Charting Our True North:

Core Concepts for Nursing Orientation

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Declarations

- No conflict of interest for any member of the planning committee or any of the presenters has been identified for this program.

- There is no commercial support for today's program.

- In order to receive contact hours please sign the roster, complete the evaluation, and attend the entire program.

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At the Conclusion of This Session, Participants Will Be Able To:

01 Identify core concepts necessary for planning effective orientation and clinical competency validation programs

02 Quantify documentation burden associated with orientation and competency validation tools

03 Select key competency program concepts that might be useful when integrated into participant agency orientation or residency programs

About Nurses International

Nurses International (NI) is a non-profit, nurse-led organization focused on helping nurses obtain the education and support they need to make a positive difference in patient outcomes worldwide. NI uses open access resources within course creation to remove barriers to access and affordability.

Open Access Resources: This concurrent session shares lessons learned and selected resources from NI's open access competency framework, research, and outcomes from a Delphi Study on framework components.

Boyer, S., & Chickering, M. (2024). Perspective Chapter: Clinical Competency Framework – Standardized Nurse Competence Development. In D. L. David, Nursing Studies – A Path to Success (pp. 1-23). London: IntechOpen. https://www.intechopen.com/chapters/1173215

Background: From New Graduate Residency to Comprehensive Model

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Initial focus on New Graduate residency program for statewide implementation. Most important component identified: preceptor development and support.

Evolution to Comprehensive Framework

Integrated significant, varied theories within the model. Evolved from new grad focus to a comprehensive orientation model applicable across experience levels.

Knowledge Sharing & Open Access

Sought to share knowledge, tools, and lessons learned, rather than marketing for gain. VT Nurses in Partnership merged with Nurses International; shared via NextGenU.org.

Preceptor Support as Core Priority

Learnings re: administrative burden, use of sampling, and accountability. Preceptor development identified as the most important component of any residency model.

Three Foundational Support Structures:

1. **Protocols and Evaluation**
   - Policies & procedures define qualifications, roles, requirements, and accountability
   - Survey and evaluation tools
2. **Competency development**
   - Orientation clinical competencies
   - Sampling and Accountability
3. **Preceptor Instruction/Support Systems**
   - Teaching, communication, CT development
   - Clinical Coaching Plans
   - Documentation burden

Evidence Based Practice
Professional Development & Transitional Support

Step 3. Comprehensive standardized process

- Pilot project in ED, ICU, Maternal-Child Health
- Outcomes: Universal framework that can be customized for setting and individuals

Step 2. Specialty Nurse Transition Project

- Can Burn Unit outcomes be replicated?
- If so, what is the impact?

Step 1. Burn Unit Project shows the impact & efficacy

- Initial Project targeted Burn ICU turnover, retention, orientation satisfaction, and preceptor attitudes.

