VOICE of nursing leadership

IN THIS ISSUE

SEPTEMBER 2026 NEW NURSES

Voice of the President

Ena Williams, 2026 president, AONL Board of Directors

One of the most important responsibilities we share as nurse leaders is preparing the next generation of nurses. Creating supportive learning environments that build clinical competence, critical thinking and professional identity is central to developing nurses who can provide safe, equitable and sustainable care.

Throughout my more than 40 years in nursing and 30 years in leadership, I am convinced that championing nurses is the core responsibility of nurse leaders. But we cannot do this work alone. Supporting new nurses requires partnerships across our organizations, collaboration with the communities we serve and engagement with policymakers to create environments where nurses can succeed.

I still recall my own experience as a new nurse. While we were supported by those who came before us, expectations were different. The pace of learning was different, and nurse leaders did not have access to the extensive resources, evidence and professional development opportunities that are available today to better understand and respond to the changing needs of the workforce. When I began my leadership journey, we often improvised support systems for new nurses because formal preparation was limited. We learned through experience, mentorship and a commitment to help others succeed.

"As nurse leaders, we have both the opportunity and the responsibility to shape the future of our profession. Let us continue to lead with purpose and wisdom, ensuring the next generation is prepared to move forward with confidence, compassion and excellence."

Today, we know more. Leadership has evolved into a recognized specialty, and nurse leaders can strengthen their effectiveness through evidence-based practice and professional development opportunities such as those provided by AONL. We have a deeper understanding of the factors that influence engagement, well-being and retention, particularly during the early years of practice. We know, for example, that Gen Z nurses require more meaningful interactions with their managers than previous generations to maintain the same level of retention. Research,

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AHA News

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AHA Events

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AONL education calendar

September 2026	
Healthcare Finance for Nurse Executives – Chicago	Sept. 10–11
Foundational Finance and Business Skills – Virtual	Sept. 10–22
Nurse Manager Institute – Virtual	Sept. 29 – Oct. 1
October 2026	
Certified Nurse Manager and Leader (CNML) Review Course – Virtual	Oct. 13 – Nov. 10
December 2026	
Emerging Nurse Leader Institute – Virtual	Dec. 3–4

Visit **aonl.org** for the latest information on AONL virtual, on-demand and in-person programs. Locations and dates are subject to change.

Celebrating Rural Health Month

November | Virtual

Throughout November, AONL will celebrate the nurse leaders advancing health and care in rural communities. Rural Health Month activities will include opportunities to learn from rural health leaders, explore innovative approaches to care delivery and workforce challenges, and connect with practical resources designed for rural settings. Programming includes live learning sessions, conversations with nurse leaders, podcasts and the launch of new microlearning content addressing topics such as leadership, workforce recruitment and retention, telehealth, safety, professional governance and community-centered care.

Join AONL in recognizing the ingenuity, resilience and essential contributions of rural nurse leaders and the communities they serve. Watch AONL communications for program details and registration opportunities.

Beyond Residency: Aligning Support for Early Tenure Nurses

Brian Burns, PhD, DNP, RN

Nurse residency programs have become a defining strategy for supporting newly licensed nurses as they move from student nurse into professional practice. These programs provide structure, connection, learning and validation during a period that can feel uncertain and overwhelming for the new graduate nurse. There is abundant research on nurse residency programs that has shown their ability to promote effective learning opportunities, skill acquisition and integration into the workplace. However, we must be careful not to mistake completion of such a program for completion of transition into independent professional practice.

Becoming a safe, confident and professionally grounded nurse takes longer than the six to 12 months covered in some residency programs. After the program ends, early tenure nurses continue to develop clinical judgment, prioritization, communication, delegation, ethical reasoning and professional identity. They are also exposed to the realities of workload, staffing strain, complex patient care and competing expectations. If the support structure fades too quickly, we leave nurses to navigate increasing responsibility without the developmental scaffolding they still need. This is the leadership challenge embedded in the question: What support structure is necessary beyond residency programs to provide safe, comprehensive and effective integration into the organization? The answer requires us to look beyond any single program and examine the broader environment that helps nurses remain, grow and belong.

Although research specifically examining post-residency support strategies remains limited, this gap should not stop nurse leaders from asking what structures may help early tenure nurses remain supported, engaged and committed to the profession. The strategies that follow are offered not as definitive solutions, but as practical areas for further examination, evaluation and research.

Transition to practice extends beyond residency

Transition to practice and nurse residency programs are important. They support safe learning, provide opportunities for reflection and help nurses begin to connect knowledge with practice. However, evidence suggests that formal transition programs alone may not be enough to produce durable improvements in well-being, job satisfaction, perceived organizational support or intent to stay. Eklund and colleagues found that nurses who completed transition programs did not differ significantly from those who had not completed such programs on their intention to leave the profession (Eklund et al., 2025).

That finding should not be interpreted as a rejection of residency programs. Rather, it should prompt nurse leaders to ask what happens next. The question is not whether the residency program is valuable. The question is whether the organization has created a transition ecosystem that continues after the formal program ends.

Early tenure nurses do not integrate into organizations through classroom content alone. Integration into the department and the team happens at the bedside, during handoff and during conversations at the nurse's station. It happens when nurses decide whether they feel safe asking for help. It happens when they learn whether their manager knows their name, whether their charge nurse will support them and whether their team views questions as learning or weakness.

If transition happens in everyday work, then everyday work must become the site of continued support.

Addressing the work environment

The early tenure period is a vulnerable point in the workforce pipeline. The recent AONL and Laudio Insights report shows that early tenure nurse turnover remains stubbornly high and occurs at nearly twice the rate of all tenure turnover across many specialties (Laudio Insights & American Organization for Nursing Leadership, 2025). The same report also highlights the importance of nurse manager span of control. Managers with larger teams may struggle to provide the visibility, coaching and individualized support early tenure nurses need.

This finding has practical implications for nurse executives. If manager connection is associated with retention, then protecting manager capacity is not optional. It is workforce infrastructure. We cannot ask front-line leaders to strengthen relationships, support psychological safety, monitor early warning signs, coach practice development and retain new nurses while also expanding their administrative burden beyond what is reasonable.

The AONL and Laudio Insights report found that manager check-ins at key intervals were associated with improved first-year retention (Laudio Insights & American Organization for Nursing Leadership, 2025). This is a simple but important reminder that early tenure nurses need to be seen. They need structured points of connection, not only during onboarding, but after the formal program concludes as well. For example, after the nurse residency program is complete

a 30-day or 45-day check-in may identify early adjustment concerns; a 6-month or 9-month conversation may reveal emerging stress, uncertainty or disengagement; a 12- or 18-month discussion may identify whether the nurse sees a future in the organization.

These check-ins should not function as performance reviews. There should be conversations where the nurse feels seen and heard. Nurse leaders may ask: What parts of your work feel manageable? What parts of the work feel unsafe? Where do you need more coaching? Do you have a sense of belonging on this team? What situations still create uncertainty? What would help you continue to be part of this team?

For leaders, these conversations also provide insight into the culture of the unit. Patterns in what early tenure nurses report can reveal where support is working, where risks emerge, and where unit-level redesign may be needed.

From task completion to role clarity

One risk in transition support is overreliance on checklists. Competency validation matters but completing a task is not the same as integrating into the professional role of the registered nurse. Early tenure nurses need to understand not only what to do, but how to think, communicate, decide, prioritize, delegate and advocate within a complex system.

Korkis and colleagues (2026) describe a transition-to-practice redesign focused on professional role clarity, role identity formation, systems thinking, readiness-to-practice indicators and structured preceptor support. Their work emphasizes that competent practice is not merely an individual skill set; it is the ability to enact the professional nursing role within a complex adaptive system. This distinction matters.

A post-residency support structure should include progressive role expectations. At 6 months, the goal may be consolidation of a typical assignment, timely help-seeking and recognition of common risks. At 12 months, the goal may include managing increasing complexity, strengthening delegation and participating more fully in team communication. At 18 to 24 months, the nurse may begin contributing to quality improvement, shared governance, peer support or specialty development.

This progression does not need to be rigid, but it does need to be visible. Early tenure nurses would likely benefit when expectations are clear and when growth is framed as normal professional development rather than as remediation. Role clarity allows feedback to become more specific. Instead of saying, "You need to improve time management," a leader may ask, "Describe how you are prioritizing competing patient needs, what cues are you using in prioritization and what prompts you to ask for support."

Building psychological safety, reflection into practice

Safe integration depends on psychological safety. Nurses must be able to say, "I am concerned," "I have a question," or "I need help." It must be clear to the nursing team that these statements are not signs of weakness. Instead, statements like these should serve as signs of professional accountability and patient safety awareness and should be framed that way for the early tenure nurse.

