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Innovative Approach to New Nurse Residency, Meaningful Use and Health Care Reform

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Abstract

The project's aim was to examine the financial impact of replacing registered nurse (RN) travelers, RN registry and RN overtime with new graduate RNs. Newly graduated RNs are often viewed by hospital administrators as a more costly staffing resource. This project contributes knowledge regarding the potential cost savings with the utilization of a centralized float pool incorporating new graduates. In addition, it contributes a novel idea for reducing organizational costs of implementing an electronic medical record with the utilization of new graduates as super users.

A new graduate program, which incorporated the use of a formal preceptor and mentoring program, was designed to train 100 nurses over the next four years. New graduates were hired as non-benefited employees into a centralized float pool. The first two cohorts consisting of 54 new graduates completed training in April 2013 and June 2013. Data were collected over a 12 month period using organizational financial reports and group discussions with the new graduates.

Overtime decreased in the areas new graduates were hired and traveler/registry usage decreased to 26.4 FTE below the budgeted level. From April 2013 through September 2013 the savings contributed to the new graduate project was two million dollars. In October 2013 an additional $500,000 was saved due to the new graduate project and this monthly savings is expected to continue. Utilizing new graduates as super users also saved the organization 375,000 dollars. Implementing a new graduate program and replacing RN traveler, registry and overtime hours proved to be cost effective.

Section II: Introduction

Prior to the recession, new nursing graduates could easily locate organizations that would hire and provide them with the additional training required to acclimate to the role of an RN. Due to the 2007 United States (US) recession, the projected nursing shortage was mitigated when experienced nurses either returned to the work force, increased the hours they were working, or delayed retirement (Buerhaus, Auerbach, & Staiger, 2009). These nursing actions resulted in hospitals' ability to elect not to invest in the costly training of new registered nurse (RN) graduates as part of the organization's financial strategic plan

Background Knowledge

Historically, the variations and vacillation between nursing supply and demand are closely aligned with the overall economy. Because nursing is still predominantly a female profession, many women who are married with children, elect not to work full time. When the economy is stable with low national unemployment rates, many nurses choose to only work enough to maintain their skills and/or licensure, increase the household income, and/or maintain employment as a safety mechanism in case of unexpected financial demand. Traditionally, when the national economy shows high unemployment, health care exhibits an ability to hire additional RNs, which increases the overall hospital employment (Staiger, Auerbach, & Buerhaus, 2012). During the 2007 economic downturn, this phenomenon was again seen, as many part time RNs returned to full time employment, and many delayed retirement; therefore, nursing experienced the largest employment growth seen in the last four decades (Buerhaus, et al., 2009; Staiger et al., 2012).

As a direct result of this economic downturn, new RN graduates experienced a high unemployment rate. The California Institute for Nursing & Health Care (CINHC) reported that in

2009, due to the changing economy, 40% of new RN graduates may not locate a hospital that would provide new graduate training opportunities. In 2009, there were 116,000 nursing positions which were intentionally left vacant (Derksen & Whelan 2009). In 2012, 43% of RNs who graduated within the previous 18 months were still unemployed as an RN. Ninety-two percent of RNs reported the reason prospective employers were not hiring them was because they lacked experience. Hospitals reported that it was too costly to train new graduates and it was more advantageous for them to hire travelers or have their existing staff work more hours (CINHC, 2012).

Patricia Benner's novice to expert theory (1984) suggests that a new RN graduate is a novice for the first year and does not reach independence and competency until year two or three. Hospitals and executives recognize that new graduates need additional training to perform effectively as RNs, and view this transition as costly to an organization with a questionable return on investment (ROI). During the first 12 to 16 weeks, and sometimes longer, the new RN graduates participate in an extensive orientation. During the first year, new graduates need support, additional training, and require more resources from the organization. Registered nurse graduates are hired into organizations at a starting salary of approximately 4,000 dollars less per year as compared to a nurse with one or more years of experience (Pay Scale, 2013).

Hospital administrators worry about spending substantial amounts of money on a new RN graduate with no guarantee of an ROI. Unlike new RN graduates, hospitals receive substantial funding from the government through Medicaid and Medical to support physician residency training programs. It is also recognized that when a physician finishes medical school, there is additional on-the-job training needed before the Physician is ready to practice independently. Physicians work as residents for four years and are paid a stipend versus a

traditional physician salary. Residents are paid between 40,000 to 55, 000 thousand dollars a year during their residency program, versus the 190,000 dollars or more they are paid after completing residency (MD Salaries, 2011). In hospitals where residents receive training, administrators do not worry about ROI through retention of the resident. Hospitals receive the ROI through the work the resident performs at a reduced cost and through the Medicare and Medical funding.

With respect to registered nurses new graduates, executives have chosen to utilize more registry/travelers and increase both the number of regular and overtime hours worked by current staff. Having existing staff work more hours has resulted in nursing staff now having less time away from work. Studies have shown that nurses are working more than 40 hours a week when evaluating multiple positions held at different locations during the same time period (Bae, 2012). Working more than 40 hours per week increases the possibility that an RN will make a medication error or be injured by a needle stick (Olds & Clarke, 2010). Nurses working longer than 12.5 hours have been shown to be three times more likely to report an error (Olds & Clarke, 2010).

Increased work hours have been linked to an increase in injury, fatigue, inpatient mortality, and high RN absenteeism (Trinkoff et al., 2011; Laschinger, Wilk, Cho, & Greco, 2009). In Canada, the RN work environment has been associated with generating more RN sick time compared to any other profession (Greco, Laschinger, & Wong, 2006). This unplanned sick time leads to more overtime by the nursing work force and an increase in the number of hours nurses work during a week as other nurses cover for the shortages. Many nurses report that they do not want to work these increased hours. The reason they often work overtime or extra shifts is because they do not want to leave their co-workers short staffed and they worry about their

patients. This high absenteeism in Canada is equal to 19,000 full-time equivalents when combining the sick time with the overall amount of overtime used by hospital staff (Greco et al., 2006).

Studies conducted by Rogers, Trinkoff et al. and Stone et al. have shown that patient care, nurses, and healthcare organizations are negatively impacted when nurses work longer shifts and have less time away from work (Rogers, 2004, Trinkoff et al., 2011 & Stone et al., 2007). Industries such as trucking, airline pilots and medical residency programs have implemented restrictions on how many hours a person can work each week as a public safety concern. While many states have passed laws preventing organizations from imposing mandatory overtime for nurses, legislation to restrict the number of hours a nurse can work each week has not yet reached the legislative floor (Dziuba-Ellis, 2005). Even the 2013 recommendations around nursing staffing neglect any regulations around limiting the hours an RN can work in a week (Schakowsky, 2013). Whether leaders have an obligation to restrict hours their current staff work as a safety concern has been debated. The dilemma is whether to use overtime or be understaffed.

While hospital administrators have turned to utilizing travelers/registry staff as a cheaper alternative to training new RN graduates, RNs through traveling companies are projected to cost twice as much as a regular staff member would cost an organization (Weist, Huff, & McMillan, 2009). Lee Memorial Health System was able to save 11 million dollars through the elimination of registry staff in 2008 (Weist et al., 2009). Trepanier, Early, Ulrich, Cherry (2012) reported that residency programs saved organizations money through retention of new graduates, accelerating the new graduates competency, and reduction of registry and overtime for staffing. They estimated the savings at possibly as much as 33.6 million dollars for the 15 hospitals

included in the study (Trepanier et al., 2012).

Using registry staff as a strategic plan to replace nursing staff also has an effect on the patients and staff. Existing staff work harder to pick up the slack of the registry staff, which may not be competent or trained in all elements needed to perform their role effectively or due to their unfamiliarity with the specific organization or unit. Staff members are forced to retrain new nurses who are not consistently employed and have no loyalty to the organization or their peers. Hospitals are responsible for assuring the registry staff nurses are trained and competent. However, hospitals with staff units consisting of more than 15% registry staff have shown an increase in patient falls and other negative effects on patient care (Bae, Mark, & Fried, 2010).

The United States has been predicting a massive nursing shortage for decades related to the aging workforce, decreased enrollment in nursing schools, technological advancement, and the aging Baby Boomers who will need more care. Currently, the average age of the national RN workforce is 46 years, with 50% of the workforce being close to retirement (ANA, 2012). It is predicted that 20% of the nursing workforce will no longer be actively employed in 2020 (Hayes, Booner, & Pryor, 2010). As technology advances and treatment modalities become more complex, projected nursing growth will be 2-3 % for several years (Buerhaus, Potter, Staiger, & Auerbach, 2008). The Bureau of Labor Statistics predicted that 581,000 new RN positions will be created by 2018 (Rosseter, 2012). As 2020 approaches, the U.S. government predicts that the retirement of nurses, along with the increase in nurses needed to care for the aging population, will create a nursing shortage between 400,000 to 1,000,000 RNs (Winter, 2009).

The US economy is currently recovering and it is expected that full employment will be reached nationally in 2017 (Staiger et al., 2012). As of May 2011, 10,000 Baby Boomers reach retirement age every day, and this trend will continue for the next 19 years (Staiger et al., 2012).

In 2006, it was predicted that nurses would start to retire in large numbers in 2011, and that this trend would continue through 2020 (Rosseter, 2006). As the national economy improves, it is predicted that nurse retirement rates will increase. Unfortunately, the downturn in the US economy has delayed the retirements thus creating a false sense of security with respect to the nurse supply and demand.

Regrettably, the nursing shortage is not the only threat to ensuring a sufficient nursing work force. The hospital environment, where the nursing profession predominantly practices, is leading to job dissatisfaction throughout the world. In 2001, the United States had the highest percentage of dis-satisfied nurses at 41% compared to other English and Chinese speaking countries (Lu, Barriball, Zhang, White, 2012). In 2010, the American Nurses Association reported that 53% of nurses were currently considering leaving the profession (Faller , Gates, Connelly, 2011). Unfortunately, it is not only older nurses who are considering leaving the profession. A 2011 survey conducted by AMN Healthcare reported that 32% of younger nurses, currently working, were planning to leave the profession in the next three years (AMN Healthcare, 2012).

Short staffing, long hours, and the restructuring of health care is demanding direct care providers to increase productivity while improving both patient satisfaction and quality of care. The overall job dissatisfaction is causing the younger nurses to report burnout. “Burnout comprises chronic emotional exhaustion, cynicism and detachment from work, and feelings of ineffectiveness in the job” (Laschinger & Leiter, 2006, p. 260). In examining the history of the nursing workforce during health care restructuring in the 1990s, it was found that 28% of nurses left the profession due to job dissatisfaction (Block, Claffey, Korow, & McCaffrey, 2005). Literature indicates several factors affecting nurse satisfaction; however, organizations can

improve nurse satisfaction through proper staffing, improved perceptions of the work environment, and the empowerment of nurses (Block et al., 2005; Kutney-Lee, Wu, Sloane, Aiken., 2012; McHugh, Kutney-Lee, Cimiotti, Sloane, Aiken., 2011).

Prior to the current economic crises, in 2002, the overall RN nationwide turnover rate was 21.3%, which made it difficult to for hospitals to ensure adequate staffing (Kleinman, 2004). This was compounded by the fact that prior to the recession, 60% of new graduates would resign their position due to lateral violence (Nursing Swat Team, 2011). The overall transition period for new nurses traditionally has resulted in exhaustion and burnout within the first 18 months (Duchscher, 2008). Because of this challenging transition, new graduates hired usually resign within one year, either locating a job with another organization or leaving the profession entirely (Duchscher & Myrick, 2008). Due to the extensive training required for a new graduate, the cost of this turnover is $88,000 every time a new graduate resigns (Kovner et al., 2009).

As a result of the cost and the turnover rate among new graduate nurses, many organizations have neither hired new graduates nor offered training or residency type programs for several years. Therefore, experienced staff did not have to train and mentor new graduates on a regular basis, which may make the new graduate transition more difficult. The decision to refrain from consistently hiring new graduates each year as part of a strategic work force plan is potentially a costly mistake for the nursing profession, patients, and the organization. Organizations that wait until the nursing shortage is evident will be forced to quickly re-create their new graduate hiring programs and hire large numbers of new graduates simultaneously. This sudden increase in a large number of novice nurses will potentially leave hospital units with insufficient experienced staff and place the patient, nurse, and organization at risk.

When units hire new graduates they require support by more experienced nurses in order

to deliver safe care. If the number of new nurses on a given unit exceeds the number of experienced nurses it will become difficult for the newer nurses to obtain information or support. Questions which the new nurses have may not be answered in a timely manner and either lead to delay in care or incorrect care delivered. The lack of support may lead to patient injuries which places the organization at an increased risk financially and may harm the organizations reputation.

New RN graduates need support with their transition from healthcare organizations. New graduates report that when they enter the work force, they do not have the expertise or confidence to perform in the current healthcare environment (Duchscher, 2008; Duchscher & Myrick, 2008). Overwhelmingly, 90% of hospital executives agree that new RN graduates are not prepared to provide safe care at the bedside (Berkow, Virkstis, Stewart, & Conway, 2008). A 10-year study revealed that new graduates have difficulty translating their clinical knowledge from academia to the bedside, resulting in 65% of new graduates demonstrating a lack of the necessary clinical skills to provide safe patient care (Ulrich et al., 2010).

To assist new graduates with the transition from academia to bedside, the Institute of Medicine (IOM) recommended formal internships and residency programs (IOM, 2010). These programs should also be provided as a means to improve quality of care and patient safety according to the Robert Wood Johnson Foundation, IOM, and the Carnegie Foundation (IOM, 2010; Benner, Sutphen, Lenard, 2010). New graduate programs have been shown to increase retention of the nursing workforce and reduce the cost of recruitment when these programs provide training to existing staff on how to be an effective preceptor and mentor (Block et al., 2005).

Formal preceptor and mentor programs affect the entire orientation positively and

enhance the socialization process of the new graduate. New graduates develop competence and increased confidence using these programs, which result in increased retention. These programs have been shown to reduce new graduate RN turnover (Trepanier et al., 2012). Preceptors and mentors also benefit from these programs with increased confidence and the ability to identify their own development needs (Block et al., 2005; Halfer, 2007). Organizationally, these programs have been associated with improving staff engagement, communication, patient outcomes, patient satisfaction, and physician satisfaction (Ulrich et al., 2010).

Local Problem (Alameda County Medical Center, Oakland California)

The Labor and Workforce Development committee predicted that California will experience a shortage of at least 117,000 registered nurses (Labor and Workforce Development Committee, 2008). Over the last several years, Alameda County Medical Center (ACMC) has hired a very limited number of new graduates. Instead, ACMC chose to staff nursing departments with existing staff working extra shifts/overtime or by utilizing travelers/registry. In the past, union contracts made it appear more financially advantageous to staff the organization using travelers/registry staff. Because of this decision, some shifts have operated with 80% of the staff being composed of traveling nurses. This high utilization of travelers has resulted in a constant influx of new staff, which requires constant orientation and training to the organizations population served and policies/procedures.

In 2011, ACMC spent over ten million dollars on traveling/registry nurses to staff the hospital's in-patient care areas. In addition to the ten million dollars spent on travelers/registry, another seven million dollars was spent on overtime worked by RNs. Relying on staff to work overtime on a regular basis has a negative effect on the organization and patients. Overtime in

the critical care arena has been linked to catheter associated urinary tract infections, decubitus ulcers, and medication errors (Sharp & Clancy, 2008).

In 2013, ACMC implemented a new Electronic Medical Record (EMR). To implement the new EMR, the organization needed to hire additional staff to provide care during training and to reduce the nursing patient loads when the system went live. ACMC hired 80 traveler RNs to care for patients to ensure that staff could be trained. However, due to the high registry prior to the EMR project, another 30 travelers were also needed for the role of super user. After the EMR implementation, all these nurses would leave the organization, taking their knowledge and skills with them.

At ACMC, new graduates are paid 39.54 dollars an hour by union contract. For each new graduate trained to a non-critical care area, training typically will last 12 weeks and cost $ 18,979 in salary to the new graduate. New graduates hired and trained into critical care areas require four additional weeks of training and will cost $25,305 per new graduate. At ACMC, the union contract also provides an additional 5% pay to preceptors. Each new graduate trained in non-critical care will therefore generate an additional $1,344 and $2,240 for critical care new graduates in preceptor pay. Providing preceptors with additional training will also cost approximately $1,920 for each new graduate hired, assuming two preceptors need to be trained. Re-establishing a new graduate program also has additional startup costs, requires additional personnel devoted to the training, and monitoring of new graduates. ACMC estimated that 30 new graduates would cost the organization approximately $734,790 (Appendix A).

For every shift in which a new graduate replaces nurses working overtime or a staffed traveler, the organization will save a minimum of $205. If a new graduate replaces a traveler 40

hours a week, they will make up their training salary and the cost of their preceptors between 14 to 30 weeks depending on if they are replacing traveler usage or staff overtime (Appendix B).

Intended Improvement/Purpose of Change

Alameda County Medical Center had three problems, which were all interconnected. First, ACMC had not been hiring new graduates for the last eight years on a regular basis, and was not prepared for the coming nursing shortage that was mitigated by the 2007 United States (US) recession. Second, because of the temporary delay in the nursing shortage, ACMC had elected not to invest in the training of new RN graduates, but instead relied on a high usage of travelers and overtime to meet staffing levels. Third, because of using overtime and travelers to staff the organization, there was not enough staff to fulfill the roles of super users for the EMR implementation.

The primary goal of this project was to reduce traveler usage and overtime. ACMC incorporated the hiring of per diem (non-benefited) new graduates into a centralized float pool as an organizational strategic plan to control costs and empower existing nursing staff. The objective was to hire 100 new graduates in groups of 15 to 30 over the next four years. It was estimated that four cohorts, consisting of 89 new graduates, would cost the organization 2,200,493 dollars in training costs (Appendix C & Appendix D).

The centralized float pool was designed to provide ACMC with an internal pool of nurses who could work in designated areas throughout the organization to replace the usage of travelers and overtime. The float pool was designed so decisions around where staff members were assigned throughout the organization were made within one central location. It was estimated the cost savings would be four million dollars after the new graduates worked for one year

(Appendix E). The centralized float pool was also created to provide nurses who would be ready to assume benefited positions as staff retired.

Additionally, since ACMC did not have the staff to supply the super users needed for the implementation of the EMR, a decision was made after the initial project was launched to hire 24 new graduates and train them as super users. Once the EMR was implemented, these 24 super users would then enter a new graduate training program. This decision was estimated to be a 60% cost savings initiative at approximately $700,000. This was not initially part of the organizational improvement plan.

ACMC developed a new graduate program, which were 12 weeks for non-critical care areas and 16 weeks for critical care areas. The program consisted of both classroom and orientation time in the departments with trained preceptors. Classes designed consisted of lecture, didactics, hands on demonstration, role-playing, and group discussions (Appendix F). The first two groups were hired into medical/surgical units; step down, telemetry, post-partum, and the operating room. This project will expand to the Skilled Nursing Facility, rehabilitation, ambulatory clinics, and psychiatric services by the end of 2014.

Prior to the new graduate programs, ACMC already had a preceptor/mentoring program. Four staff nurses were certified trainers that provide this class on an as-needed basis. This existing program was incorporated into the new graduate program. Staff members who would like to precept or mentor new graduates, who were not already trained, were provided with an opportunity to attend this formal training. This program was also assessed and evaluated during the implementation of the new graduate program for effectiveness and improvements.

An additional goal of the new graduate project was to establish a new pay rate for new graduates during their training period. A new job description was developed with a job title of

Resident (Appendix G). Initially, new graduates, who were hired into this new job description, were not hired as union members and were not guaranteed a job at completion of the program.

Section III: Literature Review

The literature review was completed using PubMed, Proquest, CINAHL, Google scholar, and nationally recognized healthcare internet sites as American Association of California Nurses, American Association of Colleges of Nursing, California Institute for Nursing and Healthcare (CINHC), Nursing World.org, and Health affairs.org. The topics reviewed were nursing shortage, job satisfaction of new graduates, cost savings through elimination of travelers and overtime, alternative transition plans for new graduates, float pools with new graduates, and EMR implementation with new graduates.

The Key words used in CINAHL and PubMed, *nursing shortage*, provided 16,021 and 13,272 responses, respectively. The search was then narrowed down to articles from the last five years, which yielded 2,546 and 251 responses, respectively. To further narrow the number of articles, the key term *new graduates* was searched, providing 2,224 articles and then narrowed down by including only United States articles and adding the additional key term of *new graduates no jobs*, resulting in 11 articles in which seven contained information regarding the nursing shortage. In searching literature on the nursing shortage, a research article was found examining who is leaving the nursing profession. This research was included in the literature review for its implications on the nursing shortage.

Is assessing new graduate job satisfaction, CINAHL and Proquest were utilized with the key terms *new graduate job satisfaction*. Initially CINAHL produced 3,456 and Proquest produced 1,043, respectively. Reducing the request to the last five years reduced CINAHL to 1,638 and Proquest to 489, respectively. Utilizing only peer-reviewed articles reduced the number to 390 and 113, respectively. Adding the key term *intention to quit* resulted in four

articles being identified. The majority of articles found were literature reviews or informative articles. Four research articles were selected.

In examining cost savings through the elimination of registry and overtime, Proquest was utilized with key terms *nurse fatigue and medical errors*, resulting in 113 articles from2004 - 2013. After removal of studies outside of the US and removal of studies that did not address nurses working longer hours in relation to patient safety, 17 articles remained. Upon reviewing the 17 articles, the majority of these articles were reviews of other articles or surveys of nurses. Three articles that discussed studies completed on patient safety in relationship to increased nursing work hours were incorporated in this literature review. Another search was done to examine the effects of nursing turnover on patient care. Proquest produced 33 articles. The majority of these articles discussed the impact of nursing management turnover on patient care. Only one article was found that directly reviewed the impact of nursing turnover on patient care, and was therefore included in this study. The last search was done to find the cost savings through the elimination of travelers two articles were found and included.

In examining nursing float pools, only 11 articles were located and out of those, only two pertained to float pools, while the rest of the articles addressed floating practices within the organization. The search for float pool utilization of new graduates was expanded to 1999 to locate information on the utilization of float pools, resulting in more articles being located. Two of the articles on float pools were low in quality due to extremely low sample size and transferability to other clinical settings being unclear. Four reviews of implementations of float pools were included, along with one literature review.

Only one article was located on EMR implementations utilizing new graduates; however, there are no studies. Twenty-seven sources of evidence were identified and utilized. The Johns

Hopkins Hospital evidence based tool (JHNEBP) was used to assess the quality and strength of the evidence.

Nursing Shortage

The literature overwhelmingly indicated that the nursing shortage has been postponed due to the economy (Appendix H). The American Nurses Association (ANA), a recognized expert leader in the healthcare arena, reported that the average age of the national RN workforce is 46, with 50% of the workforce being close to retirement, and that 20% of the current nursing workforce will no longer be actively employed in 2020 (ANA, 2012).

The American Association of Colleges of Nursing produced a document called the Nursing Shortage Fact Sheet (2012). Within this document is a collection of information on the driving forces for the coming nursing shortage. This fact sheet contains data from 2002 to 2012. One of the driving factors listed is the growth of jobs seen recently in the healthcare arena. In 2012, one in five jobs created in the United States were in healthcare. February 2012 alone showed an increase in 49,000 healthcare jobs. The Bureau of Labor Statistics (2012) listed RNs to be the top occupation for job growth through 2020, predicting that the number of RNs employed will go from 2.74 million to 3.45 million in 2020. With the current estimated nurses retiring and the new jobs being created, it is projected that 1.2 million nurses will be needed by 2020.

Buerhaus et al. (2009) retrospectively examined data from 1977 to 2008 gathered by the United States Census Bureau through Current Population Surveys, administered to 100,000 individuals in the US on a monthly basis. Over 3,000 nurses are represented in this sample every year. They created a forecasting model and used regression analysis to look at the trends past economies have had on the nursing workforce to predict future trends (Buerhaus et al., 2009).

This model revealed increased RN employment when the economy was poor and decrease in RN employment when the economy was good. One contributing factor was that 70% of RNs are married, and as economies decline, nurses return to work to increase family income; the inverse holding true in times of economic health (Buerhaus et al., 2009).

As the current economy declined in 2007 and 2008, this phenomenon continued as health care saw the largest growth in RN FTE at 18%. However, this increase was primarily generated by nurses over 50 years of age. Their prediction aligns with other experts that the shortage is still coming; estimating that the shortage will begin in 2018, reaching a shortage of 260,000 nurses by 2025 (Buerhaus et al., 2009).

Nooney, Unruh, and Yore (2010) completed a retrospective analysis to determine why nurses were choosing to leave the profession and if there were characteristics that increased the risk of a person leaving nursing. The researchers used data from the 2004 National Sample Survey of Registered Nurses, which were collected from Health Resources and Services Administration, in which 29,472 nurses participated. This survey was mailed to actively licensed RNs throughout the United States every four years and has a 70.47% return rate. In Nooney et al.'s (2010) study, nurses were classified as either exiting the work force entirely or changing careers. They examined how family structure, education, gender, and socioeconomics were correlated with attrition.

In examining age, as expected, nurses between 60 to70 are exiting the work force permanently for retirement. However, career change or exiting the work force starts increasing in the 30 to 40 year old category. Family structure was correlated with exiting the work force and for career change. Nurses with children were found to be two and a half times more likely to leave, and married women were twice as likely (Nooney et al., 2010).

Another interesting correlation was that possessing a BSN increased the possibility of leaving the profession. If a nurse was enrolled in school with another major; they were six times more likely to leave. While we have increased the number of male nurses, being male increases the risk of exiting the profession, while having an advanced degree such as nurse practitioner was found to reduce the chance of leaving the profession (Nooney et al., 2010).

There were some limitations to the study, as acknowledged during the study Women exiting with young children were considered permanently gone from the work force. Some of these women may leave the work force and return when the children are older. The researchers recommended a prospective longitudinal study to examine this topic more deeply (Nooney et al., 2010).

Job Satisfaction of New Graduates

With the anticipated nursing shortage, it is imperative that we understand the new graduates' satisfaction and experience with their career choice and their intentions to leave or stay in the profession (Appendix I). Wu, Fox, Stokes, and Adam (2012) completed a study to examine what work related stressors new graduates were experiencing, what influenced their stress, and how the stress connected with their intention to resign. They used a descriptive correlation design to examine work stressors, coping strategies, and the new graduate's intention to quit. The study examined Bachelors of Science (BSN) graduates from a university and Associate Degree in Nursing (ADN) graduates from a community college. Nurses in this study were defined as new graduates if they had graduated less than three years ago. One hundred and fifty-four new graduates participated in the study by completing surveys. The tool used was the Job Stress Scale for Newly-Graduated Nurses (Wu et al., 2012).

The study identified five factors related to stress experienced by the new graduate: demanding care, equipment issues, nursing skills, interpersonal relationships, and hospital responsibilities. Bachelor prepared nurses experienced more stress than their Associate Degree prepared counterparts. The study showed a strong correlation with stress levels decreasing the longer the nurse worked at the bedside; this change was seen around two years of experience. Wu et al. (2012) found the one stressor that was primarily linked to new graduates deciding to quit was equipment issues.

Clark and Springer (2012) completed a qualitative descriptive study to examine the job satisfaction of new graduate nurses during their transition from student to nurse in their first year of practice in a 600-bed hospital. Out of 83 new graduates hired, 37 participated in the study. They held nine focus groups and out of these came general themes. New graduates described the work place as having a "rhythm of chaos." They found the workload overwhelming, and to compensate for the chaotic environment and workload, new graduates often arrived early to prepare; however, they still felt overwhelmed all day (Clark & Springer, 2012).

Clark and Springer (2012) found that New graduates experienced enormous stress related to feelings that they did not know any of the important things needed to perform their jobs effectively. In particular, their feelings of "not knowing" was more closely associated with not being able to access policies, systems that did not work, redundant charting, unnecessary paperwork, poor staffing acuity systems that did not work, and arbitrary work schedules. It was also found that it was important for the new graduates to feel valued by the team and that they made a difference to the team. In assessing the areas in which new graduates felt they needed more training, they identified the need to learn more on how to communicate.

Laschinger et al. (2009) completed a descriptive correlation study examining how the job demands and work resources and personal resources shape the new graduates' experience of burnout, work engagement, personal health, and intentions to leave a job. In total, 420 nurses in Ontario, Canada participated in the study through questionnaires. The theoretical framework used was the JD-R model. This model examines two psychological processes, namely health impairment process and motivational process. Health impairment process is caused by excessive demands being experienced by the individual. These demands can be social or organizational, and can result in burnout and negative health outcomes for the individual. Motivational process is having the adequate resources to perform your job and results in work engagement. These resources can be social and organizational (Laschinger et al., 2009).

The study showed that demanding workloads and exposure to bullying led to nurses being burned out, increased levels of turnover and had a strong link to poor mental health of the RN. This study also showed an important connection with one's personal resource and their ability to minimize the effects of bulling. Nurses who had more "psychological capital" (Laschinger et al., 2009, p. 184) had lower levels of burnout. The authors pointed out that assisting new nurse with support, encouragement, and exposure to good role models could help improve the individuals' psychological capital.

Cost Savings through the Elimination of Registry and Overtime

Current literature revealed that nurses working long shifts had a negative effect on the quality of care and patient safety (Appendix J). Ann E. Rogers is recognized as a leader in research regarding nurse fatigue and medical error reporting. Rogers et al. (2004) completed a study of 393 nurses using logbooks to track their work patterns along with demographics. The study showed a threefold increase risk of medication error in critical care units where nurses

worked longer than 12.5 hours. In this study, 65% of participants reported making an error or having a near miss, 84% of these errors were medication, 65% of nurses reported a hard time staying awake, and 20% fell asleep during their shifts (Rogers et al., 2004). IOM recommended that nurses not work more than 12 hours in any 24-hour period, and less than 60 hours in a 7-day period in a report to AHRQ.

Trinkoff et al. (2011) completed a cross-sectional study using surveys from 633 nurses who participated in wave three of the Work life and Health Study Correlating the nurses' data with staffing data and patient outcomes data from the 71 hospitals in North Carolina and Illinois where these nurses worked. Their study showed that nursing long hours had an independent effect on patient outcomes. Nurses' lack of time away from work was associated with an increase in injury and fatigue of staff, increase in patient mortality, and a high RN absenteeism rate.

Stone et al. (2007) completed an observational study using outcome data from National Nosocomial infection surveillance. There were 15,896 patients at 31 hospitals with 1095 nurse participating through surveys examining organizational climate. The study found overtime in the critical care arena was linked to catheter associated urinary tract infections, decubitus ulcers, and medication errors. The study also found that nursing working conditions were associated with negative patient outcomes.

Bae et al. (2010) assessed how nursing turnover affected patient outcomes and the functioning of the nursing workgroup. The turnover data were gathered using six months of data collected from the Outcomes Research in Nursing Administration. This research study collected data on turnover and work group cohesion for six months. The study had a good sample size with 268 nursing units participating from 141 hospitals. The study assessed patient outcome measures in length of stay, patient satisfaction, and medication errors. Bae et al.'s (2010) research showed

that units with low turnover had a decrease in patient falls, improved work group cohesion, improved patient satisfaction, and fewer severe medication errors.

Weist et al. (2009) completed a case study in 2008 at Lee Memorial Health System in Florida. They examined what the savings were after the elimination of agency and traveling nurses. Lee Memorial is a public health system with significant seasonal staffing needs. Due to budget controls, obtaining approval for hiring permanent staff took several weeks, while travelers could be obtained in two weeks. These facts mimic the current in-patient environment at ACMC. In 2006, each traveler cost Lee Memorial two times that of a staff RN. The hospital created a centralized staffing department for deployment of resources. This department worked in collaboration with department leaders. Lee Memorial Health System was able to save 11 million dollars through the elimination of registry staff in 2008 (Weist et al., 2009).

Float Pool

Dziuba-Ellis (2005) completed a literature review examining float pools and resource pools (Appendix K). Her findings were that out of 56 articles reviewed only 12 were research articles, with the majority of these using a cross-sectional design utilizing surveys. In Dziuba-Ellis (2005) review of articles pertaining to floating, several articles discussed the floating of staff from one department to another, but did not focus on the utilization of a float or resource pool. Literature reviewed around this type of floating revealed that nurses were dissatisfied with floating and found floating to other units stressful. Staff expressed concerns about the logistics of the units to which they were floated, such as lack of knowledge as to where items were located. They were also very concerned about their competency to work with the population of the float unit (Dziuba-Ellis, 2005).

Dziuba-Ellis (2005) further found that there is no common structure established in how

the pools are organized, who works in them, and whether a standard process existed. Some studies reported that new graduates should not be used in float pools, while another study supported the use of new graduates within float pools. The literature review did find that float pools were reportedly a cost savings initiative, allowing organizations to reduce agency cost and have internal resources to mobilize throughout the organization.

Nurses might benefit from being a member of a float pool (Dziuba-Ellis, 2005). Nurses benefited by increasing their skill level, professional development, and had the ability to move more freely to opportunities throughout the organization. Studies also reported that nurses within float pools reported positively about their experiences versus nurses who are required to float, who generally reported negatively regarding floating (Dziuba-Ellis, 2005).

Crimlisk, McNulty, and Francione (2002) evaluated the hiring of new graduates into a centralized float pool. Thirty-nine new graduates were hired over 19 months. At the end of the program, 100% reported feeling that they were competent to provide care.

Davis (2008) reported on Sharp Medical Center's success of cost reduction using a centralized staffing pool. Sharp Hospital System had 1,100 nurses employed, supporting seven hospitals. Their centralized float pool contained 350 of the nurses they employed. Their model of centralizing staffing, scheduling, and decision-making through their centralized float pool resulted in a 3.5 million dollar saving the first year. Over the next three years, the savings were recorded as 16.5 million dollars (Davis, 2008).

Wright and Bretthauer (2010) completed a study looking at a coordinated scheduling model and a forecast model to determine if the approach reduced cost. The study was completed at a 526-bed hospital, and used 3 medical departments and the float pool. A centralized float pool with coordination of decision-making was shown to reduce staffing costs by 16.3%. This study

may have been biased, since the authors were validating their own tools as part of the process.

Strayer and Daignault-Cerullo (2008) reported on a nurse driven design of a critical care closed unit float design. The hospital, located in Providence, Rhode Island, had four critical care units, which were using 9.25 fulltime equivalents (FTEs) of registry staff from the hospital float pool to staff these units. A nursing committee designed a closed float pool utilizing existing critical care nurses within the four departments. Nurses created the guidelines for how the closed floating would be managed. The results were improved morale, improved staff satisfaction, and decreased costs (Strayer & Daignault-Cerullo, 2008).

Larson et al. (2012) examined hospital medical surgical units and critical care units, totaling 283 beds and nine units, to assess whether nurses working through a float pool were given higher acuity patient workloads than nurses who belonged to the unit. This was a comparative study using descriptive statistics to examine trends, patterns, and any other findings related to the patient care assignment. The findings suggested that there was no difference in the acuity level of the patient care assignments. Float pool nurses did have more admissions, discharges transfers, and surgical patients during their shifts; however, the difference was not statistically significant. In total, 217 shifts were analyzed, where shifts assessed during the study were randomly selected. Two research assistants rounded on the units selected where float pool nurses were working that day to collect staffing sheets and clarify any questions related to patients or assignments. A standardized tool was developed and acuity ranges were set 1-5.

Alternative Transition Programs for New Graduates

Hospitals faced with budget concerns and the expense of training new graduates institutions are examining alternatives to how nurses are transitioned into the work environment (Appendix L). Hospitals and government agencies are also examining how nurses are paid

during their transition period. Greene (2008) proposed a policy change to provide federal Medicare and Medicaid funding for orientation and residency programs for nurse graduates. Substantial literature documents that new nursing graduates are not prepared to work independently and need continued training in the hospitals.

In examining how to assist hospitals in offsetting the cost of training new graduates, Greene (2008) stated medical students' transition from academia to practice had been supported by federal government for many years. Hospitals that provide residency programs for medical students receive additional fees for recognized additional costs of providing this training. The funds come from Medicare and Medicaid. Annually, Medicare pays out 8.5 billion dollars to teaching hospitals to cover both direct and indirect costs of having these programs. In addition to this funding, Medicaid in 47 states provides an additional 3.2 billion dollars, "In 2001, these funds supported 79,527 residents across the United states" (Greene, 2008, p. 4). In 2008, only $105.3 million were spent nationally on nursing programs (Greene, 2008).

When physicians graduate from school, they are not expected to function at the expert level; instead, they are supported in transitioning from "novice to expert" (Benner, 1984). Pharmacy residents and pastoral care ministers are also supported with their transition with funding from Medicare and Medicaid. In the past, hospitals received funding from Medicare for nursing education, which went into the hospital general operational budget (Greene, 2008). Once all nursing education becomes solidly established with in the academic arena, this funding ceased. Nurses need to have experience and practice time to possess the needed skills to care for the complex populations served within hospitals. Greene (2008) suggested that a policy needs to be put in place that addresses the transition plan of new graduates nationally. New graduates should attend a mandatory 6-9 month residency program that takes the new graduate at least

from the Novice to Advanced Beginner on Benner's (1984) Model (Greene, 2008). These recommendations are very compelling; however, the recommendations to move to a model similar to other healthcare practitioners' salaries of new graduate nurses within these federally funded programs should also be recommended to be reduced in alliance with other healthcare professionals funded by the US government.

Other countries have recognized the new graduate transition as a national problem and have already created national standards. Adlam, Dotchin, and Hayward (2009) documented the journey in New Zealand in going from local independent new graduate programs to a national new graduate framework. These authors examined information regarding past training of new graduates, current practices, and examined work being done to move to a" nationally consistent framework" (Adlam et al., 2009, p. 570). Originally, nurses trained in hospital settings where they received both education and worked within the hospital during their training. Later, in the 1970s, nursing education was moved out of the hospital environment to the college and university environment. After students graduated, there was no consistent hospital training program. Individual hospitals designed and provided what they believed the student needed. Adlam et al. (2009) discussed that there is a clear difference between what hospitals expect new graduates to do and what educators expect.

New Zealand created a standardized national framework for the first year of practice and piloted it in three locations (Adlam et al., 2009). The results of the pilot study identified several key elements that new graduates needed for success. The new graduates needed to have a structured program to learn different skills and should have experiences in two different units. Adlam et al. (2009) also identified that sharing of the clinical load during the first six weeks was imperative for the success of the new graduates. Newly graduated nurses needed trained

preceptors who were able to help them identify their needs. The organization needed to be committed to the release of the new graduate for education time in the classroom and training and support for preceptors. New Zealand took this information and created a framework. They then designed a toolkit for hospitals to implement the training program. This resulted in a movement towards a standardized model in 2005 (Adlam et al., 2009).

Gamdroth, Budgen, and Lougheed (2006) implemented an undergraduate nurse employment project, along with a three-year concurrent evaluation. The study was a quasi-experimental design using descriptive and prospective analysis, where there were interventions with comparison groups. Four health service areas in British Colombia were used for the project implementation and evaluation (Gamdroth et al., 2006). The project allowed third and fourth year nursing students to be employed by hospitals working at their current level of practice. After 21 months, results showed that new graduates with undergraduate nurse experience were less likely to leave the hospital they were hired into after graduation compared to students who did not participate in the UNDP program. Cooperative education connecting class learning with paid work resulted in increased confidence, organizational ability, competency, and the ability to work as a team. This is now being implemented throughout the country's healthcare system (Gamdroth et al., 2006).

Steen, Gould, Raingruber, and Hill (2011) completed a quantitative study examining the effect of a student intern position and its impact on the transition of the student RN to RN. They used Benner's (1984) Clinical Competency Model for their framework. Under this framework, most of the new graduates hired from the student internship were considered advanced beginners (Steen et al., 2011). The population studied was those hired from the student internship program into a new graduate position at UC Davis. This program was in place for four years when the

study was completed with 60 potential participants. Results indicated that this program improved the transition for the new graduate by improving confidence, having an understanding of routines and the environment, established relationships with staff (Steen et al., 2011).

Owens (2013) examined the effects of having an experienced nursing faculty from a local community college partner with hospital educators to improve their current six-week program, which assists new graduates' transition from student to graduate nurse. The nursing faculty assisted with revisions of the current program and during the two four-hour classes for preceptors. Nursing Faculty provided mentorship to the hospital educators during the training period. The results indicated that new graduate nurses had increased confidence. Preceptors also expressed an increase in confidence to educate, motivate, and evaluate the new graduate (Owens, 2013). The hospital nurse educators appreciated learning the current evidence related to the new graduate learning needs. Unfortunately, this study only had one hospital educator working with the nursing faculty, thus preventing global application of the findings (Owens, 2013).

Jones and West (2013) reported on California's solution to bridging the gap of student nurse to graduate nurse through Community-Based Transition Programs. Many hospitals and schools are participating in a partnership program where postgraduate internships from 12-16 weeks are offered to new graduates who have not been able to locate employment (Jones & West, 2013). The transition program allows new graduates to obtain more clinical experience and potentially locate employment. Hospitals that provide these programs provide class training sessions as well as clinical experience with preceptors. Residents complete this training free of charge, and hospitals are under no obligation to hire any of the residents. Initial reports from hospitals and hiring data indicated this model to be very effective (Jones & West, 2013).

Johnstone and Kanitsaki (2006) completed an explorative descriptive case study incorporating both qualitative and quantitative data to examine what factors influenced new graduates' ability in clinical risk management (CRM). CRM is defined by the authors as the "process of risk management as it relates to clinical care" (Johnstone & Kanitsaki, 2006, p. 209). The study consisted of 11 new graduates, 34 key stakeholders, and patient outcome data. Data came from individual questioners, focus group interviews, participant observations, field notes, and research team meetings. In total, 63 questioners were completed, along with 35 focus group and individual interviews. The study was completed in 12 months and had five phases. Six surveys completed by new graduates during the study were designed to capture new graduates feelings, attitudes and beliefs in their ability to practice safely, practice evidence-based nursing care, asses and manage for risk in their own practice, seek advice on patient matters, recognize their own limitations as a new graduate and seek assistance when necessary, make independent clinical decisions about nursing care, report an incident and understand and practice generally the principles of CRM in nursing and health care contexts.

Johnstone and Kanitsaki's (2006) study revealed the importance of new graduates receiving education on CRM in the beginning and ongoing training for them to assume their roles. When new graduates started the program, 100% of new graduates did not know what CRM was or their role in CRM. Even after a 2-hour presentation by quality improvement personnel, 82% did not know about the existence of a quality manager or quality committees. Other items identified as imperative to assisting the new graduates' transition to practice were the new graduates being provided with corporate knowledge, geographical layout, local protocols, and risk assessment tools during orientation. Experienced nurse preceptors assumed that graduates carried preexisting knowledge of the aforementioned factors. Experienced nurses also did not

have the same corporate knowledge and often provided different answers, which frustrated the new graduates. In conclusion, Johnstone and Kanitsaki (2006) found that new graduates need development of experience rather than a perceived knowledge gap.

Theoretical Framework

In implementing a new graduate bridge program, Kotter's change model (Kotter, 1995) and Benner's learning model (Benner, 1984) will be utilized to provide the framework for this strategic innovation. To persuade organizations to embrace hiring new graduates and assist in the adaption of a new on-boarding design for new graduates, a strategic change model will need to be used to manage the activity. Kotter (1979, 1995, 2012) originally started publishing information on change management in 1979, publishing his first change model theory in 1995 with the release of *Leading Change*.

Originally, Kotter's eight steps of change were create a sense of urgency, form a powerful coalition, create a vision for change, communicate the vision, remove obstacles, create short-term wins, and anchor the changes in corporate culture. Kotter (2002) later refined the eight steps. While the steps were essentially the same, the titles of the steps were changed to: create a sense of urgency, pull together a guiding team, create clear simple uplifting visions, empower people, create short term wins, maintain momentum, and make change stick.

Kotter and Rathgeber (2006) used a fable about penguins and how they utilized the eight steps, which were again renamed to be: create a sense of urgency, build the guiding team, get the vision right, communicate for buy in, empower action, create short-term wins, do not let up, and create a new culture. Kotter and Rathgeber (2006) stated the eight steps of change and addressed the challenges with change in relation to people and their impacts on change. The Agency for Healthcare Research and Quality (AHRQ) incorporated this model into an educational program

to improve patient safety called Team STEPPS (AHRQ, 2010).

Kotter's (2012) theory promoted effective change within an organization, pointing out that change must be managed from inception to enculturation. This model provides a framework to guide the new graduate program's transition through change. In 2012, the steps were again renamed to be establishing a sense of urgency, creating the guiding coalition, developing a change vision, communicating the vision for buy-in, empowering broad-based action, generating short-term wins, never letting up, and incorporating changes into the culture.

Kotter's (2012) eight steps consist of four distinct divisions of development needed to manage change. Before making any change, it is imperative to establish what change is needed and why. Kotter (2012) referred to this phase of the process as setting the stage. During this phase, the first two steps (creating establishing a sense of urgency and creating the guiding coalition) are completed. Upon completion of the first phase, the second phase is to decide what needs to be done and to develop a change vision, which is step three in Kotter's (2012) model. With a sense of urgency in place, the team selected and the vision established, the third phase is to implement the change using the next four steps of the model (Kotter, 2012).

Kotter (2012) clearly articulated the importance of communication in the implementation of any change within an organization. It is through strategic communication that others are able to see the vision and are able to choose to get on board. It is also through constant communication of the vision that funding and organizational support is obtained (Kotter, 2012). Once people understand the vision, it is imperative to empower them so they become part of bringing the vision to reality, defined as empowering broad-based action. In the bridge program, the training of existing staff to be effective preceptors has been shown to assist with

empowerment of the preceptor, and new graduate programs have been shown to develop new graduate competency and improve their confidence (Block et al., 2005; Halfer, 2007).

