Preparing New Graduates for Interprofessional Teamwork: Effectiveness of a Nurse Residency Program

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abstract

The purpose of this project was to determine whether a nurse residency program was effective in improving satisfaction with new graduates’ performance competence in interprofessional collaboration. This was a cross-sectional survey design, comparing the satisfaction ratings of nurse leaders and staff nurses at a midwestern academic medical center to national benchmark data obtained from the 2007 Nursing Practice Readiness Tool. The sample consisted of 149 nurses who worked in inpatient units where new graduates practice. Thirty-five had 1 year or less of experience in nursing and 114 had at least 2 years of experience. Managers, experienced nurses, and new graduate nurses varied in their satisfaction ratings regarding interprofessional collaboration. Satisfaction of new graduates’ competencies by nurse managers and staff nurses were rated higher in each category, compared with the national study, with 63% of nurse leaders satisfied with new graduates’ ability to communicate with the interprofessional team, compared with the national average of 38%. Participants reported 56% satisfaction in the ability to work as a team, compared with 37% reported in the national study.


Nationally, hospital nursing staff is composed of an average of 10% of new graduate nurses (Berkow, Virskstis, Stewart, & Conway, 2008). Due to changes in the health care environment, the nursing workforce is expected to have a 19% increase from 2.71 million in 2012 to 3.24 million in 2022 to meet the demand of inevitable nursing vacancies (American Association of Colleges of Nursing, 2014). Given these statistics, it is imperative that academic and hospital nurse leaders work together in preparing new nurses for the profession (Berkow et al., 2008). Although nearly 90% of academic leaders believe their new nurse graduates are fully prepared for practice, only 10% of hospital leaders share this perspective (Berkow et al., 2008). Initiatives such as nurse residency programs have been implemented to alleviate the transition from nursing student to practicing nurse. However, for these programs to be effective, an understanding of new graduates’ limitations is necessary to narrow the education–practice gap.

Nurse leaders typically rank new graduates as being lowest in nonclinical skills, including their ability to work as a member of a team, communicate with members of the interprofessional team, and delegate appropriately (Berkow et al., 2008). These communication limitations have the potential of compromising patient care and represent an opportunity to enhance continuing education, mentorship, and professional development for new graduate nurses to help them successfully transition from their student roles to safe, competent professional nurses.

SIGNIFICANCE OF THE PROJECT TO NURSING AND HEALTH CARE

Nurses from a midwestern academic medical center integrating clinical and hospital care with research and
education and the core values of interdisciplinary teamwork and collaboration participated in this research study. An average of 120 new graduate nurses from associate and baccalaureate degree programs are hired annually at this medical center. Therefore, integrating strategies to promote interprofessional teamwork and collaboration into a nurse residency is essential to support its vision, core values, and impact on patient-centered care.

In 2007, the academic medical center became a member of the University HealthSystem Consortium/American Association of Colleges of Nursing’s nationally recognized nurse residency program, which is designed to support new graduate nurses during the first year of professional nursing practice. In 2013, due to financial and resource changes, the medical center could not sustain its membership in that program. Therefore, nursing education leaders developed and implemented a customized nurse residency program. The program included learning modules centered on professional communication, but it did not emphasize interprofessional collaboration.

LITERATURE REVIEW

An exhaustive literature search of nurse residency programs and their focus on interprofessional collaboration was conducted. Cappel, Hoak, and Karo (2013) indicated that interprofessional and team-based communication should be an essential component of a nurse-residency curriculum. However, it is unclear based on the literature whether a typical residency program has specific modules aimed at improving new graduates’ skills in interprofessional collaboration.

Research of interprofessional collaboration indicates that shared responsibility for patient care decisions, problem solving, and implementation of patient care plans leads to an increased awareness of each team member’s knowledge and skills, thus contributing to improved patient outcomes (O’Daniel & Rosenstein, 2008). In a study regarding collaborative behaviors of nurses and physicians, nurses reported that when they worked in a health care culture where they were encouraged to provide care according to professional nursing standards and to work as part of an interprofessional team, they experienced increased job satisfaction and tended to remain in their positions (Nair, Fitzpatrick, McNulty, Click, & Glenbocki, 2012). Therefore, incorporating interprofessional collaboration as a primary component of a nurse residency program may contribute to the decrease in new graduate nurse attrition.

