A Handoff Report Card for General Nursing Orientation

Linda Hargreaves, MSN, RN, PCNS-BC
Amy Nichols, EdD, RN

While redesigning nursing orientation, a gap in the transmission of information from general hospital to unit orientation was identified: Unit managers were unaware of the strengths and weaknesses identified in the nursing orientation of newly hired experienced nurses and, therefore, could not tailor the unit orientation to meet the specific needs of these orientees. The authors discuss the development and implementation of a nursing orientation report card, consisting of a 100-point score containing a summary of skills, knowledge, and Benner level measuring clinical performance and critical thinking, to facilitate better exchange of performance data.

When experienced nurses move to a new hospital or healthcare setting, they are required to complete general nursing orientation. The main purpose of this orientation is to help the nurse acclimate to the new clinical setting and learn about the professional expectations for nursing practice in the organization. The intent of nursing orientation at Lucile Packard Children’s Hospital (LPCH) is to provide the platform for nurses to offer outstanding patient- and family-centered care, exhibit excellent bedside skills, and demonstrate technical proficiency and competency with computer-based documentation.

There is a paucity of peer-reviewed literature describing the transition from general hospital nursing orientation to specific unit orientation. No model for seamless communication of nursing performance assessment from general to unit orientation exists to aid the leadership team in its appraisal of recently hired nurses. A formal, structured handoff of objective performance data regarding the orientee’s skills would assist those responsible for conducting unit orientation by identifying the areas for improvement that could then be addressed during unit orientation.

The need for communicating performance assessment from nursing orientation to the unit can be extrapolated from the literature identifying the importance of effective handoff communication. Failing to hand off pertinent information can result in a lack of knowledge of significant data or relevant actions that have occurred. Handoffs are recognized as essential for continuity and accuracy, and they facilitate the continuous flow of knowledge from one individual to another. An ideal handoff includes information about the individual’s experience and documentation of strengths and areas for improvement.

In addition, a handoff can identify potential areas of concern that would affect clinical nursing practice and patient safety. In this situation, a handoff from nursing orientation to the unit preceptor team can optimize the education and integration of a new nurse.

At most hospitals, the hospital orientation often covers the following topics: Health Insurance Portability and Accountability Act, mandatory compliance training, didactic training specific to the organization, and computer application training. Orientation may also include hands-on training, such as obtaining peripheral intravenous access or changing central line dressings. At LPCH, a 264-bed children’s hospital, nursing orientation has historically consisted of a 2- to 3-day general nursing orientation that included the topics mentioned previously and a 2-day...
intensive familiarization with the electronic medical record (EMR) followed by a unit-specific orientation (Table 1). Despite being responsible for the education and documentation of the newly hired nurse’s knowledge and skills, preceptors were rarely given specific information about prior performance during general orientation. This presented a tremendous opportunity to improve skills and enhance patient safety.

**Redesign of Nursing Orientation**

Before developing the handoff report card, LPCH formed a diverse group of RNs, managers, educators, and clinical nurse specialists to redesign general nursing orientation for the newly hired experienced RN. From a 30-member group, a smaller redesign subcommittee continued working to revamp nursing orientation. They determined that a program enhanced with simulation following didactic education ingrains knowledge and skills in addition to emphasizing team communication among the participants.

The redesign subcommittee restructured the general nursing orientation and combined didactic lectures with EMR documentation and scenario-based simulation including debriefing. The new design emphasizes that the nurse’s role includes clinical expert, collaborator, coordinator, and leader. The redesigned orientation for experienced RNs has transformed from didactic teaching to immersive hands-on learning (Table 2). The general orientation increased from 4 to 6 days over 3 weeks as the product of optimizing content and standardizing the process while incorporating innovative learning strategies. The first week concentrated on 5 content areas identified as necessary before entering the unit and included education presented with didactics and reinforced with simulation and debriefing. On the second week, orientees were oriented to their unit, and on the third week, the remaining 5 content areas were presented in the same manner as the first week. The hours committed to unit orientation vary depending on the unit and the expertise of the nurse.

