Immersion Scenarios Bridge the Education–Practice Gap for New Graduate Registered Nurses

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Mental health is an important component of holistic nursing care. Yet, many nursing programs lack sufficient clinical experiences and resources to prepare future nurses for this clinical specialty (Mullen & Murray, 2002). On graduation, many new graduate registered nurses (RNs) do not have sufficient knowledge of the many core competencies necessary to manage these challenging patients. As a result, there is a great deal of difficulty in the hiring, orientation, and retention of these new graduate RNs for clinical practice (Henderson, Happell, & Martin, 2007; Mullen & Murray, 2002). Additionally, staff turnover in small-volume clinical units has a particularly significant effect, especially when mental health clinical areas have a high patient-to-nurse ratio.

For managers and new graduate RNs, competency is the summative directive. As established by Benner (2001), the new graduate systematically progresses from novice to advanced beginner and finally to competent RN by using transformational learning methods (Benner, Sutphen, Leonard, & Day, 2010). This mental health facility’s definition of competence for the new graduate RN is achievement of specialty-specific actions within six essential criteria, as noted by The Advisory Board Company (2006, 2008). These essential criteria include clinical knowledge, technical skill, critical thinking, communication, professionalism, and management of responsibilities. Specialty-specific actions required in the area of mental health are listed in the Table and must be achieved within the formative and summative evaluation process of the new graduate RN.

This article describes educators’ efforts to bridge the gap between nursing education and competent practice for the new graduate RN in mental health clinical practice. Although the total Mental Health Orientation Plan (MHOP) incorporated the core competencies for practice and integrated specific diagnoses for classic psychiatric patients, the focus of this article is the instructional design of immersion scenarios, the creation of realistic patient care environments,
as an educational strategy to help the new graduate RN progress from advanced beginner to competent nurse (Benner, 2001).

MENTAL HEALTH ORIENTATION PLAN

The collaboration of a specialty-certified RN educator with a nursing simulation educator greatly enhanced the creation and implementation of this education plan. The specialty educator provided the content and competency expertise, and the simulation educator guided the instructional design for this transformational process. The nurse managers on the mental health units, in addition to the chief physician and chief nurse of the facility, supported this educational endeavor. They were concerned about attracting new graduate RNs, assessing their knowledge and skills, and hiring and retaining these nurses. Instructional design steps followed the ADDIE process, which includes assessment, design, development, implementation, and evaluation (Leshin, Pollock, & Reigeluth, 1992). This process is used throughout this article to present information about the overall MHOP as well as the integration of the immersion scenarios.

Assessments

A variety of preliminary assessments helped in the preparation of the MHOP. First, the psychiatric curricula of three local nursing schools were examined to determine what background the new graduate RNs had received during their basic nursing education. Common content throughout these programs included the pathophysiology of major depression, schizophrenia, bipolar disorders, therapeutic communication, psychotropic medications, and safety. This content was valuable for the student. However, nursing faculty noted a lack of consistent access to patients who demonstrated all of the desired psychiatric concepts in the clinical environment. This issue seems to be a national problem (Mullen & Murray, 2002).

The second step was to conduct an individualized needs assessment as new graduate RNs were hired. This evaluation showed inexperience in caring for classic psychiatric patients, including assessments, care plan development and maintenance, medication administration and monitoring, therapeutic communication, seclusion management, the use of restraints, physical interventions, and other emergent situations. Additionally and most importantly, the nurses needed to know when to call for assistance in a safety-challenged environment.

Another assessment was conducted by the nursing managers to define the specific competencies required for independent practice in mental health for the types of patients cared for in the facility. The Table lists these specific competencies, which built on The Advisory Board Core Competencies (The Advisory Board Company, 2008). Integrating all of the assessment data assisted in the next phase of design and development: how to build scenarios with all of the specialty-specific actions included.