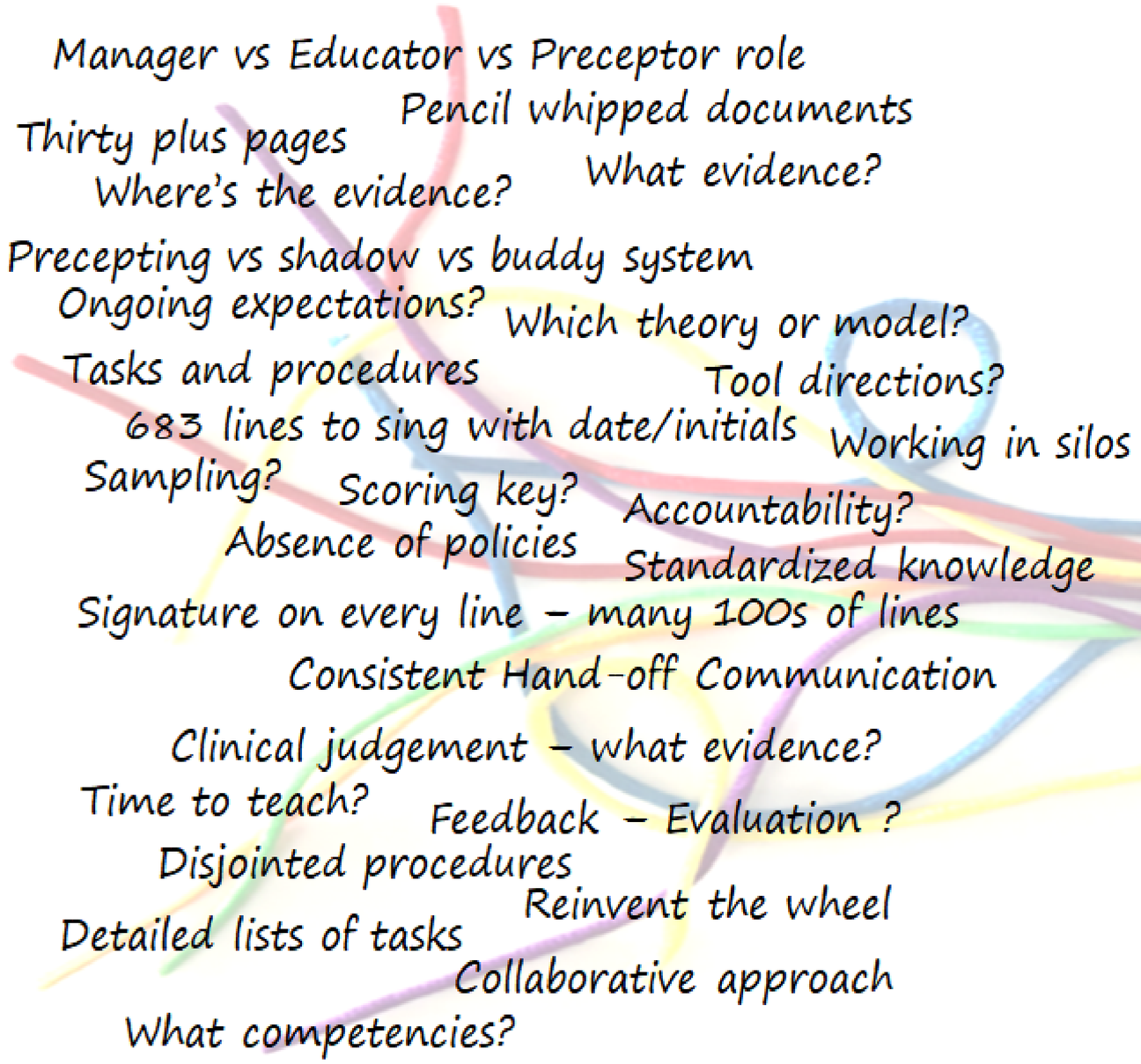
Delphi Study: Methods & Purpose

When working to optimize the orientation process for a major tertiary care center, the literature review revealed limited evidence-based data on competency framework recommendations. A Delphi Study was developed to establish expert consensus.

9% of new graduate RNs tested in 2020 were in the acceptable competency range for a novice nurse — highlighting the urgency for evidence-based orientation frameworks. (Kavanagh & Sharpnack, 2021)

1. Broad list of possible program elements developed from literature and practice.
2. Expert panel convened; elements validated and ranked for importance.
3. Consensus findings on essential competency program components identified.
4. Elements rank-ordered to guide implementation priority.

Delphi Technique – Discerning the Pieces, Pattern & Process



1. Ensure safe care
2. Evidence based delivery
3. Develop Critical thinking
4. Minimizes workload
5. Measurable competency criteria
6. Affirms accountability in role
7. Ensure 'hand-off' communications
8. Provide communication guidelines
9. Assures formative feedback
10. Identifies issues early
11. Includes clear directions
12. Patient and/or clinician-focused
13. IDs elements of professionalism
14. Employs appropriate assignment
15. Provides learning time and topics
16. Accommodates learning styles
17. Consistent with standards
18. IDs initial & ongoing expectations
19. Applies sampling concepts
20. Outlines knowledge content

Delphi Study: Core Program Components

Essential Components

- Ensure safe care
- Evidence-based delivery
- Develop critical thinking
- Minimizes workload
- Measurable competency criteria
- Affirms accountability in role
- Ensure hand-off communication
- Communication guidelines
- Formative feedback
- Identify issues early

