

Conceptual position paper

Reframing Residency in Nursing

A Prelicensure-to-Professional Nursing Residency Continuum

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Abstract

Nursing education and workforce development are organized through disconnected labels and structures. Prelicensure learners may be called students, externs, interns, apprentices, or capstone students; after licensure, newly registered nurses may be called graduate nurses, orientees, residents, or transition-to-practice participants. This fragmentation obscures one developmental journey and weakens accountability at the academic-practice boundary. Medicine offers a useful design lesson: visible progression, shared terminology, explicit supervision, and increasing responsibility across a professional continuum. Nursing should not copy medical hierarchy or imply licensure before it exists, but it can adapt these organizing principles. This conceptual position paper proposes a Nursing Residency Continuum comprising four explicitly prelicensure levels, three postlicensure RN residency levels, and optional chief resident and specialty fellowship stages. Progression is competency-based and anchored in public transparency, regulatory compliance, academic-practice co-governance, psychological safety, paid access, and equity accountability. Recent evidence supports structured transition programs and suggests that formal paid clinical employment during nursing school strengthens confidence, competence, professional identity, belonging, and workplace socialization. However, heterogeneous methods and inconsistent outcome definitions do not justify claims that terminology alone will improve readiness or retention. National consensus development and multicenter pilot testing are therefore required. Nursing leaders can begin by mapping learner labels and handoffs, crosswalking shared competencies, and piloting an equity-protected senior prelicensure residency linked to, but not substituted for, a structured postlicensure transition program.

Keywords: Nursing education; nurse residency; transition to practice; competency-based education; academic-practice partnership; workforce equity; professional identity

Position

Nursing should establish a nationally co-designed, competency-based Nursing Residency Continuum that makes professional development visible from prelicensure formation through transition to practice and specialty development. The continuum must preserve the licensure boundary, require explicit student or prelicensure modifiers, protect paid and equitable access, and undergo rigorous evaluation before broad adoption.

The Problem Is Larger Than a Name

What if nursing stopped treating graduation as the moment professional formation begins? The question exposes a structural contradiction. Nursing programs are expected to prepare practice-ready graduates, health systems are expected to transition newly licensed nurses safely into increasingly complex roles, and learners are expected to integrate knowledge, clinical judgment, workload management, professional identity, and organizational culture. Yet these responsibilities are usually organized as separate educational and employment projects rather than as one developmental system.

The language mirrors the fragmentation. A learner may move from nursing student to clinical student, extern, intern, capstone student, graduate nurse, orientee, and nurse resident within a short period. Each label may be locally sensible, but the sequence rarely communicates what the learner has demonstrated, what supervision is required, which competencies should transfer, or who is accountable for the next stage. The result is an educational cliff at graduation: competency evidence is lost at handoff,

some preparation is repeated, other support is delayed or omitted, and the new nurse is asked to reconcile two systems while simultaneously assuming licensed responsibility.

Transition shock gives this discontinuity a human face. Newly graduated nurses have described anxiety, insecurity, inadequacy, instability, and broad physical, intellectual, emotional, developmental, and sociocultural changes during initial role adaptation [1]. A systematic review found that transition strategies were associated with improvements in confidence, competence, job satisfaction, and critical thinking and with reductions in stress and anxiety, although study quality and intervention design varied [2]. The persistence of transition difficulty suggests that the answer cannot be a stronger orientation alone. The profession must examine continuity before, across, and after licensure.

Conceptual Approach

This article is a conceptual position paper, not a systematic review or an evaluation of an implemented program. The proposed framework was developed through an integrative examination of recent systematic and scoping reviews, transition-to-practice evidence, nursing education standards, academic-practice partnership guidance, and authoritative descriptions of medical education. The analysis compared how the two professions make learner status, developmental progression, supervision, assessment, and advanced formation visible. Concepts that could be adapted without changing nursing licensure, scope, or disciplinary identity were translated into design principles and an illustrative continuum.

The analysis was also informed by the author's experience across health-system nursing education and nonprofit workforce development. These practice contexts helped identify recurring discontinuities in terminology, access, supervision, and developmental handoffs; they are not presented as implementation sites or as evidence of organizational endorsement. The author's nonprofit affiliation is reported on the title page because its mission includes nursing education, professional development, and equitable workforce pathways; the main text otherwise remains suitable for blinded review.

