Organizational Readiness of a Health System for Nurse Residency Program Accreditation

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The project aim was to assess the readiness of a healthcare organization to successfully achieve national accreditation of its nurse residency program and to determine the program's capacity to meet the accreditation standards. The only other discoverable article published related to this topic was conducted by Franquiz and Seckman (2016). This project further expands on their study and adds to the body of knowledge regarding organizational readiness to undergo nurse residency program accreditation.

Nurses are an integral part of the healthcare team, and their role is crucial in caring for patients and ensuring their safety. According to the U.S. Bureau of Labor Statistics (n.d.), in 2014, there were 2.7 million registered nurses among 11.8 million workers employed in health care, making them the largest occupation. The U.S. Bureau of Labor Statistics projects employment of registered nurses to grow 12% from 2018 to 2028, much faster than the average for all occupations (U.S. Bureau of Labor Statistics, 2018).

With the ever-changing healthcare system, increased complexity of hospitalized patients, and nursing shortage, it is imperative new graduate nurses (NGNs) are given the appropriate support and resources to be successful and to provide high-quality care. Currently, nursing does not require a standardized orientation program for NGNs. Unlike other professionals, nurses often have no extensive orientation programs to support them as they enter the profession. In an appeal for the radical transformation of nursing education, Benner et al. (2009) recommended NGNs be required to complete a 1-year residency program.

The first formalized nurse residency program (NRP) was launched in 2002, and since then, the number of hospitals implementing NRPs grew exponentially (Stringer, 2016). This is partly in response to a recommendation by the Institute of Medicine for healthcare organizations to implement NRPs (Institute of Medicine, 2010). Evidence has linked participation in an NRP to improved patient outcomes and safety (Cline et al., 2017), as well as decreased turnover and increased work satisfaction, confidence, and competence (Rosenfeld & Glassman, 2016; Spector et al., 2015; Ulrich et al., 2010). In a study conducted by Goode et al. (2016), first-year turnover rate decreased from 36% to 6%, and new graduates' perception of competence and confidence increased significantly because of implementing an NRP. As of 2018, approximately half of the hospitals in the United States have established NRPs (Pokorny, 2018). Despite the proliferation of NRPs in the United States, currently, there are no requirements or regulations that exist for NRPs to be standardized or become accredited (Spector et al., 2015). This is problematic because NRP experiences differ across the country in duration and lack a standardized, evidence-based curriculum and procedural standards (Goode et al., 2016).

As a result of the variable training NGNs receive in their NRP, Goode et al. (2016) recommended accreditation by national regulatory agencies of all NRPs to ensure greater uniformity. NRP accreditation is beneficial because it allows healthcare organizations to demonstrate organizational excellence, program quality, use of evidence-based practices, and cultivation of a nursing workforce who delivers safe, high-quality care (Pokorny, 2018). NRP accreditation is voluntary and involves trained external peer reviewers who evaluate the healthcare organization's NRP compared to preestablished performance standards (Alkehenizan & Shaw, 2011). There are two NRP accrediting agencies in the United States, the Commission on Collegiate Nursing Education (CCNE) and the American Nurses Credentialing Center. To date, there are 31 NRPs that are accredited by the CCNE, only two of which are in Pennsylvania (American Association of Colleges of Nursing, 2019). Currently, public documentation related to the number of NRPs accredited by the American Nurses Credentialing Center is unavailable.

AVAILABLE KNOWLEDGE

To date, the available literature is limited on organizational readiness for NRP accreditation, and a search of this topic only yielded one discoverable result. Therefore, a literature review of readiness, benefits, and barriers of any change, although primarily focused on accreditation in health care, was conducted to improve understanding of the accreditation gap.

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The one discoverable result related directly to readiness for NRP accreditation was a study conducted by Franquiz and Seckman (2016). The study determined organizational readiness for change as well as capacity to meet CCNE standards and criteria for NRP accreditation using two quantitative assessment tools. This study served as a model to guide this project, and permission was obtained from the author to utilize their assessment tool.

Findings from organizational readiness studies indicate the most significant factors of readiness were discrepancy, efficacy, organizational valence, management support, and personal valence (Holt et al. 2007; Liu et al., 2017). In addition, accreditation readiness could be improved with adequate support from external partners (Chen et al., 2018). Organizational readiness barriers were found to be funding, workforce, usability of evaluation tools, time, and relevance (Liu et al., 2017). Findings related to benefits of accreditation indicate immediate expansions in performance management and quality improvement (Siegfried et al., 2018), as well as a highly positive impact on patient safety (Shammari et al., 2015). These findings provide insight into organizational readiness, benefits, and barriers of change.

