Table of Contents

General Information ........................................................................................................... 4
  I. Introduction .................................................................................................................. 4
  II. Summary .................................................................................................................... 4
  III. Needs Assessment .................................................................................................... 5
  IV. Program Objectives .................................................................................................. 5
  V. Program Components ................................................................................................. 6
  VI. Program Competencies ............................................................................................. 9
  VII. Guiding Principles .................................................................................................. 10
  VIII. Resident Objectives ............................................................................................... 10
  IX. Resident Responsibilities ......................................................................................... 11

Resources .......................................................................................................................... 12
  I. Nurse Educator Responsibilities ............................................................................... 12
  II. Nurse Validator Responsibilities ............................................................................... 12
  III. Nurse Preceptor Responsibilities ......................................................................... 13
  IV. Optional Peer Group Transition Guideline .............................................................. 14
  V. Optional Mentor Role ............................................................................................... 15

Agenda ................................................................................................................................ 17
  I. Agenda Guideline ...................................................................................................... 17
  II. Sample Weeks at a Glance ....................................................................................... 18
  III. Curriculum and Competency Presentation Grid ....................................................... 21

Classroom Learning .......................................................................................................... 24
  I. Curriculum Content Section Guideline ...................................................................... 24
  II. Lecture Topics ........................................................................................................... 24
  III. Organizational Specific Lecture Topic Objectives .................................................... 25
  IV. eModule Topics ........................................................................................................ 27
  V. eModule Leader Guides ............................................................................................ 28
    Program Introduction .................................................................................................... 28
    Nursing Roles and Values ......................................................................................... 40
    Communication ......................................................................................................... 61
    Professional Topics .................................................................................................. 70
I. Introduction

The Institute of Medicine 2010 Report Future of Nursing Report simulated a great deal of thinking about the function, education, and leadership role of nurses. Once second class to the hospital nurse the wide ranging roles of the Ambulatory Nurse now have center stage. This Ambulatory Nurse Residency curriculum was initially developed in 2010 based on and with the contributions from many nurse educators, KP nurse leaders, and Coalition of Kaiser Permanente (CKPU) union leaders. This Ben Hudnall Memorial Trust (BHMT) Program was first built as an instructor-led Program and piloted in KP SCAL and KPNW. The content has been very well received but the instructor-led format unsustainabe. The Program now has a variety of tools to support Ambulatory Nurse Residencies in KP Regions for BHMT eligible participants. The final product is still emerging just as ambulatory care is moving from the medical office to retail malls and ultimately to Care Anywhere the patient is.

The BHMT Ambulatory Nurse Residency Program now is best deployed through a blended learning approach. Each region or medical center can customize the Program to meet its needs. There are several online didactic modules that build a foundation for the Ambulatory Nurse (Program Introduction, Nursing Roles and Values, Communication, Professional Topics, and Situational Awareness). KP Regions will likely supplement these online didactic courses with KP region-specific and medical office specific information and policies. There are two other components to complete the learning of the Ambulatory Nurse: validation of procedural competencies and rotations in a variety of clinics and settings. There is a suggested list of procedural competencies and rotations. The KP region will ultimately select what is most appropriate and feasible.

There is a complementary online Program to prepare Validators and Preceptors for this Program available on the Ben Hudnall Memorial Trust website at https://bhmtlearn.org/default.aspx.

It is helpful to have a local person coordinate all the pieces of the Program. Funds to support study time of the Ambulatory Nurse Resident are also available through BHMT. Contact your regional workforce development committee co-chair for more information.

II. Summary

The Ambulatory Registered Nurse Residency Program is designed as a transition Program for new RN graduates and Registered Nurses new to ambulatory practice. For the new graduate, the Program bridges the gap between the academic and the service settings and to prepare novice nurses to manage patients in the ambulatory care setting. For the experienced RN new to ambulatory nursing, it provides the structure and support necessary to transition into a new specialty.

In October 2010, the Institute of Medicine (IOM) issued a report titled the Future of Nursing Leading Change, Advancing Health. The report contains eight recommendations. Recommendation 3 supports the implementation of Residency Programs and states:

“State Boards of Nursing, accrediting bodies, the federal government, and health care organizations should take actions to support nurses’ completion of a transition-to-practice..."
Program (nurse Residency) after they have completed a pre-licensure or advanced practice degree Program or when they are transitioning into new clinical practice areas."

The Program’s theoretical underpinnings are based on Benner’s novice-to-expert research (1984), Knowles’ adult-learning principles (1970), and Marlene Kramer’s research on reality shock (1974). The standards that form the basis for the Program come from Kaiser Permanente’s Vision and Values and the Models of Care, as well as the American Association of Ambulatory Nurses (AAACN) Scope and Standards of Practice for Professional Ambulatory Care Nursing. The Program competencies are from the AAACN Synergy Model of Practice.

A variety of evaluation measures will be used to determine Program success.

III. Needs Assessment

- Education to Practice Gap – educators and employers agree that there is an education to practice gap in nursing that must be addressed. Acute care nursing has embraced transition to practice Programs both for new graduates and experienced RNs new to a specialty to address the gap; ambulatory care has been slow to respond. New graduate RNs, who had previously been licensed as LVNs often have difficulty making the transition to a professional role without a structured support Program that facilitates the transition.

- Failure to Stay in the Job – many experienced RNs new to ambulatory care environments return to their prior job due to ineffective and problem-prone orientation.

- Complex Health Care Needs – sicker patients with multiple conditions are being seen more in ambulatory settings. Registered nurses can play a unique role in contributing to improved patient outcomes.

- Risk for Practice Errors – Several studies show that new nurses experience increased stress three to six months after hire which is a risk factor for patient safety due to increased practice errors.

- Slow growth of Ambulatory Care – most RN transition Programs are acute-care based. Because of this, many new RN graduates secure their first job in the acute care setting. Additionally, schools of nursing do not usually teach content and/or provide exposure to the specialty of ambulatory nursing.

IV. Program Objectives

<table>
<thead>
<tr>
<th>Problem</th>
<th>Program Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education to Practice Gap</td>
<td>Implement an Ambulatory Nurse Residency Program in select regions and medical centers within Kaiser Permanente that facilitates transition into the specialty of ambulatory nursing. Disseminate Residency Program learnings</td>
</tr>
</tbody>
</table>

V. Program Components

The Ambulatory Nurse Residency Program has three main components: online didactic learning coupled with regional training on patient safety, teams, and other topics deemed important to the region or medical center; clinical competencies which are especially important in ambulatory care such as phone advice, knee splinting, etc., and patient education (a suggested list of clinical competencies is included in this guide – please modify as necessary); and clinical rotations, to make sure that the Resident is familiar with the variety of settings an
Ambulatory Nurse may work at.

Additional didactic training, clinical competencies, and clinical rotations are the responsibility of the respective KP Region. Links to clinical competencies can be found on HealthStream and Nursing Pathways.

Facilitated sessions of the participants and/or peers for learning discussion have been found to be beneficial and fun in past sessions. These sessions are most successful when conducted once a month.

Some Programs have also instituted an optional Mentoring component. This seems to be helpful at the end of the Program.

1. Online eModules
   - RN Residents complete an online eModule to learn Program fundamentals.
   - The instructor will need to review the eModules to understand the concepts, activities, and techniques that the Residents will be bringing to their other learning experiences.

2. Classroom Learning
   - RN Residents attend classes throughout their Residency Program.
   - Some lectures focus on specific procedural competencies such as medication administration, point of care testing, using an AED, etc.
   - Other lectures focus on reinforcing concepts learned from the online eModules.
   - Instructional guides accompany most modules. They outline important information to assure consistency and continuity between varieties of instructors.
   - Learning techniques may include lecture, discussion, skills practice, and role-play scenarios. Please modify as necessary.
   - Certain content lectures are expected to be specific to an individual organization to address regional and organizational differences.

3. Clinical Learning

3.1 Competencies
   - Procedural competencies are selected based on those clinical skills that the ambulatory RN performs and/or assures that others perform correctly. Each competency is accompanied by a Validator guideline that provides consistency amongst Validators to assure quality and safety across different Validators.
   - The competencies are organized to show the procedural steps, critical thinking questions, and applicable interpersonal skills. They are based on current evidence in the nursing and medical literature.

3.2 Preceptor-Based Clinical Rotations
   - RN Residents rotate through multiple ambulatory primary and specialty clinics. Each clinical rotation has specific objectives to guide the experience.
   - Some rotations will focus only on observation. The opportunity to observe within a structured format enables the Resident to view workflow, team contributions, and communication in a different way. An Observation Guide is used to guide the activity.
   - RN Residents should also rotate through the Emergency Department with focused experiences.
   - The nursing Preceptor assists RN Residents in developing the independent leadership role of the ambulatory RN and developing team relationships to support their ability to lead.
   - The nursing Preceptor guides the Resident in gaining proficiency in nursing responsibilities, helps to develop their confidence and competence, clinical judgment, and assures their ability to provide safe, quality care.
   - Registered Nurse Preceptors are utilized to assure that the RN is able to independently act as an ambulatory RN.
   - RN Residents rotate through selected administrative and clinical meetings, which provide an opportunity to view different aspects of the RN role. The meetings are scheduled throughout the Program and contribute to leadership education.

4. Peer Group Transitioning Sessions (Optional)
   - Consistent with the National Council of State Boards of Nursing (NCSBN) recommendation to include feedback and reflection as essential parts of this Residency Program, the peer group transitioning sessions are integrated throughout the entire Program. They offer the RN Resident a safe, confidential environment in which experiences can be shared.
   - An experienced ambulatory RN educator or manager, who acts as a Facilitator, leads the sessions. The Facilitator should not have managerial responsibility for the Residents.
• By meeting with peers in small groups, the Resident learns skills in adjusting to his new professional role or new specialty environment, discusses observations made in the clinical area, and develops strategies to assist with professional development.

• Each Resident will be given a journal to focus their thinking and reflect on their experiences.

• The peer group sessions are conducted in a circle where members all see each other unencumbered by tables.

• These 60-minute sessions are optionally scheduled weekly during the first month of orientation and then at least every other week for the next two months and then monthly until completion of the Program.

5. Mentorship (Optional)

• The Mentor helps the RN Resident gain confidence to successfully adjust to the demands of an ambulatory nursing position. The Mentor shares career stories, provides insights, helps develop or add to a professional portfolio and encourages the Resident to reflect on their experiences.

• The Mentor guides the RN Resident’s assimilation into his first professional nursing position or in the case of an experienced RN, into his new specialty.

• The Nurse Educator “checks in” with both the Resident and the Mentor to ensure a positive and productive relationship.

• Nursing Mentors are recruited from experienced staff nurses, advanced practice nurses, administrative leaders, and educators. Mentors are solicited on a volunteer basis and are chosen based on experience, ability to listen, and guide nurses new to ambulatory care toward achieving their maximal potential.

• Mentors do not work in the Resident’s department, which increases the confidentiality and objectivity of the relationship.

• At their first meeting, the RN Resident and his Mentor become acquainted with each other. Subsequent meetings can occur in several different ways: such as meeting for a meal or for coffee during the work day, exchanging emails or talking on the phone. The Mentor is committed to finding time to meet on a regular basis over the course of the Program.

VI. Program Competencies

The seven competencies provide a framework to articulate the work of Registered Nurses:

• Clinical Judgment – clinical reasoning, which includes clinical decision-making, critical thinking, and a global grasp of the situation, coupled with nursing skills acquired through a process of integrating formal and informal experiential knowledge and evidence-based guidelines.

• Collaboration – working with others (e.g. patients, families, healthcare providers) in a way that promotes/encourages each person’s contributions toward achieving optimal and realistic patient/family goals. Involves intra- and inter-disciplinary work with colleagues and the community.

• Caring Practices – nursing activities that create a compassionate, supportive, and therapeutic environment for patients and staff, with the aim of promoting comfort and healing and preventing unnecessary suffering. Includes, but is not limited to, vigilance, engagement, and responsiveness of caregivers, including family and health care personnel.

• Systems Thinking – body of knowledge and tools that allow the nurse to manage whatever environmental and system resources exist for the patient/family and staff, within or across healthcare and non-healthcare systems.

• Facilitator of Learning – the ability to facilitate learning for patients/families, nursing staff, other members of the healthcare team, and community. Includes both formal and informal facilitation of learning.

• Advocacy and Moral Agency – working on another’s behalf and representing the concerns of the patient/family and nursing staff; serving as a moral agent in identifying and helping to resolve ethical and clinical concerns within and outside the clinical setting.

• Response to Diversity – the sensitivity to recognize, appreciate, and incorporate differences into the provision of care. Differences may include, but are not limited to, cultural differences, spiritual beliefs, gender, race ethnicity, lifestyle, socioeconomic status, age, and values.

VII. Guiding Principles

The Registered Nurse Residency Program in Ambulatory Nursing is based on the following guiding principles:

1. Establish a well-defined structure with integrated processes including educational content, procedural competencies, and a clinical Preceptorship through a variety of clinical rotations,

2. Establish a Program foundation based on KP Vision, Values, and Models of Care, and the American Academy of Ambulatory Nursing (AAACN) Professional Standards, and

3. Provide evaluation tools that will capture Resident learnings and their professional growth and Program input.

VIII. Resident Objectives

At the completion of the Program, each Resident will be able to:

1. Utilize critical thinking when confronted with a clinical or administrative issue demonstrated by an evaluation tool, response to unusual occurrences, Preceptor feedback, or a competency performance.
2. Work cooperatively and effectively with patients, family members, providers, other members of the health care team, and the local community demonstrated by Preceptor feedback and provider survey.

3. Provide nursing leadership in the ambulatory setting demonstrated by Preceptor and Resident feedback.

4. Anticipate patient outcomes based on timely analysis of individual responses to nursing interventions demonstrated by Preceptor and Resident feedback.

5. Perform procedural competencies effectively and efficiently as demonstrated by successful completion of competency validation tools.

6. Understand the use of resources within Kaiser Permanente and the local community as demonstrated by classroom activities and assignments.

7. Utilize Kaiser Permanente policies and procedures, national ambulatory nursing standards, and scope of practice regulations, to guide clinical decision making as demonstrated by evaluation tools and Preceptor feedback.

8. Exhibit an ability to handle, organize, and prioritize work flow in the ambulatory care setting demonstrated by evaluation tools and Preceptor feedback.

IX. Resident Responsibilities

Each Resident is expected to:

1. Attend all of this orientation to successfully qualify for completion.

2. Consistently apply concepts learned.

3. Incorporate the Vision and Values of Kaiser Permanente Nursing in nursing work.

4. Set personal goals to achieve desired outcomes.

5. Assume responsibility for own learning by seeking challenging opportunities to enhance knowledge.

6. Assume ownership for actions and learn from mistakes.

7. Be responsive to coaching and feedback.

8. Practice with confidence, competence, compassion, and integrity.


10. Provide leadership as a Registered Nurse.

Resources

I. Nurse Educator Responsibilities

Each Nurse Educator is expected to:

- Function as the coordinator for all activities within the Residency Program.
- Coordinate a local workgroup consisting of educators, managers, clinical leaders, labor partners and faculty from the affiliated school of nursing to provide the direction and oversight for the Program.
- Coordinate with the local school of nursing RN to BSN credit for the Residency Program, student ambulatory clinical rotations and opportunities to precept students during leadership rotations.
- Coordinate the Validator/Preceptor Program.
- Enable Resident success by connecting with them and their Preceptors during the clinical rotations.
- Assure successful completion of the identified procedural competencies.
- Assure compliance with Program evaluations.
- Participate in national Program calls.
- Work with Program Director to improve the Program.

II. Nurse Validator Responsibilities

The Nurse Validator’s role is to support the quality implementation of the procedural competencies through a standardized process of validation.

Responsibilities:

- Assist the RN through the competency process by evaluating their skill level (unable to perform, to perform with coaching, to perform without coaching) for each procedural step and critical thinking/interpersonal questions.
- Assures procedural competency through a standardized tool that focuses on both procedural steps and critical thinking/interpersonal questions.
- Utilizes the Validator Guideline (available in the section Forms and Evaluations) as a tool to assure consistency and continuity between Validators.
- Completes documentation on the competency tool and provides the information to the Resident’s manager and Nurse Educator.
- Reviews with the Validation experience with the Nurse Educator.
Necessary Skills and Behaviors Include:

- Dependability
- Flexibility
- Critical reasoning
- Eagerness to learn
- Fair and objective manner
- Ability to retain confidentiality
- Commitment to help new staff become integrated and competent
- At least two years of professional nursing experience in primary care or an ambulatory specialty is recommended

Training Requirements:

- Two-day Validator Program
- If performing both a Validator and a Preceptor role, RN will complete two days of the Validator course and the first day of the Preceptor course

IV. Optional Peer Group Transition Guideline

Facilitated Peer Group Sessions are optional to the Program. They have been found to be very beneficial, and most successful when conducted once a month.

