Executive Summary: Measuring Experienced Nurse Adaptation to the LDRP Model Using Change Management Principles

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Measuring Experienced Nurse Adaptation to LDRP Model

The following is an executive summary related to the DNP project titled *Measuring Experienced Nurse Adaptation to the LDRP Model Using Change Management Principles.*

Main Points

- A structured transition-to-practice (TTP) program provided an experienced women's health team with the resources as they transitioned from a separated labor and delivery unit to a Labor, Delivery, Recovery, and Postpartum (LDRP) unit.
- The team was simultaneously transitioning to a replacement hospital and new physical environment.
- Outcomes were measured related to overall LDRP competence and burnout risk.
- LDRP competence increased due to clinical simulations and didactic modules.
- Burnout-related exhaustion increased slightly, while depersonalization decreased and personal achievement remained high.
- Shared governance, system-based resources, and mentorship were key facilitators of adaptation.

Background and Purpose

The transition to an all-inclusive labor, delivery, recovery, and postpartum (LDRP) care model represented a significant operational and cultural shift for experienced nurses at a replacement hospital. Historically, the organization operated a separated labor and delivery unit, and the move to a combined LDRP model required nurses to expand their scope across all perinatal phases. Compounding this transition was the simultaneous relocation to a new hospital facility. There was a perceived lack of structured support that created a local practice gap characterized by hesitancy, nervousness, and risk for burnout among experienced nurses.

The purpose of this project was to establish a modified transition-to-practice program incorporating change management principles to support experienced nurses transitioning to the LDRP model. The project aimed to enhance competence, reduce burnout, and promote safe, high-quality patient care during a period of substantial organizational change.

Methodology

The project was guided by Lewin's Unfreeze-Change-Refreeze Model and implemented through iterative Plan-Do-Study-Act (PDSA) cycles. A convenience sample of experienced perinatal nurses participated in four survey time points spanning three months prior to the hospital move through six weeks post-move.

Design and Data Collection

Questions from two validated tools were used for the survey content. A modified version of the 2023 Casey-Fink Readiness for Practice Survey was included to measure perceived competence and readiness. The Maslach Burnout Inventory (MBI) was used to assess emotional exhaustion, depersonalization, and personal achievement. There was a total of 42 survey responses (N=42) during the implementation period. The survey results were converted to a numerical value from a Likert scale response to analyze the data more effectively.

Survey time points served as the project's tests of change with targeted interventions.

- **T1 (3 months pre-move):** System-based women's health hands-on clinical simulations and corresponding didactic modules by the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) were provided to the nurses.
- **T2 (1 month pre-move):** Mentorship through shared governance platform with unbiased leadership presence allowed the nurses to discuss baseline survey results and request

additional resources. Orientation to the new facility and LDRP unit was also provided within this time frame.

- **T3 (1 week post-move):** Existing charge nurses participated in LDRP shadowing at a sister facility to identify workflows and processes that could be replicated.
- **T4 (1.5 months post-move):** Cross-training opportunities continued as the nursing team was actively practicing in their new environment and care model.

These interventions were intentionally sequenced to support nurses' adaptation to the new care model.

Results

LDRP Competence

Nurses demonstrated increased perceived competence of the LDRP care model and skillset with a baseline mean of 4.15 increasing to 4.36. This improvement suggests that structured education, mentorship, and experiential learning effectively supported nurses' transition.

Burnout Indicators

The burnout indicator had three sub-categories: exhaustion, depersonalization, and personal achievement. Exhaustion increased from a baseline mean of 0.55 to 0.81. Depersonalization had a slight decrease in the mean from 0.14 to 0.10. Personal achievement remained high but had a slight decrease from a mean of 5.61 to 5.5. The increase in exhaustion likely reflects the intensity of organizational change, while the decrease in depersonalization suggests improved emotional connection to work. High personal achievement scores indicate sustained professional fulfillment despite transitional stress.

Strengths and Limitations

This project had numerous strengths in that there were multi-modal interventions that were provided to the staff that addressed knowledge, skills, and emotional support throughout the transition. There was a use of validated measurement tools that enhanced the reliability of the results. This experienced women's health team also had a robust shared governance platform that facilitated mentorship and engagement.

This project had limitations as this was a small sample size and survey participation decreased over time due to lack of engagement and other competing facility-related priorities post-hospital transition. There was also a shorter post-implementation measurement window, which restricts long-term evaluation. Additionally, this project had a lack of patient outcome measures that limited assessment of a broader clinical impact.

Implications and Conclusions

The structured TTP program demonstrated clear benefits in supporting experienced nurses transitioning to the LDRP model. Increased competence and sustained personal achievement indicate that the program effectively addressed knowledge and confidence gaps. The slight increase in exhaustion underscores the need for continued support during major organizational transitions.

The project's findings have meaningful implications for practice:

- Enhanced nurse readiness contributes to safer, higher-quality patient care.
- Continuity of care in the LDRP model may positively influence patient experience and access to care in this rural community.
- Structured transition programs can strengthen workforce development and retention.
- The model is feasible for replication in other clinical areas undergoing change.

In conclusion, this project successfully implemented a structured, evidence-based transition-to-practice program that improved nursing competence and supported adaptation to a new care model. The integration of change management principles was instrumental in guiding the transition and may serve as a framework for future organizational initiatives.

Future Recommendations

This quality improvement project outlines several recommendations that align with the project's findings. Dedicated training and orientation time should be allotted to all team members to ensure readiness accompanied by consistent leadership presence and engagement. Maintaining a strong shared governance structure to allow the nurses to provide real-time feedback in what they need during transition is essential. Extending the post-implementation evaluation period would capture long-term outcomes for both the nursing team and patients. Patient outcomes, like experience scores, near-miss events, and cesarean section rates, may be measured to evaluate impact. Finally, newly hired nurses must have a structured orientation and transition-to-practice program to promote success in their new role.

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