Leaders can create structures for reflection and debriefing beyond residency. These may include facilitated conversations after difficult cases, peer support groups, leader rounding focused on learning needs, or routine discussion of ethical concerns in unit-based forums. The purpose is not to create another meeting. The purpose is to make it normal for nurses to process the realities of practice with support from their nurse leaders.

Examining workload, flexibility and life fit

Nurses may leave practice early for many reasons, but workload and life fit cannot be ignored. Tate's qualitative study of RNs who left the profession within the first two years identified themes including being overworked, family obligations and lack of support from management. Tate also identified that some nurses might be willing to return to nursing if conditions were changed (Tate, 2024).This is an important leadership insight. Some nurses who leave may not be rejecting nursing itself. They may be rejecting the conditions under which they are asked to practice.

Support beyond residency must therefore include operational strategies, not only educational ones. Organizations should examine scheduling flexibility, self-scheduling processes, workload distribution, availability of rest and recovery, manager responsiveness and the fit between early career development and unit demands. If we focus only on knowledge and confidence, we may miss the underlying structural pressures that push nurses away.

This does not mean every organization can solve every workforce constraint immediately. It does mean nurse leaders should identify how these issues exist in their environment and evaluate what can be redesigned. Flexibility, workload sustainability and leader support are not separate from professional integration. They are part of it.

Studying why nurses stay

Nurse leaders need practical strategies now, but we also need stronger evidence. Too often, organizations measure residency completion and first-year retention without examining what drives retention of nurses after residency. Future work should focus on what drives nurses to remain in their respective units. This may help nurse leaders understand the role of psychological safety, perceived organizational support, ethical stress, professional belonging, confidence and workload sustainability on nurses' intent to remain in the profession.

We also need to study what works after residency ends. Which check-in intervals matter most? What forms of mentorship are most effective? How does manager span of control affect early tenure development? Which unit-based practices reduce moral distress? How do scheduling models influence retention? What support do nurses need in months 12 through 24, when formal transition structures often disappear?

These questions matter because the nursing workforce cannot be strengthened by recruitment alone. We must retain the nurses who have already chosen the profession.

Conclusion

Residency programs open the door to professional practice, but they are not the full structure required for safe and lasting integration. Early tenure nurses need continued connection, role clarity, psychologically safe learning environments, workload sustainability and leaders who have the capacity to support them.

This is the work of nursing leadership.

We must align programs, people, expectations and practice environments to ensure nurses are not simply onboarded but fully integrated into the organization. If we want nurses to remain in the profession, we must examine the conditions that help them develop, contribute and belong.

The next phase of workforce work should move beyond asking whether nurses completed residency. We should ask whether they are supported enough to stay. Continued research is needed to identify the post-residency structures that strengthen professional commitment, reduce preventable turnover and help nurses build sustainable careers in nursing. ◆

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AONL ROI Calculator Helps Leaders Make Business Case for Nursing

The AONL return-on-investment (ROI) calculator enables nurse executives and hospital leaders to turn nursing workforce investments into measurable financial outcomes by financially quantifying the impact of turnover and hospital-acquired conditions. Built in partnership with the Healthcare Financial Management Association using research-backed benchmarks, the ROI calculator translates span of accountability decisions or other nursing services investments into savings projections and long-term value. With just a few inputs, leaders can generate instant, customized ROI reports that strengthen business case development, support decision-making and demonstrate how nursing investments directly improve patient care. For more information, visit **aonl.org/resources/workforce/ROI-calculator**.

AONL Microlearning Hub Provides Concise Courses

AONL's new Microlearning Hub enables nursing leaders to explore short, practical learning strategies to strengthen their leadership skills. The resource, free to AONL members, offers concise, high-impact lessons that nurse leaders can complete at their convenience. Designed by experienced nurse leaders, educators and subject matter experts, the courses reflect healthcare challenges facing nursing leaders and offer practical strategies for immediate impact. The courses will help nurse leaders to build confidence, communication skills and stronger team relationships. AONL members can sign up to receive updates on new microlearning module releases. More information is available at **aonl.org/microlearninghub**.

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Blind Spots to Actionable Change: A Nurse-Led Strategy to Reduce First-Year RN Turnover

Summer Teel, MSN, MBA, RN, NE-BC
Lori de Celis, MBA

RN turnover continues to be one of the most pressing workforce challenges in healthcare, impacting not only our organizational costs but also patient care, staff morale and operational stability. While turnover overall is widely tracked, attrition within the first year of employment represents a uniquely disruptive phenomenon. Newly hired nurses require significant investment in recruitment, onboarding and training. When they leave early, that investment is lost and the resulting instability places additional strain on already burdened teams.

Strong, capable new nurses were leaving our organization for reasons that appeared both consistent and preventable. These included variability in onboarding practices, mismatched preceptor assignments, overwhelming patient assignments early in practice and challenges related to unit culture and support. However, these lived experiences were not clearly reflected in formal reporting systems, further widening the gap between data and reality. This disconnect underscored the need for a more unified, transparent and operationally relevant approach to understanding first-year RN turnover. To make this more challenging, we had just launched a new Human Resources Information System (HRIS) that was not fully integrated with all the pertinent data. Changes in systems, data definitions and programs can lead to discrepancies in historical comparison and may reduce confidence in the data. The focus then shifts from results to the accuracy of the data. This highlighted the importance of strengthening data collection and the employee's entire experience and culture, particularly in the critical first year.

Barriers

Despite the importance of first-year RN turnover, many healthcare organizations struggle to find a way to meaningfully address it. A primary barrier lies in the lack of a shared, standardized definition and a reliable data infrastructure. We discovered multiple interpretations of "first-year turnover" that existed simultaneously within the organization. Some defined it as any nurse leaving within 365 days of hire, while others measured it based on post-orientation timelines, fiscal year parameters, or unit transfers. Similarly, inconsistencies existed in which roles were included and whether internal movement was considered turnover. These discrepancies resulted in conflicting reports and prolonged debates over data accuracy, ultimately diverting attention away from the underlying issues driving turnover.

This lack of standardized definitions compromised data integrity and hindered the organization's ability to make timely, informed decisions. The absence of consistent framework also created ambiguity for stakeholders, reducing accountability and making it difficult to prioritize retention strategies. Without a single source of truth, leaders were relying on data that was fragmented. This delayed identifying and addressing emerging risks. Establishing clear definitions and strengthening the data is a critical first step to having more proactive and transparent management of first-year turnover.

Interventions

In response, a nurse-led initiative was launched to align definitions, integrate data sources and create a usable framework for leadership decision-making. The first and most critical step was the establishment of a single operational definition: First-year RN turnover was defined as any registered nurse who left within 365 days of their last hire date, measured within their assigned cost center. This definition provided clarity and allowed for consistent measurement across departments, creating a shared foundation for analysis and discussion. The level of clarity was critical for aligning managers and building trust in the data. A standard definition created a collective understanding across clinical, operational and human resources teams which allowed for more focus on the root causes rather than data discrepancies.

Once alignment was achieved, we worked on integrating multiple data sources to improve both accuracy and usability. Summary-level data from our HRIS system was combined with detailed termination reports to validate tenure and role classification. This information was then organized into a unit-level dashboard that allowed leaders to track turnover monthly, identify high-risk units and observe trends over time. For the first time, the organization moved from anecdotal perceptions to a clear, objective understanding of where turnover was occurring and how it was evolving. By equipping leaders with prompt and accurate information, we strengthened their ability to identify risks and intervene earlier than they had been due to lack of data clarity. This shift in understanding was a critical missing step to

build a more data-driven organization where talent decisions are transparent and consistent.

The findings from this data were both validating and revealing. First-year RN turnover was not evenly distributed across the organization; rather, it was concentrated within specific units, particularly those with higher acuity and reliance on pooled staffing. Moreover, patterns of turnover often emerged well before nurses made the decision to leave, suggesting that early intervention was both possible and necessary. This insight marked a turning point, shifting the organization's approach from reactive management to proactive retention strategies. These insights reinforced the importance of early and continuous engagement throughout the employee cycle, but most importantly in the first year of employment.