RATIONALE

Kurt Lewin's change theory provides a framework for understanding and generating change at any level—individual, group, organization, or society (Burnes, 2004). Lewin's change theory involves three distinct and vital stages: unfreezing, changing/moving, and refreezing. Unfreezing involves recognizing the need for change and rousing the current status quo, changing/moving involves moving individuals to a new level of equilibrium or state of being, and refreezing involves stabilizing the new equilibrium to ensure the change becomes routine (Wojciechowski et al., 2016). This project is focused primarily on the unfreezing stage.

SPECIFIC AIMS

The study aims were to assess the readiness of a multisite healthcare organization to undergo NRP accreditation and to assess the organization's current conditions and resources, or actual state, compared to the four standards for CCNE NRP accreditation, or desired state.

CONTEXT

The project was conducted in a multisite healthcare organization composed of seven hospitals. There is one NRP Manager who is responsible for the oversight of the entire program throughout the system. In addition, there are eight dedicated NRP coordinators throughout each of the seven hospitals who are responsible for facilitating NRP at their facility. These nine members of the NRP education team were used to identify the overall organizational readiness to undergo change and constituted Sample 1 for the project.

MEASURES

An exploratory descriptive design, using both quantitative and qualitative methods, was used to meet two study aims. Two quantitative instruments were used in this project, a modified version of the Holt Organizational Readiness for Change Tool (HORCT) and an updated version of the Accreditation Readiness Survey (ARS). Permission was obtained from both developers to use each of the instruments to assess organizational readiness for change.

The first instrument, a modified version of the HORCT, was used to assess organizational readiness for change. The HORCT assesses organizational readiness for change that involves four dimensions: appropriateness of change, management support, personal capability to enact change, and personal benefits of the change. This 25-item tool rates items on a 7-point Likert scale (1 = *strongly disagree*, 7 = *strongly agree*). A modified version, adapted by Franquiz and Seckman (2016), replaced the word "change" with the word "accreditation" throughout the tool. Franquiz and Seckman report the modified HORCT was reviewed for validity and found to have a validity index finding of .76. In addition, they omitted three items associated with the personal benefit dimension based on content expert panel recommendation. The modified HORCT consisted of 22 items and showed a Cronbach's alpha coefficient of .81 (Franquiz & Seckman, 2016).

The second instrument, an updated version of the ARS, was used to compare the actual organizational state to undergo accreditation of the NRP with the four CCNE accreditation standards. This tool was created by Franquiz and Seckman (2016) based on the four CCNE accreditation standards and included a range of 9–21 performance criteria that serve as a reference to indicate satisfaction of each standard. The ARS was updated by the DNP Project Leader to reflect the 2015 changes in the CCNE accreditation criteria. The ARS requires respondents to rate each criterion on a 5-point Likert scale (1 = *no capacity*, 5 = *optimal capacity*). Reliability and validity have not been associated with this survey; however, it was modeled after a comparable one used by Erwin (2009) to examine health department readiness to undergo accreditation (Franquiz & Seckman, 2016).

INTERVENTIONS

A mixed-methods approach was utilized to conduct the project and was consisted of two sequential stages according to the timeline. During Stage 1, CCNE NRP accreditation standards were communicated to the nine members of the NRP education team during a team meeting. Following the meeting, the DNP Project Leader electronically mailed the modified HORCT, via SurveyMonkey, to Sample 1. To enhance response rates, the survey was sent for

a second time 2 months after the first. Sample 1 was used to identify overall organizational readiness of the NRP education team to undergo CCNE accreditation.

During Stage 2, Sample 2, which was composed of a two-member self-study team (DNP Project Leader and NRP Manager Development), participated in a qualitative evaluation of the organization's current conditions and resources (actual state) compared to the four CCNE accreditation criteria (desired state). This involved three meetings led by the DNP Project Leader who was responsible for scheduling the meetings, organizing the agenda, guiding the self-study process, recording meeting minutes, and tracking goal progress.

The DNP Project Leader electronically mailed the ARS to Sample 2 prior to the self-study. During these three meetings, the self-study process included discussion of each of the accreditation criteria, evidence available, status of evidence (producible and complete), and development of an action plan for any reference criteria without adequate evidence. The first meeting involved orientation to structure, roles, and responsibilities of the self-study team and a review of the project timeline.

After each of these three meetings, the hand-written notations taken by the DNP Project Leader developed into minutes and were examined to determine the extent of discrepancy, if any, between the actual state and the reference point. The minutes were sent to the self-study team and presented at the beginning of each of the remaining meetings by the DNP Project Leader for review and/or revisions by the self-study team members. After the final meeting, the DNP Project Leader electronically mailed Sample 2 the ARS for a second time to compare preintervention and postintervention responses.

