principal Investigator/ Project Director/Clinician	Angela Dorsey/ Zakiyyah Thurman
Department/Organization	Mount St. Joseph University—School I attend TriHealth is the organization where project and survey will be used.
Street Address and City	10192 Hartwood CT
State/Province Zip/Postal code	Union, KY 41091
Country	United States of America
Telephone	859-653-7490
Email address	Angela0113@ymail.com

1. Organization Type: *Check box next to the category that best describes the type or primary purpose of your organization*.
   - ☐ Medical group/Clinical Practice
   - X Hospital
   - ☐ Academic Center
   - ☐ Private Foundation
   - ☐ Insurance Company/Health Plan
   - ☐ Government Agency
   - ☐ Consulting Firm
   - ☐ Pharmaceutical Company
   - ☐ Other: _____

2. Please briefly describe the activity in which the CD-RISC is to be used (indicate purpose, objectives, design, key sample characteristics, source of any funding): Project is to measure intent to stay in organization past the one year mark by attending focused sessions that include a separate and specific support group component at the sessions.

2. Estimated/hoped for number of people who will complete the scale (Note: A number is required): 10-15

3. Total number of times the RISC will be given to each person: Twice, once at beginning and again at the end of program 6 months

4. Duration of study/activity utilizing the scale: < 1 year__X_ 1 year___ 2 years___ 3 years__ 4+ years___

5. Method of assessment (e.g., face-to-face, mail survey or internet. If electronic/internet, please describe procedure in detail, including how survey will be distributed, storage of data, use of password protection/link to survey and protection of scale security from unauthorized use):_Face to face use of survey

6. Other measurement tools include: Demographic data only

7. Indicate if you are a student: YES working on Doctorate of Nursing Practice at Mount St. Joseph University

8. Indicate if preference for the RISC-25, RISC-10 or RISC-2: **RISC-25 please**

9. Please specify which translations you need: English only

Appendix J

Conner-Davidson Resilience Scale Survey Permission

10/2/2020
Dear Angela:

Thank you for your interest in the Connor-Davidson Resilience Scale (CD-RISC). We are pleased to grant permission for use of the CD-RISC-25 in the project you have described under the following terms of agreement:

1. You agree (i) not to use the CD-RISC for any commercial purpose unless permission has been granted, or (ii) in research or other work performed for a third party, or (iii) provide the scale to a third party without permission. If other colleagues or off-site collaborators are involved with your project, their use of the scale is restricted to the project described, and the signatory of this agreement is responsible for ensuring that all other parties adhere to the terms of this agreement.

2. You may use the CD-RISC in written form, by telephone, or **in secure electronic format whereby the scale is protected from unauthorized copying, distribution or the possibility of modification. In all presentations of the CD-RISC, including electronic versions, the full copyright and terms of use statement must appear with the scale. The scale should be accessed by password at a secure link, should not appear in any form where it is accessible to the public and should be removed from electronic and other sites once the project has been completed. The scale should not be accessed more than one time by the respondent. The RISC is not to be sent as an email attachment, and can only be made accessible after subjects have logged in with a password and given consent.**

3. Further information on the CD-RISC can be found at the www.cd-risc.com website. The scale's content may not be modified, although in some circumstances the formatting may be adapted with permission of either Dr. Connor or Dr. Davidson. If you wish to create a non-English language translation or culturally modified version of the CD-RISC, please let us know and we will provide details of the standard procedures.

4. Three forms of the scale exist: the original 25 item version and two shorter versions of 10 and 2 items respectively. When using the CD-RISC 25, CD-RISC 10 or CD-RISC 2, whether in English or other language, please include the full copyright statement and use restrictions as it appears on the scale.

5. A **student-rate** fee of $ 30 US is payable to Jonathan Davidson at 2434 Racquet Club Drive, Seabrook Island, SC 29455, USA either by PayPal (www.paypal.com, account mail@cd-risc.com), cheque or bank wire transfer (in US $$). Money orders are not accepted.

6. Complete and return this form via email to mail@cd-risc.com.

7. In any publication or report resulting from use of the CD-RISC, you do not publish or partially reproduce items from the CD-RISC without first securing permission from the authors.

If you agree to the terms of this agreement, please email a signed copy to the above email address. Upon receipt of the signed agreement and of payment, we will email a copy of the scale.

For questions regarding use of the CD-RISC, please contact Jonathan Davidson at mail@cd-risc.com. We wish you well in pursuing your goals.

Sincerely yours,

Jonathan R. T. Davidson, M.D.