While piloting the new nursing orientation for a group of experienced nurses, preceptors, assistant managers, and clinical nurse specialists, it became clear that developing a report card to hand off the orientee’s clinical skills and knowledge from general to the unit orientation was essential.

**Development of the Report Card**

The report card (Figure 1) is based on 3 assessments of the orientee: the orientee’s own self-assessment, the instructor’s assessment, and a competition of competencies.

**Self-assessment**

At the beginning of the first simulation day (Table 2), the orientees identify their own Benner level assessment, which allows the instructors to focus on the learner’s needs. This self-assessment facilitates the
scenario debriefing by adjusting the questions that reinforce the learning objectives for this specific composition of nurses. Orientee’s self-assessment includes the type of job the nurse previously held, a self-score on the Benner level of the past job, and an anticipated Benner level for the current job. A simplified Benner level criterion is provided to assist the orientee in self-identification (Figure 2).

**Instructor Assessment**

The instructor assessment includes 100 points on the report card, which quantitatively measures the knowledge and performance of the orientee (Figure 1). The instructor assessment is divided into 4 sections:

- 40-point critical behaviors as demonstrated in the scenario (component 1)
- 10-point Sweeney-Clark rubric (component 2)
- 25-point knowledge test (component 3)
- 25-point EMR evaluation (component 4)

This report card places the emphasis on behaviors and skills while still evaluating knowledge acquisition. An examiner familiar with the report card, the critical behaviors, and the Sweeney-Clark
Simulation Performance Rubric (Table 3) scores the clinical performance during test-out scenarios. Examiners completed interrater reliability (Figures 3 and 4) by scoring the critical behaviors (component 1) and the Sweeney-Clark rubric (component 2) to ensure consistency of scoring. The outlier scored on the test-out last scenario was explained by the examiner that the behavior observed would not meet the standard in the postpartum arena for escalation in reporting adverse symptoms (Figure 3). Seventy-five percent of the test-out scenarios were scored with less than 25% variability.

The first part on the instructor section of the report card begins with the critical behaviors scored on a 5-point Likert scale (component 1), that every orientee must demonstrate during the test-out scenario. Behaviors and skills are assessed using the specific components of the scenario and include patient assessment, history gathering, laboratory data and diagnostics, nursing interventions, clinical judgment, communication, and patient safety. The resulting critical behaviors’ score relates to clinical expertise and critical thinking.

The second part of the instructor section uses the Sweeney-Clark Clinical Simulation Performance Rubric (component 2), a validated assessment tool that was adopted to evaluate each orientee’s skills with patient assessment, history gathering, patient teaching, laboratory data and diagnostics, nursing interventions, clinical judgment, communication, and safety. The Sweeney-Clark rubric was originally developed for undergraduate nursing students’ performance in simulation and is based on the progression of a nurse’s skills. The Sweeney-Clark rubric is also used to categorize the nurse into one of the following Benner level of practice: novice, advanced beginner, competent, proficient, or expert. Identifying the Benner level of a nurse as her/his skills and knowledge grow from novice to expert provides essential information and assists with determining the needs for unit orientation as well as for staffing the unit.

In addition to assessing the critical behaviors and Benner levels of the orientee, the redesign subcommittee developed 2 knowledge tests. The third component includes the knowledge of policies, procedures, and specific practices (component 3) at LPCH and is available on paper or by using an audience response computer system that immediately scores the test.

The fourth component is a knowledge test that assesses the proficiency of the orientee in navigating the EMR (component 4) and is administered by an examiner who requests that the orientee demonstrate specific pertinent charting elements in the EMR chart at LPCH.

The data gathered from these 4 components of instructor assessment on the last day of general nursing orientation are integrated into the report card. Trials of the test-out scenarios and the report card were conducted before the initiation of the redesigned nursing orientation to determine efficacy as well as determine the point structure.