With this clarity, this enabled the leaders to intervene early and offer employee support and coaching to assist the new hire in the first-year transition. Leadership was also able to implement a series of targeted interventions aimed at addressing the root causes of early turnover. Onboarding processes were standardized across high-risk units to ensure consistency in expectations, structure and support. The preceptor model was strengthened through more intentional selection and reduced variability, recognizing that early clinical experiences significantly shape new nurses' confidence and engagement. Structured 30-, 60- and 90-day check-ins were reinforced to create formal opportunities for dialogue, allowing leaders to identify and address concerns before they escalated. In addition, efforts were made to stabilize patient assignments for new nurses, reducing exposure to consistently high-acuity situations without adequate support. Leadership visibility was also increased, particularly on off-shifts, reinforcing accessibility and commitment to front-line staff. Collectively this approach positions the organization and leaders to sustain long-term improvement and tools to continue to engage and retain staff.

Outcomes

Early outcomes from this work demonstrated meaningful progress. These outcomes emphasized the power of aligning data transparency with leadership accountability to drive meaningful change. Leaders gained greater visibility into unit-level performance, enabling more timely and targeted interventions. Leadership conversations evolved from questioning the accuracy of the numbers to exploring their meaning and implications. Instead of asking, "Are these numbers correct?" leaders began asking, "What is driving this trend and how can we respond?" By shifting conversations toward insight and action, greater trust, engagement and accountability flourished across the organization. Perhaps most importantly, the organization moved toward a more proactive approach to retention, focusing on early identification and prevention rather than retrospective analysis. These results highlight the value of consistent, transparent data in driving meaningful change, even when the data itself are not perfect.

Implementing this new initiative yielded first-year turnover results improved from 35.8% to 21.4%, which was a 14.4 percentage point decrease over one year. The number of first-year nurses increased from 89 to 118 nurses in the year, growing from 5.7% of the nursing workforce to 7.6%. The improvement supports greater workforce stability and positive progress in onboarding, engagement and retention effort.

This initiative also yielded several important lessons. First, clarity is essential; without a shared definition, meaningful action is not possible. Second, data must be operationally relevant, unit-level visibility is critical for engaging front-line leaders. Third, timing matters; patterns of turnover can often be identified before they result in separation, allowing for early intervention. Finally, the way data are used influences outcomes. When positioned as a tool for support rather than judgment, data can empower leaders and drive improvement. These lessons reinforce the role of data alignment, transparency and intention in driving workforce outcomes. By initiating and having clear definitions it allowed the leaders to have more timely information to move beyond reactive decisions and take a more proactive approach to addressing staffing issues.

Additionally, the transition between HRIS at this time introduced important considerations related to data integrity, continuity and interpretation. Changes in system data definitions and structures can create discrepancies in historical comparisons and may temporarily reduce confidence in the data. During the transition, differences in how turnover, tenure or employee classifications are calculated can lead to perceived shifts in trends that are not reflective of actual workforce changes. This reinforces the need for clear data and documentation between legacy and new systems. Proactively communicating these changes and educating leaders on how to use and interpret data during and after the transition is critical to maintaining trust. When managed effectively, an HRIS transition not only preserves data continuity but can also enhance reporting capabilities, improve data accuracy and provide deeper insights that further support strategic decision-making.

Conclusion

In conclusion, first-year RN turnover is more than a workforce metric, it is a reflection of organizational effectiveness, leadership practices and workplace culture. High early turnover often signals a breakdown of onboarding processes and support structures and the alignment of the first-year employee's expectations of the role and environment. Addressing first-year turnover requires more than improved reporting; it demands alignment, visibility, intentional action and sustained commitment to continual action across the organization, leadership and HR. As we continue to evolve our HRIS and integrate with other organizations, we expect to further refine how first-year turnover is defined and measured to ensure consistency and alignment across the enterprise.

We are finding that our growing need for data, insights and timely answers is increasingly outpacing the capabilities of our current health system technology. As leaders seek more real-time, actionable information to support workforce planning, patient care and operational decision-making, the limitations of our existing systems have become more apparent. Today's environment requires not only

access to data, but the ability to integrate, interpret and act on that data quickly and consistently across the enterprise.

In many ways, our technology infrastructure has not yet caught up to the demands of the future state of healthcare. However, fragmented systems, inconsistent data definitions and limited interoperability continue to create barriers to achieving these goals at scale. By establishing a unified definition, integrating data sources and implementing targeted interventions, this initiative demonstrates how organizations can move from fragmented understanding to actionable change. These efforts create a shared foundation that allows leaders to focus less on validating the accuracy of the data and more on tools for support and learning. It is important that emphasis is focused on the employee's experience, especially in the first year of practice. By centering the needs of new employees and giving leaders clear, tangible takeaways, organizations can move beyond the reactive responses to build more resilient, centered and high-performing teams. By providing clear data this approach improves retention and also strengthens culture and the delivery of high-quality patient-centered care.

The use of transparent, reliable and relevant data not only improves retention outcomes but also reinforces a culture of consistency, fairness and accountability. Ultimately, the guiding principle remains clear: You cannot fix what you cannot clearly see, but once you can see it, you must act. ◆

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Bridging Generations: Effective Communication During New-Hire Onboarding

Catherine Larson, MSN, RN, CNML

One of the standard expectations of nursing leaders is to effectively communicate and implement organizational priorities, strategic initiatives and mission-aligned behavior expectations while empowering staff to provide safe, culturally competent and excellent care. To ensure patient safety, consistent patient experience and improvements in clinical performance, frequent real-time feedback between nursing leaders and staff is essential.

There is a growing volume of literature regarding the differing communication preferences among the four generational cohorts currently in the workplace (Baby Boomers, Generation X, Millennials and Generation Z). Ensuring that messages are effectively communicated and understood becomes increasingly challenging when the leader's scope is broad. Each message is received simultaneously by a multi-generational audience who perceive styles of communication in vastly different ways.

There is no place where this tension is more fraught than with the onboarding of new hires, particularly new graduate nurses. The onboarding process is a carefully structured environment of organizational enculturation, precepted direct patient care experiences and multimodal education offerings. During this time, as the reality shock often experienced during the transition from student to practice nurse meets previously held expectations, real-time feedback is essential to growth. However, the formal and informal leaders providing onboarding are usually from a previous generation than the new hires.

This article reviews a neonatal intensive care unit (NICU) (*Figure 1*) leadership team's experience onboarding post-pandemic new hires (tenure <1 year) and the nuanced shifts in communication to ensure appropriate impact and reduced intention to leave. The unit standard had been to hire in cohorts, in conjunction with nursing school graduations in December and May.

The leadership team recognized that new graduates often bring enthusiasm, adaptability and a willingness to learn, creating opportunities to foster their growth within the unit's culture and practice environment. This NICU historically had a 16-week orientation process, which included 8 hours of weekly didactic from nursing leaders, neonatologists, neonatal nurse practitioners and senior NICU nurses. The initial day on the unit included two hours with the manager, during which the new hires would learn details about how the unit functioned, the chain of command, high reliability tools and tactics and unit expectations regarding performance and behavior.

FIGURE 1: A Neonatal Intensive Care Unit

Unit: Urban/suburban 61-bed Level 3+ NICU with ability to flex up to 86 patients.

Nursing staff: 250+ registered nurses, including specialist nurses for lactation, outcomes, perinatal accreditation, informatics, etc.

Unit leadership: 1 manager, 7 assistant managers, 1 Certified Nursing Specialist, 2 Nursing Professional Development Specialists, 1 Nursing Professional Development Generalist, 1 Therapeutic Listening Specialist, and 1 IT/Supply Analyst.

A shift in tone

In 2021, the NICU leadership team began to identify in new hires a lack of comfort in the hospital environment, reduced ability to converse with parents, knowledge gaps with basic nursing care and profound misunderstandings about the responsibilities inherently linked with employment. Many new hires spoke of virtual clinicals during the height of the pandemic, increased class sizes as nursing schools responded to the acute need for nurses, and for some, elimination of pediatric or neonatal clinicals. There was also an increase of NICU nurses leaving inpatient for ambulatory clinics at 1 to 2 years, which increased stress on senior staff consistently needed to care for high-acuity patients due to their clinical expertise, as well as the increased frequency of onboarding causing preceptor fatigue.

The situations below led to rapid cycle onboarding changes to ensure the new hires felt supported in their clinical practice and psychologically safe on the unit. As each situation coalesced, it became clear that the central challenge was the difficulty of sending, receiving and understanding feedback between generations.

