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Insights · Healthcare

The Gap Beneath the Mandatories

How nursing training is measured, and where it stops

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Most nursing training programs measure attendance. Few can produce the audit-ready competency evidence the regulators now look for.

Executive summary

Most nursing training programs stop at Kirkpatrick Levels 1 and 2 — reaction and learning. They rarely evaluate whether nurses apply competencies correctly on the unit weeks or months later (Level 3 — Behavior) or whether the training improved patient outcomes (Level 4 — Results).

That structural gap between training completion and validated competency creates accreditation and audit exposure under the Joint Commission's National Performance Goals (NPG) chapter, which became effective 1 January 2026 and consolidates existing competency expectations into a more visible, survey-relevant framework. It also exposes organizations to nurse turnover costs averaging $60,090 per replaced bedside RN (NSI Nursing Solutions, Inc., 2026).

This article provides a clear diagnosis of the problem, current regulatory context, peer-reviewed research from the past three years, a fifteen-minute self-diagnostic for nursing leadership, and a set of immediately actionable Level 3 behavior metrics by clinical specialty. **Appendix A** translates the diagnosis into acquisition-actionable language for federal healthcare buyers — VHA, DHA, IHS, BoP, HHS divisions, and adjacent public-hospital programs.

The operative framing throughout is one phrase: **audit-ready competency evidence** — dated, evaluator-signed, care-environment-specific validation records traceable to a defined standard and tied to operational outcomes. That is the artifact the modern survey, audit, or discovery request expects to see. Most hospital training programs cannot currently produce it on demand.

The workforce is already telling you

Two patterns recur in every health-system nursing leadership conversation right now.

The first is qualitative — the theme that surfaces in nurse engagement surveys with stubborn consistency. Training is described as repetitive, generic, and disconnected from the actual demands of the unit. Bedside nurses describe annual mandatory modules they have completed three, five, or eight times. They describe orientation experiences in which the calendar ran out before competence was confirmed. They describe a sense that what they were asked to learn and what they are asked to do are different things. This is not the complaint of a disengaged workforce. It is the diagnosis of a structural problem, articulated from the inside.

The second pattern is quantitative. The systematic review literature reports first-year retention rates among newly graduated registered nurses ranging from 77% to 95%, with pre-intervention turnover in some included studies reaching as high as 50% (Vázquez-Calatayud, Errasti-Ibarrondo, & Choperena, 2023). The 2026 NSI *National Health Care Retention & RN Staffing Report* places average replacement cost at $60,090 per bedside RN, with annual hospital RN turnover costs ranging from $4.2M to $6.2M, averaging $5.19M per facility (NSI Nursing Solutions, Inc., 2026). Each one-percent change in RN turnover translates to roughly $295,000 per hospital per year.

Federal healthcare systems may calculate replacement and turnover costs differently from private-sector hospitals. The operational burden — vacancy, onboarding, overtime, traveler utilization, degraded continuity of care, and erosion of unit-level competency depth — remains material across both settings.

The drivers cited in the retention literature are consistent across studies: inconsistent transition-to-practice support, insufficient new-hire orientation, weak preceptor calibration, and a gap between competencies taught and competencies required in clinical practice (Lee, Jang, & Park, 2024; Vázquez-Calatayud et al., 2023). These drivers describe a training system that does not adequately confirm what it produced.

The workforce experiences the gap structurally before leadership measures it.

A brief refresher: the Kirkpatrick four-level model

Donald Kirkpatrick's four-level model of training evaluation, first articulated in the late 1950s and refined by Kirkpatrick and Kirkpatrick (2016) in subsequent revisions, has been the dominant framework for training program evaluation across industries for more than half a century. The four levels ask four progressively harder questions about a program.

Level 1 — Reaction asks whether learners found the training useful and worthwhile.

Level 2 — Learning asks whether learners acquired the knowledge or skill the training was designed to convey.

Level 3 — Behavior asks whether learners are performing the trained behavior on the job, weeks or months after the training event.