Competencies

In addition to the 4 components, there was a need to establish the competence of central line skills that each orientee must integrate to practice safely. Therefore, as a part of the orientation, 3 hands-on skills were validated and documented on the report card to ensure communication to the unit and reduce redundancy. These competencies were maintaining...
<table>
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<th>Category</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tr>
<td>Patient assessment</td>
<td>Doesn’t Yet See Picture</td>
<td>Sees Part of the Picture</td>
<td>Sees the Basic Picture</td>
<td>Sees the Big Picture</td>
<td>Anticipate the Changing Picture</td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Performs assessment with guidance/prompts</td>
<td>Distinguishes between abnormal and normal assessment findings</td>
<td>Recognizes changes in patient condition, intervenes appropriately and reassesses</td>
<td>Classifies relative importance of multiple assessment findings over time</td>
<td>Relates ongoing findings to potential complications; modifies plan and nursing interventions</td>
<td></td>
</tr>
<tr>
<td>History gathering</td>
<td>Recalls questions for basic history data with guidance/prompts</td>
<td>Discriminates between normal and abnormal history data</td>
<td>Uses understanding of disease process to focus questioning</td>
<td>Includes past medical history to develop comparison with current condition</td>
<td>Anticipates potential outcomes based on history findings</td>
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<tr>
<td>N/A</td>
<td>Seeks guidance to answer patient/family questions</td>
<td>Explains procedures to the patient/family</td>
<td>Rephrases medical information into lay terms for patient/family</td>
<td>Modifies patient teaching based on patient/family response and learning barriers</td>
<td>Identifies need and resources for further patient/family teaching; initiates multidisciplinary involvement</td>
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<tr>
<td>Laboratory data and diagnostics</td>
<td>Reports laboratory data</td>
<td>Distinguishes between normal and abnormal laboratory data/diagnostic studies</td>
<td>Uses understanding of laboratory values/studies to plan care</td>
<td>Analyzes trends in laboratory values; compares with patient response</td>
<td>Monitors patient response via analysis of laboratory data and examination; assists with plan for future testing</td>
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<tr>
<td>N/A</td>
<td>Performs simple, basic nursing care with prompts</td>
<td>Identifies active patient problem(s) but needs help in selecting intervention(s)</td>
<td>Implements appropriate routine nursing intervention(s) and evaluates effect; may delegate</td>
<td>Implements appropriate nursing intervention plan in timely manner; consistently delegates</td>
<td>Modifies nursing care by synthesizing evidence-based knowledge into practice; utilizes and/or conducts research</td>
<td></td>
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<tr>
<td>Nursing interventions</td>
<td>Recalls norms in patient condition</td>
<td>Recognizes variations in patient condition but needs help prioritizing; may access resources</td>
<td>Determines priorities in patient care based on varying patient condition; accesses appropriate resources</td>
<td>Carries out care while managing multiple contingencies in concert with healthcare team members</td>
<td>Devises plan to avoid complications; acts as resource when patient complications occur</td>
<td></td>
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<tr>
<td>N/A</td>
<td>Repeats basic information with prompting for documentation and/or report to physician and colleagues</td>
<td>Summarizes available information for documentation and discussion with colleagues and/or physician; may use standardized approach</td>
<td>Prioritizes available information for documentation and discussion with colleagues and/or physician; uses standardized form for handoff/report</td>
<td>Draws conclusions based on available information for documentation and discussion with colleagues and/or physician; uses standardized form for handoff/report</td>
<td>Synthesizes available information and possible patient outcomes for documentation and discussion with colleagues and/or physician; uses standardized form for handoff/report</td>
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catheter patency, central venous catheter dressing change, and blood sampling from a central venous catheter.

**Dissemination of the Report Card Findings**

To facilitate the dissemination of the report card information, unit leadership was invited to a presentation explaining all aspects of the report card. Leadership was provided with reference material to facilitate a standardized interpretation of this uncomplicated 100-point report card. The presentation also emphasized the goal of individualizing unit orientation based on the performance feedback contained in the report card.