The framework is intentionally presented as a proposition for consensus development and pilot testing. It should not be interpreted as an endorsed standard, a new credential, a substitute for accreditation, or evidence that a renamed program improves outcomes. Its purpose is to make a fragmented problem discussable and testable at the system level.

Why Terminology Functions as Infrastructure

Professional language does more than describe experience. It distributes attention, authority, resources, and expectations. When a health system calls one experience an externship, another an internship, and a third a residency, the names often carry different assumptions about compensation, supervision, selection, curriculum, evaluation, and organizational responsibility. Those assumptions may be invisible until a learner moves between programs. A common continuum would force partners to specify what each stage means rather than allowing the same label to conceal widely different conditions.

Terminology also shapes professional identity. Student labels appropriately communicate legal status, but they can position clinical learning as temporary observation rather than participation in a developing profession. Employment labels may signal usefulness to the organization without recognizing an educational obligation. Postlicensure residency labels finally make structured development visible, but only after the legal transition has occurred. An explicitly prelicensure residency designation could communicate that professional formation is already underway while retaining

the student modifier that protects the public. Its value would come from the expectations attached to the title: progressive competency, prepared supervision, reflective learning, feedback, and a defined relationship to the next stage.

For leaders, common terminology can create a data architecture. If stages are defined consistently, organizations can examine entry, advancement, completion, handoff, and retention across the pipeline. Without common definitions, a high completion rate in one program may not be comparable with completion elsewhere, and retention may refer to the unit, organization, system, specialty, or profession over different intervals. The proposed continuum therefore treats names as the visible layer of a deeper operating model. Standardized language is not sufficient for transformation, but transformation is difficult to govern when participants do not share language for the work.

What Nursing Can Learn From Medicine

Medical education makes development legible. Learners progress through undergraduate medical education, residency with postgraduate-year designations, selected chief resident roles, fellowship, and independent practice. Competency-based medical education emphasizes observable abilities and patient-centered outcomes across that continuum (Association of American Medical Colleges [AAMC], n.d.). The transferable lesson is not that nursing should adopt physician identity. It is that professional formation benefits when progression, supervision, responsibility, and assessment share a visible architecture.

The distinction is essential. Medical students do not become physician residents before graduation, and nursing students must never be represented as licensed nurses. The Accreditation Council for Graduate Medical Education (ACGME) acknowledges that multiple health professions use the terms resident and fellow and emphasizes accurate credentials and transparency to prevent confusion (ACGME, n.d.). Nursing can therefore use residency language only if learner status is unmistakable to patients, families, staff, and regulators.

Design function	Medical education precedent	Nursing adaptation
Progression	Recognized stages across education, residency, and fellowship	One continuum from explicitly prelicensure formation through RN residency and specialty development
Assessment	Competencies and observable developmental milestones	AACN Essentials-aligned progression indicators and verified practice evidence
Supervision	Responsibility increases with competence and program level	Role-specific supervision and delegation within applicable nursing law and policy
Transparency	Credentials and training status are stated	Student/prelicensure modifier, visible identification, and clear patient-facing introductions
Governance	Accredited programs share defined requirements	Academic-practice co-governance with regulatory review and common evaluation definitions

Evidence for Connecting the Continuum
Prelicensure formation already influences transition

The transition to practice begins before licensure because learners form professional identity, expectations, clinical confidence, and workplace understanding during nursing school. A 2026 qualitative systematic review of 12 studies and 92 findings concluded that formal paid employment and health-related work during undergraduate education contributed to professional identity, clinical competence, confidence, workplace familiarity, and socialization [3]. The same review identified role-

boundary problems, variable supervision, and conflicting expectations. These findings support structured prelicensure employment but warn against loosely defined work experiences that rely on the learner to recon-

cile employee and student roles.

Belonging is another bridge between education and readiness. [4], synthesized 25 articles describing 20 studies and found that clinical belonging was associated with greater opportunities for learning and skill development and with confidence in clinical problem solving, patient assignments, and skill performance. A continuum should therefore treat belonging and psychological safety as developmental conditions, not as optional wellness outcomes. A label that increases exposure without strengthening relational support could intensify rather than reduce harm.

Undergraduate education also has implications for retention after qualification. [5], argued for stronger preparation related to resilience, the emo

tional and physical impact of practice, confidence, career progression, authentic leadership, and shared university-employer commitment. These are precisely the domains that disappear when prelicensure and postlicensure programs are treated as unrelated.