Design

Although it was believed that some of the required didactic information would be suited for classroom lecture and discussion, these educational modalities would not enhance the experiential competency that was so important to allow the new graduate RNs to care for and meet

<table>
<thead>
<tr>
<th>Clinical Knowledge</th>
<th>Technical Skill</th>
<th>Critical Thinking</th>
<th>Communication</th>
<th>Professionalism</th>
<th>Management of Responsibilities</th>
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</thead>
<tbody>
<tr>
<td>Pathophysiology of patient conditions</td>
<td>Admission and ongoing assessment</td>
<td>Change in patient status (side effects, withdrawal)</td>
<td>Relationship-based care</td>
<td>Working within an interdisciplinary team</td>
<td>Care planning, prioritization, implementation, and evaluation</td>
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<tr>
<td>Psychotropic medications and side effects</td>
<td>Order of protective custody</td>
<td>Use of seclusion</td>
<td>Collecting admission history</td>
<td>Environment of care</td>
<td>Management of physician’s orders</td>
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<tr>
<td>Monitoring of serum drug levels</td>
<td>Conducting patient searches</td>
<td>Administering medication to mental health patients</td>
<td>Therapeutic communication</td>
<td>Collaboration with law enforcement</td>
<td>Completion of tasks within the time frame</td>
</tr>
<tr>
<td>Suicide risk assessment</td>
<td>Suicide precautions</td>
<td>Patient and staff safety</td>
<td>Use of SBAR communication</td>
<td>Confidentiality</td>
<td>Appropriate use of resources</td>
</tr>
<tr>
<td>Age-specific care</td>
<td>Performing a physical intervention</td>
<td></td>
<td>Documentation of patient care</td>
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Note. SBAR = situation, background, assessment, and recommendation. Data from The Advisory Board Company (2006, 2008).
the needs of these specialized patients. Consequently, the supporting modality selected was immersion scenarios with “standardized patients,” actors trained to portray patients using predetermined scripts and actions (Bradshaw & Lowenstein, 2007; College of Medicine at Illinois, 2013).

**Immersion Method.** As Benner et al. (2010) related, the transformation from advanced beginner to competent nurse is aided by constructing educational activities that build from simple to complex, engage the senses, and use cognitive, psychomotor, and behavioral approaches. For adult learners, it is important to use various approaches to enhance learning. The use of immersion scenarios aligns with the philosophy of engaging learners in training.

Immersion is an educational method that further builds on the use of simulation. Whereas simulation uses either mannequins of various fidelities or standardized patients in single rooms, immersion expands the technique of simulation to incorporate realistic patient care environments (Bradshaw & Lowenstein, 2007). The reality of the entire environment affects learning and transfer of knowledge.

**Immersion Environment.** In a safety-challenged specialty, it is essential for new graduate RNs to learn their true environment. This environment includes the unit layout, the staff and their individual roles, and mental health-specific policies. The immersion scenarios were designed to take place at an 80-bed mental health facility that provides inpatient and outpatient care. Settings for the scenarios included the admission office, patient care units, therapeutic communication rooms, and seclusion rooms, and included the associated patient care supplies and equipment. The scenarios were not recorded because they took place in a real, nonsimulated environment. No actual patients were used or were present in the vicinity of the immersion activities.

**Competency Tools.** Using Kirkpatrick’s (1995) evaluation method, competency tools were constructed. The initial level, “reaction” evaluation, used a qualitative analysis tool for feedback. Immediately after each scenario, new graduate RNs provided feedback on questions about their emotional reaction to the experience, patient care assessments and interventions, teamwork, and communication (Jeffries, 2005). The feedback was analyzed by the educators for themes relative to the success of the immersion scenarios.

The second level of Kirkpatrick’s model, “learning,” used a quantitative competency grid. Grids were built for each of the four immersion scenarios that incorporated specialty-specific actions (Figure). During the immersion scenarios, the new graduate RNs’ actions were observed and the specialty educator assigned a score of 2 for “met the competency without error” or a score of 1 for “met, but with error.” A “nonatempt of the intervention” received a score of zero. In a formative style, competency grids were reviewed and discussed in the debriefing period immediately after the qualitative questions.