Peer Group Session Guideline:

1. The group Facilitator should be someone who is not in a direct management line with any Resident and has group facilitation skills.

2. Conducting the meeting in a circle enables all participants to see each other and eliminates the ability to visually disconnect from the group.

3. These 60 minute sessions are scheduled weekly during the first month of orientation, and then at least every other week for the next two months, and then monthly until the completion of the Program (ideally one year for the new graduate and six months for the experienced nurse).

4. Topics discussed may come from the Residents or the Facilitator. Topics may include: journal reflections, input after clinic observations, experiences from clinical rotations and comfort with performing certain skills or handling certain situations.

5. Sometimes a moment of quiet may be needed at the beginning of the session.

6. An external person can be brought into the group to discuss a specific issue that provides insight to a discussion topic. To support group integrity, the Residents agree to have an external person join the group, the guest is given a specific amount of time for dialogue and brought into the room at the time agreed upon. The group Facilitator should clarify with the external guest the time to join the meeting and that the focus is discussion not lecture.

7. Group agreements (these can be written on a flip chart or erase board at the first session and reviewed with the participants for acceptance):
   - The group should begin and end on time
   - What is said in the circle stays in the circle
   - Everyone participates in sharing information and responding to other’s information
   - Everyone agrees to arrive on time ready to participate
   - All cell phones and pagers will be turned off and left outside the circle
• Group members will attentively listen to each other
• Each person asks for the support that they need and gives the support that they can give

V. Optional Mentor Role

The appointment of a Mentor for each Resident is an optional component of the Residency Program.

Once individuals have agreed to be a Mentor, the Nurse Educator matches up a Resident with a particular Mentor. Considerations for a match-up might be: graduation from the same school of nursing, a common interest in a specific patient population, working in geographic proximity or a Resident’s career goals that is similar to the Mentor. It is important to note that sometimes, obvious similarities are not evident and yet successful Mentor-mentee relationships are forged.

Remember that not every Mentor-mentee relationship works. The Nurse Educator should periodically check with both the Mentor and Resident to make sure things are going well. If Mentors need to be changed, the Nurse Educator should facilitate the change.

A Mentor:
• Serves as a role model
• Provides support, encouragement, and positive perspectives
• Recommends ways for the Resident to develop specific job skills effective behavior, and how to thrive in the work environment
• Acts as a source of information regarding career development
• Seeks information to answer questions
• Expands the Resident’s perspective about nursing, healthcare and the Registered Nurse role
• Shares willingly about things that helped you be successful
• Provides support as needed
• Suggests resources

Necessary Skills and Behaviors Include:
• RN with experience in the same field
• Experience in the same specialty in which Resident works can be helpful
• Show enthusiasm for work that is contagious
• Serves as inspiration to others just by doing what they enjoy most
• Willing to share own career aspirations and interests with the Resident

Logistics for the Mentor Role:

How often you meet with your Mentor is ultimately a decision between the two of you. However, the following are Program recommendations:

• Meet with the Resident consistently at least once a week via phone, email, or face to face for coffee or a meal during the first two months and then at least every two weeks thereafter.
• Be willing to continue in this Mentoring relationship for ideally one year for the new graduate and six months for the experienced nurse.
• Agree to a no-fault conclusion of the Mentoring relationship when (for any reason) the time is right.
**Agenda**

**I. Agenda Guideline**

The suggested Agenda contained in this section helps guide the organization in preparing their agenda over the course of the Program. It is recommended that agendas be prepared at least two months in advance to assure adequate scheduling for both the site and the Resident.

- Agendas should contain enough daily diversity so that there is blended learning for a variety of Program components.
- The Curriculum/Competency Grid contains suggestions to assure connections between curriculum content and procedural competencies and to provide suggested timing for presentation.
- Scheduling a review session the day before or the same day as the validation may assist in the validation process. Providing the tools to the Residents at least a week before should facilitate this process.
- Clinical rotations should be interspersed between content and procedural competency validation to build on prior learning and enable clinical practice under the guidance of a Preceptor.
- Peer group transition sessions should be ideally scheduled weekly during the first month of the Residency Program and then at least every other week during the next three months.
- Selected administrative and clinical meetings should be scheduled throughout the Program to provide an opportunity to view different aspects of the RN role and contribute to leadership growth.
- At least one Scavenger Hunt should be scheduled early in the Program to help the RN Resident identify with the clinical setting. A second scavenger hunt would be helpful in identifying with the clinical setting. A second scavenger hunt would be helpful in
- Daily start and end times, breaks and lunch times are arbitrary. Each organization will need to accommodate their usual schedules into the agenda.
- Organizational specific opportunities should be included in the Program.
- If your organization has a Flu Advice call center, the Residents would benefit from a training session prior to a rotation in the call center. A training manual (5 days) is provided from San Diego for the use of trainers at other sites. The educational content contains a Standardized Procedure (California Law) to prescribe specific medications. The contact in San Diego for this Program is Ruth Ann Obregon RN MSN, EdD(s) Nurse Educator 619-641-4137; Ruth.A.Obregon@kp.org.

In San Diego, the Cold and flu advice call center lasts for four months. It has been helpful to have the Residents in the call center for at least six weeks. Their learning consists of improving skills in the following areas: communication, telephone assessment, prescribing interventions, recommendations for follow-up and patient education. During their time in the Cold and Flu call center, the Residents are continually precepted by experienced staff Registered Nurses, a Nurse Practitioner, a Physician’s Assistant and the site manager. They are visited weekly by the Nurse Educator to assess their progress and discuss concerns.

**II. Sample Weeks at a Glance**

The following are sample weekly agendas for the Ambulatory Residency Program. Please modify to accommodate your medical center’s needs.

<table>
<thead>
<tr>
<th>RN AMBULATORY RESIDENCY PROGRAM AGENDA</th>
<th>Week One at a Glance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday</strong></td>
<td><strong>Tuesday</strong></td>
</tr>
<tr>
<td>8:30-9:30a SITE</td>
<td>8:30-9:30a SITE</td>
</tr>
<tr>
<td>Welcome</td>
<td>Vision and Values</td>
</tr>
<tr>
<td>Introductions</td>
<td>PREPARATOR</td>
</tr>
<tr>
<td>Review</td>
<td>9:30-10:30p</td>
</tr>
<tr>
<td>-Program Overview</td>
<td>-Scope of Practice</td>
</tr>
<tr>
<td>-Overview</td>
<td>PRESENTER</td>
</tr>
<tr>
<td>-Program Principles</td>
<td>10:30-10:45p</td>
</tr>
<tr>
<td>-Resident Checklist</td>
<td>Break</td>
</tr>
<tr>
<td>-Peer Group</td>
<td>10:45-12:15p</td>
</tr>
<tr>
<td>Overview</td>
<td>-The Health Care</td>
</tr>
<tr>
<td>-Peer Group Transition Session</td>
<td>Team</td>
</tr>
<tr>
<td>-Feedback Document</td>
<td>-RNLINMA job</td>
</tr>
<tr>
<td>-Journaling</td>
<td>descriptions</td>
</tr>
<tr>
<td>-Agenda PRESENTER</td>
<td>PRESENTER</td>
</tr>
<tr>
<td>Lunch on your own</td>
<td>12:45-1:45p</td>
</tr>
<tr>
<td>10:30-10:45a Break</td>
<td>Break</td>
</tr>
<tr>
<td>10:45-12:00p Above continued</td>
<td>1:45-2:30p</td>
</tr>
<tr>
<td>12:00-1:30p Lunch and Peer Group</td>
<td>Situational Awareness</td>
</tr>
<tr>
<td>Discussion</td>
<td>-Review of Observation</td>
</tr>
<tr>
<td></td>
<td>Guide</td>
</tr>
<tr>
<td></td>
<td>2:30-2:45p Break</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>
### RN Ambulatory Residency Program Agenda

#### Week Two at a Glance

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-10:30a</td>
<td>SITE</td>
<td>8:30-10:30a</td>
<td>SITE</td>
<td>8:30-10:30a</td>
</tr>
<tr>
<td>Medication Safety</td>
<td>Immunizations and Influenza PRESENTER</td>
<td>-Laboratory visit -Lab test safety collection, labeling PRESENTER</td>
<td>-Communication SBAR PRESENTER</td>
<td>-Communication SBAR PRESENTER</td>
</tr>
<tr>
<td>-Safe Practices</td>
<td>-Residents will be rotated through selected clinics to practice giving immunizations and TSTs to finalize Validation. Other previously Validated competencies can be added.</td>
<td>10:30-10:45a</td>
<td>10:45-12:00p</td>
<td>10:45-12:00p</td>
</tr>
<tr>
<td>-Medication Errors</td>
<td>-Point of Care Testing PRESENTER</td>
<td>12:00-1:00p</td>
<td>12:00-1:00p</td>
<td>12:00-1:00p</td>
</tr>
<tr>
<td>-Safe Storage</td>
<td>-Lunch on your own</td>
<td>1:30-3:00p</td>
<td>-Communication RN/MD PRESENTER</td>
<td>-Communication RN/MD PRESENTER</td>
</tr>
<tr>
<td>-Look alike, sound alike drugs PRESENTER</td>
<td>-Urine pregnancy</td>
<td>3:30-3:45p</td>
<td>3:30-3:45p</td>
<td>3:30-3:45p</td>
</tr>
<tr>
<td>10:30-10:45a</td>
<td>Break</td>
<td>8:30-10:30a</td>
<td>Break</td>
<td>10:45-12:00p</td>
</tr>
<tr>
<td>Video</td>
<td>SITE</td>
<td>SITE</td>
<td>SITE</td>
<td>SITE</td>
</tr>
<tr>
<td>-Flu Update</td>
<td>-SBAR PRESENTER</td>
<td>10:30-10:45a</td>
<td>10:45-12:00p</td>
<td>10:45-12:00p</td>
</tr>
<tr>
<td>-Flu clinic work流程</td>
<td>-Point of Care Testing PRESENTER</td>
<td>12:00-1:00p</td>
<td>12:00-1:00p</td>
<td>12:00-1:00p</td>
</tr>
<tr>
<td>-Patient education PRESENTER</td>
<td>-Lunch on your own</td>
<td>1:30-3:00p</td>
<td>-Communication RN/MD PRESENTER</td>
<td>-Communication RN/MD PRESENTER</td>
</tr>
<tr>
<td>11:45-12:45</td>
<td>Break</td>
<td>8:30-10:30a</td>
<td>Break</td>
<td>10:45-12:00p</td>
</tr>
<tr>
<td>?</td>
<td>10:45-12:00p</td>
<td>8:30-10:30a</td>
<td>10:45-12:30p</td>
<td>12:30-1:00p</td>
</tr>
<tr>
<td>12:45-2:30p</td>
<td>Medication Administration</td>
<td>10:30-10:45a</td>
<td>Wound Care Staging</td>
<td>-Review/Validation -Arm Sling &amp; Elastic (ACE) WRAP BANDAGE -Staging -Revalidation Validator</td>
</tr>
</tbody>
</table>

#### Week Three at a Glance

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-10:30a</td>
<td>SITE</td>
<td>8:30-10:30a</td>
<td>SITE</td>
<td>8:30-10:30a</td>
</tr>
<tr>
<td>Skin Assessment</td>
<td>Orthopedics</td>
<td>8:30-10:30a</td>
<td>SITE</td>
<td>8:30-10:30a</td>
</tr>
<tr>
<td>-Issues in ambulatory care</td>
<td>-Arm sling &amp; Elastic (ACE) WRAP BANDAGE -Staging -Revalidation Validator</td>
<td>8:00-5:00p</td>
<td>SITE</td>
<td>8:00-5:00p</td>
</tr>
<tr>
<td>-Assessment</td>
<td>-Review/Validation</td>
<td>8:00-5:00p</td>
<td>CLINIC ROTATION Assignment: Orthopedic, Wound Care, &amp; Nurse Clinic</td>
<td>8:00-12:30p</td>
</tr>
<tr>
<td>-Intervention-supplies/medication</td>
<td>-Documentation PRESENTER</td>
<td>CLINIC ROTATION Assignment: Orthopedic, Wound Care, &amp; Nurse Clinic</td>
<td>CLINIC ROTATION Assignment: Orthopedic, Wound Care, &amp; Nurse Clinic</td>
<td>CLINIC ROTATION Assignment: Orthopedic, Wound Care, &amp; Nurse Clinic</td>
</tr>
<tr>
<td>-Education</td>
<td>-Referral</td>
<td>Refer to learning experiences and objectives</td>
<td>Refer to learning experiences and objectives</td>
<td>Refer to learning experiences and objectives</td>
</tr>
<tr>
<td>-Referral</td>
<td>-Documentation PRESENTER</td>
<td>10:45-12:30p</td>
<td>10:45-12:30p</td>
<td>10:45-12:30p</td>
</tr>
<tr>
<td>10:45-12:45</td>
<td>Break</td>
<td>CLINIC ROTATION Assignment: Orthopedic, Wound Care, &amp; Nurse Clinic</td>
<td>CLINIC ROTATION Assignment: Orthopedic, Wound Care, &amp; Nurse Clinic</td>
<td>CLINIC ROTATION Assignment: Orthopedic, Wound Care, &amp; Nurse Clinic</td>
</tr>
<tr>
<td>10:45-12:30p</td>
<td>Wound Care Staging</td>
<td>8:00-12:00p</td>
<td>Clinic to assign lunch times and breaks</td>
<td>Clinic to assign lunch times and breaks</td>
</tr>
<tr>
<td>-Intervention-supplies/medication</td>
<td>-Review/Validation -Arm Sling &amp; Elastic (ACE) WRAP BANDAGE -Staging -Revalidation Validator</td>
<td>12:30-2:00p</td>
<td>Lunch and Peer Group Discussion</td>
<td>(Bring Journal)</td>
</tr>
</tbody>
</table>
### III. Curriculum and Competency Presentation Grid

The following is a Curriculum and Competency grid that serves as a guide to determine the Resident’s progress. Please keep in mind that although there may be content and competencies that need to be met at certain times, there might be Residents and even Programs that progress at different schedules.