Kotter (2012) also emphasized the importance in celebrating short-term wins to help with the change occurring and sustaining. Change does not come easily, as tradition dies a hard death (Kotter & Rathgeber, 2006), and if the change process is not managed, people will revert to tradition and their un-empowered ways. The guiding team therefore needs to keep pushing to make the vision a reality. The final step in the process is to sustain the change, which is also considered the most difficult. It is where the change becomes part of the organization's culture and becomes the new standard, incorporating changes into the culture (Kotter, 2012).

To get organizations on board with hiring new graduates and providing them with the necessary training, hospital administrators need to believe that there is a sense of urgency to hire new graduates and understand why. Hospital administrators believe it is a more economically beneficial decision to utilize travelers and current staff to fill vacancies. Hospital executives need to understand that the nursing shortage is coming.

With many hospitals delaying the hiring of new graduates, hospitals will be forced to hire new graduates in large numbers, as soon as nurses start retiring in large numbers. This inexperienced work force will challenge organizations for several years. Benner's (2001) learning model from novice to expert explains the natural progression of learning in relation to time. With the anticipated retirement rate, some hospital units may lack the experienced support needed to assist with nurses' progression through the learning stages while ensuring patient safety (Benner, 2001).

As new graduates are hired, they will be novice learners for the first year. This means they will be task focused and only able to respond to situations by following rules and doing

what they are told to do. They come with an inability to be flexible in their thinking, and therefore patient safety depends on them having more experienced staff to help by providing them with instructions on what to do and how to do things (Benner, 2001).

Generally, as new graduates have one year of experience, they will become advanced beginners capable of recognizing reoccurring patterns so they can formulate their own guidelines on how to manage and respond to situations they have seen before (Benner, 2001). Unfortunately, when they come to a problem they have not previously encountered, they revert to being task-oriented, and again they need the experienced nurse to guide them in their decisions (Benner, 2001). In Benner's model, it is not until two to three years of work experience in the same work setting, that a new graduate will reach competency. Once a nurse reaches the learning level of a competent nurse, he/she plans their own actions and is aware of long-term goals and their impact on patient care (Benner, 2001). Competent nurses assist with efficiency of patient care and help organizations meet their goals (Benner, 2001).

As a nurse reaches four years of experience, she/he becomes proficient and is able to view situations and problems as a whole process versus individual parts (Benner, 2001). The individual now has a holistic understanding of the nursing process, which improves their decision-making abilities. They have learned what to expect in certain situations and are able to modify their plans quickly to meet the patient's needs (Benner, 2001).

The final step in Benner's (2001) learning model is reached when a nurse becomes an "Expert." This nurse no longer needs rules or guidelines to connect what is going on in a situation and take appropriate action. These nurses are able to take in multiple amounts of information and make quick decisions with what appears to be no thought at all (Benner, 2001). When you ask these nurses why they made their decisions, they will have difficulty answering

your question. After spending some time thinking, they will be able to tell you why they made that decision. These nurses do not make the best preceptors for new graduates, as they no longer process their work in steps (Benner, 2001).

The theories of Kotter (2012) and Benner (2001) work well in managing this new graduate initiative. Kotter's (2012) model provides a framework for the implementation, while Benner's (2001) model provides an understanding of how the new graduate will progress through their development and articulates the importance of having more seasoned nurses available to support their transition and growth. Health care executives need to understand the implications of how nurses progress in learning to understand the implications of having several new graduates on one unit with little resources.

Kotter's (2012) model is being used to manage the implementation of the new graduate program, while Benner's (2001) model is being utilized during the implementation to establish how many nurses are hired in each cohort. The goal is to ensure that there are not several novice nurses on one shift at any time. In recognizing that new graduates take two to three years to reach competency, the goal is to add to the organization consistently so there is not a sudden influx of new nurses at the novice level.

The program's effectiveness will include organizational metrics as well as retention of the new graduates. The evaluation of the program will also incorporate Kotter's (2012) model to assist in determining where opportunities for improvement exist for future hiring of new graduates. Benner's (2012) model will be utilized to evaluate staffing patterns in relation to patient safety and to determine the number of new graduates to hire for subsequent cohorts.

Section IV: Methodology

This project was a process improvement initiative, which focused on organizational improvements. The program's overall effectiveness was primarily evaluated through routinely collected organizational data. Information was also obtained from individuals through group meetings and individual surveys. Program evaluation will continue with additional data collected from future new graduate participants.

Ethics

This project did not require IRB consent per the APA Ethics Code, as the initiative was conducted in relation to organizational effectiveness and there was no risk to the participants' employment and confidentiality was protected (APA, 2010). This project was still submitted and approved by the Alameda County Hospitals IRB committee (Appendix M). An application was also submitted to the University of San Francisco's IRB and the study was deemed a quality improvement project, excluding it from the need for IRB approval.

To ensure prospective new graduates were informed of the organization's process improvement project utilizing new graduates, information was provided to all candidates during their interview. The first interviewed cohort of new graduates was verbally provided information that the new graduate program was a new design. Information was provided regarding the fact that they were being hired into a new paid graduate residency program where they were not guaranteed a job after they finished the residency and they were not union members. Upon successful completion of the residency program, ACMC intended to hire them as services as needed staff members and they would be placed into a centralized float pool. They were reminded that they were not guaranteed a job upon completion of the new graduate program.

The second cohort was provided the same information; except that they were informed they were being hired directly into the float pool as services as needed new graduate staff members. This group was also provided information on the concept of hiring them in to be trained as EMR super users before they entered the new graduate program. The EMR super user program was explained to candidates. Applicants were also informed that there was sparse literature showing this model would be successful.

Both cohorts were acquainted with how the new graduate program was set up and provided information on how the training would occur. All candidates were informed that there would be analysis done on this program. Candidates were assured that being hired was not contingent on participating in the analysis of the program. Candidates were informed that if they were hired into the new graduate program, more information would be provided on the study and they would have an opportunity to ask more questions and choose whether they wanted to participate.

At no time was protected health information documented or used during this project. There was no potential physical, mental, or emotional risk identified for participants. The project was limited to evaluation of the new graduate program, organizational effectiveness, and financial impact. The only cost to the participants was their time in completing surveys or providing feedback on the program during group meetings which was during paid time.

Locations and Facilities

Highland Hospital is an acute care hospital with 236 licensed beds located in Oakland, California. The hospital contains medical surgical units, Telemetry, Step-down unit, Intensive Care Unit (ICU), Operating Room (OR), Post Anesthesia Care Unit (PACU), Labor and Delivery (L&D), post-partum, and a Neonatal Intensive Care Unit (NICU) department. New graduates

were hired and provided training in all areas (except for the ICU and NICU). It was identified that the volume of NICU admissions were too small to train new graduates adequately, and experienced internal staff wanted cross training to ICU.

John George Psychiatric Pavilion has 80 licensed beds and is located in San Leandro California. John George provides both inpatient and outpatient services, providing care for psychiatric emergencies and substance abuse. This facility plans to train and hire new graduates in 2014.

Fairmont Hospital is a 159-bed hospital and provides sub-acute, skilled nursing, and inpatient rehabilitation services. There are four sub-acute units, two skilled nursing units, and a rehabilitation center. The rehabilitation center was struggling with an extremely low census area, so new graduates were not provided training in this area. New graduates hired were provided cross training in both the sub-acute areas and skilled nursing areas as a learning opportunity to improve some of their clinical skills, as well as to utilize them as staff in these areas after training was completed.

The new-graduate program was overseen by the Director of Nursing (DON) for the adult service areas in collaboration with the Assistant Director of Nursing (ADON). The Director of Education was responsible for overseeing the development and implementation of a new graduate program. The HR manager coordinated the hiring process and participated in collecting data on impact of the new graduate program. Labor relations were responsible for creation of the new job descriptions and negotiations with the union. The DON oversaw the coordination of the hiring and training of new-graduates. Once the new graduates successfully completed their training they were moved to the centralized float pool and were overseen by the ADON (Appendix N).

Planning the Implementation

A new graduate RN program was incorporated into the organizational strategic plan as a means to control costs, prepare for the coming nursing shortage and empower existing staff. The program was designed to train 100 new graduates, in five to six separate cohort groups, over three to four years. The goal of this project was to design and implement a new graduate program that was cost effective for the organization. In building this program, the development of organizational systems and structures had to be completed. The evaluation of this program was examined through organizational finance, registry/traveler usage, EMR implementation, new graduate turnover, and development of a new pay structure for on boarding of new graduates. Because of the implementation of the new graduate program, successes, opportunities for improvement, and short falls were identified.

This project originally was only designed to hire new graduates directly into a new graduate training program. Once the organization identified there were not enough staff super users for the EMR implementation a decision was made to hire new graduates and train them first as EMR super users. The new graduates were hired as “services as needed” RN status and assigned to the centralized float pool.

This project incorporated building a new graduate program, re-establishment of the existing preceptor/mentoring program, creation of a new pay structure for new graduates, implementation of a centralized float pool, and designing a unique on-boarding program for new graduates who were hired as super users for the EMR implementation. This project pinpointed strengths and weaknesses of the organization in training and on boarding of new graduates. These findings have been utilized for next steps and future training programs. The results may also be utilized to help other organizations formulate new directions in utilizing new graduates.

While this paper is reporting on the implementation of this program over the last 12 months, it is only a starting point for this project. The tools chosen to evaluate this program, which were not used in these rotations, will be utilized with future cohorts. Subsequent cohorts hired will participate in further studies on how the new graduate program is affecting their transition from student to RN. Additionally, other areas within the organization will be moving to hiring and utilizing new graduates over the next several years.

Implementation

Hiring. Determining the correct number of new graduates to hire was the first part of the implementation process. The goal was to reduce the traveler usage in designated areas by a minimum of 65% by September 2013. Traveler usage from inpatient areas was utilized to determine the number of FTE new graduates that would needed to reduce the number of travelers. Assumptions made were that all new graduates hired would need to work a minimum of three to four days a week to master their new role after they had completed orientation. New graduates would be scheduled so ideally there would be no more than three new graduates on any shift during training and no more than two on any shift once training was completed. The first cohort was assigned and oriented on either days or evenings, while the second cohort was assigned and oriented on all shifts. New graduates would be assigned a primary shift after training was completed.

To reduce the number of applicants ACMC received, the positions were only posted for one week per county hiring requirements Over 1000 applications were received. In order to reduce the applications a scoring tool was developed and utilized by the human resources department. New graduates received credit for additional training they had sought outside of

their traditional nursing program, work experience in other fields and a variety of other factors including completing the application accurately.

Fifty-four new graduates were hired into two distinct cohorts. The first group consisted of 30 new graduates, which were hired in November 2012 and started training in the new graduate program immediately. The second group consisted of 24 new graduates, which were hired in January 2013. Their initial orientation was to their role as an EMR super user. After the EMR implementation, they entered the new graduate program in March 2013.

After candidates were hired, during orientation, more information was provided on the improvement project and the details of the project. During new graduate orientation, a consent process was implemented (Appendix O). Information was provided by the Director of Nursing and the Human Resources (HR) manager on the purpose of the project, expected duration, and procedures. Participants were provided their rights to decline or withdraw from participation at any time without consequences. Consent was obtained by the project manager and HR manager. Participants were assured that nursing staff would not be informed of who chose to participate. Participants were provided with the Director of Nursing's contact information, and the HR manager, in case there were further questions.

Orientation/training. ACMC had not hired new graduates into a formal centralized large program for several years. The education department lacked current resources or a program to train new graduates. A training program was developed where new graduates participated in classes, completed online training modules, and worked with an assigned preceptor. Class orientation included lectures, discussions, and presentations from different departments within the organization. New graduates attended classes two days a week for 12 weeks and spent three days a week on their designated units receiving training for 12-16 weeks (Appendix E).

This program was evaluated by the new graduates and drastic changes were made throughout the program. In December 2012, after extensive negative feedback was received, the class content was recreated with a focus of hands-on learning, equipment training, and role-playing. This new training program was utilized for the training of cohort two (Appendix P). This new style of training focused on many of the tasks identified by new graduates as unclear, specifically on how to perform such tasks per ACMC policy and procedures. These classes were also taught by several of the bedside nurses. This second format was successful and will be utilized with subsequent cohorts.

New graduates as EMR super users. No studies were found on the utilization of new RN graduates as super users for EMR implementations. However, UCLA posted jobs on the intranet advertising to hire new graduates in 2012 to assist with their EMR implementation. In 2011, Palomar Pomerado Health hired new RN graduates and trained them to assist with their EMR implementation and found it to be a very successful endeavor (McKissick, 2009). In 2012, INOVA hired 150 new RN graduates to assist with the implementation of their new EMR (INOVA, 2012).

The second new graduate cohort was hired in to be utilized as super users for an EMR implementation. Once the EMR implementation was complete they would then participate in the new graduate program. Recognizing that this group would be educating the nursing staff it was decided they would need specifically designed training to support them with assuming this role. After they completed the EMR super user training course they attended classes on change management, leadership, effective communication and teaching techniques (Appendix Q). During these classes they all participated in taking the Myers- Briggs Assessment and discussing how people approach things differently.

Once their training was complete they were divided into three main groups: creation of tools, communication/scheduling, and sandbox training. Once the new graduates completed their training, they worked in one of these three groups for four weeks. Each group had an assistant nurse manager, manager, or director that worked closely with the new graduates. This model allowed new graduates to receive individual coaching on how to handle difficult situations. It also provided an opportunity for the new graduates to get involved at an organizational level on designing a change. The residents met leaders from other departments and became familiar with the hospital lay out on where things were located. They were learning how to manage projects in the hospital setting and learning the challenges behind the scenes. These new graduates saw the bureaucracy and work needed to create a change from a front row seat.

The EMR system being implemented lacked the necessary tools identified for the implementation. New graduates assigned to creation of tools group designed quick reference materials and other tools to help with the live implementation (Appendix R, Appendix S, and Appendix T). Implementation of the EMR was to occur within six weeks from training of the super users, training of staff, and going live. Staff was required to attend two distinct training days to receive the necessary education. New graduates monitored the progress of completion of the classes and managed the scheduling of nurses. Only three nursing staff members did not complete the training classes prior to going live, due to the new graduates' vigilance. The other group managed the sandbox training sessions, which included training, scheduling, and mentoring of staff. Sandboxes were set up on two inpatient areas and the new graduates provided this additional training to nurses for ten days around the clock prior to the EMR go live date.

During going live, new graduates worked 10-hour overlapping shifts. They provided assistance with the EMR documentation to nursing and physicians as requested. Unit staff

verbally expressed how excellent they were at helping them to learn and navigate the new system. After the system was up for one week, the new graduates used the competency tool created and assessed, and documented staff members were competent. Within 12 days, ACMC had returned to normal staffing ratios. After the EMR implementation was completed and stabilized, new graduates started the training program in March 2013.

Preceptor/mentor program. ACMC has a certified preceptor and mentor program, which had not been utilized for several years due to the lack of hiring of new graduates. This program provided staff with training on how to be an effective preceptor or mentor. ACMC has four certified trainers on staff that provides this class as needed. In preparation of hiring new graduates, additional training was provided to nurses who were assigned as preceptors. This program was evaluated during the first cohort implementation, and corrections/enhancements were made to both the preceptor and mentor programs.

Centralized float pool. A float pool is defined as a "group of nurses who accommodate unit staffing in response to variability in patient care needs" (Larson et al., 2012, p. 1). ACMC established a centralized float pool to accommodate the new graduates. A cost center was created to house the nurses and was placed under the ADON. Experienced "services as needed" staff members who had been hired and scheduled by individual units were transferred to the centralized float pool. The goal was to have centralized decision making to determine how the "services as needed" were scheduled and utilized. Guidelines were established on how many new graduates could work on a unit at the same time upon completion of training and hiring into an official position.

The project took place over 12 months and is still being modified for the third cohort, which will be hired in 2014. Additional cohorts will be hired and provided an opportunity to

participate voluntarily in studying the impact of the new graduate program on their transition. Unfortunately, this was not studied with the first two groups due to the numerous elements that needed to be addressed with the current program. Data were reviewed and analyzed, and results were discussed with leadership at Alameda County for further refinement of the next training program and study.

During the initial program implementation, several problems arose which prevented the study from progressing as planned. As these problems were identified, mitigation plans were created to redesign the program in motion. This meant energy was diverted from the planned new graduate assessment to correcting organizational design problems. These included changing the training program mid-stream, additional support of the new graduates on the floor, and hiring process changes.

Planning the Study of the Intervention

The specific aim of this project was to improve the organization's financial position by reducing the usage of overtime and travelers. ACMC was expected to save over two million dollars in one year with reducing traveler cost by 1,315,000 dollars and additional savings with reduction in staff overtime (Appendix U). Prior to the implementation of this program ACMC spent over $5,065,129 on travelers in the units where new graduates were being hired and ten million dollars in overtime in inpatient care areas.

Additionally, ACMC was focused on reducing the cost of training new graduates. New graduates traditionally were paid $39.54 dollars an hour and ACMC wanted to change the training cost to $20 dollars an hour. This would result in an approximant savings of 284,700 dollars for 30 new graduates being trained to medical surgical areas and 357,540 dollars for 30 new graduate trained in critical care (Appendix V). Originally four cohorts consisting of 89 staff

was projected to cost 2,200,493 dollars now with the reduction in training costs for the last two cohorts the new projected training cost is estimated at 1, 813,820 dollars (Appendix W).

The EMR implementation plan, which was added to the plan in January 2013, was initiated as a cost savings initiative and due to lack of available staff to assume the role of super users. The effectiveness of this programmatic design was done by evaluating the effectiveness of the implementation of the new EMR, new graduates ability to create items needed for implementation, time it took to go back to ratios and success in working effectively with existing staff during implementation. Use of the new graduates as super users saved the Information Technology (IT) department 375 thousand dollars.

Methods of Evaluation

New graduates participated in providing structured feedback, within group settings, on the successes and changes needed for the new graduate program to provide them with the skills they needed to be successful. Individuals also provided feedback in unsolicited one-on-one conversations. Questionnaires were also sent to graduates via Survey Monkey for additional observations and assessments. Financial reports were provided by the Chief Nursing Officer for review and analysis.

Analysis

Qualitative and quantitative data were utilized to examine the impact of the organizational process improvement project. The primary outcomes were the FTE usage of overtime, traveler usage in departments where new graduates were working, and the overall organization use of travelers. Financial analysis, using Excel, and descriptive statistics were used to assess the current impact of this program. Prior to the study, initial data were collected using traveler usage reports, unit budgets, and overtime reports. These reports are produced routinely

and were utilized for measuring the financial impact. Descriptive statistics were used to assess key elements of the new graduates' experience.

Section V: Results

The first new graduate training curriculum ACMC, launched in November 2012, was not completely successful. New graduates verbally expressed that they were not learning what they needed to know to transition from student to nurse. On December 27, 2012, leaders met with all 30 new graduates, for eight hours, to develop an understanding of what they perceived to be missing from the program and to determine how the program could be corrected to meet their needs. The new graduates provided concerns along with recommendations for improving their training.

The culmination of the new graduates' frustration was regarding the training curriculum design and content. The original class consisted primarily of lectures related to care delivery. The new graduates stated that they did not want or need more theory on the how to assess a patient or on diseases. The new graduates wanted classes that provided more practical training. Unanimously, they believed the most important thing they needed to learn was how to use all the different types of equipment they would encounter in the course of a day. The new graduates expressed that it was stressful to try to learn how to use different equipment while providing care to the patient. The new graduates believed that if they knew how to use the equipment learning their role would be easier. The group consensus was that they wanted a practical skills day where they had mock drills on using routine equipment as well as utilizing equipment during emergency situations.

New graduates expressed further concerns around their inability to locate items or departments. The graduates found that during the course of a shift, they often needed to retrieve items or transport patients throughout the organization; however, as new nursing staff they lacked the ability to do this task efficiently due to no orientation. The new graduates as a group

felt that they were wasting valuable time on these errands, which reduced their time on the unit to deliver care and resulted in the new graduates feeling more stressed for time. The new graduates requested a detailed tour and map of the organization so they could more effectively locate departments.

Another element that they reported was unnecessarily wasting their time was navigating through the burdensome organizational systems on a daily basis. As new nursing staff they were frustrated with their lack of organizational knowledge on how to find policies and procedures, how to fill out an occurrence report, when to fill out an occurrence report, how to make schedule changes, request pay adjustments, or who to call with a computer access issue. The new graduates requested that some of this information be added to their orientation in writing so they could refer to it when needed.

Unfortunately, the orientation on the units was also meeting additional challenges. Some of the new graduates had already experienced bullying behavior and several of the new graduates expressed that they had experienced situations where it was difficult to communicate with either a preceptor or another staff member. New graduates were frustrated with the different answers they would receive to the same question and were unclear on how to determine whose answer was correct. They requested classes, which included role-playing on how to communicate more effectively with their preceptors and other staff members.

Based on the feedback provided by the new graduates, the program was redesigned to meet their identified needs. All the above items were incorporated into the training program. Additionally, the new class included tips and tools for the new graduate and education was framed around case studies. The second program design worked effectively for the first cohort. When the second cohort went through this revised training, they felt that it met their needs and

were satisfied with the program. This revised training program will be utilized with subsequent new graduate programs.

Considering how the first cohort training started, a surprising finding was how much more prepared the new graduates were than expected. They were able to step into working on their units with very little prompting and were extremely comfortable and confident in their skills. Unfortunately, during the two training programs we had to release three new graduates for their inappropriate behavior towards other staff and preceptors, specifically around their inability to take constructive feedback.

Utilizing new graduates as EMR super users was successful. The new graduates did an excellent job at managing their assigned roles. The new graduates designed the training in the sandboxes, which they staffed around the clock for ten days prior to the EMR go live. They also developed exceptional tools to be utilized during the implementation at ACMC. Due to the exceptional work of these new graduates, the EMR implementation was a success. Nurses made the transition to this system quickly. ACMC was able to return to normal staffing ratios 12 days after implementation, nine days sooner than anticipated.

The new graduates expressed how much they appreciated getting to learn who their leaders were by working alongside of them and revealed how much they were learning about how a hospital worked. The second cohort of new graduates stated that they enjoyed getting to know the staff in a different role before they started training. Many expressed feeling that they already had positive relationships with several of the nurses they had helped teach and felt this would make their transition easier. Nurses on the floors reported that the new graduates were very helpful in the transition to the EMR. Nurses created relationships with the new graduates

during the EMR implementation and identified several new graduates which they wanted to stay on their unit.

Once these new graduates started their new graduate training program, they were already familiar with the layout of the organization. They had all worked different units so they had met a number of the staff they would be working with during training. New graduates reported that the classes provided for the EMR implementation helped them with interactions in the clinical settings.

The float pool was activated for staffing the organization once the first cohort was off orientation. It was designed so decisions around staffing were centralized. Rules had been established on how many new graduates could work on one shift at a time and were scheduled so they were working three to four days a week. The float pool design has worked effectively and has needed no adjustments. New graduates are supportive of the float pool model, which is still in place. One suggestion the new graduates have made is that new graduates receive more exposure to other units they might work on during their initial orientation.

ACMC started seeing a ROI immediately as the first cohort completed orientation and started working as staff. Prior to the implementation of this program, in 2012, overtime and callback pay was running extremely high. After the EMR implementation, in late April and early May, the first cohort started working as staff. With the new graduates working as staff, ACMC started meeting their budget in these areas (Appendix X).

In the past, registry usage has run significantly higher than budgeted. In fiscal year 2011/2012, it ran at approximately 80-90 FTE over budget per pay period. Starting in fiscal year 2012/2013, ACMC ran over 90 FTE per pay period over budget. After the first cohort completed their training and were being utilized as staff, the Registry usage dropped to just 50 FTE over

budget per pay period. At the end of April, registry usage was no longer running over the budgeted FTE (Appendix Y). As of May 25 2013, the areas where new graduates were working decreased their registry usage to 26.4 FTE below budgeted (Appendix Z).

In March 2013, the first cohort of new graduates was slowly starting to be moved into services as needed positions with all of cohort one working as staff by the second week of April. The second cohort came off from orientation in July. Out of the 54 new graduates, three were released for behavior issues leaving 51 new graduates in the float pool in July. From April 2013 to September 2013, ACMC saved two million dollars. In October 2013, ACMC saved 500,000 dollars due to the new graduates' replacement of registry and overtime.

When this program was first conceived, the goal was to hire new graduates at a different pay rate during their training period. Unfortunately, this could not be done with the first two cohorts. However, there is now a new salary established for future new graduates of 20 dollars an hour while they are in training. This decreases the training costs for future new graduates substantially.

One unintentional impact of the program was how existing staff members reacted to the new graduate program. Surprisingly, the staff members were very positive and appreciative of the new graduates who were used as super users. The existing staff complemented the new graduates on how well they taught and supported the staff with the EMR implementation and they treated them very respectively. On the other hand, staff members were concerned they were being "moved out" by the residents with respect to their jobs and were apprehensive with them being hired; this caused some friction within the organization. Presently, staff members realize this is untrue and concerns are no longer apparent. Currently, ACMC does not have any patient impact data to report; however, there has been no negative impact to date associated with the

new graduates.

Relation to Other Evidence

In reviewing different articles and studies on how organizations are hiring new graduates, it became apparent that across the United States new graduates are being hired in and trained differently. There is no standard in how new graduates are transitioned into the work world. New graduate programs ranged from six weeks to one year. The majority of organizations hire new graduates on as staff and they place them in a new graduate program. However, some organizations are electing to provide residency programs (unpaid), which may or may not lead to a job offer.

A very interesting finding was that other countries have also identified the new graduate transition as a problem in regards to recruitment, retention, and cost. Three countries have put national plans in to place to improve the transition experience of new graduates. Finland has now created a national program outlined for the transition program, Canada hires new graduates while they are students to try to prepare them for the work force, and Australia is focusing on teaching new graduates about Clinical Risk Management. These countries have pulled together national approaches to hiring and training of new graduates. In the United States, we do not have state consensus, let alone the entire country (Adlam, Dotchin and Hayward, 2009 & Gamdroth, Budgen and Lougheed, 2006& Johnstone and Kanitsake, 2006).

Another interesting finding is that Owens (2013) discussed the issue that hospitals lack the dedicated resources to manage new graduate programs. ACMC was challenged in meeting the needs of the new graduates due to not having enough dedicated resources and not truly understanding what the new graduates needed to assist them with the transition. Other organizations are starting to address this issue through collaborating with academia.

ACMC established a centralized float pool and hired "services as needed" new graduates into the pool with the goal of reducing the number of travelers and the amount of overtime existing RN staff were working. The results have already been financially beneficial to the organization, with over two million dollars in cost savings in just a few months. The new graduates have successfully transitioned to staff nurses working out of the float pool. This project's results align with other organizations' findings.

In 1999, an inter-city hospital successfully hired new graduates into a float pool (Crimlisk, 2002). In 2001, a 150-bed hospital in Eastern Massachusetts successfully hired new graduates into a float pool (Almada et al., 2004). Lee Memorial Health System saved 11 million dollars through the elimination of registry staff in 2008 (Weist et al., 2009). Sharp Medical Center created a centralized float pool and saved 3.5 million dollars the first year with OT and registry reduction, followed by 16.5 over the next three years (Davis, 2008). While ACMC is already capturing financial benefits in the millions, only time will tell if the organization also realizes a savings by decreasing adverse care events associated with fatigue, staff over time, and high traveler usage.

Unexpectedly, new ACMC graduates expressed concerns around their training, which was found in other studies (Clark & Springer, 2012). Clark and Springer (2012) reported that new graduates found it frustrating not having the organizational knowledge needed to perform their job. This study pointed out that a lack of knowledge of how to access policies, systems, and how to do manage the day-to-day things were a concern for new graduates. Wu et al. (2013) reported on the top five stresses new graduates experienced. During this project, two of the top five were concerns for these new graduates not knowing how to use equipment and interpersonal relationships.

Barriers to Implementation/Limitations

Initially, ACMC hired the first training cohort in November 2012 as nurse residents. In this model, new graduates were hired into a program and paid for 12 to 16 weeks. They were not guaranteed employment after their training and they were not union members during their training period. The second group, hired in December 2012, was hired as "services as needed" clinical nurses. The Human Resources Department stated that they had to be hired in this fashion since they were being utilized productively as super users. This group was within the clinical classification and started their probationary period unlike the first group hired.

This initial hiring of these groups caused much turmoil within the organization. Due to ACMC being a public facility, it took three months to rectify this problem. Finally, after three months of concerns, cohort one members' hire date was backdated to November 2012. Unfortunately, this hiring process caused mistrust in leadership and discord between the two groups.

Preceptors/Mentors

Nurses were asked by leadership if they would be preceptors or mentors to these new graduates. Nurses who had not been formally trained as preceptors were sent through the preceptor/mentor training program. Unfortunately, after matches were made some nurses decided that they no longer wanted to provide training to the new graduates. Some staff believed that the new graduates were there to take their jobs, so they did not want to train them. This made it difficult to keep all new graduates with trained preceptors.

Mentors were also assigned to new graduates after being contacted by leadership. Mentors agreed to participate in the program with the new graduates. However, once the new graduates started, the mentors did not reach out to the new graduates. Many even reported that

they were never asked to be mentors, and that they were just assigned. Since the new graduates were already on board and the training program was occurring, the new graduates were divided into four groups and an assistant nurse manager was assigned to oversee each of these four groups. Their role was to provide temporary support and guidance to the new graduates as we got the preceptor/mentor program operational.

Modifications to the new graduate program prevented the study of the new graduates' experience. Due to the number of issues which arose around training with preceptors and mentors, the project did not collect all of the intended data from participants. Instead, the programs were adjusted and evaluation of participants will occur during another cohort hiring.

Originally, one of the metrics the project planned to use to assess the program's effectiveness was new graduate retention rates. However, with the lack of jobs currently available for new graduates, retention rates may be affected by the current lack of hiring of new graduates within the region. Currently, one new graduate voluntarily resigned her position and took another position at a different local hospital. ACMC attempted to complete an exit interview with no success.

Interpretation

In the beginning of the orientation period the organization did expect that not all RNs would embrace the new graduates. What was not expected was that staff would fear that the new graduates were going to replace the existing work force. In making any change within an organization fear is often an emotion felt by those being impacted by the change. In this change effort the nurses had fear that the new graduates would make them obsolete. This fear made it more challenging for the preceptor and mentoring program to perform to expectations. This was a huge hurdle in pulling the program together.

As leaders within an organization our perceptions of what new graduates would need and want during their orientation was different then what was originally offered. In designing a new graduate programs it is imperative to understand what the student needs. This improvement project discovered that many of the students expressed needs have already been identified within other studies. Organizations starting new graduate programs would benefit from reviewing the literature on what new graduates express that they need to be successful before designing their program.

The new graduates were more prepared to assume their roles at completion of orientation than expected. Perhaps they were more prepared due to the changing of the new graduate program within the first month based on their recommendations. Since they were more prepared then expected the organization started seeing a return on investment sooner.

Conclusion

The nursing shortage is coming; it is just a matter of when. The aging work force, baby boomers demanding more care, advancing technology, along with the threat of younger nurses leaving the profession, due to dissatisfaction with their career, is a perfect storm. Financially, hospitals are struggling to ensure the maintenance of a healthy margin. Hiring new graduates instead of utilizing travelers and overtime is not only a good economical decision, but helps organizations prepare for the coming nursing shortage and ensures a future pipeline of nurses. Taking the time now to establish a different pay scale for nurses during training makes sense for healthcare today and tomorrow. Reducing new graduates pay during their initial orientation puts nurses pay in line with how other healthcare providers are transitioned into the working market. It makes training new graduates more affordable.

Hiring new graduates into centralized float pools has been done successfully at other organizations. Internal float pools with centralized decision-making have been shown to save organizations millions of dollars. Float pools have been shown to reduce overtime and provide the necessary resources to staff the organization during census changes. These pools also provide a potential future supply of nurses when others leave the organization.

Literature shows that new graduate programs improve the success and retention of the new graduate (Block, L., Claffey, C., Korrow, M., & McCaffrey, R., 2005, Halfer, 2007, Twibell, 2012 & Ulrich, 2010). Reestablishing or establishing a new graduate program is a challenging endeavor, and hospitals in general may lack the necessary resources to manage the development of these programs. Typically, these programs are assigned to a leader who already has much to do. Organizations could hire partners more economically from the academic world to build these programs and even oversee them. Academia may have a better understanding of the new graduates' needs for transition.

Nurses who have graduated years ago and have not worked in a hospital will require much training. As prospective nursing students continue to hear that nurses cannot locate jobs after graduation, they may choose to abandon nursing as a career option, resulting in a decline in enrollment in nursing schools. ACMC hired new graduates to reduce costs, prepare for the nursing shortage, and help ensure the future workforce of tomorrow. It was simply the right thing to do for business, patient care, and the nursing work force.

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Appendix A

Financial Cost of Training New Graduates

Summary of Cost/Savings	Medical/Surgical 12 weeks of Training	Critical Care 16 Weeks of Training	Information
Orientation Cost for Training	$18,979/RN	$25,035	Current salary of $39.54
After Completion of Program Additional classes	$1,760 - $3,520 / RN	$1,760 - $3,520/ RN	Additional Classes Needed by New Graduate after training. Cost
Preceptor Stipend	$1,344/RN	$2,240/RN	Part of Current Contract
Materials Needed	$50/RN	$50/RN	
Cost Per RN Approx	$23,893	30,845	
Instructor Cost	Approx 18,000 per Training Program	Approx 18,000 per Training Program	Based on Class Time Taught and Estimated Hourly Pay
Total Training Cost for 30 New Graduates	$734,790	925,350	
Additional Cost to Train Preceptors			
Preceptor Training Class 2 Days	$960/RN	$960/RN	2 preceptors are needed for every new graduate

Material/Cost for 30 New Graduates

ITEM	UM	COST	NEED	TOTAL COST
COPY PAPER	CASE(10 reams)	$35.00	3 CASES	$105.00
BINDERS	EA	$2.50	50	$125.00

MANILA FOLDERS	BX	$13.00	3	$39.00
PENS	DZ	$3.00	18	$54.00
TONERS	EA-COLOR	$85.00	3	$255.00
TONER	EA-BLK	$25.00	1	$25.00
PAPERCLIPS	BX	$5.00	5	$25.00
STAPLER	EA	$5.00	10	$50.00
PENCILS	DZ	$5.00	10	$50.00
DIVIDERS	ST	$3.00	50	$150.00
DIVIDERS	ST	$2.50	50	$125.00
ERASERS	PK	$1.00	10	$10.00
CORRECTION	EA	$1.50	50	$75.00
HIGHLIGHTERS	DZ	$6.00	10	$60.00
WRITING PADS	DZ	$5.00	10	$50.00
SCISSORS	EA	$3.00	50	$150.00
STAPLES	BX	$2.00	5	$10.00
STAPLE REMOVER	EA	$2.00	50	$100.00
POST ITS	DZ	$4.00	10	$40.00
				$1,498.00

Appendix B

Break Even for Training Costs

Summary of Cost/ Savings	Medical/ Surgical 12 weeks of Training	Critical Care 16 Weeks of Training	Info	New Graduate Cost per shift	Traveler cost per shift	Staff On Overtime Minimum Cost	Savings
Orientation Cost for Training	$18,979/RN	$25,035	Current salary of $39.54	$315	$520	$720	$205/ $405
After Completion of Program Additional classes	$1,760 - $3,520 / RN	$1,760 - $3,520/ RN					
Preceptor Stipend	$1,344/RN	$2,240/RN					
Materials Needed	$50/RN	$50/RN					
Cost Per RN Approx.	$23,893	30,845			Break-even 119 and 154 shifts	Break-even 58 and 76 shifts	
Instructor Cost	Approx. 18,000 per Training Program	Approx. 18,000 per Training Program	$600/RN if a class has 30		Break-even 3-5 shifts	Break-even 3-5 shifts	
Additional Cost to Train Preceptors							
Preceptor Training Class 2 Days	$960/RN	$960/RN	2 preceptors are needed for every new graduate		Break-even 5-7 shifts	Break-even 5-7 shifts	

Number of shifts to Break Even	**14 weeks to 33 weeks to break even if the new graduate is working full time. The number of weeks to break even is based on if the new graduate is replacing overtime of a staff nurse or a traveler.**
68 shifts to 167 shifts	

Appendix C

Training Budget for Four Cohorts

Appendix C Training Budget

New Graduate Program Training Budget for first 89

Organization:	Alameda County Medical Center		Year:	2013	
Department:	Nursing- New graduate program		Submitted by:	Pamela Stanley	
Annual training allotment:					
1 cohort:	$683,210	3 cohort:	$420,279	Total Budget:	$2,200,493
2 cohort	$554,504	4 cohort:	$542,500		

1st Training Budget- 30 New Grads

Line	Item	Description/Justification	Qty.	Unit Cost/Rate	Total
1	Program development one time	Develop new grad program--one time cost	1	$ 10,000.00	$10,000
2	Salary of educator	for new graduate program	1.5	$ 12,000.00	18,000
3	Salary of Nurses to ed	cost for RN to assist with class training of new grads	1	$ 10,000.00	10,000
4	Preceptor trainers	Cost of trainers for preceptor/mentor classes	2	$ 480.00	960
5	Salary for one n new grad	Salary for one new graduate 12 weeks	30	$ 18,979.00	569,370
6	Salary for one new graduate	salary for one new graduate 16 weeks	0	$ 25,305.00	0
7	Instructional materials	for student	30	$ 100.00	3,000
8	HR procesing	cost per hire	30	$ 220.00	6,600
9	preceptor pay	For 12 weeks	30	$ 1,344.00	40,320
10	preceptor pay	For 16 weeks		$ 2,240.00	0
11	Class set up expense		1	$ 4,000.00	
12	preceptors trained for new grad	preceptors trained	26	$ 960.00	24,960
13					0
14					0
15					0
				Grand Total	$683,210

Appendix C Training Budget

New Graduate ProgramTraining Budget for first 89

Organization: Alameda County Medical Center Year: 2013

Department: Nursing- New graduate program Submitted by: Pamela Stanley

Annual training allotment:

1 cohort:	$683,210	3 cohort:	$420,279	Total Budget:	$2,200,493
2 cohort	$554,504	4 cohort:	$542,500		

2nd Training Budget- 24 new grads

Line	Item	Description/Justification	Qty.	Unit Cost/Rate	Total
1	Program development one time	Develop new grad program--one time cost	0	$ 10,000.00	0
2	Salary of educator	for new graduate program	1.5	$ 12,000.00	18,000
3	Salary of Nurses to ed	cost for RN to assist with class training of new grads	1	$ 10,000.00	10,000
4	Preceptor trainers	Cost of trainers for preceptor/mentor classes	2	$ 480.00	960
5	Salary for one n new grad	Salary for one new graduate 12 weeks	24	$ 18,979.00	455,496
6	Salary for one new graduate	salary for one new graduate 16 weeks	0	$ 25,305.00	0
7	Instructional materials	for student	24	$ 100.00	2,400
8	HR procesing	cost per hire	24	$ 220.00	5,280
9	preceptor pay	For 12 weeks	12	$ 1,344.00	16,128
10	preceptor pay	For 16 weeks	12	$ 2,240.00	26,880
11	Class set up expense		1	$ 4,000.00	4,000
12	preceptors trained	Preceptors trained to work with new grads	16	$ 960.00	15,360
13					0
14					0
15					0
				Grand Total	**$554,504**

Appendix C Training Budget

New Graduate ProgramTraining Budget for first 89

Organization:	Alameda County Medical Center		Year:	2013	
Department:	Nursing- New graduate program		Submitted by:	Pamela Stanley	
Annual training allotment:					
1 cohort:	$683,210	3 cohort:	$420,279	Total Budget:	$2,200,493
2 cohort	$554,504	4 cohort:	$542,500		

3rd Cohort Training Budget-15

Line	Item	Description/Justification	Qty.	Unit Cost/Rate	Total
16	Program development one time	Develop new grad program--one time cost	0	$ 10,000.00	0
17	Salary of educator	for new graduate program	1.5	$ 17,280.00	25,920
18	Salary of Nurses to ed	cost for RN to assist with class training of new grads	1	$ 10,000.00	10,000
19	Preceptor trainers	Cost of trainers for preceptor/mentor classes	2	$ 480.00	960
20	Salary for one n new grad	Salary for one new graduate 12 weeks	8	$ 18,979.00	151,832
21	Salary for one new graduate	salary for one new graduate 16 weeks	7	$ 25,305.00	177,135
22	Instructional materials	for student	15	$ 100.00	1,500
23	HR procesing	cost per hire	15	$ 220.00	3,300
24	preceptor pay	For 12 weeks	8	$ 1,344.00	10,752
25	preceptor pay	For 16 weeks	7	$ 2,240.00	15,680
26	Class set up expense		1	$ 4,000.00	4,000
27	preceptors trained	Preceptors trained to work with new grads	20	$ 960.00	19,200
28					0
29					0
30					0
					$420,279

Appendix C Training Budget

New Graduate ProgramTraining Budget for first 89

Organization:	Alameda County Medical Center		Year:	2013	
Department:	Nursing- New graduate program		Submitted by:	Pamela Stanley	
Annual training allotment:					
1 cohort:	$683,210	3 cohort:	$420,279	Total Budget:	$2,200,493
2 cohort	$554,504	4 cohort:	$542,500		

4th Cohort Budget-20

Line	Item	Description/Justification	Qty.	Unit Cost/Rate	Total
31	Program development one time	Develop new grad program--one time cost	0	$ 10,000.00	0
32	Salary of educator	for new graduate program	1.5	$ 12,000.00	18,000
33	Salary of Nurses to ed	cost for RN to assist with class training of new grads	1	$ 10,000.00	10,000
34	Preceptor trainers	Cost of trainers for preceptor/mentor classes	2	$ 480.00	960
35	Salary for one n new grad	Salary for one new graduate 12 weeks	10	$ 18,979.00	189,790
36	Salary for one new graduate	salary for one new graduate 16 weeks	10	$ 25,305.00	253,050
37	Instructional materials	for student	30	$ 50.00	1,500
38	HR procesing	cost per hire	20	$ 220.00	4,400
39	preceptor pay	For 12 weeks	10	$ 1,344.00	13,440
40	preceptor pay	For 16 weeks	10	$ 2,240.00	22,400
41	Class set up expense		1	$ 4,000.00	4,000
42	preceptors trained	Preceptors trained to work with new grads	26	$ 960.00	24,960
43					0
44					0
45					0
				Grand Total	$542,500

Attachment D
Milestones- Time line

	Description	Completion Date
Phase 1	Obtain approval for submission of business plan	5/2012
	Develop a formal business plan and obtain approval	10/1/2012
	Creation of residency job description	9/15/2012
	Creation of a SANS 1 classification	9/15/2012
	Develop a hiring process Interview tool/selection panel	10/15/2012
	Train additional preceptors/mentors	7/2012, 11/2012,4/2013, 7/2013
Phase 2	Develop training program	11/2012
	Evaluate training program	12/2012-1/2012
	Re-design training program	2/2013
	Build survey Monkeys	1/2013
Phase 3	Hiring of first cohort	11/2012
	Hiring of second cohort	12/2012
	Initiation of first training cohort	11/29/2012
	Evaluation of program with first Cohort - During monthly meetings-	12/2012, completion 5/2013
	Float pool designed and implemented	1/1/2013
Phase 4	Hiring of second Cohort	December 20,2012
Phase 5	Preparing super users	1/7/2013-1/30/2013
Phase 6	Second cohort training staff on EMR	1/30/2013-3/10/2013
Phase 7	End of cohort 1 training and start working as SANS 1	3/17/2013
	Monitoring of first cohort and regular check ins/ evaluation	4/1/2013
Phase 8	Orientation of new grads to other areas	3/1/2013-6/15/2013
Phase 9	End of 2nd cohort being used as super users and initiation of training	3/17/2013
Phase 10	Implementation of surveys	September/2013

Appendix E

New Graduate Program ROI

Appendix E New Graduate Program ROI>
Capital Budgeting—Return-on-Investment (ROI) analysis
11/1/2012

Data cell key
User data entry or item description are white cells
Formula cells are grey colour: Totals are calculated and filled in automatically.