Ultimately, the summative evaluation, Kirkpatrick’s third level, “transfer” of learning, was determined by completion of a competency checklist by the new graduate RNs’ preceptors. The preceptors observed the daily care provided by the new graduate RNs to determine competency using mental health care standards. On completion of the competency checklist, the content was reviewed by managers and discussed with the new graduate RNs. Satisfactory completion of the competency checklist signified completion of the orientation period and competence to care for patients independently. “Competence” was defined as demonstrating knowledge, skills, and actions that followed the prescribed standards of care in the context of the particular situation (Benner, 2001). Transfer of knowledge indicated that the education–practice gap was bridged for the new graduate RNs.

**Development**

**Immersion Content.** To capture the situations commonly seen with mental health patients, the educators jointly developed plausible patient cases, medications, and reactions. The process was akin to making a movie with scenes and dialogue. The specialty educator developed realistic scenarios that addressed required specialty-specific actions and that realistically occur in the psychiatric clinical environment. The educational design of the immersion scenarios was the responsibility of the simulation educator. Medical record documentation, including admission, physicians’ orders, nurses’ notes, and medication administration, was created so that new graduate RNs could document their care of the standardized patients on actual hospital medical records. Simulated medications and other props necessary for the scenarios were also used.

Based on the needed clinical competencies, four scenarios were developed that were integral to the learning activity.

The first scenario included an adolescent girl who had made a suicide attempt and presented to the facility with her father for treatment of major depression. Immersion scenes took place in the admission office, the inpatient unit, and a therapeutic communication room.

A critical care environment, a security guard, restraints, physical interventions (“take down”), and a
seclusion room were part of the second scenario of a patient who presented to the unit under an order of protective custody.

An inpatient unit, including a patient room, a nursing station, and medication dispensing equipment, was used for the third scenario in which a patient experienced significant side effects from psychotropic medication.

The fourth scenario was set in the inpatient withdrawal unit. In this scenario, a patient who was nearing a critical period of withdrawal from alcohol experienced a critical change in medical status. A nursing station, drug dispensing equipment, and emergency medical equipment were used.

“Standardized” Participants. Two types of participants fulfilled standardized roles (actual health care providers and paid actors) according to prescribed scripts and actions. Charge nurses, the rapid response team, and even security officers within these immersive environments performed their own health care roles to support the unfolding action of the scenarios occurring on the units. Resident physicians who were completing mental health rotations supported the immersion scenarios by using situation, background, assessment, and recommendation (SBAR) communication. Telephones were included within the environments so that new graduate RNs could call the residents, who would respond with applicable orders to simulate further interdisciplinary care.

The second type of standardized role was performed by actors who portrayed the mental health patients. Cast members included actors who played the suicidal adolescent girl and her father, the patient experiencing the psychotic episode, the man experiencing medication side effects, and the patient experiencing withdrawal. As educators searched for actors, clinical assistants working at the mental health site volunteered to portray the standardized patients because they were familiar with the behavior of the patients. The actors were paid for

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<tr>
<th>Objective</th>
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<th>Inappropriate</th>
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<tr>
<td>Complete Admission History</td>
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<td>Assess for Suicide Risk</td>
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<td>Assess for Triggers for Suicidal Ideation</td>
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<td>Perform Skin Assessment (Contraband Search)</td>
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<td>Initiate Plan of Care</td>
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<td>Attempt De-escalation Techniques</td>
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*Figure.* Competency grid for mental health standardized patient with major depression, suicide attempt scenario. Data from Kirkpatrick (1995).
their participation. Their familiarity with the scenarios greatly enhanced the realism of the immersion activities. The selected actors were instructed on the goal of the learning activity, the scenario objectives, and the scripts, including expected actions. Actors were given an opportunity to rehearse their roles and were provided with retraining for subsequent simulations. Experience working with mental health patients proved to be an essential skill set and saved a significant amount of training time. Nursing managers supported the extra costs because this educational experience was essential to effective clinical practice.