<table>
<thead>
<tr>
<th>Curriculum/Curriculum</th>
<th>Competency/Policy &amp; Procedure</th>
<th>Y=YES</th>
<th>Presentation Sequence New Grad</th>
<th>Exp RN</th>
<th>weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Nursing – Standards of Practice</td>
<td>1st day</td>
<td>1st day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory Nursing Roles</td>
<td>1st day</td>
<td>1st day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KP Nursing Model, Vision, and Values</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scope of Practice</td>
<td>1st day</td>
<td>1st day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Work Behavior</td>
<td>1st week</td>
<td>1st week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Health Care Team</td>
<td>1st week</td>
<td>1st week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situational Awareness</td>
<td>1st week</td>
<td>1st week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Strategic Goals, Ambulatory</td>
<td>2nd week</td>
<td>2nd week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall Prevention</td>
<td>2nd week</td>
<td>2nd week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Administration</td>
<td>Medication Administration</td>
<td>1st two weeks</td>
<td>1st two weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intramuscular Injections</td>
<td>Intramuscular Injections</td>
<td>1st two weeks</td>
<td>1st two weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subcutaneous Injections</td>
<td>Subcutaneous Injections</td>
<td>1st two weeks</td>
<td>1st two weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations</td>
<td>Immunizations</td>
<td>1st two weeks</td>
<td>1st two weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&amp; Observation Grids</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FACILITATOR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:30-3:15p Competencies continued</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:15-3:30p Break</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:30-5:15p Competencies continued</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5:15-5:30p Assignments for the next three days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>

### Hypertension

<table>
<thead>
<tr>
<th>Hypertension</th>
<th>weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure Measurement, Electronic</td>
<td>1st two weeks</td>
</tr>
<tr>
<td>Communication, SBAR</td>
<td>1st three weeks</td>
</tr>
<tr>
<td>Secure Messaging/Email</td>
<td>1st three weeks</td>
</tr>
<tr>
<td>IOM Report 2010</td>
<td>1st month</td>
</tr>
<tr>
<td>Code of Ethics for Nurses</td>
<td>1st month</td>
</tr>
<tr>
<td>Infection Control in Ambulatory Care – 1 day</td>
<td>1st month</td>
</tr>
<tr>
<td>Blood Glucose Monitoring</td>
<td>1st month</td>
</tr>
<tr>
<td>HipAA</td>
<td>1st month</td>
</tr>
<tr>
<td>Point of Care Testing</td>
<td>1st month</td>
</tr>
<tr>
<td>Urine Dipstick</td>
<td>1st month</td>
</tr>
<tr>
<td>Blood Glucose Monitoring</td>
<td>1st month</td>
</tr>
<tr>
<td>TST</td>
<td>1st month</td>
</tr>
<tr>
<td>Nasal Pharyngeal Specimen Collection</td>
<td>2nd month</td>
</tr>
<tr>
<td>Nasal Pharyngeal Specimen Collection</td>
<td>2nd month</td>
</tr>
<tr>
<td>Spirometry</td>
<td>2nd month</td>
</tr>
<tr>
<td>Throat Culture</td>
<td>2nd month</td>
</tr>
<tr>
<td>Nasal Culture</td>
<td>2nd month</td>
</tr>
<tr>
<td>Visual Acuity using the Snellen Chart</td>
<td>2nd month</td>
</tr>
<tr>
<td>Visual Acuity – Pediatrics</td>
<td>2nd month</td>
</tr>
<tr>
<td>Eye Drop Instillation</td>
<td>2nd month</td>
</tr>
<tr>
<td>Ear Lavage</td>
<td>2nd month</td>
</tr>
<tr>
<td>Skin and Wound Care – 1 day</td>
<td>2nd month</td>
</tr>
<tr>
<td>Wound Care</td>
<td>2nd month</td>
</tr>
<tr>
<td>Emergency Procedures</td>
<td>2nd month</td>
</tr>
<tr>
<td>Epi Pen</td>
<td>2nd month</td>
</tr>
<tr>
<td>EKG – 12 Lead</td>
<td>2nd month</td>
</tr>
<tr>
<td>EKG Interpretation</td>
<td>2nd month</td>
</tr>
<tr>
<td>Triage, face to face</td>
<td>2nd month</td>
</tr>
<tr>
<td>FOB/POS</td>
<td>3rd month</td>
</tr>
<tr>
<td>Age Related Care</td>
<td>3rd month</td>
</tr>
</tbody>
</table>
Classroom Learning

I. Curriculum Content Section Guideline

This section contains the curriculum content that is part of the RN Residency Program. Each lecture has objectives and an Instructor Guideline to assure consistency and quality between Instructors. The Instructor Guide contains strategies to make the session more interactive. This information is underlined in the guidelines. Lectures that need to be developed by the organization have identified objectives in its own section.

At the completion of all the content lecture, the Resident will be able to:
- Apply the standards to ambulatory professional practice.
- Demonstrate the role of the professional ambulatory registered nurse.
- Demonstrate leadership skills in the ambulatory setting.

In order to assure currency, the lecture content provided through the Program will be updated as regulations and clinical guidelines change. Each Nurse Educator is asked to discuss any needed updates to Program content with the Program Director.

II. Lecture Topics

The following is an outline of lecture topics that the Program covers. Some content may also be available in an eModule format, which can be reinforced in a classroom session. Other content may be delivered according to the medical center’s discretion.

<table>
<thead>
<tr>
<th>Topics</th>
<th>Instructor Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational Systems</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Nursing Practice</td>
<td>Yes</td>
</tr>
<tr>
<td>Ambulatory Nursing Standards of Practice</td>
<td>Yes</td>
</tr>
<tr>
<td>Communication – Nurse Physician</td>
<td>Yes</td>
</tr>
<tr>
<td>Communication – Crucial Conversations</td>
<td>Yes</td>
</tr>
<tr>
<td>Educational Resources</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare Team</td>
<td>Yes</td>
</tr>
<tr>
<td>HIPAA (Organization Specific)</td>
<td>Objectives Provided</td>
</tr>
<tr>
<td>Message Management (Organization Specific)</td>
<td>Objectives Provided</td>
</tr>
<tr>
<td>National Patient Safety Goals – Clinical Strategic Goals (Organization Specific)</td>
<td>Objectives Provided</td>
</tr>
<tr>
<td>Proactive Care Skills (POE) Proactive Office Skills (POS) (Organization Specific)</td>
<td>Objectives Provided</td>
</tr>
<tr>
<td>Situational Awareness</td>
<td>Yes</td>
</tr>
<tr>
<td>Scope of Practice – SOCAL (Template for Other Regions)</td>
<td>Yes</td>
</tr>
<tr>
<td>Secure Messaging/Email Etiquette (ambulatorypractice.org)</td>
<td>Online</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The Professional Nurse Role

- Critical Thinking                                  Yes
- Ethics Code for Nursing                             Yes
- Integrity                                          Yes

<table>
<thead>
<tr>
<th>Patient Education/Patient Self-Management</th>
<th>3rd month</th>
<th>3rd month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arm Sling &amp; Elastic (ACE) Wrap Bandage</td>
<td>3rd month</td>
<td>3rd month</td>
</tr>
<tr>
<td>Splinting</td>
<td>3rd month</td>
<td>3rd month</td>
</tr>
<tr>
<td>Bladder Scan</td>
<td>3rd month</td>
<td>3rd month</td>
</tr>
<tr>
<td>Urinary Catheter Insertion and Removal</td>
<td>3rd month</td>
<td>3rd month</td>
</tr>
<tr>
<td>Intravenous Administration</td>
<td>3rd month</td>
<td>3rd month</td>
</tr>
<tr>
<td>Leadership</td>
<td>3rd month</td>
<td>3rd month</td>
</tr>
<tr>
<td>Communication, RN/MD</td>
<td>3rd month</td>
<td>3rd month</td>
</tr>
<tr>
<td>Critical Thinking</td>
<td>3rd month</td>
<td>3rd month</td>
</tr>
<tr>
<td>Accountability</td>
<td>3rd month</td>
<td>3rd month</td>
</tr>
<tr>
<td>Central Lines, Assessment, Care, and Dressing Change</td>
<td>3rd month</td>
<td>1st month</td>
</tr>
<tr>
<td>Urinary Catheter Dressing Change Peripherally Inserted</td>
<td>3rd month</td>
<td>3rd month</td>
</tr>
<tr>
<td>Message Management</td>
<td>3rd month</td>
<td>3rd month</td>
</tr>
<tr>
<td>Educational Resources</td>
<td>4th month</td>
<td>4th month</td>
</tr>
<tr>
<td>Professional Portfolio</td>
<td>6th month</td>
<td>4th month</td>
</tr>
<tr>
<td>Communication, Crucial Conversations</td>
<td>4th month</td>
<td>4th month</td>
</tr>
<tr>
<td>Urinary Catheters for Special Procedures</td>
<td>4th month</td>
<td>3rd month</td>
</tr>
<tr>
<td>Telephone Advice</td>
<td>4th month</td>
<td>3rd month</td>
</tr>
<tr>
<td>Chronic Care Model</td>
<td>4th month</td>
<td>3rd month</td>
</tr>
<tr>
<td>Brief Negotiation</td>
<td>5th month</td>
<td>4th month</td>
</tr>
<tr>
<td>Diabetes</td>
<td>3rd month</td>
<td>3rd month</td>
</tr>
<tr>
<td>Foot Exam</td>
<td>3rd month</td>
<td>3rd month</td>
</tr>
<tr>
<td>Insulin Management</td>
<td>5th month</td>
<td>5th month</td>
</tr>
<tr>
<td>Therapeutic Phlebotomy</td>
<td>6th month</td>
<td>4th month</td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>6th month</td>
<td>5th month</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>5th month</td>
<td>5th month</td>
</tr>
<tr>
<td>Advanced Directives</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
III. Organizational Specific Lecture Topic Objectives

These objectives serve as a guide to develop organizational specific lectures.

Upon completion of the lecture, the RN Resident will be able to:

HIPAA
1. Understand the policies and procedures within the organization related to patient privacy and confidentiality
2. Understand specific HIPAA requirements as it relates to minors
3. Explain specific nursing responsibilities to assure patient privacy and confidentiality

Message Management
1. Explain the organizational policy and procedure for effective handling of messages
2. Explain how scope of practice guides the RN in appropriately managing messages within the ambulatory department

National Patient Safety Goals – Clinical Strategic Goals (CSGs)
(may not be applicable to all organizations)
1. Relate the current National Patient Safety Goals to Ambulatory Practice
2. Identify the organization specific CSGs
3. Describe the relationship between organization specific CSGs and National Patient Safety Goals
4. Explain the relationship of each CSG to nursing practice and the contribution of the RN

Proactive Care Skills (POE)/Proactive Office Skills (POS)
1. Identify opportunities to improve quality of care
2. Identify opportunities to improve the patient experience
3. Explain the processes used to improve preventative and chronic care management
4. Explain the processes to improve efficiency

Central Line Access & Dressing Change
1. Demonstrate the ability to inject medications safely into a variety of central lines
2. Describe precautions that are necessary when accessing central lines and performing a dressing change
3. Explain the components of site assessment
4. Utilize sterile technique when performing these procedures

Emergency Procedures
1. Understand organizational policies and procedures for specific emergencies such as chest pain, shortness of breath, and falls
2. Explain what emergency equipment are available and their locations in the primary clinic where the RN will be working
3. Utilize the emergency equipment appropriately and safely
4. Understand the emergency numbers used to contact internal and external support

Immunizations
1. Explain the use of the immunization patient education forms
2. Administer immunizations safely according to the national guidelines
3. Explain the possible reactions and the appropriate next steps
4. Explain the RN role in appropriately verifying the immunizations given by medical assistants before being given to a patient
5. Explain the current guidelines on administering the Flu Vaccine

Infection Control
1. Understand the components of and when to implement standard and airborne precautions
2. Explain the use of the State Public Health form on reportable diseases and the organizational policy and procedure
3. Perform adequate hand washing, and know when to wash hands
4. Understand the use of PPE
5. Demonstrate the process of donning and doffing in appropriate sequence

Medication Administration

1. Explain organization specific policies and procedures
2. Explain how to avoid interruptions and distractions during medication preparation
3. Explain the RN role in appropriately verifying the immunizations given by medical assistants before being given to a patient
4. Demonstrate the process of medication reconciliation

Oxygen Administration

1. Demonstrate the use and maintenance of an O2 E Tank
2. Understand the different oxygen delivery systems used in the ambulatory setting
3. Explain the clinical monitoring required for any patient receiving oxygen
4. Explain the precautions related to the safe administration of oxygen for a variety of age groups

Skin & Wound Assessment

1. Perform a complete skin assessment
2. Perform a complete wound assessment
3. Understand the referral process to the Wound Care Clinic
4. Demonstrate the appropriate dressing procedure on a variety of wounds

IV. eModule Topics

RN Residents are to complete online eModules to learn Program fundamentals as required prior to attending classes and/or clinical.

Available eModules:

- Program Introduction - the Resident is expected to become a contributing part of the health care team and transition well in the organization, whether the Resident is a new-graduate nurse, or an experienced nurse new to the specialty.

- Nursing Roles and Values - the Resident is expected to know his role in the interdisciplinary health care team, while promoting the nursing role through careful observation of both the profession and the organization’s vision, values, and model of care.

- Communication I and II - effective communication is central to the success of a healthcare team, and Residents must learn and apply principles and techniques to their new roles in Ambulatory Practice.

- Professional Topics - the Resident is expected to represent the nursing profession well, work collaboratively and effectively with patients, family members, and the healthcare team, utilize critical thinking, and exhibit nursing leadership to be successful in the Residency Program and beyond.

- Situational Awareness - the Resident is expected to understand what is going on around him and use critical thinking skills to decide what is likely to happen next.

V. eModule Leader Guides

To help reinforce the concepts learned from the online eModules, the following guides are outlined for application through concept reviews, discussions, role plays, and similar activities. Accompanying PowerPoints are also available for these classroom sessions. Please modify the PowerPoints, presentation styles, and scenarios to best fit your medical center’s needs.

Program Introduction

1. Ambulatory Nurse Residency Program

SAY: Welcome to the Residency Program and the class on Program Introduction.

DO: Ask the class what they remember as the definition of a “Residency Program”.

Write their responses in a list for the class to see.

EXPECTED ANSWERS:

Transition Program from:
- A pre-licensure or advanced degree Program
- Another clinical area

SAY: In 2010, the Institute of Medicine, or IOM, published their “Future of Nursing Report”. One of the recommendations of the report is to implement Nurse Residency Programs. It states (you can choose to either say this verbatim or have this written for the class to see):

“State boards of nursing, accrediting bodies, the federal government, and health care organizations should take actions to support nurses’ completion of a transition-to-practice Program (nurse Residency) after they have completed a pre-licensure or advanced degree Program or when they are transitioning into new practice clinical areas.”

SAY: Not all RN Residents in the program will have the same background or experience. Let’s talk about this.
DO: Ask the class to group themselves into new-graduate nurses and nurses new to the specialty.

SAY: Each group has its own set of challenges. No matter how limited or substantial your nursing experiences are, you are all newcomers to the Ambulatory setting. On a piece of paper, in your own groups first, write down how the Residency Program will be able to help you transition.

EXPECTED ANSWERS:
New-grads:
- Bridge the gap between theory and practice
- Reduce practice errors
- Offer the clinical experience that they did not have in school

Experienced RNs:
- Practice skills they probably have not used in awhile
- Provide support as they adapt to a new environment
- Provide additional training on skills that were seldom applied in previous practice areas

DO: Have the students share their responses in a small group setting first, then come back together as a class and share differences and similarities of the Program between the two groups as a large group.

SAY: No matter which group you belong to, the Residency Program is here to support you and help you become successful. We may not realize it right away, but we actually need such a Program for a variety of reasons:

(List the bulleted items down for the class to see as you lecture):
Needs Assessment:
- Complex Health Care Needs – [say] Patients are sicker, with multiple health conditions. Patients are at different stages of their health, requiring varied professional competencies and distinct clinical skills.
  You have mentioned not using certain skills in the other areas of nursing you came from- you may see many different kinds of patients in the ambulatory setting who need many different kinds of care.
- Education-to-Practice Gap – [say] Educators and employers agree that there is a gap in nursing between school and actual practice, especially in the ambulatory setting, that needs to be addressed.
  This was already mentioned too, especially by the new grad group.

- Risk for Practice Errors – [say] A National Council of State Boards of Nursing study found that newly licensed RNs report significantly fewer errors when they have a transition Program with a specialty content.
  This is a benefit, I believe, not only for the new grad group, but for all of you.
- Failure to Stay in the Job – [say] Exit interview data of Ambulatory RNs who left KP in the past indicated that many felt training was not adequate, and that the working environment was not tolerant of a transitioning RN.
  Having a support system for a number of months can really help a nurse talk through the challenges of being in a brand new job or environment.
- Slow Growth of Ambulatory Nursing – [say] Most RNs are employed in inpatient settings and there is a lack of ambulatory clinical rotations.
  Even if Ambulatory Nursing has been around for awhile, and a shift is moving towards primary care, rotations in this area of nursing are still very limited, and a transition Program will surely be beneficial for both the new and experienced nurse.

SAY: Let’s talk about the Program components and what you should expect from the Program overall.

SAY: The length of the program will depend on the medical center where you will be at. Sometimes, for the new grads, the Program is one year long. Sometimes, for experienced RNs, the Program is only six months long. During the time period, no matter the length of the program, RN Residents will rotate through different program components.

What are these Program components anyway?

DO: Ask for volunteers to role play the following scenarios in front of the class. After each scenario, ask the class which Program component the role play corresponds to.

SUGGESTED SCENARIOS:
(Randomize presentation; some of the suggested scenarios/scenario components may not be applicable to region [italicized]; Alternatives
offered whenever possible. Please modify as needed.)