Evidence suggests that inadequate interprofessional communication skills may contribute to new graduate nurses’ stress and burnout (Laschinger, Finegan, & Wilk, 2009). Nurse residency programs can provide opportunities to develop professional skills, including interprofessional communication, which may increase the satisfaction of nurse leaders and experienced nurses working with new graduates (Bratt, 2009). Williams, Goode, Krsek, Bednash, and Lynn (2007) found that graduates who participated in nurse residency programs showed an improvement in their ability to communicate with other disciplines.

Adjusting to the role of registered nurse creates significant pressure on new graduates, particularly when trying to assimilate with other members of the health care team (Santucci, 2004). It is a role expectation that the new graduate nurse will be able to interact with demanding staff, make recommendations for patient care, question accepted practice, and speak and collaborate with physicians, yet research indicates that new graduates have difficulty in these areas (Williams et al., 2007). A national survey conducted by Berkow et al. (2008) showed that 75% of nurse leaders ranked new graduates as less than satisfactory in all of the 36 clinical and nonclinical competencies on the Nursing Practice Readiness Tool that are deemed necessary for practice.

Graduate nurses reported a high degree of stress during the first 6 to 9 months of employment and perceived preceptors and managers to be unsupportive (Dyess & Sherman, 2009). Although 57% of chief nursing officers reported that new graduates are unsafe for practice, the National Council of State Boards of Nursing’s survey reported that 38% of new nurses have six to seven patients assigned to their care per shift and that 11% care for more than seven patients (Casey, Fink, Krugman, & Propst, 2004). These findings suggest that the transition to practice merits additional research.

Qualitative data generated from established nurse residency programs suggest that nurse residencies ease the transition to the professional nursing role (Beecroft, Santner, Lacy, Kunzman, & Dorey, 2007). As an outcome of participation, nurse residents reported feeling less isolated, more self-confident, and able to manage their workload, and they experienced improved relationships with interprofessional team members (Bratt, 2009).

PROJECT DESIGN

This project used a cross-sectional survey design to compare the satisfaction rates of nurse managers and staff nurses at the academic medical center as measured by the Nursing Practice Readiness Tool with those obtained from a benchmark study conducted in 2007 using a national sample of nurse leaders.

Human Subjects

This study was approved as exempt from review by the medical center’s institutional review board. ANO-
nimity and confidentiality were guaranteed because participants were deidentified using SurveyMonkey®. Information was stored in a data management and storage platform securely supported by the Nursing Executive Center. Participants could exit the survey at any time and could decline participation in the study with no effect on their employment or status at the medical center. An electronic consent form completed by the participant prior to beginning the survey indicated that completion of the survey was evidence of informed consent, and confidentiality was ensured.

Sample
A list of potential participants was obtained by the medical center’s nursing organization and included 1,000 inpatient unit nurse managers, assistant nurse managers, and staff RNs. Nurses working in outpatient units, operating departments, or laboratories were excluded, given that new graduate nurses are not typically hired directly into these areas at this academic medical center.

Instrument
In 2007, the Nursing Executive Center developed the Nursing Practice Readiness Tool in an effort to provide a more detailed understanding of new graduates’ competencies deemed by nursing management to be specific, actionable, and reflective of current hospital demands. The survey instrument was repeatedly revised until all recommendations were incorporated from a broad cross-section of experts, including hospital-based nurse executives and directors, nursing school deans, and nursing education representatives (Berkow et al., 2008). This comprehensive sampling of nursing leaders provided detailed analyses of deviations in satisfaction with new graduate ability. The Nursing Executive Center ran a split-half reliability analysis, randomly assigning all of the competencies into two groups and determining split-half reliability. For this test, alpha = .92, indicating high reliability (M. Fennessey, Account Management Associate for The Advisory Board Company, personal communication, November 12, 2013).

