



EVIDENCE PACK

Making Readiness Visible

The readiness evidence pack - the research, the named outcomes from leading health systems, and what measuring readiness would look like across your own. Prepared for nursing leadership.

EXECUTIVE SUMMARY

The systems that can see readiness are the ones improving it.

Across US health systems, the readiness of newly qualified nurses has been measurably declining for a decade. For most organizations it stays invisible - you find out whether a nurse was ready at the moment a patient depends on the answer, not before.

This pack sets out three things: what the research actually shows, what leading health systems measured when they changed their approach, and what it would take to see readiness clearly in your own organization. The throughline is simple. The systems getting results stopped treating readiness as something they hoped education produced, and started treating it as workforce infrastructure - something you measure, manage, and improve. When they did, the outcomes were not marginal.

88%

less training time, outcomes held
- Memorial Hermann (17-hospital system)

60%

fewer medication errors
- Hoag Hospital

49→89%

sepsis bundle compliance
- Carle Health

Those are not our claims about our product. They are what named health systems measured against their own baselines. The pages that follow give you the evidence, the method behind it, and an honest account of what it would - and wouldn't - mean for you.

01 · THE READINESS GAP

Readiness has been falling for a decade - and you can't see it until a patient does.

This isn't a generational opinion; it's measured. Across 2011–2015, just 23% of new graduate nurses met expected entry-level competency (Kavanagh & Szweda, 2017). By 2020, fewer than one in ten did (Kavanagh & Sharpnack, 2021). It's the gap your preceptors describe feeling on every shift - and the reason the first year on a unit is so fragile.

It carries a cost that lands on the same desk. More than one in five newly hired nurses leave within their first year, and each departure costs about \$60,090 to replace (NSI, 2026) - before counting the preceptor hours that walk out of the building with them.

The gap, measured

Across 2011–2015, about 23% of new graduate nurses met expected entry-level competency; by 2020, fewer than one in ten did. Today, more than one in five newly hired nurses leave within their first year - at about \$60,090 to replace each one.

But the deeper problem isn't the number. It's that the number is invisible. Every system records the education hours its nurses complete. Almost none can say whether those hours produced a nurse who can make the call at the bedside. Completion has been measured for years. Readiness hasn't.

02 · THE REFRAME***The problem was never the amount of education. It's that readiness was invisible.***

The instinct, faced with a widening gap, is to add more education. But the volume of education was never the constraint. The constraint is that no one could see whether any of it worked - whether a given nurse, on a given unit, was actually ready, or had simply completed the modules. And you cannot manage what you cannot see.

The shift that changes the picture is small to state and large in consequence: treat clinical readiness as workforce infrastructure. Something a system measures, manages, and improves - like capacity, or quality, or safety - rather than a stack of completed modules that you hope did their job. Once readiness is visible, it becomes a lever leadership can actually pull.

03 · THE EVIDENCE

What leading systems measured when they made readiness visible.

The evidence below comes from named health systems, measured against their own baselines, peer-reviewed or independently reported where indicated. The point of reading them together is the pattern, not any single number.

Memorial Hermann - a 17-hospital system

Memorial Hermann rebuilt a section of its nurse residency around active clinical decision-making rather than passive e-learning. The headline figure is striking: sixteen hours of e-learning became two. But the figures that matter to a chief nurse are quieter. The outcomes held. Learner satisfaction rose to 89%. And fourteen hours per nurse went back to the bedside - capacity returned to care. Their AVP of Clinical Education led the implementation, proven first in a rigorous proof of concept the system is now extending more widely; their own clinical leaders, several of them initially sceptical, became its advocates once they could see what it surfaced.

System	Approach	What they measured	Source
Memorial Hermann · TX	New-nurse residency section rebuilt around clinical decision-making (proof of concept, now scaling)	88% less training time (16→2 hrs), outcomes maintained, 89% satisfaction, 14 hrs/nurse returned to care	Becker's, 2026
Hoag · CA	Medication scenarios built on the error patterns in their own data	60% reduction in medication errors	Pub. pending
Carle Health · IL	Sepsis recognition and bundle scenarios	Sepsis bundle compliance from 49% to 89%	Peer-reviewed, 2023
Stony Brook · NY	Decision-based simulation compared head-to-head with manikin-based simulation	No significant difference in outcomes - equivalence to the established standard	Hulfish et al., 2024
NHS · UK	Learning measured three months after training	89% still applying the learning; judged superior to e-learning	Mallik et al., 2021

Read together, the pattern is consistent. The gains didn't come from teaching people something new - they came from letting clinicians practice the decision until it held, and from making that practice visible. The Stony Brook equivalence finding matters for a different reason: it shows the approach performs on par with the established gold standard, while reaching far more people, far more consistently.