Level 4 — Results asks whether the training produced changes in operational, financial, or patient-level outcomes — and whether those changes can be attributed to the training rather than to confounding factors.

The model's difficulty is asymmetric: Levels 1 and 2 are inexpensive and well-instrumented in virtually every training environment, while Levels 3 and 4 require structured records, calibrated observers, and analytic capability that most programs do not maintain. Miranda and colleagues (2025), in a recent integrative review of thirteen studies applying Kirkpatrick's framework to nursing training across multiple countries, concluded that *"evaluation of results in organizational practices is the most challenging level"* (p. e4431).

Kirkpatrick itself is not a regulatory requirement. It is the explanatory framework most often used to describe the artifact the regulators ask for. The artifact, increasingly, is a Level 3 record.

Level 3 metrics in nursing — by specialty

Level 3 evaluates whether learners apply trained skills correctly in the real clinical environment, typically 30–180 days post-training. The examples below are immediately implementable Level 3 metrics across common acute-care specialties. The metrics, methods, and thresholds are **illustrative planning targets** — not authoritative regulatory minimums. Calibrate to organizational policy, accreditor language, clinical specialty, baseline performance, and risk tolerance before adoption.

Med-Surg — Pain Management. Percent of patients with pain reassessed within 60 minutes of intervention. Method: chart audit plus direct observation. Frequency: monthly. Target: ≥92%.

Med-Surg — Fall Prevention. Percent of at-risk patients with completed fall-prevention interventions. Method: chart audit plus incident review. Frequency: monthly. Target: ≥95% completion; ≥25% reduction in falls year-over-year.

ICU — Sedation Management. Correct RASS score titration and documentation. Method: MAR audit plus observation. Frequency: monthly. Target: ≥95%.

ICU — CLABSI Prevention. Full sterile-barrier and bundle compliance on line insertions and maintenance. Method: bundle audit. Frequency: monthly. Target: 100%.

ED — Triage Accuracy. Percent of triage assignments validated as correct by dual review. Method: dual review. Frequency: monthly. Target: ≥90%.

L&D — Fetal Monitoring. Timely interpretation and escalation of Category II strips. Method: strip review by qualified reviewer. Frequency: monthly. Target: ≥95%.

OR / PACU — Surgical Safety Checklist. Full timeout compliance per WHO / Joint Commission framework. Method: direct observation. Frequency: per case. Target: 100%.

All units — Medication Administration. Reduction in rights violations per 1,000 administrations. Method: MAR plus smart-pump data. Frequency: monthly. Target: ≥40% reduction over baseline.

All units — Service Recovery. Correct application of the recovery model after a service failure. Method: supervisor observation. Frequency: monthly. Target: ≥90% of events.

The shared structure is what matters: a defined competency paired to an observable behavior, a measurement method drawn from records the organization already maintains, a defined frequency, and a threshold the organization commits to in advance. That structure converts Kirkpatrick Level 3 from an aspiration into an instrument. It is also the structure a Joint Commission surveyor, a contracting officer, or a plaintiff's expert witness will expect to see in the personnel record.

> *The practical compliance burden now falls on Level 3-type evidence — proof that staff can apply required competencies in the actual care environment.*

What the regulators are now saying

Three regulatory frameworks bear directly on the gap this article describes. Each requires what most hospital nursing programs do not currently document at a defensible level.

CMS Conditions of Participation for Hospitals (42 CFR Part 482)

The Centers for Medicare and Medicaid Services Conditions of Participation require that nursing care be assigned according to the specialized qualifications and competence of nursing staff, and that the personnel record document that both training and **demonstration of competency** were successfully completed. The regulatory standard is demonstration of competency, not completion of training. The Conditions have read this way for years; many programs do not document to it.

The Joint Commission — Standard HR.01.06.01

The Joint Commission's longstanding human resources standard requires that staff competence be assessed and documented, with reassessment at least every three years or more frequently per organizational policy (The Joint Commission, 2024a). The Commission is explicit that competency is distinct from education and training and requires evidence that the nurse can apply knowledge in a real scenario — not merely that the nurse passed an examination (The Joint Commission, 2024b).