Additional Components

- Includes clear directions
- Patient and/or clinician-focused
- Elements of professionalism
- Appropriate assignment
- Learning time and topics/content
- Accommodates varied learning styles
- Consistent with standards
- Identifies initial & ongoing expectations
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Core Concepts – Nurse Orientation

1. Evidence based Competency Framework: COPA Model
2. Sampling Concepts applied to orientation - documentation burden
3. Accountability for professional actions - as applies to all roles
4. Teaching/Learning concepts - Benner's model - 3 high end apprenticeships
5. Continuous support structures – preceptor, clinical preceptor, mentor
6. Standardized Knowledge - Form Directions - KISS Principle
7. Data collection and Rapid Cycle Quality Improvement

The concepts are interdependent: changing one tool or workflow can affect how we address accountability, documentation burden, coaching quality, evidence, and/or learner progression.

Clinical Competencies: COPA Model & Nurse-Centric Statements

Competence Outcomes Performance Assessment, teaches us how to write clinical competencies that target the top of Bloom's pyramid.

COPA Model Principles

- Includes Critical Thinking, Human Caring, Management & Knowledge Integration.
- Observable behaviors, validation via observing actions, behaviors, and words.
- Scoring key defines validation, backed by policy.
- Avoids revisiting 'Nursing 101'
- Demonstrate vs. Differentiate, high-level action verbs.

Medical Model vs. Nurse & Patient-Centric

Assists the physician in the minor procedure room.	Ensures well-being of patient experiencing minor procedures with or without sedation.
Addresses cardiac dysfunction with resuscitation skills.	Manages care of the patient presenting with 'complaint of chest pain'.

Key Concepts for Application

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Sampling, documents, & KISS Principle

Use sampling concepts to manage documentation burden and validate competency without exhaustive checklists. Keep It Short and Simple!!!!

Accountability

Professional accepts accountability for what they do, what they do not do, what they know, and what they don't know

Standardized Knowledge

Making use of teaching/learning preferences and styles, promoting critical thinking and reflection

Clinical Teaching Plans

Customized coaching plans that support deliberate practice and progressive development toward expertise

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Sampling Strategies & Documentation Burden

Documentation burden is one of the greatest barriers to effective preceptorship. Sampling concepts dramatically reduce documentation burden while maintaining competency validation integrity, applying the KISS Principle: Keep It Short and Simple.

Tool	Checklist Approach	Sampling (TIP-TOP)	Reduction
Universal CBO	308 signatures (12 pages)	75 total (6 pages)	**75% ↓**
Burn ICU Specific	224 signatures (15 pages)	52 (3 pages)	**77% ↓**
Overall Total	683 signatures (37 pages)	127 (9 pages)	**81% ↓**

Accountability: Each professional is responsible for what they do, what they do not do, what they know, what they do not know. Professional accountability fills the gap for orientation.

Sampling makes competency validation feasible and defensible

⚠
High risk
Situations where failure could cause harm

↻
High frequency
Clinical care commonly performed in the unit


Quality signals
Priorities from incidents, QI, or regulatory focus


Learner capability
Sample intensity adjusts to experience level

Competence is extrapolated from a representative sample of observed performance—not from every possible task or procedure.

Bolded items in tools identify minimum required validation elements for orientation.
Each component appearing on the page of directions is there for a reason!

1. List that encompasses professional practice
2. Written at the highest level of action verb possible
3. Observable behaviors/actions
4. Novice to expert continuum – but clarify ‘competence’

The scoring key translates development into observable evidence

1 Identified Limitation	2 Capable	3 Independent	4 Proficient	5 Expert
Requires direct guidance; little or no experience	Familiar; may need assistance; seeks support	Safe performance from training and experience	Able to teach and mentor others	Fluid, intuitive, evidence-based practice

A score of 2 or better validates capability for initial orientation when supported by accountability and appropriate help-seeking.