Manager to orientee communication

Situation #1: Framing the First Year

In the initial meeting with new hires, the manager of the unit will discuss the challenges of the first year of nursing, followed by recommendations for self-care. This was to normalize the anxiety and fear prevalent as new nurses take on the immense

FIGURE 2: Types of Feedback Nurses Receive in the First Year of Nursing

Sender	Receiver	Type of Feedback	Details	Additional Considerations
Preceptor	**Orientee**	• Clinical guidance • Social enculturation	• Real-time • Received while expected to simultaneously accomplish physical tasks	• First experience with full responsibility of patient load • Often first experience in NICU acuity/ urgency can cause heightened emotions • The relationship with the preceptor, as well as the preceptor's standing amongst peers can markedly impact orientee experience
Leader Takeaways • Assess communication between preceptor and orientee daily. Is there a difference between the orientee and the preceptor's perception of orientee skill level and performance? How is the preceptor providing feedback? • A preceptor team made of varying seniority can prevent preceptor fatigue and provide orientee different methods of receiving clinical feedback. • Options to provide additional outlets for understanding unit culture and communication include providing another nurse as a "big sister/ brother" or utilizing informal leaders to help orientee connect with social opportunities on unit.				
Charge RN	**1st year RN**	• Clinical guidance • Leadership liaison	• Provide expectations about patient management • Guidance on families/ social situations • Expects updates on patient's clinical status & on heaviness/ appropriateness of assignment	• Informal leader, may be susceptible to gossip or other negative behaviors • Control over assignments • Resource for clinical questions & help Emotional support
Leader Takeaways • Formal leaders should continually assess new charge nurses. As informal leaders, they wield power and responsibility over clinical area in formal leader's absence. Ensure no opportunities in communication or favoritism with assignments. • Do a mock report to a charge nurse during orientation, so that regardless of preceptor, orientee understands key elements of charge role, information expected from the charge, and when to escalate to charge. • Explain chain of command in detail during orientation. (i.e., charge nurses can respond to real-time behavioral concerns among the staff, but the direct leader holds staff accountable.)				
Fellow nurses	**1st year RN**	• Clinical guidance	• Real-time • Expectation that new nurses will ask questions, not vice-versa	• Peer groups and cliques can impact clinical communication if lacking leader oversight • Layout of clinical area may limit input (i.e., lack of visibility into single patient rooms)
Leader Takeaways • New hires may be hesitant to approach fellow nurses. • Peers may be hesitant to provide clinical guidance unless asked, or obvious concern.				
Providers	**1st year RN**	• Education about pathophysiology • Expectations for direct care • Concerns about clinical status	• Formalized during rounds • Informal communication via phone/in person re: abnormal labs, change in clinical status, etc.	• Physician communication often more concise than nursing communication • Inpatient providers have more bandwidth on day shift than night shift (3 teams vs. 1 team) • May exhibit lack of patience with new staff if carrying heavy patient load
Leader Takeaways • Providers may be unfamiliar with new nurses and assume they are floats, agency, or PRN staff. Ensuring providers are aware that there are new staff coming off of orientation can improve bidirectional feedback by preempting concern. • Teaching & practicing Situation, Background, Assessment, and Recommendations (SBAR) communication for emergent and routine situations during orientation as a preferred method of communication with providers can increase brevity and specificity of communication between groups.				
Direct leader/ manager	**1st year RN**	• Performance • Behavior • Attendance	• Formal 1:1s & performance evaluations • Staff meetings • Huddles	• Differing views of hierarchy between generations
• Identifying respectful communication, preferred method of urgent and non-urgent communication, availability and what scenarios need escalation to a formal leader can help new nurses and leaders navigate this relationship.				

responsibility of independently caring for patients. In 2022, the nursing leader who facilitated hospital-wide orientation later informed the manager that the new NICU nurses were very upset and discouraged by the idea that the first year would be hard.

Resolution:

- **Service recovery:** The manager and the nursing professional development specialist met with the orientees that week to apologize for diminishing their excitement in their new roles and explained the positive intent behind the message.
- **Change to initial manager session:** Future cohorts received a brief comment about the stress of the first year, with more emphasis on the support available.
- **Unit change:** Increased emotional support, as new hires inevitably began to describe increased anxiety as they progressed through orientation and encountered increased acuity:
  - » Added a monthly voluntary "Rocking Chair Time" for new hires within the first year. Rocking Chair Time was a NICU tradition utilized to debrief difficult patient situations/outcomes with a small group of nurses/providers/staff and a leader certified in mental health. This version would allow the new hires to speak about concerns privately, with only themes going to management to help the leadership understand concerns and also protect the confidentiality and the psychological safety of the new hire.
  - » Added a "First Year Check In," in which the new hires could spend a half hour with leadership to discuss how they were feeling, as well as their goals.

Situation #2: Scheduling

Unit leader states to new hire, "You didn't put in your full schedule. I only see two shifts on X week." The new hire responds, "Oh, I didn't want to work three days that week." The new hire was very upset with leadership upon understanding the necessity to work their full-time equivalent (FTE) and the perceived complexity of the paid-time-off (PTO) process. Another new hire, despite being reminded over a series of months that she would need to work a holiday, ultimately refused to work said holiday by calling in.

Earlier cohorts previously held jobs as support staff or other employment prior to starting their first nursing job. The unit increasingly found that the new graduate nurses had never been employed before and usually still resided with their parents, reducing their understanding of job expectations and the financial necessity of following the rules to maintain safe staffing.

Resolution:

- **Change to initial manager session:** Discussion of FTE, hours necessary for schedule, associated benefits, and how vacation could be obtained in granular detail.
- **Change to orientation:** Included a mandatory meeting for all new hires to learn how to schedule and how to manage their timecards.
- **Unit change:** Increased transparency surrounding all scheduling: vacation process, call ins, floating, holiday assignments, etc.

Senior nurse to orientee communication

Situation #1: Nuanced Communication Goes Unrecognized

A unit leader met with a first-year nurse coming off night shift. Leader: "Some of the senior nurses overnight were concerned that your patient was desaturating throughout the night." The new hire confidently said, "Oh, that baby is just drifty." Leader: "What do you mean?" New hire: "Some babies just desaturate a lot." The leader paused. "So, unless we have done all the troubleshooting we can with oxygenation and ventilation with the physicians, it is not okay to let patients desaturate. End organs need oxygen."

The new hire became upset and said, "If everyone was so worried last night, why didn't anyone say something to me?" Also curious about this, the leader asked, "Did any of the nurses talk to you last night?" New hire: "They just kept coming by asking if the baby was okay, had I reached out to the resident and if I needed any help." The leader, finally understanding: "That was the nurses telling you."

It was apparent in this situation that the nurses' questions did not trigger any alarms in the new hire. The subtlety of repeated questions indicating concern was not concrete enough for the new hire to understand that her lack of intervention was causing concern that she was not providing the proper escalation of care.

Resolution:

- **Change to initial manager session:** An hour on feedback to expect during their time as a nurse on the unit, and what it would look and sound like.

Situation #2: Sink or Swim vs. a Careful Transition

Unit leadership received several concerns from the quality and safety leaders of the unit that the new hires felt they were receiving unfair assignments. The manager asked a few new hires how assignments had been since orientation, and some spoke of the fear they experienced receiving high-acuity patients on jet ventilators, while others said they had had a three-patient low acuity assignment for weeks, and hadn't had a patient on mechanical ventilation since orientation. Upon reviewing assignment sheets, there was an imbalance of which new hires were receiving high-acuity patients versus low-acuity patients.

Resolution:

- **Change to orientation:** Creation of a transition-to-practice "roadmap" of purposeful assignments that provided a gradual ramp up of acuity for new hires ending orientation.
- **Unit change:** Creation of a documented assessment of each teammate's skill level quantified and verified by all leaders on the unit to ensure growth of staff clinical skills. Levels included: orientee, transition to practice, novice, advanced beginner, intermediate, senior, and clinical expert. Moving between skill

levels included increased comfort with vented patients, cooling patients, as well as specific training, such as cardiac, micropreemie and extracorporeal membrane oxygenation (ECMO) training. Each direct leader was tasked with ensuring their direct reports were growing on the skill level during each 1:1, and the list was reviewed twice a year by the entire leadership team.

Unit perception of changes

The NICU leaders made every attempt to meet the new hires where they were at, sometimes to the detriment of senior staff opinion. For instance, while the new hires welcomed the Transition to Practice roadmap, the nurses on the unit, and even some of the leaders, were very polarized regarding the change. Many were vocal about how the only way to succeed as a new nurse was through the "sink-or-swim" approach and that the new hires would lose their acuity skills from orientation as they went through the roadmap. This led to a staff meeting in which leadership had bidirectional dialogue with the team that included a gentle reminder that the roadmap was only three weeks long, and if there was a more supportive way to onboard new hires based on advances in adult learning principles, it was an important change. This was a change that took a year to hardwire, partially due to resistance to the change, but also due to the size of the unit and the fluctuating acuity. Infrequently charge nurses found it difficult to make assignments to support the process, which was partially alleviated by the NICU quality and safety team reviewing the assignments daily.