ANALYSIS
SurveyMonkey was used collect the quantitative data related to the modified HORCT. These data were entered into a defined data file in IBM SPSS Statistics for analysis. Data were verified via double data entry and screened via frequency analysis, which revealed no missing data and the data to be within expected score ranges. Inspection for outliers revealed five outliers on the preintervention HORCT and three outliers for the postintervention HORCT for Sample 1. No outliers were revealed for the modified HORCT results for Sample 2. Data analysis, both with and without the outliers, revealed no statistical significance.

Descriptive and nonparametric statistics were produced using IBM SPSS Statistics. Demographic statistics are reported for both samples. Sample 1 modified HORCT scores were used to determine organizational readiness to pursue NRP accreditation, with a median of ≥ 5 indicating a higher degree of readiness. Sample 2 modified HORCT scores were used to determine if there was a significant change in scores between pre- and postintervention using a Wilcoxon signed-ranks test. Sample 2 ARS results were used to determine accreditation capacity, with a median of ≥ 4 indicating a greater capacity. Results derived from the self-study were used to describe any discrepancy between the current program state and the CCNE NRP accreditation criteria.

ETHICAL CONSIDERATIONS
The project did not meet the criteria for Human Subjects Research; therefore, a Nonhuman Subjects Research determination was received from the appropriate institutional review boards on October 25, 2019, and November 25, 2019. All participants were informed that their participation was voluntary and that responses were anonymous.

RESULTS
Sample 1 included between six and seven members of the nine-member NRP education department team. The preintervention modified HORCT response rate was 7/9, and the postmodified HORCT response rate was 6/9. Demographics were obtained on 6/7 respondents. Sample 1 consisted of all White women, with the majority being greater than 59 years of age. The majority held graduate degrees (83.33%), with half working in their current position for at least 1 year but less than 3 years and the other half working over 5 years. Most of Sample 1 (66.67%) had been employed in nursing for greater than 20 years. Sample 2 consisted of two members of the self-study team who were both White women over the age of 30 years. All held graduate degrees, had been employed in nursing for over 15 years, and had been in their current roles for less than 1 year and greater than 5 years, respectively.

Phase 1—Organizational Readiness for Change
The preintervention modified HORCT combined score for Sample 1 revealed overall that the organization was somewhat ready for change associated with NRP accreditation (Mdn = 5, interquartile range [IQR] = 1.5), and for Sample 2, it was revealed overall that the organization was ready for change associated with NRP accreditation (Mdn = 6, IQR = 0). As depicted in Table 1, the highest rated organizational readiness dimension for both samples was appropriateness of accreditation (Mdn = 5.75, IQR = 0), whereas the lowest rated organizational readiness dimension was management support (Mdn = 3.75, IQR = 0). Findings for Sample 1 revealed a range in median scores between 2 and 7, with data dispersion of 0–5 based on IQR.

The lowest readiness for change score for Sample 1 (2) was the perception that accreditation will not make their jobs easier, and for Sample 2 (1), it was the perception of lack of senior leader commitment to accreditation. The highest score for Sample 1 (7) was the perception that the time spent on accreditation is valuable, and for Sample 2 (7), they were the organization will benefit from

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TABLE 1	Organizational Readiness for Change Scores (Holt Organizational Readiness for Change Tool)—Preintervention (Scale: 1–7)		
	Education Department (*n* = 7) Mdn (IQR)	Self-Study Team (*n* = 2)	Total
Appropriateness	5 (2.5)	6.5 (0)	5.75 (0)
Management support	4.5 (2.5)	3 (0)	3.75 (0)
Personal capability	5 (2)	6 (0)	5.5 (0)
Combined	5 (1.5)	6 (0)	5.5 (0)

accreditation, time spent on accreditation is valuable, there are legitimate reasons to pursue accreditation, accreditation matches the priorities of the organization, and the belief they could learn everything that would be required for accreditation.

Four of the 10 items in the appropriateness dimension indicated strong agreement that accreditation is appropriate for the organization. Three of the six items in the personal capability dimension indicated strong agreement that the educators believe they can participate in the accreditation process. There was a significant change, according to a Wilcoxon signed-ranks test, in perceived organizational readiness following participation in self-study meetings ($z = -3.457$, $p < .001$), with a strong correlation ($r = .8$). The median score on the modified HORCT scale for Sample 2 increased from preintervention (*Mdn* = 6) to postintervention (*Mdn* = 7).