Documentation Burden - CAF

Varies by specialty unit

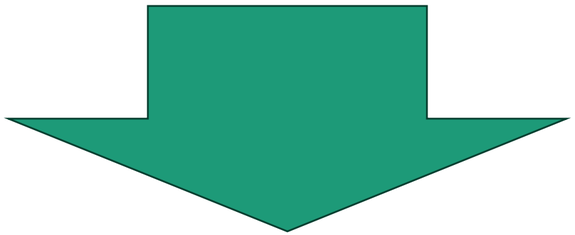
ED = 97 (7 pages)
OB = 271 (6 pages)
ICU = 115 (4 pages)

	SAMMC (Checklist focus)	TIP-TOP (Concept focus)	Comments
Universal CBO	308 (12 pages)	75 total (1 instruction page + 6 pages of competencies)	New Universal CBO for all competencies applicable to inpatient nursing units (Approved by Chief Nurse)
Burn Specific	224 (15 pages)	52 (3 pages; Learning Guide/Coaching Care Plan)	Each specialty inpatient unit will have additional "Unit-Specific" CBO (Approved by Unit/Section Chief)
Restraints	111 (4 pages)	0	NEO training; in Universal CBO *Not part of current Restraint Policy
Ketamine	10 (4 pages)	0	Covered in Moderate Sedation training and unit-specific training; in Unit-Specific CBO
Med Admin	30 (2 pages)	0	In Unit-Specific CBO
TOTAL Signatures	**683** (**37** pages in CAF) Plus unit memos for telemetry, pediatric meds, moderate sedation, triage, ketamine	**127** (**9** pages in CAF)	

Quantifying Documentation Burden

- Evaluate your current form and format
- Rank the directions for ease of completion – Likert scale 1-10
- Assess forms for consistency from one tool to another
- Determine adherence to protocols/policy statements
- Count the number of slots requiring preceptor/educator signature
  - Rows and columns
  - Notes, completion, ranking, etc.

Documentation Burden Assessment



KISS Principle – Keep It Short and Simple!!!

Keep tools short, simple, and clinically usable

Clear
Directions tell users what to do and what signatures mean

Concrete
Performance expectations are observable

Concise
No redundant documentation already tracked elsewhere

Complete
Evidence is filed with the directions and tool

Precepting is additional work. The assignment must establish time to teach, observe practice, validate performance, and document accurately.

A useful test for new tools: “Does this simplify the work while preserving the evidence?”

The accountability statement makes expectations explicit

“Orientation cannot provide exposure to all aspects of patient care delivery. I accept accountability for my clinical practice and continued learning.”

Start of orientation
Preceptor introduces the expectation early.

✓
Completion of orientation
Orientee validates responsibility by signing.

↻
Ongoing practice
Provider seeks resources when unfamiliar care is encountered.

Key message: accountability protects patients when orientation cannot sample every possible clinical situation.

Accountability Statement

Sample: Evaluate Suitability for Your Setting

As a professional healthcare provider, I acknowledge the fact that orientation cannot provide exposure to all aspects of patient care delivery. I accept accountability for my professional practice and continued learning. When asked to engage skills, tasks, or other responsibilities that are not familiar to me; I will access appropriate resources for assistance, information, or guidance. Resources may include written directions, procedure manuals, learning modules, and/or the expertise of colleagues. I will ensure that each patient that comes under my supervision receives safe, effective care that adheres to all established protocols.

The requirements remain consistent; the patient assignment sample may differ

Geriatric patient
Population-specific core issues

Orthopedic surgery
Post-op/fx stabilization

Diabetes care
Preventive and medication priorities

Discharge teaching
Complex patient education

A 3–4 patient assignment can reveal multiple Medical–Surgical competencies at once.

✓ Adapts to workflow

✓ Manages multi-patient care

✓ Alleviates distress

✓ Uses teamwork/delegation

✓ Seeks help when needed

Preceptor Development: Underlying Theories

Two complementary models underpin preceptor development across progressive levels of practice:

Benner's Novice to Expert Model

Highlights the progression of skill development, emphasizing experiential learning in developing competent preceptors who embody core professional values.

➡ Progressive development fostering systematic preceptor capability.

Dreyfus Model of Skill Acquisition

Outlines five stages of skill development, enabling preceptors to understand their role in facilitating skill development through tailored guidance and support.