04 · HOW IT WORKS***Making readiness visible.***

The method is straightforward, and it's where the visibility comes from. Nurses make real clinical decisions inside immersive scenarios, and the platform captures how they reason - not just whether they finished. Three things happen at once:

- Practice the decision, not the slideshow. Nurses work through realistic clinical scenarios and make the actual decisions the role demands - assessment, prioritization, recognition, escalation - in a place where a wrong call harms no one.
- Capture the reasoning. AI virtual patients respond to what the learner does, and a clinically validated feedback engine records how each decision was made. Performance becomes data - what a nurse assessed, how they prioritised, where they hesitated, what they missed - rather than a completion tick.
- See readiness across the system. Those signals roll up by cohort, unit, and competency, so readiness becomes something leadership can see, compare, and act on - consistently, and at the scale of a multi-site system.

This is the data layer that physical simulation can't produce. That data layer is the workforce-infrastructure piece - the part that turns readiness from a hope into something you can manage.

05 · THE BUSINESS CASE***The clinical case comes first. The economics follow it.***

The reason to act is clinical: a ready workforce is a safer one, and the systems above measured that directly. But the economics are real and worth stating plainly. Average first-year turnover at 22.7% and about \$60,090 per replacement is a recurring, budgeted loss. Returning fourteen preceptor hours per nurse, as Memorial Hermann did, is capacity recovered without new headcount. An independent analysis by the York Health Economics Consortium has put the return on simulation of this kind across a wide range - from roughly 120% to several thousand percent, with the breadth reflecting variation in facilities, spend, and current approach. Ultimately the economics are a consequence of getting the clinical question right, and the only way to size them *for* you is to measure them *with* you.

06 · WHAT THIS LOOKS LIKE FOR YOUR SYSTEM

***We can't tell you what readiness looks like in your system.
We can measure it with you.***

Everything in this pack came from health systems measuring against their own baselines - which is exactly why we won't put a number on your organization from the outside.

Outcomes vary by system, by starting point, and by where the gap actually sits. The credible first step is small: a readiness baseline on a single cohort or unit, run on your own data, so you can see what's visible now and what isn't - before anything scales.

THE CONVERSATION

See what readiness looks like in your system.

We'll reach out to arrange the walkthrough at a time that suits you - working from your program, not a generic list. No obligation, and nothing to prepare in advance.

SOURCES & METHOD***The evidence behind this pack.***

Every figure here is drawn from a named health system or a peer-reviewed or independent source. Figures reflect each organization's own results, measured against their own baselines; outcomes vary by setting.

Kavanagh, J. M., & Sharpnack, P. A. (2021). Crisis in Competency: A Defining Moment in Nursing Education. OJIN: The Online Journal of Issues in Nursing, 26(1).

Kavanagh, J. M., & Szveda, C. (2017). A Crisis in Competency: The Strategic and Ethical Imperative to Assessing New Graduate Nurses' Clinical Reasoning. Nursing Education Perspectives, 38(2), 57-62.

NSI Nursing Solutions (2026). National Health Care Retention & RN Staffing Report (2025 data) - average RN replacement cost (\$60,090) and first-year (first-year-of-employment) RN turnover.

Memorial Hermann Health System - clinical-education outcomes, reported via Becker's Healthcare (2026).

Carle Health (2023) - evaluation of simulation on sepsis bundle compliance (49.5% → 89%).

Hoag Hospital - IRB-approved evaluation of simulation on medication-error reduction; publication pending.

Stony Brook University (Hulfish et al., 2024) - comparative outcomes study, decision-based vs manikin-based simulation.

Mallik et al. (2021) - NHS evaluation of learning transfer at three months.

York Health Economics Consortium - independent return-on-investment analysis of Oxford Medical Simulation.

The New Ready. Oxford Medical Simulation.