- **Classroom Learning** – RN scanned the glucose strip prior to putting it into the glucometer to check the patient’s blood glucose level before he has a meal. However, he forgot to scan the patient’s ID band, so the instructor interfered and explained the steps to him again (Other examples: IV insertion, IV pumps, informational lectures, etc.).
- **Clinical Learning** – RN was changing a wound dressing, dropped the gauze on the floor, picked it back up, and continued to use it on the patient. The RN observing pulls this RN aside to let him know that he was not successful with the demonstrated competency.
- **Clinical Rotations** – RN is handing a bag of fluids and the RN who is assisting him asks who the fluids are for, what fluids they are preparing, how fast it is going to run, where they are going to hook it up, and when or how long does the patient need it (five rights of medication safety).
- **Peer-Group Sessions** – RN is sitting with a group of other RNs and they are talking about challenges in their rotations (not keeping up with skills, talking to patients, triaging patients, talking to the physicians, etc.). Another RN looks like he is leading the conversation.
- **Mentoring** – RN is having coffee with another RN and he is talking about how he feels Ambulatory Nursing may not be right for him. The other RN suggests he gives it at least a couple more weeks because he is only two weeks into the Program, and gives tips on how he “survived” (time management, let go of things you don’t have control over, etc.). This RN also offers to meet more often than usual if that will help the other RN.

**SAY:** Great job on remembering all the Program components. I hope you actively participate and really utilize all the resources provided to you.

Speaking of resources, aside from ones we already mentioned like the Preceptor and the Mentor, there are more who are available to you in this Program.

Let’s meet all of them.

**[It will be nice to actually have people with these roles drop by in the class to introduce themselves and share what they do. If not possible, just please proceed with the lecture].**

**SAY:** In the Residency Program, you will have four people who will primarily be your support system. They have different roles. Let’s discuss:

**DO:** Read the following scenario to the class (modify based on region if necessary) and allow for time to answer and talk as a large group after each section of the scenario:

“You are learning how to wrap ace bandages and apply splints. You are really nervous about your upcoming return demonstration on bandages and want to go over the steps with somebody first. Who should you approach?”

**EXPECTED ANSWER:** Validator.

“You are stressed out because you did not do well in your bandages return demonstration and need to talk to somebody. Who should you approach?”

**EXPECTED ANSWER:** Mentor.

“You think your relationship with your Mentor is not working out, and is not as therapeutic as you expected and needed it to be. Who should you approach?”

**EXPECTED ANSWER:** Nurse Educator.

“The Nurse Educator understood your frustration and source of stress,
and gave you a second chance at becoming successful at that return demonstration. Who should you approach? [EXPECTED ANSWER: Validator].

“You are very happy that you finally passed the return demonstration. You actually have a patient today who needs his leg bandaged. You need to review the orders to make sure you will carry out the intervention appropriately. Who should you approach?” [EXPECTED ANSWER: Preceptor].

2. Ambulatory Nursing Practice

**DO:** Ask the class what the Levels of Prevention are, and give examples. Write these down in a list for the class to see.

**EXPECTED ANSWERS:**
- **Primary** – Directed at individuals, groups, or populations who can be either well or ill. Examples: annual flu shots, well-baby check-ups, sports physicals.
- **Secondary** – Directed at people who already have an illness or disease. Requires early diagnosis and prompt treatment to avoid disability. Examples: treating diseases in the ED, administering medications, further screening for an existing illness.
- **Tertiary** – Directed at individuals who are recovering from an illness. Involves rehabilitation to return the body to its optimal function. Examples: smoking cessation, physical and occupational therapy.

**SAY:** Now that we understand the levels of prevention we are responsible for, as well as our main patient population groups, let us see where we work as Ambulatory Nurses.

**SAY:** Ambulatory Nurses work in a variety of different settings. Let’s talk about some of the most common.

(List the bulleted items down for the class to see as you lecture):
- **Urgent Care** – [say] Found inside or outside of hospitals. Most patients get confused on whether they need to go to the urgent care or the emergency department. Because of this, you may see patients who are acutely or chronically ill, requiring quick triage and possible emergency care.
- **Health Centers** – [say] can be found in universities, colleges, and some communities. Centers can offer immunizations, and provide general information and health education.
- **Procedure Centers** – [say] Most of these are outpatient centers, like surgery centers that perform same-day interventions such as tonsillectomies, adenoidectomies, endoscopies, and skin biopsies.
- **Clinics** – [say] Patients in clinics can have needs that are very broad or very specific. Clinics can be an OB-GYN clinic, a physician’s office, or a community health clinic.

**DO:** Ask the class if there are examples of practice settings they can think of that are not common.

**EXPECTED ANSWERS:**
- **Health Maintenance Organizations (HMOs)** – Provide integrated care and focus on prevention and wellness.
- **Government Health Systems** - Also focused on prevention and wellness, but health care is provided and financed by government through tax payments, such as Britain’s National Health Service.
- **Homeless Shelters** – Most shelters are run by not-for-profit organizations where nurses can volunteer and advocate for the shelter Residents.

**SAY:** What do you think of when you hear “shift to primary or preventive care”? Let’s talk about this.

**SAY:** There are several reasons that brought about the movement to preventive care, as opposed to reactive care, or simply treating diseases as they surface. Let’s list some of the main examples.

(List the bulleted items for the class to see as you lecture):
- **Changes in Reimbursement Strategies** – [say] Prospective payment for inpatient service has compressed hospital length of stay and moved care into ambulatory settings. Also, the growth of HMOs and capitalized reimbursement has created financial incentives to keep patients out of the hospitals and shifted the emphasis to preventive care.
- **Surgical Changes** – [say] There are improved methods for short-term anesthesia, minimally invasive surgical techniques, and advances in vascular access and intravenous pump
technologies, so surgeries considered major in the past can now be performed in an outpatient setting.

- Procedure Sites – [say] there is a growth of ambulatory surgery centers, infusion centers, and outpatient testing centers, which enable ongoing care for even severe chronic diseases like heart disease, cancer, and renal failure.

SAY: There are other trends impacting the growth of the ambulatory nursing field. I will list them for you to see, then we will divide the class into five small groups, I will assign a trend, and your group will talk about how the trend impacts you as Ambulatory Nurses. After a brief discussion in your small group we will share each group’s thoughts in a large class discussion.

DO: Clarify if there are any questions. Proceed with the activity.

OTHER TRENDS:
(List only the bulleted points for the class to see)

- Increasing Life Expectancy – Increasing the incidence of people living with chronic diseases and terminal illnesses. [EXPECTED ANSWERS: Shifting focus from reactive care to a more preventive type of care management and disease prevention; advancing skills to care for more people with chronic and terminal illnesses coming into outpatient settings.]

- Environmental Threats – More challenges from diseases emerging from mutating microbes, global warming, war, and terrorism. [EXPECTED ANSWERS: Become internationally aware in order to address health issues and the potential for the rapid spread of disease; be able to respond immediately and understand new treatment interventions, isolation techniques, and operational changes.]

- Increased Legislation and Regulation – New mandates such as HIPAA require organizations to securely promote, transmit, and house personal health information (PHI). [EXPECTED ANSWERS: Become more involved in patient advocacy not only in the clinical setting, but also in the legislative process; Center for Medicare and Medicaid Services (CMS) does not pay for some nosocomial (hospital-acquired) infections.]

- Technological Advances – Communication progress has introduced new ways of documenting and retrieving information, and has allowed for long distance diagnosis and monitoring. [EXPECTED ANSWER: Need to be technologically sophisticated, and be the translator for the technologically-challenged or non-tech savvy patient.]

- Consumer Awareness – There is an increased demand for accurate diagnosis, appropriate therapies, and reasonable reassurance that health concerns are addressed by a courteous and caring staff. [EXPECTED ANSWER: Need to include the patient and their families in clinical decision making, and make them partners in their plan of care.]

DO: Ask the class if there is anything else they can add to how these trends impact their nursing care. If they missed points listed here under expected answers, make sure that you highlight those during the discussion.

3. Transition into Ambulatory Care

SAY: Let’s review the differences between inpatient and ambulatory care settings.

DO: Ask the class to name the six major areas of difference between the two settings. List these for the class to see.

Inpatient vs. Ambulatory Care

- Treatment Episode
- Observation Mode
- Management of Treatment Plan
- Primary Intervention Role
- Workload Variability/Intensity
- Organizational Nursing Presence

DO: Ask the class for volunteers to role play the following scenarios regarding inpatient and ambulatory care setting differences. After each scenario, ask the class to name the challenge(s) Ambulatory Nurses might face in the given situation.

SUGGESTED SCENARIOS:
(Some of the suggested scenarios/scenario components may not be applicable to region. Please modify as needed.)

- Treatment Episode – Patient calls the outpatient clinic complaining of chest pain. Nurse gathers as much information as he can and advises patient to come in and get checked out. Patient ends up being admitted for an acute myocardial infarction. [EXPECTED CHALLENGE: The Ambulatory Nurse has a limited amount of time over the phone or even face-to-face to triage and assess the patient and get him the appropriate care and treatment he needs.]

- Observation Mode - Ambulatory Nurse refers a patient to be admitted to the inpatient unit for status asthmaticus. Patient gets discharged from the hospital and is back to the emergency room two days later. [EXPECTED CHALLENGES: The Ambulatory Nurse has to establish relationships with his
patients and the community because they can come back at any time. The nurse’s assessments and patient teaching? Need to be thorough, no matter how brief the first encounter was.]

- Management of Treatment Plan – Patient’s wound is being dressed by the nurse prior to being discharged from the hospital. Patient is advised to visit the clinic to follow-up with his dressing after 24 hours. In the clinic, the nurse teaches the patient to dress his own wound, and provides the patient his initial wound care supplies and resources on where to buy or obtain more. The nurse also teaches the patient about the signs and symptoms of infection, and when to call the clinic about his wound. [EXPECTED CHALLENGES: Ambulatory Nurses should be well-informed to address their patient’s needs and partner with them in implementing their plan of care. Sometimes, involving family members, other care givers, and outside resources is part of the nurse’s role as well.]

- Primary Intervention Mode – Mother asks the Ambulatory Nurse where she can buy and how she can pay for her infant’s higher calorie formula that was prescribed because she can’t find it in most stores. Nurse asked how she was getting it in the hospital, and the mother said that it came already prepared for them. [EXPECTED CHALLENGES: The Ambulatory Nurse acts more as a care manager than a care implementer. The Ambulatory Nurse needs to work more closely with the health care team and know various resources in order to be a better advocate for the patient.]

- Workload Variability/Intensity – It is flu-season and the clinic has patients ranging from infants who need the vaccine for the first time, to the elderly who are showing signs and symptoms of influenza. [EXPECTED CHALLENGES: Patients coming to ambulatory care have no set time or schedule, and their acuity may vary. There is also a wide variety in the age range in some areas of the ambulatory setting, and nurses need to be familiar with how to adjust their care based on these patients’ needs.]

- Organizational Presence of Nursing – The nurse’s patient was stable when first admitted to the clinic but rapidly deteriorated. The nurse looked for the physician, and informed him directly of the patient’s status. [EXPECTED CHALLENGE: Ambulatory Nurses often work more closely with physicians, as well as other members of the health care team, and do not have any other voice but their own when advocating for their patients.]

SAY: Even with these identified challenges, a lot of nurses like you still transition to the ambulatory setting. Let’s look at some reasons why.

SAY: Some of the identified reasons that nurses move to the ambulatory setting are as follows:

Reasons for Transition:
(List only the bulleted points for the class to see.)

- Work More Closely with Physicians – [say] Working in the ambulatory setting can be seen as a great opportunity for professional development as we advance the nursing profession towards greater professional autonomy and collaboration.

- Independence with the Nursing Role – [say] with the advancement of the nursing profession, there is also a push for independence in practicing within the nursing role. Ambulatory Nurses act with more autonomy, especially when conducting patient assessments and being patient advocates.

- Alternative Nursing Opportunities – [say] Ambulatory Nurses also work more closely with patients and family members, and even with other members of the health care team, as teachers and collaborators to design and implement the patient’s plan of care.

DO: Ask the class what their personal reasons are for their transition or choice to work in the ambulatory setting. Have a short discussion about this. List some of their reasons for the class to see, as related to the three identified “Reasons for Transition” (for example, if somebody says they chose the ambulatory setting for scheduling flexibility, that can still be related in a way to alternative nursing opportunities where the nurse is not always exhausted at work and has more time to spend with patients and family members).

SAY: We discussed expected challenges that Ambulatory Nurses face in the practice setting. Let’s talk about what you think you will face as new nurses to the specialty.
**SAY:** Before we begin, let’s revisit some of the responsibilities that are expected of you as new nurses.

(List only the bulleted points for the class to see.)

- **Organization of Care** – [say] this means setting priorities and effective communication, not only with your patients, but also with your colleagues.
- **Triage** – [say] this is practicing a good screening and referral process, along with accommodating for possible sensory overload.
- **Gaining Knowledge** – [say] this means taking on the responsibility to continue to grow professionally by integrating old and new knowledge to your care delivery.

**DO:** Ask the class to share which of these responsibilities they think will have the most challenges. List the responses for the class to see.

After 5-10 examples, share how one can overcome the listed challenges.

**Examples:**
- **Time Management** – Falls under organization of care. Make sure you are effectively prioritizing and delegating patient care so you have time to divide between your patients and your workload.
- **Talking to Physicians/Practitioners** – fall under organization of care. Effective communication may come with practice, but remind them that they have a module coming up (if they have not taken it yet) about the SBAR method of communication that may be able to help.
- **Triage** – This may be a completely new skill for most nurses, but assure them that they will receive the proper training and orientation on how to be effective on the job.

**DO:** Ask the class if they have any more questions or clarifications about all the concepts discussed today. Clarify or reinforce those concepts if needed.

**SAY:** This concludes our class on Program Introduction. Remember that this is only the beginning – we do not expect you to be experts right from the start. Do not be afraid to ask questions, this is your time to learn, so please use your time well. Remember that you bring your own unique experience to the Program, no matter if you are a brand new nurse, or a nurse with years of experience. Again, I welcome you to the Residency Program.

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**Nursing Roles and Values**

1. **Role Clarification in the Health Care Team**

**SAY:** Before we review the members of the Health Care Team, let’s take a step back and talk about what a team is.

**DO:** Ask the class what is their definition of “team”.

Write their responses in a list for everyone to see.

**SAY:** “Team”, simply defined, is a number of persons associated in some joint action, for example, “a team of advisers”, or in our case, “a health care team”.

**DO:** Point out some of the responses. See if anybody said that a “team” is a “group”, then say the following:

**SAY:** Is a group a team? How do teams develop? Let’s talk about this.

**SAY:** A group does not make a team. Members of a work group can be independent and may simply influence one another in their actions. A team, on the other hand, has members who are interdependent, and who collaborate with each other.

Groups can become teams. Let’s see how teams develop (list the bulleted items for the class to see as you lecture):

- **Forming** – [say] Members define tasks, determine acceptable ways to interact, and learn how to address problems.
- **Storming** – [say] Members try to work things out but may still see frustration arguments; defensive behavior & competition may ensue.
- **Norming** – [say] Members formulate new rules and agree on approach to problem-solving; disagreements are negotiated, and members learn to share one another’s strengths and weaknesses, leading to potential relationships outside the team.
- **Performing** – [say] Members integrate and apply the knowledge, skills, values, and attitudes gained and experienced to achieve the desired outcome related to the identified goals and objectives.
SAY: Teams can have different functions. Let's look at the different types of teams we can have in our organization.

SAY: Teams can vary based on what they are meant to accomplish.

(List the bulleted items for the class to see as you lecture):

- **Task Team** – [say] Members come together for meetings with a goal to accomplish a specific task such as resolving a particular work environment problem.
- **Work Team** – [say] Members are permanently committed to a collaborative responsibility for producing services.
- **Program/Project Team** – [say] Members work together to introduce a new product, Program, system or initiative.

**DO:** Ask the class for examples for each of the types of teams. Write down their responses for the class to see. Some of the suggested examples may not be applicable to region. Please modify as needed.

**SUGGESTED EXAMPLES:**

**Task Team**
- Group of nurses conducting “skin rounds” to help reduce risks for pressure ulcers
- Quality personnel checking staff compliance with hand washing and donning personal protective equipment (PPE)

Work Team
- Nursing team
- Pharmacy team

Program/Project Team
- Super users for new hospital equipment
- Group of nurses preparing staff for The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)/Magnet visit

**SAY:** Just because you have, or joined, a team does not mean you will automatically become successful. Let's take a look at the characteristics of an effective team.