The Joint Commission — National Performance Goal 12, Health Professional Resource Management (effective 1 January 2026)

Effective 1 January 2026, the Joint Commission's new National Performance Goals (NPG) chapter replaces the prior National Patient Safety Goals chapter and is organized into fourteen measurable goals. Two of those goals — reducing suicide risk and Health Professional Resource Management — were elevated to NPG status because of their tie to CMS Conditions of Participation and their critical importance to safe care delivery (The Joint Commission, 2025).

The Joint Commission's own November 2025 guidance is careful to characterize the change. While the NPG chapter is structurally new, **no new requirements have been introduced**; the NPGs consolidate existing requirements that rise above regulation into a more visible, measurable, survey-relevant framework. For nurse staffing and competency specifically, however, professional bodies have read the architecture as the first explicit accreditation tie between nurse staffing adequacy, nurse competency, and the specific care environment in which each nurse practices (American Association of Critical-Care Nurses, 2025).

NPG 12 directs that the hospital be staffed to meet the needs of the patients it serves and that staff be competent to provide safe, quality care. It does not codify Kirkpatrick Level 3 evaluation, and it does not formally require any specific training-evaluation methodology. What it does is sharpen the **practical compliance burden**. Hospitals will increasingly need defensible, current evidence that staff can apply required competencies in the actual care environment — not merely that staff completed the relevant training. That evidence, in substance, is a Level 3 artifact.

Taken together, these three frameworks tell a consistent story. The regulators have moved away from training completion as the measured artifact and toward validated, environment-aligned competency as the measured artifact. The documentation a surveyor, contracting officer, or plaintiff's attorney will expect to see is the dated, evaluator-signed record traceable to a defined standard. Most hospital training programs cannot currently produce it on demand.

The knowledge-competence gap in current research

A substantial body of peer-reviewed nursing education research, accumulating over the past decade and accelerating in the last three years, characterizes the gap between what nurses are taught and what they can demonstrably do in clinical practice. The terminology varies — knowledge-practice gap, theory-practice gap, competency gap — but the underlying phenomenon is consistent.

An integrative review published in *Nurse Education Today* identified three categories of factors that produce the knowledge-practice gap: individual nurse factors, educational structure factors, and organizational characteristics (Saifan et al., 2021). The authors emphasize that organizational characteristics — specifically the structures by which competency is validated and recorded — are an underexamined driver of the gap and a primary site of intervention.

Buljac-Samardzic, Doekhie, and van Wijngaarden (2020) note that systematic interventions to improve team effectiveness in health care are well-described at the input level but inconsistently measured at the outcome level — a pattern the authors attribute to records-system fragmentation and the absence of joinable cohort data. Nahm and colleagues (2023) describe the same disconnection at the institutional boundary between academic preparation and hospital-side workplace validation, arguing that closing what they term the *"chasm between academia and practice"* will require investment in workplace competency architecture, not in additional instructional content.

Most hospitals can demonstrate that staff attended training. Far fewer can produce the audit-ready competency evidence the regulators now require.

A self-diagnostic for healthcare leaders

The following ten questions are designed to surface, in roughly fifteen minutes of leadership conversation, where your organization sits on the Kirkpatrick maturity spectrum. They do not require external data. They require honest answers. Bring them to your next nursing leadership meeting and observe where the discussion concentrates.