Phase 2—Accreditation Readiness
Accreditation readiness was assessed by Sample 2 using the ARS. Prior to the three self-study meetings (preintervention), Sample 2 scores revealed agreement that the NRP had *significant capacity* to satisfy the CCNE criteria for accreditation. The respondents perceived *significant capacity* to meet three out of four accreditation standards and *moderate capacity* to meet the fourth. The highest perceptions were related to Program Effectiveness: Assessment and Achievement of Program Outcomes, whereas the lowest were related to Program Quality: Delivery. The range in median scores for the reference criteria was 1–5, with data dispersion of 0 based on IQR.

Following engagement in self-study meetings, final consensus of Sample 2 indicated that the NRP currently demonstrated *optimal capacity* to satisfy 52% of the reference criteria for accreditation (*n* = 26/50), *significant capacity*

to satisfy 30% of the reference criteria for accreditation (*n* = 15/50), *moderate capacity* to satisfy 16% of the reference criteria for accreditation (8/50), and *minimum capacity* to satisfy 2% of the reference criteria for accreditation (1/50). Criteria categorized as *no capacity, minimal capacity,* and *moderate capacity* to satisfy accreditation criteria were designated as gaps in accreditation readiness (*n* = 9/50), therefore requiring the development of a gap closure plan. There was no discrepancy between the actual and desired state Program Quality: Curriculum standard (*n* = 0/21), whereas the greatest discrepancy was present in the Program Quality: Institutional Commitment and Resources standard (*n* = 4/11).

SUMMARY
The purpose of this project was to assess the organizational readiness as well as the organization's current conditions and resources, compared to the four CCNE standards for NRP accreditation. This assessment of people, processes, structures, and ways of thinking will serve to inform the leadership at the project site the current state of organizational readiness that is present. The findings revealed the NRP education team is in a favorable state of readiness to change; the team members agreed that accreditation is beneficial, appropriate for the organization, legitimate, worthwhile, and consistent with the organization's priorities and viewed senior leaders as supportive, encouraging, and committed to accreditation. Minimal additional action by the NRP education team is needed to successfully initiate change.

In Stage 2, the self-study process revealed that the NRP has an 82% capacity to adequately meet the CCNE accreditation criteria. Criterion related to sufficient fiscal and physical resources was ranked among one of lowest accreditation criteria. Franquiz and Seckman (2016) recommended conducting a cost–benefit analysis to determine the anticipated return on investment and added value since accreditation is costly. The gap closure plan was discussed with the leadership team and will be used to increase the likelihood of a successful accreditation effort. Overall, these findings were consistent with the results collected from Franquiz and Seckman.

The key outcome of this project was the formulation of new knowledge regarding organizational readiness and capacity to satisfy CCNE NRP accreditation criteria. Attainment of this information served as an initial step toward a successful accreditation attempt and was consistent with the unfreezing stage of Lewin's change theory. According to Lewin's change theory, to attain the goal of NRP accreditation, the organization must progress to the changing stage. This project was the first of three steps needed to adequately effect change.

INTERPRETATION
This quality improvement project provided valuable information regarding assessment of organizational readiness

and benefits of a self-study to prepare an organization to undergo national accreditation of their NRP. Results of the modified HORCT favor readiness of the organization to initiate this process. The self-study revealed that the organization has significant capacity to meet the four CCNE accreditation standards. Because the lowest ranking scores on the modified HORCT were related to adequate fiscal and physical resources, notification of these findings to the leadership team was imperative to increase resource availability. Prior to increasing the allocation of resources, it was recommended that the leadership team conduct a cost–benefit analysis to determine the anticipated return on investment and added value. Plans for dissemination included this intervention.

LIMITATIONS

There are several limitations of this project that should be addressed in future research. First, the sample size was small, which reduced the power of the study and increased the margin of error. Second, there was a lack of prior research related to organizational readiness for NRP accreditation by the CCNE. Only one study had been published to date. Further research in this area of study is warranted. Lastly, one of the tools used, the updated ARS, had no established validity and reliability. Piloting and testing of the ARS will be needed to determine actual degree of validity and reliability of the tool. Despite these limitations, the information attained from this project is useful to the body of knowledge related to organizational readiness to undergo NRP accreditation by the CCNE and is consistent with comparable studies.

CONCLUSIONS

Benefits of both NRPs, as well as accreditation in the healthcare sector, have been well documented in the literature. According to Alkhenizan and Shaw (2011), evidence illustrated accreditation in healthcare sectors improved care processes, clinical outcomes, and therefore should be supported as a tool to improve the quality of healthcare services. Although the process to become accredited requires an assiduous effort, its proven benefits of increased quality and outcomes of care are unparalleled.

ACKNOWLEDGMENT

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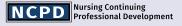
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