Demographic data gathered included the type of nursing units hiring new graduates, the number of new graduates hired each year, and the number of patients for which new graduates typically provided care. The 36 competencies in the Nursing Practice Readiness Tool deemed necessary for practice included the broad categories of clinical knowledge, technical skills, critical thinking, communication, professionalism, and management of responsibilities. This survey was designed to take no longer than 15 minutes to complete.

Procedure
The principal investigator (J.L.H.) individually discussed the study’s purpose with nurse managers and distributed flyers with a description of the survey. In addition, flyers with information about the survey were posted in the nursing staff lounges in each inpatient unit. Within 2 days of discussing the study with each nurse manager, the principal investigator sent an e-mail providing information about the study, with a link for accessing it, to the nurse managers, which was then e-mailed to all nursing staff in their units. To maximize the response rate, participants were given 2 weeks to access the survey. During this time, the principal investigator sent a reminder e-mail to all eligible nurses requesting that they complete the survey.

Threats to Validity and Mitigation Strategies
Threats to validity included the varying clinical skill sets held by new graduates and the varying competence of their clinical preceptors. For example, nurses practicing in specialty units, such as intensive care or pediatrics, have specific competencies and skill sets, compared with nurses on medical–surgical units. This could negatively influence responses by nurses in the specialty units because some of their skills may not be learned or emphasized as much in undergraduate programs, compared with the medical–surgical skills. Likewise, nurse managers of specialty units may have different expectations of staff nurses’ competencies and skill sets and, therefore, rate new graduates based on different criteria. This variation was controlled for by identification of the unit type on the survey as a demographic variable. In addition, new graduate nurses were assigned to clinical preceptors with varying levels of clinical experience and skill level, factors that may influence their performance level on completion of the program. These factors could not be controlled.

Furthermore, respondents were asked about their own attitudes or opinions regarding new graduate nurses. Respondents’ opinions may have been biased by recent interactions with new graduates. This may have threatened validity, as respondents may have had preconceived opinions of new graduate performance.

Finally, because professional nurses graduated from associate or baccalaureate degree programs with varying skill preparation, clinical hours, simulation laboratory hours, and didactic presentations, the strength of the new graduates’ competencies and skills may have influenced their confidence in performance. The goal to mitigate these factors was to obtain as large a sample size as possible.
STUDY FINDINGS AND DISCUSSION

Demographic Characteristics

A total of 149 RNs completed the survey, yielding a response rate of 14.9%. Table 1 presents demographic data, including the respondents’ number of years of experience as an RN, job title or primary role, and area of specialty. Years of experience as a nurse ranged from less than 1 year to 10 years or more. The median experience as an RN was 6 years, and the mode was 10 years or more. The respondent was asked to indicate years of experience as less than 1, 1, 2, 3, 4, 5, 6, 7, 8, 9, or 10 years or more. Nurses identifying themselves as having less than 1 year or 1 year of experience were considered new graduate nurses. Respondents with 2 or more years of experience, regardless of job title, were categorized as experienced nurses.

The majority (66%) of respondents identified themselves as staff nurses. Thirteen (8.7%) of the respondents described their primary role as charge nurse. Charge nurses at this medical center are counted in staffing numbers and provide hands-on patient care; therefore, they were included in the same group with staff nurses in the analysis of survey results.

Of the respondents, 26% identified themselves as being in a leadership role. Nurses who categorized their job title as director (2.7%), manager (8.7%), nurse educator (4.7%), clinical nurse specialist (0.67%), and other (8.1%) were included in the managers-only group for analysis.

Fifty-nine (39.6%) of the respondents reported that they practiced on medical-surgical or telemetry units, while 40 (26.9%) practiced in critical care–emergency departments. The specialty area of women’s health or pediatrics had 25 (16.8%) nurse respondents. The category of other was identified by 25 (16.8%) of the nurses, possibly related to their being employed in the cancer center, which was not a medical–surgical or telemetry category.