➡ Integrating frameworks aligns educational practices with evolving challenges.

Theories & Teaching/Learning Strategies

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Benner's Three High-End Apprenticeships

Cognitive (knowledge & reasoning), Practice (skilled know-how & judgment), Ethical (professional formation & accountability)

Concept-Based Learning

Focus on broad transferable concepts rather than isolated facts, builds clinical reasoning applicable across situations

Reflective Learning Strategies

Tanner's clinical judgement model: Noticing → Interpreting → Responding → Reflecting. Experiential learning through structured reflection

Deliberate Practice

Focused, intentional repetition with feedback, Clinical Coaching Plans guide progressive skill development toward expertise

Standardized Knowledge Foundations

Making use of learning preferences and styles; developing customized teaching plans; promoting critical thinking development

Rapid Cycle QI (PDSA)

Plan-Do-Study-Act cycles evaluate program efficacy and drive continuous improvement, rapid-cycle feedback to refine tools

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Reflective learning develops judgment—not just skill completion

What went well?

What was difficult?

What cues were noticed?

What could be different next time?

Weekly conference time gives preceptors a structured opportunity to foster clinical reasoning.

Deliberate practice builds confidence, dexterity, and automaticity

Repeated similar assignments allow thinking and hands-on skill to integrate before the learner is pushed into more complex situations.

Concept-based learning helps nurses connect across diagnoses and situations

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What is the same?

Identify recurring patterns across patient situations.

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What is different?

Recognize context, priorities, and risk variation.

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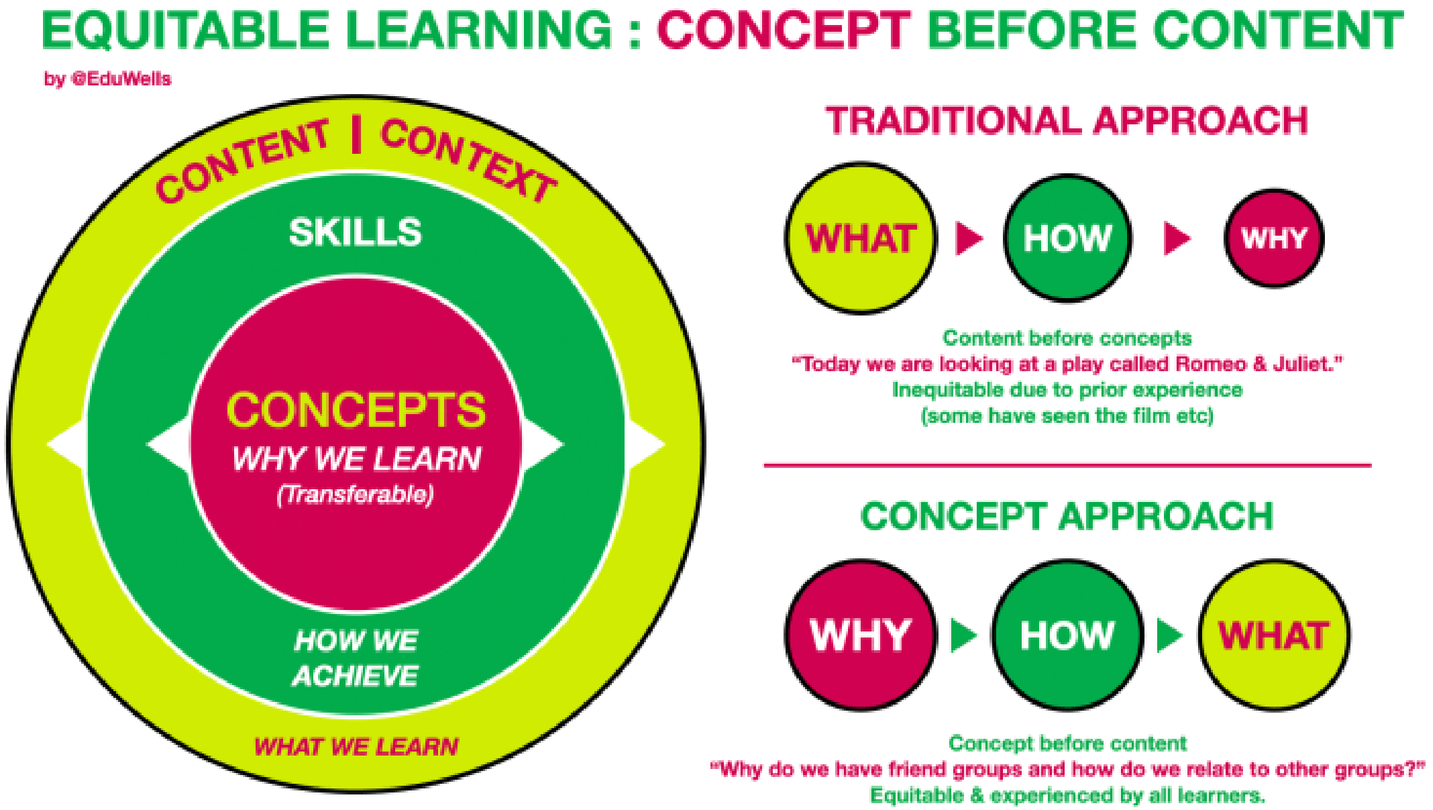
What does it mean?