**SAY:** For a team to be effective, it has to have several characteristics:

(List the bulleted items for the class to see as you lecture):

- **Objectives** – [say] a team has a purpose or a mission that is understood, shared, and felt to be worthwhile by every member involved. The mission provides a point of reference and focus for all decision making and encourages commitment from the team members.
- **Structure** – [say] the roles and responsibilities of each team member are defined.
- **Atmosphere** – [say] Team members develop a distinctive spirit of trust, support, openness, caring, commitment, and enjoyment when working with each other.
- **Energy** – [say] Team members’ enthusiasm for reaching their common goal is contagious and motivating.
- **Output** – [say] Team members build on each other’s talents, help each other, and produce more than any one individual could have.

**SAY:** In the health care setting, individuals from different disciplines come together to care for patients. They become one cohesive team and display teamwork when they work towards the same goal and have the effective team characteristics we just outlined.

Let's take a closer look at the different members of our health care team.

**DO:** Ask the class to name the members of the health care team.

**EXPECTED ANSWERS:**

- Physician
- Registered Nurse (RN)
- Licensed Vocational Nurse (LVN)
- Medical Assistant (MA)
- Pharmacist
- Therapists
- Dietary Personnel
- Unit Clerk
- Volunteers, etc.

**SAY:** As nurses, you will work closely with the nursing team.

**DO:** Ask the class to identify the nursing team, along with their roles.

**EXPECTED ANSWERS:**

- **RN** – responsible for implementation of plan of care and supervision of assistive personnel
• **LVN** – responsible for basic nursing care  
• **MA** – responsible for assisting with direct patient care and performing routine procedures

**SAY:** Aside from those basic responsibilities, you must know the role differences of the members of the nursing team when it comes to the application of the nursing process, as well as delegation. Let’s explore these some more.

**SAY:** Let’s look at the following scenarios and figure out which member of the nursing team should do the task that is called for, or if the task they are doing is appropriate for their role.

**DO:** Ask for volunteers to role play the following scenarios (modify based on region as necessary) and allow for time to answer the questions and talk as a large group after each:

**SUGGESTED SCENARIOS:**

- A patient walks into the clinic complaining of a headache. He was taken to the exam room and needs to have his vitals recorded. Most members of the nursing team are busy with other admissions and patients, so the **LVN** assigned the vitals to another team member.
  
  **QUESTION 1:** Who should take the patient’s vitals?  
  **EXPECTED ANSWER:** MA; **QUESTION 2:** Did the **LVN** assign the task appropriately?  
  **EXPECTED ANSWER:** Yes (LVNs can assign tasks to MAs).

- The **MA** was not happy that the **LVN** asked him to do something, so he looked for another MA to do it for him.  
  
  **QUESTION:** Did the **MA** assign tasks appropriately?  
  **EXPECTED ANSWER:** No (MAs cannot assign tasks or delegate responsibilities).

- The **LVN** found out that the **MA** whom he approached to obtain vitals did not perform his task, and asked another person to do his job. The **LVN** told another **LVN** about what happened.
  
  **QUESTION:** Was this an appropriate escalation of issue?  
  **EXPECTED ANSWER:** No (should be RN).

- The **RN** was finally informed of the issue, and spoke with the **LVN** and **MA** to find out what happened. The **RN** needs to talk to the **MA** further, but realized he is behind on his cares. He asked the **LVN** to finish his interventions for him.
  
  **QUESTION:** Was this an appropriate delegation?  
  **EXPECTED ANSWER:** Yes (RN can delegate to LVN who can do basic assessment without synthesis of data, diagnosis, or evaluation).

**SAY:** We have been saying that **RN**s can delegate, and **LVN**s can assign, but what is the difference between these two terms?

**DO:** Ask the class the difference between delegation and assignment. Write their responses in a list for the class to see.

**SAY:** With defined roles, members helping each other, open communication, and a common goal, the health care team can surely be effective and lead to better patient outcomes, higher patient/customer satisfaction, greater patient safety, and high quality results.

Most of all, we will look forward to going to work every day because we actually like where we work and who we work with!
2. Nursing Roles in Ambulatory Care

DO: Ask the class what comes to mind when they hear the term “conceptual framework”.

EXPECTED ANSWERS:
- Blueprint
- Guide
- Diagram

SAY: In 1998, Dr. Sheila Haas led a group of AAACN members to develop the ambulatory care nursing conceptual framework, which aimed to describe the ambulatory care nurse role and the essential knowledge and skills required by nurses practicing in this role.

The conceptual framework has 61 core areas of knowledge and skills identified as Dimensions of Practice, which are organized into 3 broad roles. To complete the framework, the patient population was also defined in the categories of well, acute, chronic, and terminally ill—the types of patients we may see in the ambulatory setting today.

Let’s look at the 3 broad categories of nursing roles more closely.

DO: Ask the class if they remember the 3 broad nursing roles as outlined by the conceptual framework.

EXPECTED ANSWERS:
- Organizational/Systems
- Professional
- Clinical

SAY: Let’s talk about Organizational/Systems first. Nurses practice within this role when they:
- Manage and coordinate resources
- Advocate for one patient or a group of patients
- Participate in internal and outside meetings to make changes to improve the care experience for all patients
- Delegate care and supervise that delegation

DO: Ask the class what nursing positions come to mind when they think of the Organizational/Systems role. Write their answers down in a list under “Organizational/Systems” for the class to see. Some of the examples provided may not be applicable to region—please modify as necessary.

SUGGESTED EXAMPLES:
- Ambulatory Nurse
- Case Manager
- Nurse Manager
- Advanced Practice Nurse

DO: Ask the class if they can remember the members of the nursing care team who can delegate.

EXPECTED ANSWER:
- RN

SAY: Remember that only RNs can delegate care. LVNs can assign care. MAs cannot delegate nor assign care. All of the RN roles we named can delegate, but as a rule of thumb, ask these questions before delegating a task:
- Does the task require nursing knowledge, skill, or independent judgment?
- Is the task within scope of practice or educational preparation?
- Is the person competent to perform the task?
- How often does the person do the task?
- Does the task involve initial RN assessment, analysis, development of plan, or evaluation of patient’s response or progress?

SAY: Let’s move on to the next category—the Professional role.
SAY: Nurses practice within the Professional role when they:

- Practice according to professional, ethical, and organizational standards
- Continually expand nursing knowledge of self and staff [highlight expanding knowledge]
- Continuously improve the quality of health care practices and outcomes
- Demonstrate leadership skills within the healthcare organization, in the community, and across the profession
- Apply current best-evidence to guide health care decisions, also known as evidence-based practice [highlight evidence-based practice]

DO: Ask the class what nursing positions come to mind when they think of the Professional role. Write their answers down in a list under “Professional” for the class to see. Some of the examples provided may not be applicable to region—please modify as necessary.

SUGGESTED EXAMPLES:
- Ambulatory Nurse
- Case Manager
- Nurse Manager
- Advanced Practice Nurse
- Nurse Educator
- Nurse Informatics Specialist

SAY: Evidence-based practice is such a buzz word, but what does that mean to you, if you are a nurse in one of the roles that we just named?

DO: Have the class discuss as a large group the different ways they can demonstrate evidence-based practice. Encourage them to be as specific as possible. Modify/add to examples as necessary to accommodate regional differences.

SUGGESTED EXAMPLES:
- Ambulatory Nurse – nurses have been taught to not give oxygen to patients who have chronic obstructive pulmonary disease (COPD). However, evidence suggests that withholding oxygen from these patients in an effort to prevent hypercarbia is dangerous and unwarranted.
- Nurse Manager/Case Manager – in some hospitals, there are policies that limit the number of visitors, or who specifically can visit the patient while hospitalized. Reasons behind such policies can be summarized into concerns for space, crowding, and the nurses’ perception that they need to provide care for both the patient and visitors. However, studies have shown that liberal visiting policies actually have beneficial effects on both the patient and family. The Joint Commission recently acknowledged the importance of family-centered care and visitation in providing support to patients.
- Advanced Practice Nurse/Educator – in many hospitals the use of cell phones on patient floors, especially critical care areas with machines, has been banned. The science behind this is that cellular devices, when turned “on”, transmit detrimental electromagnetic interference that may affect medical devices. Many nursing apps that help practitioners and students nowadays are on smart phones, and a cell phone ban on units excludes a key tool that is used as a vital source of information. Evidence suggests that the range of electromagnetic interference with various types of medical equipment is 0 to 300cm (9 feet). Based on this, new guidelines must be developed that would change current policies of hospital-wide cell phone bans.
- Nurse Informatics Specialist – even though most hospitals have transitioned to using electronic medical records (EMRs) already, most still duplicate effort by resisting change and continuing to paper chart. Paper charting, when unnecessarily done, is the most expensive yet least measured cost expenditure within health care organizations.

SAY: Evidence-based practice, defined, is the conscientious and judicious use of current best evidence to guide health care decisions.

DO: Ask the class why evidence-based practice is not being practiced more consistently.

SUGGESTED ANSWERS:
- The “we’ve always done it this way” mentality
- Nothing bad has happened
- Lack of knowledge related to knowing about the best practices and how they should be applied

SAY: As professional nurses, we need to change this mentality and push the use of evidence when we deliver patient care. Applying evidence and not just doing what we’ve always done:

- Enhances our practice
- Reduces variations in practice
- Integrates clinical expertise with best available evidence from research
- Improves quality
- Reduces cost
- Demonstrates the value of nursing
SAY: Still staying in the Professional role, what other main point did we emphasize you should do to keep up with your knowledge and skills as an Ambulatory Nurse?

EXPECTED ANSWERS:
- Staff Development
- Certifications

SAY: Let’s talk about these more closely.

SAY: Nursing professional development is a lifelong process of nurses actively participating in activities that assist in developing and maintaining competence.

DO: Ask the class how they keep current on changes in nursing and medicine that affect their practice.

SUGGESTED ANSWERS:
- Access databases - Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, or MedLine
- Read journals - Journal of Ambulatory Care Management and Nursing Economics, etc.
- Be involved in organizations – American Academy of Ambulatory Care Nursing; other local organizations

SAY: These resources can advance your nursing knowledge and skills by providing you with information and even education to keep you up to date on your role. But how can you validate these skills and abilities in your area of practice?

SUGGESTED ANSWER:
- Certification

SAY: A certification is a mechanism to validate and recognize knowledge, skills, and abilities in an area of specialty practice. As Ambulatory Nurses, we can obtain certification in Ambulatory Care Nursing. This is available through the American Nurses Credentialing Center, or ANCC, a division of the American Nurses Association.

Benefits of being certified include professional and personal recognition, career progression and opportunities, increased quality of care, and increased patient safety. Some hospitals also compensate more if a nurse has certifications for a particular specialty (regionalism).

SAY: Finally, let’s move on to the last big category – the Clinical role.

SAY: Nurses practice within the Clinical role when they:
- Provide direct patient care
- Engage in patient care management and the advocacy for options and services to meet an individual’s needs
- Promote patient self-management, which is involving the patient more in his plan of care in order to adopt healthy behaviors

DO: Ask the class what nursing positions come to mind when they think of the Clinical role. Write their answers down in a list under “Clinical” for the class to see. Some of the examples provided may not be applicable to region- please modify as necessary.

SUGGESTED EXAMPLES:
- Ambulatory Nurse
- Case Manager
- Advanced Practice Nurse
- Clinical Nurse
- Advice Nurse

SAY: Let’s talk about advocacy. That’s another term that we hear a lot in nursing. What comes to mind when you hear “advocacy”, or being a “patient advocate”? [Write responses down for the class to see].

EXPECTED ANSWERS:
- Active support of an important cause
- To assert the patient’s choices or desires on behalf of a patient

SAY: In the role of an advocate, the nurse acts to protect human dignity, privacy, and self-determination choices.
DO: Read the following suggested scenarios to the class. After each scenario, have a large group discussion on how the nurse can display patient advocacy. Some scenarios may not be applicable to the region. Please modify as needed. Emphasize empowering patients to transition better to the next concept.

SUGGESTED SCENARIOS:

- You are taking care of an older patient who is turning 65 in a few months and need Medicare insurance advice. [EXPECTED ANSWERS: Updated patient’s records, provided resources on several insurance companies with supplemental Medicare insurance plans, arranged for a case worker to work with patient to get in touch with those insurance companies to see which plan best meets the patient’s needs.]

- A 40-year-old female has been diagnosed with breast cancer after a follow-up biopsy following an abnormal mammogram. [EXPECTED ANSWERS: Gave the patient information about her diagnosis, educated her on what treatment options to expect, helped her coordinate the health care team that would be involved in her plan of care, answered any other questions and concerns she may have with honesty.]

- The son of an elderly man contacted the clinic asking about obtaining some wound care for his father who was just discharged. [EXPECTED ANSWERS: Gathered more information to develop a wound care plan with practitioner or physician, contacted a case worker to arrange for care, and sent a home health nurse to help apply dressings twice a day and teach the patient and family members the process.]

SAY: If you have noticed in our examples, the nurse does not just educate the patient and let them be. The nurse educates the patient, and then provides the patient with resources to better help him or her with the plan of care. Let’s talk some more about this.

DO: Ask the class what they think the difference is between patient education and self-management. Write their answers down in a list for everyone to see, separated in a group for patient education, and self-management.

EXPECTED ANSWERS:

Patient Education
- One-way communication
- Provider-centered
- Increases knowledge

Self-management
- Two-way communication
- Patient-centered
- Helps patient adopt health behaviors

SAY: There is nothing wrong with patient education, in fact, that is something we need to be providing. But we need to make sure that instead of just giving the patient or family information, we are partnering with them in their plan of care. Self-management is more than just teaching and learning. Behavioral change is required for the patient to adopt what they have learned.

DO: Ask the class to name the self-management examples in the scenarios that were discussed under advocacy.

EXPECTED ANSWERS:

- Medicare example – gave the patient resources for him to choose which one may fit his needs, as compared to just telling the patient what will be best for him without his input.

- Breast cancer example – empower the patient with information and the option to choose who will be involved in her health care team, instead of just telling her what happens next.

- Wound care example – arranging for a nurse to help with the dressings and have the patient and family be able to perform dressing changes as well.

SAY: Remember that in the ambulatory setting, we function more as care managers than implementers. We function in this collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes.

We also help set goals for our patients that are specific, timely, achievable, and measurable, which ensures their success in adhering to their plan of care.

SAY: We have just learned about the three broad nursing roles in the ambulatory care setting – Organizational/Systems, Professional, and Clinical – and the many “hats” or other roles that nurses perform under each.

With today’s changing health care demands and the advancement of technology in the care industry, there are two specific roles that are emerging in Ambulatory Nursing. Let’s take a closer look at these two.
DO: Ask the class if they remember what a Chronic Disease Manager does. Have a short large group discussion.

EXPECTED ANSWERS:
- Relies on aggressive prevention of complications as well as treatment of chronic conditions
- Involves a clear understanding of the natural course of a disease in a population and the effect of interventions
- Utilizes resources in the community, the role of the family, patient self-management, and the health care practice

DO: Ask the class where Chronic Disease Managers might work. Add to the list as necessary. Have a short discussion on who may want to go into this role, or who finds this role fascinating, and why.

EXPECTED ANSWERS:
- Specialty clinics
- Outpatient centers
- Case management

SAY: How about Telehealth nursing? What does that entail?

EXPECTED ANSWERS:
- It is the delivery, management, and coordination of care and services provided via telecommunication technology within the domain of nursing
- It integrates electronic information and telecommunication technologies to increase access, improve outcomes, and contain or reduce cost of care

DO: Ask the class where Telehealth nurses might work. Add to the list as necessary. Have a short discussion on who may want to go into this role, or who finds this role fascinating, and why.

EXPECTED ANSWERS:
- Specialty clinics
- Surgery centers
- Outpatient centers
- Insurance helplines

SAY: Now that we are a lot more familiar with the variety of roles we can assume as Ambulatory Nurses, let’s talk about the Standards of Practice that help inform our practice as we perform our chosen roles.

SAY: The Scope and Standards of Practice for Professional Ambulatory Care Nursing was first published in 1987, and is being continuously revised with the expanding specialty and the changing health care environment. We are currently on the eighth edition, published in 2010.