Investment overview
Project name: <New Graduate Program>
Project sponsor: Pamela Stanley
Date of request: April 2013
General description of benefits: Replace existing high cost overtime and registry staff with stable cost effective work force by hiring new RN Graduates

Cash flow and ROI statement

BENEFIT DRIVERS Travelor savings 22.5/hour	YEAR			
	0	1	2	3
7 west travelor reducation of hours 15000		$382,500		
7 east travelor reducation of hours 9000		$202,500		
5 east travelor reducation of hours 8000		180,000		
SDU travelor reducation of hours 5700		128,258		
MCH travelor reducation of hours 1000		23,500		
ICU travelor reducation of hours 10000				225,000
SNIF travelor reducation of hours 2000		45,000		
overtime reducation inpatient med/surgical areas		3,000,000	2,000,000	
overtime reducation MCH areas				
overtime reducation Snif areas				500,000
improved staff satisfaction and reduced turnover				
improved patient satisfaction/quaulity of care				
EMR implementation savings with new grads		748,800		
Total annual benefits		*$4,710,558*	*$2,000,000*	*$725,000*
Implementation filter		85%	90%	95%
Total benefits realized		*$4,003,974*	*$1,800,000*	*$688,750*

Cash flow and ROI statement				
BENEFIT DRIVERS Travelor savings 22.5/hour	YEAR			
	0	1	2	3
7 west travelor reducation of hours 15000		$382,500		
7 east travelor reducation of hours 9000		$202,500		
5 east travelor reducation of hours 8000		180,000		
SDU travelor reducation of hours 5700		128,258		
MCH travelor reducation of hours 1000		23,500		
ICU travelor reducation of hours 10000				225,000
SNIF travelor reducation of hours 2000		45,000		
overtime reducation inpatient med/surgical areas		3,000,000	2,000,000	
overtime reducation MCH areas				
overtime reducation Snif areas				500,000
improved staff satisfaction and reduced turnover				
improved patient satisfaction/quaulity of care				
EMR implementation savings with new grads		748,800		
Total annual benefits		*$4,710,558*	*$2,000,000*	*$725,000*
Implementation filter		85%	90%	95%
Total benefits realized		*$4,003,974*	*$1,800,000*	*$688,750*

Costs	Year 0	Year 1	Year 2	Year 3
Total	*$1,236,337*	*$411,639*	*$543,280*	*$300,000*

Benefits	Year 0	Year 1	Year 2	Year 3
Annual benefit flow	*($1,236,337)*	*$3,592,335*	*$1,256,720*	*$388,750*
Cumulative benefit flow	*(1,236,337)*	*2,355,998*	*3,612,718*	*4,001,468*

Discounted benefit flow	Year 0	Year 1	Year 2	Year 3
Discounted costs	*$1,236,337*	*$357,947*	*$410,798*	*$0*
Discounted benefits	*0*	*3,481,717*	*1,361,059*	*452,864*
Total discounted benefit flow	*(1,236,337)*	*3,123,770*	*950,261*	*452,864*
Total cumulative discounted benefit flow	*(1,236,337)*	*1,887,433*	*2,837,694*	*3,290,558*

Initial investment	Year 0	Year 1	Year 2	Year 3
Initial investment	**$1,236,337**	**$411,639**	**$543,280**	**$300,000**
Implementation costs	**0**	**0**	**0**	**0**
Ongoing support costs	**0**	**0**	**0**	**0**
Training costs	**0**	**0**	**0**	**0**
Other costs	**0**	**0**	**0**	**0**
Total costs	*$1,236,337*	*$411,639*	*$543,280*	*$0*

ROI measures				
Cost of capital	**15%**			
Net present value	*$3,093,303*			
Return on investment		*218%*	*242%*	*264%*
Payback (in years)	*3.00*			

Appendix F

New Graduate Training Program First Cohort

April 30, 2013

Dear Nursing Student:

Thank you for your interest in Alameda Health System – Highland Hospital Campus. At this time, we have filled all of our available positions for our New Grad RN positions with internal candidates who have completed our Residency Program. However, we are hoping to open-up more positions by the end of 2013 to the beginning of 2014. Please feel free to visit our website for any up-to-date information regarding our New Grad / RN Residency program. In the meantime, I definitely want to assist you in career searches in the future, so here are some suggestions to aid you in your search:

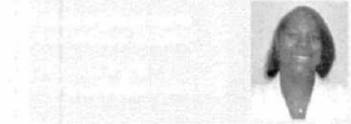
- **If it is your first time applying for a job in healthcare**, be open to **all departments and all areas** in the acute setting. Also, be open to **all shifts** (days, afternoons, nights, 8's and 12's), and to **full** and **part-time**.
- **Consider expanding your search to Long-Term Care or Skilled Nursing Facilities. If possible, expand your job search outside of the state. There may be other hospitals with new grad/residency programs, as well! I have hired many individuals who have left the state to work at different facilities and have returned to the area with great clinical experiences.**
- **Consider volunteering your time as a Volunteer RN at a hospital that may offer this opportunity. This will allow you to gain excellent clinical experience and will help you to keep your skills active (depending on the scope of practice allowed in this Volunteer RN role).**
- Talk to **everyone** in your own network (relatives, friends, neighbors, former teachers, former co-workers etc.) because they may be able to assist you in your job search.
- Find networking opportunities through local employment agencies, professional groups, and via social networking websites such as **Linked-In**, **Facebook** and **Twitter**. There are many pages with information on job postings and certain companies have their own individual pages on these websites. In addition, seek out opportunities to attend field-related presentations or seminars, where you can network with other professionals. Ask **who/what do they know** about current openings.
- Continue your education, if you are interested and if it is feasible. Make sure that your certifications are up-to-date and if necessary, take a RN Refresher Course to keep your skills active. You want to make sure that you are doing everything within your power to maintain your skills while search for a position.

I know that this job market is very tough, especially for our new grad RNs. I definitely encourage you to **STAY POSITIVE!** I sincerely wish you the best of luck in your future career endeavors and I hope that you will check our website for opportunities in the future.

Have an excellent day and I wish you good luck on your search!

Kevin Silvestre, M.S.
RN Nursing / Cardiology / Radiology / Psychiatry / Strategy Divisions
HR Workforce Planning & Recruitment
Alameda Health System (formerly Alameda County Medical Center)
Highland Hospital Campus
1411 East 31st Street
Oakland, California 94602
E-mail: KSilvestre@acmedctr.org / Phone: 510 -869-7383
Hospital Website: http://www.alamedahealthsystem.org

4/30/13



Highland Hospital

1411 East 31st Street
Oakland, CA 94602
(510) 437-4800

www.acmedctr.org

Emergency Department
Phone: (510) 437-4559

Human Resources
Phone: (510) 895-7383

Highland Hospi al

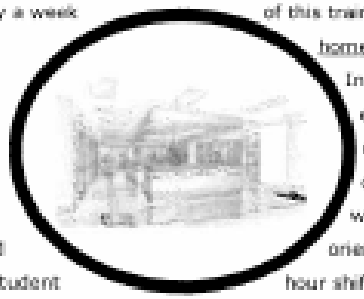
Emergency Department Training Program

July 2012

A 16-week training program designed specifically for new grads and first time ED nurses.

Emergency Department Training Program

This program offers both didactic and clinical experiences for the new Emergency Department nurse. Classes are one day a week for the duration of the program. Class consists of review and / or testing of the following: your clinical experiences during orientation, documentation, ECGs, homework assignments from emergency nursing modules, and discussion of case studies each student will prepare. An Emergency Nursing and ECG textbook will be required as part of class. You will also attend a 2-day ECG class as part of this training program. There is a lot of homework associated with this course. In addition to the one day of class each week, you will orient in the department with an assigned preceptor and have regular meetings with the ED CNS. Each orientee will orient a combination of 8-hour and 12-hour shifts totaling a 40-hour work week for the duration of the training program.



Artist's rendition of Critical Care Station One in the Emergency Department

The Hiring Process

First, complete an on-line application for the desired ED position.

Second, qualified candidates will be screened and interviewed.

Third, Human Resources will notify desired candidates of acceptance into the program and an offer of employment will be made contingent on a background check and pre-employment physical.

Certification/License Requirements

CA RN License

BLS, ACLS, PALS or ENPC

TNCC (once eligible for trauma assignment)

CEN preferred within 1 year of hire

Highland History & Fast Facts

Highland Hospital was awarded trauma designation in January 1987. Highland's Level II trauma center serves the community of Northern Alameda County. The Emergency Department (ED) at Highland Hospital is a Safety Net Hospital which sees about 84,000 patients per year; approximately 2,500 of which arrive as trauma patients.

Since Spring of 2004, we have enjoyed our new ED. We are licensed for 42 beds in the ED and 9 beds in our Fastrack area. Our ED serves a diverse population and our staff enjoy the fast-paced, team-oriented environment where we see and treat a variety of patients with high acuities. We are a teaching hospital with excellent learning opportunities. Once a part of our team, specialty training and continuing education is available. Advanced training for code rooms, triage, and trauma is also provided for our experienced ED Staff.

Important Dates

New Employee Orientation

July 23 & 24, 2012

8:30-5pm

Emergency Department "Day with the CNS"

July 26, 2012

7am-3:30

Emergency Department Orientation Program

July 23 — November 16, 2012

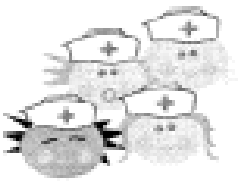
ED Training Program Class Dates

Every Friday beginning August 3

7am-3:30

Building Excellence

The ACMC EXPERIENCE



As a recent graduate, where you choose to launch your career can make all the difference. At ACMC, we don't want you to ever feel lost or overwhelmed. We customize our programs to accommodate your needs as a new graduate and pair you up with unit-experienced preceptors to carefully nurture your growth and confidence. Our multi-disciplinary education programs are designed to facilitate this transition so that you can have a strong foundation for your future professional advancement. In the ACMC RN Residency program you will have an excellent opportunity to utilize your acquired skills and apply them in an acute care setting that is culturally diverse and rich in oppoetunities to experience many different disease conditions.

Each new grad will attend a series of new graduate transition to RN classes and preceptor support up to at least twelve weeks or more, depending on the specialty of the unit. Upon the successful completion of the program, you may be hired into an FTE (full time employment) or SAN (Services as Needed) Clinical Nurse I role.

REQUIREMENTS:

- EDUCATION:

  Graduation from an accredited School of Nursing in any of the following:

  - Associate's Degree in Nursing (A.D.N.)
  - Bachelor's Degree in Nursing (B.S.N.)
  - Master's Degree in Nursing (M.S.N.)

- REQUIRED LICENSES/CERTIFICATIONS

  - California State License as a Registered Nurse
  - CPR/BLS
  - ACLS – Depending on unit area (requirement for all Critical Care areas)

- PALS – Depending on unit area (requirement for all Critical Care and Maternal-Child areas)

➢ **KNOWLEDGE OF:**

- Anatomy, physiology, chemistry, pharmacology, growth and development, basic medical and surgical nursing, and nutrition.
- Wellness to illness continuum.
- Nursing procedures, techniques, equipment, and supplies.
- Health systems, agencies, and patterns of referral.
- Major disease conditions, including current knowledge of tests, therapies, and treatments.
- Assessment techniques.
- Principles and processes of problem solving.
- Principles and practices of effective cost control.

➢ **ABILITY TO:**

- Utilize concepts of assessment, priority setting, organization, and evaluation.
- Practice safe, thorough nursing care with effective, economic use of supplies and with reasonable speed.
- Practice effective nursing in diverse environments.
- Write concisely, legibly and with correct spelling.
- Communicate effectively.
- Teach patients, families, and staff.
- Work professionally with personnel and medical staff.
- Respond effectively to emergency situations.
- Identify etiology of a problem and make essential decisions utilizing the problem-solving process

➢ **PHYSICAL REQUIREMENTS/WORK ENVIRONMENT**

The physical demands and work environment described here are representative of those that must be met by an employee to successfully perform the essential functions of the job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

PERFORMANCE WILL BE MEASURED AGAINST SPECIFIC, AGREED UPON GOALS AND TIMELINES

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See addendum to Job Description, **REQUIRED AGE SPECIFIC COMPETENCIES**

FORMAL PROGRAM:

- For the New Graduate Nurse
- 12-week program; can be extended at the discretion of the unit manager or at the recommendation of clinical educators
- Each resident will be assigned a preceptor who will guide the 8-hour or 12-hour, hands-on clinical experience 2-3x per week
- Weekly skills and didactic classroom experiences
- Use of the Essentials of Critical Care Orientation (ECCO) modules adopted from the American Association of Critical Care Nurses to be assigned weekly and completed at the RN Resident's home or at ACMC's library.

PROGRAM EMPHASIS:

- Critical Thinking
- Patient Safety
- Leadership Skills
- Communication Skills
- Research-based Practice
- Professional Development

PROGRAM OBJECTIVES- At the completion of the RN Residency program, the RN Resident will be able to:

- Care for patients with the increasing levels of acuity and complexity currently found in the hospital setting.
- Develop effective decision making skills related to clinical judgment and performance.
- Develop clinical nursing leadership at point of care.
- Have a strengthened commitment to nursing as a professional career choice.
- Develop individual career goals.
- Bring evidence based practice to the bedside.
- Develop clinical and leadership skills necessary for the advanced beginner nurse to be a successful member of the health-care team.

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- Improve patient safety and quality of care.

CURRICULUM DESCRIPTION

Didactic classes and clinicals: You will attend didactic classes **two times a week** and do clinicals with your preceptors in your assigned units unless otherwise specified (two to three days a week, depending on your unit shifts: **3 days if working 8 hours; 2 days if working 12hours**). Check your schedule with your unit manager or preceptor when these times and dates will be.

ECCO modules: You will also be assigned weekly ECCO (Essentials of Critical Care Orientation) modules on the ACMC Intranet website under Education & Training. Go to http://www.webinservice.com/Alameda/ to access the **e-learning on the Learning Zone**; you will be asked to enter your user ID and password that has been assigned to you to access the modules; you can complete them in the venue of your choice (home or the ACMC library). You will need to submit a copy of your post-test for each system you complete on the dates assigned (see weekly schedule for details). A module has several lessons, each with a post test that you need to get a score of 80% to pass. You can repeat the test as many times as you need until you get a passing grade. There is no way to print the results from the ECCO screen, so you may have to get a screen shot of your test results, print them, and submit to any of the educators on the dates assigned (see weekly schedule).

Note: If you are assigned in the **OR/perioperative** area, you will follow the Stepdown/ Telemetry modules.

Below is a description of the ECCO modules.

A. ECCO MODULES- MEDICAL-SURGICAL UNITS

1. ECCO Module 00-01: Essentials of Critical Care Orientation 2.0 - Introduction
2. ECCO Module 01-03: Introduction to Care of the Critically Ill - Organizing the Care of the Critically Ill Patient (1 hr)
3. ECCO Module 01-04: Introduction to Care of the Critically Ill - Evidence - Based Practice (1 hr) (except topic 5: VAP)
4. ECCO Module 02-01: Care of the Patient with Cardiovascular Disorders - Cardiovascular System Anatomy and Physiology (1 hr)
5. ECCO Module 02-02: Care of the Patient with Cardiovascular Disorders - Assessing the Cardiovascular System (1 hr)
6. ECCO Module 02-03: Care of the Patient with Cardiovascular Disorders - Management of Acute Coronary Syndromes (4 hrs)
7. ECCO Module 02-04: Care of the Patient with Cardiovascular Disorders - Pathologic Conditions (5 hrs)

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8. ECCO Module 03-01: Care of the Patient with Pulmonary Disorders - Pulmonary System Anatomy and Physiology (1 hr)
9. ECCO Module 03-02: Care of the Patient with Pulmonary Disorders - Respiratory Assessment (1.5 hrs)
10. ECCO Module 03-03: Care of the Patient with Pulmonary Disorders - Pathologic Conditions (2 hrs)
11. ECCO Module 03-04: Care of the Patient with Pulmonary Disorders - Airway Management (0.5 hr)
12. ECCO Module 03-06: Care of the Patient with Pulmonary Disorders - Thoracic Surgical Procedures (1 hr)
13. ECCO Module 05-01: Care of the Patient with Neurologic Disorders - Neurologic System Anatomy and Physiology (1 hr)
14. ECCO Module 05-02: Care of the Patient with Neurologic Disorders - Assessment and Diagnostic Techniques (1 hr)
15. ECCO Module 05-04: Care of the Patient with Neurologic Disorders - Ischemic and Hemorrhagic Stroke (2 hrs)
16. ECCO Module 05-05: Care of the Patient with Neurologic Disorders - Other Pathological Conditions (2 hrs)
17. ECCO Module 06-01: Care of the Patient with Gastrointestinal Disorders - Gastrointestinal System Anatomy and Physiology (1 hr)
18. ECCO Module 06-02: Care of the Patient with Gastrointestinal Disorders - Diagnostic Testing (1 hr)
19. ECCO Module 06-03: Care of the Patient with Gastrointestinal Disorders - Pathologic Conditions (2 hrs)
20. ECCO Module 06-04: Care of the Patient with Gastrointestinal Disorders - Nutritional Support of Critically Ill Patients (1 hr)
21. ECCO Module 07-01: Care of the Patient with Renal Disorders - Renal System Anatomy and Physiology (1 hr)
22. ECCO Module 07-02: Care of the Patient with Renal Disorders - Renal Assessment and Monitoring (0.5 hr)
23. ECCO Module 07-03: Care of the Patient with Renal Disorders - Fluid and Electrolyte Disturbances (1 hr)
24. ECCO Module 07-04: Care of the Patient with Renal Disorders - Renal Disease (1.5 hrs)
25. ECCO Module 07-05: Care of the Patient with Renal Disorders - Renal Replacement Therapy (1 hr)
26. ECCO Module 08-01: Care of the Patient with Endocrine Disorders - Endocrine System Anatomy and Physiology (0.5 hr)
27. ECCO Module 08-02: Care of the Patient with Endocrine Disorders - Endocrine System Assessment (0.5 hr)
28. ECCO Module 08-03: Care of the Patient with Endocrine Disorders - Pathologic Conditions (1.5 hrs)
29. ECCO Module 09-01: Care of the Patient with Hematological Disorders - Hematologic System Anatomy and Physiology (0.25 hrs)
30. ECCO Module 09-02: Care of the Patient with Hematological Disorders - Hematologic Diagnostic Tests (0.5 hrs)
31. ECCO Module 09-03: Care of the Patient with Hematological Disorders - Pathologic Conditions (1 hr)
32. ECCO Module 10-01: Care of the Patient with Multisystem Disorders - Shock (1 hr)
33. ECCO Module 10-02: Care of the Patient with Multisystem Disorders - Sepsis, SIRS and MODS (2 hrs)
34. ECCO Module 10-03: Care of the Patient with Multisystem Disorders - Overdose (0.5 hrs)
35. ECCO Module 01-02: Introduction to Care of the Critically Ill - Care of Specialty Populations in the Critical Care Unit

B. ECCO MODULES- STEPDOWN/ TELEMETRY UNITS

1. ECCO Module 00-01: Essentials of Critical Care Orientation 2.0 - Introduction
2. ECCO Module 01-03: Introduction to Care of the Critically Ill - Organizing the Care of the Critically Ill Patient (1 hr)
3. ECCO Module 01-04: Introduction to Care of the Critically Ill - Evidence - Based Practice (1 hr) (except topic 5: VAP)
4. ECCO Module 02-01: Care of the Patient with Cardiovascular Disorders - Cardiovascular System Anatomy and Physiology (1 hr)
5. ECCO Module 02-02: Care of the Patient with Cardiovascular Disorders - Assessing the Cardiovascular System (1 hr)
6. ECCO Module 02-03: Care of the Patient with Cardiovascular Disorders - Management of Acute Coronary Syndromes (4 hrs)
7. ECCO Module 02-04: Care of the Patient with Cardiovascular Disorders - Pathologic Conditions (5 hrs)
8. ECCO Module 02-05: Care of the Patient with Cardiovascular Disorders - Cardiac Surgery (2 hrs)
9. ECCO Module 02-06: Care of the Patient with Cardiovascular Disorders - Cardiac Pacemakers (1.5 hrs)
10. ECCO Module 03-01: Care of the Patient with Pulmonary Disorders - Pulmonary System Anatomy and Physiology (1 hr)
11. ECCO Module 03-02: Care of the Patient with Pulmonary Disorders - Respiratory Assessment (1.5 hrs)

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12. ECCO Module 03-03: Care of the Patient with Pulmonary Disorders - Pathologic Conditions (2 hrs)
13. ECCO Module 03-04: Care of the Patient with Pulmonary Disorders - Airway Management (0.5 hr)
14. ECCO Module 03-05: Care of the Patient with Pulmonary Disorders - Basic Ventilator Management (2 hrs)
15. ECCO Module 03-06: Care of the Patient with Pulmonary Disorders - Thoracic Surgical Procedures (1 hr)
16. ECCO Module 05-01: Care of the Patient with Neurologic Disorders - Neurologic System Anatomy and Physiology (1 hr)
17. ECCO Module 05-02: Care of the Patient with Neurologic Disorders - Assessment and Diagnostic Techniques (1 hr)
18. ECCO Module 05-04: Care of the Patient with Neurologic Disorders - Ischemic and Hemorrhagic Stroke (2 hrs)
19. ECCO Module 05-05: Care of the Patient with Neurologic Disorders - Other Pathological Conditions (2 hrs)
20. ECCO Module 06-01: Care of the Patient with Gastrointestinal Disorders - Gastrointestinal System Anatomy and Physiology (1 hr)
21. ECCO Module 06-02: Care of the Patient with Gastrointestinal Disorders - Diagnostic Testing (1 hr)
22. ECCO Module 06-03: Care of the Patient with Gastrointestinal Disorders - Pathologic Conditions (2 hrs)
23. ECCO Module 06-04: Care of the Patient with Gastrointestinal Disorders - Nutritional Support of Critically Ill Patients (1 hr)
24. ECCO Module 07-01: Care of the Patient with Renal Disorders - Renal System Anatomy and Physiology (1 hr)
25. ECCO Module 07-02: Care of the Patient with Renal Disorders - Renal Assessment and Monitoring (0.5 hr)
26. ECCO Module 07-03: Care of the Patient with Renal Disorders - Fluid and Electrolyte Disturbances (1 hr)
27. ECCO Module 07-04: Care of the Patient with Renal Disorders - Renal Disease (1.5 hrs)
28. ECCO Module 07-05: Care of the Patient with Renal Disorders - Renal Replacement Therapy (1 hr)
29. ECCO Module 08-01: Care of the Patient with Endocrine Disorders - Endocrine System Anatomy and Physiology (0.5 hr)
30. ECCO Module 08-02: Care of the Patient with Endocrine Disorders - Endocrine System Assessment (0.5 hr)
31. ECCO Module 08-03: Care of the Patient with Endocrine Disorders - Pathologic Conditions (1.5 hrs)
32. ECCO Module 08-04: Care of the Patient with Endocrine Disorders - Managing Hyperglycemia in the Critically Ill Patient (1.5 hrs)
33. ECCO Module 09-01: Care of the Patient with Hematological Disorders - Hematologic System Anatomy and Physiology (0.25 hrs)
34. ECCO Module 09-02: Care of the Patient with Hematological Disorders - Hematologic Diagnostic Tests (0.5 hrs)
35. ECCO Module 09-03: Care of the Patient with Hematological Disorders - Pathologic Conditions (1 hr)
36. ECCO Module 10-01: Care of the Patient with Multisystem Disorders - Shock (1 hr)
37. ECCO Module 10-02: Care of the Patient with Multisystem Disorders - Sepsis, SIRS and MODS (2 hrs)
38. ECCO Module 10-03: Care of the Patient with Multisystem Disorders - Overdose (0.5 hrs)
39. ECCO Module 01-02: Introduction to Care of the Critically Ill - Care of Specialty Populations in the Critical Care Unit

For Didactic Courses- please refer to the Weekly Calendar Schedule
For Clinical Hours- please refer to the Weekly Calendar Schedule

SUMMARY OF PROGRAM HOURS & CONTENT-
MEDICAL-SURGICAL UNITS (7e, 7w)

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ECCO Hours TOT: 43.75 hrs	ECCO Content		Didactic Hours TOTAL: 160 hrs	Clinical Hours TOTAL: 238 hrs
Week 1 11/25-12/1/12 M/S: Module 1, start 4-6	Intro to ECCO See content for Weeks 2-3		none	none
CARDIOLOGY- 11 hrs **Week 2** 12/9-12/15/12 M/S: Modules 4-6 **Week 3** 12/9-12/15/12 Modules 7-9	A&P Assessment Management Pathologic Conditions	1 1 4 5 11	Wk 2- 16 hrs Wk3- 16 hrs Tot: 32 hrs	Wk 2- none Wk 3- 24 hrs Tot: 24 hrs
PULMONARY- 6 hrs **Week 4** 12/16-12/22/12 M/S: Modules 10-12	A&P Assessment Pathologic Conditions Airway Mgmt Thoracic Surg Procedures	1 1.5 2 0.5 1 6	Wk 4- 8 hrs Tot: 8 hrs	Wk 4- 32 hrs Tot: 32-hrs
NEUROLOGY- 6 hrs **Week 5** 1/6-1/12/13 M/S: Modules 13-16	A&P Assessment & Diagnostics Stroke Pathologic Conditions	1 1 2 2 6	Wk 5- 16 hrs Tot 16 hrs	Wk 5- 24 hrs Tot: 24 hrs
GASTRO-INT - 5 hrs **Week 6** 1/13-19/13 M/S: Modules 17-20	A&P Diagnostic Tests Pathologic Conditions Nutritional Support	1 1 2 1 5	Wk 6- 16 hrs Tot: 16 hrs	Wk 6- 24 hrs Tot: 24 hrs
RENAL- 5 hrs **Week 7** 1/20-1/26/13 M/S: Modules 21-25	A&P Assessment Fluids & Electrolytes Renal Dz Replacement Therapy	1 0.5 1 1.5 1 5	Wk 7- 16 hrs Tot: 16 hrs	Wk 7- 24 hrs Tot: 24 hrs
ENDOCRINE- 2.5hrs **Week 8** 1/27-2/1/13 M/S: Modules 26-28	A&P Assessment Pathologic Conditions	0.5 0.5 1.5 2.5	Wk 8- 16 hrs Tot: 16 hrs	Wk 8- 24 hrs Tot: 24 hrs
HEMATOLOGY- 1.75 hrs	A&P	0.25	Wk 9- 16 hrs	Wk 9- 24 hrs

Week 9 2/3-9/13 M/S: Modules 29-31	Diagnostic Tests Pathologic Conditions	0.5 1 1.75	Tot: 16 hrs	Tot: 24 hrs
MULTI-SYSTEM- 3.5 hrs **Week 10** 2/10-16/13 M/S: Modules 32-34	Shock Sepsis, SIRS, MODS Overdose	1 2 0.5 3.5	Wk 10- 16 hrs Tot: 16 hrs	Wk 10- 24 hrs Tot: 24 hrs
EBP, SPECIAL POPULATIONS- 3hrs **Week 11** 2/17-23/13 M/S: Modules 2,3,35	Special Populations (except Topic 1: Pediatrics) Organizing Care EBP (except Topic 5: VAP)	1 1 1 3	Wk 11- 16 hrs Tot: 16 hrs	Wk 11- 24 hrs Tot: 24 hrs
Week 12 2/24-3/2/13	NO ECCO MODULES		Wk 12- 8 hrs Tot: 8 hrs	Wk 12- 24 hrs Tot: 24 hrs

SUMMARY OF PROGRAM HOURS & CONTENT-

STEPDOWN/ TELEMETRY UNITS (SDU/5e)

ECCOHours TOT: 50.75 hrs	**ECCO Content**		**Didactic Hours TOTAL: 160 hrs**	**Clinical Hours TOTAL: 238-242 hrs**
Week 1 11/25-12/1/12 SDU/Tele: Mod 1, start 4-7	Intro to ECCO See content for Weeks 2-3		none	none
CARDIOLOGY- 14.5 hrs **Week 2** 12/2-12/8/12 SDU/Tel: Modules 4-7 Week 3 12/9-12/15/12 Modules 8-11	A&P Assessment Management Pathologic Conditions Cardiac Symptoms Pacemakers	1 1 4 5 2 1.5 14.5	Wk 2- 16 hrs Wk3- 16 hrs Tot: 32 hrs	Wk 2- none Wk 3- 24 hrs Tot: 24 hrs
PULMONARY- 6 hrs Week 4 12/16-12/22/12 SDU/Tel: Modules 12-15	A&P Assessment Pathologic Conditions Airway Mgmt Thoracic Sx Procedures	1 1.5 2 0.5 1 6	Wk 4- 8 hrs Tot: 8 hrs	Wk 4- 32- 36 hrs SDU- 36 hrs 5e- 32 hrs Tot: 32- 36 hrs
NEUROLOGY- 6 hrs	A&P	1	Wk 5- 16 hrs	Wk 5- 24 hrs

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Week 5 1/6-1/12/13 SDU/Tel: Modules 16-19	Assessment & Diagnostics Stroke Pathologic Conditions	1 2 2 6	Tot: 16 hrs	Tot: 24 hrs
GASTRO-INT 5 hrs **Week 6** 1/13-19/13 SDU/Tel: Modules 20-23	A&P Diagnostic Tests Pathologic Conditions Nutritional Support	1 1 2 1 5	Wk 6- 16 hrs Tot: 16 hrs	Wk 6- 24 hrs Tot: 24 hrs
RENAL- 5 hrs **Week 7** 1/20-1/26/13 SDU/Tel: Modules 24-28	A&P Assessment Fluids & Electrolytes Renal Dz Replacement Therapy	1 0.5 1 1.5 1 5	1 Wk 7- 16 hrs Tot: 16 hrs	Wk 7- 24 hrs Tot: 24 hrs
ENDOCRINE- 2.5hrs **Week 8** 1/27-2/1/13 SDU/Tel: Modules 29-32	A&P Assessment Pathologic Conditions	0.5 0.5 1.5 2.5	Wk 8- 16 hrs Tot: 16 hrs	Wk 8- 24 hrs Tot: 24 hrs
HEMATOLOGY- 1.75 hrs **Week 9** 2/3-9/13 SDU/Tel: Modules 33-35	A&P Diagnostic Tests Pathologic Conditions	0.25 0.5 1 1.75	Wk 9- 16 hrs Tot: 16 hrs	Wk 9- 24 hrs Tot: 24 hrs
MULTI-SYSTEM- 3.5 hrs **Week 10** 2/10-16/13 SDU/Tel: Modules 36-38	Shock Sepsis, SIRS, MODS Overdose	1 2 0.5 3.5	Wk 10- 16 hrs Tot: 16 hrs	Wk 10- 24 hrs Tot: 24 hrs
EBP, SPECIAL POPULATIONS- 3hrs **Week 11** 2/17-23/13 SDU/Tel: Modules 2,3,39	Special Populations (except Topic 1: Pediatrics) Organizing Care EBP (except Topic 5: VAP)	1 1 1 3	Wk 11- 16 hrs Tot: 16 hrs	Wk 11- 24 hrs Tot: 24 hrs
Week 12 2/24-3/2/13	NO ECCO MODULES		Wk 12- 8 hrs Tot: 8 hrs	Wk 12- 24 hrs Tot: 24 hrs

SUPPLEMENTARY MATERIALS/ADDITIONAL RESOURCES

On the ACMC Intranet: Krames-on-Demand

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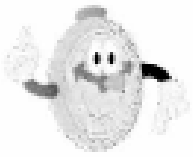
Up to Date
Mosby's Skills/Mosby Nursing Consult
Nursing Policies & Procedures
Micromedex
Nutritional Care Manual



WEEKLY CALENDAR SCHEDULE/ ASSIGNMENTS*

*Schedule is tentative and subject to change

- **Note about Schedule flexibility & Room Availability:**
  The Clinical Education Department reserves the right to make adjustments or changes throughout the program. RN Residents are responsible to learn about these changes if they miss any class time.

Date, Location **Week 1** 11/25-12/1/12	Time Slot	Activity	Speaker(s)	Assignment/ Tests Due
Mon, 11/26/12 **Classroom A**	ALL DAY 8am-5pm	**NEO- New Employee Orientation**		
Tue, 11/27/12 **Classroom A**	ALL DAY 8am-5 pm	**NNO- New Nurse Orientation**		**MED-SURG:** **ECCO Modules** **1** **start 4-6**
Wed, 11/28/12 **Classroom C**	0800-1000	Welcome & Introductions, Students introduce themselves	Clinical Education Team	
	1000-1200	Program overview- mission, vision, theoretical framework, prof role	Nursing leadership	**SDU/Tele:** **ECCO Modules** **1** **start 4-7**
	1200-1300	**WELCOME LUNCH**		
	1300-1400	Intro to ECCO, overview of syllabus, clinical rotation; case study assignments	Educators	
	1300-1600	Continue Program overview; MEET & GREET	Educators, Nsg Council, Transitional Committee, Charge Nurses, Preceptors	Submit **CV** post test on **Tue, 12/18/12, first hour**
Thur, 11/29/12		ECCO on own		
Fri, 11/30/12 **Fairmont H 124**	12pm-3pm	**ALARIS Pump Training** ECCO on own post Alaris training	Reps, super-users	

Date, Location	Time Slot	Activity	Speaker(s)	Assignment/

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Week 2 12/2-12/8/12 Cardiovascular Focus				Tests Due
Mon, 12/3/12 **Classroom C**	ALL DAY 8a- 5pm	Merlin Training, **grp 1**; rest stay home and do ECCO	Jennifer, Tiffany,	MED-SURG: ECCO Modules 4--6 SDU/Tele: ECCO Modules 4-7 Submit CV post test on Tue, 12/18/12 first hour
Tue, 12/4/12 **Classroom C**	ALL DAY 8a- 5 pm	Merlin Training, **grp 2**; rest stay home and do ECCO	Jennifer, Tiffany,	
Wed, 12/5/12 **Classroom C**	ALL DAY 8a- 5 pm	Merlin Training, **grp 3**; rest stay home and do ECCO	Jennifer, Tiffany,	
Thur, 12/6//12 **Classroom C**	8a-5p	EKG Intensive	TBD	
Fri, 12/7/12 **Classroom C**	8a-5p	EKG Intensive	TBD	

Date, Location Week 3 12/09-12/15/12 Cardiovascular/ Pulm Focus	Time Slot	Activity	Speaker(s)	Assignment/ Tests Due
Mon, 12/10/12 EVS Conference Rm	0800-1000	Risk Mgment, Regulatory issues, documentation	Susan Brajkovic	MED-SURG: ECCO Modules 7-9 SDU/Tele: ECCO Modules 8-11 Submit CV post test on Tue,12/18/12, first hour
	1000-1200	Multidisc plan of care	Educators	
	1200-1300	LUNCH	On own	
	1300-1500	Head to toe assessment	Educators	
	1400-1700	Equipment- Zoll, pace-makers, crash cart	Educators	
Tue, 12/11/12 EVS Conference Rm	0800-0900	Debriefing, Recap, Expectation, Evaluations	Educators	
	0900-1100	CV Pharma	Pharmacist	
	1100-1200	CV pharma, nursing considerations	Educators	
	1200-1300	LUNCH	On own	
	1300-1700	ACLS Review, code blue forms, documentation	Educators	
CLINICAL 2-3 DAYS – unit-specific as arranged; check with manager for schedule • Variable; depends on unit shifts if 8hrs or 12 hrs; may include weekends ○ If unit is 12 hour shift (SDU)- do 2 clinical days ○ If unit is 8 hour shift (5e, 7e, 7w)- do 3 clinical days				

Date, Location	Time Slot	Activity	Speaker(s)	Assignment/

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Week 4 12/16-12/22/12 Pulmonary Focus				Tests Due
Mon, 12/17/12		ECCO on own		
Tue, 12/18/12 **Classroom C**	0800-0900	Debriefing, Recap, Expectation, Evaluations	Educators	MED-SURG: ECCO Modules 10-12 SDU/Tele: ECCO Modules 12-15 Submit CV post test on Tue.12/18/12, first hour
	0900-1100	CV Case Presentations	RN Residents Educator feedback	
	1100-1200	RT lecture, Breath sounds	RT- Rick Spann, Tony Picciono	
	1200-1300	Lunch on own		
	1300-1500	Resp hands on assessment, ABGs, BIPAP	RT-Rick, Tony Educators	
	1500-1700	Resp case studies	RT- Rick, tony	
CLINICAL 2-3 DAYS – unit-specific as arranged; check with manager or preceptor • **Variable; depends on unit shifts if 8hrs or 12 hrs; may include weekends** ○ **If unit is 12 hour shift (SDU)- do 2 clinical days** ○ **If unit is 8 hour shift (5e, 7e, 7w)- do 3 clinical days**				

*****12//23/12- 01/05/13 HOLIDAY BREAK*****

Date, Location	Time Slot	Activity	Speaker(s)	Assignment/ Tests Due
Week 5 1/6-1/12/13 Neuro focus				
CLINICAL 2-3 DAYS – unit-specific as arranged; check with manager or preceptor • **Variable; depends on unit shifts if 8hrs or 12 hrs; may include weekends** ○ **If unit is 12 hour shift (SDU)- do 2 clinical days** ○ **If unit is 8 hour shift (5e, 7e, 7w)- do 3 clinical days**				**MED-SURG:** **ECCO Modules 13-16** SDU/Tele: ECCO Modules 16-19 Submit Pulm post test on Thur. 1/10/13 first hour
Thur, 1/10/13 Fairmont	0800-0900	Debriefing, Recap, Expectation, Evaluations	Educators	
	0900-1200	Neuro review, Head Traumas, Traumatic Brain Injury, Spinal Cord Injury etc.	Andria Sievers	
	1200-1300	Lunch on own		
	1300-1500	Chest, Abdominal trauma	ER Educators, Staff	
	1500-1700	Trauma, stroke assessment, case studies	Educators	
Fri, 1/11/13 Fairmont	0800-1000	Shock	Amy Ruff/ ER	
	1000-1200	Trauma team, Equipment	Amy Ruff	

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		demo, chest tubes,	Andria Sievers	
	1200-1300	Lunch on own		
	1300-1500	Disaster training	Sandra Williams	
	1500-1700	Neuro case studies	Educators	

Date, Location **Week 6** 1/13-19/13 Gastro-int Focus	Time Slot	Activity	Speaker(s)	Assignment/ Tests Due
CLINICAL 2-3 DAYS – unit-specific as arranged; check with manager for schedule • Variable; depends on unit shifts if 8hrs or 12 hrs; may include weekends ○ If unit is 12 hour shift (SDU)- do 2 clinical days ○ If unit is 8 hour shift (5e, 7e, 7w)- do 3 clinical days				MED-SURG: ECCO Modules 17-20 SDU/Tele: ECCO Modules 20-23
Thur, 1/17/13 Fairmont	0800-0900	Debriefing, Recap, Expectation, Evaluations	Educators	
	0900-1000	Nutrition, Tube Feedings	Helen/ Dietician	
	11000-1200	Culture of Safety	Adrian Smith	
	1200-1300	Lunch on own		
	1300-1500	GI pathology	MD- TBA	Submit Neuro post test on Thur, 1/17/13, first hour
	1500-1700	OD, Alcohol withdrawal, IVDA, botulism	Educators	
Fri, 1/18/13 Fairmont	0800-1000	EGD, colonoscopy, TEE, GI procedures	Endoscopy RN Marian Espiritu	
	1000-1200	GI PHARMA	Educators, Pharmacist	
	1200-1300	Lunch on own		
	1300-1500	TF Protocol, NGT mgment, Enteral pump hands-on (Kangaroo)	Educators	
	1500-1700	GI case studies	Educators	

Date, Location **Week 7** 1/20-1/26/13 Renal Focus	Time Slot	Activity	Speaker(s)	Assignment/ Tests Due
CLINICAL 2-3 DAYS – unit-specific as arranged; check with manager or preceptor • Variable; depends on unit shifts if 8hrs or 12 hrs; may include weekends ○ If unit is 12 hour shift (SDU)- do 2 clinical days ○ If unit is 8 hour shift (5e, 7e, 7w)- do 3 clinical days				MED-SURG: ECCO Modules 21-25 SDU/Tele: ECCO Modules 24-28
Thur, 1/24/13 Fairmont	0800-0900	Debriefing, Recap, Expectation, Evaluations	Educators	

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	0900-1000	Quality	Satira Dalton	Submit GI post test on **Thur, 1/24/13, first hour**
	1000-1100	Quick Renal physiology & pathology review	MD- TBA	
	1100-1200	Renin-Angiotensin-Aldosterone-System	MD- TBA	
	1200-1300	Lunch on own		
	1300-1500	Renal pharma	Educators	
	1500-1700	Special procedures- continuous bladder irrigations, coude catheters	Educators	
Fri, 1/25/13 Fairmont	0800-1000	Fistulas, Hemodialysis, Peritoneal dialysis, grafts	Educators	
	1000-1200	Infection control, PPE	Rachel Poulous	
	1200-1300	Lunch on own		
	1300-1700	Ortho applications- SCD, CPM, skeletal traction, trapeze	Phil McKeown	

Date, Location **Week 8** **1/27—2/2/13** Endocrine **Focus**	**Time Slot**	**Activity**	**Speaker(s)**	**Assignment/ Tests Due**
CLINICAL 2-3 DAYS – unit-specific as arranged; check with manager or preceptor • **Variable; depends on unit shifts if 8hrs or 12 hrs; may include weekends** ○ **If unit is 12 hour shift (SDU)- do 2 clinical days** ○ **If unit is 8 hour shift (5e, 7e, 7w)- do 3 clinical days**				**MED-SURG: ECCO Modules 26-28** **SDU/Tele: ECCO Modules 29-32** Submit **Renal** post test on **Thu, 1/24/13, first hour**
Thur, 1/24/13 Fairmont	0800-0900	Debriefing, Recap, Expectation, Evaluations	Educators	
	0900-1000	Endocrine physiology & pathology	MD- TBA	
	1000-1100	Electrolyte imbalance, types of IVF, TPN	Pharmacist	
	1200-1300	Lunch on own		
	1300-1500	Diabetes, DKA	Vicki Roberts	
	1500-1700	Diabetes pharma, case studies	Pharmacist, educators	
Fri, 1/25/13 Fairmont/Highland?	0800-1700	Tentative : SOARIAN training ALL DAY		

Building Excellence

Date, Location **Week 9** 2/3-9/13 Hematology Focus	Time Slot	Activity	Speaker(s)	Assignment/ Tests Due
CLINICAL 2-3 DAYS – unit-specific as arranged; check with manager or preceptor • Variable; depends on unit shifts if 8hrs or 12 hrs; may include weekends ○ If unit is 12 hour shift (SDU)- do 2 clinical days ○ If unit is 8 hour shift (5e, 7e, 7w)- do 3 clinical days				MED-SURG: ECCO Modules 26-28 SDU/Tele: ECCO Modules 29-32 Submit Endo post test on Thur, 2/7/13 first hour
Thur, 2/7/13 Fairmont	0800-0900	Debriefing, Recap, Expectation, Evaluations	Educators	
	0900-1100	Vascular Access	Terry Hall, Genentech	
	1100-1200	PICC, central line mgment	Terry hall, Genentech	
	1200-1300	Lunch on own		
	1300-1500	Hematology pathology	MD- TBA	
	1500-1700	Wound Care	Karen Ross	
Fri, 2/8/13 Fairmont	0800-1000	Boot Camp- Body Mechanics	Jason Brown	
	1000-1200	Equipment hands-on Cooling blanket, Bair hugger	Educators	
	1200-1300	Lunch on own		
	1300-1500	Ortho Practical Applications	Phil McKeown	

Date, Location **Week 10** 2/10-16/13 Multi-sys Focus	Time Slot	Activity	Speaker(s)	Assignment/ Tests Due
CLINICAL 2-3 DAYS – unit-specific as arranged; check with manager or preceptor • Variable; depends on unit shifts if 8hrs or 12 hrs; may include weekends ○ If unit is 12 hour shift (SDU)- do 2 clinical days ○ If unit is 8 hour shift (5e, 7e, 7w)- do 3 clinical days				MED-SURG: ECCO Modules 32-34 SDU/Tele: ECCO Modules 36-38 Submit Hemat post test on Thur, 2/14/13 first hour
Thur, 2/14/13 Fairmont	0800-0900	Debriefing, Recap, Expectation, Evaluations	Educators	
	0900-1100	Sepsis Cascade Review/ACMC Protocol	Karen Young	
	1100-1200	RRT	Dave Fulkerson	
	1200-1300	Lunch		
	1300-1500	Mock code	Educators	
	1500-1700	Case studies/ Early Goal Directed Therapy (EGDT)	Educators	
Fri, 2/15/13 Fairmont	0800-1700	Palliative Care ALL DAY tentatively hospital-wide	Cheryl Massey, Linda Bulman	

Building Excellence

Date, Location **Week 11** 2/17-23/13 EBP, Special Populations	Time Slot	Activity	Speaker(s)	Assignment/ Tests Due
CLINICAL 2-3 DAYS – unit-specific as arranged; check with manager or preceptor • **Variable; depends on unit shifts if 8hrs or 12 hrs; may include weekends** ○ **If unit is 12 hour shift (SDU)- do 2 clinical days** ○ **If unit is 8 hour shift (5e, 7e, 7w)- do 3 clinical days**				**MED-SURG:** **ECCO Modules 35-36** **SDU/Tele:** **ECCO Modules 39-40** Submit **Multi-sys** post test on **Thur, 2/21/13, first hour**
Thur, 2/21/13 Fairmont	0800-1700	Crisis prevention Intervention (CPI) class	Cheryl Massey	
Fri, 2/22/13 Fairmont	0800-1700	Crisis prevention Intervention (CPI) class	Cheryl Massey	

Date, Location **Week 12** 2/24-3/2/13	Time Slot	Activity	Speaker(s)	Assignment/ Tests Due
CLINICAL 2-3 DAYS – unit-specific as arranged; check with manager or preceptor • **Variable; depends on unit shifts if 8hrs or 12 hrs; may include weekends** ○ **If unit is 12 hour shift (SDU)- do 2 clinical days** ○ **If unit is 8 hour shift (5e, 7e, 7w)- do 3 clinical days**				**NONE!**
Thur, 2/28/13 Fairmont	0800-0900	Debriefing, Recap, Expectation, Evaluations	Educators	
	0900-1100	Rehab admissions, SNF Transfers	Nicole Nikkari	
	1100-1200	Chemo spills, pharma waste	Maria Garcia-Valdivar	
	1200-1300	Lunch on own		
	1300-1500	Autoimmune disorders	MD- TBA	
	1500-1700	Multi-disc case studies	Educators	
Fri, 3/1/13 TBD	0800-1400	**GRADUATION CELEBRATION**		
		Evaluations, picture-taking		
		Graduation Lunch		

Building Excellence

Evaluation: To be used as a development tool to provide a mutual exchange between RN resident and manager, preceptor and educators. This will help identify action plans for future effectiveness and achievement. Evaluation by manager, preceptor and educators will occur every week in order to provide timely feedback. The evaluation tool to be used is found in the Addendum section.