Postlicensure transition programs are valuable but inconsistently defined

Nurse residency and transition-to-practice programs are established workforce interventions, yet the evidence base remains difficult to compare. NCSBN's national work found better outcomes when programs were formalized, integrated into the organization, supported by senior leadership, paired with prepared preceptors, sustained for 9 to 12 months, and designed to provide feedback, reflection, and specialty-relevant content (National Council of State Boards of Nursing [NCSBN], n.d.). These features describe organizational infrastructure rather than a single curriculum.

A 2024 systematic review found nurse residency programs promising for first-year retention but included only five eligible studies and could not perform meta-analysis because of methodological heterogeneity [6]. A subsequent systematic review of 19 reviews reported connections between transition programs and critical thinking, competency, and retention, while also finding low overlap among reviews, inconsistent program defi-

nitions, limited patient-level outcomes, and unresolved questions about optimal duration [7]. The appropriate response is not to abandon residency. It is to define it more carefully and evaluate it more consistently.

Recent studies reinforce the need to distinguish program format from program function. In a national observational study of 3,153 newly licensed nurses, virtual and in-person residency cohorts had comparable overall transition scores after adjustment, although virtual participants reported weaker peer interaction and support [8]. A five-year organizational review likewise emphasized the need for standardized retention definitions to support valid comparisons [9]. A continuum can create the definitional and measurement discipline needed to learn across formats and settings.

The Nursing Residency Continuum

The Nursing Residency Continuum is a competency-based nomenclature and governance framework spanning prelicensure formation, entry into licensed practice, and specialty development. The labels create a common map; they do not create a license, employment status, credential, or scope. Levels I-IV can align with phases of a program, but advancement should depend on demonstrated development rather than semester, seat time, or degree type. This preserves applicability across associate degree, baccalaureate, accelerated, diploma, and other approved entry pathways. and summative information require explicit policy. The receiving organization

Proposed title	Focus	Illustrative outcomes	Required safeguard
Prelicensure Nurse Resident I	Foundations	Professional identity, safety, communication, assessment, supervised participation	Explicit student status; faculty-led assessment
Prelicensure Nurse Resident II	Clinical integration	Concept integration, basic prioritization, teamwork, patient-centered care	Shared faculty-practice feedback; defined activities
Prelicensure Nurse Resident III	Advanced readiness	Clinical reasoning, population health, quality, informatics, delegation concepts	Common rubrics and progression review
Prelicensure Nurse Resident IV	Immersion	Paid or credit-bearing senior immersion and readiness portfolio	Named preceptor, protected learning time, equitable access
RN Resident I	Orientation	Role entry, unit competence, workload progression, safety and escalation	Licensed scope, prepared preceptor, intensive feedback
RN Resident II	Consolidation	Clinical judgment, communication, evidence use, reflective practice	Cohort learning, coaching, peer support
RN Resident III	Integration	Professional autonomy, improvement, career planning, system navigation	Completion based on outcomes, not attendance alone
Chief Nurse Resident	Peer leadership	Resident voice, peer learning, program improvement	Not a management title; transparent selection and workload protection
Nursing Specialty Fellow	Specialty formation	Advanced development after foundational transition	Qualified mentors, specialty standards, defined outcomes

Note. Titles and outcomes are illustrative and require consensus development, legal review, and pilot evaluation. Prelicensure titles must never be shortened to 'nurse resident' in patient-facing use.

From Nomenclature to an Operating Model

A continuum changes practice only when the stages are linked. The first linkage is curricular. Academic and practice partners should identify a limited set of competencies that persist across licensure while the expected level of performance and supervision changes. Communication, clinical judgment,

escalation, evidence use, professionalism, patient-centered care, teamwork, quality, and informatics are likely candidates because they span the educational and employment boundary. The goal is not to make a school

curriculum identical to employer orientation. It is to make the relationship between them explicit enough that the next stage can build on verified learning.

The second linkage is the learner handoff. A traditional transcript confirms courses and grades but provides limited information about observed performance in context. A residency-continuum handoff could include a concise competency profile, learner reflection, areas requiring continued coaching, and verified experiences. Such a handoff must be learner-centered and cannot become an informal blacklist. Consent, access, correction procedures, data retention, and the distinction between formative

remains responsible for its own assessment of safe practice and cannot outsource hiring or orientation decisions to an academic portfolio.