1. For a randomly selected nurse hired six months ago, can your organization produce, within twenty-four hours, a dated and evaluator-signed competency record traceable to a defined competency standard? *If the answer involves more than two systems, the answer is effectively no.*
2. What is your written organizational definition of competency, and how does it differ from training completion in your records? *If the two are indistinguishable in your documentation, your program operates at Kirkpatrick Level 2 by definition.*
3. How are your preceptors and competency validators qualified, calibrated, and re-certified? *If preceptor selection is based on clinical seniority and willingness alone, instructor calibration is not occurring.*
4. When the annual nurse engagement survey returns the theme "training is repetitive," what specific structural change does that theme trigger? *If the answer is "we acknowledge it," the workforce is naming a structural problem your records cannot address.*
5. If your accreditor asked tomorrow under National Performance Goal 12 to demonstrate that staff competencies align with the care environment, what artifact would you produce? *If the artifact is the orientation completion record, you are producing a Level 1 artifact for a Level 3 requirement.*
6. Across your nursing units, how consistent is the meaning of "competency validated"? *If the standard varies materially by unit or by site, validation is not occurring against a shared definition.*
7. Can you state, with records, whether your spring orientation cohort is performing differently from your fall cohort on any measurable outcome? *If the answer is no, you cannot diagnose your own program.*
8. Has your nursing leadership ever attributed a change in a patient safety metric, a turnover metric, or a throughput metric to a specific training intervention with structured evidence? *If not, you are operating at Kirkpatrick Level 1 or 2 on outcomes that live at Level 4.*
9. When a certification lapses — Trauma Nursing Core Course, Advanced Cardiac Life Support, Pediatric Advanced Life Support — what defined recovery procedure activates, and what is the time-to-detection? *If recovery is ad hoc, your bright-line currency rule is decorative under operational pressure.*
10. If you had to pick one Kirkpatrick level to invest in over the next twelve months, which would produce the most defensibility for your next accreditation cycle? *The answer should not be Level 1 or Level 2.*

There is no scoring rubric here. The diagnostic value is in the texture of the conversation the questions produce — and in noticing which questions are answered confidently and which produce silence. Silence

on questions one, five, seven, and eight is the most reliable marker that your program operates at the level this article describes.

Where the field is heading

The convergence of three forces — the workforce signal, the regulatory escalation, and the maturation of nursing-education research — points consistently toward a single direction of travel.

First, competency-based education at the academic front-end is becoming the standard. The American Association of Colleges of Nursing's 2021 *Essentials* made the shift explicit at the academic level; the hospital-side workplace validation architecture is following at variable pace.

Second, validated, environment-aligned workplace competency — not merely documented training — is becoming the records standard. Joint Commission HR.01.06.01 has implied this for years; NPG 12, by elevating Health Professional Resource Management into the new NPG framework, makes the surveyor's expectation more visible. The trajectory does not reverse.

Third, training-to-outcome linkage is moving from aspirational to operational. As hospitals invest in unified records architectures and as patient safety reporting matures, the technical preconditions for Level 4 evaluation — cohort-level joinable records, structured observation data, attribution analysis — are becoming achievable in ways they were not a decade ago. The leading-edge health systems are not waiting for the regulation to make Level 4 mandatory. They are building it because the workforce, the patient safety record, and the financial cost of turnover all reward it.

What this means for any healthcare organization reading this article is concrete. The question is no longer *whether* to move from Level 2 to Level 3 — the regulators have decided that question. The question is the pace and the architecture. Hospitals that begin the work now, deliberately and against a defined competency standard, will be ready when the survey arrives.

A note on authorship and intent

I write this article as someone who has spent a career inside training systems with regulated stakes. Thirty years as a United States Air Force officer, including command of a KC-135 squadron and service as Chief of Operations at the United States Strategic Command Global Operations Center, taught me that the difference between trained and competent is not academic. Five years at Booz Allen Hamilton directing a $563 million Department of Defense human-performance training contract across the Army, Navy, and Air Force taught me that the same lesson scales — and that records systems are the single most under-instrumented function in most training programs. McLean Performance Group is the practice I built to operationalize what I learned. We design the training compliance architecture organizations need to satisfy external audit and produce measurable return on training investment at Kirkpatrick Levels 3 and 4.