Satisfaction Ratings of Experienced Nurses, Compared With National Sample Ratings

The Nursing Practice Readiness Tool measures 36 discrete competencies. Given that the focus of this study was on the new graduate nurse’s ability to function as a member of the interprofessional team, performance ratings on the interprofessional collaboration items were compared between the medical center’s experienced nurses and the 2007 national benchmark survey. Each competency rating within this broad category achieved higher ratings, compared with the national benchmark ratings. Competencies representing interprofessional collaboration included communication with the interprofessional team, ability to work as part of a team, recognition of when to ask for assistance, ability to accept constructive criticism, interpretation of physician and interprofessional orders, communication with physicians, conducting appropriate follow up, conflict resolution, and delegation of tasks (Table 2).

The medical center’s experienced nurses ranked communication with the interprofessional team highest of all competencies in this area, with a 63% satisfaction rating, compared with a national benchmark satisfaction rate of only 38%. Fifty-six percent of experienced nurses also stated they were satisfied with the new graduates’ ability to work as part of a team. The national benchmark was 37%. Recognition of when to ask for assistance received a 50% satisfaction rating by experienced nurses. The national benchmark for this competency was 35%.

Communication with physicians received a 51% satisfaction rating by experienced nurses, whereas this competency received a national rating of 23% satisfaction. Ability to accept constructive criticism had a 38% satisfaction rate by the experienced nurses, compared with the national benchmark of 30%. Delegation of tasks, a
<table>
<thead>
<tr>
<th>New Graduate Competencies</th>
<th>National Data (N = 3,265 [%])</th>
<th>Experienced Nurses (N = 114 [%])</th>
<th>New Graduates (N = 35 [%])</th>
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<tbody>
<tr>
<td>Utilization of information technologies</td>
<td>53</td>
<td>74</td>
<td>94</td>
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<tr>
<td>Rapport with patients and families</td>
<td>51</td>
<td>67</td>
<td>94</td>
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<tr>
<td>Respect for diverse cultural perspectives</td>
<td>49</td>
<td>70</td>
<td>100</td>
</tr>
<tr>
<td>Conducting patient assessments</td>
<td>44</td>
<td>74</td>
<td>94</td>
</tr>
<tr>
<td>Customer service</td>
<td>43</td>
<td>48</td>
<td>88</td>
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<tr>
<td>Documentation of patient assessment data</td>
<td>41</td>
<td>72</td>
<td>94</td>
</tr>
<tr>
<td>Administration of medications</td>
<td>41</td>
<td>74</td>
<td>100</td>
</tr>
<tr>
<td>Patient advocacy</td>
<td>38</td>
<td>51</td>
<td>81</td>
</tr>
<tr>
<td>Communication with the interprofessional team&lt;sup&gt;b&lt;/sup&gt;</td>
<td>38</td>
<td>63</td>
<td>88</td>
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<tr>
<td>Ability to work as part of a team&lt;sup&gt;b&lt;/sup&gt;</td>
<td>37</td>
<td>56</td>
<td>94</td>
</tr>
<tr>
<td>Recognition of when to ask for assistance&lt;sup&gt;b&lt;/sup&gt;</td>
<td>35</td>
<td>50</td>
<td>94</td>
</tr>
<tr>
<td>Accountability for actions</td>
<td>35</td>
<td>51</td>
<td>94</td>
</tr>
<tr>
<td>Knowledge of pathophysiology</td>
<td>35</td>
<td>58</td>
<td>63</td>
</tr>
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<td>Patient education</td>
<td>34</td>
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<td>81</td>
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<tr>
<td>Understanding the principles of evidence-based practice</td>
<td>33</td>
<td>61</td>
<td>75</td>
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<tr>
<td>Ability to accept constructive criticism&lt;sup&gt;b&lt;/sup&gt;</td>
<td>30</td>
<td>38</td>
<td>94</td>
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<tr>
<td>Compliance with legal issues relevant to nursing practice</td>
<td>30</td>
<td>60</td>
<td>75</td>
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<tr>
<td>Recognition of unsafe practices by self and others</td>
<td>28</td>
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<td>Knowledge of pharmacological implications of medications</td>
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<td>Performing clinical procedures</td>
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<tr>
<td>Utilization of clinical technologies</td>
<td>27</td>
<td>63</td>
<td>81</td>
</tr>
<tr>
<td>Interpretation of physician and interprofessional orders&lt;sup&gt;b&lt;/sup&gt;</td>
<td>26</td>
<td>48</td>
<td>81</td>
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<tr>
<td>Communication with physicians&lt;sup&gt;b&lt;/sup&gt;</td>
<td>23</td>
<td>51</td>
<td>75</td>
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<tr>
<td>Decision making based on the nursing process</td>
<td>20</td>
<td>42</td>
<td>73</td>
</tr>
<tr>
<td>Conducting appropriate follow up&lt;sup&gt;b&lt;/sup&gt;</td>
<td>19</td>
<td>37</td>
<td>81</td>
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<tr>
<td>Recognition of changes in patient status</td>
<td>19</td>
<td>46</td>
<td>94</td>
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<tr>
<td>Ability to take initiative</td>
<td>19</td>
<td>26</td>
<td>69</td>
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<tr>
<td>Interpretation of assessment data</td>
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<td>44</td>
<td>75</td>
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<tr>
<td>Ability to work independently</td>
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<td>47</td>
<td>88</td>
</tr>
<tr>
<td>Understanding of quality improvement methodologies</td>
<td>18</td>
<td>44</td>
<td>69</td>
</tr>
<tr>
<td>Completion of individual tasks within expected time frame</td>
<td>17</td>
<td>30</td>
<td>69</td>
</tr>
<tr>
<td>Ability to keep track of multiple responsibilities</td>
<td>12</td>
<td>30</td>
<td>75</td>
</tr>
<tr>
<td>Conflict resolution&lt;sup&gt;b&lt;/sup&gt;</td>
<td>12</td>
<td>31</td>
<td>56</td>
</tr>
<tr>
<td>Ability to prioritize</td>
<td>12</td>
<td>26</td>
<td>69</td>
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<tr>
<td>Ability to anticipate risk</td>
<td>11</td>
<td>27</td>
<td>75</td>
</tr>
<tr>
<td>Delegation of tasks&lt;sup&gt;b&lt;/sup&gt;</td>
<td>10</td>
<td>24</td>
<td>53</td>
</tr>
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</table>