The "first year check-ins" were also a topic of discussion on the unit, with the senior nurses making jokes during leader rounding like "I've been here for 20 years, and no one has ever checked on me," and "by the time I get checked on, I'll be dead." The new hires reported feeling supported and enjoying the sessions, so unit leadership opened the criteria for check-ins to all staff, but no additional nurses signed up. When rounding on the unit, one of the nurses summarized the lack of interest as, "No offense, but I don't want to be in your office. I was brought up to believe being in the manager's office is never a good thing."

Reflection

While the situations described can be seen as humorous misunderstandings between generations, those moments of uncertainty for the new staff affected their understanding of their roles, their confidence and their trust in the leadership team. Even after careful recruitment, it can be exceedingly difficult to retain staff if the message being sent is not being received in the same spirit it was sent. There is a genuine opportunity for leaders to take a step back and recognize that preparing new hires for the types of feedback they will receive can help them navigate their first year more successfully. ◆

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Shared Governance as a Foundation for Developing New Nurse Leaders

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Samantha Toth, BSN, RN, MEDSURG-BC

Sustaining nursing excellence requires the intentional development of future nurse leaders. At Atlantic Health System Newton Medical Center (AHNMC), shared governance serves as a structure for the development of leadership skills among new nurses, while promoting engagement, retention and professional growth (Green et al., 2024). AHNMC is a 148-bed acute care community hospital located in rural northwestern New Jersey. The organization has maintained Pathway to Excellence® designation from the American Nurses Credentialing Center since 2017, achieved its first Magnet® designation in May 2025 and earned Practice Transition Accreditation Program (PTAP) accreditation in March 2025. Sustaining these distinctions requires strong organizational and departmental structures that promote staff shared decision-making, staff engagement and a healthy work environment.

The medical-surgical department at AHNMC exemplifies these principles through a robust shared governance structure that empowers clinical nurses to partner with formal nursing leaders in shaping practice, improving outcomes, and bringing the team together as a community of caregivers. The department is a 69-bed unit with an average daily census of 56 patients and is supported by a leadership team consisting of a nurse manager (1.0 full-time equivalent [FTE]), assistant managers (3.6 FTEs), and a unit educator (0.8 FTE). The department's unit-based Shared Governance Council (UBC) meets monthly and is co-led by two clinical RNs.

Clinical nurses are taught that discharge planning starts at hospital admission. Similarly, the development of the next generation of leaders begins the moment they are hired. This is the lived experience of nurses hired to the medical-surgical department at AHNMC. The leadership team, led by a transformational nurse manager with over 25 years of experience, is committed to creating an environment where all team members are empowered to contribute, grow professionally and develop leadership capabilities. Shared governance is a key mechanism for achieving these goals.

Supporting new nurses through shared governance

Nurses joining the medical-surgical department arrive with a variety of clinical backgrounds. Some are new graduate RNs (NGRNs), while others transition from different levels of care within AHNMC, other hospitals, or long-term care settings with limited acute care experience. A critical component of this transition process is fostering a sense of belonging and engagement from the outset. One strategy used to facilitate assimilation is encouraging attendance and participation in the UBC. Through involvement in shared governance, new nurses gain an understanding of how decisions are made, how they can influence practice and how their contributions can shape the culture and success of the department.

Reducing turnover through engagement, professional growth

Retention of NGRNs through their first two years of practice remains a significant challenge for healthcare organizations (Clement & Chappel, 2026). The orientation processes utilized by the medical-surgical department address new nurse needs identified in a scoping review by Clement and Chappel (2026), including transition success, clinical and psychological readiness, professional role identity, professional growth and psychological functioning to respond to workplace demands and the work environment.

To support a successful transition to practice and reduce turnover, all AHNMC NGRNs participate in a comprehensive yearlong nurse residency program. AHNMC recognizes that attributes such as confidence, comfort, teamwork, psychological safety, professional growth, autonomy, inclusion, engagement and well-being are critical to new nurse success and long-term retention. Several of these concepts, including confidence, comfort, engagement and well-being, are formally assessed periodically through the first year of employment.

Structured orientation meetings provide opportunities for open dialogue regarding professional development, well-being, belonging and ongoing support needs. These conversations occur throughout orientation and continue through informal meetings with nursing leadership, mentor interactions, and participation in the nurse residency program. NGRNs also engage in group mentoring sessions that foster peer support and professional growth. To strengthen a sense of belonging, engagement and commitment to the unit and organization, unit leadership partners with preceptors to coordinate new nurse

TABLE 1: Shared Governance Leadership Progression Aligned with the AONL Competencies

Professional Practice Timeline	Shared Governance Opportunity	AONL 2026 Core Domain	*Developing* Relevant AONL Subdomains
0–1 Year	Unit-Based Council (UBC) Attendance; Project Participation	Leader Within	Reflective Practice & Foundational Thinking; Career Development; Personal Well-Being
		Professionalism	Professional and Organizational Accountability; Disparities in Care; Governance
		Communication & Relational Management	Effective Communication; Relationship Management
		Knowledge of the Healthcare Environment	Evidence-Based Practice and Innovation
1–2 Years	Project Participation; Serve on Committees; Engage in Clinical Ladder Activities	Leader Within	Reflective Practice & Foundational Thinking; Career Development; Personal Well-Being; Innovation and Entrepreneurship; Relationship-Centered Leadership
		Leadership	Courageous Leadership; Transformation & Innovation
		Professionalism	Professional and Organizational Accountability; Disparities in Care; Governance
		Communication & Relational Management	Effective Communication; Influencing Behaviors; Relationship Management
		Knowledge of the Healthcare Environment	Evidence-Based Practice and Innovation; Quality, Safety, & Improvement Science
		Business Skills & Principles	Workforce Leadership and Optimization
Beyond 2 Years	UBC Co-Chair; Hospital-Wide Council Chair; Health System Shared Governance Participation; Health System Council Chair	Leader Within	Reflective Practice & Foundational Thinking; Career Development; Personal Well-Being; Innovation and Entrepreneurship; Relationship-Centered Leadership; Professional Identity
		Leadership	Courageous Leadership; Transformation & Innovation
		Professionalism	Professional and Organizational Accountability; Disparities in Care; Governance; Advocacy
		Communication & Relational Management	Effective Communication; Influencing Behaviors; Relationship Management; Psychological Safety; Interprofessional Collaboration
		Knowledge of the Healthcare Environment	Evidence-Based Practice and Innovation; Quality, Safety, & Improvement Science; Practice Oversight; Economics & Policy; Community & Population Health; Digital Health, Informatics, & AI Leadership
		Business Skills & Principles	Workforce Leadership and Optimization; Strategic Management; Financial Management

AONL, 2026.

attendance at medical-surgical UBC meetings and at least one hospital-level shared governance meeting during their first year of practice. In 2025, the national RN turnover rate was 17.6%, while turnover among medical-surgical nurses was slightly higher at 18.1%, equating to a retention rate of 81.9%. These findings highlight the ongoing challenge of nurse retention and underscore the importance of targeted strategies to support early career nurses and strengthen workforce stability (NSI Nursing Solutions, 2026). Since the implementation of the UBC engagement strategy in 2022, the department has sustained an RN retention rate of 96.8%.

"The Unit-Based Council was instrumental in my leadership development as well as showed me how my nursing leaders implement changes as well. It provided a supportive, safe environment where I could build confidence, develop my voice as an advocate for nursing practice and lead initiatives that improved our unit and organization. My involvement in UBC helped me recognize the impact a nurse can have in shaping the future of patient care and professional practice."

— Kyle Romanelli, RN, MEDSURG-BC

The Unit-Based Council as a leadership development structure

The Medical-Surgical UBC operates through an open membership model, allowing all staff members to participate. The council is co-chaired by two clinical nurses and facilitated by the unit educator. The unit educator serves as a mentor to council leaders, guiding agenda development, project management, follow-up processes and effective meeting facilitation. Council chairs receive coaching on leadership skills such as conflict resolution, maintaining productive discussions, managing competing priorities and addressing off-topic concerns. The facilitator also collaborates with UBC co-chairs to escalate issues requiring nurse manager support and helps connect them with appropriate stakeholders throughout the organization.

The support provided by the unit educator as UBC facilitator creates an environment in which nurses can develop leadership competencies while learning how organizational systems and decision-making processes function. Participation in shared governance allows nurses to step away from bedside care and begin developing systems thinking, organizational awareness, professional autonomy and leadership self-efficacy. Through active involvement in decision-making processes, nurses gain experience influencing practice at both the unit and organizational levels.