Policy for Late/Missing Assignments and Tests: Late assignments will not be accepted. You will be directed to your manager for further action.

Policy for Tardiness or Absence: If unforeseen, excusable circumstances will result in your being tardy or absent during **didactic classes**, please notify or leave a message on Terri's voice mail at:

Terri Hughes
Clinical Education Department Secretary
510-437-4165

If you are tardy or absent on your clinical day, please call your unit preceptor or manager.

Absences and tardy occurrences will be directed to your manager for further action.

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ADDENDUM

REQUIRED AGE SPECIFIC COMPETENCIES

Demonstrates ability to provide appropriate care based on the needs of a specific individual, including the patient's age in the following age categories, if applicable:

☒**Infant/Toddler: 1 month to 2 years**
Involve parents in assisting with procedures.
Incorporates age, weight, and physiologic needs in implementing the plan of care.
Considers cognitive and motor abilities and psychosocial needs in implementing the plan of care.
Uses safety precautions to prevent falls, ingestion, burns, suffocation, etc…

☒**Child: Preschool Child and School Age Child: 3-11 Years**
Discuss procedures with the child in ways the child can understand
Consider cognitive, motor, and social development in implementing the plan of care.
Involves the child in choices whenever possible.

☒**Adolescent: 12Years to 17 Years**
Explains procedures to adolescents and parents using understandable terminology and giving rationale.
Encourages participation in decision-making and planning.

☒**Adult 18 Years to 64 Years**
Encourages participation in decision making and planning
Allows patient to address concerns and make arrangements to temporarily transfer job/family responsibilities to others.

☒**Geriatric: 65 Years and Older**
Incorporates age, weights, and physiologic needs into plan of care.
Considers cognitive and physical abilities, motor skills and psychosocial needs in implementing the plan of care.

	Clinical Areas	Non-Clinical Areas
☒Highland	☒Age-specific competencies required	☐N/A. No direct/in-direct patient contact
☒Fairmont	☒Age-specific competencies required	☐N/A. No direct/in-direct patient contact
☒John George	☒Age-specific competencies required	☐N/A. No direct/in-direct patient contact
☒Ambulatory Care	☒Age-specific competencies required	☐N/A. No direct/in-direct patient contact

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Weekly RN Resident Evaluation

Unit Assigned – Highland Campus

The evaluation process is intended to: provide an opportunity to set goals, reinforce positive behavior, correct unacceptable behavior, and provide the basis for advancement.

Clinical / Professional Competency Assessments	Unable to Perform	Performs with Assistance	Performs Independently
1. Initiates accurate and ongoing assessments of physical and psychosocial concerns of patients on the Med/Surg Unit			
2. Analyzes assessment data to formulate nursing diagnoses and identify collaborative problems for each patient and/or family.			
3. Identifies expected outcomes individualized to the Med/Surg patient based on: assessment, nursing diagnosis, collaborative problems, and/or medical diagnosis.			
4. Formulates a plan of care for the MED/Surg patient and/or family based on: assessment, nursing diagnosis, collaborative problems / identified outcomes, and/or medical diagnosis within the nurse's legal scope of practice.			
5. Implements a plan of care based on assessment, nursing diagnoses and/or collaborative problems, and outcomes identification.			
6. Evaluates and modifies the plan of care based on observable patient responses and attainment of expected outcomes.			
7. Determines priority and patient flow of care based on physical developmental and psychosocial needs.			
8. Evaluates the quality and effectiveness of Med/Surg nursing practice.			
9. Adheres to established standards of practice including activities and behaviors that characterize professional status.			
10. Engages in activities and behaviors that characterize a professional.			
11. Provides care based on philosophical and ethical concepts. These concepts include reverence for life; respect for the inherent dignity, worth, autonomy, and individuality of each human being; and acknowledgment of the diversity of all people.			
12. Ensures open and timely communication with Med/Surg patients, significant others, and other health care providers through professional collaboration.			
13. Collaborates with other health care providers to deliver patient-centered care in a manner consistent with safe, efficient, and cost-effective resource utilization.			

Appendix G

Residency Job Description

ALAMEDA COUNTY MEDICAL CENTER
Resident Registered Nurse – RN Residency Program

SUMMARY

Under close supervision, to obtain clinical experience while providing nursing services; and to do related duties as required.

CLASS CHARACTERISTICS

The ACMC RN Residency program will provide newly Licensed Registered Nurses (e.g. Licensed New Graduates) an excellent opportunity to utilize their acquired skills and apply them in an acute-care setting. Upon the successful completion of the program, the RN Resident may be hired into a FTE or SAN Clinical Nurse I role.

DUTIES & ESSENTIAL JOB FUNCTIONS

NOTE:

The following are the duties performed by the Resident Registered Nurse via the RN Residency Program. However, employees may perform other related duties at an equivalent level. Not all duties listed are necessarily performed by each individual in the classification.

1. Under the direction of a Registered Nurse, administers treatment and other nursing tasks as assigned; provides hygienic care for patients; performs catherizations and bladder irrigations on male patients; assists in feeding patients; gives cleansing and retention enemas to male patients; and administers medications.

2. Obtains and sets up suction equipment; administers oxygen using cannulas and masks; reports on level and rate of flow of I.V. fluids turns and positions patients; assists patients to gurneys and wheel chairs and assists patients in ambulating.

3. Answers call lights and administers to patient comfort and safety by adjusting beds, lights, pillows, and bedclothes, and by arranging bedside tables and equipment.

4. Assists physicians in examinations and treatments as directed; takes patients' temperatures, pulse, respiration, blood pressure; performs routine tests such as urine, sugar acetone; prepares patients for surgery and applies unsterile dressings.

5. Administers simple range of motion exercises; assists in application of traction devices; and positions and drapes patients for examination or treatment.

6. Assists in assembling and operating equipment and supplies such as bladder irrigation sets, spinal tap sets, and surgical packs and dressings; watches fluid levels in intravenous feedings and solution levels on gastric suction machines.

7. Maintains patient areas; cleans, maintains and sterilizes equipment; obtains specimens as directed and does special tasks unique to the service area assigned.

QUALIFICATIONS

REQUIRED

Any combination of education and experience that would provide the knowledge, skills and abilities listed.

Education:

Graduation from an accredited School of Nursing:
- Associate's Degree in Nursing (A.D.N.)
- Bachelor's Degree in Nursing (B.S.N.)
- Master's Degree in Nursing (M.S.N.)

REQUIRED LICENSES/CERTIFICATIONS

- California State License as a Registered Nurse
- CPR/BLS
- ACLS – Depending on unit area (requirement for all Critical Care areas)
- PALS – Depending on unit area (requirement for all Critical Care and Maternal-Child areas)

SUPERVISORY RESPONSIBILITY
None

REQUIRED AGE-SPECIFIC COMPETENCIES

See addendum
KNOWLEDGE, SKILLS, AND ABILITES

Knowledge of:

- Anatomy, physiology, chemistry, pharmacology, growth and development, basic medical and surgical nursing, and nutrition.
- Wellness to illness continuum.
- Nursing procedures, techniques, equipment, and supplies.
- Health systems, agencies, and patterns of referral.
- Major disease conditions, including current knowledge of tests, therapies, and treatments.
- Assessment techniques.

- Principles and processes of problem solving.
- Principles and practices of effective cost control.

Ability to:

- Utilize concepts of assessment, priority setting, organization, and evaluation.
- Practice safe, thorough nursing care with effective, economic use of supplies and with reasonable speed.
- Practice effective nursing in diverse environments.
- Write concisely, legibly and with correct spelling.
- Communicate effectively.
- Teach patients, families, and staff.
- Work professionally with personnel and medical staff.
- Respond effectively to emergency situations.
- Identify etiology of a problem and make essential decisions utilizing the problem-solving process.

Skill in:

PHYSICAL REQUIREMENTS/WORK ENVIRONMENT

The physical demands and work environment described here are representative of those that must be met by an employee to successfully perform the essential functions of the job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

PERFORMANCE WILL BE MEASURED AGAINST SPECIFIC, AGREED UPON GOALS AND TIMELINES

FLSA Status: Nonexempt
Bargaining Unit/Local: Unrepresented

Human Resources Officer Approval/Date:

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ADDENUM TO JOB DESCRIPTION
Position Title: Resident Registered Nurse – RN Residency Program
REQUIRED AGE SPECIFIC COMPETENCIES

Demonstrates ability to provide appropriate care based on the needs of a specific individual, including the patient's age in the following age categories, if applicable:

☒**Infant/Toddler: 1 month to 2 years**

Involve parents in assisting with procedures.
Incorporates age, weight, and physiologic needs in implementing the plan of care.
Considers cognitive and motor abilities and psychosocial needs in implementing the plan of care. Uses safety precautions to prevent falls, ingestion, burns, suffocation, etc…

☒**Child: Preschool Child and School Age Child: 3-11 Years**
Discuss procedures with the child in ways the child can understand
Consider cognitive, motor, and social development in implementing the plan of care.
Involves the child in choices whenever possible.

☒**Adolescent: 12Years to 17 Years**

Explains procedures to adolescents and parents using understandable terminology and giving rationale.
Encourages participation in decision-making and planning.

☒**Adult 18 Years to 64 Years**

Encourages participation in decision making and planning
Allows patient to address concerns and make arrangements to temporarily transfer job/family responsibilities to others.

☒**Geriatric: 65 Years and Older**

Incorporates age, weights, and physiologic needs into plan of care.
Considers cognitive and physical abilities, motor skills and psychosocial needs in implementing the plan of care.

Clinical Areas		**Non-Clinical Areas**
☒Highland	☒Age-specific competencies required	☐ N/A. No direct/in-direct patient contact
☒Fairmont	☒Age-specific competencies required	☐ N/A. No direct/in-direct patient contact
☒John George	☒Age-specific competencies required	☐ N/A. No direct/in-direct patient contact
☒Ambulatory Care	☒Age-specific competencies required	☐ N/A. No direct/in-direct patient contact

Alameda County Medical Center

Position Title: **Resident Registered Nurse – RN Residency Program**

PHYSICAL REQUIREMENTS AND WORK ENVIRONMENT

1. Check the frequency and number of hours a day the worker is required to do the following specific types of activities:

ACTIVITY	FREQUENCY		# OF HOURS A DAY								
	CONTINUOUS	INTERMITTENT	1	2	3	4	5	6	7	8	8+
a. Sitting		**X**						**X**			
b. Walking		**X**	**X**								
c. Standing		**X**	**X**								
d. Bending		**X**	¼								
e. Squatting		**X**	¼								
f. Climbing		**X**	¼								
g. Kneeling		**X**	¼								
h. Twisting		**X**	¼								
i. Lifting		**X**	¼								

LIFTING ☒ 0-20 lbs. ☐ 20-30 lbs. ☐ 40-60 lbs. ☐ Over 60 lbs.

2a. HAND MANIPULATION REQUIRED? ☐ Yes (If yes, complete a,b,c,d,e,f) ☒ No

2b. Repetitive hand movements? ☐ Yes ☐ No

2c. Simple Grasping?	Right Hand ☐ Yes ☐ No	Left Hand ☐ Yes ☐ No
2d. Power Grasping?	Right Hand ☐ Yes ☐ No	Left Hand ☐ Yes ☐ No
2e. Pushing Pulling?	Right Hand ☐ Yes ☐ No	Left Hand ☐ Yes ☐ No
2f. Fine manipulation:	Right Hand ☐ Yes ☐ No	Left Hand ☐ Yes ☐ No

3. (a) Does the job require worker to reach or work above the shoulder? ☐ Yes ☐ No ☒ Frequency

(b) Reaching at or below shoulder level? ☐ Yes ☐ No ☒ Frequency (ONCE IN A WHILE)

4. Does the job require use of his/her feet to operate foot controls or for repetitive movement? ☐ Yes ☒ No

5. Are there special visual or auditory requirements? For example: Working with computer terminal ☐ Yes ☒ No

WORK ENVIRONMENT:

a. Does the employee work near moving mechanical parts; in high, precarious places; and in outside weather conditions? ☐ Yes ☒ No

b. Is the employee exposed to fumes or airborne particles? ☒ Yes ☐ No

BLOOD/FLUID EXPOSURE RISK: (check the right category)

☒ **Category I:** Tasks involve exposure to blood, fluids or tissue

☐ **Category II:** Usual tasks do not involve exposure to blood, body fluid, or tissues but job may require performing unplanned Category I tasks.

☐ **Category III:** Tasks involve no exposure to blood, body fluids, or tissues. Category I task are not a condition of employment.

Appendix H

Nursing Shortage Evidence Table

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength of Evidence using JHNEBP	Quality A-High B-Good C-Low
Nursing shortage-							
Authors: ANA, American Nurses Association Year 2012 Citation-N/A Aim of review- obtain expert opinion on nursing shortage Review design	Associations position on nursing shortage	Weakness- not all facts provided have references to how numbers obtained and reported	N/A	This review and addition is important to inclusion of expert organizations opinions on the current nursing shortage Outcomes-N/A	Limitations- ANA could be bias in supporting the concept of a coming nursing shortage	Level 5	Quality high- A Expertise is clearly evident

Nursing Fact Sheet							
Authors: The American Association of Colleges of Nursing. Year 2012 Aim of review: to obtain expert opinion	Created a document which captures information on the nursing shortage from 2002 -2012	Weaknesses- may have bias in wanting to demonstrate the nursing shortage is still a reality since their graduates are not locating jobs.	N/A	This review and addition is important to inclusion of expert organizations opinions on the current nursing shortage Outcomes-N/A	Limitations- could be bias in supporting the concept of a coming nursing shortage since they are responsible for producing the new graduates and they are currently not obtaining jobs upon graduation	Level 5	Quality high- A Expertise is clearly evident
The Recent Surge In Nurse Employment: Causes And Implications.							
Authors: Buerhaus, P., Auerbach, D., & Staiger, D. Year 2009 Citation 42 CINHAL	Report the research question- review- to examine the impact of recessions on the past, present and	The population studied was selected from those who participated in providing information to the Outcomes Research in Nursing Administration. 268	N/A	Brief description of method and process of analysis- Used a forecasting model with regression analysis to predict the future Outcomes: During economy down turn	Limitations identified by author- study does not give the demographic composition of the RN in the labor	Level 3	Quality High-A

Review design- Retrospective study using data from 1973-2008	possible the future of the nursing work force in-order to make recommendations	units from 141 hospitals State how many- more than 3000 every year Inclusion criteria- individuals between 23-64 who reported their occupation between 1973-2008 Exclusion Criteria- none Missing information- only those who reported their occupation during survey were tracked. Unclear if different or same individuals tracked each year		nursing employment goes up. During Economy Booms nursing employment goes down	market Evidence gaps and or recommendations for future research- most RN growth seen in the market the last few years is from RNs over 50. There has been an increase in younger nurses' entering the work force compared to years past. It is unclear if this is caused by the economy or by good marketing to children to choose nursing as a career more research needs to be done to understand if this is a		

					sustainable trend and what the possible drivers are Source of funding- Johnson and Johnson Campaign for the future of nursing.		
Should I stay or should I go? Career change and labor force separation among registered nurses in the US.							
Nooney, J. Unruh, L. Yore, M. Year 2010 Citations- Proquest 8 Review Design- Retrospective survival analysis and the data is cross-sectional This study used data	1.When do nurses leave the profession and how can it be prevented at different ages 2. How do age effect what the exit path is 3. What are the socioeconomic, family structure and demographic predictors of attrition and by what path: leaving the work force or a career change	2004 National Sample Survey of Registered Nurses- which is administered by the Health Resources and Service Administration (HRSA)- there is over a 70% response rate nurses with an active license receive the survey	None	Descriptive statistics were used to assess the data along with Cox's regression model	Limitations identified by the authors were once a persons license was not active information would not be gathered to identify them, when they left and why. Also some nurses with children who left the profession may have returned years later but there is no way to	Level 3	Quality High

from 2004 National Sample Survey of Registered Nurses and used survival analyses to study nursing workforce withdraw					track it in this study. Authors recommend a prospective study		

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength of Evidence using JHNEBP	Quality A-High B-Good C-Low

Appendix I

Job Satisfaction on New Graduates Evidence Table

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength of Evidence using JHNEBP	Quality A-High B-Good C-Low
Nurse Residents first-hand accounts on transition to practice							
Clark, Springer 2012	Qualitative descriptive study with the goal of studying the "lived experience" of new nurses and examine the relationship to job satisfaction	600 bed hospital 37 new graduate nurses participated out of 83 Nine focus groups were held. General themes were then compiled together to create a view of the new graduates experience with their transition and satisfaction	None	Themes were identified through focus groups with were: Rhythm of chaos, feeling valued, and stress from not know, lifelong learning and preserving the profession. Having supportive preceptors, staff and feeling valued were important contributing factors to job satisfaction.	Limitations small sample size. Data collected during focus groups	Level 3	Quality c-fair
Work related Stress and Intention to quit							
Wu Fox	Descriptive correlation	Graduates from a BSN and ADN	N/A	Study identified five factors related to new	New graduates were defined as 3	Level 3	Quality B-

Stokes Adam Year 2012 Cited by 3 Aim of review- to review stress among new graduates and understand if there are identifiable risk factors of new graduates and their intention to quit.	design examining work stressors, coping strategies and the new graduates' intention to quit.	community college nursing program who had graduated in the previous three years. 154 participated in the study through the completion of surveys. The tool used was the Job Stress Scale for Newly Graduated Nurses		graduate stress. 1) Demanding care 2) equipment issues 3) nursing skills 4) interpersonal relationships and hospital responsibilities. The primary stressor linked to intention to quit was equipment issues.	years and most turnovers happen within the first year. There was no identification if staff were on their first job. Nursing graduating with a BSN could have been returning to school and had longer than 3 years of experience		medium

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength of Evidence using JHNEBP	Quality A-High B-Good C-Low
New graduate burnout: The impact of professional practice environment on workplace civility, and empowerment							
Lasinger, Finegan Wilk 2009 Cited by 32	Cross sectional data collected from staff RN in 2006 used to create a sample of 247 new graduates from this original study. The Practice Environmental Scale of the Nursing Work Index was used. Descriptive inferential statistical analysis was completed on the data	RN with less than 2 years, Ontario province who participated in original national survey identified 247.	none	New graduates did report high levels of exhaustion. Predictors of burnout were perceptions of support for professional nursing practice and having a civil working environment	Due to the study design it does not measure burnout over time. The author points out a longitudinal study would provide a better under standing	Level 3	Quality B-good

Appendix J

Cost Savings Evidence Table

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength of Evidence using JHNEBP	Quality A-High B-Good C-Low
The working Hours of Hospital Staff Nurses and Patient Safety: both errors and near errors are more likely to occur when hospital staff nurses work twelve or more hours at a stretch							
Authors: Rogers, E., Hwang, W., Scott, L., & Finges, D. Year 2004 Cited CINAHL129 Proquest 186 Review design-self report study or concurrent validity	Research question- examine the work patterns of hospital staff nurses and to determine if there is a relationship between hours worked and the Frequency of errors. Theoretical approach- data collected from log books and demographic questioner were analyzed using	Report the population studied- how were they recruited 333 nurses participated Inclusion criteria Data was collected by sending out a random nationwide eligibility criteria to 4320 ANA members— 891 were eligible to participate 40% return rate of log books on their work schedule. What method	Interventions none	Brief description of method and process of analysis "Subjects completed seventeen to forty items per day; all forty questions were completed only on days the nurses worked. Questions regarding errors and near errors were included, and space was provided for nurses To describe any errors or near errors that might have occurred during their work periods. On days off, nurses were asked to complete the first seventeen questions about their sleep/wake patterns, mood, and caffeine	Limitations identified by author- low return rate (40%) due to the amount of work-small number of staff so may not be reflective of all of nation Evidence gaps and or recommendations for future research- this was one of the first studies done. University of	3	good

	descriptive statistics and frequency tables	What setting by whom and when		intake." Conclusion- threefold increase risk of a medical error in critical care units where nurses worked longer than 12.5 hours. 65 % report making an error or having a near miss, 84% of these errors were medication, 65% of nurses reported a hard time staying awake and 20% fell asleep during their shift.	Pennsylvania approved this study and subjects were paid 140 dollars		
Impact of nursing unit turnover on patient outcomes in hospitals.							
Authors: Bae, S., Mark, B. & Fried, B. Year 2010 Citation proquest14 PubMed 5 Aim of review- study to examine how nurse turnover affects the staff work groups and quality of care	Report the research question Theoretical approach sample size with 268 nursing units participating from 141 hospitals The turnover data was gathered using six months of data collected	Report the population studied- how were they recruited –by identifying who already had participated in another study and using part of that data Inclusion criteria registered nurse and patient data from 268 nursing units at 141 hospitals collected as part of the Outcomes	N/A	Outcomes: Showed units with low turnover had decrease in patient falls, improved work group cohesion, improved patient satisfaction and fewer severe medication errors.	Limitations identified by author none Further investigation is needed to assess the turnover-outcomes relationship as well as the mediating effect of workgroup processes on this relationship.	Level 3	Quality B-good

	from the Outcomes Research in Nursing Administration	Research in Nursing Administration (ORNA II) project					

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength of Evidence using JHNEBP	Quality A-High B-Good C-Low
Nurse working conditions and patient safety outcomes							
Authors: Stone, P., Mooney-Kane, C., Larson E., Year 2007 Citation CINHAL38 Proquest 70 Aim of review to study the effects of working conditions on the patients in ICU	Report the research question Examined outcomes sensitive to nursing care. [CLBSI], [VAP], [CAUTI]). Decubitis and 30-day mortality Study type- observational with patient outcome data and nursing	Report the population studied- 15,846 patients 51 adult intensive care units in 31 hospitals 1095 nurses were surveyed. Recruitment of hospitals was through the Association for Professionals in Infection Control and Epidemiology, Inc., Inclusion criteria Exclusion Criteria		Brief description of method and process of analysis- variables were computed on a monthly basis. Individual patients were analyzed based on the month they were in the ICU. If a patient's stay covered more than 1 month, they were assigned to the period in which they had the longest stay. Descriptive statistics were examined and multivariate logistic regressions were constructed for each outcome	Limitations identified by author- Nurses may float between units, which results in measurement error. Also payroll data does not capture whether overtime is mandatory or voluntary or the use of contract	3	high

	surveys Country	non ICU patients Patients were excluded from an analysis if: (1) infection surveillance was not conducted that month, (2) the risk adjustment perfectly predicted an outcome		The study found overtime in the critical care arena was linked to catheter associated urinary tract infections, decubitus ulcers and medication errors. The study also found that nursing working conditions were associated with negative patient outcomes.	nurses. Evidence gaps and or recommendations for future research Larger sample sizes and longitudinal data would be beneficial. Exploration of human capital variables Funded by AHRQ grant		

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength of Evidence using JHNEBP	Quality A-High B-Good C-Low
Nurses' work schedules characteristics, nurse staffing and patient mortality							
Authors: Trinkoff, A., Johantegen, M., Storr, C., Gurses, A., Liang, Y., & Han, K. Year 2011 Citation CINHAL11 Proquest 12 Review design-cross sectional design	Report the research question "determine if, in hospitals where nurses report more adverse work schedules, there would be increased patient mortality, controlling for staffing" Theoretical approach-8 independent variables were examined related to the work schedules	633 nurses working at 71 acute non-federally funded hospitals in North Carolina and Illinois were surveyed. The mortality data came from AHRQ The staffing data came from the American Hospital Association Annual Survey of Hospitals Inclusion criteria-those who participated in 3rd wave		Brief description of method and process of analysis data analysis using Predictive Analytics Software with descriptive statistical analyses Work schedule was significantly related to mortality of patients	Limitations identified by author- the nurses were working at teaching hospitals and more educated then their national counterparts so it might not be transferable Evidence gaps and or recommendations for future research Additional study using a unit-level approach would be beneficial.	3	High quality

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength Evidence using JHNEBP	Quality A-High B-Good C-Low
Give nurses the right tools and labor costs go down							
Authors: Weist, Huff and McMillian Year 2009 Citation 1 CINHAL Aim of review- With labor costs on the rise, many health organizations should consider optimizing their Human resource consumption based on predicted volumes.	Case study examining Lee Memorial Health System in Florida Examining if a centralized staffing model with a float pool while eliminating travelers would be cost effective Study type- Case study or process change and results on finance Country--US	Report the population studied- Public hospital allot like ACMC with current traveler use and hiring process delays into positions in the organization	Implementation of a centralized staffing model, established a centralized float pool.	Conclusion saved 11 million dollars A 20 percent improvement in daily bed fill rate > A 200 percent increase in direct placement PRNs > A 23 percent drop in PRN cancellation rates after one year > Better staff coverage on units > Reduced nursing overtime by 3 percent at three campuses > An initial decrease in PRÑ cancellations >under budget by $6 million in Contracted labor. ➢ 2008. the health system Cancel2d travel contracts.		3	good

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength of Evidence using JHNEBP	Quality A-High B-Good C-Low
The working hours of hospital staff nurses and patient safety							
Rogers 2004 Cited by 186	Descriptive statistics and frequency tables were used to assess the data from the log books the participants reported in	4,320 nurse members of ANA in 2002 received a cover letter explaining the study and seeing if they were interested in participating, 1,725 returned the survey and 891 met the criteria to participate. 393 nurses completed the survey by completing their log books. All participants worked full time. Participants were paid 140 dollars to participate in the stud	None	The study showed a threefold increase risk of a medical error in critical care units where nurses worked longer than 12.5 hours. In this study 65 % report making an error or having a near miss, 84% of these errors were medication, 65% of nurses reported a hard time staying awake and 20% fell asleep during their shift. IOM in a report to AHRQ recommends that nurses not work more than 12 hours in any 24 hour period and less than 60 hour in a 7 day period. Funding was provided by AHRQ and the Robert Wood Johnson Foundation.	Relayed on self reporting of errors and near misses. Many times nurses are unaware of the errors made or near misses.	3	High Quality

Appendix K

Float Pool Evidence Table

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength of Evidence using JHNEBP	Quality A-High B-Good C-Low
Float teams and resource teams							
Authors Dziuba-Ellis Year 2006 Proquest cited by 8	Literature review	56 articles located only 12 were research of those most had to do with floating from department to department and did not focus on the utilization of a float pool	Most studies were cross-sectional designs	General findings were nurses found it stressful to float from unit to unit. Staff concerned with locating items and competency Articles divided on if new graduates should be used in float pools Nurses within float pools report a more positive experience than those who are required to float from their unit to another	This is only a literature review; however, it does demonstrate the lack of literature available on the subject	2	b

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength of Evidence using JHNEBP	Quality A-High B-Good C-Low
New graduate Rn's in a float pool; An inter-city hospital experience							
Authors: Crimlisk, J., McNulty, M., & Francione, D. Year 2002 Citation 9 Pub Med	Report the research question- program evaluation of hiring new graduates into a float pool	Report the population studied- how were they recruited State how many- 39 new graduates over 19 months entered the program- 32 completed the survey and were sent surveys 23/32 responded and participated in follow up surveys Inclusion criteria- those who remained in the organization after the training was complete Exclusion Criteria- those who left the organization	Orientation pathway for new graduates followed. Training program provide with both in class learning and clinical	Brief description of method and process of analysis Conclusion-the float pool was successful. New graduates did well in the float pools with 100% reporting after the program they were able to provide safe competent care	Limitations identified by author—none identified Evidence gaps and or recommendations for future research- none identified. There is little research on new graduates success and utilization in float pools Source of funding- none the intercity hospital reported out on their programs success	Level 2	Quality C due to small sample size and year of study

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength of Evidence using JHNEBP	Quality A-High B-Good C-Low
Performance Strategies.							
Authors: Davis, A. Year 2008 Report out on Sharp healthcare reduction in cost using a float pool and centralized staffing model.	Report out by Sharp on how they reduced costs, improved quality and how these process changes made it easier for reporting out when they applied and received the Malcolm Baldridge National Quality Award Sharp does not say how they collected the data.	Report the population studied- how were they recruited	Float pool and centralized staffing model implemented	Sharp assessed their savings by reduction in overtime and the use of outside registry Key themes relevant to this review- 1,100 employees with 350 in the float pool resulted in 3.5 million dollar savings the first year and 16.5 over the next 3 years	Limitations identified by author- none Evidence gaps and or recommendations for future research- Source of funding- none however, the article is used to promote a centralized staffing model. ACMC owns this staffing program currently and is not utilizing as a centralized process.	Level 5	Quality B-good

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength of Evidence using JHNEBP	Quality A-High B-Good C-Low
Strategies for Addressing the Nursing Shortage: Coordinated Decision Making and Workforce Flexibility.							
Authors: Wright, P. D., & Bretthauer, K. M. Year 2010 Citation Proquest 4 References 34 Review design	Report study if a coordinated scheduling model along with a forecast model could improve financials. Theoretical approach Study type Country How was data collected What method What setting by whom and when	Report the population studied- 526 bed hospital using 3 medical departments and the float pool. how were they recruited	Implementation of using a centralized coordinated scheduling model Implementation of using a allocation and adjustment model	Brief description of method and process of analysis complicated algorithms were used to asses multiple data points Conclusions- centralized decision making in collaboration with the staffing office and managers is essential for cost reduction Increasing the size of a float pool can help meet staffing target levels and cost reduction	Limitations identified by author-None The tools that are being assessed were developed by the authors. It would be helpful to replicate this study with more hospitals in a variety of regions to determine if the model works in different hospital environments. Source of funding	2	Quality C unclear how it will work in a variety of settings. Study in one setting 3 departments.

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength of Evidence using JHNEBP	Quality A-High B-Good C-Low
Closing the healthcare workforce gap: Reforming federal healthcare workforce policies to meet the needs of the 21st century.							
Authors: Derksen, D., & Whelan, E. Year 2009 Review design—this is a review of 62 different sources of evidence with the goal of making recommendations to the government on needed changes within healthcare.	Theoretical approach- gathering from multiple sources data and expert opinion with the goal of making recommendations for healthcare changes		N/A	Recommendations made to the government. Some of these recommendations we are seeing support of	Included in the recommendations for the future are: Understanding are healthcare workforce shortages, (nursing and diversity) Funding of educational programs for health professionals Source of funding- Centers for American Progress	4	Quality A high- expert nationally recognized authors

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength of Evidence using JHNEBP	Quality A-High B-Good C-Low
Staffing patterns of scheduled unit staff vs. float pool nurses a pilot study							
Larson, N Sendelbach, S Missal, B Fliss, J Gailard, P Year 2012	Comparative study using descriptive statistics to examine trends and patterns to how assignments were given to nurses in float pools. 217 shifts were analyzed these shifts were randomly selected. Standardized tool was developed with acuity range from 1-5	238 beds with 9 units Examined if nurses from the float pool received a higher acuity patient load	None	There was no difference in the acuity level. While float pool RNs had more admissions, transfers and discharges it was not statistically significant.	Recommendation for further studies	3	Good

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength of Evidence using JHNEBP	Quality A-High B-Good C-Low
A staff nurse strategy							
Strayer and Daignault-Cerullo Year 2008 Cited by 2	Report out of a closed unit float design by the RN staff	4 critical care units created a float pool for these units	Implementation of a closed float pool for 4 critical care units	Committee of nurses designed the changes. Surveys and financial reports were used to asses program	Improved morale, improved staff satisfaction and decreased costs	2	Fair

Appendix L

Alternative Transition Programs Evidence Table

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength of Evidence using JHNEBP	Quality A-High B-Good C-Low
Paying for Nurses Orientation							
Greene, M. Year 2010 Cited by 6	Analysis of contributing factors to the difficulty in nurses transitioning from student to RN		NONE	Gathering of information on the evolution of nursing training and comparing the transition of other healthcare workers to nursing. Also examined the financial burdens of training nurses vs. resident MD Interesting explanation to how nursing has lost funding which used to be provided when nursing went to academic based education vs. hospital education	Not a study just a review and opinion	2	low

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength of Evidence using JHNEBP	Quality A-High B-Good C-Low
Nursing first year of practice, past, present and future: Documenting the journey in New Zealand							
Adlam, Dotchin and Hayward Year 2009	Documentation of New Zealand's Journey to a national new graduate framework	New graduate RNs	Implementation of a standardized training program for new graduates which was piloted in 3 sites	Pilot identified key elements new graduates needed for success. Structure, trained preceptors and sharing of the work load during training. The organization needed to be dedicated to supporting the new gradates time needed in classroom settings Implemented in the entire country now	Done in another health care setting	3	good
Feasibility and outcomes of paid undergraduate student nurse positions.							
Gamdroth, Budgen and Lougheed Year 2006	Quasi experimental project with 3 years concurrent evaluation Used descriptive and prospective evaluation	Nurses in British Colombia	Implemented an undergraduate nurse employment project Project allowed hiring 3rd and 4th year nursing	Results were nurses were more prepared. Nurses who participated in this study were less likely to leave their place of employment after graduation Increased The nurses competency, organizational ability and improved ability	Study done outside the US where all students in 4 year programs.	3	good

			students and working them to their current level of education	to work as a team This project has been implemented throughout British Columbia			
Effect of student nurse intern position on ease of transition from student nurse to registered nurse							
Steen, Gould, Raingruber and Hill Year 2011	Qualitative study examining the effect of a student intern position on the transition of the student to RN	Interns at UC Davis Hospital	Provided a student internship and then hired RNs from that group and examined the impact of the program	Program improved transition by improving confidence, having an understanding of routines and environment and already knowing the staff	No control group.	2	fair
New graduate nurse preceptor program: A collaborative approach with academia							
Owens Year 2013	Examined the effects of using faculty from a community college to improve their new graduate program	Hospital nurse educator, nursing staff and new graduates hired at one hospital	Used an educator to revamp their program and provide training and support to onsite educator	New graduates had increased confidence as well as preceptors. The educator felt they learned the current evidence related to new graduate needs	Only one hospital educator involved. No control group	2	fair

Review Details	Review Study Parameters	Review Population and setting	Interventions	Methods of analysis & Outcomes	Limitations Evidence gaps	Strength Evidence using JHNEBP	Quality A-High B-Good C-Low
Community-based transitioning programs: California's answer to the new graduate hiring crises							
Jones and West Year 2013	Report out on California's solution to new graduates not finding jobs	California new graduates	Implemented a transition program where new graduates were provided free residency training in local hospitals	New graduates are often hired after the program	Reports are still not providing all the data numbers of how many nurses obtain jobs along with retention rate and orientation time	3	fair
Patient Safety and the integration of graduate nurses into effective organizational clinical risk management systems and process.							
Johnstone and Kanitsake Year 2006 Cited by 7	Explorative descriptive study using both qualitative and quantitative data Used questioners, focus groups participant observation and pt outcome data 12 month study with 5 phases	Examining new graduates and what factors influenced their ability in performing their role in clinical risk management	New graduates provided education on clinical risk management during their training	Study revealed the importance of new graduates receiving education on CRM for their transitioning to their roles Findings new graduates need development of experience vs. a knowledge gap		3	Good

Appendix M

IRB at Alameda County Medical Center

ALAMEDA COUNTY MEDICAL CENTER

INVOICE IRB Review Fee (Attachment O) (Rev 9/11)

(IRS Form W-9 must be submitted with invoice)

Billed to: This is an internal study
Date _____

DESCRIPTION	AMOUNT
☐ Review fee for initial submission $1500 Title of Study: ☐ Review fee for annual renewal submission $500 IRB# _____	
	TOTAL: $

Please make checks payable to ***Alameda County Health Care Foundation***. Please mail to:

Institutional Review Board
C/O IRB Administrator
Alameda County Medical Center
Highland Campus
1411 E 31st Street, , Wing E, 4th Floor

QIC: 22131
Oakland, CA 94602

If you have questions, please call:
IRB Administrator
(510) 437-8450
FAX (510) 437-8355
Email: kjames@acmedctr.org

I. Introduction

A. Background

Due to the 2007 United States (US) recession, the predicted nursing shortage was mitigated, resulting in hospitals electing not to invest in the training of new registered nurse (RN) graduates. Prior to the recession new nursing graduates could easily locate organizations that would hire and provide them with the additional training required to learn the role of RN. This training was typically provided on the job in a 12-16 week program. Unfortunately, new RN graduates need support from healthcare organizations with their transition from student to clinician at the bedside, yet organizations are electing not to hire inexperienced nurses. New graduates report that when they enter the work force they do not have the expertise or confidence to perform in the current healthcare environment (Boychuk, 2008). Overwhelmingly, 90% of hospital executives agree that new RN graduates are not prepared to provide safe care at the bedside (Berkow &Virkstis, 2008). A ten year study revealed new graduates have difficulty translating their clinical knowledge from academia to the bedside; resulting in 65% of new graduates demonstrating a lack of the necessary clinical knowledge to provide safe care (Del Bueno, 2005).

The transition period for new nurses has resulted in exhaustion and burnout within the first 18 months. (Boychuk, 2008). This exhaustion and burnout has been associated to new graduates

experiencing horizontal violence, poor interdisciplinary communication, feelings of isolation and work environments which do not empower nurses (Dyess & Sherman, (2009).As a result of this challenging transition, 33-61% of new graduates hired will resign within one year and either locate a job with another organization or leave the profession entirely (Boychuck, Myrick, 2008). Every new graduate resignation costs an organization $88,000 (Kovner, et al., 2009). Studies have shown that new graduate programs decrease new graduate turnover (Nursing SWAT Team, University of Pittsburgh Medical Center, 2011). In order to assist new graduates with this transition the Institute of Medicine (IOM) recommends that hiring organizations provide formal internships and residency programs in order to facilitate a comprehensive and organized transition from the academic to the practice setting (Hofler, 2008). These programs should also be provided as a means to improve quality of care and patient safety according to the Robert Wood Johnson Foundation, IOM and the Carnegie Foundation (IOM, 2010 & Benner, Sutphen., Lenard, et al, 2010).

New graduate programs have also been shown to increase retention of the nursing work force and reduce the cost of recruitment when these programs are also provided with formal training to existing staff on how to be an effective preceptor and mentor (Block, L., Claffey, C., Korrow, M., & McCaffrey, R., 2005). These formal programs, where preceptors and mentors are prepared to work with new graduates, positively affect the entire orientation and enhance the socialization process of the new graduate. New graduates develop competence and improved confidence through these programs resulting in increased retention. Mentors also benefit from these programs with increased confidence and the ability to identify their own development needs (Block, Claffey, Korrow, et.al, 2005, Halfer, 2007). A five-year research study examining 20 hospitals based, Nursing Residency Programs demonstrated that the residency

program assisted with the professional socialization of the nurse, which positively impacted the organization and the practice of other healthcare providers. Organizationally these programs have been associated with improving the following: staff engagement, communication, patient outcomes, patient satisfaction and physician satisfaction (Ulrich, 2010).

In the past, formal new graduate programs were frequently offered, however as the nursing shortage waned, many of these programs disappeared. The downturn in the United States (US) economy allowed organizations the opportunity to make decisions not to utilize new graduates. Traditionally when the national economy loses jobs, health care experiences an increased ability to hire into positions increasing overall employment (Staiger, Auerbach, Buerhaus, 2012). This phenomenon again held true with the 2007 economic downturn when the nursing profession experienced the largest growth seen in the last four decades from 2005-2010 (Staiger, Auerbach, Buerhaus, 2012). When the economy started faltering many part time RNs returned to the workforce full time and many others delayed retirement (Halsey, 2009 & Murdock, 2009).

This delay in retirement of nurses is preventing new graduate nurses from finding an organization which will hire an inexperienced nurse. Our academic partners have increased enrollment in nursing programs over the last several years in preparation of the predicted nursing shortage (California Institute for Nursing Health Care, 2012). Organizations failure to hire new graduate nurses is jeopardizing healthcares future ability to hire nurses. Potentially hospitals lack of hiring new graduates may negatively impact the availability of RNs in the future. As new graduates report their continued difficulty in locating employment individuals who have not started nursing school may be influenced to select a different career path resulting in less RN graduates as the nursing shortage arrives. California Institute for Nursing & Health Care (CINHC) reported that in 2009, due to the changing economy, 40% of new Registered Nurse

graduates may not locate a hospital that would provide new graduate training opportunities. In March 2012, it was reported by the California Institute for Nursing & Healthcare that 43% of registered nurses who graduated within the last 18 months were still unemployed as an RN. Ninety-two percent of RNs report that the reason prospective employers were not hiring them is because they lacked experience. Hospitals report it is too costly to train new graduates and it was more advantageous for them to hire long-term travelers (CINHC, 2012).

The US economy as a whole is currently recovering and it is expected that nationally full employment will be reached in 2017 (Staiger, Auerbach, Buerhaus, 2012). As the national economy improves it is predicted nurses will start retiring. As of May 2011, 10,000 baby boomers are retiring each day and this trend is expected to continue for 19 years. In 2006, it was predicted that nurses would start to retire in large numbers in 2011 and that this massive retirement would continue through 2020 (Rosseter, 2006). The United States has been predicting a massive nursing shortage for decades related to the aging workforce, decreased enrollment in nursing schools, technological advancement and the aging of the baby boomers that will need more care. The down-turn in the US economy has given a false sense of security that there is no nursing shortage.

B. Significance

California is near the bottom in the number of nurses per capita at 647 RNs for every 100,000 persons versus nationally 825 RNs per 100,000 persons (Labor and Workforce Development Committee, 2008) As technology advances and treatment modalities become more complex it is projected nursing growth will be 2-3 % for several years (Buerhaus, Potter, Staiger, & Auerbach, 2008). The Bureau of Labor Statistics predicts 581,000 new RN positions will be created through 2018 (Rosseter, 2012). As 2020 approaches, the U.S. government predicts the

retirement of nurses along with the increase in nurses needed to care for the aging population will create a nursing shortage between 400,000 to 1,000,000 RNs (Winter, 2009). The Labor and Workforce Development committee predicts at least 117,000 of that number belong to California. (Labor and Workforce Development Committee, 2008) Currently, the average age of the RN workforce is 46 years with 50% of the workforce being close to retirement (ANA, 2012).

The hospital environment within which the nursing profession practices in is leading to job dissatisfaction throughout the world. Short staffing long hours and the restructuring of health care is demanding direct care providers to increase productivity while improving both patient satisfaction and quality of care. This environment and overall job dissatisfaction is causing younger nurses to report *burnout*. In 2011, a survey reported 32% of younger nurses, currently working, are planning to leave the profession in the next three years (AMN Healthcare, 2011). An examination of the historic health care restructuring of the 1990's resulted in 28% of nurses leaving the profession due to job dissatisfaction (Block, Colleen, Korow, McCaffrey, 2005). This dissatisfaction and burnout is not just a US problem. In England and Scotland 30% of nurses under 30 are also planning to leave their jobs within the next year (Aiken et al, 2002).

Hospitals reported to CINHC that they were electing to have their current staff work more hours or to use experienced registry/traveler staff to fill their staffing needs instead of hiring new nurses. (California Institute for Nursing & Health Care, 2012). Organizations' reported it was more economical to use current staff or registry to fill hospital staffing needs. Organizations' decision not to consistently hire new graduates, on a yearly basis, as part of a strategic work force plan is potentially a costly mistake. In reality this decision is costly for the work force, patients and the organization. This decision has resulted nursing staff now having less time away from work and work longer shifts.

A study conducted by Rogers, et al (2004) revealed that 43 % of nurses worked more than 40 hours in a work week. This lack of time away from work has been linked to an increase in injury and fatigue of staff, an increase in patient mortality and is linked to high RN absenteeism (Trinkoff, et al. 2011 &Laschinger, Wilk, Cho, Greco, 2009). In Canada this stress has been associated with high absenteeism resulting in nursing generating more sick time compared to any other profession. When you combine that sick time with the overall amount of overtime, it is equal to 19,000 full-time equivalents (Greco, Spencer, Wong, 2006). At Alameda County Medical Center we spent million dollars on nurses' sick time, resulting over 10 million for overtime and over 7 million for contract labor expense.

This current situation puts all of health care in a precarious position. As nurses retire in mass numbers, organizations will be forced to return to hiring new graduates in order to replace the vacancies created. In the past many new graduates left an organization due to the lack of support of staff and management. Prior to the current economical crises the high turnover rate nationwide made it difficult to staff hospitals. In 2002, the average national turnover rate was 21.3% (Klienman, 2004). Prior to the recession 60% of new graduates would resign their position due to lateral violence (Nursing Profession, 2011). Many organizations have not been hiring new graduates for several years. This means programs that used to be in place to hire new graduates, train and socialize them to their role and organization have not been utilized. Staff has also not had to train and mentor new graduates on a regular basis which may make the transition more difficult for new nurses. Organizations will be forced to rapidly develop new graduate hiring programs. This increased hiring of new graduates will leave several hospital units staffed with several inexperienced nurses.

C. Study aim and objectives

Organizations can reduce the risk of nursing turnover through the creation and support of an organization environment that empowers and motivates new graduates (Boychuck & Myrick, 2008). New graduate programs should be provided as a means to empower our existing staff and to control costs. Empowerment has been associated with employees getting more involved, resulting in improved staff satisfaction (Laschinger, Wilk, Cho, et. Al, 2009) High staff engagement and satisfaction has been shown to lead to high patient satisfaction. Traditionally, new graduate programs are viewed as costly to an organization. The investment is high to staff with no commitment to staying in your organization. However, we continue to invest in high overtime and expensive registry costs. As a profession, we need to change the way we view new graduate programs. Currently, ACMC is spending over 17 million dollars in overtime and traveler costs alone. Training 30 new graduates will cost this organization less than one million dollars. Once these new graduates have completed orientation they will make a little less than 40 dollars an hour. Currently we pay travelers and registry staffs 65 dollars an hour and we pay are regular staff between 75-100 dollars and more when they work overtime. New graduates will quickly return a financial savings to the organization.