<sup>a</sup> Experienced nurses includes staff nurses and managers with 2 or more years of experience as an RN.

<sup>b</sup> Indicates a competency associated with functioning as part of the interprofessional team.
critical skill for nurses, was rated lowest by experienced nurses, at 24%, compared with the national benchmark of 10%.

**New Graduate Nurses’ Self-Rating, Compared With Experienced Nurses’ Perceptions**

Comparisons were made not only between the experienced nurses at the medical center and the national benchmark but also between experienced nurses and new graduate nurses. New graduate nurses were those with less than 1 year or 1 year of experience as an RN. Interestingly, new graduate nurses rated themselves significantly higher in every competency, compared with the national survey respondents and compared with the experienced nurse cohort (Table 2). For example, 88% of new graduate nurses rated themselves as satisfied or very satisfied with their performance in the category communication with the interprofessional team, compared with a 63% satisfaction rating by experienced nurses and 38% by the national respondents. Similarly, 94% of new graduates were satisfied with their ability to work as part of a team, compared with a 56% satisfaction rating by the experienced nurses and 37% by the national cohort. New graduates had a 94% self-satisfaction rating on their ability to recognize when to ask for assistance, compared with the hospital’s experienced nurses rating of 50% and the national benchmark rating of 35% satisfaction.

Interpretation of physician and interprofessional orders received an 81% self-satisfaction rating by new graduate nurses, compared with the experienced nurses’ rating of 48% and the national benchmark rating of 26%. The new graduates’ self-rating of 94% in the competency ability to accept constructive criticism was significantly higher than the national rating of 30% and the medical center’s experienced nurses’ rating of 38%. Finally, new graduate nurses self-rated delegation of tasks lowest of all the competencies, at only 53% satisfaction. This is still higher than the experienced nurses’ rating of 24% and the national benchmark of 10% satisfaction in this category. Table 2 presents a complete comparison of all competencies with regard to new graduate nurses’ self-assessment, national benchmark data, and experienced nurses’ satisfaction ratings.