There are ten standards of Professional Nursing Practice [list these as you lecture]:
- Ambulatory administrative nursing practice
- Staffing
- Competency
- Clinical nursing practice
- Continuity of care
- Ethics
- Environment
- Nursing knowledge development
- Performance improvement
- Leadership

For our purposes, we will focus on four standards that we encounter a lot more than the others in our practice, but I invite you to be familiar with all of them. These four standards are:
- Competency
- Clinical nursing practice
- Continuity of care
- Ethics

DO: Ask the class if they remember what each of the four standards mean. Write down their responses for the class to see.

EXPECTED ANSWERS:
- Competency – having the ability to demonstrate the technical, critical thinking, and interpersonal skills necessary to perform your job.
- Clinical nursing practice – involves identifying clinical situations that run across populations of patients based on age and geographic area.
- Continuity of care – care received over time and across venues that is coordinated by information that is shared, plan of care that is shared, and handoffs that are seamless by the health care team.
- Ethics – supporting a process of informed decision-making by the patient or their family by providing information, listening to questions, helping to problem-solve, and assuring continuity of care.
DO: Ask for volunteers to role-play the following scenarios in front of the class. After each scenario, ask the class which standard was demonstrated. Some scenarios may not be applicable to region. Please modify as necessary.

SUGGESTED SCENARIOS [Mix up presentation]:

- **Competency** – the physician ordered digoxin for the patient. The nurse counted the patient’s apical pulse and it was 40, so he held the drug and informed the physician.

- **Clinical nursing practice** – the nurse noticed an increasing number of patients coming in for vomiting and diarrhea. He looked up that these patients are from the same county and have the same water supply, so he contacted the local health care department to alert them of the issue.

- **Continuity of care** – the nurse is transferring a pediatric patient who was admitted for asthma to the pulmonary unit. However, the patient’s family still hasn’t arrived from admission, so the nurse traveled with the patient to ensure his care and to be able to answer questions about his history and medications.

- **Ethics** – a mother is refusing to have her infant vaccinated. Instead of “forcing” the mother to conform, the nurse gave her educational resources about the pros and cons of vaccinations, and where to locate forms to submit to daycare/school about her unvaccinated child.

SAY: We can take on any role in ambulatory nursing, but always remember the responsibilities that come with each role, and have the standards guide your practice no matter which area of ambulatory care you end up working.

3. Nursing Vision, Values, and Model of Care

DO: Ask the class if they remember the organization’s Vision.  

EXPECTED ANSWER: 

- Extraordinary nursing care, every patient, every time.

SAY: Before we go on and talk about our Nursing Values that help guide us in delivering extraordinary nursing care at all times, let’s take a step back and discuss the Code for Nurses and see where it all started.

SAY: From its inception as a professional group, nursing has been concerned with the moral responsibility of its practitioners, has expressed a commitment to high ideals for providing service, and has professed a belief in the pivotal role nurses must play in improving patient welfare, no matter what the setting.

The first recognized Code came about in 1893 with the Florence Nightingale Pledge.

Beginning in the 1920s, drafts of Code were written and suggested by the American Nurses Association, or ANA, but it wasn’t until 1950 that the ANA adopted the first official Code. Since then, revisions were written, and in the 70s, interpretive statements were added.

We are at the 2001 edition where 9 provisions were written with interpretive statements. The first 3 describe the most fundamental values and commitment of the nurse. The second 3 address boundaries of duties and loyalty. And the last 3 address aspects of duties beyond individual patient encounters.

Let’s look at each provision more closely.

DO: Have the class divide themselves into three groups. Give each group a “cluster” of provisions (i.e. group 1 gets provisions 1-3; look up provisions on ANA’s website). Let the groups discuss their cluster, and then come up with one or two short scenarios of what they might see in the clinical setting and how they can uphold the nurse’s code.

SUGGESTED EXAMPLES: [Modify based on region as necessary]

- **Provisions 1-3**: Family refuses to put child on an Allow Natural Death (AND) code status, even though the child’s quality of life is already compromised; Nurses work through differing opinions to attain same goal of patient safety; Nurse gives the patient additional information about his plan of care in order to involve him in his care decisions.

- **Provisions 4-6**: Nurse follows up on the vital signs that she assigned the MA to obtain from the patient they just admitted; Nurse documents that the patient missed his morning meds because of a miscommunication with pharmacy, and to make sure that the patient is dosed appropriately for the next round;
Nurse is supportive and encouraging of his fellow nurses who are learning, or who may have made mistakes, and focuses on steps to make the person and profession better.

- Provisions 7-9: Nurse is actively applying evidence-based practice in his cares; Nurse is active in the community and aware of public health efforts in his area; Nurse is involved or shows enthusiasm about research and certification to advance the nursing profession.

SAY: There is also the International Code of Ethics for Nurses that works hand in hand with the Codes we just discussed. The Code of Ethics has four fundamental responsibilities [you can choose to list the bulleted points for the class to see as you lecture]:

- To promote health
- To prevent illness
- To restore health
- To alleviate suffering

It also has the four elements of:

- Nurses and people
- Nurses and practice
- Nurses and the professions
- Nurses and co-workers

How do we implement the Code of Ethics in our everyday practice? We need to know that the environment in which we work supports its provisions, as it does in our organization, and use the voice that it gives to nursing.

SAY: The Code should inform how we deliver our nursing care. Our knowledge and practice of the Code should also work hand in hand with the six Nursing Values that serve as our organization’s principles for conflict resolution and decision-making.

DO: Ask the class if they remember what the six Nursing Values are. List their answers for the class to see.

EXPECTED ANSWERS:

- Professionalism
- Patient and Family-Centered Care
- Compassion
- Teamwork
- Excellence
- Integrity

SAY: Let’s look at our Values more closely.

SAY: I will read you a scenario, then you tell me which Value it pertains to and why.

SUGGESTED SCENARIOS [Mix up presentation; modify scenarios as needed to accommodate regional differences]:

- Anita shows up to work every day on time, and displays collegial behavior as she works with the different members of the health care team [EXPECTED ANSWER: Professionalism – valuing the profession, acting in accordance with our standards of care].
- Jenna asks the patient’s son about the best way to clean his elderly mother’s G-Tube site [EXPECTED ANSWER: Patient and Family-Centered Care – honoring the essential role of the patient and family in all aspects of care].
- Amber skips her break to stay with her patient who is receiving blood for the first time and is very afraid something bad might happen [EXPECTED ANSWER: Compassion – realizing the difference we make in the lives of our patients and families when they are most vulnerable, caring with a personal touch].
- Trent wants to change his patient’s wound vac dressing, but decides to wait on the ostomy nurse who requested that he assess the patient’s wound to recommend further interventions [EXPECTED ANSWER: Teamwork – respecting the collective contributions of each member of the team, partnering for success].
- Jake makes sure that he chooses the correct blood pressure cuff for his patient before obtaining the patient’s vital signs, even though everybody else has been using a regular adult cuff on the smaller-sized adult patient [EXPECTED ANSWER: Excellence – integrating compassionate care with evidence-based practice and nursing theories].
- Sabrina tells her patient that she will be back with his meds in ten minutes. After ten minutes, the patient’s meds have not arrived from pharmacy yet, but Sabrina makes sure that she still goes back to her patient and tells him what is going on [EXPECTED ANSWER: Integrity – upholding the trust that others place in us].
SAY: We reviewed what our organization’s Vision is. We learned about the Code for Nurses and how it guides us as we deliver extraordinary care. We also revisited the six Nursing Values that help us with our everyday decision-making.

It’s time to bring it all together and look at the Nursing Model of Care that describes how we practice, collaborate, communicate, and develop professionally. Our Model of Care is a unifying framework for what we believe about nursing practice and supports nursing care across the continuum.

SAY: The Nursing Model has five key components. Some of the components may already sound familiar to you, as they are also part of our nursing values. Let’s discuss.

[List the bulleted points for the class to see as you lecture.]

- **Patient and Family-Centered Care** – [say] at the heart of our Nursing Model is our Patients and Families. We value who they are as individuals, we acknowledge their preferences and choices, and accept what they bring to the health care partnership.

- **Discipline and Practice of Nursing** – [say] nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human responses, and advocacy in the care of individuals, families, communities and population.

- **The Four Components of Nursing’s Work** – [say] nursing work involves Quality and Safety, Leadership, Professional Development, and Research and Evidence-Based Practice. These four pillars support the work of nursing and are instrumental in helping us tackle our objectives.

- **Nursing Work Environments** – [say] composed of the caring environment, the healing environment, and the collaborative work environment. Our focus in nursing is on building authentic, personal connections with each patient and family, which helps us keep them at the center of all care decisions. We must recognize that those tasks and scenarios that seem routine to us are often perceived very differently by those for whom we care. Collaboration is a true partnership with all members of the health care team, the patient and their family.

- **Total Health, Healthy Communities, and Population Health** – [say] total health is state of complete physical, mental and social well-being for all people. Our goal is to improve our ability to monitor population health in order to support surveillance, member reporting, population and individual care.

SAY: And that wraps up our class on Nursing Roles and Values.

DO: Ask the class if there is anything else they want to add or ask about the topics discussed. Clarify any remaining misconceptions about the concepts.
Communication

1. Basics of Communication

**DO:** Ask volunteers if they can remember why effective and clear communication is important, and what could happen when communication goes wrong.

**DO:** Discuss as a class the difference between active listening and ineffective listening. Compare this to effective and ineffective expression. You may wish to make a comparison chart.

**SAY:** Have you ever experienced any of the ineffective forms of expression when you were trying to explain something? This can include:

- Me-too-ism
- Being judgmental
- Forcing you to divulge more
- Arguing/disagreeing
- Giving unwanted advice/consolation

How did it make you feel?

2. Techniques for Effective Communication

**DO:** If you have data from your organization that shows the positive and/or negative outcomes associated with good and/or poor communication, please share this information now and explain that this data can be positively influenced by using the SBAR techniques.

**DO:** Review SBAR and give short examples.

- **Situation** – current problem stated in 5-10 seconds. Identify self, identify patient in question, and state the current problem succinctly. **EXAMPLES:** "This is Samantha from the pulmonary clinic calling about your patient Ms. Smith…"; "This is Carrie in urgent care calling about patient Joseph Lee who came in today with a headache of 10/10…"
- **Background** – provide objective data, relevant numbers, and relevant history. **EXAMPLES:** "…Ms. Smith has a history of cystic fibrosis and came in for a follow-up pulmonary function test, which was worse than her last…"; "Joseph is a previously healthy college student but reported hitting his head earlier today during basketball practice…"
- **Assessment** – give only the information you think is necessary and state what you think the core problem is **EXAMPLES:** "…on exam, Ms. Smith’s breath sounds are diminished with crackles, she has a nonproductive cough, and a temperature of 102 F…"; "on exam, Joseph does not have any obvious head wounds but his pupils are equal but fixed, his speech seems slurred, and he is getting more and more lethargic…"
- **Recommendation** – what action is needed to correct the problem, what do you need from the provider to improve the patient’s condition, and in what specific time frame do you expect this action to take place? **EXAMPLES:** "I think we need to admit Ms. Smith to the pulmonary unit today to start her on an aggressive pulmonary toilet regimen and treat the underlying cause of her fever; ‘I need you to see Joseph as I am concerned about his head trauma and deteriorating status’"

**DO:** Review different examples of recommendations:

**SAY:** Of course, it may not always be easy or comfortable for you to make a recommendation. Other common recommendations you may need to make include:

- Come see the patient now;
- Talk to the patient and/or family;
- Ask for a consultant to see the patient now;
- Order lab work or other tests;
- Order or change medication;
- Transfer patient to a higher level of care;
- Or, Book the patient in a specific time slot

**DO:** Situation Simulation

Organize the class into 4 teams of three to practice these techniques via role plays.

Assign each member of each team one of the three roles below.

- Communicator – develops and presents scenario
- Receiver of SBAR – responds to presentation
- Observer – uses checklist (below) and shares comments at the end of the scenario

Give the participants a time frame to have each do an SBAR on a particular situation.

If the class is large, you may want to give more than one group the same scenario to have the participants understand the differences.

Distribute the Observer Checklist to each Resident so they understand
what is expected:

Observer Checklist
- Got the person’s attention
- Expressed concern
- Stated the problem (clear, concise)
- Gave appropriate background
- Communicated assessment of situation
- Proposed recommendation(s) (action)
- Reasserted as necessary
- Reached decision
- Escalated if necessary

DO: Have the groups create an SBAR for their assigned roles and scenario. As they work, observe each group. When they are finished, have each group present their role play so the other groups can take notes and learn from their example.

1st Scenario
An 18-year-old female named Mary arrives at the front desk with her boyfriend Burt. Mary asks if she can see the doctor right now. She is asked if she has an appointment. She says no. She could only get a ride here this morning. When asked why she is here, she starts to cry and says Dr. Smith has seen her since she was a baby, and she thinks she might be pregnant. The nurse is called and Mary is placed in a room.
Create an SBAR between the RN and the physician.

2nd Scenario
Mark, a 20-year-old male, arrives at the office with his mother and siblings at 4:45 pm on a Friday. Mark is holding a dishtowel over his leg. Mark’s mother explains to the receptionist that Mark was outside chopping wood with his brother and the axe head flew off the handle and landed in his leg. The dishtowel is soaked with a moderate amount of blood. Mark looks scared and angry. The LVN/LPN arrives and escorts the family to the treatment room. Mark has a blood pressure of 108/72, pulse of 82, RR of 20 and his temperature is 98.0. The LVN/LPN pages the RN.
Create an SBAR communication between the LVN/LPN and RN.

3rd Scenario
Christine, a 5-year-old female, is sitting with her mother in the waiting area eating a candy peanut butter cup. Her mom notices that Christine is wheezing and starts to complain of stomach cramps. Christine begins to scratch at her chest area. Her mother calls out for help. The receptionist pages an RN STAT.
Create an SBAR communication between the RN and the physician.

4th/5th Scenario(s)
A 2-year-old girl, Susan, arrives with her parents for a routine well-child check. Susan has a respiratory rate of 62, nasal flaring and substernal retractions. She is listless and limp. Her temperature is 99.3 and her pulse is 88. Susan is placed on a pulse oximeter and her O2 saturation is 88 on room air. The MA who is rooming her notifies the RN and the RN contacts the physician.
Create an SBAR communication between the MA and the RN, then the RN and the MD.

3. Common Difficult Scenarios

DO: Review the Assertion Model and the SBAR approach and how they relate to each other. Answer any questions the class might have.

SAY: How many here have had to be assertive on behalf of a staff member or patient?
SAY: How many of you found it hard to be assertive? How did you overcome that?

DO: Discuss reasons why Residents found it difficult to be assertive and remind them how those reasons are common barriers to effective communication. The Assertion Model and SBAR give them a structure method of communication to help overcome this difficulty.

DO: Have two volunteers present the SBAR examples below. Then see if the class can determine which requires more assertiveness.

**Example: Wrong Day Appointment** — Explain that in some organizations the standard is to consult with the provider when patients need to be added to the schedule.
- $S =$ Mrs. Jones arrived for her appointment today but it is on the wrong day. She is scheduled for next week.
- $B =$ She made the appointment for a pap smear. Her last one was 5 years ago and it was normal.
A = She provides care for her mother and has difficulty keeping appointments. She came 40 miles and needed to have a friend drive. You have a cancellation at 11 am.

R = Can I book her in your 11 am appointment slot for a pap smear?

Example: Medication Error -- Explain that this would require more assertiveness.

S = You asked me to give Mr. Smith a flu shot and I gave him pneumovax.

B = I took out the wrong vial. He had a pneumovax two weeks ago.

A = He feels fine, has no respiratory problems, and I will fill out an incident report. However, I need to give the flu vaccine.

R = Shall I go ahead and give the flu vaccine and let him know what happened or do you want to speak with him first with me present?

DO: Explain that in some organizations and for some situations (such as an appointment change) you may not need to check with the physician. If any exceptions to SBAR and the Assertion Model are true for your organization, explain this now.

DO: Clarify any misconceptions Residents have on the Assertion Model or SBAR techniques and answer any questions they have.