At ACMC, we recognize the importance of investing in our future and in our community by hiring new graduates and providing them with a new graduate program. Our goal is to hire 100 new graduate nurses over the next 14-months and provide them with training, certified preceptors and certified mentors. As we begin our hiring process of 100 new nurse graduates, we want to study the impact our program has on retention of our new nurses, acceleration of their learning, satisfaction of our preceptors/mentors, effect on patient/staff satisfaction scores, effect on specific quality indicators and effect on our financial spending on nursing personnel.

We propose to collect information regarding the effectiveness of the program via feedback from our Managers, Preceptors, Mentors and New Graduates during the training program and six months after. Managers will be asked to complete the RN Transition Program Employer Survey (attachment 1) upon completion of each New Grad Hiring Cycle. The goal of this survey is to assess the manager's view on the effectiveness of the program. Preceptors will be asked to complete two surveys online to determine their satisfaction with the program (attachment 2).This data is being collected to see if there is a correlation between the new preceptors experience with the program and retention and engagement of staff. Both preceptors and new graduates will complete the RN transition competency assessment tool three times during training to assess the new graduates' competency (attachment 3). This tool will a comparison of when the preceptors believe the new graduates are prepared to work independently and the new graduates perception of their ability to work independently. New graduates will also complete the Casey-Fink New Graduate Experience Survey upon completion (attachment 4). This survey is being administered to assess the new graduates overall experience during their training program focusing on perceived stress and role understanding. Studies have shown that the new graduates' perception of their orientation process is highly correlated with new graduate retention rate.

Both preceptors and new graduates will complete the VARK Learning Styles Inventory prior to preceptors being assigned to the new graduate RN (attachment 5). The goal is to match the learning style of the new graduate with that of their preceptor to assist the educational process and make it a more positive experience for the educator and learner. Surveys will be completed via the Survey Monkey database or via paper surveys. All surveys will be overseen by Kevin Silvestre in the Human Resources Workforce Planning and Recruitment Department.

D. Methods

1. General study design

   This study is exploratory, description, correlation and cross-sectional. New Graduates will be hired into the residency program. The program will range from 12 to 16 weeks. The VARK Learning Styles Inventory created by Neil Fleming will be used to identify individual learning styles in order to match the preceptors and new graduates. This questionnaire will be completed prior to matching the preceptor and new graduate. Benner's Novice to Expert will be used as the framework around the residency program.

2. Study site(s): The setting for this program is ACMC nursing care units, Highland and Fairmont Campus nursing units.

3. Subject selection

   a. Who and why

      The subjects for this study are: Nurse Managers who hire Nurses into the residency program, Resident RNs, Preceptors and Mentors who participate in our new graduate training program. Organizational metrics will also be used and assessed during this study.

      Why- To determine the effects of a new graduate residency program on the new graduate, current nursing staff, patients and the organization

   b. Inclusion/exclusion criteria

      Inclusion Criteria: All new graduates hired into the residency program will be included into the study. All certified preceptors/mentors who are assigned an RN from the residency program. All managers who have an RN from the

residency program assigned to their department will be included in all settings where the new graduate was hired.

Exclusion: Preceptors and managers who do not have a resident RN assigned to them or individuals who decide to opt out of the study. Opting out of the study does not preclude the new nurse, preceptor/mentor or manager from participation in the program. Exclusion from the program will occur if the participant loses their nursing license.

c. Total number/number per group

Three groups of nurses will be hired, with 35-40 per group. A total of 100 RN residents will be hired. This number is based on the number of identified positions we will have over the next 14 months. Preceptors and mentors will be 50-70 with 15-20 managers involved in each group hire.

d. Method of subject contact and recruitment

Subjects will be recruited to apply for posted positions using the below marketing plan and target market grid. New RNs will be hired, following the rules and regulations of the Human Resources Workforce Planning and Recruitment Department. Once the new RNs are hired and have met all requirements, they will be asked if they are willing to participate in the study. At no time will participants be identified to the nursing management team.

Target market (examples of target audience):

S/N	Target Market
1	Internal staff who have already completed and passed their boards
2	External Candidates with A.D.N., B.S.N. or M.S.N.
3	Completion of BLS Certification
4	Completion of ACLS Certification

5	Completion of NRP Certification
6	Completed a post graduate volunteer program
7	Previous acute care experience
8	Prior experience as a L.V.N.
9	Prior experience as a C.N.A. or E.M.T.

Marketing Plan

S/N	Marketing Plan
1	E-mail the California Institute of Nursing/Healthcare and utilize their lists to e-mail students within our region about the RN Residency Program
2	Notify the RN Programs within our immediate region regarding the requirements of the program, application/interview process, etc.
3	General information about the RN Residency Program on the ACMC Position Manager website

After new graduates RNs are hired into the program they will be asked by the Human Resources Workforce Planning and Recruitment team if they would be willing to participate in the study. Nursing Administration will not know which new graduate hires are participating and which ones are not.

E. Study protocol

All contact of subjects will occur through Human Resources (HR). HR will contact participants in person or will use E-mail, postal mail and phone calls. Surveys will be completed on line using Survey Monkey when possible. All paper surveys will be hand delivered or mailed through HR. Staff can return these surveys through interoffice mailed in confidentiality.

Procedures

VARK Leaning Style Assessment

ALL Resident RN, preceptors/mentors will be given the VARK questionnaire. This questionnaire will be used to assess Preceptors/Mentors and Resident RN learning preference. The goal is to match individuals with people who learn in the same manner to improve their

learning and increase the time it takes to move an individual from Novice to Advanced-beginner. This will be given to everyone, even those not participating in the study.

The RN Transition Program Competency Assessment Tool

All Resident RN and Preceptors will complete the Competency Assessment tool three times during the program to assess the RN resident's competency. This will be done initial, at week 6 and at completion of the program. This will be completed on Survey Monkey through HR.

The Casey-Fink New Graduate Experience Survey (SMU/FINAL)

All Resident RN will complete this in order to evaluate the new graduates experience and determine how the program may have assisted them in their transition to leader at the bedside. This will be completed through HR.

The Graduate RN Transition Program Employer Survey

This will be provided to the managers to assess the programs impact from their perspective. This will be completed through HR.

Key Performance Indicators (KPIs) Being Tracked

S/N	Key Performance Indicators (KPIs)	2012	2013	2014	Total
1	Savings				
2	Contribution (e.g. new jobs)				
3	Retention				
4	Reduction in usage of Registry Staff				
5	Improved Care Experience scores HCAPS				
6	Improved CAL NOC scores				

Time

This study will be active for 2 years starting with the first group hired and ending 12 months after the last group is hired. The RN residency can expect to have 5 surveys that will be completed during their training program; each survey will take between 15 to 30 minutes to complete. The first survey will be completed after the hiring process before orientation starts. All surveys after that may be taken on work time. The preceptors will complete 5 surveys which will take between 15-20 minutes all surveys can be completed on work time. The managers will complete 1 survey at the completion of each group hired. This survey will take approximately 30 minutes and can be completed on work time.

F. Consent

All consents will be handled by Healthcare Recruiter in HR Workforce Planning and Recruitment Operations.

After all paper work is completed and the Registered Nurse is officially hired they will be asked if they would participate in this study. All questions will be answered by Human Resources. Potential subjects will also be provided with Pamela Stanley's contact information for further questions. All managers and Preceptors will be contacted by Human Resources and asked if they will participate in the study.

1. Attach consent form(s)

G. Data analysis

1. Outcome measures

S/N	Key Performance Indicators (KPIs)	2012	2013	2014	Total
1	Financial Savings				
2	Contribution (e.g. new jobs)				
3	Retention				
4	Reduction in usage of Registry Staff				
5	Improved Care Experience scores				
6	Improved CAL NOC scores				
7	Graduate experience with program				
8	Mangers perceptions of the program				
9	Effectiveness of matching learning styles				

2. Statistical methods

Descriptive analysis measuring central tendency will be used to explore the similarities and differences of new Nurses, Preceptors/Mentors and Managers. Pearson correlation will be used to estimate changes between outcomes overtime. Some of the raw data is currently generated through regular organizational reports will be examined visually using trend lines and bar graphs.

II. Patient protection issues in detail

A. Risks/discomforts

New graduates may be worried that Administration will know who is participating in the program. New Graduates may worry these surveys will be used as a means for evaluation of their performance and not kept confidential. Human resources will meet with all new hires and address the choice to participate in this study has nothing to do with their selection or progress in the program. New hires will also be assured that administration does not get

individual data which is identifiable. Participants may find the process time consuming and boring

B. Treatment and compensation for injury

The investigator has reviewed and is fully knowledgeable of the policies and procedures of Alameda County Medical Center pertaining to the treatment and compensation of the study subjects. The study poses no physical or psychological harm to the study subjects that are outside of what would be experienced by new graduate RNs who were not participating in a study of this type. The study sponsor will not be held liable for injury suffered by the subject as a result of this study that is outside of the study sponsors normal and customary liability based on the sponsor title and positions within the organization.

C. Costs to the subject

There are no costs involved to the participants of the study.

D. Reimbursement of subjects

There is no payment for participating.

E. Alternatives to participation

If an individual elects not to participate in the study you will still be enrolled into the same RN residency program and receive the same training, education and resources

F. Confidentiality of records

Information that is obtained about our Registered RN, Preceptors, Mentors, etc. will be solely used for the purpose of determining the success of the New Graduate RN Program at Alameda County Medical Center. Participants will be required to sign a confidentiality agreement in order to be fully compliant with the program.

III. Qualifications of investigators

Pamela Stanley RN, MSN, MBA
Director of Nursing (Inpatient Services)
Alameda County Medical Center
Principle investigator.
DNP student at San Francisco University
See attached Resume.

Kimberly Horton RN, MSN, FNP, DHA, FACHE
Chief Nursing Executive
Alameda County Medical Center
Co-investigator.

HR Workforce Planning and Recruitment Department

RN Nursing / Cardiology / Radiology / Strategy Divisions
Alameda County Medical Center – Health System

Director of Emergency Room and Trauma
Alameda County Medical Center

Project Manager
Alameda County Medical Center

IV. Reference to attachments and special requirements

All application attachments or enclosures (e.g., consent form, questionnaires, data collection sheets, other committee approvals, letters of support or sponsor's indemnification policy) should be referenced in this section.

COVER PAGE (Attachment H) (Rev 12/11)

Project Title: New Nurse Graduate Residency

X New project ☐Annual renewal ☐Modification.

If new project, seeking expedited review? X Yes ☐No If yes, specify permissible category(ies) justifying expedited review: _This is a study done in conjunction with hiring new graduate nurses into a training program. There is no healthcare information involved.

If not new, IRB number _____

If Annual renewal, does this submission differ from the last submission? ☐ Yes ☐ No

If yes, please submit a modification application.

Principal Investigator (must be ACMC Medical Staff member):

Pamela Stanley RN, MSN, MBA
Director of Nursing Inpatient Units
Alameda County Medical Center
Nursing Administration
1411 E 31st Street
Oakland Ca 94602
Is P.I. Advisor only? ☐Yes **X** No

Co-PI:

Kim Horton RN, MSN, FNP, DHA, FACHE
Chief Nursing Executive

Alameda County Medical Center
Nursing Administration
1411 E 31st Street
Names/Titles/Email Addresses/Phone #'s of all other investigators:

Healthcare Recruiter - RN Nursing / Radiology / Cardiology / Strategy Divisions
HR Workforce Planning and Recruitment Operations
Alameda County Medical Center
Human Resources Department - Building C
15400 Foothill Blvd.
San Leandro, California 94578

Director of Emergency room and Trauma
Alameda County Medical Center
Nursing Administration
1411 E 31st Street

Project Manager
Alameda County Medical Center
Nursing Administration
1411 E 31st Street
Oakland Ca 94602

Procedures (List all procedures to be done for purposes of the study):

New Graduate Residence RN

1. After all hiring paperwork is complete the new graduate will be asked if they would participate in the study.
2. All information will be explained by HR and Consents signed.
3. All residency RNs will be given the VARK learning assessment tool in-order to be matched with a preceptor who learns in the same manner.
4. All residency RNs will attend a formal education program with classes and clinical work. This training will last 12-16 weeks
5. Resident RNs will complete the RN transition Program Competency Assessment during day three of orientation, six weeks and at completion of orientation
6. Resident RN will also complete the Casey-Fink Surveys after the program is completed.

Preceptors/Mentors

1. All preceptors/mentors will be certified through the onsite program

2. All preceptors/mentors will complete an evaluation of the RN Residency progress towards competency using the RN transition Program Competency Assessment. This will be done after working one week with their preceptee, six weeks and at completion of orientation.
3. All preceptors will complete two satisfaction surveys during the training program.

Managers

1. Will complete the New Graduate RN Transition Program Employer Survey at completion of every co-hart group hired

Drugs and Devices: None
Name: _____ IND/IDE _____
☐Seeking non-significant risk determination.

Radioisotopes: Will any radioactive materials be used? ☐Yes ☒No If yes, explain in detail in application and ACMC Radiation Safety Committee approval is required prior to IRB approval.

Subjects (explain in detail in application): Total number 250 Number of controls____0____

Source(s)__Nurses_____

Reimbursement: ☐Yes ☒No Will minors be involved? ☐Yes ☒No

Costs: Will there be any charges to the subjects or their 3rd party carriers due to participation in the study? ☐Yes ☒No If yes, specify which costs (explain in detail in application):

_____ _____ Approximate maximum amount: _____

Funding: Will this study be funded? ☐Yes ☒No ☐Pending ☐Federal funding ☐Other

Name of funding source_____

Will all research subjects be given the "**Experimental Subject's Bill of Rights**" (Attachment N)? ☒Yes ☐No

Have all investigators signed the "**Conflict of Interest Disclosure Statement**" (Attachment M)? ☒Yes ☐No

For new studies please document approval of the ACMC **Department Chair**:

I have read the attached protocol and attachments, and I approved the study? ☐Yes ☐No

Signature, Department Chair

For new studies and annual renewals, has the **Chief Medical Officer** approved the study?
□Yes □No

Principal Investigator Signature: _____

Information and Consent Form (Template) **Attachment C**

Alameda County Medical Center (ACMC) Department of Nursing

Study Title: New Graduate Residency Program

Investigators (names of the researchers): Pamela Stanley

You must read and understand this form before signing it. We encourage you to ask Human Resources or Pamela Stanley questions about this research study. You will receive a copy of this form to take home.

Why are we doing this study?

This study is being done to examine the impact of providing a new graduate program with certified preceptor/mentor who has the same learning style on the organization and staff. Our goal is to examine the benefits on the new graduate on the organization and personnel. We are examining:

- The transitional experience from student to nurse with this program
- Retention of new graduates
- Financial performance of the organization
- Patient satisfaction.
- CAL NOC quality indicators.
- Staff engagement

Who can be in this study?

All New Graduates hired into the Residency Program can choose to participate in this study.
All certified mentors/preceptors of personnel in this program can choose to participate
All Hiring managers of staff in this program may choose to participate

How the study works:

During this study you will participate in 1-6 surveys. These surveys will either be on survey monkey or paper.

VARK Leaning Style Assessment

This questioner will be used to assess Preceptors/Mentors and Resident RN learning preference. The goal is to match individuals with people who learn in the same manner to improve their learning and increase the time it takes to move an individual from Novice to Advanced-beginner.

The Casey-Fink New Graduate Experience Survey (SMU/FINAL)

This will be used to evaluate the new graduates experience to evaluate how the program assisted them in their transition to leader at the bedside.

The Graduate RN Transition Program Employer Survey

This will be provided to the managers to assess the programs impact from their perspective.

Surveys on satisfaction on readiness for the New Graduate to work independently

Possible problems from participating in this study:

Completing these surveys may take 10-30 minutes of your time. If you agree to participate in the study, you are still free to withdraw from the study (stop participating) at any time. At no time will the nursing management or division know who is or is not participating in the study.

Possible benefits:

This study may encourage other organizations to actively initiate their own new graduate residency program resulting in more jobs for New RN Graduates in the future. This study may also provide information on how to assist the new nurse effectively with the transition from student to leader at the bedside

Alternatives to participating in this study:

You may choose not to participate and your training program will not be affected. You will still be provided the same training and framework to facilitate your success in your transition.

Costs and Reimbursement: It costs you nothing to participate in this study. You will receive no payment for participating.

Confidentiality:

Participation in this study is confidential. Human Resources will not disclose to nursing who is participating in the study.

Voluntary Participation:

Participation is voluntary and you can withdraw at any time without penalty. Participating in this study is voluntary. You will still receive the same training and resources if you choose not to participate. You may stop participating in the study at any time without penalty.

Questions, Problems, Follow-up:

If you have any other questions, concerns, or problems while participating in the study, or in the future, you are encouraged to speak with the study investigator or Pamela Stanley or Kevin Sylvester in HR.

Provide contact information for someone not involved with the study who can answer questions about participants' rights as a research subject. This is usually the ACMC IRB Chair.

Agreement to participate: I have read and understand this Consent Form. I have had an opportunity to ask questions about the study and to discuss it with my doctor, other health care providers and my family.

_____
Subject's Name Printed

_____ _____
Subject's Signature Date

_____ _____
Witness Signature Date

_____
Investigator Signature Date

Conflict of Interest Disclosure Statement (Attachment M) (Rev 9/11)

This form is to be completed by every member of the research team. Terms in **bold** are defined at the end of this document.

1. Do you or any **family member** have a **financial interest** (including ownership, equity, or otherwise) in, or participate in, or have a consultantship with any activities or businesses that might or might appear to *affect the design, conduct, or reporting* of this study or its results? Yes☐ No ☒

If "yes,"

a) Is the **financial interest** expected to exceed $10,000 in a twelve month period? Yes☐ No ☐

b) Does the ownership interest exceed 5%? Yes☐ No☐

c) Is this research for the purpose of **regulatory approval** (or does it involve **Human Subjects**)? Yes☐ No☐

2. Do you or a **family member** have a financial, managerial, or ownership (equity or otherwise) interest in the sponsoring entity of this activity which is expected to exceed $10,000 in a twelve month period, and/or ownership in excess of 3%? (This question does not apply to governmental or non-profit sponsors.) Yes☐ No ☒

3. Are you providing privileged access to information from this activity, to an entity in which you or a member of your immediate family has a financial interest? Yes☐ No ☒

4. Do you have direct supervisory authority over a faculty member, student, or employee who receives funds for this activity from a business in which you or a member of your immediate family has a management or financial interest? Yes☐ No ☒

5. Are you purchasing equipment, instruments, or supplies for this activity from a firm in which you or a member of your immediate family has a financial or other interest? Yes☐ No ☒

I certify that my responses above are complete and accurate, and that during the life of this project, if circumstances occur which change my answer to any of these questions, I will immediately submit a revised Conflict of Interest Disclosure Statement

_____ _____

Principal Investigator Signature Date

Oath of Confidentiality (Attachment E) (Rev 9/11)

As required to conduct experimental research (regulated by Federal statute) ay Alameda County

Medical Center, I, _____ agree to obtain informed consent from subjects as approved by the Alameda County Medical Center Institutional Review Board and not to publish confidential information about subjects without their prior written approval.

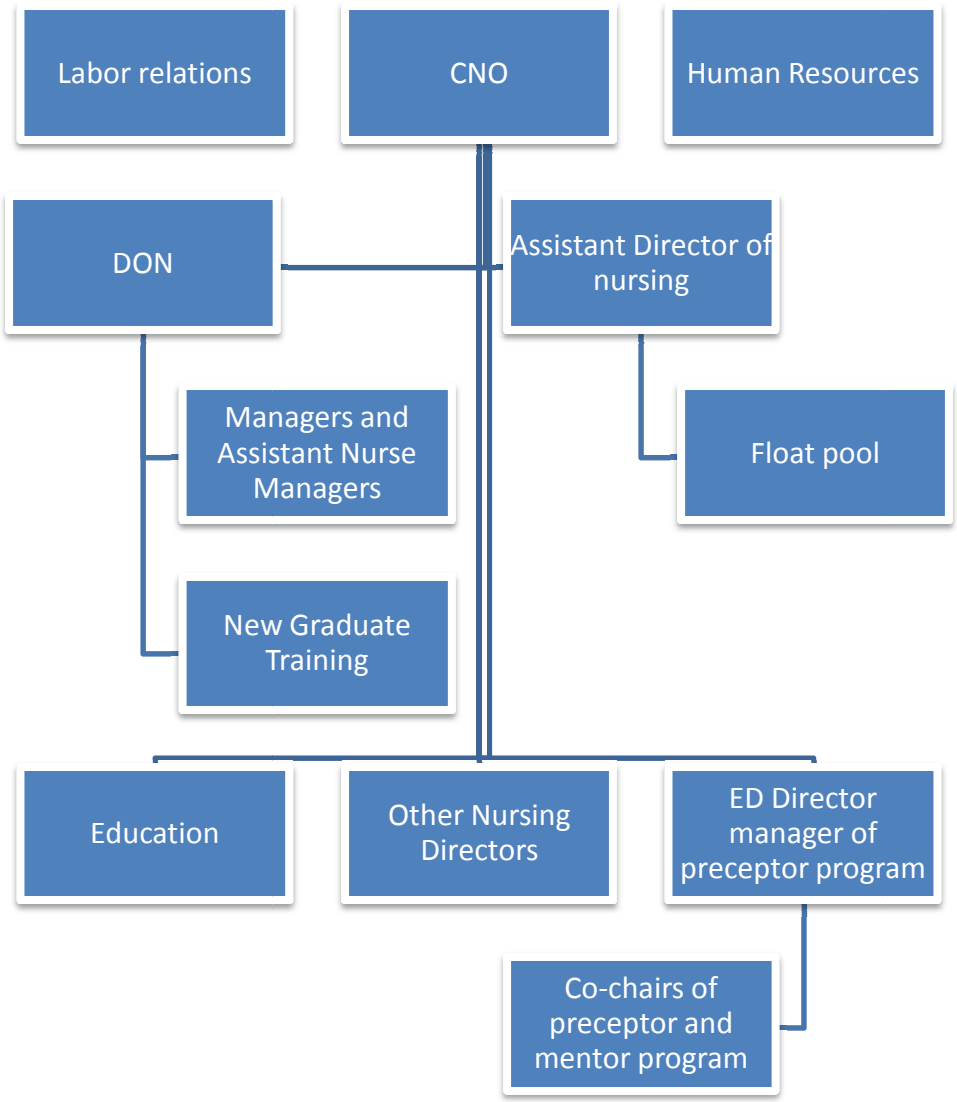
I recognize that the violation of this oath may make me subject to a civil action suit under provisions of the California Government and Welfare & Institution Codes.

_____ _____

Signature of Investigator Date

Appendix N

Project Organizational Diagram



Appendix O
Consent Form

Information and Consent Form (Template)

Alameda County Medical Center (ACMC) Department of Nursing

Study Title: New Graduate Residency Program

Investigators (names of the researchers): Pamela Stanley

You must read and understand this form before signing it. We encourage you to ask Human Resources or Pamela Stanley questions about this research study. You will receive a copy of this form to take home.

Why are we doing this study?

This study is being done to examine the impact of providing a new graduate program with certified preceptor/mentor who has the same learning style on the organization and staff. Our goal is to examine the benefits on the new graduate on the organization and personnel. We are examining:

- The transitional experience from student to nurse with this program
- Retention of new graduates
- Financial performance of the organization
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- CAL NOC quality indicators.
- Staff engagement

Who can be in this study?

All New Graduates hired into the Residency Program can choose to participate in this study. All certified mentors/preceptors of personnel in this program can choose to participate
All Hiring managers of staff in this program may choose to participate

How the study works:

During this study you will participate in 1-6 surveys. These surveys will either be on survey monkey or paper.

VARK Leaning Style Assessment

This questioner will be used to assess Preceptors/Mentors and Resident RN learning preference. The goal is to match individuals with people who learn in the same manner to improve their learning and increase the time it takes to move an individual from Novice to Advanced-beginner.

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The Graduate RN Transition Program Employer Survey

This will be provided to the managers to assess the programs impact from their perspective.

Surveys on satisfaction on readiness for the New Graduate to work independently

Possible problems from participating in this study:

Completing these surveys may take 10-30 minutes of your time. If you agree to participate in the study, you are still free to withdraw from the study (stop participating) at any time. At no time will

the nursing management or division know who is or is not participating in the study.

Possible benefits:

This study may encourage other organizations to actively initiate their own new graduate residency program resulting in more jobs for New RN Graduates in the future. This study may also provide information on how to assist the new nurse effectively with the transition from student to leader at the bedside

Alternatives to participating in this study:

You may choose not to participate and your training program will not be affected. You will still be provided the same training and framework to facilitate your success in your transition.

Costs and Reimbursement: It costs you nothing to participate in this study. You will receive no payment for participating.

Confidentiality:

Participation in this study is confidential. Human Resources will not disclose to nursing who is participating in the study.

Voluntary Participation:

Participation is voluntary and you can withdraw at any time without penalty. Participating in this study is voluntary. You will still receive the same training and resources if you choose not to participate. You may stop participating in the study at any time without penalty.

Questions, Problems, Follow-up:

If you have any other questions, concerns, or problems while participating in the study, or in the future, you are encouraged to speak with the study investigator or Pamela Stanley or Kevin Sylvester in HR.

Provide contact information for someone not involved with the study who can answer questions about participants' rights as a research subject. This is usually the ACMC IRB Chair.

Agreement to participate: I have read and understand this Consent Form. I have had an opportunity to ask questions about the study and to discuss it with my doctor, other health care providers and my family.

_____

Subject's Name Printed

_____ _____

Subject's Signature Date

_____ _____

Witness Signature Date

_____ _____

Investigator Signature Date

Appendix P
New Graduate Program Re-Design

ALAMEDA COUNTY
MEDICAL CENTER

New Graduate RN Residency Program

CLASSROOM INSTRUCTION (Mandatory)
Every Wednesday and Thursday, 0800-1630 for 11-weeks*

CLINICAL PRECEPTORSHIP
3- 8 hour shifts on a Medical-Surgical Unit (5East/7East/7West) weekly, for 11-weeks*
2- 12 hour shifts on a Step-Down-Unit (SDU) weekly, for 11-weeks*

- Each New Graduate RN will be assigned a primary preceptor and secondary preceptor on his/her assigned unit.
- Each New Graduate RN will adhere to his/her assigned unit's clinical checklist and patient care load assignments weekly.

*Schedule is subject to change at the discretion of Nursing Administration.

PROGRAM DESCRIPTION
This 11-week program is designed to assist the New Graduate RN in developing as a professional nurse by examining nursing theories and principles in classroom instruction, and applying these skills in the clinical setting. The New Graduate RN exercises the leadership role, develops communication styles, utilizes critical thinking, analyzes current research literature, and advocates for patient safety. The focus is to provide the New Graduate RN with knowledge of and preparation for the Clinical Nurse I/II position.

PROGRAM OBJECTIVES
At the conclusion of the program, the New Graduate RN will successfully be able to meet the following ACMC's Clinical Nurse I Job Role Description:

1. Accompany, assist, and represent the needs of patients to other providers.
2. Accurately provide evidence based, best practice care with respect to medication administration, skin and wound care, ADLs and other essential patient care related activities.
3. Develop, implement, evaluate and make modifications in the nursing care plan; prepare required records and reports.
4. Gather and analyze information on patients to best determine the course of treatment; assist and consult with physician in the performance of procedure and diagnostic

tests; contacts physicians and/or other departments to obtain or provide patient information.

5. May provide oversight to staff who monitor telemetry systems; alert primary nurse of changes of underlying rhythms and of any life threatening arrhythmias that may develop; interprets and document telemetry at the hours specified; admits and discharges patients with telemetry units as appropriate.

PROGRAM OBJECTIVES (continued)

6. Participate in promoting a healthful, safe, and therapeutic environment for patient care standards, infection control standards and quality assurance criteria; assist with conducting studies; participate in unit and other meetings.
7. Provide and evaluate the standard of patient care and criteria in conformity with the nursing care plan. Monitor patients for significant and critical changes and initiate procedures as required; document care given according to set standards and at required intervals. Interpret and explain procedures, regimens, and services to patient and families; teaches patient and family members health care and disease prevention techniques. Prepare patient and/or area for procedures and operations; assist physicians; uses instruments and equipment related to the area of assignment.

At the conclusion of the program, the New Graduate RN will successfully develop the following ACMC's Clinical Nurse I Knowledge, Skills and Abilities:

1. Act in an appropriate and professional manner as defined by the company's Standards of Behavior, Policy and Procedures, and Scope of Services.
2. Anatomy, physiology, chemistry, pharmacology, infection control, growth and development, basic medical surgical nursing, and nutrition.
3. Continue one's self-development with guidance.
4. Demonstrate effective utilization of feedback and noted areas for additional education and focus.
5. Identify etiology of a problem and make essential decisions utilizing the problem-solving process.
6. Informally teach patients, families and staff.
7. Knowledge of wellness to illness continuum.
8. Major disease conditions, including current knowledge of tests, therapies, treatment, and interview & assessment techniques.
9. Make maximum use of available materials and human resources.
10. Nursing procedures, techniques, equipment, and supplies; health systems, agencies, and patterns of referral.
11. Practice safe, thorough nursing care with effective, economic use of supplies and with reasonable speed in diverse environments.
12. Principles and processes of problem solving, organization and effective cost control.
13. Professional nursing practice, attitude and mission.
14. Respond effectively to emergency situations.
15. Role model ACMC Standards of Behavior.
16. Utilize concepts of assessment, priority setting, organization and evaluation.

17. Work congenially and professionally with personnel and medical staff.
18. Write concisely, legibly and with correct spelling; communicate effectively.

REQUIREMENTS

Education

Graduate of an accredited nursing program through National League of Nursing (NLN) or Commission on Collegiate Nursing Education (CCNE) required. This includes an Associate Degree in Nursing (ADN), Bachelor's Degree in Nursing (BSN), or Master's Degree in Nursing (MSN).

Licensure & Certifications

State of California Registered Nurse License

Basic Life Support (BLS)

Advanced Cardiac Life Support (ACLS)

Pediatric Advanced Life Support (PALS)

COMPUTER LITERACY

Alameda County Medical Center frequently distributes important documents via computer technology. The New Graduate RN is expected to have basic computer word processing skills. The program also utilizes E-learning software for enhancing nursing content. The New Graduate RN must have access to a personal computer or utilize the employer's computer systems for education, work and communication purposes.

COMMUNICATION

The New Graduate RN is expected to use email/webmail, internet, mail, phone, and voicemail when communicating to staff.

TEACHING/LEARNING STRATEGIES

Critical thinking involves experience, expression and application of nursing theory and the latest evidenced based practice. The teaching and learning methods will include discussion and demonstration using PowerPoint visuals, case study, role playing, in-class exercises, expert presentation, return demonstration, and clinical practice.

The New Graduate RN Residency Program requires New Graduate RNs to be proactive in classroom instruction and clinical preceptorship. Remember that active and receptive learning

takes initiative, and valuable experience takes effort and a strong work ethic. New Graduate RNs are expected to engage, learn, listen, ask questions, participate, and have a positive attitude. New Graduate RNs who are struggling to meet program requirements are strongly advised to discuss performance and barriers to their primary preceptor, Assistant Nurse Manager, New Graduate RN Program Coordinator and Director of Inpatient Adult Services as soon as possible.

CLASSROOM CASE STUDY REPORT

New Graduate RNs will present a case study report from their clinical patient care experience during classroom lecture either individually or with another New Graduate RN in the same assigned unit. The New Graduate RN will use the Case Study Report template and complete the necessary information in order to paint a patient's clinical presentation to the class. The Clinical Educators will facilitate further critical thinking inquiry and discussion using each case study report. The purpose of the case study report is to bridge the gap between classroom nursing theory and clinical systems application.

SUPPLEMENTAL RESOURCES FOR NURSING PRACTICE

Located on the ACMC Intranet are links to supplemental resources for nursing practice. The New Graduate RN can access the following resources under the "ACMC Web Applications" section on any ACMC desktop computer.

Krames On-Demand

Resource provides patient health education materials in lay-person terms and various languages.
Account name: ACMC
User Name:
Password:

MicroMedex Health Care

Resource provides medication information from literature.
Username:
Password:

Mosby's Nursing Skills

Resource provides step-by-step instructions, illustrations, review points, and quizzes of nursing skills.

Policy & Procedures (Policytech)

Resource provides policy and procedures of clinical and organizational practice.
To log in, you will need to enter your Network username and password.
Contact the Help Desk for "forgot your password" issues, and any questions at ext. 44503.

Essentials of Critical Care Orientation (ECCO) Modules

Resource provides critical care nursing lessons and post-tests on each body system. The ECCO modules can be found on the ACMC Intranet website under the "Education & Training" tab.

The modules can also be accessed at home on the *E-learning on the Learning Zone* website, http://www.webinservice.com/Alameda/ . To access the *E-learning on the Learning Zone*; enter your user ID and password that has been assigned to you.

Below is a description of the ECCO modules.

A. ECCO Modules: Medical-Surgical Unit

1. ECCO Module 00-01: Essentials of Critical Care Orientation 2.0 - Introduction
2. ECCO Module 01-03: Introduction to Care of the Critically Ill - Organizing the Care of the Critically Ill Patient (1 hr)
3. ECCO Module 01-04: Introduction to Care of the Critically Ill - Evidence - Based Practice (1 hr) (except topic 5: VAP)
4. ECCO Module 02-01: Care of the Patient with Cardiovascular Disorders - Cardiovascular System Anatomy and Physiology (1 hr)
5. ECCO Module 02-02: Care of the Patient with Cardiovascular Disorders - Assessing the Cardiovascular System (1 hr)
6. ECCO Module 02-03: Care of the Patient with Cardiovascular Disorders - Management of Acute Coronary Syndromes (4 hrs)
7. ECCO Module 02-04: Care of the Patient with Cardiovascular Disorders - Pathologic Conditions (5 hrs)
8. ECCO Module 03-01: Care of the Patient with Pulmonary Disorders - Pulmonary System Anatomy and Physiology (1 hr)
9. ECCO Module 03-02: Care of the Patient with Pulmonary Disorders - Respiratory Assessment (1.5 hrs)
10. ECCO Module 03-03: Care of the Patient with Pulmonary Disorders - Pathologic Conditions (2 hrs)
11. ECCO Module 03-04: Care of the Patient with Pulmonary Disorders - Airway Management (0.5 hr)
12. ECCO Module 03-06: Care of the Patient with Pulmonary Disorders - Thoracic Surgical Procedures (1 hr)
13. ECCO Module 05-01: Care of the Patient with Neurologic Disorders - Neurologic System Anatomy and Physiology (1 hr)
14. ECCO Module 05-02: Care of the Patient with Neurologic Disorders - Assessment and Diagnostic Techniques (1 hr)
15. ECCO Module 05-04: Care of the Patient with Neurologic Disorders - Ischemic and Hemorrhagic Stroke (2 hrs)
16. ECCO Module 05-05: Care of the Patient with Neurologic Disorders - Other Pathological Conditions (2 hrs)
17. ECCO Module 06-01: Care of the Patient with Gastrointestinal Disorders - Gastrointestinal System Anatomy and Physiology (1 hr)
18. ECCO Module 06-02: Care of the Patient with Gastrointestinal Disorders - Diagnostic Testing (1 hr)
19. ECCO Module 06-03: Care of the Patient with Gastrointestinal Disorders - Pathologic Conditions (2 hrs)
20. ECCO Module 06-04: Care of the Patient with Gastrointestinal Disorders - Nutritional Support of Critically Ill Patients (1 hr)
21. ECCO Module 07-01: Care of the Patient with Renal Disorders - Renal System Anatomy and Physiology (1 hr)
22. ECCO Module 07-02: Care of the Patient with Renal Disorders - Renal Assessment and Monitoring (0.5 hr)
23. ECCO Module 07-03: Care of the Patient with Renal Disorders - Fluid and Electrolyte Disturbances (1 hr)
24. ECCO Module 07-04: Care of the Patient with Renal Disorders - Renal Disease (1.5 hrs)
25. ECCO Module 07-05: Care of the Patient with Renal Disorders - Renal Replacement Therapy (1 hr)
26. ECCO Module 08-01: Care of the Patient with Endocrine Disorders - Endocrine System Anatomy and Physiology (0.5 hr)
27. ECCO Module 08-02: Care of the Patient with Endocrine Disorders - Endocrine System Assessment (0.5 hr)
28. ECCO Module 08-03: Care of the Patient with Endocrine Disorders - Pathologic Conditions (1.5 hrs)
29. ECCO Module 09-01: Care of the Patient with Hematological Disorders - Hematologic System Anatomy and Physiology (0.25 hrs)
30. ECCO Module 09-02: Care of the Patient with Hematological Disorders - Hematologic Diagnostic Tests (0.5 hrs)
31. ECCO Module 09-03: Care of the Patient with Hematological Disorders - Pathologic Conditions (1 hr)

32. ECCO Module 10-01: Care of the Patient with Multisystem Disorders - Shock (1 hr)
33. ECCO Module 10-02: Care of the Patient with Multisystem Disorders - Sepsis, SIRS and MODS (2 hrs)
34. ECCO Module 10-03: Care of the Patient with Multisystem Disorders - Overdose (0.5 hrs)
35. ECCO Module 01-02: Introduction to Care of the Critically Ill - Care of Specialty Populations in the Critical Care Unit

B. ECCO Modules: Step- Down/Telemetry Unit

1. ECCO Module 00-01: Essentials of Critical Care Orientation 2.0 - Introduction
2. ECCO Module 01-03: Introduction to Care of the Critically Ill - Organizing the Care of the Critically Ill Patient (1 hr)
3. ECCO Module 01-04: Introduction to Care of the Critically Ill - Evidence - Based Practice (1 hr) (except topic 5: VAP)
4. ECCO Module 02-01: Care of the Patient with Cardiovascular Disorders - Cardiovascular System Anatomy and Physiology (1 hr)
5. ECCO Module 02-02: Care of the Patient with Cardiovascular Disorders - Assessing the Cardiovascular System (1 hr)
6. ECCO Module 02-03: Care of the Patient with Cardiovascular Disorders - Management of Acute Coronary Syndromes (4 hrs)
7. ECCO Module 02-04: Care of the Patient with Cardiovascular Disorders - Pathologic Conditions (5 hrs)
8. ECCO Module 02-05: Care of the Patient with Cardiovascular Disorders - Cardiac Surgery (2 hrs)
9. ECCO Module 02-06: Care of the Patient with Cardiovascular Disorders - Cardiac Pacemakers (1.5 hrs)
10. ECCO Module 03-01: Care of the Patient with Pulmonary Disorders - Pulmonary System Anatomy and Physiology (1 hr)
11. ECCO Module 03-02: Care of the Patient with Pulmonary Disorders - Respiratory Assessment (1.5 hrs)
12. ECCO Module 03-03: Care of the Patient with Pulmonary Disorders - Pathologic Conditions (2 hrs)
13. ECCO Module 03-04: Care of the Patient with Pulmonary Disorders - Airway Management (0.5 hr)
14. ECCO Module 03-05: Care of the Patient with Pulmonary Disorders - Basic Ventilator Management (2 hrs)
15. ECCO Module 03-06: Care of the Patient with Pulmonary Disorders - Thoracic Surgical Procedures (1 hr)
16. ECCO Module 05-01: Care of the Patient with Neurologic Disorders - Neurologic System Anatomy and Physiology (1 hr)
17. ECCO Module 05-02: Care of the Patient with Neurologic Disorders - Assessment and Diagnostic Techniques (1 hr)
18. ECCO Module 05-04: Care of the Patient with Neurologic Disorders - Ischemic and Hemorrhagic Stroke (2 hrs)
19. ECCO Module 05-05: Care of the Patient with Neurologic Disorders - Other Pathological Conditions (2 hrs)
20. ECCO Module 06-01: Care of the Patient with Gastrointestinal Disorders - Gastrointestinal System Anatomy and Physiology (1 hr)
21. ECCO Module 06-02: Care of the Patient with Gastrointestinal Disorders - Diagnostic Testing (1 hr)
22. ECCO Module 06-03: Care of the Patient with Gastrointestinal Disorders - Pathologic Conditions (2 hrs)
23. ECCO Module 06-04: Care of the Patient with Gastrointestinal Disorders - Nutritional Support of Critically Ill Patients (1 hr)
24. ECCO Module 07-01: Care of the Patient with Renal Disorders - Renal System Anatomy and Physiology (1 hr)
25. ECCO Module 07-02: Care of the Patient with Renal Disorders - Renal Assessment and Monitoring (0.5 hr)
26. ECCO Module 07-03: Care of the Patient with Renal Disorders - Fluid and Electrolyte Disturbances (1 hr)
27. ECCO Module 07-04: Care of the Patient with Renal Disorders - Renal Disease (1.5 hrs)
28. ECCO Module 07-05: Care of the Patient with Renal Disorders - Renal Replacement Therapy (1 hr)
29. ECCO Module 08-01: Care of the Patient with Endocrine Disorders - Endocrine System Anatomy and Physiology (0.5 hr)
30. ECCO Module 08-02: Care of the Patient with Endocrine Disorders - Endocrine System Assessment (0.5 hr)
31. ECCO Module 08-03: Care of the Patient with Endocrine Disorders - Pathologic Conditions (1.5 hrs)
32. ECCO Module 08-04: Care of the Patient with Endocrine Disorders - Managing Hyperglycemia in the Critically Ill Patient (1.5 hrs)

33. ECCO Module 09-01: Care of the Patient with Hematological Disorders - Hematologic System Anatomy and Physiology (0.25 hrs)
34. ECCO Module 09-02: Care of the Patient with Hematological Disorders - Hematologic Diagnostic Tests (0.5 hrs)
35. ECCO Module 09-03: Care of the Patient with Hematological Disorders - Pathologic Conditions (1 hr)
36. ECCO Module 10-01: Care of the Patient with Multisystem Disorders - Shock (1 hr)
37. ECCO Module 10-02: Care of the Patient with Multisystem Disorders - Sepsis, SIRS and MODS (2 hrs)
38. ECCO Module 10-03: Care of the Patient with Multisystem Disorders - Overdose (0.5 hrs)
39. ECCO Module 01-02: Introduction to Care of the Critically Ill - Care of Specialty Populations in the Critical Care Unit

ROLE OF PRECEPTORS

Preceptors are experienced registered nurses who are passionate about their nursing profession and clinical nurse instruction. The preceptor's role is to guide the New Graduate RN with acquiring thorough and efficient nursing skills through discussion, demonstration and return-demonstration methods. Skills such as time management, prioritization, nursing tasks, patient assessment, nurse care process, and communication will be taught, scrutinized, and given constructive feedback for further improvement. Developing competency in these skills is extremely valuable in a registered nurses career.

ROLE OF CLINICAL NURSE IV/ASSISTANT NURSE MANAGER

Clinical Nurse IV/Assistant Nurse Managers are experienced registered nurses who have upper management and leadership expertise on their clinical units. Their role is to help promote a conducive, learning environment and experience with the New Graduate RNs, preceptors, and fellow staff. Clinical Nurse IVs have been assigned to specific units for supervision for the New Graduate RN Residency Program.

Should any New Graduate RNs have any clinical questions and/or concerns that warrant attention, please see the appropriate Clinical Nurse IV/Assistant Nurse Manager:
SDU:
7West:
5East, 7East, OR/SDS:

Please note: Preceptors and hospital units do not solely make the New Graduate RN's learning experience advantageous. The New Graduate RN is expected to use the nursing process in all aspects of life: assessment of a situation, identification of problems and barriers, solution recommendations, and communication of needs. There will be personality conflicts and structure issues in any profession. A goal for this New Graduate RN Residency Program is to help the New Graduate RN advocate for patients and themselves and to problem-solve with honesty and integrity in a professional setting.

SCHEDULE FOR CLINICAL PRECEPTORSHIP

Overview

The core staffing unit schedule for 5East, 7East, 7West and SDU is handled by --------- Administrative Assistant. The core staffing unit is scheduled in a 4-week period and

electronically inputted into the ANSOS scheduling system. A print-out of the unit schedule is available on every unit. ANSOS is the method of tracking the staff expected for scheduled shifts. Staff is expected to call the Staffing Unit#####when he or she is reporting tardiness or absence for the scheduled work day. A no call-no show result may result in disciplinary action.

New Graduate RN Residency Program: Clinical Preceptor Schedule
Each New Graduate RN has been assigned to a Medical-Surgical, Telemetry, or Step-Down Critical Care Unit for the clinical preceptorship. A primary and secondary preceptor from the

New Graduate RN Residency Program: Clinical Preceptor Schedule (continued)
Designated unit has been assigned to each New Graduate RN. The New Graduate RN will spend most of the clinical hours with the primary preceptor. The secondary preceptors will precept the New Graduate RN when the primary preceptor is not scheduled to work for that clinical week. The primary or secondary preceptor can complete the Clinical Evaluation forms. Any experienced registered nurse can validate the Competency Checklist when the New Graduate RN demonstrates the skill competency in front of an experienced nurse.

has been appointed the Master Scheduler for the New Graduate RN's clinical preceptorship schedule. Robbie will only schedule the New Graduate RN on clinical days in which the assigned primary and secondary preceptor is scheduled to work. New Graduate RNs are expected to strictly follow their assigned clinical schedule.