**Management Perceptions, Compared With Benchmark Data, of New Graduate Nurse Competency**

Finally, comparisons were made between how the managers-only group rated new graduates in each competency, compared with the national data (Table 3). Staff nurses were not included in this cohort. Respondents in this cohort reported they had worked as an RN for 7 to 10 or more years.

Although the managers-only group rated new graduate nurses higher than average in several clinical skill sets, in some categories the satisfaction ratings were similar to the national average. For example, the managers-only group rated communication with physicians at 29% satisfaction, compared with the national benchmark data of 23% satisfaction. Of note, conflict resolution earned a 0% satisfaction rating from the managers-only cohort. This competency was low in the national benchmark study, with a 12% satisfaction rating.

**DISCUSSION**

The survey results provide valuable information about the effect of nurse residency programs on satisfaction ratings of new graduate nurses’ performance competencies between nurse leaders and staff nurses. Experienced nurses, managers only, and new graduates ranked various skills at different levels of satisfaction. For example, the managers-only group rated new graduates much higher in their ability to work as part of a team (71% satisfied), compared with experienced nurses (56% satisfied). Although the experienced nurses group included managers and staff nurses, the variation in satisfaction reflects that staff nurses have a different perspective of this skill. This may be explained by experienced staff nurses working side-by-side with new graduates throughout the shift, whereas managers have limited exposure to the nurses.

However, the managers-only cohort rated new graduates lower in the category of communication with the interprofessional team (50% satisfied), compared with experienced nurses (63% satisfied). Also, managers rated new graduates’ competency lower in the communication with physicians (29% satisfied), compared with experienced nurses (51% satisfied). Typically, physicians tend to report any difficult encounters or conflicts with staff nurses directly to a nurse manager, whereas staff nurses may not be aware of such conflicts.

One area of concern in the managers-only data is the 0% satisfaction rating in the conflict resolution competency. Experienced nurses rated this skill low (31% satisfaction); however, nurse managers reported being less satisfied than experienced staff nurses. Perhaps this could be explained by considering when new graduates experience conflict, they are more likely to bring it to their nurse manager’s attention than would a more experienced staff nurse.

Responses of the new graduate nurses suggest that they believe they are more effective with interprofessional collaboration, compared with the perceptions of
TABLE 3

PERCENTAGE OF RESPONDENTS SELECTING SATISFIED OR VERY SATISFIED, PER COMPETENCY ON THE NURSING PRACTICE READINESS TOOL

<table>
<thead>
<tr>
<th>New Graduate Competencies</th>
<th>National Data (N = 3,265 [%])</th>
<th>Managers Only (N = 37 [%])</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization of information technologies</td>
<td>53</td>
<td>92</td>
</tr>
<tr>
<td>Rapport with patients and families</td>
<td>51</td>
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<td>Customer service</td>
<td>43</td>
<td>50</td>
</tr>
<tr>
<td>Documentation of patient assessment data</td>
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<td>93</td>
</tr>
<tr>
<td>Administration of medications</td>
<td>41</td>
<td>79</td>
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<tr>
<td>Patient advocacy</td>
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<td>64</td>
</tr>
<tr>
<td>Communication with the interprofessional team</td>
<td>38</td>
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<tr>
<td>Accountability for actions</td>
<td>35</td>
<td>43</td>
</tr>
<tr>
<td>Knowledge of pathophysiology</td>
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<td>71</td>
</tr>
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<td>Patient education</td>
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<td>Understanding the principles of evidence-based practice</td>
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<td>Ability to keep track of multiple responsibilities</td>
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<td>Conflict resolution</td>
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<td>Ability to anticipate risk</td>
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<tr>
<td>Delegation of tasks</td>
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* Indicates a competency associated with functioning as part of the interprofessional team.
experienced colleagues and nurse managers. Given that the medical center already has residency seminars in communication, such discussions may have influenced the higher satisfaction rating. Of note is that new graduate nurses rated themselves significantly higher in every competency, compared with the ratings of the experienced nurses and managers. This disparity needs additional study because the survey relies on self-report of new graduates and the recall of experienced nurses and nurse managers, without evidence of patient outcomes or interprofessional feedback.

