Letter to the Editor

Re: "Desperately Seeking New Graduates with Specialized Expertise," editorial, 20(3), 2007

Dr. Pringle provides an excellent overview of the latest iteration of a long-standing issue for the profession – how to prepare nursing graduates for the demands of practice. Given that the projected nursing shortage is expected to be worse and more complex than past episodes of shortage, perhaps it is time that we collectively address the root causes of the problem.

In my opinion, we have not yet tackled fundamental questions, such as:

- Should we prepare for generalist versus specialist entry to practice?
- What is the definition of specialty practice, and what is a specialist nurse?
- Can there be a generalist nurse working in a specialty area of practice?
- How do we reconcile rural settings that require a "generalist–specialist"?
- What constitutes an effective and efficient transition from school to work?
- Is there any such thing as a basic entry-level context in the modern acute care setting?
- What is required for entry to practice in a high-acuity/specialty context?
- What is required for entry to practice in other sectors, such as public health and community nursing?
- What is the role of (a) the educator, (b) the nurse and (c) the employer in specialty practice readiness?

- What is the potential contribution of the practical nurse to specialty practice?
- Who should provide post-basic continuing nursing education (as distinct from graduate education), and how should it be structured for the new degree-prepared consumer?

Pringle mentions the list of Canadian Nurses Association (CNA) specialties as a starting point for identification of specialty practice types. The CNA certification programs are not designed to reflect entry to practice to a specialty; they are a validation of expertise gained through a mixture of CE and experience in the specialty. They are not linked in any way to formal education. The current list of required competencies outlined in the Critical Care Nursing Specialty Certification program, for example, are primarily skills-based and do not reflect the breadth of knowledge demanded of critical care nursing.

It should concern all of us that nurses in many Canadian jurisdictions are hired to practise in critical care units without formal educational preparation and that employers determine what educational preparation is to be provided – often on the basis of available resources and not necessarily on the competencies required. Sometimes these orientation programs are offered in-house, and they vary in length from two weeks to six weeks, suggesting a lack of standardization in content. Sometimes, local colleges are contracted to provide this education, but the length and content of the program are dictated by what the employer can afford to pay (often, the historic six weeks). Thus, the college is often limited to ensuring that the nurse can safely carry out technical tasks and interpret assessment data. Further, nurses who complete these programs are not eligible for an educational credential or transfer of credit.

Turnover in critical care units is high; employers lament that they have invested in an extensive orientation program, but the nurse still leaves within one year. Employers are caught in a cycle of recruiting, orienting and replacing that is costly in dollars, productivity and team stability, not to mention patient risk. Studies cited in the literature indicate that nursing turnover in critical care units is linked to moral and ethical distress, a feeling of not being sufficiently prepared, and poor team support. We are now seeing high attrition from the profession (not just from the practice setting) in the first five years following graduation. These facts point to the pressing need to do something different. There are jurisdictions in Canada that are doing a better job of preparing and retaining critical care nurses, but these jurisdictions have provincial government support for their programs and they are delivered by post-secondary institutions. Most of these programs are at least one semester of FT study in length. Most, however, still offer PT concurrent study in place of an entry-to-practice model.

I have focused on the critical care issue, but pressing need for better-prepared nurses has been identified in oncology, paediatrics, palliative care, emergency and trauma, and neonatal care, to name just a few. In addition, the high acuity and complexity of acute care inpatient units today have led some employers to suggest that we need post-basic education in acute medical–surgical nursing for the new graduate.

As a former member of a federal/provincial/territorial committee on health human resources and a former provincial chief nursing officer, I do not support pre-graduate specialization. We will need all the flexibility that we can muster in the nursing workforce to meet the demands of the projected shortage. It is likely that nurses will need to be educationally well prepared for entry to specialty practice, but we cannot afford to lengthen the preparation time beyond the current four years. Students will not pay for it and the system will not wait for it.

This is a complex issue. We must be vigilant about the risk of premature simplification of the problem and premature closure in selection of options for solutions. It is all too easy to fall back on old solutions. Pringle has made several viable suggestions, but entirely new strategies may be required for a brand new context. As Sr. Elizabeth Davis said in the *Toward 2020: Visions for Nursing* (CNA 2006):

> We're in a new place; we're not on the edge of the old place. We're not pushing the envelope; we're in a totally new envelope. So the rules have changed. Every fundamental premise of the old way of thinking no longer applies.

I applaud Dr. Pringle for suggesting that we may need a national task force on specialization in nursing and requirements for entry to practice. We need a broad-based consensus on how we can accomplish this in the current context. Perhaps with leadership from the Office of Nursing Policy, and participation by the CNA and its member jurisdictions, ACEN and CASN, we can begin to explore the true boundaries of this issue and to generate novel approaches to meeting the demands of practice, and the needs and expectations of patients for knowledgeable, skilled nurses.

Sincerely,

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