This article is not a pitch. It is an invitation. The questions in the self-diagnostic are the same questions I would ask in the first thirty minutes of any engagement; they are useful whether or not you ever speak to me. If the discussion in your nursing leadership meeting produces silence on the same four or five questions consistently, you have identified your organization's principal training-compliance exposure — and you have a place to start.

The entry product is the **Program Audit**. The audit reviews the existing training program against the seven-document MPG Framework and the regulatory authorities that govern your environment, identifies the gap between attended training and demonstrated competency, and produces a written engagement plan that closes the gap. Two to three weeks, principal-delivered, $2,500 to $4,500. Write to Adam@McLeanPerformanceGroup.com or call 256-270-6582.

I welcome correspondence. Comments, disagreements, and especially counter-examples — programs that have built the Level 3 / Level 4 architecture well, and what was hard about it — are useful contributions to a field still finding its footing on the new standard.

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> **Note on LinkedIn publishing:** the article body above stands alone as a private-sector thought-leadership piece (~3,700 words). Appendix A below adds another ~1,400 words of acquisition-actionable framing for federal healthcare buyers. For LinkedIn publish, consider either (a) publishing the full version with Appendix A included for federal-audience reach, or (b) publishing the body only and treating Appendix A as a federal-buyer follow-on attachment used in capture conversations.

Appendix A. For Federal Healthcare Buyers

This appendix translates the diagnosis above into language a federal acquisition team can use. It does not change the substance of the article; it restates the offering in terms a Contracting Officer, Contracting Officer's Representative (COR), program manager, small-business teaming partner, or capture lead can map to a Performance Work Statement, sources-sought response, BPA call, task order, or pilot.

A.1 How this translates into an acquisition requirement

FAR Part 37 directs that service-contracting policy use performance-based acquisition methods to the maximum extent practicable. NPG 12, HR.01.06.01, and 42 CFR Part 482 together describe a performance need — **audit-ready competency evidence** — that maps cleanly onto a performance-based requirement.

A sample performance statement that captures the work:

> *Develop and implement a competency validation program that enables the agency to demonstrate, for selected nursing roles and care environments, documented post-training behavioral competency and linkage to defined operational and patient-safety outcomes.*

As a value proposition: **McLean Performance Group helps healthcare organizations move from training-completion records to audit-ready competency evidence — dated, evaluator-signed, care-environment-specific validation records traceable to a defined standard and tied to operational outcomes.** The work is performed without replacing existing learning management, human resources, quality, or electronic health record systems.

A.2 Example engagement deliverables

The deliverables below are illustrative of the artifacts a federal engagement would produce. Specific scope, deliverable timing, and acceptance criteria are written into the resulting task order or Statement of Work.

Competency Standards Crosswalk. Mapping required competencies by role, unit, care environment, accreditor requirement, and internal policy — produces a single authoritative reference for what each nurse, in each environment, must demonstrate.

Kirkpatrick Level 3 Validation Protocols. Structured observation tools, chart-audit templates, evaluator instructions, and validation thresholds calibrated to specialty and risk profile.

Evaluator / Preceptor Calibration Package. Qualification criteria, calibration scenarios, inter-rater reliability process, and revalidation cadence — closes the variability that undermines current preceptor models.

Competency Evidence File Specification. Required data elements for an audit-ready record: nurse, role, unit, competency, date, evaluator, evidence type, result, remediation, recheck. Works as a specification for whichever system holds the record.

Pilot Implementation Report. Findings from one or more units, including baseline gaps, implementation barriers, corrective actions, and recommended scale-out approach.

Level 4 Outcome Linkage Framework. Recommended patient safety, retention, throughput, and quality measures to evaluate training impact, with an attribution model the customer can defend.

Executive Dashboard Prototype. Visual summary of competency currency, validation status, risk areas, and outcome trends — suitable for governing-body and senior-leader briefings.

Sustainment SOP. Governance model, roles, cadence, data stewardship, and continuous-improvement process to keep the architecture current after MPG departs.