The skewed ratings may be related to the smaller sample size in the new graduate group. A total of 35 nurses with less than 2 years of experience completed the survey, compared with 114 experienced nurses (those with 2 or more years of experience). Nurse residents who responded to the survey may have self-selected and may be more competent and confident.

LIMITATIONS
Several study limitations should be considered. First, although a response rate of 14.9% was adequate to perform data analysis, some departments had more nurses respond to the survey than others. This may not have provided an accurate overall representation of the experienced nurses’ views of new graduate nurse performance. For example, only 25 nurses responded from the women’s or children’s health units. This could be explained by the fact that these specialty units do not hire the same number of new graduates as do the adult medical–surgical units; therefore, the nurses may not have felt as committed to answer the survey.

Another limitation is the consideration that new graduate nurses may have been reluctant to provide an honest self-assessment of their competencies for fear of being viewed as inadequate or below average in their skill sets. This may have affected how they rated their competencies. In addition, although general descriptions were reported by the nurses regarding the type of unit in which they were employed (i.e., medical–surgical, critical care or emergency, women’s or children’s health), it is not known whether a higher percentage of nurses in one or two particular units provided most of the responses in that broad area or whether it was a general sample from across the hospital. For example, seven nurses from the same orthopedic unit may have completed the survey, but none may have completed the survey from a general surgical unit. Both of these units would fall under the broad category of medical–surgical unit. This may affect the results, as nurses in one unit may have a different experience in working with new graduates, compared with nurses in another unit.

key points

Interprofessional Teamwork

1. New graduates typically struggle in adjusting to the RN role, particularly with nonclinical skills, such as communication and interprofessional collaboration.

2. A collaborative approach to problem solving and implementation of patient care plans leads to an increased awareness of each team member’s knowledge and skills, thus contributing to improved patient outcomes.

3. Inadequate interprofessional communication skills may contribute to new graduate nurses’ stress and burnout.

4. A nurse residency program may ease the transition to practice, but specific exercises including interprofessional collaboration may enhance new nurse professional development in this area.

Nurses employed in critical-care units and the emergency department may have a different level of expectation of new graduates’ competency performance, compared with nurses employed in a medical–surgical or telemetry unit. This may decrease their satisfaction with the new graduate and therefore affect the overall results of the survey. Managers of specialty units also may have higher expectations of new graduates in certain competencies and may express a stronger dissatisfaction with them in certain areas (i.e., recognition of changes in patient status) than would a manager of a medical–surgical unit.

Finally, some units may have a higher percentage of new graduates with an associate degree in nursing, compared with units with a higher percentage of new graduates with a baccalaureate degree. The expectations of the nurses and managers and the performance levels of the new graduates may vary depending on this factor. Some new graduates may have higher skill sets than others, depending on the college or type of program the new graduate attended. This could influence the participant’s responses regarding various competencies.

CONCLUSIONS
The survey results indicated that the majority of new graduates rated themselves higher than did the nurse managers and staff nurses and higher than the national
sample of managers and staff nurses (Berkow et al., 2008). Engaging in interprofessional collaboration may present a daunting challenge for the new graduate nurse who is adapting to professional practice in an unfamiliar sociocultural and political organization (Pfaff, Baxter, Jack, & Pleog, 2013). The evidence suggests that lack of confidence, lack of clinical knowledge and experience, and fear of rejection by the health care team are factors that influence whether new nurses will initiate or engage in interprofessional collaboration. Understanding the factors influencing interprofessional collaboration among new graduate nurses may offer strategies to enhance their retention (Pfaff et al., 2013).

A nurse residency program may ease the transition to practice, but specific exercises including interprofessional collaboration may enhance new nurse professional development in this area. Collaborative practice occurs when multiple health care workers from different professional backgrounds provide comprehensive services by working with patients and families to deliver high-quality care (World Health Organization, 2010).

This project was noteworthy because new graduate nurses comprise 10% of a health system’s nursing staff. This number is expected to grow, given the percentage of nurses nearing retirement age.

REFERENCES