Agreed to by:

Appendix K

Turnover/Retention of NLRN on Project Unit

Pre-Intervention		**Post-Intervention**	
Month/Year	**# Voluntary Resignations & Months on the Job**	**Month/Year**	**# Voluntary Resignations & Months on the Job**
September 2019	0	September 2020	0
October 2019	1 (9 months)	October 2020	0
November 2019	0	November 2020	0
December 2019	0	December 2020	1 (6 months)
January 2020	1 (10 Months)	January 2021	1 (8 months)
February 2020	0	February 2021	0
TOTAL	**2**	**TOTAL**	**2**
Turnover percentage	**2/12=17%**		**2/21=9.5%**
Retention Percentage	**10/12= 83%**		**18/21= 90.5%**

Appendix L

Six Month Education Plan

Month	NRP Topic	Teaching Strategies	Support Group Question & Opener/Closer	Resiliency Tool Discussion
1	Introduction, expectations, quality measures and feedback	Handouts, power point presentation, role play, SLC member presentation	Guiding question on delegation and concerns	Introduction of 10 tools
2	PPE, restraints, preventing falls and infections and interprofessional communication	Handouts, power point presentation, role play, demonstrations	Guiding question on interactions and conflicts with other disciplines	Turn on/turn off, self-care and mindfulness
3	Code Readiness	Simulation with time to review the crash cart, documentation, and what happens during the first 15 minutes of a CODE	Guiding question on teamwork and time management	Huddling, reflection and gratitude
4	Critical patients	Simulation experiences of a patient with chest pain and a patient going septic	Guiding question on stress and coping	Positivity and journaling
5	Patient outcomes, wound care, pain management, medication administration and errors and wound care	Handouts, power point presentation, role play, demonstrations, guest speakers	Guiding question on time management, dealing with demanding patients	Best friend at work and joy in work
6	Caring for the suicidal or withdrawing patients and difficult families	Handouts, power point presentation, role play, demonstrations,	Guiding question on dealing with difficult patients and families	Review of all 10 tools and what worked the best for each participant

Appendix M

Resiliency Tools

Free Tools to Support the Mental Health and Resilience of All Nurses

During these unprecedented times, the ANA Enterprise continues its commitment to supporting nurses through programming. As nurses strive to meet the needs of their patients amidst a global pandemic, they themselves experience extraordinary stress and personal hardship. In response to the growing need to support the mental health and well-being of nurses, the American Nurses Foundation partnered with five leading nurse organizations to create the Well-Being Initiative; a suite of free tools and resources specifically designed to support the mental health and well-being of our nation's nurses. A brief summary of these tools and resources is included below. To learn more visit nursingworld.org/thewellbeinginitiative.

Stress Self-Assessment

An important part of self-care for nurses is understanding and connecting with their mental health needs. This evidence-based Stress Self-Assessment tool recommended by APNA will help nurses identify symptoms, understand if they need to seek help, and direct them to relevant resources.

Nurses Together: Connecting Through Conversations

There is tremendous value in connecting with people undergoing similar experiences during times of crisis. Nurses Together offers a series of nurse facilitated video calls in which nurses talk openly about self-care and wellness, recovery resilience, bereavement, and other issues pertinent to well-being.

Moodfit Mobile App

Practicing self-care during stressful times is imperative. The Moodfit app supports the overall wellness of nurses by allowing them to set personal goals related to exercise, nutrition, sleep, mindfulness, and more. Participants can then track their goals and monitor progress on the app by setting up convenient activity reminders.

Happy App

Provides an opportunity for nurses to receive much needed support through empathy, listening and making connections. Through the Happy app nurses have access to free 24/7, one-on-one conversations with Support Giver team members right from the comforts of their own homes.

Narrative Expressive Writing

The COVID-19 Narrative Expressive Writing Program provides nurses with an opportunity to utilize writing as a tool to assist with navigating through stresses resulting from the COVID-19 pandemic response. This free, evidenced-based, and confidential online expressive writing program for nurses offers five weekly sessions in which nurses write in response to a series of prompts that are reviewed and responded to by trained professionals.

Mental Health Support Services

Looking for help and not sure where to start? Use this Nurses' Guide to Mental Health Support Services to better understand what support systems and services are available to you and how to locate them. From peer support options to easy and anonymous ways to find a mental health provider, this guide breaks down what you need to know and do to locate the mental health support that is right for you. Coronavirus Online Therapy, Give an Hour, and Talkspace Online Counseling are just a few of the options available for free and discounted mental health treatment for nurses.

Healthy Nurse Healthy Nation

Healthy Nurse, Healthy Nation (HNHN) is s free nurse wellness initiative comprised of a multitude of resources to support nurses' well-being. In addition, HNHN's blog; Mental Health Help for Nurses, contains specific resources aimed at supporting nurses well-being during the Covid-19 Pandemic.

Guide to Sleeping Better & Restoring Energy

This guide provides recommendations for sleep and fatigue management during high-intensity periods of work as a result of COVID-19.

For additional information, questions, and comments about the Well-Being Initiative and its resources, please contact wellbeing@ana.org

Our Partners:

ANA AMERICAN NURSES ASSOCIATION

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

American Psychiatric Nurses Association

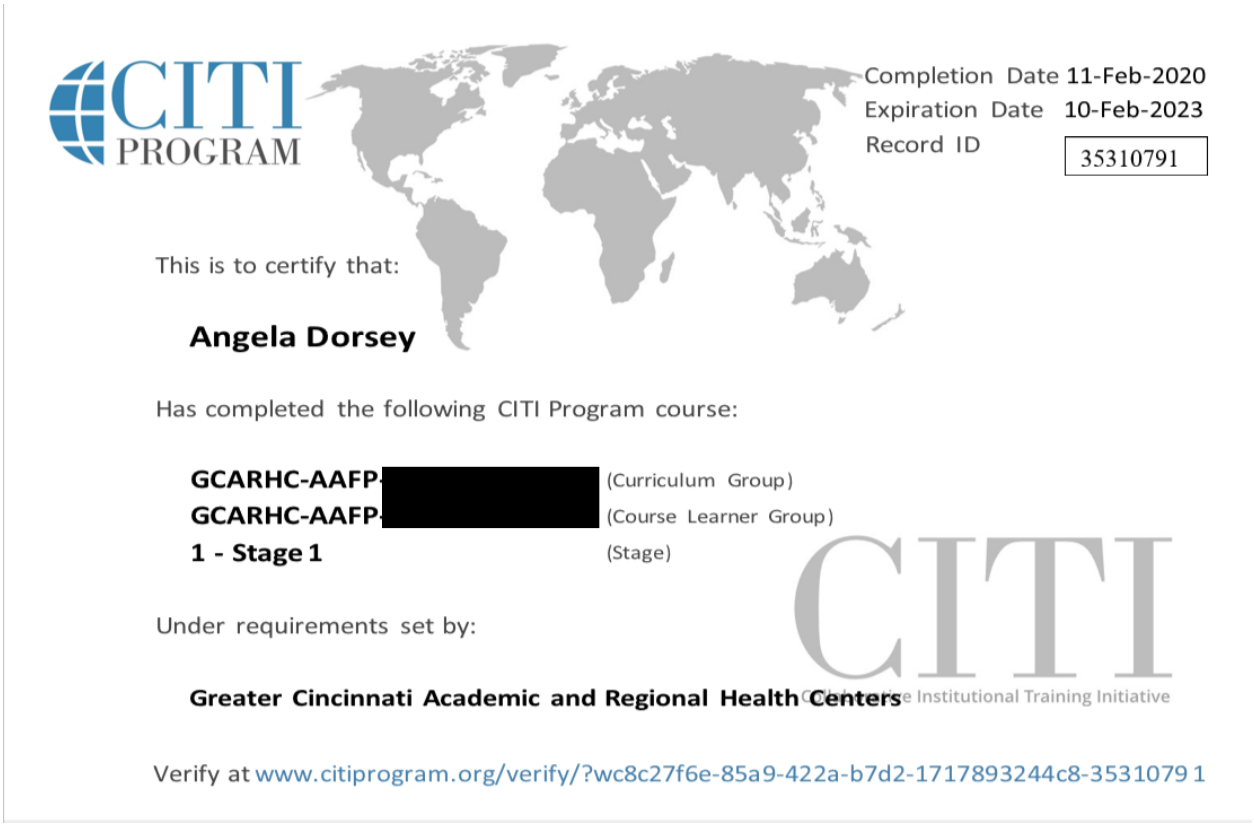
ENA EMERGENCY NURSES ASSOCIATION

AORN SAFE SURGERY TOGETHER


Going Home Checklist
At the end of your workday, before going home, take these steps to decompress.
For more well-being resources, visit: NursingWorld.org/TheWellBeingInitiative
✓ Review
Acknowledge a challenge you faced, take a deep breath, and let it go.
✓ Reflect
However small, consider and appreciate three positives in your day.
✓ Regroup
Offer support to your colleagues—and ask for help when you need it.
✓ Reenergize
Turn your attention to home. Focus on relaxing and resting.
Well-Being INITIATIVE
AMERICAN NURSES FOUNDATION
ANA
ENA

Appendix N

CITI Training Certificates



CITI PROGRAM

Completion Date 11-Feb-2020
Expiration Date 10-Feb-2023
Record ID 35310791

This is to certify that:

Angela Dorsey

Has completed the following CITI Program course:

GCARHC-AAFP-[redacted] (Curriculum Group)
GCARHC-AAFP-[redacted] (Course Learner Group)
1 - Stage 1 (Stage)

Under requirements set by:

Greater Cincinnati Academic and Regional Health Centers

Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?wc8c27f6e-85a9-422a-b7d2-1717893244c8-3531079 1

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 1 OF 2
COURSEWORK REQUIREMENTS*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Angela Dorsey (ID: 8906702)
- **Institution Affiliation:** Greater Cincinnati Academic and Regional Health Centers (ID: 1379)
- **Institution Email:** [redacted]
- **Institution Unit:** Nursing Educator
- **Phone:** 513-569-6000 14154

- **Curriculum Group:** GCARHC-AAFP-[redacted] (2017)
- **Course Learner Group:** GCARHC-AAFP-[redacted]
- **Stage:** Stage 1 - Stage 1

- **Record ID:** 35310791
- **Completion Date:** 11-Feb-2020
- **Expiration Date:** 10-Feb-2023
- **Minimum Passing:** 80
- **Reported Score*:** 92