**Outcomes**

The report card is handed off upon completion of nursing orientation promoting an unambiguous transfer of responsibility from nursing orientation to the unit leadership. This report card, used as a checklist of strengths and areas for improvement, is discussed with the orientee at the end of the last day of orientation. The instructor explains that the report card is one tool that conveys abilities to the leadership team so that orientation can be focused and that the report card is not a formal evaluation of performance. An electronic version of the report card is e-mailed to the leadership team for the unit and frequently includes a manager, a clinical nurse specialist, and a preceptor. Using an electronic copy further ensures that accurate information is conveyed directly to the involved individuals and is based on handoff strategies. An accompanying letter states that the purpose of this communication is to relay the current assessment of the orientee with the goal of customizing the unit orientation to enhance learning for the individual and ensure success. It is crucial that the report card information be conveyed to the preceptor because the preceptor is the individual responsible for the ongoing, daily focused assessment, teaching, and evaluation of the orientee.

During the trial period, 3 nurses who scored very low on the report card exhibited poor performance during unit orientation and eventually were relieved of their jobs during the probationary period.

**Conclusion**

Rarely before has general nursing orientation provided a standardized, multivariate, and evidence-based performance appraisal to the unit with a goal of individualizing the unit-based orientation. Identifying the report card scores for an individual allows the customization of the unit orientation for individual needs,
which should decrease teaching time and increase person-specific education and result in a more efficient unit orientation. Understanding which areas need improvement facilitates more rapid skill and knowledge acquisition because more time could be concentrated on those items.

One of the challenges while trialing the report card was determining the best way to collect all of the results and data and to deliver the information in a timely fashion. Scoring and completing the report card takes several minutes for each individual, making it a challenge for the instructors to give the results on the last day of orientation. We problem solved this by designating a specific individual who collates the test-out results, puts them into an electronic copy, and e-mails the report card to the unit leadership while an examiner discusses the report card results and implications with each orientee.

An additional challenge was the concern about the report card documentation. Although having a clear report about performance in orientation is beneficial, there is concern about scoring orientees’ abilities and whether it stands alone as evaluative criteria on job performance. The report card is not intended to be punitive or disciplinary and is expected to help identify areas to focus on during orientation to ensure success while embracing healthy work environment standards.9

Future progression of this project includes using the Sweeney-Clark rubric to rate nurses’ performance in the nursing units at the end of unit orientation as well as with ongoing periodic evaluation. Rating individuals at specific times during their orientation and employment will add consistency and reliability to an area that frequently is subjective. This rubric will also be used as a tool to identify nurses’ practice level for a new scheduling program that is based on the Benner levels of practice.

Further study includes identifying the correlation between poor performance in orientation and poor performance in unit orientation. The ability to predict individuals who may not meet the needs of the

Figure 3. Nursing orientation test-out scenario scoring. Validation of interrater Reliability: 6 different interrater observed the videotaped scenarios and scored them on the test-out score sheet. The interraters scored the first 3 scenarios with in G25Q difference in scores. One rater scored the final scenario 16 points below the average.

Figure 4. Sweeney-Clark rubric interrater scoring. Validation of interrater Reliability: 6 different interraters observed the videotaped scenarios and scored the Sweeney-Clark Rubric. The Inter-raters scored the first scenario, followed by additional teaching with a result of a G25% difference in scores for subsequent scenarios.
unit while still in the initial orientation process would be beneficial to any hospital.

The report card from nursing orientation is a novel, unique handoff tool designed to assist the unit leadership and preceptors customize unit orientation by using the assessment information on the report card. Unit leadership will be able to individualize unit orientation, which will optimize how quickly the orientee can adopt the skills and behaviors necessary to be a good fit with the needs of the unit. The orientee will experience a successful orientation which is individualized for them and designed for success.

References