Unit-based council participation

Participation in the UBC provides nurses with a meaningful opportunity to influence unit operations, patient care, staff engagement and workplace culture. New nurses quickly learn that the success of the department is directly influenced by the involvement and leadership of front-line staff. Council discussions may focus on operational processes, scheduling practices, patient care initiatives, staff recognition and performance improvement opportunities. New nurses are encouraged to identify challenges and develop projects that improve patient outcomes, unit function, team morale and staff engagement. Whether working independently or collaboratively, nurses receive support from other UBC members, UBC co-chairs and unit leaders as they develop projects and implement their plans.

One example of a successful UBC initiative was the creation of the unit's Fun Club, a subcommittee dedicated to fostering engagement, supporting community outreach and promoting staff well-being. The Fun Club organizes a variety of activities throughout the year, including potluck events, themed scrub days and ice cream socials. Community-focused initiatives have included donations to local animal shelters, food drives and support for local nonprofit organizations serving asset-limited, income-constrained employed individuals and families. To promote team well-being, the committee sponsors interdisciplinary outdoor activities such as biannual hikes and bicycle rides. As new nurses recognize the autonomy they have to influence their work environment, many become increasingly engaged and motivated to assume additional leadership responsibilities.

"Being a part of unit-based council has been a great way for me to bring my past experience to Atlantic Health. In council, we develop our team-building skills (fun club), create a space that supports our community through donations/volunteerism and develop our best professional selves. I can say that through UBC, I have personally and professionally grown in my practice and am excited to see what my future brings!"

— Catherine Mandara, RN, MEDSURG-BC

Shared governance and clinical advancement

AHNMC utilizes a registered nurse clinical advancement ladder that is standardized across Atlantic Health System hospitals. Key elements of clinical advancement portfolio submissions include demonstrations of professional engagement and leadership, and contributions to the clinical practice environment. Participation in UBC initiatives provides nurses with opportunities to advance on the clinical advancement ladder.

"Unit-Based Council helped me develop my voice as a nurse leader and gain confidence in leading change. Serving as a UBC Chair provided me with opportunities to advocate for staff and patients, lead quality improvement initiatives, and collaborate with interdisciplinary teams to improve outcomes. The leadership skills and confidence I gained through Shared Governance inspired me to take on additional leadership roles." — Luz Parris, BSN, RN, MED-SURG-BC, GERO-BC

Developing future nurse leaders

The UBC also serves as a pipeline for future nurse leaders. Generally, during the first year of practice, nurses attend shared governance meetings, participate in projects and begin developing organizational awareness (Table 1). During the second year, many assume greater responsibility through participation in projects, serving on committees and engaging in clinical ladder advancement activities. As the RNs' experience and confidence increase, nurses are encouraged to pursue leadership opportunities such as serving as UBC co-chair, charge nurses and preceptors. Through mentorship and support from unit leaders, nurses gain confidence in navigating organizational processes, identifying key stakeholders and advancing practice initiatives. As nurses become more engaged in shared governance, they often pursue additional leadership opportunities such as serving as a hospital-wide council member or health system shared governance representative.

Nurses who began their leadership journey through the medical-surgical UBC have advanced to leadership positions within the organization, including assistant manager roles. Shared governance participation has also created opportunities for professional growth beyond the organization. Nurses have been sponsored to attend national conferences, where they have identified innovative practices and products that have subsequently been evaluated for implementation at AHNMC. For example, a former UBC co-chair who attended the ANCC Magnet and Pathway Conference introduced a product identified during the conference that was ultimately reviewed through the Atlantic Health House Value Analysis Council for potential adoption. Similarly, another former UBC co-chair was selected to serve as a Magnet escort during the organization's Magnet site visit, demonstrating the confidence, professionalism and leadership presence cultivated through shared governance involvement.

Shared governance participation provides a developmental pathway that aligns with the 2026 AONL Nurse Leader Core Competencies. Early engagement cultivates communication, accountability, and organizational awareness. Intermediate participation continues the leadership competency growth initiated in the early phase, but adds the concepts of modeling, influence, innovation, governance and relationship-centered leadership. Advanced shared governance involvement develops systems thinking, strategic management, quality improvement expertise, team leadership and business acumen. This progression prepares clinical nurses for increasing leadership responsibility and influence while strengthening shared governance across the organization.

Conclusion

Engaging nurses in shared governance opportunities early in their careers provides meaningful opportunities for leadership development (Green et al., 2024). Through active participation, mentorship and involvement in decision-making, new nurses develop the confidence, skills and professional identity necessary to become influential leaders within their unit, organization and profession. By ensuring that every team member has a voice, opportunities to lead and a meaningful role in driving improvement, the council cultivates both professional growth and a strong sense of community. For the medical-surgical leadership team at AHNMC, engaging nurses in shared governance early in their careers provided a strategy to develop future nurse leaders while also strengthening engagement, retention and professional practice. ◆

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Improving NICU Nurse Retention Through Therapeutic Listening, Strategic Preceptor Pairing and Structured Professional Development

Christina Banialis, MSN, APRN, PMHNP-BC

Following the COVID-19 pandemic, many neonatal intensive care units (NICUs) experienced significant nursing workforce challenges. During 2022-2023, Advocate Children's Hospital's 61-bed Neonatal Intensive Care Unit-Oak Lawn (NICU-OL), faced increased new hire nursing turnover, extended leaves of absence among experienced nurses and the need to rapidly onboard newly hired nurses. Many of the new hires were new graduates from nursing schools, contributing to a decrease in experience and seniority among NICU staff. Over a four-month period, nursing leadership was tasked with hiring 34 new NICU nurses in the spring/summer of 2023 to maintain safe staffing levels. At the same time, preceptor fatigue and burnout increased as experienced nurses balanced patient care responsibilities with the demands of orienting several novice nurses.

Approximately 100,000 registered nurses left the workforce during the two years following COVID-19 pandemic due to stress, burnout and retirements. The challenge was compounded by national nursing migration trends. Increased starting salaries and travel nursing opportunities resulted in higher turnover among first-year nurses, making retention a priority. Leadership recognized that successful onboarding required more than clinical education alone. New nurses needed meaningful relationships, individualized support and opportunities to build confidence within a high-acuity environment. To address these challenges, the NICU implemented a multifaceted retention strategy focused on therapeutic listening, intentional preceptor matching, structured education and ongoing support after orientation.

Therapeutic listening and strategic preceptor matching

The first component of the retention strategy focused on intentional matching of new nurses with preceptors. Rather than assigning preceptors based solely on scheduling availability, the leadership team sought to create educational partnerships that aligned learning styles, communication preferences and personality characteristics.

This process began during recruitment. Leadership intentionally hired a diverse group of nurses whose backgrounds, experiences and personalities would complement the variety of teaching styles already present within the unit. During the interview process, a Therapeutic Listening Nurse Specialist participated in candidate evaluation and assessed factors such as communication style, previous experiences, learning preferences, professional goals and personal interests.

The Therapeutic Listening Nurse was uniquely qualified for this role because of their extensive involvement within the NICU and their familiarity with the personalities, strengths and teaching approaches of current staff members who would act as preceptors for the new nurses. This knowledge allowed for thoughtful pairing of new hires with preceptors who were most likely to support successful learning experiences and unit integration.

Following hiring, the Therapeutic Listening Nurse Specialist met with new nurses to further assess interests, learning needs, self-care practices and professional goals. Additional meetings were conducted with preceptors to prepare them for teaching their assigned orientees. Throughout the 16-week orientation period, the Therapeutic Listening Nurse Specialist and educational team regularly checked in with both preceptors and new nurses to identify concerns, address communication barriers and resolve potential educational needs early on. This ongoing support allowed both parties to focus on learning and professional development while strengthening the overall orientation experience.

Structured orientation and didactic education

The second component of the retention strategy involved a structured educational curriculum originally developed in 2018 by a multidisciplinary team of nursing education and leadership experts. The curriculum was designed to support the transition from novice nurse to competent NICU clinician through a combination of classroom learning and hands-on experiences.

During the first 10 weeks of orientation, newly hired nurses participated in weekly didactic classes covering essential NICU concepts and clinical skills. These sessions incorporated simulation, equipment demonstrations and hands-on practice opportunities that allowed participants to learn in a safe environment before independently caring for patients.

The educational approach emphasized active learning and encouraged participants to ask questions, make mistakes and

develop critical thinking skills without fear of judgment. This structure was particularly beneficial for new graduate nurses who were transitioning from academic settings into highly specialized and complex clinical environments. By combining theoretical knowledge with practical application, the curriculum helped increase confidence, competence and readiness for independent practice.