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Belmont Report and Its Principles (ID: 1127)	08-Feb-2020	3/3 (100%)
Humanitarian Use Devices (HUDs) (ID: 16306)	08-Feb-2020	5/5 (100%)
History and Ethics of Human Subjects Research (ID: 498)	08-Feb-2020	5/5 (100%)
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	08-Feb-2020	4/5 (80%)
Assessing Risk - SBE (ID: 503)	10-Feb-2020	5/5 (100%)
Informed Consent (ID: 3)	10-Feb-2020	4/5 (80%)
Privacy and Confidentiality - SBE (ID: 505)	10-Feb-2020	5/5 (100%)
Records-Based Research (ID: 5)	11-Feb-2020	3/3 (100%)
Research and HIPAA Privacy Protections (ID: 14)	11-Feb-2020	5/5 (100%)
Conflicts of Interest in Human Subjects Research (ID: 17464)	11-Feb-2020	4/5 (80%)
Conducting Investigator-Initiated Studies According to FDA Regulations and GCP (ID: 1355)	11-Feb-2020	3/3 (100%)
Detecting and Evaluating Adverse Events (ID: 1360)	11-Feb-2020	4/4 (100%)
Reporting Serious Adverse Events (ID: 1361)	11-Feb-2020	4/4 (100%)
Audits and Inspections of Clinical Trials (ID: 1363)	11-Feb-2020	5/5 (100%)
Investigator Obligations in FDA-Regulated Research (ID: 14615)	11-Feb-2020	5/5 (100%)
Research Misconduct (RCR-Basic) (ID: 16604)	11-Feb-2020	4/5 (80%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	11-Feb-2020	3/5 (60%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

Verify at: www.citiprogram.org/verify/?ke179d8f1-1e8d-417b-8f53-6e727f27a671-3531079 1

Collaborative Institutional Training Initiative (CITI Program)
Email: support@citiprogram.org
Phone: 888-529-5929
Web: https://www.citiprogram.org

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 2 OF 2
COURSEWORK TRANSCRIPT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Angela Dorsey (ID: 8906702)
- **Institution Affiliation:** Greater Cincinnati Academic and Regional Health Centers (ID: 1379)
- **Institution Email:** [redacted]
- **Institution Unit:** Nursing Educator
- **Phone:** 513-569-6000 14154

- **Curriculum Group:** GCARHC-AAFP-[redacted] (2017)
- **Course Learner Group:** GCARHC-AAFP-[redacted]
- **Stage:** Stage 1 - Stage 1

- **Record ID:** 35310791
- **Report Date:** 11-Feb-2020
- **Current Score**:** 92

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	08-Feb-2020	4/5 (80%)
Informed Consent (ID: 3)	10-Feb-2020	4/5 (80%)
Belmont Report and Its Principles (ID: 1127)	08-Feb-2020	3/3 (100%)
Records-Based Research (ID: 5)	11-Feb-2020	3/3 (100%)
Assessing Risk - SBE (ID: 503)	10-Feb-2020	5/5 (100%)
Conducting Investigator-Initiated Studies According to FDA Regulations and GCP (ID: 1355)	11-Feb-2020	3/3 (100%)
Privacy and Confidentiality - SBE (ID: 505)	10-Feb-2020	5/5 (100%)
Investigator Obligations in FDA-Regulated Research (ID: 14615)	11-Feb-2020	5/5 (100%)
Research Misconduct (RCR-Basic) (ID: 16604)	11-Feb-2020	4/5 (80%)
Detecting and Evaluating Adverse Events (ID: 1360)	11-Feb-2020	4/4 (100%)
Research and HIPAA Privacy Protections (ID: 14)	11-Feb-2020	5/5 (100%)
History and Ethics of Human Subjects Research (ID: 498)	08-Feb-2020	5/5 (100%)
Reporting Serious Adverse Events (ID: 1361)	11-Feb-2020	4/4 (100%)
Audits and Inspections of Clinical Trials (ID: 1363)	11-Feb-2020	5/5 (100%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	11-Feb-2020	3/5 (60%)
Humanitarian Use Devices (HUDs) (ID: 16306)	08-Feb-2020	5/5 (100%)
Conflicts of Interest in Human Subjects Research (ID: 17464)	11-Feb-2020	4/5 (80%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

Verify at: www.citiprogram.org/verify/?ke179d8f1-1e8d-417b-8f53-6e727f27a671-35310791

Collaborative Institutional Training Initiative (CITI Program)
Email: support@citiprogram.org
Phone: 888-529-5929
Web: https://www.citiprogram.org