Implementation

The site-based educator was responsible for scheduling the unit and the actors for each scenario. These scenarios were scheduled every other week and took approximately 4 hours to complete. Each immersion event included a prebriefing session with the new graduate RNs to review the case, the expected interventions, the scenario with its specific scenes, and the environment. Deliberate preparation of the new graduate RNs for the immersion scenarios resulted in enhanced engagement and better learning outcomes.

As with all simulations, debriefing is the impetus for transfer of knowledge that indicates that learning has led to a change in behavior (Jeffries, 2005). Debriefing uses a formative process and is confidential. This process is learner-driven because learners must be comfortable addressing their own deficiencies and suggesting their own solutions. The time allotted for debriefing should be the same as the time allotted for each scenario (Jeffries, 2005). Debriefing took place in a conference room on the unit immediately after completion of the scenario. A formal process with standardized questions and review of the competency grids (Figure) was used to ensure that all issues or questions were addressed.

Evaluation

Kirkpatrick’s evaluation was undertaken to provide a rich, full description of the entire immersion educational process. The goal of the process was to bridge the mental health education–practice gap for new graduate RNs.

Kirkpatrick’s Level 1 “Reaction”: New Graduate RN Qualitative Evaluation of Immersion. Anecdotal observations were obtained from the new graduate RNs after each scenario. Overall, the new graduate RNs described the use of immersion scenarios as a valuable experience and identified the time invested as being essential to bridge the education–practice gap. The educators analyzed the observations to identify themes. Three themes emerged: (1) reality of the patient, situation, and environment; (2) safety to allow learning to occur in a nonthreatening environment; and (3) change in knowledge, skills, and behaviors in caring for mental health patients.

Feedback from new graduate RNs about the reality of the immersion included the following:

I’ll admit that I was skeptical at first, thinking the simulations might be . . . goofy, in a word . . . and that I would have trouble buying into the scenario, but I found the complete opposite to be true. The simulation was as close to a real-world experience as one could hope to achieve, and the acting skill displayed by my fellow mental health compatriots was surprisingly good (and accurate) as well.

The [psychotic patient] scenario by design was chaotic (as these situations really are). [The actor] did a phenomenal job playing the role of the out-of-control psychotic patient. The Satori Alternative to Managing Aggression instructors responded to the Code Gray, assisted with emergency medication administration and the restraint process, and participated in the post-Code Gray debriefing. All of these components contributed to a realistic scenario that challenged us to use critical thinking.

Providing safety and the freedom to learn in a nonthreatening environment was paramount to nursing educators and administrators. The new graduate RNs appreciated the opportunity to experience a stressful event in a controlled environment. The role-playing staff was mentioned as contributing to the safe learning environment. Two new graduate RNs stated:

The post-scenario debriefing continues to be a valuable component and provides a safe place to analyze the good, the bad, and the ugly of what happened over the course of the scenario. These experiences will better prepare us for working with patients we will inevitably encounter down the road.

[The actor] was very realistic in playing her role of the adolescent who attempted suicide. I learned a lot about how to take care of this patient. This is a good way to get me thinking and gain helpful insight in a safe place where I can experience clinical situations. I was able to experience the whole admission process. I am looking forward to the next simulation.

The new graduate RNs reported that they experienced a change in knowledge, skills, and behavior in caring for mental health patients, especially during the debriefing sessions.

The pre-scenario briefing clearly sets the stage for the objectives for the ensuing scenario. Having realistic props in a realistic scenario with people realistically pre-
senting symptoms and behaviors is providing us with a real learning opportunity, and we like the scenario-based learning much better.

In the next scenario, where the patient experienced a seizure, [the actor] presented very realistic seizure-like activity. A Code Down was called and interventions were made. When the situation escalated to a full Code Blue, anxiety was obvious. CPR was initiated after someone was sent to call Code Blue. The debriefing helped us know what to do differently in future Code Blue situations.