Rocking Chair Time

Recognizing that the transition to practice extends beyond formal orientation, the NICU developed a post-orientation support program known as Rocking Chair Time. The name reflects one of the most meaningful aspects of NICU nursing—rocking infants to provide moments of comfort and connection. Similarly, the program was designed to provide a supportive space for new nurses as they transitioned into independent practice.

Rocking Chair Time consists of six facilitated sessions with the Therapeutic Listening Nurse Specialist beginning approximately one month after orientation completion and continuing through six months post-orientation. The sessions allow nurses to discuss challenges, share experiences and receive guidance from peers and leaders who understand the demands of NICU practice.

Topics include integration into a high-functioning team, communication with providers and colleagues, professional confidence, stress management, resilience and navigating challenging clinical situations. The sessions provide opportunities for reflection, mentorship and peer support while reinforcing the organization's commitment to new nurse success.

To evaluate the effectiveness of the program, participants complete pre- and post-program surveys that assess comfort levels, stress, confidence and overall transition experiences. Survey results help leadership identify opportunities for improvement and provide additional support to team members or the entire cohort of new nurses when needed.

Ambassador program

To compliment the Rocking Chair Time, the Therapeutic Listening Nurse Specialist recruited a team of 15 nurses with 1 to 7 years of NICU experience to serve as ambassadors to our new nurses. The ambassadors received a training session on communication, confidence building strategies and work-life balance teaching. The role was supported within the organization by allotting a resource RN for night shift to assist with check-ins of new nurses. The ambassadors also organized several welcome events to encourage integration of the new team members into our unit culture. Ambassadors-themed programs such as a Christmas cookie exchange, a soup-off (best soup competition) and a hot chocolate bar were centered around fellowship.

The Ambassador program not only provides mentoring and assistance to our new nurses. Becoming an ambassador has been a positive way to provide opportunities to our staff nurses that are seeking ways to gain involvement in our NICU. An analysis study published in 2023 noted younger, less-experienced nurses had unprecedented level of burnout during the pandemic contributing to the cycle of turnover (Martin et al., 2023). Many of the ambassadors are interested in becoming a charge nurse or preceptor but require more NICU experience for those roles. Keeping these nurses deeply embedded in meaningful work has improved retention of our 1–5-year nurses. Ongoing professional growth of younger nurses helps prepare them for a preceptor role earlier by providing opportunities to improve communication and mentorship, thus allowing the senior nurses a break from the orientation cycle sooner.

Outcomes

The retention strategy has produced encouraging results. In 2025, the NICU-OL had 20 new nurses complete orientation. All 20 new nurses are working in the NICU today resulting in a retention rate of 100%. These outcomes are particularly significant given ongoing workforce challenges and the complexity of specialty nursing practice.

Survey data collected through Rocking Chair Time demonstrated positive perceptions among participating nurses, with 88% of participants reported feeling very comfortable in their role within the NICU. In addition, 12% reported feeling somewhat comfortable. Importantly, no participants reported feeling uncomfortable in the NICU or in their role at the completion of the program. These findings suggest that ongoing mentorship, structured support and intentional relationship building contribute to successful transition and professional confidence. After completion of Rocking Chair Time one new nurse stated, "Rocking Chair's supportive environment allowing me time to discuss challenging days with my peers and receive real-time, practical strategies for decreasing stress that has helped me build my confidence."

Additional organizational outcomes have also been observed. As of June 2026, all budgeted nursing FTE positions have been filled, and the unit has not required additional hiring during the summer months. Historically, this period represented one of the highest-volume recruitment seasons due to turnover and staffing vacancies. Achieving full staffing during this traditionally challenging period suggests improved workforce stability and retention. Lower turnover rates translate to a financial savings for a hospital organization of $313k per 100 nurses (Pascale et al., 2026).

Conclusion

Improving nurse retention requires a comprehensive approach that begins during recruitment and extends well beyond orientation. Through therapeutic listening, intentional preceptor matching, structured educational programming and longitudinal support, our NICU in Oak Lawn created an environment that promotes belonging, confidence and professional growth among newly hired nurses.

The positive retention outcomes, high levels of reported comfort among participants and achievement of full staffing demonstrate the potential impact of investing in individualized support throughout the transition-to-practice process. As healthcare organizations continue to address workforce shortages and increasing clinical complexity, strategies that emphasize relationships, psychological

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HOT TOPICS

Affirming Nursing's Covenant: Clarifying the Architecture of Nursing Professional Governance

Tim Porter-O'Grady, DM, EdD, APRN, FAAN

Conversations with chief nurse executives, published case reports and leaders' accounts of navigating mergers, staffing shortages, pandemic surges and emergency responses reveal a recurring pattern. Nursing professional governance increasingly is described as a collection of principles that can be incorporated into traditional organizational structures rather than as a decisional framework in its own right. Leaders speak of bringing the tenets of professional governance into an existing command framework, a transition plan, a quality initiative or a new service line. The intention is honorable and the language is hopeful. Yet this framing often obscures the true nature of nursing professional governance (NPG).

Having worked on the development of professional governance frameworks for more than four decades, I have come to recognize this inversion as the most common and most consequential misunderstanding we encounter in the field (Porter-O'Grady & Clavelle, 2021; Start et al., 2024). It is not the error of any single author or institution. It is a conceptual gap distributed widely across the profession, reaching into the executive suite, the academy, the American Nurses Credentialing Center (ANCC) Magnet Recognition Program® and the literature itself. Many chief nursing officers who genuinely champion nursing governance and invest in its structures have not yet demonstrated a complete understanding of NPG's theoretical and structural foundations. The result is well-intentioned but incomplete: governance embraced as philosophy, not yet operationalized as decisional architecture. This observation is not a criticism of any leader. It is a call to deeper developmental investment in what NPG requires of every level of nursing leadership.

Governance as structure, not supplement

The framing most frequently encountered in the field positions professional governance as a collection of principles to be integrated into other frameworks. The question asked is, *How do we incorporate governance tenets into this work?* The assumption embedded in that question, however, inverts the essential relationship. In a mature NPG environment, the question is not how governance tenets enrich existing organizational structure but rather how the professional accountability structure that already governs nursing practice adapts its own processes to meet the demands of a given circumstance (Porter-O'Grady & Clavelle, 2019). The locus of authority is what matters here. In the first framing, governance serves a separate coordinating structure. In the second, governance remains the organizing framework, with operational coordination managed through appropriately streamlined processes that report to, and remain answerable within, the professional accountability architecture.

This is not a semantic distinction. It reflects fundamentally different understandings of where decisional ownership resides, where accountability is located and how the profession's covenant with the community it serves is actually exercised.

Participation is not ownership

One of the most instructive markers of this misunderstanding is the vocabulary that accompanies it. Leaders describe *adaptive and participative decision-making*, *shared accountability*, *structural empowerment*, *closed-loop communication with staff* and *feedback mechanisms from the front line*. These are genuine management virtues, and they reflect leaders who respect their teams. But participation is not ownership. Being invited to provide input is not the same as bearing the obligation and authority to decide. In a true professional governance model, staff professionals do not merely inform the decisions of those above them; they own the decisions that fall within their defined scope of practice, quality/value, competence, and knowledge (Porter-O'Grady & Clavelle, 2021; Start et al., 2024).

The language of *shared* decision-making belongs to the early shared governance models of four decades ago, models that were an important step forward in their moment but that the field has been working to mature beyond ever since. The contemporary professional governance framework is organized around ownership, not participation; around obligation, not permission; around accountability, not delegation (Porter-O'Grady & Clavelle, 2019). When leaders describe their governance work predominantly in the vocabulary of participation and shared input, it signals that the underlying structure has not yet moved from engagement to ownership. This distinction is intended as diagnostic observation, not criticism.

Operational and professional decisions are not the same thing

A further and consequential gap in how NPG is frequently described concerns the absence of any clear distinction between operational decisions and professional decisions. In any organization, particularly under conditions of pressure, operational, resource and logistical decisions (human, fiscal, material, support and systems) may appropriately be managed through coordination structures that emphasize speed and unified action. This is legitimate and necessary functional and operational work.

Professional practice decisions, however, are of a different order altogether. Knowledge, clinical judgment, service provision, standards of care, scope of practice, competency determination and the ethical obligations attached to each of these are not properly subject to command authority. They belong to the profession. They arise from the moral and legal covenant between nursing and the community it serves (Porter-O'Grady et al., 2025; Start et al., 2024). A mature NPG framework maintains this distinction even under the most severe duress, ensuring that while operational coordination may shift to expedited structures, professional accountability remains firmly with the practitioners who bear it. The collapse of all decisions into a single coordinating hierarchy, however well-intentioned, erodes the essential frame for effective professional decision-making.