Appendix O

IRB determination form

<table>
<tr><td>  </td><td colspan="2">Determining Whether a Proposed Activity is Human Research According to DHHS or FDA Regulatory Definitions
Investigators: Please complete the top text boxes. Submit the form as an email attachment to the administrative assistant in the Provost’s office. You will be notified via email of the IRB's determination.</td></tr>
<tr><td rowspan="3">Person Requesting Determination and Contact Information</td><td>Name & Degree Angela Dorsey for DNP degree</td><td>Department Nursing</td></tr>
<tr><td>Phone 859-653-7490</td><td rowspan="2">Mailing Address 10192 Hartwood Ct. Union, KY 41091</td></tr>
<tr><td>Email angela.dorsey@msj.edu</td></tr>
<tr><td>Title of Project</td><td colspan="2">Using a Nurse Residency Program and Monthly Support Groups to Decrease New Nurse Tturnover</td></tr>
<tr><td>Description of Project, Including Whether or Not Findings Will Be Generalizable</td><td colspan="2">As the Baby Boomer generation continues to age, many are entering retirement while others are sick, hospitalized and need care from nurses in a hospital setting. A new generation of nurses are needed to care for this aging population and to fill the open positions that are being vacated by retirement. As the newest generation of nurses are entering the workforce, there is a high turnover rate before they reach completion of the first year as a registered nurse (RN) due to poor job satisfaction related to working conditions, stress, incivility, and a gap between expectations and reality, to name a few.
This purpose of this DNP evidence-based project is to pilot a monthly support group with resiliency training for 6 months, as part of the organization's mandatory Nurse Residency Program for newly licensed registered nurses (NLRN) to determine the effect on resilience and the NLRN turnover rate in the first year of practice. Nursing literature provides strong evidence of supportive interventions to assist with decreasing turnover for the NLRN. The NLRN will attend the monthly 1-hour support group for 6 months. This is a requirement for all NLRN hired to the telemetry unit. The NLRN participants will complete a tool to measure resiliency (the CD-RISC 25 survey) at month one to assess if NLRN are feeling supported and resilient. Additionally, turnover will be examined pre and post the monthly support groups. This pilot project is being implemented for the purpose of decreasing NLRN turnover for the project site telemetry unit; the results are not intended to be generalized to other organizations.</td></tr>
<tr><td colspan="3">Research for which DHHS regulations or MSJ Policies may apply</td></tr>
<tr><td colspan="3"><u>BOTH</u> "Research" and "Human participants" categories <u>OR</u> "FDA" (next page) must be true for IRB review to be required.</td></tr>
</table>

☐ The activity involves **RESEARCH** because BOTH of the following are true.

- ☐ The activity is a systematic investigation, including a systematic collection of data.
- ☐ The activity is designed to develop or contribute to generalizable knowledge.

☒ The activity involves intervention or interaction with **HUMAN PARTICIPANTS** because BOTH of the following are true.

☒ Human participants are involved because EITHER of the following is true.

- ☒ The data being collected are about living individuals.
- ☐ The data being collected include genetic/biological material (sputum, tissue, swab, blood, body fluids, etc.).

Intervention or interaction is involved because EITHER of the following is true.

The investigator plans to obtain the data through ANY of the following (select all that apply).

- ☒ Physical procedures performed on or by participants.
- ☒ Manipulation of participants.
- ☒ Manipulation of participants' environment.
- ☐ Communication with participants.
- ☐ Interpersonal contact with participants.

The information collected is BOTH of the following.

Private, because EITHER of the following is true.

- ☐ The information is about behavior that occurs in a context in which the individual can reasonably expect that no observation or recording is taking place (such as in a home or a private office).
- ☒ The information is provided by the individual for a specific purpose which the individual can reasonably expect will not be made public (such as class assignments or medical records).

Individually identifiable, because EITHER of the following is true.

- ☒ The identity of the individual is or may readily be ascertained by the investigator.
- ☐ The identity of the individual is or may readily be associated with the information (including a master list linking identity and study ID#).

☒
☒

Research for which FDA regulations or MSJ policies may apply.

AT LEAST ONE of the following three categories must be true for IRB review to be required.

☐

☐

☐

☐

The activity involves the use of an investigational **DRUG** because ALL of the following are true

At least ONE of the following is true (select all that apply). The article is recognized in the official United States Pharmacopoeia, official Homeopathic

☐ Pharmacopoeia of the United States, or official National Formulary, or any supplement to them.

☐ The article is intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans or other animals.

☐ The article (other than food) is intended to affect the structure or any function of the body of humans or other animals.

☐ The article is intended for use as a component of any article specified in the above items.

EITHER of the following is true. The article is NOT approved by the FDA for marketing.

☐ The article is NOT being used in the course of medical practice. The article or activity will be used on one or more humans.

The activity involves the use of an investigational **MEDICAL DEVICE** because ALL of the following are true.

At least ONE of the following is true (select all that apply). the article is recognized in the official United States Pharmacopoeia, or official National Formulary, or any supplement to them.

☐ The article is intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans or other animals.

ALL of the following are true. The article is intended to affect the structure or any function of the body of humans or other animals.

☐ The article does NOT achieve any of its primary intended purposes through chemical action within or on the body of humans or other animals.

☐ The article is NOT dependent upon being metabolized for the achievement of any of its primary intended purposes.

☐ EITHER of the following is true. The article is NOT approved by the FDA for marketing. The article is NOT being used in the course of medical practice.

☐ The article or activity will be used on one or more humans.

☐ The activity is **OTHERWISE** subject to FDA regulation because AT LEAST ONE of the following is true.

☐ Data from the activity will be submitted to or be held for inspection by the FDA. The activity involves at least ONE of the following FDA regulated articles (select all that apply). Food or dietary supplement that bears a nutrient content or a health claim. Food or color additive for human consumption.

☐ Infant formula. Biological product for human use.

☐ Electronic product for human use. Other article subject to the Food, Drug & Cosmetic Act.

☐ The activity is being done to determine the safety or effectiveness of the drug or device.