The third linkage is shared faculty and preceptor development. Learners experience discontinuity when academic and practice evaluators use different language for the same behaviors or apply different thresholds without explanation. Joint preparation can establish consistent observation, feedback, coaching, psychological safety, and escalation practices. It can also clarify when the learner is functioning in a student role, an employee role, or both. Role clarity is especially important in paid prelicensure models, where productivity pressures may compete with learning needs.

The fourth linkage is governance. A standing academic-practice body should review progression criteria, learner experience, preceptor capacity, access and compensation, safety concerns, and outcome data. Students and newly licensed nurses need voting or otherwise meaningful representation rather than symbolic consultation. Governance should include authority to pause a pathway when role confusion, inequitable selection, inadequate supervision, or unsafe workload progression appears. In this sense, residency is not simply a curriculum delivered to individuals. It is an organizational commitment to develop them responsibly.

Design Principles

Competency before chronology

Levels should communicate demonstrated development. Time can structure opportunity, but it cannot substitute for evidence. The 2026 AACN Essentials and associated progression indicators provide a contemporary foundation for identifying observable behaviors across professional nursing education [10]. The continuum should crosswalk these indicators with organizational competencies and postlicensure expectations rather than build a parallel competency system.

One visible licensure boundary

Every prelicensure title must include student or prelicensure in full. Identification badges, introductions, documentation permissions, permitted activities, supervision, and patient education must state the learner's status. RN Resident should begin only after authorization to practice under applicable law. Because nurse practice acts vary, each pilot requires jurisdiction-specific legal and regulatory review [11]. If a modified residency title remains likely to confuse the public, Nursing Formation Resident or another locally approved term should be used.

Academic-practice co-governance

Schools and practice organizations should jointly define outcomes, supervision, faculty and preceptor preparation, learner handoffs, data governance, escalation processes, and evaluation. The AACN/AONL Academic-Practice Partnership Playbook emphasizes shared vision, practice readiness, workforce sustainability, and measurable partnership outcomes [12]. The continuum converts those principles into a developmental operating model.

Paid and equitable access

A national framework must not turn high-value clinical exposure into a privilege for students with financial flexibility, transportation, schedule control, or insider access. Senior immersion and employment-based pathways should be paid whenever learners provide organizational value. Selection criteria, compensation, schedules, transportation supports, disability access, and advancement decisions require equity review. Access and outcomes should be stratified by race and ethnicity, first-generation status, socioeconomic position, disability, program type, geography, and practice setting where legally and ethically appropriate. The National Academies' Future of Nursing 2020-2030 report makes clear that robust education and supportive work environments are prerequisites for nursing's health equity mission (National Academies of Sciences, Engineering, and Medicine

[13].

Psychological safety and belonging

Progression systems can support growth or magnify hierarchy. Feedback, remediation, error reporting, and coaching must be designed to support learning without humiliation, retaliation, or avoidable exclusion. Preceptors need preparation, time, and escalation support; learners need accessible mechanisms to report role conflict, incivility, unsafe assignments, or bias. Chief resident roles should elevate resident voice without creating popularity-based status or uncompensated labor.

Portable evidence and responsible data use

The learner handoff should communicate verified evidence, not subjective reputation. A portable portfolio might include observed competencies, reflective work, simulation outcomes, and learner goals, but it must protect privacy, consent, and due process. Data should support development rather than become a hidden hiring screen. Learners must know what is shared, with whom, for what purpose, and how inaccuracies can be challenged.

Anticipated Objections

A student cannot be a nurse resident

This objection is legally and ethically serious. The response is not to blur the boundary but to make it more visible. The full title must always be Prelicensure Nurse Resident or Student Nurse Resident. No element of the framework permits independent nursing practice before licensure. Local law and public understanding take priority over terminology.

The proposal medicalizes nursing

The framework does not import physician scope, financing, training length, or professional hierarchy. It adapts a systems-design principle: development should be visible, staged, assessed, supervised, and continuous. Nursing retains its own disciplinary knowledge, relational practice, population focus, and ethical commitments. The model should be governed by nursing and co-designed with students, patients, regulators, and interprofessional partners.

New terminology will not repair structural problems

Correct. A residency label without prepared preceptors, protected learning time, workload progression, fair compensation, psychological safety, and outcome accountability would be empty and potentially exploitative. The name should follow the model. It must never substitute for investment.