Link assessment to judgment and action.



Coaching plans - connect knowledge, experience, and validation

Standardized knowledge
Policies, standards, guidelines, texts, and learning modules

Guided experiences
Patient assignments chosen to develop required capability

Reflective prompts
Questions that move the learner from activity to judgment

Evidence capture
Observed performance documented in competency tools

Coaching Plan Link

Standardized knowledge - keeps coaching aligned without overloading the form

Policies Agency protocols and procedures

Standards Specialty organization expectations

Guidelines Clinical practice guidance

Modules Targeted learning resources

Texts Expert published references

Coaching plans point learners to the knowledge base rather than recreating every resource inside the competency tool.

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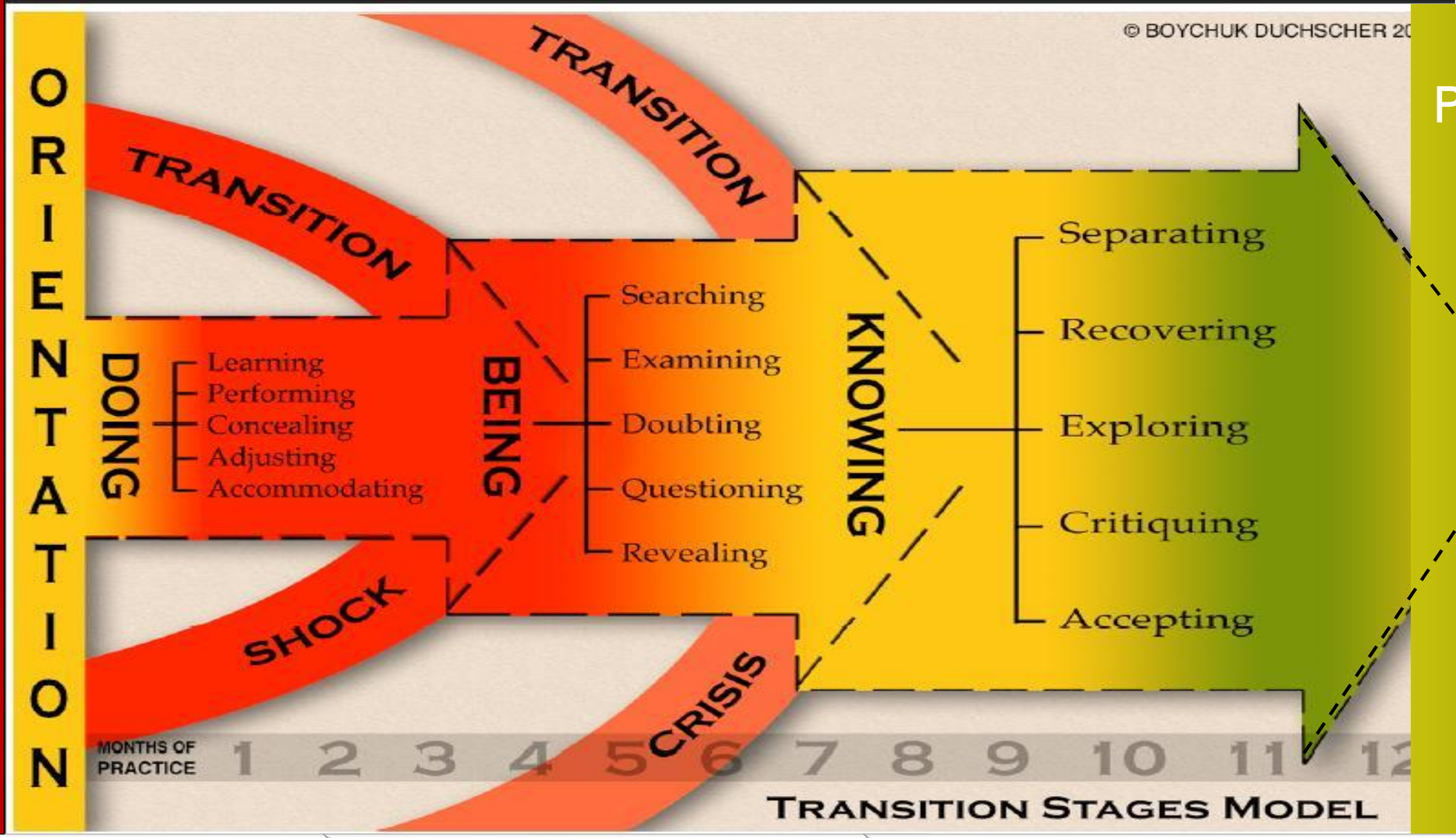