The covenant at risk

There is a consequence of this conceptual collapse that is often felt more deeply than it is articulated. Every day, in every unit, the organization depends upon the professional competence, clinical judgment and decisional integrity of its nurses. The institution places its confidence in their capacity to assess, to decide and to act in the interest of patients and communities. That reliance is not incidental; it is the foundation upon which safe, effective care rests.

When, at moments of greatest organizational consequence, a structure signals to those same professionals that their judgment is suddenly insufficient for the circumstance, that decisions must now flow downward from a controlling (command) authority rather than outward from the practitioners who hold the knowledge, something more than a structural shift occurs. A breach of faith takes place (Porter-O'Grady et al., 2025; Start et al., 2024). The message, however unintended, is unmistakable: We depend on your competence in ordinary times but do not rely on your decisional capacity when it matters (is needed) most. That message does not go unnoticed. Its corrosive effects on professional identity, engagement, satisfaction, wellbeing and retention extend well beyond any specific event.

If the organization's structures communicate that professional ownership is conditional and operative only when circumstances are manageable and suspended whenever pressure rises or is externally commanded, then the relational covenant between institution and profession is compromised at its core. The profession has suffered through too many iterations of this pattern across the past century to regard it lightly.

What Kahneman teaches us about governance under pressure

Daniele Kahneman's work on decision-making under uncertainty offers a useful framework for understanding and governance under pressure (Kahneman, 2011). His distinction between System 1 thinking (fast, intuitive, default) and System 2 thinking (deliberative, structured, effortful) illuminates an organizational parallel many of us have observed. The reflexive reversion to command and control under demand or pressure is a System 1 response, familiar and seemingly reassuring. Professional governance, by contrast, requires the discipline of both System 1 and System 2 operating in concert, a more challenging but more complete framework for decisions that carry professional and moral weight.

If our governance structures are operative only when circumstances are ordered or calm, if they must be subordinated to hierarchical control whenever urgency or demand increases; then what we have is not professional governance; it is instead permission. Professionals do not operate on permission; they operate on obligation, ownership and accountability.

An alternative path

What might a mature professional governance response to operational control look like? Consider the following: The

professional governance councils activate an expedited decisional process; council chairs and core members convene rapidly through digital platforms and AI-supported infrastructure and coordination; point-of-service decisional authority is broadened with real-time communication pathways; and professional staff own clinical and practice-related decisions while coordinating with organizational leadership on logistics and operations (Porter-O'Grady & Clavelle, 2019; Porter-O'Grady et al., 2025). This is not theoretical. It is what a mature NPG system is designed to do. A true and effective governance infrastructure already has the communication pathways, the accountability structures and the decisional clarity (and now AI toolsets), to function under pressure. Crisis and fast decision-making do not suspend professional accountability. It intensifies it.

A sustaining reflection

None of this diminishes the genuine commitment and effective operational leadership that many nurse leaders have demonstrated in challenging moments. Good participatory management within hierarchical structures is useful, and the individuals who practice it often serve their organizations and their communities well. What is being suggested here is that we, as a profession, should be wise about how we characterize these practices. Good "line" management is not professional governance. When we conflate the two, we risk diminishing the profession's understanding of what NPG requires and what it makes possible. In a professional context, nurse managers are not simply supervising employees; they are leading professional colleagues, which requires a different set of leadership competencies.

The maturation of our governance frameworks depends on our willingness to hold the concept with precision, particularly when circumstances tempt us toward simpler, more familiar models of control (the historic organizational drivers for nurses and nursing). What is ultimately at stake is the integrity of nursing's social mandate to its governance as a profession. If we accept that our accountability structures must yield to hierarchical command whenever the environment becomes difficult, we concede that professional governance is a fair-weather framework, operative only in stability and abandoned in adversity. That concession would undermine the very foundation upon which nursing's covenant with society rests and upon which nursing professional legitimacy is based.

The profession's primary obligation to the public it serves does not diminish in crisis or critical decisions. It deepens. And the structures through which that obligation is exercised must be resilient enough to function not only in ordinary times but also in extraordinary ones. ◆

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such as the 2026 Engaging and Retaining Gen Z Nurses: Trends and Strategies report by AONL and Laudio, provides a wealth of knowledge about the nursing workforce. Now, rather than rely on instinct, we can use evidence to design work environments and support strategies to build stronger teams and support long-term retention, as noted in Summer Teel and Lori de Celis in this issue of the Voice.

New nurses today are entering a profession shaped by workforce challenges, increasing complexity, rapid technological advancement and evolving expectations. Supporting them requires more than clinical preparation. It requires intentional leadership, meaningful connection, mentorship and commitment to creating environments where nurses can build confidence and grow as professionals. As the articles in this issue of the Voice indicate, we need to quickly adapt to the changing needs of today's workforce to create more flexible environments where new nurses can grow, contribute and sustain long-term careers.

Catherine Larson reminds us that successful onboarding extends beyond clinical orientation. By adapting communication, clarifying expectations and creating psychologically safe environments where feedback is understood and valued, nurse leaders can help new nurses build confidence, strengthen professional identity and launch meaningful careers.

Professional governance serves as a powerful strategy for developing future nurse leaders while strengthening engagement and retention. Lenore Reilly and Samantha Toth share how a robust unit-based council and yearlong residency supports onboarding at Atlantic Health Newton Medical Center and builds a sense of belonging. The initiative reinforces that leadership development begins on day one and grows through mentorship, engagement and meaningful opportunities to lead.

Nurse residency programs are an important foundation for new nurse graduates, but they do not complete a nurse's transition to independent practice. Brian Burns highlights the need for nurse leaders to create a sustained support structure that builds trust and sets clear expectations for new hires. The goal is to move beyond onboarding to create an environment where nurses can grow and build lasting careers.

Christina Banialis demonstrates that successful nurse retention begins during recruitment and extends well beyond orientation. Through intentional preceptor matching, therapeutic listening, structured education and ongoing mentorship, her team has created a supportive environment that fosters confidence, belonging and professional growth among new nurses.

The articles in this issue remind us that there is no single approach to preparing the next generation of nurses. We must remain open to new ideas and be willing to adapt our leadership strategies to meet the needs of an increasingly diverse workforce. Extended onboarding, meaningful mentorship, professional or shared governance and data-informed leadership are complementary strategies to help create environments where nurses feel valued, connected and equipped to succeed. As nurse leaders, we have both the opportunity and the responsibility to shape the future of our profession. Let us continue to lead with purpose and wisdom, ensuring the next generation is prepared to move forward with confidence, compassion and excellence. ◆

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safety and professional development may provide sustainable solutions for nurse retention and workforce stability. ◆

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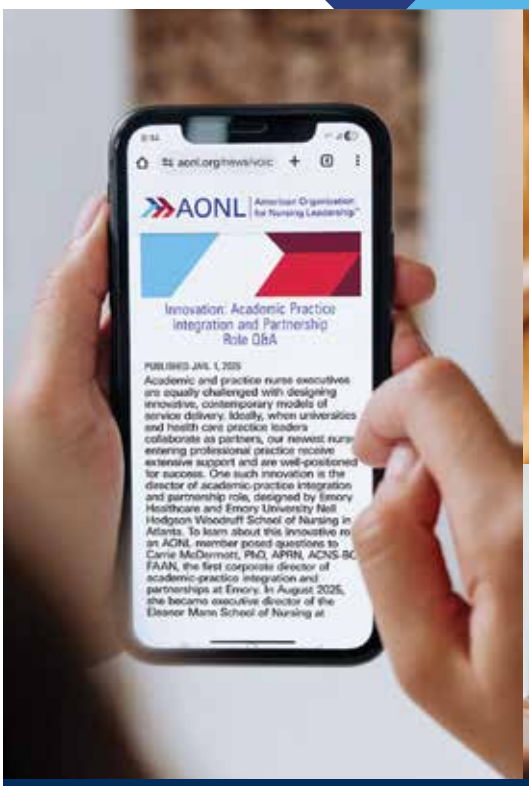

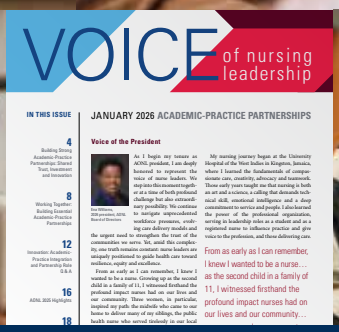

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