Once the official assigned clinical schedules are printed, changes to individual schedules are strictly prohibited. There is only 1 modification allowance per 4-week period. Failure to follow this expectation may result in not completing the exit criteria of the New Graduate RN Residency Program. NO EXCEPTIONS.

SHADOWING RAPID RESPONSE TEAM NURSE
New Graduate RNs will be required to spend 1 clinical day shadowing with the Rapid Response Team Nurse (RRT). RRT responds to subtle signs of patient deterioration, thus, preventing medical codes and protecting patients. The RRT shadowing experience will enable New Graduate RNs to trust their own instincts and recognize acute changes in their patient's condition, apply critical thinking in emergent situations, understand the interdisciplinary team approach, and identify diversion and code responses at the organizational level. The New Graduate RN Program Coordinator will schedule the New Graduate RN with RRT, starting Clinical Week 3.

CLINICAL PRECEPTORSHIP PATIENT CARE LOAD ASSIGNMENTS
On the 1st Day of Clinical Preceptorship, New Graduate RNs will not have a primary patient care assignment. New Graduate RNs will complete and fill out Scavenger Hunt paperwork, discuss their program goals/expectations with preceptor, shadow preceptor activities, and go over unit policy and procedures. The preceptor may or may not have assigned patients on this 1st day.

The table below serves as a guide for the number of patients the New Graduate RN is expected to be assigned to care for during a designated shift. Adherence to this clinical table is strongly encouraged as this will enable the New Graduate RN to steadily transition towards to practicing nursing independently.

Clinical Preceptorship Patient Care Load Assignment Table

Program Week	Clinical Week	Program Week	Number of Clinical Days	5East/7East/7West Patient Care Load
3	1	3/31/13 - 4/6/13	1st Day	0
3	1	3/31/13 - 4/6/13	2nd & 3rd Day	1
4	2	4/7/13 - 4/13/13	3 days	2
5	3	4/14/13 - 4/20/13	3 days	3
6	4	4/21/13- 4/27/13	3 days	4
6	**4**	**4/21/13- 4/27/13**	**MIDTERM**	**EVALUATION**
7	5	4/28/13 - 5/4/13	3 days	5
8	6	5/5/13 - 5/11/13	3 days	5
9	7	5/12/13 - 5/18/13	3 days	5
10	8	5/19/13 - 5/25/13	3 days	5
10	**8**	**5/19/13 - 5/25/13**	**FINAL**	**EVALUATION**
11	9	5/26/13 - 6/1/13	3 days	5

Program Week	Clinical Week	Program Week	Clinical Day of the Week	SDU Patient Care Load
3	1	3/31/13 - 4/6/13	Day 1	0
3	1	3/31/13 - 4/6/13	Day 2	1
4	2	4/7/13 - 4/13/13	Day 1	1
4	2	4/7/13 - 4/13/13	Day 2	2
5	3	4/14/13 - 4/20/13	Day 1	2
5	3	4/14/13 - 4/20/13	Day 2	2
6	4	4/21/13- 4/27/13	Day 1	2
6	4	4/21/13- 4/27/13	Day 2	2
6	**4**	**4/21/13- 4/27/13**	**MIDTERM**	**EVALUATION**
7	5	4/28/13 - 5/4/13	Day 1	2
7	5	4/28/13 - 5/4/13	Day 2	3
8	6	5/5/13 - 5/11/13	Day 1	3
8	6	5/5/13 - 5/11/13	Day 2	3

9	7	5/12/13 - 5/18/13	Day 1	3
9	7	5/12/13 - 5/18/13	Day 2	3
10	8	5/19/13 - 5/25/13	Day 1	3
10	8	5/19/13 - 5/25/13	Day 2	3
10	**8**	**5/19/13 - 5/25/13**	**FINAL**	**EVALUATION**
11	9	5/26/13 - 6/1/13	Day 1	3
11	9	5/26/13 - 6/1/13	Day 2	3

CLINICAL PRECEPTORSHIP EVALUATION METHODS

Weekly New Graduate RN Clinical Evaluations
New Graduate RNs will be evaluated on their clinical performance at the end of each week by their primary/ secondary clinical preceptor, responding to the following questions and checking the boxes appropriately. This Weekly Evaluation will enable the New Graduate RN to set goals, promote professional behavior, and improve nursing process and patient care delivery.

The New Graduate RN will be expected to fill out the weekly goal portion at the bottom of each form. After evaluation is completed and signed by the preceptor, the New Graduate RN is expected to make 2 additional copies of this form and submit them to the designated individuals the next week:

3 copies of Weekly New Graduate RN Clinical Evaluation Form:
(1) Original – Submit to New Graduate RN Residency Program Coordinator
(2) 2nd Copy- Submit to assigned unit's Assistant Nurse Manager
(3) 3rd Copy- Self; Place copy in his or her New Graduate RN Residency Program Binder under "Evaluations" index tab for own records

Midterm New Graduate RN Clinical Evaluation (4/21/13- 4/27/13)
New Graduate RNs will be evaluated on their clinical performance over the past 4 clinical weeks by their primary/ secondary clinical preceptor, responding to the following questions and checking the boxes appropriately. This Midterm Clinical Performance Evaluation will enable the New Graduate RN to set goals, promote professional behavior, and improve nursing process and patient care delivery. The preceptor will list the area(s) the New Graduate RN needs to improve and a plan of action to successfully demonstrate clinical competency for the remainder of the residency program.

After evaluation is completed and signed by the preceptor, the New Graduate RN is expected to make 2 additional copies of this form and submit them to the designated individuals the next week:

3 copies of MIDTERM New Graduate RN Clinical Evaluation Form:
(1) Original – Submit to New Graduate RN Residency Program Coordinator
(2) 2nd Copy- Submit to assigned unit's Assistant Nurse Manager

(3) 3rd Copy- Self; Place copy in own New Graduate RN Residency Program Binder under "Evaluations" index divider for own records

Final New Graduate RN Clinical Evaluation (5/19/13 - 5/25/13)
New Graduate RNs will be evaluated on their overall clinical performance during the past 10 clinical weeks by their primary/ secondary clinical preceptor, responding to the following questions and checking the boxes appropriately. This Final Clinical Performance Evaluation will

Final New Graduate RN Clinical Evaluation (5/19/13 - 5/25/13) (continued)
enable the New Graduate RN to set short and long term goals, promote professional behavior, and improve nursing process and patient care delivery. This final evaluation also serves as a preceptor recommendation for successful completion of the residency program.

After evaluation is completed and signed by the preceptor, the New Graduate RN is expected to make 2 additional copies of this form and submit them to the designated individuals the next week:

<u>3 copies of FINAL New Graduate RN Clinical Evaluation Form:</u>
(1) Original – Submit to New Graduate RN Residency Program Coordinator
(2) 2nd Copy- Submit to assigned unit's Assistant Nurse Manager
(3) 3rd Copy- Self; Place copy in own New Graduate RN Residency Program Binder under "Evaluations" index divider for own records

NEW GRADUATE RN RESIDENCY PROGRAM COMPETENCY CHECKLISTS
New Graduate RN Peripheral IV Insertion Competency Form
New Graduate RNs are expected to successfully perform 2 peripheral IV insertions using aseptic technique. Each IV insertion must be performed from 2 different location sites on a living patient. Peripheral blood draws are excluded. The New Graduate RN can perform the skill and have it validated by any experienced registered nurse. IV insertion form must be signed and submitted to the New Graduate RN Coordinator.

New Graduate RN Medical-Surgical Competency Checklist
New Graduate RNs are expected to perform correct verbal and return demonstration of clinical competencies from their assigned units. (1) First, New Graduate RNs will fill out the self-assessment column in all of the applicable items. (2)Then, throughout the clinical preceptorship, New Graduate RNs will demonstrate the skills and their assigned preceptor or another experienced registered nurse validate and sign the completed item(s).

New Graduate RNs are strongly encouraged to complete the Medical-Surgical Competency Checklist items periodically, well before the Residency Program concludes. During Final Evaluation Week (**5/19/13 - 5/25/13**), New Graduate RNs will submit the original to the New Graduate RN Residency Program Coordinator.

New Graduate RN Soarian Competency Checklist

New Graduate RNs are expected to perform verbal and demonstration of the Registered Nurse Soarian Competency Checklist. (1) First, New Graduate RNs will fill out the self-assessment column. (2) Then, New Graduate RNs will demonstrate the skills and have their assigned preceptor or another experienced nurse validates and signs the completed item(s).

New Graduate RNs are strongly encouraged to complete the Soarian Registered Nurse Competency Checklist items before the end of Clinical Week 1. During Final Evaluation Week

New Graduate RN Soarian Competency Checklist (continued)
(**5/19/13 - 5/25/13**), New Graduate RNs will submit the original to the New Graduate RN Residency Program Coordinator.

CRITERIA FOR SUCCESSFUL COMPLETION OF RESIDENCY PROGRAM
To successfully complete the exit criteria for the New Graduate RN Residency Program, the following items must be filled out, signed, and submitted on-time to the New Graduate RN Residency Program Coordinator:

Item Description	Deadline
Case Study Report - 1 presentation	5/23/2013
IV Insertion Competency Form	1- 4/24/13 2- 5/22/13
Medical-Surgical Competency Checklist	5/22/2013
Soarian RN Competency Checklist	5/22/2013
8 - Weekly RN Clinical Evaluation Form	Following Wednesdays
Midterm RN Clinical Evaluation Form	5/1/2013
Final RN Clinical Evaluation Form	5/22/2013
Midterm Preceptor Evaluation Form	5/1/2013
Final Preceptor Evaluation Form	5/22/2013

Attendance	Quantity	Deadline
Tardiness	< 3 Total	5/30/2013

Absences	< 3 Total	5/30/2013

New Graduate RN may only be tardy < 3 times of total classroom and clinical days.

New Graduate RN may only be absent < 3 times of total classroom and clinical days.

REPORTING ABSENCES

Policy for late/missing assignments:
Late assignments are not accepted. The New Graduate RN is expected to act professionally and submit original work promptly.

Policy for tardiness or absence during classroom lecture:
If any unanticipated situation arises that will result in the New Graduate RN being tardy or absent during classroom lecture, please notify or leave a voice/text message:

******
CN-IV, New Graduate RN Residency Program Coordinator

Policy for tardiness or absence during clinical preceptorship:
If you are tardy or absent on your expected clinical day, please call your unit preceptor, staffing office **** and unit Assistant Nurse Manager/Manager.

Frequent absences and tardiness will be directed to the New Graduate RN Program Coordinator, Assistant Nurse Manager and Director of Inpatient Nursing for further action. All employees are expected to follow Alameda County Medical Center's Human Resources Policy and Standards of Behavior.

POLICY FOR CLOCKING-IN AND OUT-OF KRONOS
(Recording System of Time Keeping Punches)

To clock-in Kronos, know your assigned unit's cost center number. Before you swipe your badge, push the "Cost Center Transfer" button located on the top left corner of the time clock. Next, push the "enter" button. The Department's name of the cost center will appear on the screen. Then swipe your badge and you will be clocked in.

To clock out-out of Kronos, simply swipe your badge.

Unit-Specific Cost Center Numbers:

5East: #16172	7East: #16173	Pre-Op: # 17429	Float Pool: #98722
SDU: #16150	7West: #16174	SDS: #17430	

New Graduate RNs must enter their assigned unit's cost center number when they are attending classroom instruction and clinical preceptorship.

POLICY FOR RECORDING KRONOS VARIANCES

Outside of the Nursing Administration Office is a (1) white, Kronos Float Pool and New Grads Binder and a (2) red, Float Pool and New Grad Kronos Activity Log Binder. These Kronos binders are separate from other Nursing Units because two Administrative Assistants will be handling Kronos, [redacted]for New Graduates.

Individual Kronos time sheets will be printed out and filed in the New Graduate Kronos Binder on the Monday afternoon after Payday Friday.

In the event that there are time variances due to missed punches, meeting attendance, education leave, overtime, etc., be sure to fill-out the Kronos activity log sheet accordingly, and obtain the Manager/Assistant Nurse Manager/House Supervisor's signature on duty that day. Remember, the primary mode of clocking-in is with your badge swipe using Kronos clocks. If you come to work without your badge, you will not be allowed to enter the clinical area and perform patient care, nor will you be allowed to make-up clinical hours for that week.

It is the New Graduate RN's responsibility to stay on top of his or her hours. New Graduate RNs are strongly discouraged from changing their assigned work schedule as ANSOS is the checks and balance system for Kronos time reports. Any correction to Kronos time sheets and paychecks will **not** be issued without Management signature.

If there is a discrepancy of Kronos time sheets and/or live Paychecks, the deadline to submit written correction(s) for that affected pay period is:

(1) Wednesday at 1200pm of the week in which Kronos time sheets were placed in the Kronos binder
(2) The following Wednesday that paychecks were distributed on Payday dates.

Within 3-5 days after submitting correction to --[redacted]a live paycheck from the Payroll Department will be available for individual pick-up at the Fairmont Hospital Campus.

For questions/concerns about this process, please notify ********

NEW GRADUATE RN RESIDENCY PROGRAM
COMPLETION CRITERIA CHECKLIST

EMPLOYEE NAME:_____ UNIT:_____ DATE:_____

Instructions to the New Graduate RN Residency Program Coordinator: Please evaluate the New Graduate RN's overall classroom and clinical performance during the 11-week program. Check the appropriate box to ensure the following items are complete and submitted. All criteria items must be complete in order to successfully graduate from the New Graduate RN Residency Program.

Item Description	Submitted Yes/No	Date Completed	Initials	Comments
Case Study Report - 1 presentation				
IV Insertion Competency Form				
Medical-Surgical Competency Checklist				
Soarian RN Competency Checklist				
Shadow Rapid Response Team RN				
8 - Weekly RN Clinical Evaluation Form				
Midterm RN Clinical Evaluation Form				
Final RN Clinical Evaluation Form				
Midterm Preceptor Evaluation Form				
Final Preceptor Evaluation Form				

Attendance	Quantity	Dates Affected	Initials	Comments
Tardiness				
Absences				

New Graduate RN may only be tardy < 3 times of total classroom and clinical days.
New Graduate RN may only be absent < 3 times of total classroom and clinical days.

Did the New Graduate RN successfully complete all exit criteria? ☐ YES ☐ NO

Comments:

MIDTERM New Graduate RN Clinical Evaluation

Instructions to the Preceptor: Please evaluate the New Graduate RN's clinical performance over the past 4 weeks, responding to the
following questions and checking the boxes appropriately. This Midterm Evaluation will enable the New Graduate RN to set goals,
to promote professional behavior, and to improve nursing process and patient care delivery.

List overall strength:_____

List overall weakness:_____

*Meets Expectation is defined by RN being able to demonstrate item correctly and independently.

Clinical Competency Criteria	Meets Expectation	Does Not Meet Expectation	Comments for Improvement
Assessment: Correctly assesses a patient's physical, mental, and emotional status which leads to identification of health needs and creation of nursing care plan.			
Evaluation: Correctly evaluates a patient's response to nursing interventions and makes appropriate changes.			
Medications: Practices safe administration of medications.			
Safety: Provides a safe environment for patients and staff.			
Patient Teaching: Demonstrates appropriate education methods across the life span.			
Skills: Correctly performs nursing skills with efficiency.			
Time Management: Arranges nursing tasks with structure and completes promptly.			
Prioritization: Identifies critical assessments and implements appropriate interventions.			
Communication: Demonstrates verbal and written forms of describing relevant patient needs accurately and promptly.			
Professional Leadership: Demonstrates professional appearance, behavior, attendance, and responsibility of patient care.			

Overall, did the New Graduate RN meet weekly goals? ☐ YES ☐ NO

List the area(s) the New Graduate needs to improve and plan of action to successfully demonstrate clinical competency.

Clinical Performance Improvement Needs	Plan of Action

FINAL New Graduate RN Clinical Evaluation

Instructions to the Preceptor: Please evaluate the New Graduate RN's overall clinical performance during the past 10 weeks,
responding to the following questions and checking the box appropriately. This Final Clinical Performance Evaluation will enable
the New Graduate RN to set short and long term goals, promote professional behavior, and improve nursing process and patient
care delivery. This final evaluation also serves as a preceptor recommendation for successful completion of the residency program.

List overall strengths:
_____

List overall
weakness:_____
_____

*Meets Expectation is defined by RN being able to perform item correctly and independently.

Clinical Competency Criteria	Meets Expectation	Does Not Meet Expectation	Comments for Improvement
Assessment: Correctly assesses a patient's physical, mental, and emotional status which leads to identification of health needs and creation of nursing care plan.			
Evaluation: Correctly evaluates a patient's response to nursing interventions and makes appropriate changes.			
Medications: Practices safe administration of medications.			
Safety: Provides a safe environment for patients and staff.			
Patient Teaching: Demonstrates appropriate education methods across the life span.			
Skills: Correctly performs nursing skills with efficiency.			
Time Management: Arranges nursing tasks with structure and completes promptly.			
Prioritization: Identifies critical assessments and implements appropriate interventions.			
Communication: Demonstrates verbal and written forms of describing relevant patient needs accurately and promptly.			
Professional Leadership: Demonstrates professional appearance, behavior, attendance, and responsibility of patient care.			

Overall, did the New Graduate RN meet weekly goals? ☐ YES ☐ NO

Does the New Graduate RN demonstrate safe clinical competency as a Clinical Nurse I/II independently? ☐ YES ☐ NO

Comments:

Case Study Report

EMPLOYEE NAME:_____ UNIT:_____ DATE:_____

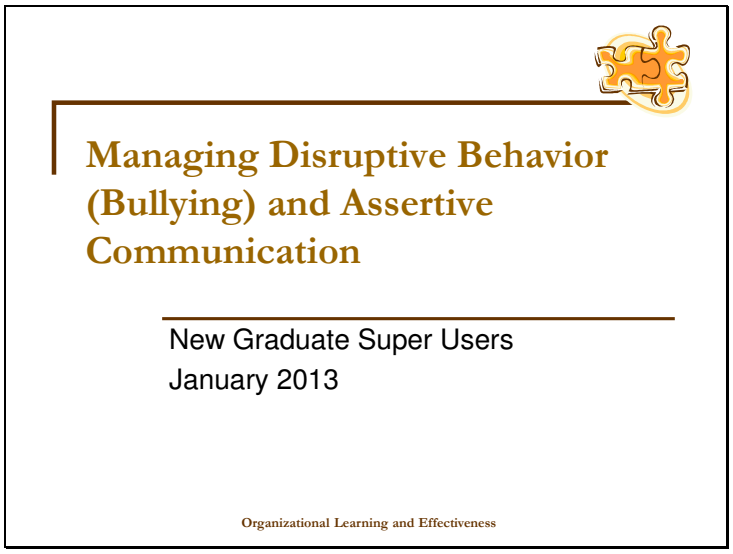
Appendix Q

EMR Super Users Training Classes

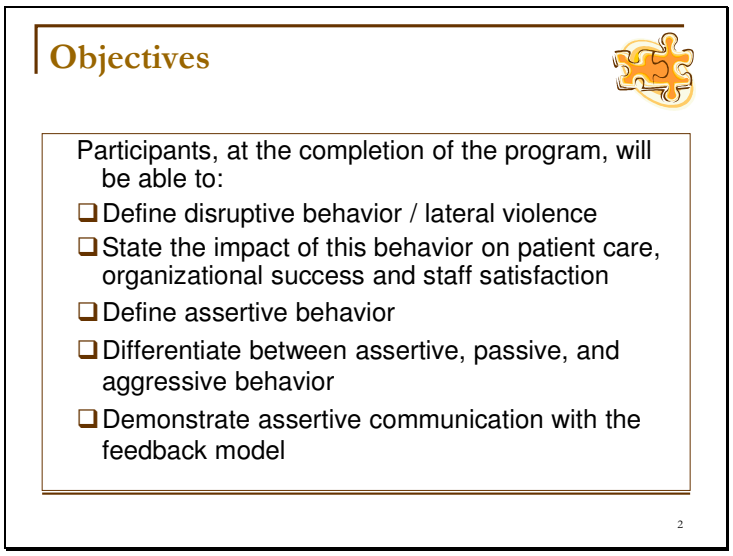
Created by OLE at ACMC

Managing Disruptive Behavior

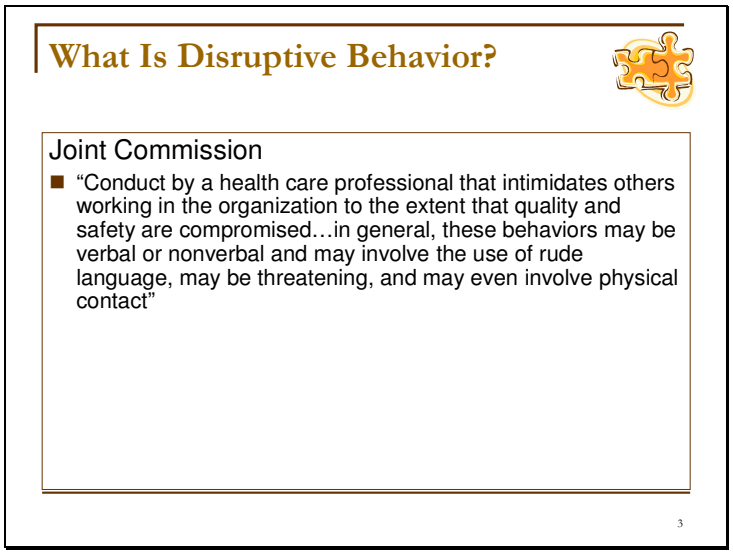
Slide 1



Slide 2

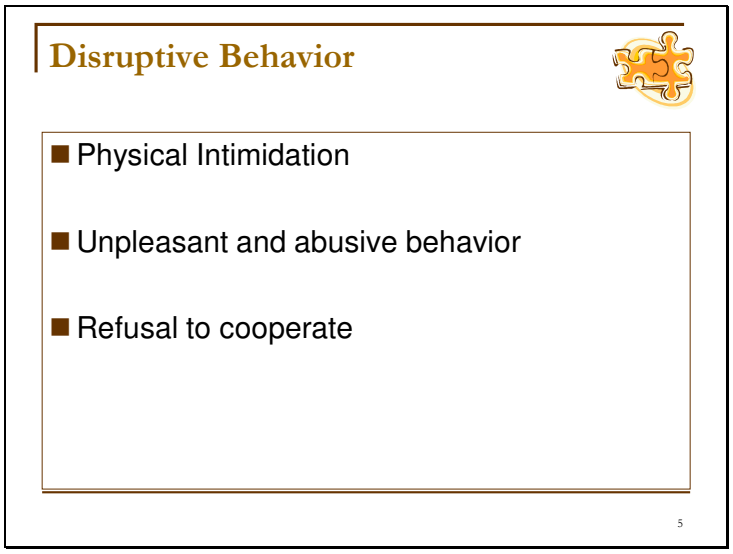

Objectives
Participants, at the completion of the program, will be able to:
Define disruptive behavior / lateral violence
State the impact of this behavior on patient care, organizational success and staff satisfaction
Define assertive behavior
Differentiate between assertive, passive, and aggressive behavior
Demonstrate assertive communication with the feedback model
2

Slide 3

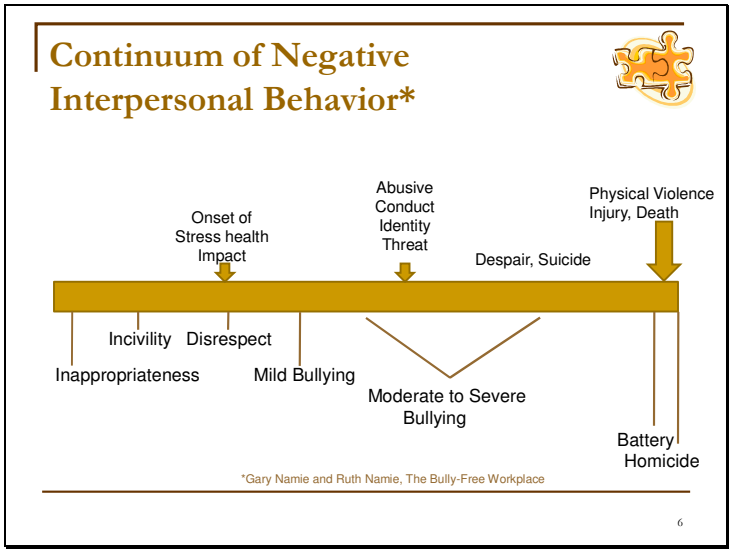

What Is Disruptive Behavior?
Joint Commission
"Conduct by a health care professional that intimidates others working in the organization to the extent that quality and safety are compromised…in general, these behaviors may be verbal or nonverbal and may involve the use of rude language, may be threatening, and may even involve physical contact"
3

Slide 4

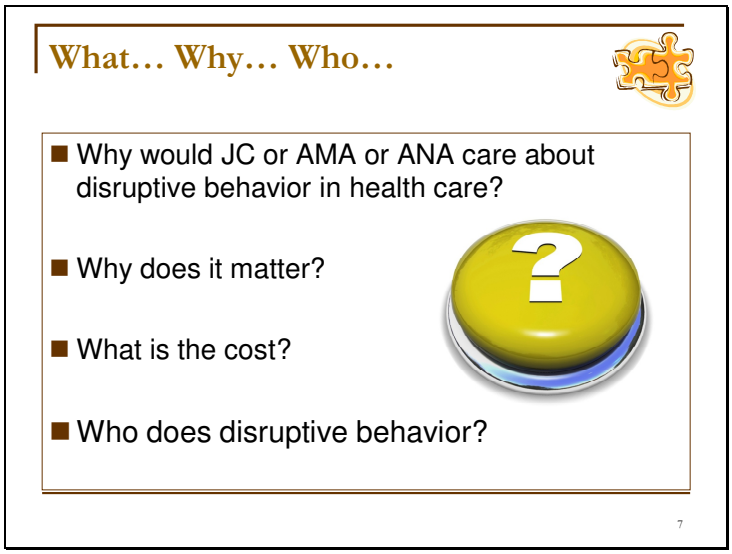
Slide 5



Slide 6



Slide 7



7% bad behavior of providers of health care contributed to medical errors (JC 2008 report)
Survey Institute for Safe Medication Practices – almost half of the respondents felt pressured to administer a drug even though they had serious and unresolved safety concerns

Need to move from acceptance/allow disruptive behavior in health care facilities – of avoid the disruptive person- resign self to putting up – tolerate - tell stories
Move to address, educate, support, building new stories that tell the culture
If we do not deal with behavior – we say it is ok – reinforce it

So if we know it is important and costly why don't EE report?

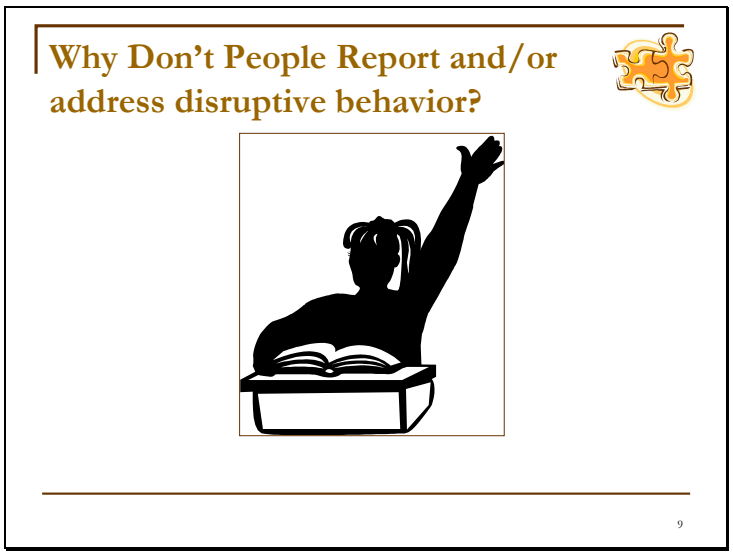
Slide 8

7% bad behavior of providers of health care contributed to medical errors (JC 2008 report)
Survey Institute for Safe Medication Practices – almost half of the respondents felt pressured to administer a drug even though they had serious and unresolved safety concerns

Need to move from acceptance/allow disruptive behavior in health care facilities – of avoid the disruptive person- resign self to putting up – tolerate - tell stories
Move to address, educate, support, building new stories that tell the culture
If we do not deal with behavior – we say it is ok – reinforce it

So if we know it is important and costly why don't EE report?

Slide 9



So if we know the cost and importance of reporting why don't we hear more?

Slide 10

Slide 11

Building the Skills and Will Assertiveness Is……

- Expressing yourself effectively and standing up for your point of view, while also respecting the rights and beliefs of others
- Based on mutual respect
  - You respect yourself, because you're willing to stand up for your interests and express your thoughts and feelings
  - Respect and awareness of the rights of others and willingness to work on resolving conflicts
- Balance of directness and sensitivity to other's feelings

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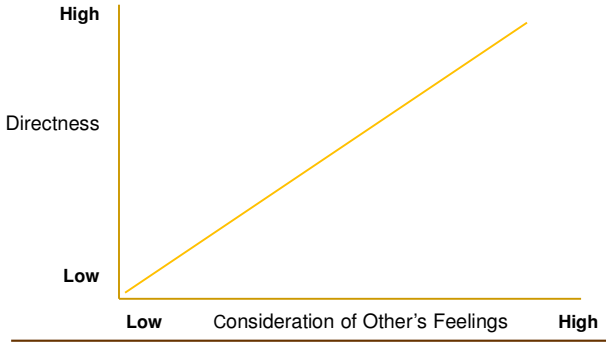
Slide 12

Assertive Behavior- A Balance



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Slide 13

Communication Styles

Submissive: individuals have a pattern of avoiding expressing their opinions or feelings, protecting their rights, and identifying and meeting their needs. It says "I'm not worth taking care of"

Aggressive: individuals express their feelings and opinions and advocate for their needs in a way that violates the rights of others

Passive Aggressive: individuals appear passive on the surface but are really acting out anger in a subtle, indirect, or behind-the-scenes way; subtly undermining; smile while setting booby traps all around you

Assertive: individuals express their feelings effectively and standing up for their point of view, while also respecting the rights and beliefs of others

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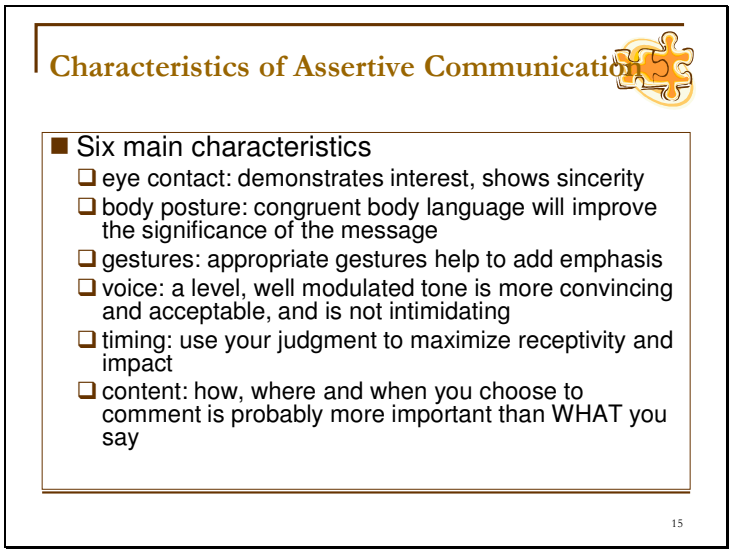
Slide 14

Balancing Act

Submissive	Assertive	Aggressive
•Avoid conflict or stating opinions •Use "we" statements •Message that my thoughts and feelings are not important •Can lead to resentment •Do not respond to hurtful or angry inducing situations	•Express needs/wants clearly and respectfully •Use "I" statements •Communicate respect for others and self •Listen without interrupting •Don't allow others to abuse or manipulate them	•Verbally or physically abusive; •Use of "you" statements •Dominate others •Rude, blame, critique in front of others •Use of fear •Speak loudly, over bearing, demanding •Poor listener, interrupts •"Nibbling" (Passive Aggressive Behavior)

14

Slide 15



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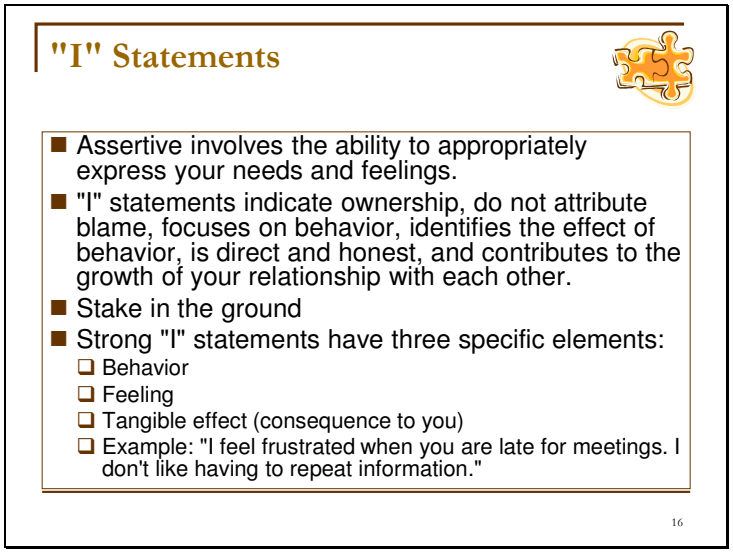

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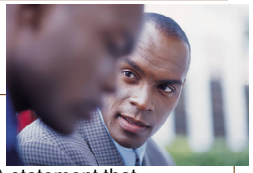
Feedback Model



- When to use
- Model
  - **Empathy/Validation:** (as appropriate) statement that demonstrates an understanding of the person's feelings
  - **See**
    - What is the behavior?
    - Specific
    - *Key step to success*
  - **Impact/feeling**
  - **Do**
  - **Check for Understanding**

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Feedback Examples

Examples
1. Some staff going to lunch and not involving others
2. Co-worker tells a pt – those new nurses don't know anything- don't know their head from a hole in the ground, ignore them
3. Physician yells at you in front of pt and pt's family
4. Co-worker consistently leaves work incomplete which dumps on you
5. Employee being trained on Sorian complains to other staff about your lack of skills and dumb system
6. Employee talking to another employee re: organizational "horror" stories at the front desk near patients
7. You witness a staff member yelling and finger pointing at a new nurse
8. Nursing manager for the 4th month in a row has changed your schedule, posted the changes without talking to you, given you shifts when you have to come back after 8 hours.

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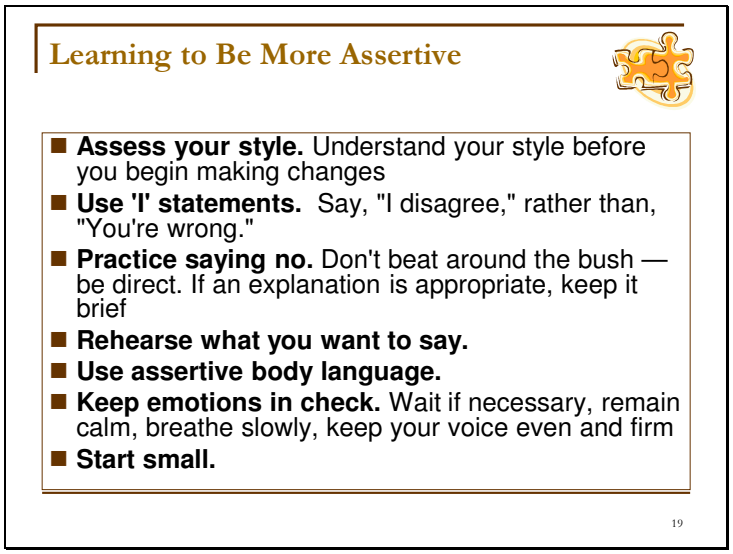
Slide 19



Do you voice your opinions or remain silent?
Do you say yes to additional work even when your plate is full?
Are you quick to judge or blame?
Do people seem to dread or fear talking to you?
People develop different styles of communication based on their life experiences. Your style may be so ingrained that you're not even aware of what it is. People tend to stick to the same communication style over time. But if you want to change your communication style, you can learn to communicate in healthier and more effective ways.
Here are some tips to help you become more assertive:

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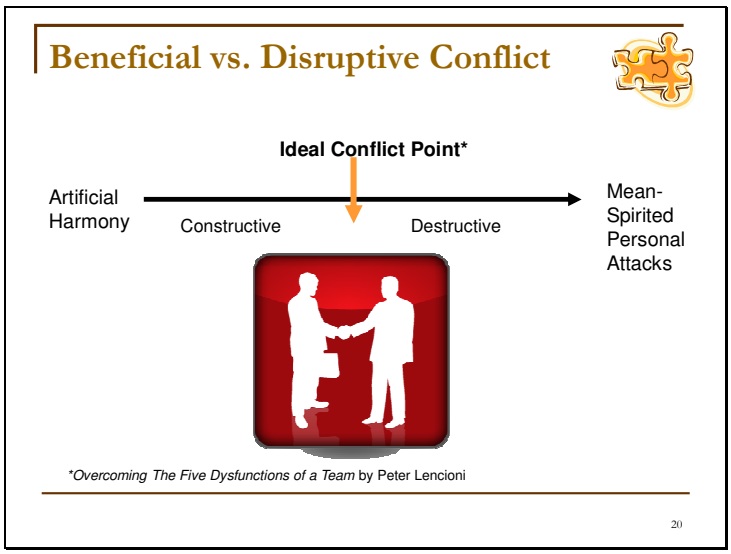

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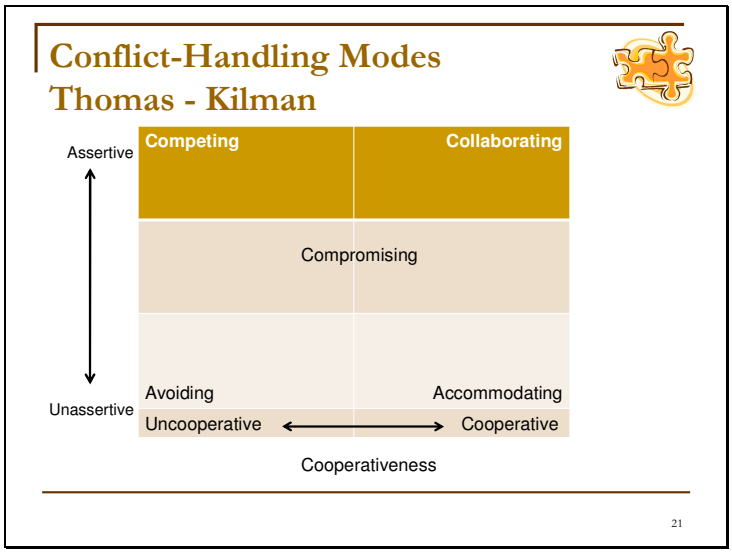

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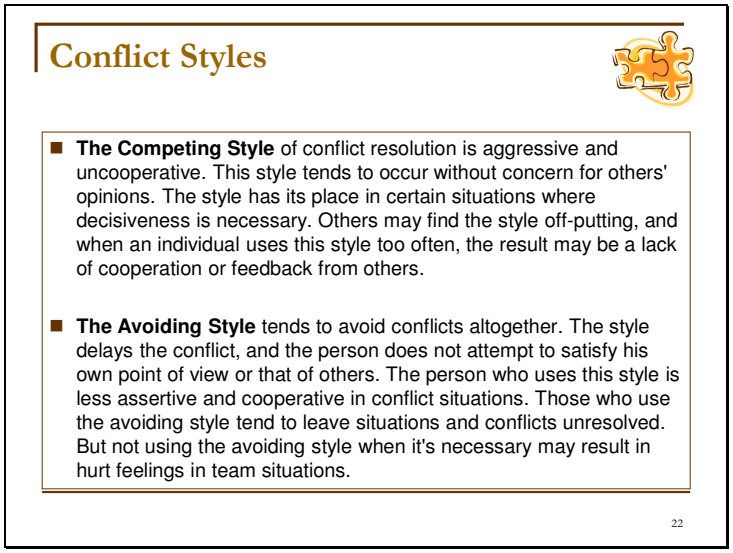

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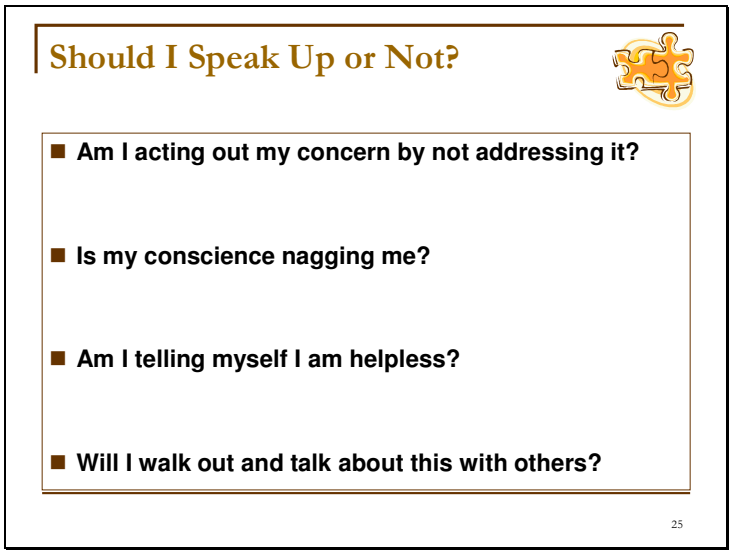

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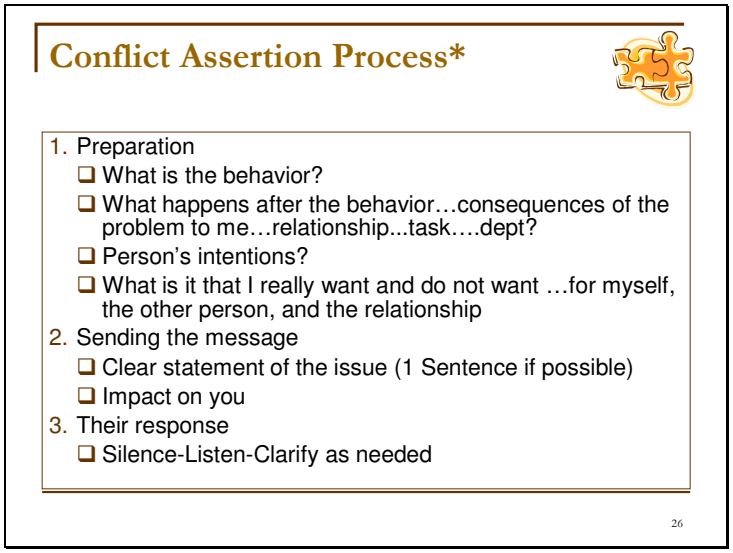

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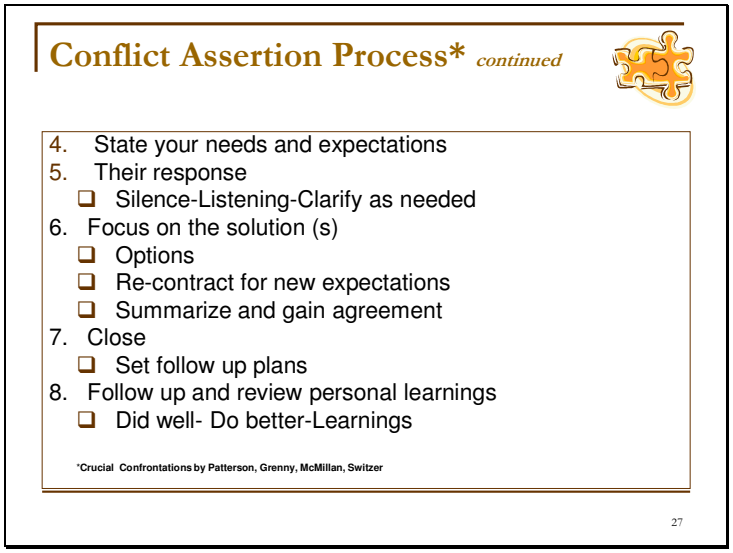

Slide 28

Feedback Examples

Examples
1. Co-worker tells a pt – those new nurses don't know anything- don't know their head from a hole in the ground, ignore them
2. Employee being trained on Sorian complains to other staff about your lack of skills and dumb system
3. You witness a staff member yelling and finger pointing at a new nurse
4. Nursing manager for the 4th month in a row has changed your schedule, posted the changes without talking to you, given you shifts when you have to come back after 8 hours.

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Slide 29

Tools For Dealing With Difficult Situations

Human-Business-Human

- Selective Agreement
- Acknowledge and Name the Emotion
- Identify with the Person
- Apology
- Supporting Actions

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Slide 30

To Give Is To Receive……

- Focus on the content, not the person
- Frame it as *data*
- Listen calmly
- Clarify *as needed*
- Acknowledge the concern
- Avoid defending or lengthy explanations
- ***Breathe***

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Slide 31

Few Secretes

- What vs. Why
- Prepare when possible
- Cool off when necessary
- Once it is done it is done!
- Importance of being heard vs. agreed with

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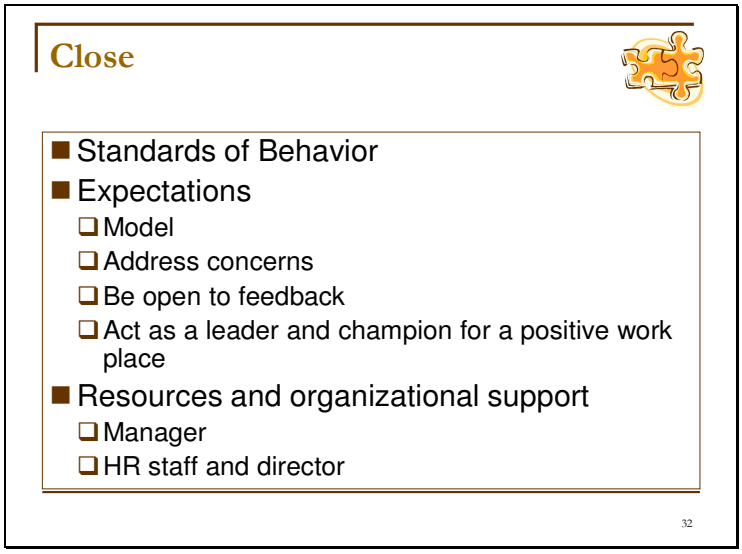

In this room you have 10% of the employee population which is a great base for change.