☐

For IRB Office Use Only

Determined to be human research requiring IRB review, submission to the IRB is required. ☐

Determined NOT to be human research requiring IRB review, submission to the IRB is NOT required. ☑

Tracy A. McDonough, PhD

Signature of IRB Chair or Designee

11/6/2020

Date

Appendix P

IRB Determination Form Midwest Healthcare Organization

[redacted]

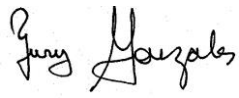
10/20/20

IRB #: 20-101
Study Title: Decreasing turnover with support groups and resiliency training

Dear Angela Dorsey,

The [redacted] Institutional Review Board (IRB) acknowledges receipt of the Quality Improvement (QI) proposal titled "Decreasing turnover with support groups and resiliency training" (dated 10/13/20). This proposal does not meet the regulatory criteria for research that requires IRB review.

Sincerely,



Yury R. Gonzales, MD, FACP
Chairman
[redacted] Institutional Review Board
FWA 00003114 - IRB00002744

Institutional Review Board
10496 Montgomery Road, Suite 101
Cincinnati, OH 45242

Phone: 513.865.5248
FAX: 513.852.3825
E-mail: [redacted]

Appendix Q

Support Group Confidentiality Agreement

Support Group

You have the right to confidentiality and privacy by me as the group leader and other group members. Confidentiality within the group setting is a shared responsibility of all members and myself as the group leader. Confidentially within the group setting is based on mutual trust and respect. As a member of this group, you agree to not disclose to anyone outside the group any information that may help to identify another group member. This includes, but is not limited to, names, physical descriptions, and specific to the content of interactions with other group members.

Signature_____

Date_____

As the group leader, I can promise to maintain confidentiality unless, of course, there is a concern of harm to self or to others.

Signature_____

Date_____

Appendix R

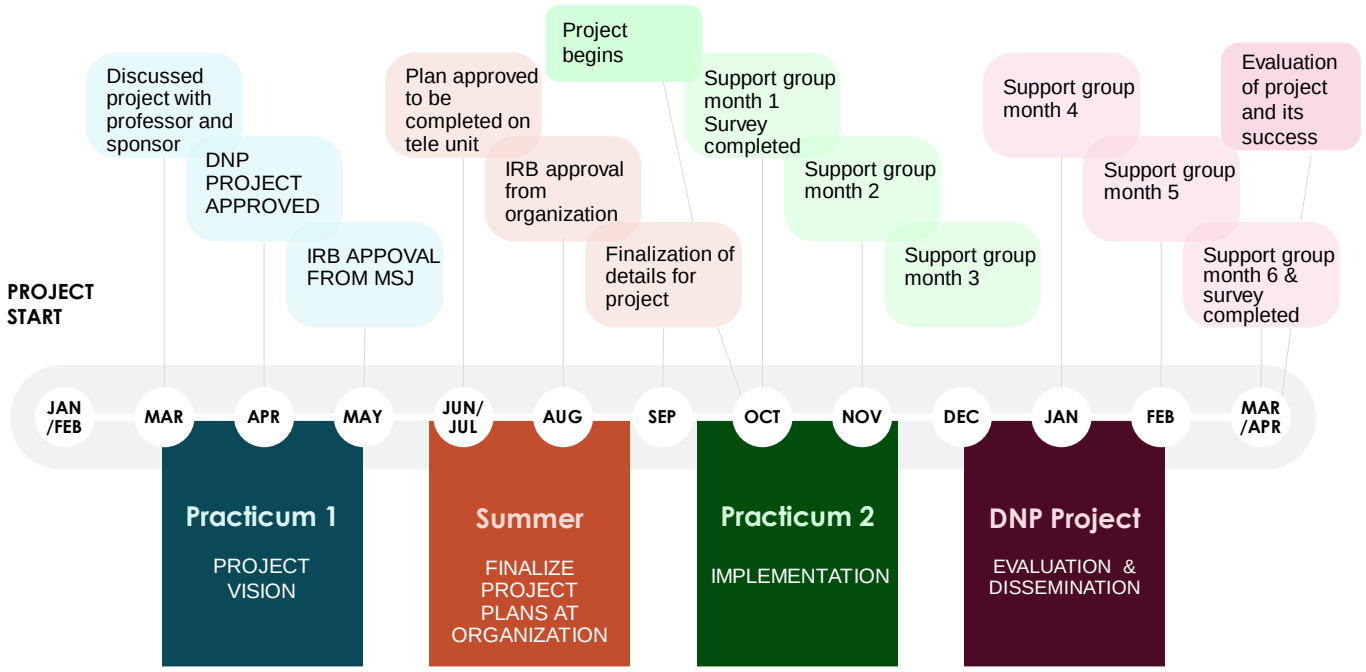
Budget

Budget Item	Cost to Student	In-kind Cost
RN Salary ($25 per hour x 4 hours per session x 21 RN* x 6 sessions)		$100 per RN per session ($12,600 in total for 21 NLRN)
Copies		$100 in copies for 21 NLRN
Pens, paper, folders, notebooks, photo boxes	$70	$100 for a total of 21 NLRN
Cookies, snacks, candy	$100	
TOTAL	$170	$12,600
Total Cost of Project	**$12,430**	

*This cost is based on hiring 21 NLRN; the cost may increase or decrease based on the number of new hires.