DO: Ask for volunteers to recall the 7 categories of difficult scenarios:

1. Broken rules
2. Lack of support
3. Mistakes
4. Incompetence
5. Poor Teamwork
6. Disrespect
7. Micromanagement

Advanced Alternative: If the groups did an exceptional job making the nurse and provider roles during the Situation Simulation realistic, then, as a class, see if any of the scenarios they just performed fall into these categories. Discuss differences of opinion, or any factors which may make a scenario more likely to fall under one category than another.

Then discuss how these simulations successfully addressed the conversations by utilizing all of the effective communication techniques and principles learned thus far:

- Active listening
- Effective expression
- Good body language
- Assertion Model and SBAR
- Making it safe
- Identifying/Addressing the pattern
- Stopping disrespectful behavior

SAY: Now let’s extend this discussion from simulations into what we’ve all experienced in the real world.

SAY: Let’s discuss addressing patterns of behavior first. Have any of you tried to break a pattern of behavior which could or had led to serious patient safety and/or quality issues. Did it go well? If so, what happened? If not, how did the other person react?

DO: Continue the discussion until various situations, reactions, and results are discussed.

DO: Tell participants that being able to “make it safe” for others to open up to them is a critical skill. Review the common scenarios in which they may need to approach a conversation with this strategy.

Assign participants a partner and have them practice what they would say if they had to address a fellow RN’s incompetence. Remind them to make it safe.

Have each partner take a turn then discuss what worked and what didn’t as a class.

SAY: Think about all of the techniques you’ve learned for effective communication. Now think about a time when you broke a rule or witnessed someone breaking a rule. What happened?

DO: Brainstorm as a class some common examples of broken rules, as this may be one of the most frequent scenarios they will encounter. Common examples could include:

- Not washing or sanitizing hands sufficiently
- Not changing gloves when appropriate
- Failing to check armbands for patient identification
- Not performing safety checks
- Using abbreviations that are not approved
- Violating policies on storing or dispensing medications
Now discuss whether participants have ever had to deal with a broken rules situation. What did they do?

Review any regulations your organization has for dealing with rules violations.

**DO:** Review any regulations your organization has for dealing with lack of support scenarios.

**DO:** Have volunteers describe lack of support situations they’ve experienced. Alternatively, if no one volunteers a situation, provide one from your own experience.

Call a volunteer to the front of the class and perform a situation simulation with him or her, demonstrating for the class the best way to deal with the details of that scenario.

Repeat with other volunteers, until a variety of situations are demonstrated. Then discuss the nuances of approach with the class.

**SAY:** What do you think the differences and similarities between a broken rules scenario and a mistakes scenario might be?

**DO:** Brainstorm a list of differences, referring back to the list of broken rules from earlier.

**DO:** Review any regulations your organization has for dealing with mistakes.

**SAY:** What types of SBAR approaches might you have to prepare to have with a mistake scenario? Keep in mind: patient safety is your first priority.

**DO:** Discuss as a class. Clarify misconceptions and answer any questions.

**SAY:** Addressing incompetence can also be awkward and stressful. This conversation can cause people to reconsider their view of themselves and their abilities. This can be a painful process for them.

**DO:** Describe a situation from your organization where incompetence may have been at play.

Then have volunteers answer the following within the context of SBAR by briefly role playing the situation you presented:
- How would you show you care about his or her best interests?
- How would you show that you care about and respect him or her?

**SAY:** What causes poor teamwork?

**DO:** Discuss as a class all of the sources for poor teamwork. Make a web diagram to help visualize how these causes can interconnect. This should lead the participants to realize that personal problems, organizational issues, bullying, disrespect, and other difficult scenarios can all create an environment ripe for poor teamwork.

Then have pairs work together to come up with SBAR approaches to a poor teamwork scenario.

Have volunteers present and discuss as a class.

**SAY:** Let's discuss disrespectful behavior for a moment. This can be one of the more difficult scenarios to deal with because it can be one of the layers of several other common difficult scenarios.

**DO:** Remind participants that when they try to stop someone's disrespectful behavior, they have to consider the listener's point of view. What are the consequences they care about? Discuss as a class some consequences physicians, surgeons, fellow RNs, or other colleagues might be concerned with.

Remind the class about the situation in the eModule where a group of physicians went into a patient room without washing hands and did a procedure without masks or gloves. The Resident in this scenario stayed silent because the chief physician is disrespectful.

**SAY:**
- What would you have said?
- Would you have left the room as the chief physician asked?
- If using SBAR with the Assertion Model didn't work, what else might you do?

**DO:** Review any regulations your organization has for dealing with similar scenarios.

**DO:** Transition to a discussion about micromanagement. Ask volunteers the following:
- How do you react when you feel that you are micromanaged in situations where you feel capable?
- How do you handle those situations, if at all?
- How will you know if you are the one doing the micromanaging?
- What would you say to someone who wanted to talk about
being micromanaged?

Remind participants of the consequences of both sides of micromanagement.

- **Being Micromanaged:**
  - Avoidance
  - Lack of initiative
  - Unwilling to intervene in harmful situations

- **Micromanaging:**
  - Lack of trust
  - Requiring employees to check in too often
  - Coaching on procedures the other person has already been validated to do alone

Remind the class of the procedures to deal with such a situation within your organization (such as seeking help from the Nurse Educator).

**DO:** Have a brief discussion to discover how confident Residents feel with their knowledge of SBAR, assertiveness, and effective communication.

Make sure you answer any remaining questions they may have.

Clarify any remaining misconceptions.

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**Professional Topics**

1. **Professional Work Behaviors**

**DO:** Ask the class what comes to mind when they hear “Professional Work Behaviors”.

Write their responses in a list for the class to see. Try to categorize the answers given by Actions, Communication, and Appearance.

**SAY:** As you have learned, Professional Work Behaviors in the nursing profession is defined by your actions, your communication, and your appearance.

**SAY:** Let’s start by talking about Actions. Patient Advocacy, Accountability, and Integrity are some examples of actions that can demonstrate the nurse’s professionalism.

**DO:** Ask the class if they remember what each of the examples mean.

- **Patient Advocacy** - being empathetic and responsive to the needs of the patient, ensuring their confidentiality and privacy, and being sensitive to the differences in their cultural, ethical, and religious values.
- **Accountability** - acceptance of our responsibility, accepting blame if we are wrong, sharing credit where credit is due, and being able to answer for our actions and decisions.
- **Integrity** - being honest, not taking “short cuts”, being present in mind and attitude to be able to focus at work while at work, and a commitment to excellence by doing one’s best at all times.

**SAY:** Let’s look at some scenarios where Professional Action may come into play.
**DO:** Ask for volunteers to role play the following scenarios in front of the class. After each scenario, ask the class whether the Action showed Patient Advocacy, Accountability, or Integrity. Then ask the class again how these simple actions can be further improved while still displaying the key action identified.

Some of the suggested scenarios/scenario components may not be applicable to region (italicized). Alternatives offered whenever possible. Please modify as needed.

**Suggested Scenarios:**

1. Patient who is allergic to penicillin was prescribed penicillin. Penicillin was not listed as an allergy on the patient’s chart. **[EXPECTED ANSWERS:** Patient advocacy – RN tells practitioner/physician about wrong medication and patient’s allergy. Further Improved By – RN makes sure that allergy gets noted on patient’s chart.]

2. RN used the wrong dressing change kit to change patient’s peripherally inserted central catheter (PICC)/central venous catheter (CVC) dressing. Kit was taken from shelf labeled PICC/CVC Dressing Kits. **[EXPECTED ANSWERS:** Accountability – RN accepts blame and corrects error. Further Improved By – RN makes sure kits are in the correct shelves.]

3. RN dropped patient’s medications on the floor, orders new pills from pharmacy instead of picking them up and giving them to patient. **[EXPECTED ANSWERS:** Integrity – RN makes sure he does his best and gives quality patient care at all times. Further Improved By – Medication may be administered late because of the event, RN fills out event/incident report.]

**SAY:** Next we’ll talk about Communication. The nurse displays professionalism in communication whenever he or she is open, uses language skillfully, and is willing to collaborate.

**DO:** Ask the class if they remember the key points about Openness, Skillful Use of Language, and Willingness to Collaborate.

- **Openness** - being able to provide feedback, request feedback, and reflect on the feedback received.
- **Skillful Use of Language** - being able to communicate clearly and effectively through the use of appropriate words and correct grammar.
- **Willingness to Collaborate** - treating everybody with respect by saying “please”, “thank you”, and also practicing collegial behavior across disciplines.

**SAY:** Let’s look at some common scenarios related to Professional Communication.

**DO:** Ask for volunteers to role play the following scenarios in front of the class. After each scenario, ask the class whether the Communication showed Openness, Skillful Use of Language, or Collaboration. Then ask the class again how these can be further improved while still displaying the communication technique identified.

Some of the suggested scenarios/scenario components may not be applicable to region (italicized). Alternatives offered whenever possible. Please modify as needed.

**Suggested Scenarios:**

1. New RN is charting on the hospital’s electronic medical record (EMR)/paper charting system for the first time. He asks his Preceptor to check if anything was missed. **[EXPECTED ANSWERS:** Openness – RN requested feedback. Further Improved By – RN observes and reflects on how experienced nurses chart to incorporate best practices identified.]

2. Patient speaks little English. English as a second language is not noted on the patient’s chart. RN gets a translator to help with patient education. **[EXPECTED ANSWERS:** Skillful Use of Language – RN makes sure that he communicates with the patient clearly and effectively. Further Improved By – RN marks the patient’s chart as needing a translator for his next visit so instructions can be delivered more clearly.]

3. Parent does not want RN to give her child a flu shot because child is afraid of needles. Child is a healthy preschooler. **[EXPECTED ANSWERS:** Accountability – RN makes sure that he communicates with the patient clearly and effectively. Further Improved By – RN marks patient’s preference on his chart.]

**SAY:** The last component of Professional Work Behaviors is Appearance. The way the nurse looks and displays self-confidence and positive attitude shows professionalism.

**DO:** Ask the class what Proper Work Attire, Self-confidence, and Positive Attitude means as related to Professional Work Appearance.

- **Proper Work Attire** - excellence in appearance. A well-dressed appearance tends to convey a higher level of knowledge.
- Self-confidence - comes with knowledge and proper training. It can be manifested by being independent and efficient in our actions.
- Positive attitude - shows through when we conduct ourselves in a friendly, cheerful manner towards everybody we work with, and with whatever task we do.

**SAY:** Let's look at some common scenarios that involve Professional Appearance.

**DO:** Ask for volunteers to role play the following scenarios in front of the class. After each scenario, ask the class whether Appearance showed Proper Work Attire, Self-confidence, or Positive Attitude. Then ask the class again how these can be further improved while still displaying the professional appearance identified. Some of the suggested scenarios/aspect components may not be applicable to region (italicized). Alternatives offered whenever possible. Please modify as needed.

**Suggested Scenarios:**

1. RN attended a wedding over the weekend and had her nails painted with bright gel polish. She made sure this was removed before her shift the following week. *(EXPECTED ANSWERS: Proper work attire – RN demonstrated professional appearance. Further improved By - RN also made sure that her nails were trimmed and clean in accordance to her unit’s dress code policy.)*

2. New RN is admitting a patient for the first time. Preceptor reviewed the procedure with RN, and asked if he wants Preceptor to be in the room with him. RN stated that he should be able to do the admission alone. *(EXPECTED ANSWERS: Self-confidence – RN showed independence in action following proper training. Further improved By – New RN offers to do several more admissions to master the process.)*

3. RN is taking care of a “difficult” patient who keeps asking for pain meds for his back pain, but just had both his scheduled and Q4 PRN med. Instead of dismissing the patient, RN talked to the patient and found an alternative way to address the patient’s pain by giving him a hot compress which the patient appreciated. *(EXPECTED ANSWERS: Positive attitude – RN conducted himself in a friendly manner and was able to address the patient’s needs. Further improved By – RN passes information alongmarks the patient’s chart that patient responds well to alternative means of addressing pain in between meds.)*

2. **Professional Integrity**

**DO:** Ask the class to give examples of times when they have experienced integrity issues at work. Write their responses in a list for the class to see. Categorize the answers given by “good” and “bad” scenarios.

**SAY:** It is important that as nurses, we practice with integrity. The Code of Ethics for Nurses Provision 5, as well as the Kaiser Permanente (KP) Nursing Value of Integrity guides us to make sure that we are upholding the profession’s standards.

**DO:** Ask the class if they remember what the Code of Ethics for Nurses Provision 5, and the KP Nursing Value of Integrity states.

- **Code of Ethics for Nurses Provision 5** - The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
- **KP Nursing Value of Integrity** – Upholding the trust that others place in us; doing the right thing at all times for the right reason.

**SAY:** Let’s try to connect some of the examples that you gave with the key concepts from the Code of Ethics and the KP Nursing Value.

**DO:** Connect some of the examples given to key concepts from the Code of Ethics and the KP Nursing Value of Integrity. For example, if somebody said “somebody did not follow through on a commitment”, this does not display integrity, because the KP Nursing Value states that nurses should “uphold the trust that others place in us”.

**SAY:** Now that we understand how a person of integrity acts, and why integrity is important in the nursing profession, let us take a closer look at the application of integrity in the workplace.
SAY: Professional Integrity in the nursing profession is the application of key integrity characteristics in the workplace. These key characteristics are Trustworthy Relationships, Therapeutic Boundaries, and Authentic Collaboration.

DO: Ask the class if they remember the definition for each of the characteristics.

- **Trustworthy Relationships** - having trustworthy relationships mean that our patients can rely on us to keep our commitments and deliver timely and efficient care at all times.
- **Therapeutic Boundaries** - mean that there should be a line between personal and professional relationships, even if it can be challenging to discriminate between roles at times.
- **Authentic Collaboration** - to engage in authentic collaboration requires us to be open and bear some consequences of actions such as correcting an error, apologizing for shortcomings, and even changing our behavior.

SAY: Let’s look at some scenarios and see which of the key integrity characteristics is being upheld or compromised.

DO: Ask for volunteers/teams to answer scenario questions in front of the class. After each scenario, ask which of the key integrity characteristics are Trustworthy Relationships, Therapeutic Boundaries, or Authentic Collaboration is either upheld or compromised. If compromised, ask how the characteristic can be upheld.

Some of the suggested scenarios/scenario components may not be applicable to region (italicized). Alternatives offered whenever possible. Please modify as needed.

**Suggested Scenarios:**

1. Patient asked RN to have her medication changed from liquid to pill form. **RN said he will take care of the patient’s issue,** but forgot about it and patient was given a liquid medication again next time it was due. **[EXPECTED ANSWERS: Trustworthy Relationship Compromised – RN did not keep his commitment to have patient’s medication order changed. How Integrity Can Be Upheld – RN spoke to practitioner/physician about patient’s request right away; alternatively, RN explains to patient why medication does not have a pill form.]**
2. New RN is related to the unit’s RN manager and did not have

SAY: Your Validators and Preceptors are expected to always utilize the key integrity characteristics we discussed to support your success in the Residency Program. Let’s look at their individual roles again.

3. **Critical Thinking**

SAY: Let’s review the levels of thinking.

DO: Ask the class if they remember the definitions for each level of thinking.

- **Literal** - information is absorbed at face value and accepted with no critical judgment; focuses on one right answer.
- **Interpretive** - there is an attempt to evaluate and interpret information, but still falls short on “digging deeper” for an answer.
- **Critical** - ability to comprehend, interpret, analyze, infer, and evaluate, and recognize relevant information; accepts that
even experts do not have all of the answers.

**SAY:** Literal and interpretive thinking may cause patient harm and inefficient care delivery. As nurses, we must always think critically to deliver safe and effective care.

**DO:** Ask for volunteers to role-play the following suggested scenario answers in front of the class (you will read the scenario). After each answer, ask the class which level of thinking was demonstrated.

Some of the scenario components may not be applicable to region (italicized). Alternatives offered whenever possible. Please modify as needed.

**Suggested Scenario:**

1. RN sees an order to turn and reposition an ambulatory (independent) adult patient every two hours. Patient is not at risk for skin breakdown. However, patient is indeed just lying in bed watching TV.

**Scenario Answer 1:** RN turns and repositions the patient every two hours because the practitioner/physician ordered it.

[**LEVEL OF THINKING:** Literal]

**Scenario Answer 2:** RN thinks the order is silly, but tells the patient that he needs to be turned and repositioned because the practitioner/physician ordered it so.