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Slide 34

Action Plan

The value of training is the participant's use of the information.
Actions I will take based on this training:
1.

2.

3.

One action to be taken in the next 48 hours

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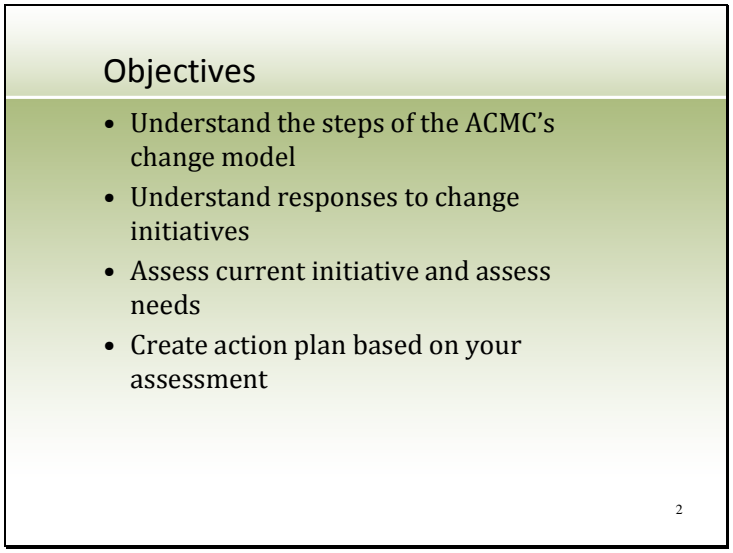
Super User Training

Change Leadership for Quality Patient Care

Created by OLE at ACMC

Slide 1

Slide 2



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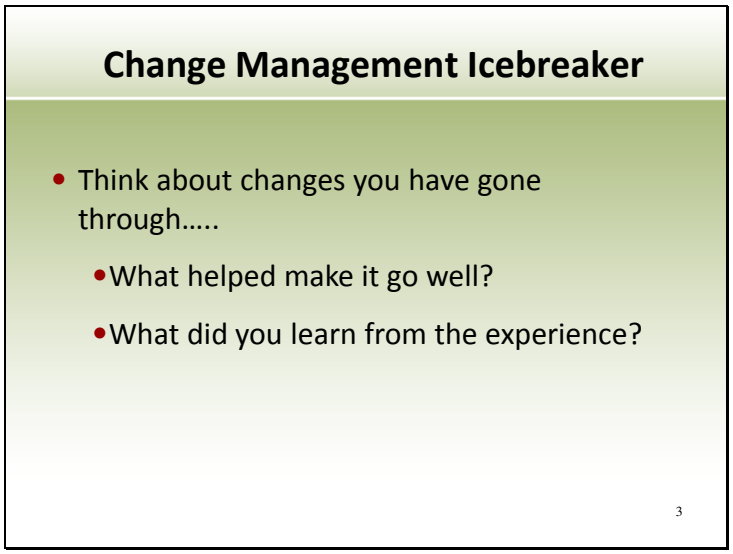

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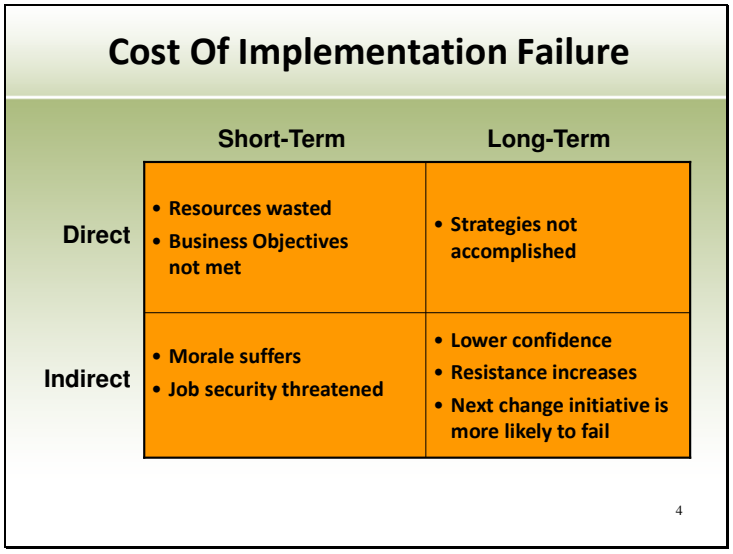

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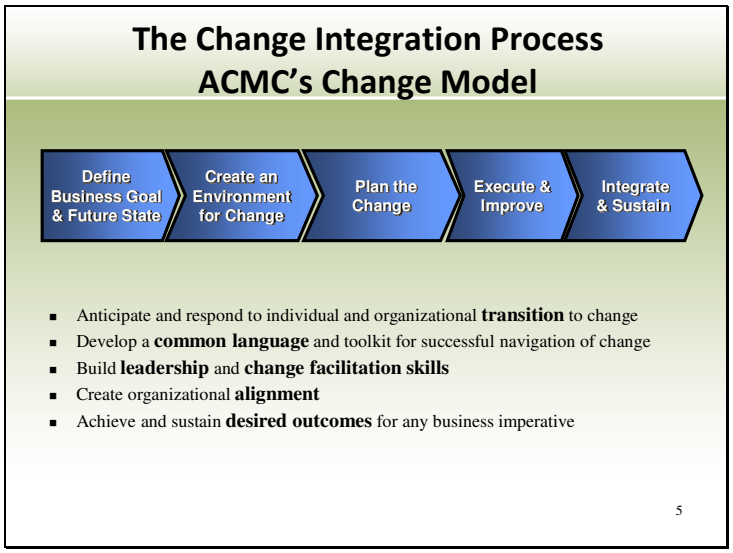

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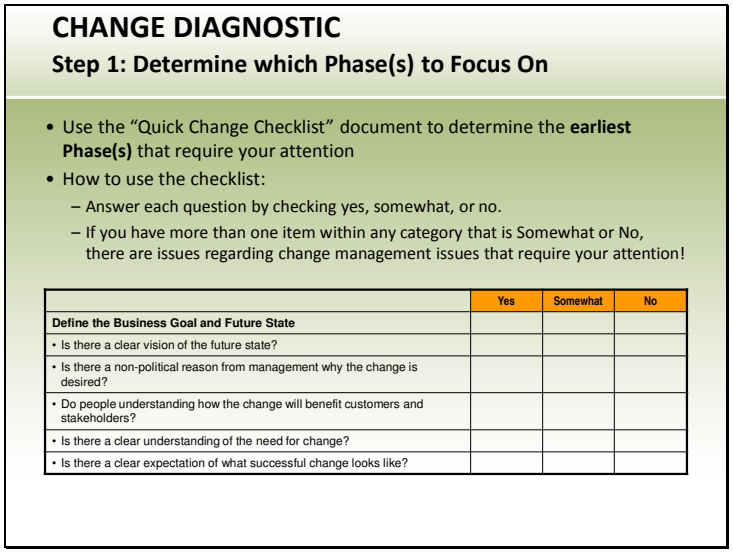

Slide 7

CHANGE DIAGNOSTIC

Step 1: Determine which Phase(s) to Focus On

	Yes	Somewhat	No
Create an Environment for Change			
• Is there recognition of who needs to be committed to the change in order to be successful?			
• Is there enough specificity so that the involvement can be useful?			
• Are leaders willing to act as champions for the future state?			
• Are leaders willing to commit resources to the implementation and sustainability of the change?			
• Is there a safe outlet for feedback including reactions, concerns and comments regarding the planned change?			
Plan for the Change			
• Have we assessed our organization's readiness for change?			
• Is there an understanding of how to sustain the change through modifying systems (such as staffing, training, appraisal, rewards, communication)?			
• Are there well-trained people with time available within the company to carry out the change plan?			
• Is there approval from a sponsor and stakeholders to proceed with the strategies for change?			
• Are there enough resources to carry out the strategies (people, time and money)?			

Slide 8

CHANGE DIAGNOSTIC

Step 1: Determine which Phase(s) to Focus On

	Yes	Somewhat	No
Execute & Improve			
• Are we following our change plan?			
• Are we modifying our change plan as needed?			
• Are we recognizing role models for this change?			
• Are we building upon our success and using change to create more change?			
• Is there a means of measuring successful change?			
• Will there be progress measurement at regular intervals during the project?			
• Are there process performance measures as well as results measures?			
• Are measures motivating the teams to work together?			
• Is there communication about measurement outcomes?			
Integrate and Sustain the Changes			
• Is there a short and long- term plan to keep attention focused on the change?			
• Have new measurement and reward systems been implemented?			
• Have new training and development systems been implemented?			
• Is the organization structure appropriate for the future state?			
• Does the organization have the skills / competencies to get the job done?			
• Is there understanding of how to sustain the change among leaders?			
• Is there a plan for adapting the change over time to shifting circumstances?			
• Is the support that people will need going forward understood?			

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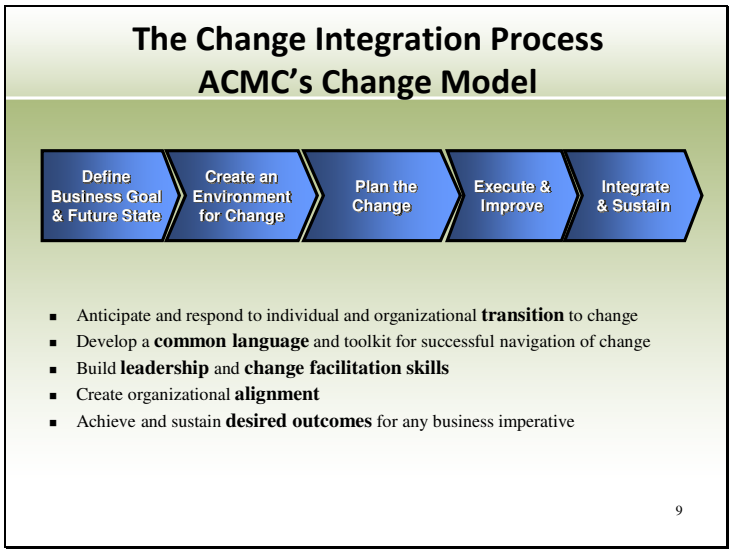

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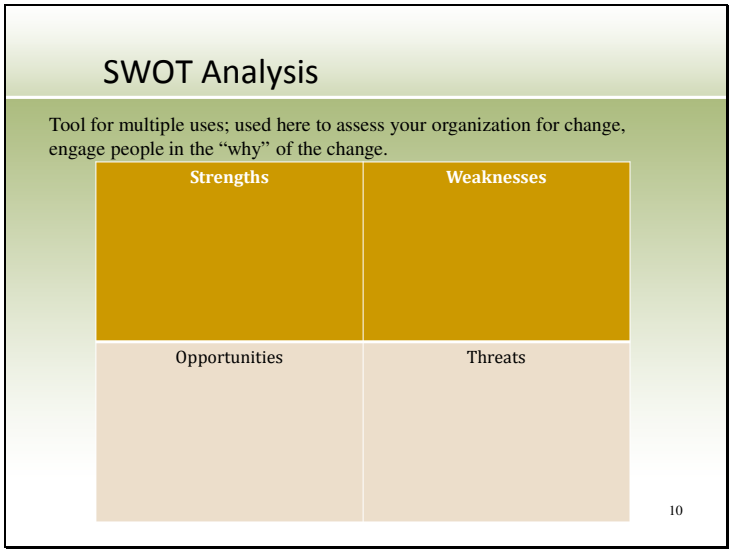

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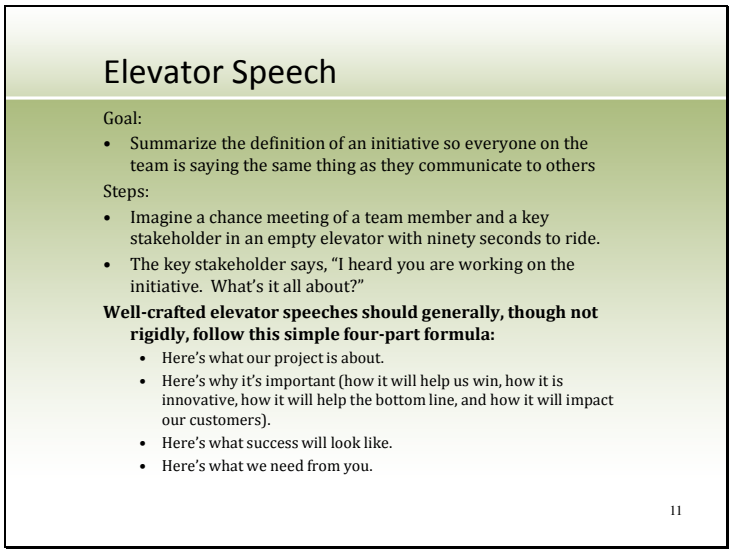

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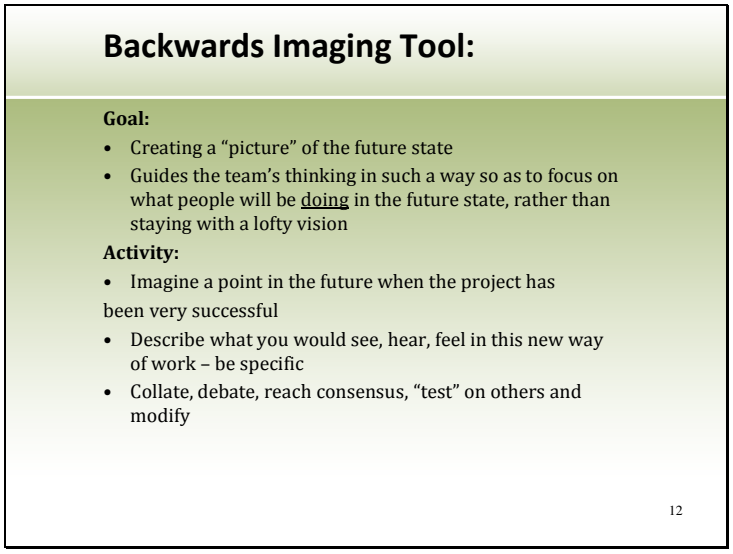

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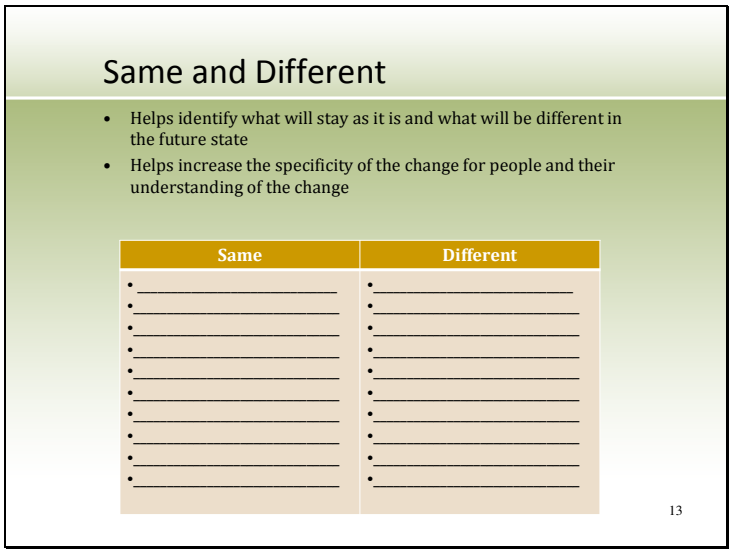

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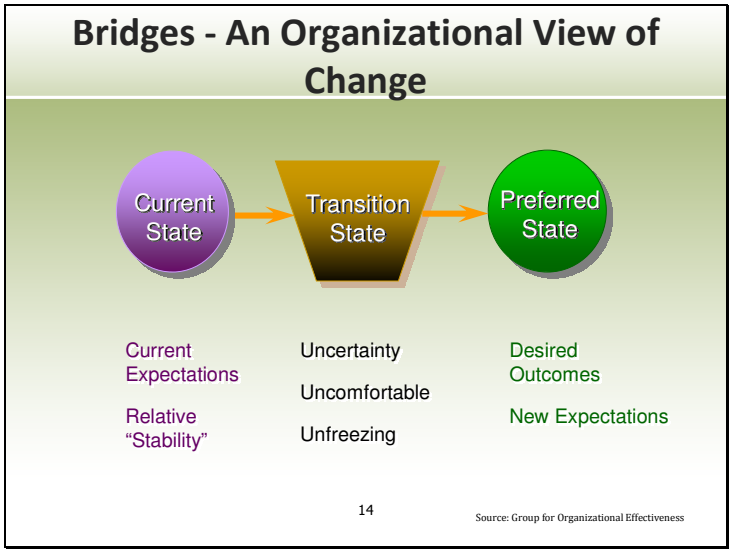

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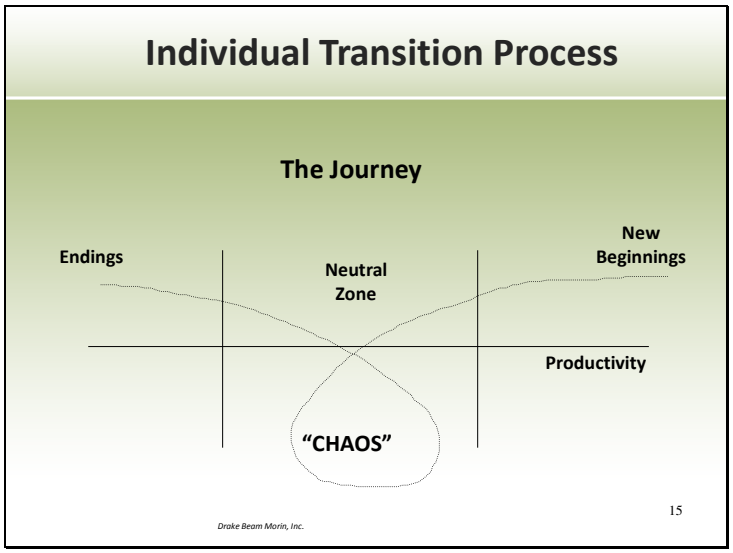

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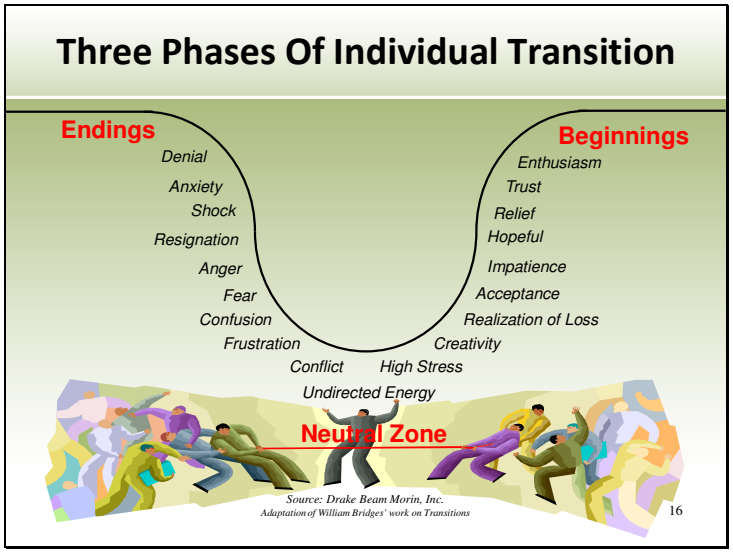
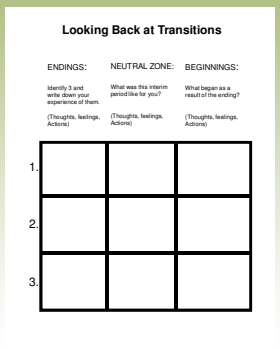


Slide 17

Looking Back at Transitions - 1

Instructions:

1. Work alone and take a few moments to "look back" at previous transitions you have made.
2. For each one, think about the 3 phases … Endings, Neutral Zone and Beginnings … and jot down some thoughts, feelings and/or actions that you recall.
3. Be prepared to share with the full group.



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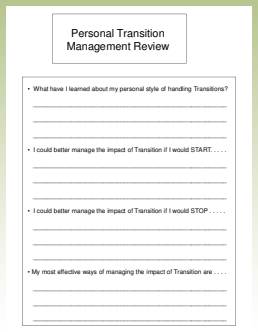
Slide 18

Looking Back at Transitions - 2

Instructions:

1. Now take a few moments to reflect on what you have learned and some things you should "start" or "stop" doing to improve your effectiveness in navigating through Transition
2. Be prepared to share with the full group.



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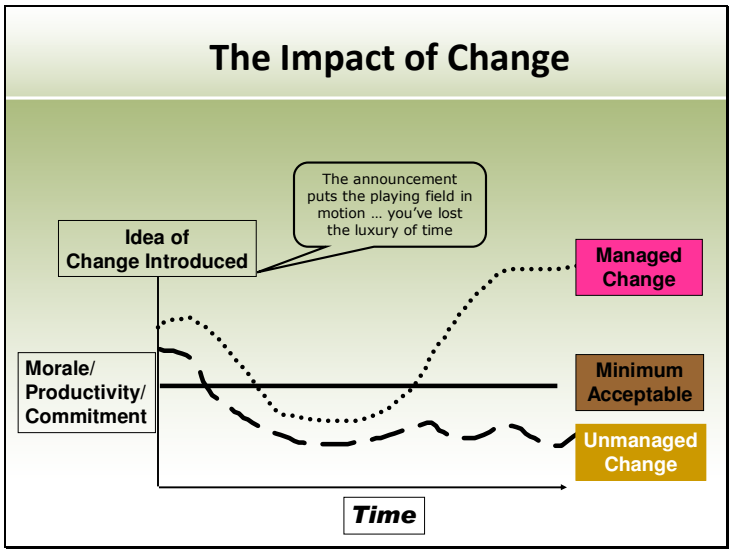

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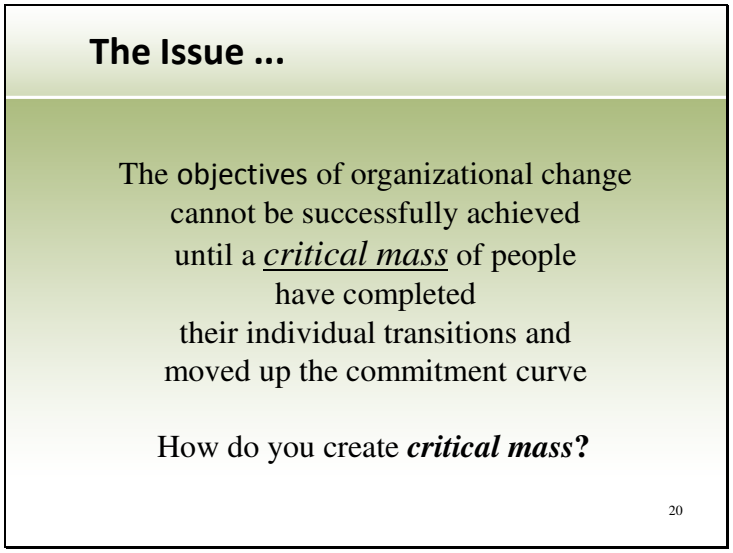

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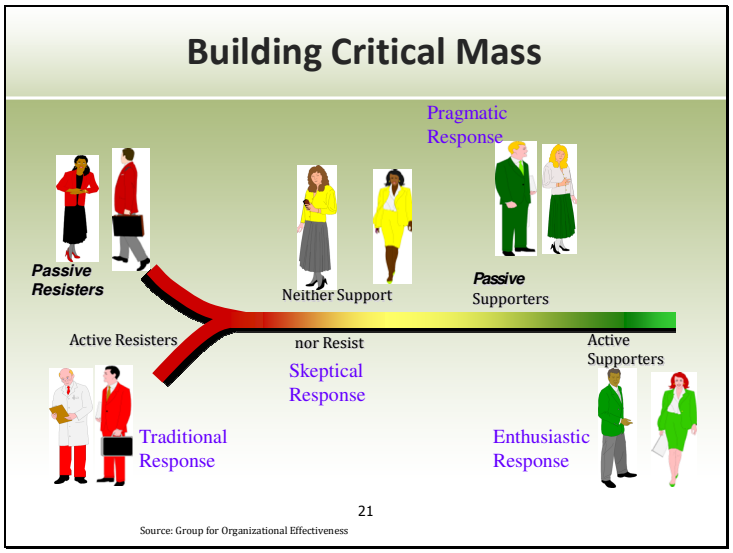

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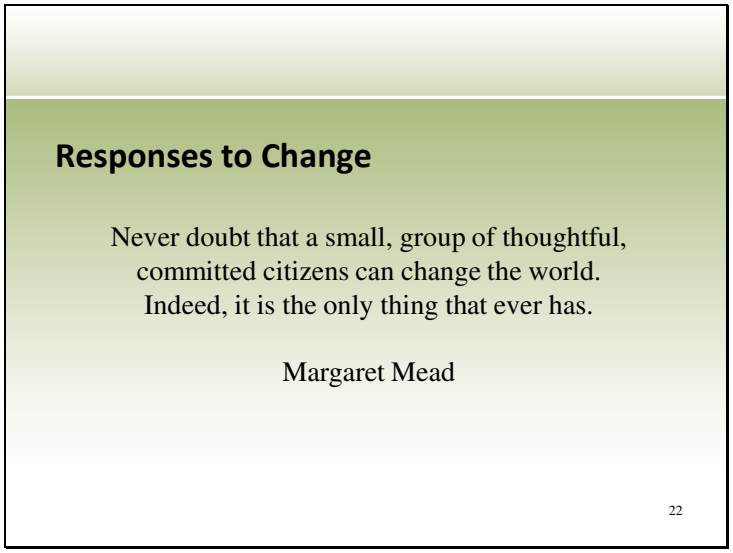

Slide 23

Successful Change

Core of change is about changing people's behavior which happens mostly by speaking to people's feelings *(Heath & Heath)*

- Leaders need to speak to the Elephant (emotional side) as well as to the Rider (rational side)
  - We need to direct the Rider and motivate, engage and acknowledge the Elephant.
- Change is not about ANALYZE-THINK-CHANGE

  SEE-FEEL-CHANGE

23

Slide 24

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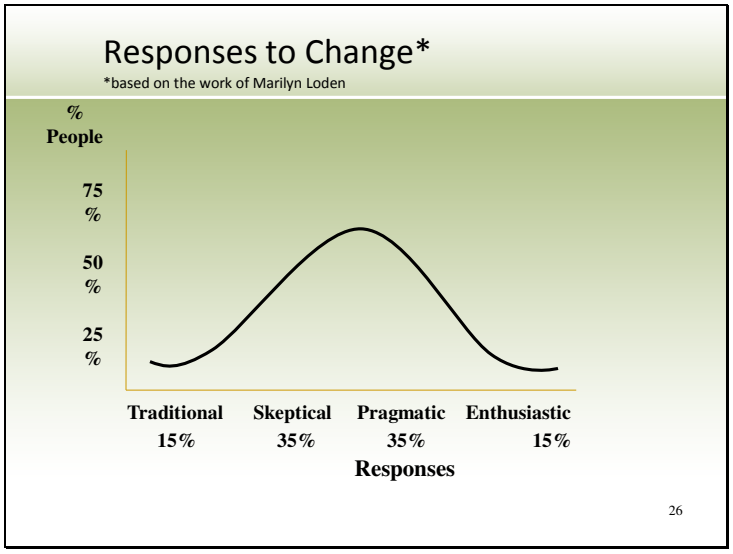
Slide 25

Slide 26



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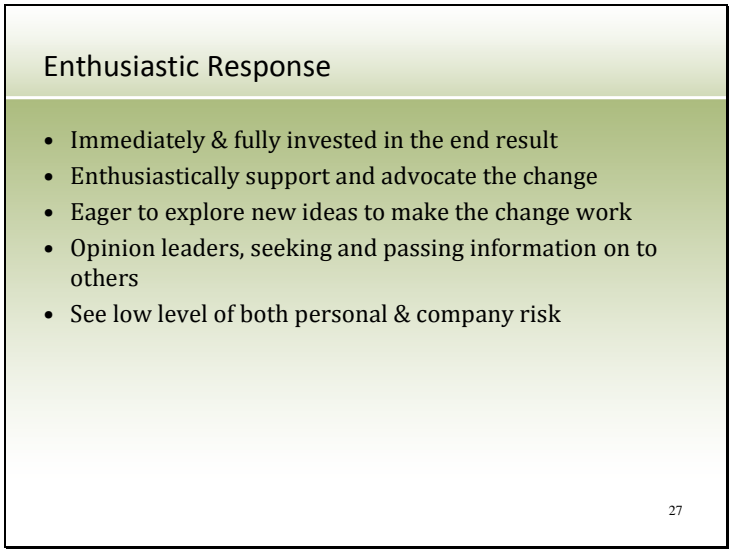

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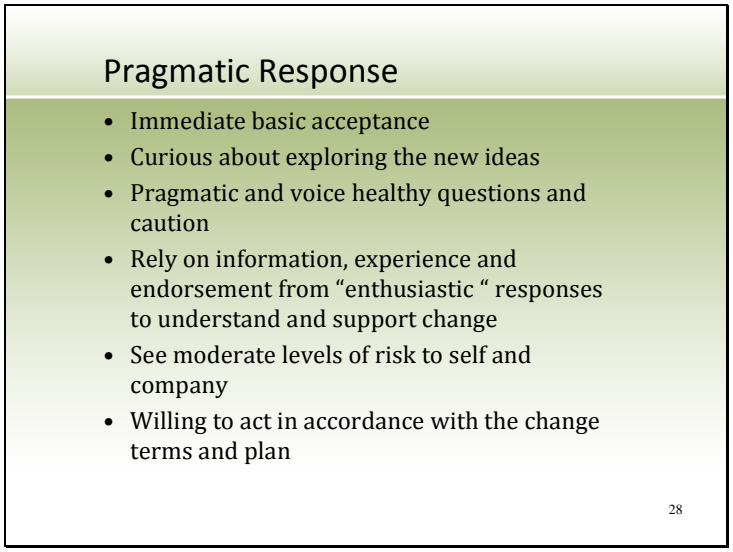

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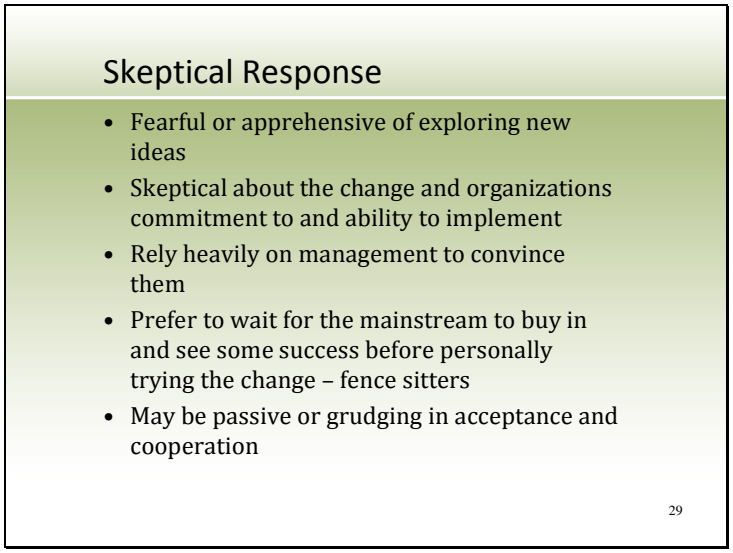

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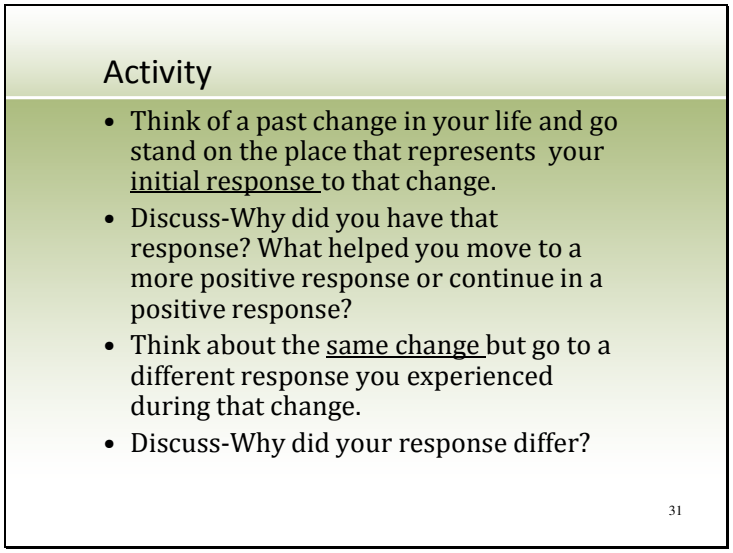

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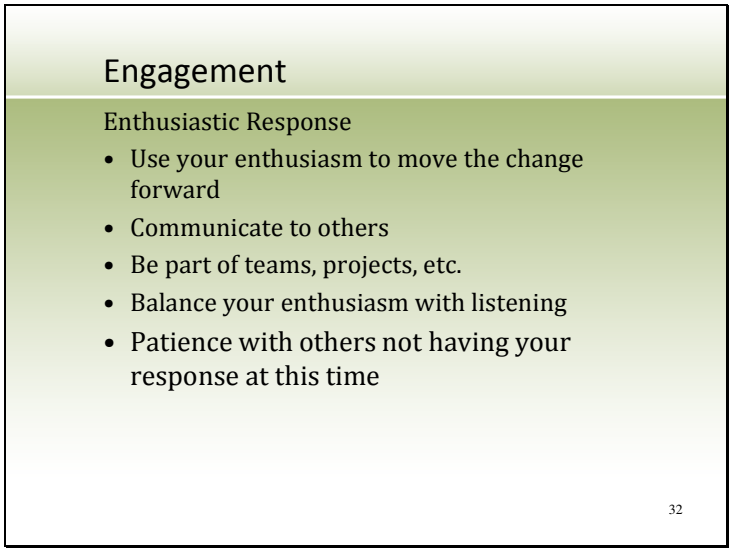

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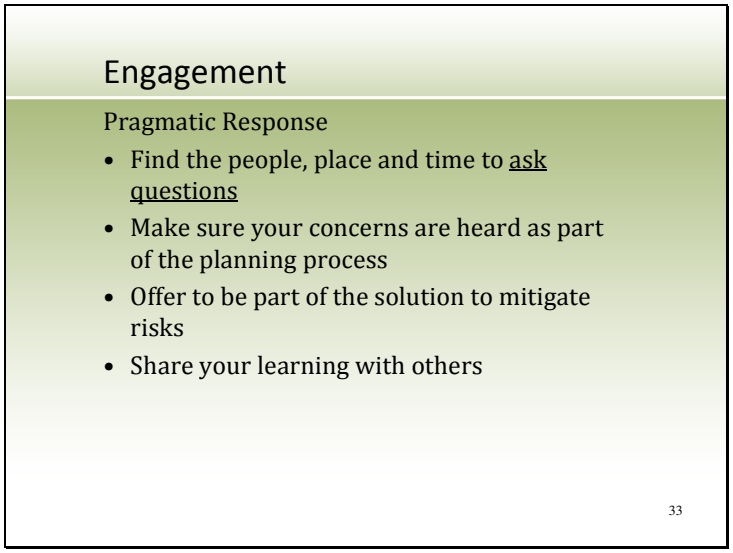

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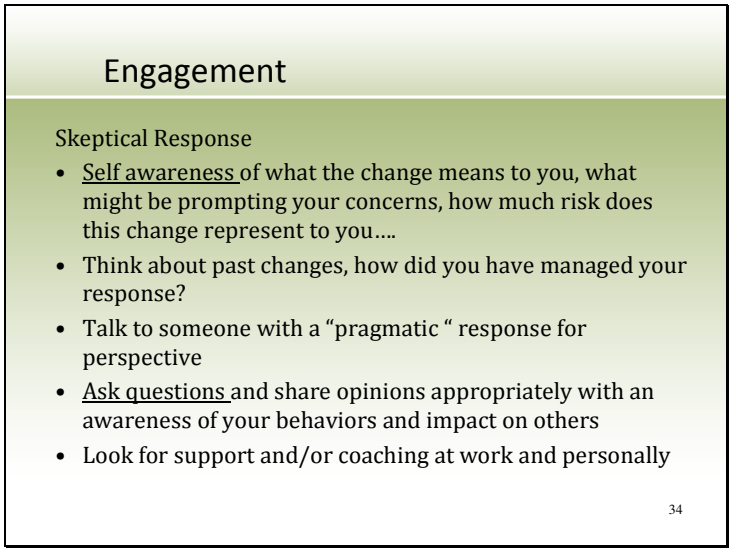

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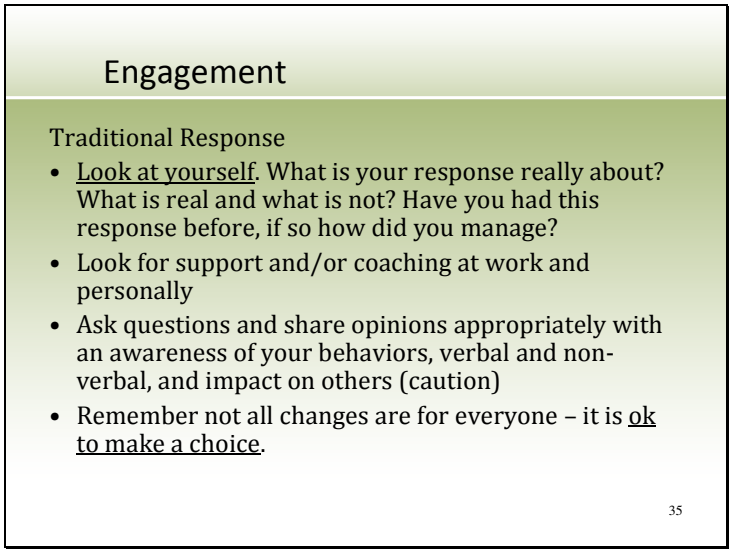

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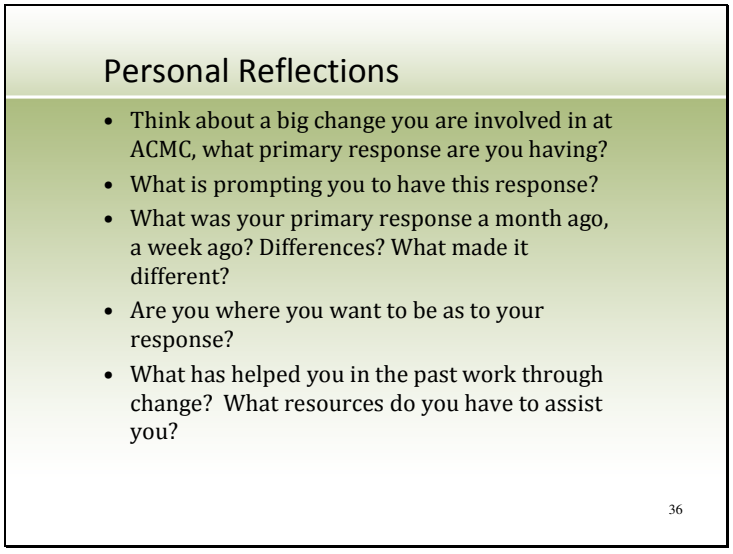

Slide 37

It takes a lot of courage to release the familiar and
seemingly secure, to embrace the new. But there is
no real security in what is no longer meaningful.
There is more security in the adventurous and
exciting, for in movement there is life, and in
change there is power.

Alan Cohen

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Slide 38

Change Continuum

Key Points

- Placement on the continuum is **not permanent**
- Organizations don't change, **individuals** change, so...
  - Must **know** how a person is responding to know how best to work with them
- Can't expect the **same action** to help everyone (it's why a team "pep talk" only goes so far)
  - **Different** people need different actions to help them work through the change
- **You** fall along the continuum too!
- Remember, if you move a few people **one notch** you'll start to build **critical mass**

Source: Adapted from Group for Organizational Effectiveness

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Slide 39

Knowing Responses

- How does knowing the responses to change supports your role?
  - What will you do differently?
  - How will you engage
  - How will you train people?
  - How will you communicate?
- How does this information help you with "self management"?

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Slide 40

What Is Change Management?

Change management involves getting individuals and groups **ready**, **willing**, and **able** to *implement* and *sustain* new ways of working

Ready	Willing	Able
Leaders communicate a clear vision **Associates understand the vision and why it is important to them and the business**	**Associates know their role in the vision and are excited about the future** **Associates believe there is a broad support of the vision**	**Associates are trained and have the tools to do the Work** **Associates are measured and rewarded for supporting the vision**

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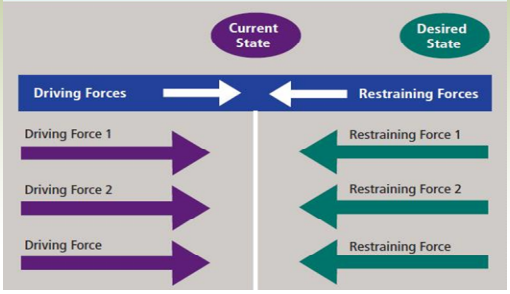
Slide 41

Force Field Analysis

Goal: Assess forces in the internal and external environment that will make change last or hinder change over the long term. Helps to develop plans to leverage forces that will support success and minimize or elevate those that may derail the change.

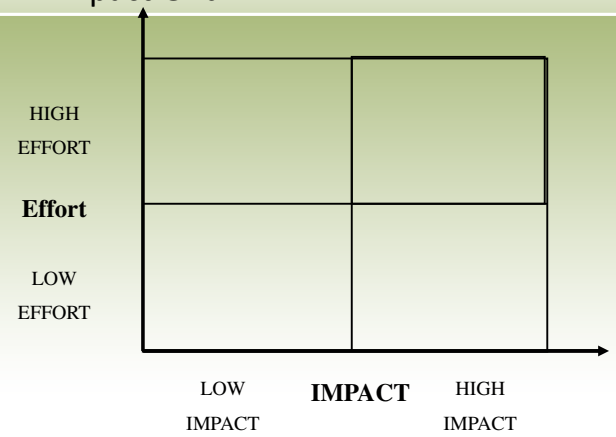
FIGURE 1: Force Field Analysis (2)



41

Slide 42

Impact Grid



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Slide 43

CHANGE DIAGNOSTIC

Step 1: Determine which Phase(s) to Focus On

- Use the "Quick Change Checklist" document to determine the **earliest Phase(s)** that require your attention
- How to use the checklist:
  - Answer each question by checking yes, somewhat, or no.
  - If you have more than one item within any category that is Somewhat or No, there are issues regarding change management issues that require your attention!

	Yes	Somewhat	No
Define the Business Goal and Future State			
• Is there a clear vision of the future state?			
• Is there a non-political reason from management why the change is desired?			
• Do people understanding how the change will benefit customers and stakeholders?			
• Is there a clear understanding of the need for change?			
• Is there a clear expectation of what successful change looks like?			

Slide 44

CHANGE DIAGNOSTIC

Step 1: Determine which Phase(s) to Focus On

	Yes	Somewhat	No
Create an Environment for Change			
• Is there recognition of who needs to be committed to the change in order to be successful?			
• Is there enough specificity so that the involvement can be useful?			
• Are leaders willing to act as champions for the future state?			
• Are leaders willing to commit resources to the implementation and sustainability of the change?			
• Is there a safe outlet for feedback including reactions, concerns and comments regarding the planned change?			
Plan for the Change			
• Have we assessed our organization's readiness for change?			
• Is there an understanding of how to sustain the change through modifying systems (such as staffing, training, appraisal, rewards, communication)?			
• Are there well-trained people with time available within the company to carry out the change plan?			
• Is there approval from a sponsor and stakeholders to proceed with the strategies for change?			
• Are there enough resources to carry out the strategies (people, time and money)?			

Slide 45

CHANGE DIAGNOSTIC

Step 1: Determine which Phase(s) to Focus On

	Yes	Somewhat	No
Execute & Improve			
• Are we following our change plan?			
• Are we modifying our change plan as needed?			
• Are we recognizing role models for this change?			
• Are we building upon our success and using change to create more change?			
• Is there a means of measuring successful change?			
• Will there be progress measurement at regular intervals during the project?			
• Are there process performance measures as well as results measures?			
• Are measures motivating the teams to work together?			
• Is there communication about measurement outcomes?			
Integrate and Sustain the Changes			
• Is there a short and long- term plan to keep attention focused on the change?			
• Have new measurement and reward systems been implemented?			
• Have new training and development systems been implemented?			
• Is the organization structure appropriate for the future state?			
• Does the organization have the skills / competencies to get the job done?			
• Is there understanding of how to sustain the change among leaders?			
• Is there a plan for adapting the change over time to shifting circumstances?			
• Is the support that people will need going forward understood?			