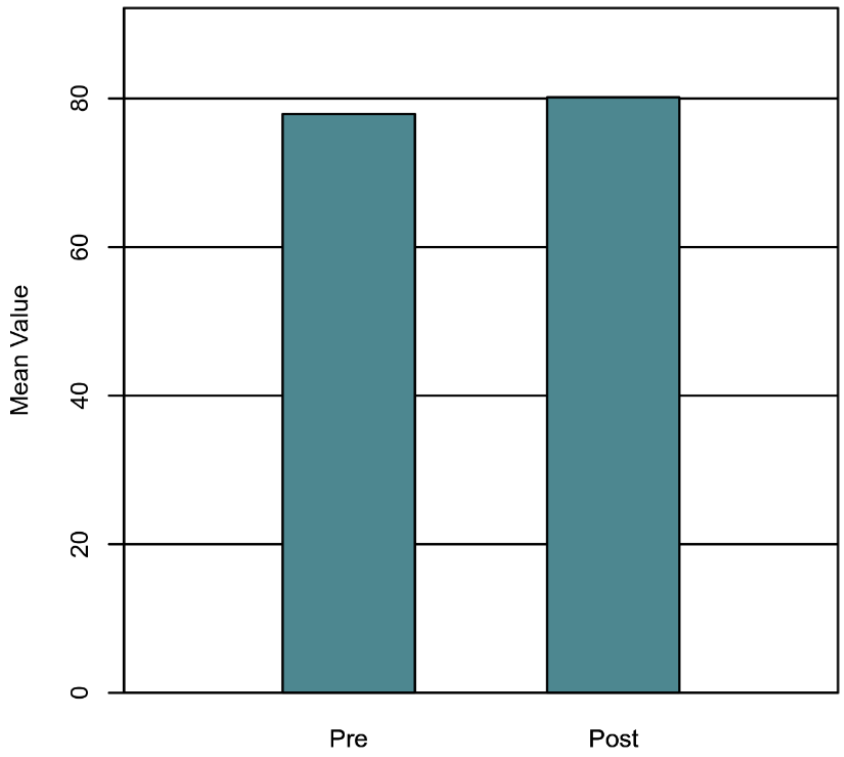
Appendix S

Timeline for DNP Project



Appendix T

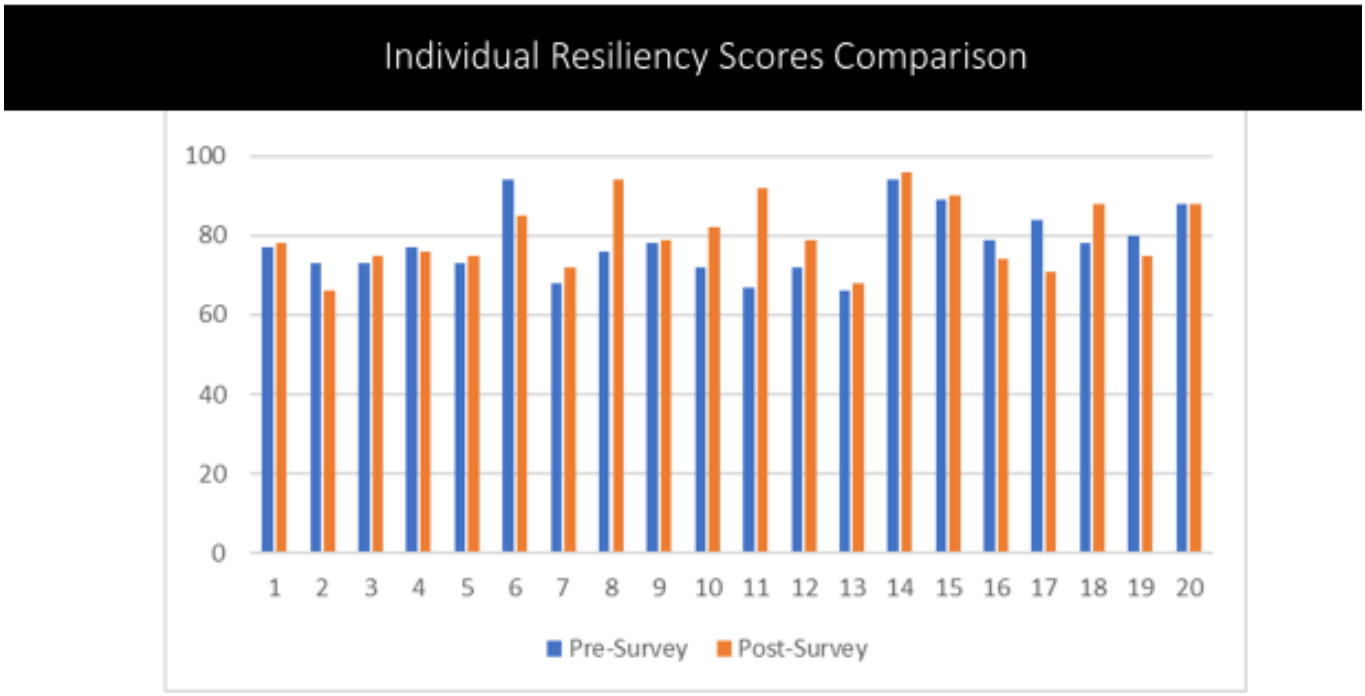
Resiliency Pre/Post Score Mean Comparison