**Kirkpatrick’s Level 2 “Learning”: New Graduate RN Quantitative Evaluation of Immersion.** During each immersion scenario, the specialty educator observed and documented the interventions of the new graduate RNs on each competency grid. After the immersion scenario, in the formative style, debriefing helped to reinforce appropriate actions or provided an opportunity for remediation in cases when inappropriate action or no action was taken. Debriefing took place in the unit conference room immediately after the immersion scenario.

**Kirkpatrick’s Level 3 “Transfer”: New Graduate RN Quantitative Evaluation of Immersion.** Ultimately, summative competency was determined when the preceptor observed and documented new graduate RNs’ proficiency when working with actual admitted patients on the unit (Wright, 2005). The summative assessment was accomplished by completion of the competency checklist and is beyond the scope of this article.

**Educator Evaluation of Immersion.** Immersion scenarios were jointly reviewed by specialty and simulation educators after implementation to analyze and correct problems. Some script sections and supportive documentation needed to be revised. Rehearsal time for each scenario with the standardized patients was increased as well. Challenges included scheduling time on busy patient care units and assuring the availability of ancillary staff to assist in the scenarios. Return on investment, competence, and retention are integral to continuation of the MHOP. All indicators were measured by each new graduate RN at specific intervals throughout the year as part of the orientation program. The educators informed the managers of the analysis of Kirkpatrick’s level 1 “reaction” qualitative themes and the grading of Kirkpatrick’s level 2 “learning” quantitative competency grids for the new graduate RNs. Analysis of the difficulties evident from the competency grids led to more emphasis on the content in the didactic portion of the MHOP.

Evaluation of the immersion activities took place after the initial cycle, with adjustment for future hiring cycles. Few new graduate RNs are hired into the mental health specialty. The initial immersion activities were implemented with two new graduate RNs, and four additional new graduate RNs have participated in immersion activities since that time. Plans are underway for orientation of three new graduate RNs.

**EDUCATIONAL OUTCOMES**
Enhanced knowledge transfer occurs when learners see, hear, think, and do various simulation activities (Jeffries, 2005). Immersion scenarios further build on simulation because the environment, including interactions with health care providers, is realistic. This realism makes immersion a viable teaching method. At the completion of their total learning experiences within the MHOP, 100% of the new graduate RNs were able to independently manage care for mental health patients on a specialty patient care unit according to established standards of practice. Completion of all of the specialty-specific actions shown in the Table satisfied Kirkpatrick’s level 3 “transfer” of knowledge, skills, and behavior, acknowledging competency within context. Progression of new graduate RNs to the level of competence in the care of patients with psychiatric problems was facilitated by the immersion scenarios. Hiring new graduate RNs into the mental health field can be difficult. The return on investment of resources devoted to immersion scenarios is ultimately measured by nurse competence and retention. For the initial groups of new graduate RNs, nurse managers have realized the value of immersion as a way to bridge the gap from education to practice. With the success of immersion in achieving competency, it is hoped that retention will increase because turnover in a small unit is acutely felt. Nurse managers continue to support the immersion method with subsequent new graduate RN hires. Because the number of new hires is low, analysis of the immersion method is ongoing.

This organization has used immersion scenarios with other specialties, including emergency, acute, critical, and surgical care for adults and children as well as women’s health. In these cases, the immersion environments are based in a repurposed hospital and use mannequins of various fidelities as simulated patients. It is clear that learning is improved by simulation and further enhanced by simulation in a realistic environment, or immersion. Since 2011, this organization has supported immersion activities for six cohorts of new graduate RNs.

**REFERENCES**
New graduate registered nurses (RNs) often lack sufficient knowledge of the many core competencies needed to manage mental health patients.

Immersion scenarios, using realistic patient care environments, were created as an educational strategy to help new graduate RNs progress from advanced beginners to competent nurses.

Educators recognize enhanced knowledge “transfer” when learners see, hear, think, and do various simulation activities.

In this study, progression of new graduate RNs to competent nurses was facilitated by immersion scenarios, and 100% of the new graduate RNs were able to independently manage care for mental health patients on a specialty patient care unit according to established standards of practice.