Slide 46

Change is inevitable, except from vending machines.

Unknown

46

Slide 47

Questions

47

Slide 48

Action Plan

The value of training is the participant's use of the information.
Actions I will take based on this training:
1.

2.

3.

One action to be taken in the next 48 hours

48

Appendix R

What to Chart

ALAMEDA COUNTY MEDICAL CENTER

Highland Campus • Fairmont Campus
John George Psychiatric Pavilion
Ambulatory Healthcare Services

WHAT & HOW OFTEN TO DOCUMENT CHECKLIST

ns: Refer to this checklist to ensure
have everything documented that is
.
:ck List
ents**^
Assessment – Physical (Every 4 hours &
PRN Clinical change)
- Assessment
- HEENT
- Neurological
- Cardiovascular
- Gastrointestinal
- Respiratory
- Genitourinary
- Musculoskeletal
- Integumentary
- Wounds (sites 5-8)
- PsychoSocial
- Pain
- IV Site
- Braden
- Fall Risk
- Vitals (Q4 & more frequently PRN; If Ill=Q2 & more frequently PRN)

:ducation (Q 8 HRS & PRN, Take the
redit, document!)
- Translator/Translation items

- ADL (Q 4 Hours)
  - Can document the following items:
    - Isolation
    - Turn / Reposition (Q 2 HRS)
    - SCD
    - Fall and Skin interventions
    - Incentive Spirometry (Per Order)
- Sepsis Screen (0800, 1600, 0000 hrs)
- Intake and Output (Q 8 Hours)
- Notification

Misc Assessments
- ETOH Assessment (Q 4 Hours & more frequently PRN)
- Restraint
  - Initiation
  - Monitoring (Q 2 Hours & more frequently PRN)
- Epidural (Q 4 Hours)
- PCA (Q 4 Hours & More frequently PRN)
- Pre-Op Checklist (PRN OR)
- Point of Care
- Transfusion – also requires Blood Bank

paper documentation.
in chart & send original
bank with empty bag.

Orders
- Acknowledge
- Review active orders
- Check Worklists for:
  - Medications to
  - Specimens to B
  - Interventions

Meds
- Verify
- Administer Meds
- For applicable meds, cc
  off/2nd RN co-sign in M

Resources available in OAS Gol
- Face Sheet
- Labels
- ADT functions

Paper
- Consents
- Nursing Care Plan
- Hourly Rounding

* some assessments are part of
assessment as well as a standal
^ if assessment is not on your fi
on the "All" tab

Admission Check List
Allergies
Home Medication Collection
Assessments*^

- Admission
  - Admission
  - Past Med/Surg History
  - Patient History
  - Influenza
  - Pneumococcal
  - Belongings
  - Vitals (Q4 & more frequently PRN; ICU=Q2 & more frequently PRN)
- Assessment – Physical (And Q 4 hours & PRN Clinical change)
  - Assessment
  - HEENT
  - Neurological
  - Cardiovascular
  - Gastrointestinal
  - Respiratory
  - Genitourinary
  - Musculoskeletal
  - Intugementary
  - Wounds (sites 5-8)
  - PsychoSocial
  - Pain
  - IV Site
  - Braden
  - Fall Risk
  - Vital Signs (Q4 & more frequently PRN; ICU=Q2 & more frequently PRN)
- Education (Q 8 HRS & PRN, Take the credit, document!)
  - Translator/Translation items
- ADL (Q 4 Hours)
  - Can document the following items:
    - Isolation
    - Turn/ Reposition (Q 2 HRS)
    - SCD
    - Fall and Skin interventions
    - Incentive Spirometry (Per Order)
    - MRSA Screen completed
- Belongings
  - Complete form in Soarian & print for patient signature
- Sepsis Screen (0800, 1600, 0000 hrs)
- Intake and Output (Q 8 Hours)
- Notification

Misc Assessments

- ETOH Assessment (Q 4 Hours)
- Restraint
  - Initiation
  - Monitoring (Q 2 Hours & more frequently PRN)
- Epidural (Q 4 Hours)
- PCA (Q 4 Hours & more frequently PRN)
- Pre-Op Checklist (PRN OR)
- Point of Care
- Transfusion – also requires Blood Bank paper documentation. Keep paper copy in chart & send original back to Blood bank with empty bag.

Orders

- Acknowledge
- Confirm appropriate notices to ancillaries generated from assessments (nutrition, pharmacy, social services)
- Check Worklists for:
  - Medications to be Administered
  - Specimens to Be Collected
  - Interventions

Meds

- Verify
- Administer Meds
- For applicable meds; complete hand-off/2nd RN co-sign in MAK

Resources available in OAS Gold

- Face Sheet
- Labels
- ADT functions

Paper

- Consents
- Nursing Care Plan

* some assessments are part of a chaptered assessment as well as a standalone assessments
^ if assessment is not on your filtered list, check on the "All" tab

Transfer to Your Unit

- Verify the following are completed
  - Admission form and Home Medications
  - Patient belongings

Assessments*^

- Assessment – Physical (and every 4 hours & PRN Clinical change)
  - Assessment
  - HEENT
  - Neurological
  - Cardiovascular
  - Gastrointestinal
  - Respiratory
  - Genitourinary
  - Musculoskeletal
  - Intugementary
  - Wourds (sites 5-8)
  - PsychoSocial
  - Pain
  - IV Site
  - Braden
  - Fall Risk
  - Vital Signs (Q4 & more frequently PRN; ICU=Q2 & more frequently PRN)
- Education (Q 8 HRS & PRN, Take the credit, document!)
  - Translator/Translation items
- ADL (Q 4 Hours)
  - Can document the following items:
    - Isolation
    - Turn / Reposition (Q 2 HRS)
    - SCD
    - Mode of arrival in comments
    - Fall and Skin interventions
    - Incentive Spirometry (Per Order)
    - MRSA Screen completed
- Sepsis Screen (0800, 1600, 0000 hrs)
- Intake and Output
- Notification

Misc Assessments

- As needed

Orders

- Trarsfer to a different level of care requires the physician to discontinue orders and enter new orders
- Acknowledge
- Review active orders
- Check Worklists for:
  - Medications to be Administered
  - Specimens to Be Collected
  - Interventions

Meds

- Verify
- Administer Meds
- For applicable meds; complete hand-off/2nd RN co-sign in MAK

Paper

- Consents
- Nursing Care Plan
- Hourly Rounding

Transfer From Your Unit

- Verify the following are completed
  - Admission form and Home Medications
  - Patient belongings
- Complete and fax No Delay Nursing Report
- Call to answer questions from receiving nurse and confirm No Delay Nursing Report received
- Complete hand-off/2nd RN co-sign in MAK for PCA
- Document skin condition

Orders

- Transfer to a different level of care requires the physician to discontinue orders and enter new orders

Discharge Home

Remember:

- MRSA screening if meets criteria
- Adult influenza/pneumococcal immunization protocol
- Discontinue lines
- Document skin condition

Nurse (many disciplines have part in providing discharge instructions to the patient, the steps below highlight nursings' role)

Once Nurse sees Discharge Instructions in Scheduled/In progress Assessments and orders for Discharge, they will perform the following

- Open Discharge Instructions form
  - Has Physician entered Discharge Instructions?
    - If No-- The nurse will need to be educated to close the Discharge Instructions, notify Physician to fill out order and then the nurse can open and complete the Discharge Instructions.
    - If Yes-- Review / Update Discharge Instructions form as needed. Examples: provide information on dressing supplies and handouts given.
    - If Social Worker, Utilization Review, Schedulers and Ancillary Rehab have documented on designated discharge forms the information will display on Discharge Instructions form.
    - Save IN Progress Status.
- Print Discharge Instructions via Print function while in Patient Record.
  - Print Discharge Instructions from Assessment Time View Reports.
  - Print Discharge Medications List
  - Print Belongings
- Nurse provides Nursing Instructions, Patient Belongings and Medication Scripts and Discharge Medications Instructions to Patient
- Nurse can fax Discharge Medication Instructions to the Highland Pharmacy
- Patient Discharged from facility.
- Open Discharge Instructions Assessment and complete appropriate fields. Sign status of Complete.
- Complete other forms as appropriate - Discharge Assessment form

Discharge to Fairmont/Other Facility

Remember:

- MRSA screening if meets criteria
- Adult influenza/pneumococcal immunization protocol
- Discontinue lines
- Document skin condition
- Additional information can be printed if the facility requires it

Nurse (many disciplines have part in providing discharge instructions to the patient, the steps below highlight nursings' role)

Once Nurse sees Discharge Instructions in Scheduled/In progress Assessments and orders for Discharge, they will perform the following

- Open Discharge Instructions form
  - Has Physician entered Discharge Instructions?
    - If No-- The nurse will need to be educated to close the Discharge Instructions, notify Physician to fill out order and then the nurse can open and complete the Discharge Instructions.
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  - Print Discharge Instructions from Assessment Time View Reports.
  - Print Discharge Medications List
  - Print Belongings
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- Nurse can fax Discharge Medication Instructions to the Highland Pharmacy
- Patient Discharged from facility.
- Open Discharge Instructions Assessment and complete appropriate fields. Sign status of Complete.
- Complete other forms as appropriate - Discharge Assessment form

Discharge to Morgue

- MD to:
  - Notify next of kin
  - Write death note
- RN to:
  - Inform MD
  - Document on Postmortem form (found in the Documentation 'All' tab in Soarian)
- Complete care
  - Discontinue lines (if coroners case do not discontinue lines)
  - Post mortem care (cadaver shroud, tags)

Appendix S

RN Quick Reference Sorian Document

NURSES

SOARIAN CHEAT SHEET

EFER
O THIS
HECKLIST
O ENSURE
OU
OCUMENT
LL THAT IS
EQUIRED

- ASSIGN PATIENTS
- ASSESSMENTS
- ADMISSIONS
- DOCUMENTATION
- TRANSFERS
- DISCHARGES
- MAK
- PCA
- SPECIMEN COLL.
- ICONS

ALAMEDA

ASSIGN PATIENTS

- Click on the *Assign* Icon
- Click in the *time field* and enter the time your assignment ends
- Click on the box that says *Assign* to the right of the patient
- Click *Save* at the bottom of the screen
- You will get a pop-up screen that states Assign was saved successfully.
- Click *Close*
- Upon returning to the Census, the patients you have assigned are now at the top of the list.

ASSESSMENT

- Sepsis Screen (**0800,1**
- Intake and Output (**Q**
- Notification Misc Asse
- ETOH Assessment (**Q4 Hours and/or PRN**
- Restraint
  - Initiation
  - Monitoring (**Q2 hrs and/or**
- Epidural (**Q4 hrs**)
- PCA (**Q4 hrs and/or P**
- Pre-Op Checklist (**PRN**
- Point of Care
- Transfusion – also requ
  Bank paper docume
  Keep paper copy in
  send original back to
  Bank with empty bag

Orders

- Acknowledge
- Review active orders
- Check Worklists for:
  - Medications to Administered

continued...

- Specimens to Be Collected
- Interventions

Meds
- Verify
- Administer Meds
- For applicable meds; complete hand-off/2nd RN co-sign in MAK

Resources available in OAS Gold
- Face Sheet
- Labels
- ADT functions

Paper
- Consents
- Nursing Care Plan
- Hourly Rounding

Note: *some assessments are part of a chaptered assessment as well as a standalone assessments*
^ *if assessment is not on your filtered list, check on the "All" tab*

ASSESSMENT CHECKLIST

Assessment
(Q4 hrs & PRN clinical change)

- Physical Assessment
  - Assessment
  - HEENT
  - Neurological
  - Cardiovascular
  - Gastrointestinal
  - Respiratory
  - Genitourinary
  - Musculoskeletal
  - Integumentary
  - Wounds (sites 5-8)
  - Psychosocial
  - Pain
  - IV Site
  - Braden
  - Fall Risk
  - Vitals (**Q4 hrs & more frequently PRN; ICU = Q2 hrs and/or PRN**)
- Education (**Q8 hrs & PRN; Take the credit & document!**)
  - Translator/translation items
- ADL (**Q4 hrs**)

Can document the following items:
- Isolation
- Turns/Reposition (**Q2 hrs**)
- SCD
- Fall & Skin interventions
- Incentive Spirometry (**per order**)

continued...

ADMISSION CHECKLIST

Allergies

Home Medication Collection

Assessments

Admission
- Admission
- Past Med/Surg History
- Patient History
- Influenza
- Pneumococcal
- Belongings
- Vitals (**Q4 hrs and/or PRN; ICU=Q2 hrs and/or PRN**)

Assessment – Physical (**Q4 hours and/or PRN**)
- Assessment
- HEENT
- Neurological
- Cardiovascular
- Gastrointestinal
- Respiratory
- Genitourinary
- Musculoskeletal
- Integumentary
- Wounds (sites 5-8)
- Psychosocial
- Pain
- IV Site
- Braden
- Fall Risk
- Vital (**Q4 hrs and/or PRN; ICU=Q2 hrs and/or PRN**)

continued...

ADMISSION CHECKLIST

Orders
- Acknowledge
- Confirm appropriate notices to ancillaries generated from assessments (nutrition, pharmacy, social services)
- Check Worklists for:
  - Medications to be Administered
  - Specimens to Be Collected
  - Interventions

Meds
- Verify
- Administer Meds
- For applicable meds; complete hand-off/2nd RN co-sign in MAK

Resources available in OAS Gold
- Face Sheet
- Labels
- ADT functions

Paper
- Consents
- Nursing Care Plan

Note: *some assessments are part of a chaptered assessment as well as a standalone assessments*
^ if assessment is not on your filtered list, check on the "All" tab

TRANSFER (TO) YOUR UNIT

  - Turn / Reposition (**Q2 hrs**)
  - SCD
  - Fall and Skin interventions
  - Incentive Spirometry (**Per Order**)
- MRSA Screen completed
- Belongings
  - Complete form in Soarian & print for patient signature
- Sepsis Screen (**0800,1600,0000 hrs**)
- Intake and Output (**Q8 hrs**)
- Notification

Misc Assessments
- As needed

Orders
- Transfer to a different level of care requires the physician to discontinue orders and enter new orders
- Acknowledge
- Review active orders
- Check Worklists for:
  - Medications to be Administered
  - Specimens to Be Collected
  - Interventions

Meds
- Verify
- Administer Meds

continued...

TRANSFER (TO) YOUR UNIT

- For applicable meds; complete hand-off/2nd RN co-sign in MAK

Paper
- Consents
- Nursing Care Plan
- Hourly Rounding

TRANSFER (TO) YOUR UNIT

Verify the following are completed
- Admission form and Home Medications
- Patient belongings

Assessment
(**Q4 hrs & PRN clinical change**)

- Physical Assessment
  - Assessment
  - HEENT
  - Neurological
  - Cardiovascular
  - Gastrointestinal
  - Respiratory
  - Genitourinary
  - Musculoskeletal
  - Integumentary
  - Wounds (sites 5-8)
  - Psychosocial
  - Pain
  - IV Site
  - Braden
  - Fall Risk
  - Vitals (**Q4 hrs and/or PRN; ICU = Q2 hrs and/or PRN**)
- Education (**Q8 hrs and/or PRN; Take the credit & document!**)
  - Translator/translation items
- ADL (**Q4 hrs**)
  Can document the following items:
  - Isolation

continued...

ADMISSION CHECKLIST

- Education (**Q8 hrs & PRN, Take the credit, document!**)
  - Translator/Translation items
- ADL (**Q4 hrs**)
  Document the following items:
  - Isolation
  - Turn / Reposition (**Q2 hrs**)
  - SCD
  - Fall and Skin interventions
  - Incentive Spirometry (**Per-Order**)
- MRSA Screen completed
- Belongings
  - Complete form in Soarian & print for patient signature
- Sepsis Screen (**0800,1600,0000 hrs**)
- Intake and Output (**Q8 hrs**)
- Notification

Misc Assessments
- ETOH Assessment (**Q4 hrs**)
- Restraint
  - Initiation c Monitoring (**Q2 hrs and/or PRN**)
- Epidural (**Q4 hrs**)
- PCA (**Q4 hrs and/or PRN**)
- Pre-Op Checklist (**PRN OR**)
- Point of Care
- Transfusion – also requires Blood Bank paper documentation. Keep paper copy in chart & send original back to Blood Bank with empty bag.

continued...

TRANSFER (FROM) YOUR UNIT

Verify the following are completed:

- Admission form and Home Medications
- Patient belongings

- Complete and fax No Delay Nursing Report
- Call to answer questions from receiving nurse and confirm No Delay Nursing Report received
- Complete hand-off/2nd RN co-sign in MAK for PCA
- Document skin condition orders
- Transfer to a different level of care requires the physician to discontinue orders and enter new orders

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DISCHARGE HOME

- If Social Worker, Utilization Review, Schedulers and Ancillary Rehab have documented on designated discharge forms, the information will display on the Discharge Instructions form.
- Save In Progress Status.

- Print Discharge Instructions via Print function while in Patient Record.
  - Print Discharge Instructions from Assessment Time View Reports.
  - Print Discharge Medications List
  - Print Belongings
- Nurse provides Nursing Instructions, Patient Belongings and Medication Scripts and Discharge Medications Instructions to Patient
- Nurse can fax Discharge Medication Instructions to the Highland Pharmacy
- Patient will now be discharged from facility.
- Open Discharge Instructions Assessment and complete appropriate fields.
  Sign status as Complete.
- Complete other forms as appropriate – **Discharge Assessment form**

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DISCHARGE TO FAIRMONT/ OTHER FACILITY

- If Social Worker, Utilization Review, Schedulers and Ancillary Rehab have documented on designated discharge forms, the information will display on the Discharge Instructions form.
- Save In Progress Status.

- Print Discharge Instructions via Print function while in Patient Record.
  - Print Discharge Instructions from Assessment Time View Reports.
  - Print Discharge Medications List
  - Print Belongings
- Nurse provides Nursing Instructions, Patient Belongings and Medication Scripts and Discharge Medications Instructions to Patient
- Nurse can fax Discharge Medication Instructions to the Highland Pharmacy
- Patient will now be discharged from facility.
- Open Discharge Instructions Assessment and complete appropriate fields.
  Sign status as Complete.
- Complete other forms as appropriate – **Discharge Assessment form**

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DISCHARGE TO MORGUE

MD to:

- Notify next of kin
- Write death note

RN to:

- Inform MD
- Document on Postmortem form (found in the Documentation 'All' tab in Soarian)
- Complete care
- Discontinue lines (if coroners case do not discontinue lines)
- Post mortem care (cadaver shroud, tags)

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DISCHARGE TO FAIRMONT/ OTHER FACILITY

Remember:

- MRSA screening if criteria is met
- Adult influenza/ pneumococcal immunization protocol
- Discontinue lines
- Document skin condition
- Additional information can be printed if the facility requires it

Nurse (many disciplines have a part in providing discharge instructions to the patient; the steps below highlight nursings' role). Once nurses see Discharge Instructions in Scheduled/In Progress Assessments and Orders for Discharge, they will perform the following:

- Open **Discharge Instructions** form
- Has Physician entered Discharge Instructions?
  - If *No*-- The nurse will need to be educated to close the Discharge Instructions, notify Physician to fill out order and then the nurse can open and complete the Discharge Instructions.
  - If *Yes*-- Review / Update Discharge Instructions form as needed. Examples: provide information on dressing supplies and handouts given.

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continued...

DISCHARGE HOME

  - If Social Worker, Utilization Review, Schedulers and Ancillary Rehab have documented on designated discharge forms, the information will display on the Discharge Instructions form.
  - Save In Progress Status.
- Print Discharge Instructions via Print function while in Patient Record.
  - Print Discharge Instructions from Assessment Time View Reports.
  - Print Discharge Medications List
  - Print Belongings
- Nurse provides Nursing Instructions, Patient Belongings and Medication Scripts and Discharge Medications Instructions to Patient
- Nurse can fax Discharge Medication Instructions to the Highland Pharmacy
- Patient will now be discharged from facility.
- Open Discharge Instructions Assessment and complete appropriate fields. Sign status as Complete.
- Complete other forms as appropriate – **Discharge Assessment form**

12

MED ADMINISTRATION (MAK)

Review allergies. Update allergies if necessary

- Review, clarify and or verify medications. Perform an intervention if necessary
- Administer scheduled and PRN medications
  - Scan medication(s)
  - Scan patient
  - Scan MAK badge

PCA

CLEARING PCA

Document respiratory rate, sedation score, pain level and oxygen saturation level

Record number of attempts, number of injections and total dose received

PCA PUMP CLEARING SCHEDULE FOR ALL SHIFTS

1400, 2200, 0600

END OF SHIFT

Off going and on coming RN's to review PCA orders and sign in EMR

Note: *2(RN) SIGNATURES AND EVERY SHIFT REQUIRED!*

DISCONTINUING PCA MEDICATION OR EXPIRATION OF PAIN MEDICATION

2 RN signatures required in EMR

SPECIMEN COLLECTION

WORKLIST

All Urine/Blood/Stool/Sputum/ Bodily Fluid collection orders should appear on the Worklist.

SDU/ICU: All blood collection orders will go to your specimen collection list.

Med/Surg/Tele: Blood collection orders will not go to specimen collection list.

If the order is STAT, and you will draw it, go to the orders page and revise the order by clicking on it and selecting REVISE from the dropdown. Check sample collected and sign the order.

For ALL specimens collected, on the Worklist click on the box next to the order, then click the vial icon at the top. Fill in the information and click OK. This should print a Lab Slip on your unit printer to go with the specimen.

CENSUS ICONS

- **VIP** - Indicates that the patient is classified as a very important person by ACMC.
- **Publicity** - Indicates that publicity regarding this patient should be limited. A tool-tip displays the publicity level.
- **Alerts** - Provides access to the alerts that are assigned to this patient. You can also access alerts from the **Alerts Worklist**.
- **Clinical Summary** -
- **Patient Record** - Enables you to manage the patient's information across the continuum of care.
- **Charting** - Enables you to manage the patient's charted data.
- **Orders** - Enables you to manage the patient's order information.
- **Visit** - Enables you to manage the patient's demographics and visit details.
- **Facesheet**
- **Isolation** - Indicates that the patient is currently under isolation precautions. Hovering over this icon will reveal which precautions.
- **Deceased** - Indicates that the patient is deceased.
- **New results** or a new assessment has been entered for this patient within the last 24 hours.
- **New critical results** have been entered for this patient within the last 24 hours. This indicator also appears for new, critical, nursing data.
- **Open Visit** - Indicates that the current visit is active.
- Indicates that the current visit is marked for discharge.
- **Closed Visit** - Indicates that the current visit is closed.
- **Outpatient**
- **Add Patient** to personal census
- **Remove Patient** from personal census

SPECIMEN COLLECTION

RNs ONLY

- Select patient
- Click order icon (test tube)
- Click add order
- Type free text (lab specific)
- Click lab button
- Click specific lab (to the right)
- Click on the words of the specific lab
- Click checkbox of specimen collection
- Click add to order session
- Click close

continued...

PCA

INITIATING PCA

- Review PCA orders.
- Clarify any discrepancies with ordering physician
- Verify PCA order

Record respiratory rate, sedation score, pain level and saturation level in Soarian

- Q 15 minutes for the first hour
- Q 30 minutes for the second hour
- Then Q 4 hour

Note: *PCA vital signs may be taken more often if patients condition dictates*

SHIFT DOCUMENTATION

Record the number of attempts, the number of injections and the total dose received Q 1 hour for the first 2 hours

continued...

PATIENT SPECIFIC WINDOW

 - Patient Facesheet

 - Patient Record

 - Clinical Summary

 - Charting / Documentation

 - Review/Add Orders

CHART ICONS

 - Graphing and trending

 - Links

 - Finalize Chart

TRACKING BOARD ICONS

 - Similar name exists

 - Patient Specific Information Window

 - Refresh screen

 - Show/hide open beds

 - Show/hide filter row

 - Clear filter

 - Meds validated - to be given

 - Meds in process of validation

 - New orders to be acknowledged

 - New results

 - Log specimen collection

 - New intervention/assessment

 - Multiple visits within 72 hour period

 - Social Worker Requested

 - Seen by Social Worker

 - Notify police

 - Early Intervention Plan

Appendix T

MD Quick Reference Sorian Document

PHYSICIANS

OARIAN CHEAT SHEET

K
RENCE
ELP

UGH
R DAY

- CENSUS MNGT.
- ORDERS
- LABS
- MEDICATION LISTS
- MEDICATION-RECONCILIATION
- TRANSFERS
- DISCHARGES
- ICONS

ALAMEDA

CENSUS MANAGEMENT

Add a patient to your Census

Search:

- Enter patient name, click search
- Select patient
- Add to census

Note: *Patients manually added to your census will be in gray.*

Remove patient from census:

- Click on patient name on census
- Click on the icon
- Click close

1. Go to Patient Record
2. Select Laboratory from the left drop down menu

Note: *to order Labs, please s "Orders" section*

1

MEDICATION LIST MANAGEMENT

1. Click on  icon at upper left
2. Locate medication in the Home Medication box
3. Click the  to add to planned orders
4. To make changes to the medication, click the name and fil the appropriate sections
5. To complete, click 

ORDERS

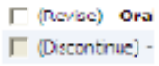
Add Orders

1. Click on 

2. Search order set:
   - Text search
   - ALL/MEDS/LABS
3. Close
4. Go to Orders → Unsigned Orders
5. Click 

Revise Orders

1. Go to 

2. Select the medication under Current Medications list
3. On the pop up window, select "Revise"
4. In the Unsigned Orders section, both revision and discontinuation of orders appear 

5. 

ADMISSION MED RECONCILIATION

1. Click Orders
2. Click Admission Reconciliation or 
3. Click Add Medication
4. Enter text and select from drop down menu
5. Complete medication details
6. Click the  to add to planned orders
7. Select status, click Sign & Close

PATIENT TRANSFERS

1. Click Visit
2. Click on Transfer tab

CENSUS ICONS

- **VIP** - Indicates that the patient is classified as a very important person by ACMC.
- **Publicity** - Indicates that publicity regarding this patient should be limited. A tool-tip displays the publicity level.
- **Alerts** - Provides access to the alerts that are assigned to this patient. You can also access alerts from the **Alerts Worklist**.
- **Clinical Summary**
- **Patient Record** - Enables you to manage the patient's information across the continuum of care.
- **Charting** - Enables you to manage the patient's charted data.
- **Orders** - Enables you to manage the patient's order information.
- **Visit** - Enables you to manage the patient's demographics and visit details.
- **Facesheet**
- **Isolation** - Indicates that the patient is currently under isolation precautions. Hovering over this icon will reveal which precautions.
- **Deceased** - Indicates that the patient is deceased.
- **New results** or a new assessment has been entered for this patient within the last 24 hours.
- **New critical results** have been entered for this patient within the last 24 hours. This indicator also appears for new, critical, nursing data.
- **Open Visit** - Indicates that the current visit is active.
- Indicates that the current visit is marked for discharge.
- **Closed Visit** - Indicates that the current visit is closed.
- **Outpatient**
- **Add Patient** to personal census
- **Remove Patient** from personal census

PATIENT SPECIFIC WINDOW ICONS

- Patient Facesheet
- Patient Record
- Clinical Summary
- Charting / Documentation
- Review/Add Orders

10

DISCHARGES

1. Go to Charting
2. Select Documentation on the left
3. Select Discharge Instruction on the right
4. Fill in the form
5. When finished, change status from "In Progress" to "Complete" Status In progress
6. And click to save

8

DISCHARGE MED RECONCILIATION

1. Click Orders
2. Click Discharge Reconciliation or
3. Click the to add Current and Home meds to Discharge Medications or Add Prescription to Discharge
7. Select status, click Sign & Close

6

PATIENT SPECIFIC RECORD ICONS

- Data has been **modified** from its original value
- A **comment** or **note** has been added
- Click to view and/or enter additional data
- Data is preliminary
- Data - Final result (normal range)
- Data H - Abnormal High
- Data HH - Critical High
- Data L - Abnormal Low
- Data LL - Critical Low
- Long text data, click to view
- Result data is an image, click to view
- Click to view result image details

Charting

- Assessment browser
- Add a **Clinical Note**
- Sign
- In Progress / Incomplete Assessment
- Draft Assessment

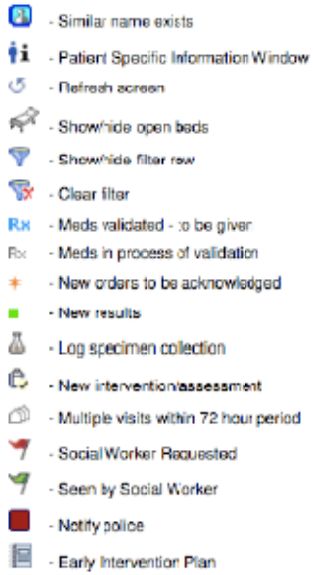
Orders

- Active
- In progress
- Complete
- Incomplete
- Suspended

MAK ICONS

- **Requires Verification** - the medication entered by pharmacy must be checked against the original doctor's order
- **CPOE** - this order was entered electronically by a doctor
- **Intervention** - an issue was encountered and an action has been requested of the pharmacy.
- **Order Reset** - pharmacy has reviewed the intervention and has made no change.
- **STAT/Now** - a medication was administered without going through Pharmacy.
- **Co-signature Required** - this medication requires a double check by a second nurse prior to administration
- 15:45 METOPROLOL SR - **Green check and background** - A **correct** scan of the product matched the selected order.
- 15:45 METOPROLOL SR - **Red X and background** - An **incorrect** scan of the product did not match the selected order.
- 17:45 SEVELAMER - **Yellow caution and background** - The product scan step was **overridden**, and the system cannot verify that the drug matches the order.
- 15:46 15:46 METOPROLOL S - **N/A and blue background** - The medication will not be administered.
- 14:00 HEParin (Porcine) - **Peach background** - the medication is past due.
- 17:11 MorpHINE - **Red star** - A follow is required, such as charting effectiveness.
- 10:00 MORPHINE - **Bold red medication in active worklist** - signifies a **STAT** dose.
- **Bar code override** - Click this button if a bar code cannot be scanned.
- **History** - Information has been updated for this order.
- Open **interventions**
- Patient Search
- Log out

TRACKING BOARD ICONS



- Similar name exists
- Patient Specific Information Window
- Refresh screen
- Show/hide open beds
- Show/hide filter row
- Clear filter
- Meds validated - to be given
- Meds in process of validation
- New orders to be acknowledged
- New results
- Log specimen collection
- New intervention/assessment
- Multiple visits within 72 hour period
- Social Worker Requested
- Seen by Social Worker
- Notify police
- Early Intervention Plan

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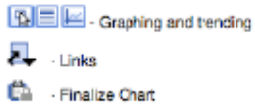
CHART ICONS



- Graphing and trending
- Links
- Finalize Chart

12

Appendix U

Estimated Saving Calculation for Replacement of Travelers

For Units New Graduates are being hired into in 2012 and 2013

Approximated Registry Hours Calculated for Participating Units Using 2012 Data

Unit	Unit Estimated Registry Cost 2012	Estimated Registry Hours 2012 - (Total cost÷65)	New Grads to work 65%	Estimated cost new grad hours X 40	# of Registry Used After New Grads Hired	Cost of Registry After New Graduate Implementation (Registry hours x $ 65/hr)	New Total Cost	Unit Cost Savings
5 East	$862,749	13,273 Hours	8627 hrs	$345,080	4646 hrs	$301,990	$647,070	$215,679
SDU	$582,557	8,962 Hours	5827 hrs	$233,080	3090 hrs	$200,850	$453,273	$129,284.
7 East	$959,892	14,767 Hours	9598 hrs	$438,392	5169 hrs	$335,986	$774,378	$185,514
7 West	$1,515,896	23,321 Hours	15158 hrs	$606,320	8162 hrs	$530,530	$1,136,850	$379,096
Post Partum	$ 133,666 + OT $ 257,000	n/a	n/a	n/a	n/a	n/a	small savings	OT savings
L&D	$1,010,369	15,544 Hours	10100 hrs	$404,000	5440 hrs	$353,600.	$757,600	$252,769
TOTAL	$5,065,129	75,867 Hours	49,310 Hours	$2,026,872	26,507 Hours	$1,722,956	$3,749,828	1,315,301

75,867 hours =9,483 shifts/year or182 shifts/week or 26 shifts/day of travelers in 5 units

Appendix V

Cost Savings with Reduction in Salary during Training

Summary of Cost/Savings	Medical/Surgical 12 weeks of Training	Critical Care 16 Weeks of Training	Reduction of Salary Med/Surg	Critical Care
Orientation Cost for Training	$18,979/RN	$25,035	$9,489	$12,517
After Completion of Program Additional classes	$1,760 - $3,520 / RN	$1,760 - $3,520/ RN	$1,760 - $3,520 / RN	$1,760 - $3,520/ RN
Preceptor Stipend	$1,344/RN	$2,240/RN	$1,344/RN	$2,240/RN
Materials Needed	$50/RN	$50/RN	$50/RN	$50/RN
Cost Per RN Approx.	$23,893	30,845	14,403	18327
Instructor Cost	Approx. 18,000 per Training Program	Approx. 18,000 per Training Program	Approx. 18,000 per Training Program	Approx. 18,000 per Training Program
Total Training Cost for 30 New Graduates	$734,790	925,350	450,090	567,810

Appendix W

Updated Training Costs

Appendix W

Training Budget

New Graduate Program Training Budget for first 89

Organization: Alameda County Medical Center — Year: 2013

Department: Nursing- New graduate program — Submitted by: Pamela Stanley

Annual training allotment:

1 cohort: $583,210 — 3 cohort: $255,036 — Total Budget: $1,813,820

2 cohort: $554,504 — 4 cohort: $32,070

1st Training Budget - 90 New Grads

Line	Item	Descriptions/Justifications	Qty.	Unit Cost/Rate	Total
1	Program development one-tim	Develop new grad program-one time cost	1	$ 10,000.00	$10,000
2	Salary of educator	for new graduate program	15	$ 12,000.00	18,000
3	Salary of Nurses to ed	cost for 3M to assist with class training of new grads	1	$ 10,000.00	10,000
4	Preceptor trainers	Cost of trainers for preceptor/mentor classes	2	$ 480.00	960
5	Salary for one - new grad	Salary for one new graduate 12 weeks	90	$ 16,973.00	569,370
6	Salary for one new graduate	salary for one new graduate 16 weeks	0	$ 25,305.00	0
7	Instructional materials	for student	30	$ 100.00	3,000
8	HR processing	cost per hire	30	$ 220.00	6,600
9	preceptor pay	For 12 weeks	90	$ 1,344.00	40,320
10	preceptor pay	For 16 weeks		$ 2,240.00	0
11	Class set up expense		1	$ 1,000.00	
12	preceptors trained for new gi	preceptors trained	26	$ 960.00	24,960
13					0
14					0
15					0
				Grand Total	1003,210

New Graduate ProgramTraining Budget for first 89

Organization: Alameda County Medical Center Year: 2013

Department: Nursing- New graduate program Submitted by: Pamela Stanley

Annual training allotment:

1 cohort:	$683,210	3 cohort:	$255,036	Total Budget:	$1,813,820
2 cohort	$554,504	4 cohort:	$321,070		

2nd Training Budget- 24 new grads

Line	Item	Description/Justification	Qty.	Unit Cost/Rate	Total
1	Program development and	Develop new grad program--one time cost	0	$ 10,000.00	0
2	Salary of educator	for new graduate program	1.5	$ 12,000.00	18,000
3	Salary of Nurse trained	cost for RN to assist with class training of new grads	1	$ 10,000.00	10,000
4	Preceptor trainers	Cost of trainers for preceptor/mentor classes	2	$ 480.00	960
5	Salary for one new grad	Salary for one new graduate 12 weeks	24	$ 18,979.00	455,496
6	Salary for one new graduat	salary for one new graduate 16 weeks	0	$ 25,305.00	0
7	Instructional materials	for student	24	$ 100.00	2,400
8	HR processing	cost per hire	24	$ 220.00	5,280
9	preceptor pay	For 12 weeks	12	$ 1,344.00	16,128
10	preceptor pay	For 16 weeks	12	$ 2,240.00	26,880
11	Classroom expense		1	$ 4,000.00	4,000
12	preceptors trained	Preceptors trained to work with new grads	16	$ 960.00	15,360
13					0
14					0
15					0
				Grand Total	$ 0

New Graduate ProgramTraining Budget for first 89

Organization: Alameda County Medical Center Year: 2013

Department: Nursing- New graduate program Submitted by: Pamela Stanley

Annual training allotment:

1 cohort: $683,210 3 cohort: $255,036 Total Budget: $1,813,820

2 cohort $554,504 4 cohort: $321,070

3rd Cohort Training Budget-15

Line	Item	Description/Justification	Qty.	Unit Cost/Rate	Total
16	Program development one-	Develop new grad program--one time cost	0	$ 10,000.00	0
17	Salary of educator	for new graduate program	1.5	$ 17,280.00	25,920
18	Salary of Nurse trained	cost for RN to assist with class training of new grads	1	$ 10,000.00	10,000
19	Preceptor trainers	Cost of trainers for preceptor/mentor classes	2	$ 480.00	960
20	Salary for one new grad	Salary for one new graduate 12 weeks	8	$ 9,395.00	75,160
21	Salary for one new graduate	salary for one new graduate 16 weeks	7	$ 12,652.00	88,564
22	Instructional materials	for student	15	$ 100.00	1,500
23	HR processing	cost per hire	15	$ 220.00	3,300
24	preceptor pay	For 12 weeks	8	$ 1,344.00	10,752
25	preceptor pay	For 16 weeks	7	$ 2,240.00	15,680
26	Class set up expense		1	$ 4,000.00	4,000
27	preceptors trained	Preceptors trained to work with new grads	20	$ 960.00	19,200
28					0
29					0
30					0
					$ -

New Graduate ProgramTraining Budget for first 89

Organization: Alameda County Medical Center Year: 2013

Department: Nursing - New graduate program Submitted by: Pamela Stanley

Annual training allotment:

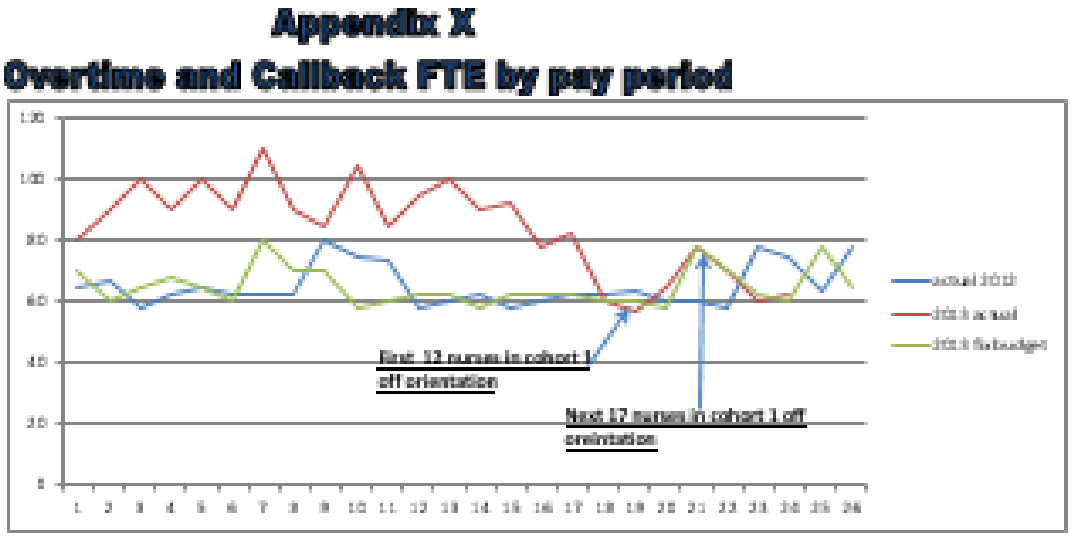
1 cohort:	$683,210	3 cohort:	$255,036	Total Budget:	$1,813,820
2 cohort	$554,504	4 cohort:	$321,070		

4th Cohort Budget-20

Line	Item	Description/Justification	Qty.	Unit Cost/Rate	Total
31	Program development one	Develop new grad program - one time cost	0	$ 10,000.00	0
32	Salary of educator	for new graduate program	1.5	$ 12,000.00	18,000
33	Salary of Nurse trained	cost for RN to assist with classr training of new grads	1	$ 10,000.00	10,000
34	Preceptor trainers	Cost of trainers for pre-ceptor/mentor classes	2	$ 480.00	960
35	Salary for one new grad	Salary for one new graduate 12 weeks	10	$ 9,489.00	94,890
36	Salary for one new graduat	salary for one new graduate 16 weeks	10	$ 12,652.00	126,520
37	Instructional materials	for student	30	$ 50.00	1,500
38	HR processing	cost per hire	20	$ 220.00	4,400
39	preceptor pay	For 12 weeks	10	$ 1,344.00	13,440
40	preceptor pay	For 16 weeks	10	$ 2,240.00	22,400
41	Class return expense		1	$ 4,000.00	4,000
42	preceptors trained	Preceptors trained to work with new grads	26	$ 960.00	24,960
43					0
44					0
45					0
				Grand Total	$$$$$$

Appendix X

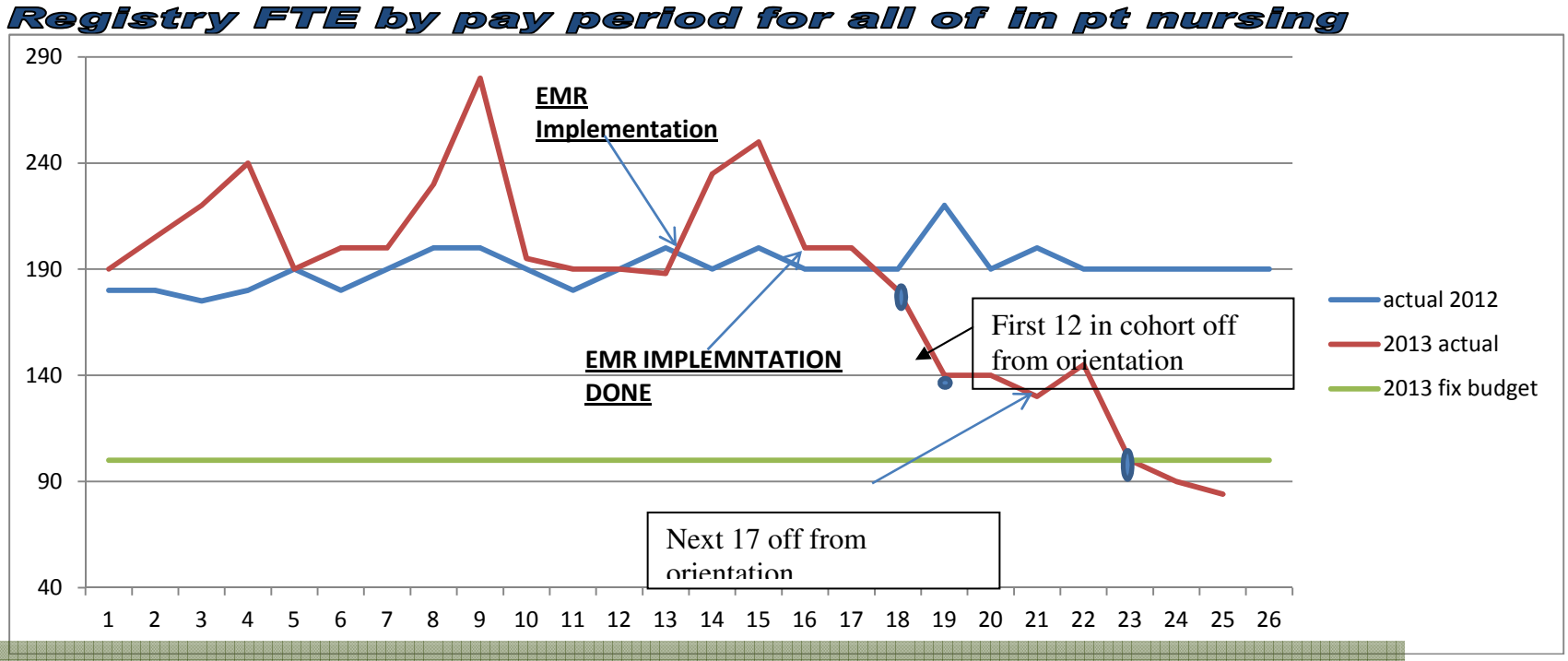
Overtime and Callback Pay



12	End December 7, 2012	new graduate Cohort 1 starts
13	End December 21, 2012	
14	End January 5, 2013	new graduate cohort 2 starts
15	End January 19, 2013	Increased staffing for EMR implementation
16	End February 2, 2013	
17	End February 16, 2013	EMR implemented
18	End March 2, 2013	decreasing agency support for EMR implementation
19	End March 16, 2013	First 12 nurses off orientation and on staff
20	End March 30, 2013	second cohort starts new grad training
21	End April 13, 2013	second group 17 RN off orientation

Appendix Y

Registry FTE by Pay Period



Events Coordination with changes in Registry being used

12	End December 7, 2012	new graduate Cohort 1 starts
13	End December 21, 2012	
14	End January 5, 2013	new graduate cohort 2 starts
15	End January 19, 2013	Increased staffing for EMR implementation
16	End February 2, 2013	
17	End February 16, 2013	EMR implemented
18	End March 2, 2013	decreasing agency support for EMR implementation
19	End March 16, 2013	First 12 nurses off orientation and on staff
20	End March 30, 2013	second cohort starts new grad training
21	End April 13, 2013	second group 17 RN off orientation

Appendix Z

Registry usage