A.3 Working inside existing systems

MPG's approach is **system-agnostic**. The objective is not to replace the learning management system, the human resources information system, the quality platform, or the electronic health record. The objective is to define the competency evidence architecture those systems must support and to help leadership create joinable records across existing data sources. Implementation typically lives inside the customer's current technology footprint, with the MPG team producing the standards, protocols, and specifications that the customer's existing platforms can host.

This positioning matters in federal procurement. It avoids the new-software-purchase profile (with its FedRAMP, ATO, and licensing implications) and remains within a professional services scope that contracting officers can route through existing services-acquisition vehicles.

A.4 Data sensitivity and federal environment alignment

Competency records, chart audits, and outcome-linkage data can implicate personally identifiable information (PII), protected health information (PHI), controlled unclassified information (CUI), and agency-specific data-handling rules. MPG engagements are designed to operate within the customer's existing privacy, security, and records-management framework. Where chart-level data is sampled, sampling is conducted in coordination with the customer's privacy and quality offices, under existing data-use authorities, and within the customer's environment whenever feasible.

MPG does not require new cloud infrastructure, does not require the export of patient-level data, and does not introduce a new system of record. The deliverables produced are specifications, protocols, and dashboards designed to be hosted by the customer's existing platforms. Where access to customer-owned electronic systems is required, MPG personnel comply with the customer's onboarding, training, background, and access controls.

A.5 Target federal healthcare environments

The competency-evidence gap described in this article is especially relevant for large, distributed healthcare systems where nursing practice occurs across multiple facilities, care environments, and documentation platforms. The MPG offering aligns well with the operating profile of:

- **Veterans Health Administration (VHA)** — large distributed nursing workforce, complex care environments, recurring accreditation cycles, strong emphasis on workforce competency, retention, patient safety, and standardized training evidence.
- **Defense Health Agency (DHA)** and the Military Treatment Facility network — clinical readiness, staff competency, turnover, training, and standardization challenges across geographically distributed facilities.
- **Indian Health Service (IHS)** — workforce shortages, rural care constraints, and competency validation challenges that amplify the audit-evidence problem.
- **Federal Bureau of Prisons (BoP)** and correctional healthcare — high competency, training-documentation, staffing, and patient-safety risk profile.
- **HHS operating divisions** and federally funded healthcare programs — applicable to technical assistance, quality improvement, workforce modernization, and training-evaluation lines of effort.
- **State and local public hospitals** participating in cooperative purchasing or grant-funded quality programs — adjacent but procurement-accessible through similar mechanisms.

A.6 Market-research language for acquisition staff

The paragraph below is written for direct reuse in a Request for Information (RFI), sources-sought notice, or market-research summary. Agencies are welcome to copy or adapt it.

> *Agencies seeking to assess this capability should ask vendors to describe prior experience designing workplace competency validation programs; methods for post-training behavioral observation; approaches to evaluator and preceptor calibration; ability to integrate competency evidence with existing learning-management, human-resources, quality, and patient-safety records; and experience linking training interventions to operational outcomes. Vendor responses should distinguish consulting deliverables from software products and should describe how proposed methods would operate within the customer's existing data-security and records-management framework.*

A.7 Why MPG

MPG is a **service-disabled veteran-owned small business (SDVOSB)**. The principal, Adam J. McLean, PhD, served 30 years as a United States Air Force officer; commanded the 63rd Air Refueling Squadron at MacDill AFB; served as Chief of Operations at the United States Strategic Command Global Operations Center; directed a $563 million Department of Defense human-performance training contract as Lead Associate at Booz Allen Hamilton across Army, Navy, and Air Force programs; and holds a doctorate in performance psychology from Grand Canyon University. The MPG Framework™ is the seven-document controlled set registered with the U.S. Copyright Office in May 2026.

High-reliability operational environments — military aviation, nuclear command and control, special operations — do not treat training completion as competence. They require validated performance, calibrated evaluators, repeatable records, and command visibility into readiness. Federal healthcare is mov-

ing toward the same expectation. MPG translates the discipline of one environment into the records architecture the other now requires.

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