Levels could become status rankings

Levels should signal developmental support and verified outcomes, not personal worth. Advancement criteria must be transparent, remediation must be educational rather than punitive, and equivalent pathways must remain available across program types and settings. Chief resident selection deserves particular scrutiny so visibility, schedule flexibility, or proximity to leadership do not become hidden prerequisites.

From Concept to National Pilot

The immediate goal should be consensus and feasibility rather than rapid standardization. National organizations representing academic nursing, nursing leadership, professional development, regulation, students, and practice should convene a structured consensus process. The work should include direct-care nurses, patients and families, unions or workforce representatives, community and nonhospital settings, associate degree and baccalaureate programs, and learners whose pathways are often underrepresented in national design.

- Develop a national glossary distinguishing clinical education, externship, apprenticeship, orientation, transition to practice, residency, fellowship, and continuing professional development.

- Use a Delphi or comparable consensus process to refine levels, titles, competencies, supervision, and advancement criteria.
- Crosswalk the framework to the AACN Essentials, state requirements, organizational competencies, transition-to-practice accreditation standards, and specialty standards.
- Co-design a paid or credit-bearing Prelicensure Nurse Resident IV pilot linked to an existing 9- to 12-month RN residency while keeping licensure status and assessment rules distinct.
- Pilot in diverse academic-practice partnerships, including nonhospital and rural settings, with a shared minimum data set and phased or comparative designs when feasible.
- Publish feasibility, equity, implementation, patient, workforce, and cost findings before recommending accreditation or regulatory adoption.

Evaluation Agenda

Domain	Illustrative measures
Learner development	Competency progression; clinical judgment; confidence; professional identity; belonging; psychological safety; well-being
Transition	NCLEX success; handoff completeness; time to role milestones; orientation extension; remediation; peer and preceptor support
Workforce	12-, 24-, and 36-month retention using shared definitions; internal mobility; vacancy; contract labor; preceptor capacity
Patient and quality	Escalation behavior; safety events; selected unit-sensitive outcomes; patient understanding of learner roles
Equity	Access, compensation, advancement, attrition, and outcomes stratified by learner and program characteristics
Implementation	Acceptability; adoption; fidelity; feasibility; role clarity; supervision reliability; unintended burden
Economics	Program cost; learner financial burden; turnover avoided; productivity assumptions; return on investment with sensitivity analysis

The strongest initial study would not attempt to prove the value of the entire continuum at once. A pragmatic multisite pilot could test the senior prelicensure-to-RN-residency handoff, where discontinuity is most visible and where role, equity, and supervision safeguards can be assessed directly. Outcomes should be examined by program type and learner characteristics, and patient-level measures should be included when sample size and attribution permit.

Implications for National and System Leaders

For academic nursing organizations, the continuum offers a structure for translating competency-based education and progression indicators into academic-practice handoffs. For nursing leadership organizations, it offers a workforce architecture connecting preparation, onboarding, retention, professional governance, and specialty development. For professional development organizations, it clarifies the relationship among orientation, residency, fellowship, and continuing development. For regulators, it creates an opportunity to establish clear public-protection guardrails before terminology spreads unevenly.

System-level nurse educators can begin without changing titles. They can map every current learner and new-nurse program, identify duplicated or missing competencies, examine who gains access to paid prelicensure roles, and create a shared readiness handoff with academic partners. That current-state map becomes the baseline against which a future terminology or pathway pilot can be judged.

Limitations

The Nursing Residency Continuum is a conceptual framework and has not been validated through formal consensus, legal review across jurisdictions, or empirical testing. Its medical education comparison is functional rather than historical and does not account for major differences in regulation, financing, employment, program length, or professional scope. The evidence supporting prelicensure employment and postlicensure transition is heterogeneous and cannot establish that connecting or renaming programs will improve clinical, workforce, or equity outcomes. Some stakeholders may reasonably conclude that residency should remain exclusively postlicensure. These limitations make transparent consensus and pilot evaluation essential [14,15].

Conclusion

Nursing formation does not begin at hire, and professional transition does not end at orientation. The profession already has competency-based education, employment-based student roles, nurse residency programs, and specialty fellowships. What it lacks is a shared architecture connecting them. Medicine demonstrates the organizational power of visible developmental stages, but nursing must build a model faithful to its own identity, regulation, and equity commitments.