Age Range	n and %	Range of Resiliency Scores	Pre-intervention Resiliency Score	Post-intervention Resiliency Score
20-25	14/20= 70%	66-94	78	78.3
26-30	3/20= 15%	76-98	80	84.6
31-35	2/20= 10%	67-84	75.5	81.5
>50	1/20= 5%	89	89	90

Appendix U

Individual Resiliency Scores Comparison



Appendix V

Conner-Davison Resilience Scale Scoring & Interpretation

Scoring and Interpretation of the Connor-Davidson Resilience Scale (CD-RISC©)

Scoring the CD-RISC-25©

Each item ranges in score from 0 to 4. The total score is obtained by adding up all the 25 items, which gives a score that can range from 0 to 100. Lower scores indicate less resilience and higher scores indicate greater resilience. We do not recommend using any factors or subscales, except for the established shorter RISC-10 and RISC-2 scales (see below).

How Do I Interpret the CD-RISC-25© Score?

General population scores for the CD-RISC-25 have been obtained from the US general population, in whom the mean score was 79.0 (all subjects in sample). The population was then divided into quartiles. For the lowest quartile (i.e. from 1-25% of the general population), the score ranged from 0-73. For the second quartile (i.e. from 26-50%) the scored ranged from 74-82. For the third quartile (51-75% of the population) the score ranged from 83-90. For the highest quartile
(76-100% of the population) the score ranged from 91-100. Therefore, a score of 55 in that population (but not necessarily others) would place an individual in the lowest 25% of the population as measured by the CD-RISC and, depending on the reason why the scale was administered, could suggest the need to explore ways to strengthen coping or adaptability. Although the CD-RISC is not intended to be a diagnostic instrument, we have found that low scores can also accompany clinical depression, anxiety and posttraumatic stress disorder. Although the general population score reflects a representative sample, in certain groups the mean score may be different, reflecting selection factors. Many of the studies of college students have yielded scores which are 3-5 points lower than the US adult population mean. Some studies conducted outside the US have yielded lower or higher scores (see manual).

The CD-RISC-25 consists of statements describing different aspects of resilience.
The scale incorporates items which measure hardiness (i.e. commitment/challenge/control) (items 5, 10, 11, 12, 22, 23, 24), coping (2, 7, 13, 15, 18), adaptability/flexibility (items 1, 4, 8), meaningfulness/purpose (items 3, 9, 20, 21), optimism (items 6, 16) regulation of emotion and cognition (items 14, 19), and self-efficacy (items 17, 25). In some cases, the items overlap more than one of these constructs.
The CD-RISC-25 score can change during treatment/counseling/stress management, to reflect growth of resilience in a wide range of conditions, e.g. PTSD, medical problems, stress. These changes may be apparent within a few weeks. Thus, the CD-RISC-25 can reflect change over time, or improvement from treatment/self-help. It can also be used to compare the effect of different interventions. For example, 4 studies of civilian medical employees in a US health

system and providers in the military showed a statistically significant increase in CD-RISC score after stress management or meditation, with the mean score increasing from 68 to 79, 70 to 73, 73 to 81 and 76 to 84.

Scoring the CD-RISC-10©

The CD-RISC-10© consists of 10 statements describing different aspects of resilience. The scale serves mainly as a measure of hardiness, with items corresponding to flexibility (1 and 5), sense of self-efficacy (2, 4 and 9), ability to regulate emotion (10), optimism (3, 6 and 8) and cognitive focus/maintaining attention under stress (7). Each item is scored on a five-point scale ranging from 0 to 4, with 0 representing that the resilience statement is not at all true and a score of 4 indicating that the statement is true nearly all the time. The total score is obtained by adding up all 10 items. The total can therefore range from 0 to 40. Higher scores suggest greater resilience and lower scores suggest less resilience, or more difficulty in bouncing back from adversity.

How Do I Interpret the CD-RISC-10© Score?

Population scores for the CD-RISC-10© have been obtained from two US communities, which yielded mean scores of 32.1 and 31.8. In the Memphis study, the authors presented score distribution by quartile. They found that the lowest quartile (i.e. from 1 to 25% of the population) scored between 0-29. The second quartile (i.e. from 26-50%) scored between 30 and 32. The third quartile (51-75% of the population) scored between 33 and 36. The top quartile (i.e. 76-100%) scored between 37 and 40.

The scale is neither intended to provide diagnostic information, nor to indicate that treatment or counseling is required. However, in conjunction with other assessments, it could provide one piece of useful information in deciding whether an intervention is appropriate. A score in the lowest or second quartile may suggest problems in coping with stress or bouncing back from adversity.

The CD-RISC© can change during treatment, counseling or stress management, to reflect growth of resilience in a wide range of conditions, e.g. PTSD, medical problems, stress. These changes may be apparent in a few weeks.

Scoring and Interpretation of the CD-RISC-2 ©

The total score is derived by adding up the two items, which can range in total from 0 to 8. Higher scores reflect greater resilience. This scale provides a brief indication of a person's ability to bounce back and adapt in response to setbacks. Mean or median general population scores have been obtained from three US studies, and one each from China, Italy, Norway and Portugal, which range between 5 and 7. Scores on the CD-RISC-2 can change from intervention or treatment.