Professional Role

Critical Thinking

Nursing Judgment

Proficient /Expert Practice

Clinical Preceptor → **Clinical Mentorship** → **Professional Mentorship**

Professional formation as a Registered Nurse - visible integration of values, judgment, and action

⚖️ **Ethical demeanor**

How practice is carried out

📍 **Situational competence**

Competence varies by setting and patient need

🧠 **Clinical judgment**

Reasoning guides tasks & interventions

❤️‍🔥 **Patient-centered action**

The patient is the organizing focus

Rapid Cycle Quality Improvement: Plan-Do-Study-Act

Strategies for determining whether orientation programs achieve intended outcomes using small-scale, rapid tests to continuously evaluate and refine.

PLAN

Identify a change in orientation content or delivery; design a test using survey tools and learner feedback.

DO

Implement on a small scale; collect data on learner outcomes, preceptor confidence, and satisfaction scores.

STUDY

Analyze results: compare outcomes to predictions; identify gaps, strengths, and areas needing refinement.

ACT

Adopt, adapt, or abandon the change; restart the cycle for ongoing quality improvement of the program.

Evaluation tools include: learner satisfaction surveys, preceptor attitude surveys, competency validation completion rates, and turnover/retention tracking.

Session Summary & Key Takeaways

Objective 1

Core concepts: COPA, sampling, accountability, Benner's apprenticeships, standardized knowledge, speed and simplify competency validation.

Objective 2

Documentation burden can be reduced by 75–81% using sampling strategies, with no loss of validation integrity.

Objective 3

Delphi-informed strategies and open-access resources can be integrated directly into your agency's orientation or residency program.

Closing Reflection

What competency concepts or orientation strategies would be most valuable to implement in your organization?

References

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Any Questions ?

The Clinical Competency Framework (CCF)

Evidence and practice experience informed development, providing a comprehensive, standardized structure for orientation, residency, and competency validation.

1. Protocols & Evaluation

- Policies & procedures define qualifications, roles, requirements, and accountability.
- Survey and evaluation tools.
- Data collection processes.
- Sampling and Accountability.

2. Competency Development

- Orientation clinical competencies.
- COPA model, nurse and patient-centric.
- Standardized templates as starting points.
- Builds on prior evidence-based work.

3. Preceptor Instruction & Support

- Teaching, communication, CT development.
- Clinical Coaching Plans.
- Documentation burden management.
- Protects new staff and patients.