A Nursing Residency Continuum could turn a collection of programs into one developmental pathway. Its legitimacy will depend on more than language: explicit licensure boundaries, prepared supervision, portable evidence, paid access, psychological safety, academic-practice co-governance, and rigorous evaluation. The call to leadership is therefore both bold and practical: stop managing disconnected programs and begin designing one profession-wide journey.

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Author Roles

Conceptualization, analysis, framework development, and manuscript preparation: Tamara Washington-Brown.

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Organizational role and disclaimer

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References

1. Duchscher, J. E. B. (2009). Transition shock: The initial stage of role adaptation for newly graduated registered nurses. *Journal of Advanced Nursing*. 65: 1103-1113. <https://doi.org/10.1111/j.1365-2648.2008.04898.x>
2. Edwards, D., Hawker, C., Carrier, J., & Rees, C. (2015). A systematic review of the effectiveness of strategies and interventions to improve the transition from student to newly qualified nurse. *International*

- Journal of Nursing Studies. 52: 1254-1268. <https://doi.org/10.1016/j.ijnurstu.2015.03.007>
3. Park, S. A. S., Eckert, M., Sharp, R., Clark, B., & Peters, M. D. J. (2026). How employment-based clinical experience during undergraduate education influences transition to practice: A qualitative systematic review. *Nurse Education Today*. 160: 106988. <https://doi.org/10.1016/j.nedt.2026.106988>
 4. Nease, B., Corbett, C., Armstrong, S., & Casey, K. (2026). Clinical setting belongingness and development of perceived practice readiness in prelicensure nursing students: A scoping review. *Nurse Education Today*. 158: 106941. <https://doi.org/10.1016/j.nedt.2025.106941>
 5. Collard, S. S., Scammell, J., & Tee, S. (2020). Closing the gap on nurse retention: A scoping review of implications for undergraduate education. *Nurse Education Today*. 84: 104253. <https://doi.org/10.1016/j.nedt.2019.104253>
 6. Mohamed, Z., & Al-Hmamat, N. (2024). The effectiveness of nurse residency programs on new graduate nurses' retention: Systematic review. *Heliyon*. 10: e26272. <https://doi.org/10.1016/j.heliyon.2024.e26272>
 7. Miake-Lye, I. M., Schlak, A. E., Thies, J., Higgins, P. S., & Couig, M. P. (2025). A landscape of evidence on RN transition to practice programs: A systematic review of reviews. *Medical Care*. 64: S26-S37. <https://doi.org/10.1097/MLR.0000000000002230>
 8. Mastro, K. A., Giordano, N. A., Polomano, R., Smith, B. A., Book, K., Ballinghoff, J., & Mattioni, C. (2026). A comparison of transition experiences and practice readiness of newly licensed nurses with in-person and virtual residency training: A national observational study. *Nurse Education in Practice*. 91: 104721. <https://doi.org/10.1016/j.nepr.2026.104721>
 9. Failla, K. R., Pelletier, L. R., & Poeltler, D. M. (2026). Newly licensed nurse retention: What a 5-year review of data tells us. *a. Nursing Administration Quarterly*. 50: 3-8. <https://doi.org/10.1097/NAQ.0000000000000735>
 10. American Association of Colleges of Nursing. (2026). The Essentials: Core competencies for professional nursing education (2026 ed.). <https://www.aacnnursing.org/essentials>
 11. National Council of State Boards of Nursing. (2021). NCSBN model act. <https://www.ncsbn.org/papers/ncsbn-model-act> National Council of State Boards of Nursing. (n.d.). Transition to practice study results. <https://www.ncsbn.org/nursing-a-regulation/practice/transition-to-practice/study-results.page>
 12. American Association of Colleges of Nursing, & American Organization for Nursing Leadership. (2025). Academic-Practice Partnership Playbook: From shared vision to action. <https://www.aacnnursing.org/academic-practice-partnerships/implementation-tool-kit>
 13. National Academies of Sciences, Engineering, and Medicine. (2021). The future of nursing 2020-2030: Charting a path to achieve health equity. The National Academies Press. <https://doi.org/10.17226/25982>
 14. Accreditation Council for Graduate Medical Education. (n.d.). AC-GME frequently asked questions. <https://www.acgme.org/about/acgme-frequently-asked-questions/>
 15. Association of American Medical Colleges. (n.d.). Competency-based medical education. <https://www.aamc.org/about-us/medical-education/cbme>

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