[**LEVEL OF THINKING:** Interpretive]

**Scenario Answer 3:** RN assesses the patient’s ability to turn and reposition himself independently, updates his Braden Score, and notifies the practitioner/physician that the order is unnecessary upon presentation of facts.

[**LEVEL OF THINKING:** Critical]

**SAY:** We always want to use higher-order critical thinking, but what are the two key characteristics of a critical thinker?

- Asking Relevant Questions
- Analyzing

Let’s talk about Asking Relevant Questions first.

**SAY:** Many people find the “why” word threatening and then dismiss the person who is asking the question. Others take it as an opportunity to support, teach, and improve their own learning.

**DO:** Ask the class if there have been any protocols at work/things nurses “have always done” that they have questioned before and what came of it. Write their responses in a list for the class to see.

**Suggested Examples:** Evidence-based practice scenarios of things nurses “have always done” but are not rooted in evidence/literature:

1. Flushing a gastrostomy tube (GT) with soda/pop to unclog it.
2. Trendelenburg position for patient in shock.
3. Turning and repositioning every two hours.

Some of the suggested examples may not be applicable to region. Please modify as needed.

**SAY:** The next important characteristic of a critical thinker is that he is always analyzing.

**DO:** Ask the class what “Analyzing” as it relates to Critical Thinking is.

**EXPECTED ANSWER:** Analyzing – breaks down things for better understanding, reduces a difficult situation into manageable pieces, alerts to problems, and anticipates possible outcomes of various actions.

**DO:** Ask for volunteers to role-play the following scenarios in front of the class. After each scenario, ask the class how analysis was used in the situation.

Some of the scenarios/scenario components may not be applicable to region (italicized). Alternatives offered whenever possible. Please modify as needed.

**Scenarios:**

1. RN is taking care of multiple busy patients (or triaging a busy clinic) today. To help with her assignment, she looks at all of her patients and effectively prioritizes them based on their acuity level. [**EXPECTED ANSWER:** The RN reduced this seemingly difficult situation into something more manageable.]
2. There is a new IV stabilization device (or any other “new” protocol/skill) that is being trialed on the unit. Because this device has not been tested on all patients yet, the RN makes sure that the unit still has the “old” IV equipment available in
Suggested Topics:

- New protocol from something that “we’ve always done a certain way” (a dressing change, changing IV tubing, etc.).
- Technology in the clinic/hospital (EMR, barcode scanners, etc.).
- Younger leadership (newer graduate clinical leaders, graduate-entry nurse practitioners, etc.)

Some of the suggested topics may not be applicable to region (italicized). Alternatives offered whenever possible. Please modify as needed.

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Expected Answers</th>
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<tbody>
<tr>
<td>1. The RN thinks that the practitioner/physician wrote a certain order for the wrong patient. He did not hesitate to seek out the practitioner/physician so the error can be corrected.</td>
<td>Confidence – the RN trusted his reasoning abilities and is ready to justify why he thinks the order was written in error.</td>
</tr>
<tr>
<td>2. A pediatric patient who is awaiting surgery for cleft palate is being assessed for feeding difficulties. The mother is complaining that the “special nipples” she was instructed to use</td>
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does not work all the time with feeding. RN tried to use a syringe during feeding and the infant fed well. [EXPECTED ANSWER: Contextual perspective – the RN understood that some situations may have more than one solution; something “effective” for one patient may not be the case for another.]

3. RN is taking care of a patient with sickle-cell disease who came in for a crisis. RN thinks that the patient is not managing his disease well at home, but objectively listens to the patient’s report so that she may be able to design his care appropriately. [EXPECTED ANSWER: Open-mindedness – RN looks at both sides of the issue and tries to get to the truth instead of caring about herself being right.]

4. Transformational Leadership

SAY: Describe a leader; it could be anyone, just give characteristics that make this person a leader.

DO: Collect as many characteristics as possible. Write the class’ responses in a list for everyone to see.

SAY: Robin Sharma, a leadership expert, defined leadership as not being about your position, but your passion. He is an advocate for leading without titles.

DO: Review the characteristics given by the class. Ask how many of the people they described actually held positions or titles.

SAY: We tend to compare leaders and managers and put managers in a bad light. Some leaders go on to be great managers. Some managers are not effective leaders. The real difference is that management, or any title, is an appointed position or a formally assigned role, usually with an authority to direct other people.

DO: Ask the class if anybody remembers what the leadership recommendation of 2010 Institute of Medicine (IOM) Future of Nursing Report states.

EXPECTED ANSWER: To prepare and enable nurses to lead change to advance health.

SAY: With this recommendation, the IOM puts the responsibility not only on nurses, but also on nursing education Programs, nursing associations, and healthcare decision makers to all participate in providing opportunities for nurses to become leaders.

SAY: See if you can identify as a class which entity is taking an active part in providing leadership opportunities in the following examples:

Suggested Examples:
1. Nurses – an ADN nurse going back to school to get her BSN; a nurse taking on more responsibilities on the unit.
2. Nursing Education Programs – an undergraduate nursing Program focusing on evidence-based practice; a graduate nursing Program incorporating MBA courses into their curriculum.
3. Nursing Associations – a nursing league (can use specific examples like National League for Nursing, etc.) offering CEUs to nurses; associations holding leadership seminars for members.
4. Healthcare Decision Makers – local lawmakers involving nurses in legislative decisions; hospital asking unit staff to sit in a board meeting that may affect their unit.

Some of the suggested examples may not be applicable to region. Please modify as needed.

SAY: How can you, in your position today, become a leader?

DO: Discuss briefly as a class.

SAY: Let’s take a look at the steps to help you realize your leadership potential.

SAY: There are six steps that you as a nurse today can take in order to become tomorrow’s leader.

DO: Ask the class to name and attempt to define the six steps. List the six steps for the class to see, and write the key definitions for each.

EXPECTED ANSWERS:
- Apply stewardship – placing the interest of the patient and the organization above our personal agenda, having a broad and multidimensional perspective, and believing in something bigger than ourselves.
- Be passionate – making a personal decision of service leadership, bringing your heart, creating your vision, and continuously using your dedication to the cause to push for more.
- Create a professional development plan – defining objectives with desired outcomes or goals that are specific, measurable, attainable, resonant, and timely (SMART), and defining tactics by identifying own self-learning needs, seeking out subject matter experts or Mentors to learn from, and conducting
frequent self-reflection to evaluate self.

- **Start locally** - participating in or leading unit-based teams, committees, in-service meetings, care conferences and grand rounds, councils, and groups at work, and engaging colleagues verbally and in writing by providing feedback, being receptive to feedback, and even becoming a Mentor.

- **Build connections** - actively participate or volunteer in professional organizations, regional or service area committees and groups, and health advisory boards, and networking with a Mentor or leader, including those who may not be in the nursing profession.

- **Seek ongoing professional education and development** - participating in educational leadership development conferences and workshops, obtaining certification in area of specialty, including Six Sigma, obtaining a higher level degree or continuing to attend business and healthcare economics classes, and entering a leadership fellowship Program.

**SAY:** Let’s see how each step can be applied to common scenarios that you may see in practice today.

**DO:** Ask for volunteers to give concrete examples for each of the steps. After each answer, ask the class if it is something they can see themselves doing or if it is a fairly easy task to do. The point is to emphasize that anybody can become a leader, even without a title.

Write the example(s) given together with the listed step/definition from the discussion so that the class will see the connections better.

**Suggested Examples:**

1. **Stewardship** – it is very time consuming to accommodate a mother who is breastfeeding/gives only breast milk to her infant, but RN understands that the patient’s interest is above his own.
2. **Be passionate** – RN finds ways to brighten his unit/clinic by decorating the break room/common areas and adding a bulletin board with useful nursing/hospital information.
3. **Professional development plan** – RN knows that he is not well-acquainted with how to take care of rehab patients, so he asks to be floated to the rehab unit/clinic more often to learn.
4. **Start locally** – RN volunteers to be the “super user” and attends the trainings for new protocols/skills first, which he can then bring back to his unit.
5. **Build connections** – knowing that technology is a big “push” in nursing, RN partners with the IT department leads to identify gaps between nursing and technology so they can effectively address them through new trainings.
6. **Seek ongoing education** – RN has been taking care of oncology patients in the clinic, so he obtains a certification to be able to administer chemo meds.

Some of the suggested examples may not be applicable to region. Please modify as needed.

**DO:** Have a brief discussion to discover how confident Residents feel with their knowledge of the Professional Topics they just learned. Make sure that you answer any remaining questions they may have. Clarify any remaining misconceptions.
# Situational Awareness

## Situational Awareness at the Point of Care

**DO:** Ask the class if they remember what “Situational Awareness” means.

**EXPECTED ANSWER:**
- Situational Awareness is the ability to identify, comprehend, and act on critical information about what is happening around you.

**SAY:** Having Situational Awareness is very helpful for us in the medical field. It helps us gather the right information, analyze this information, make projections based on our analysis, and be able to do something with the information.

But where did having “Situational Awareness” come from? Let’s talk about this some more.

**SAY:** The term was first used by the United States Air Force fighter aircrew, where observing your opponent’s current move and anticipating his next move a fraction of a second before he can observe and anticipate yours is crucial. Situational Awareness is also broadly used in the aviation industry where people interact a lot with machines and instruments.

**SAY:** With this being said, why do you think health care adapted the concept of Situational Awareness?

**EXPECTED ANSWERS** [list answers for the class to see]:
- It is important in mission-critical situations.
- It is important in situations where the flow of information is high and where poor decisions can lead to serious consequences.
- There is an added level of complexity in health care as we are dealing with live individuals, not just machines.

**SAY:** Having Situational Awareness is particularly important in environments where the flow of information is high and where poor decisions can have serious consequences.

We can say that we do deal with more complex issues, sometimes even life-or-death situations in health care, so it is only proper that we have Situational Awareness.

Let’s talk about what happens if we lack this awareness of what is going on around us.

**SAY:** Lacking Situational Awareness has been identified as one of the primary factors in accidents attributed to human error.

**DO:** Ask the class to give examples of some key ways they might lose Situational Awareness personally, or at work. List their answers for the class to see.

**EXPECTED ANSWERS:**
- Overload
- Fatigue
- Cultural differences
- Unrealistic attitudes
- Poor group dynamics
- Poor staffing
- Selective attention

**SAY:** All of these things can surely affect our awareness of our surroundings, but let’s talk about selective attention some more.

**DO:** Show the class the Simons and Chabris (1999) video about Selective Attention: [https://www.youtube.com/watch?v=vJG698U2Mvo](https://www.youtube.com/watch?v=vJG698U2Mvo).

**DO:** Have the participants define Selective Attention and explain why it matters.

**EXPECTED ANSWERS:**
- Selective Attention is the natural tendency to focus on certain things and filter out other stimuli.
- Selective Attention matters because it means you are not observing your environment carefully and might miss other important details.

**SAY:** In order to maintain Situational Awareness, we need to override this natural tendency to filter out information. Can you think of ways that we can do this?

**EXPECTED ANSWERS** [List for the class to see]:
- Developing mental models
- Enhancing human factor skills like briefing, cross-checking and verifying, identifying red flags, and using callouts
SAY: We mentioned Mental Models. Let’s talk about this some more.

SAY: One way to improve our Situational Awareness is through creating accurate mental models. A mental model is a set of well-defined, highly-organized knowledge that helps shape behavior and set an approach to solving problems and doing tasks, like a personal algorithm.

Mental models are developed over time from experience. Do not expect to have a model in place right away, especially when you are starting in a new specialty like ambulatory nursing. But you will receive the support and information you need as you build these models to guide you in your clinical decision-making.

DO: Ask the class how they think or process data when they receive nursing reports. Experienced nurses may offer more information on this, but even newly graduated nurses should be able to share information from their clinical rotations or professional Preceptorship experiences.

SUGGESTED ANSWERS:
- By systems – cardiovascular, respiratory, GI, GU, etc.
- Head to toe
- Order of importance – pertinent information first: is the patient on oxygen, can the patient walk, etc.
- Plan of care or goal for the patient – what we are working towards, is the patient going home today, etc.
- SBAR

SAY: Each person has his own preference of a “mental model”; develop one that works for you so no matter how the other person gives you the information, you can categorize or write down information in your own way that makes sense to you.

SAY: There are several Human Factor skills that we can use to build mental models more quickly and maintain Situational Awareness. They are:

[You can choose to list these for the class to see]:
- Briefing
- Cross-check and verify
- Identify red flags
- Callouts

Let’s talk about each one of them more closely.

SAY: Briefing is a two-way dialogue that is concise, relevant, and in a way, helps you transfer your mental map to someone else. It also uses the SBAR method, with slight modifications:

S – The situation briefly describes the problem
B – The background provides objective data, relevant numbers, and relevant history
A – Addresses threats and potential risks
R – Recommends next steps and asks open-ended questions.

DO: Ask for volunteers to role play the following scenario and have the class rate the Briefing as poor, fair, or excellent. If the rating was poor or fair, ask the class to identify the issues, and what their recommendations are to make the Briefing better. Please modify scenario to accommodate for regional differences where necessary.

SUGGESTED SCENARIO:
A nurse from the pulmonary clinic is taking over a patient who will be coming from radiology; first she is calling that department to get report.

Pulmonary Nurse: Hello, this is Staff Nurse from the pulmonary clinic, and I am assuming care of Patient A, are you ready to give report?

Radiology Nurse: Sure, we have Patient A, who had a chest x-ray and is coming to you for a bronchoscopy. He has a history of cystic fibrosis and is having increased secretions with difficulty clearing them. He is currently snacking and should be ready to be transferred to you at any time.

Pulmonary Nurse: We can’t take him at that state, can you tell them to reschedule?

DO: Ask the class to rate the Briefing that happened.

EXPECTED ANSWER:
- Poor

DO: Ask the class to identify what the pulmonary nurse missed in her Briefing, and how she could have made it better.

EXPECTED ANSWERS:
- Did not identify the situation – the nurse could have re-identified the patient who she was getting.
- Did not state the patient’s background – the nurse again could have restated what the patient was there for.
- Did not clearly state the threats and potential risks – even though the nurse did say they can’t take the patient at that state, the radiology nurse may not know that the patient needs to be NPO for a bronchoscopy, that it is not safe for the patient to be under anesthesia when he just ate.
- Did not recommend steps or ask open-ended questions – the nurse simply asked for the patient to reschedule. She could have verified what the patient was snacking on – sometimes clears are allowed up to 4 hours before the procedure, and the patient may have been able to wait. Overall, she could have explored the situation more and not just dismissed the patient.

**SAY:** Remember that Briefing is best done in transitional moments to briefly check in with colleagues that everyone is on the same page.

Next, let’s talk about Cross-check and Verify.

**SAY:** Keep in mind five points to Cross-check and Verify:
- Monitor the situation
- Recognize deviations
- Communicate
- Be assertive
- Follow-up

**DO:** Ask the class for examples related to each of the points on Cross-checking and Verifying. List their answers for the class to see. Have a short discussion on real-life situations they may have encountered in their personal lives or at work where these things came into play.

**SUGGESTED EXAMPLES** [Modify based on region as necessary]:
- Monitoring the Situation
  - Conducting a thorough patient assessment
  - Turning and repositioning your patient to assess skin integrity
- Recognizing Deviations
  - Knowing vital signs that are not within the patient’s baseline
  - Checking the patient’s lab value trend
- Communicate Effectively
  - Telling your charge nurse that you have a patient concern

**SAY:** Now that we have an idea how to Cross-check and Verify, let’s talk about Identifying Red Flags.

**SAY:** There are some clear signs that point to a loss of Situational Awareness. When they happen, the situations set us up for human error. Do you remember what some of these common Red Flags are?

**EXPECTED ANSWERS** [List these for the class to see]:
- The person is stressed and not communicating
- The person is preoccupied or “off”
- The person is unclear

**SAY:** Let’s talk about what typically happens when each of these Red Flags occur.

When someone is stressed and not communicating, his mental capacity may be limited, and he may fail to use all his senses to process what is going on around him.

When someone is preoccupied or “off”, he typically tunes out, or ignores the obvious.

And when someone is unclear or deviating from normal, he makes assumptions, and fails to ask appropriate questions.
DO: Ask the class for volunteers to role play the following suggested scenarios. After each scenario, have the class identify which Red Flag was portrayed. Have a short discussion on how to correctly respond to the identified Red Flag. List the answers for the class to see.

SUGGESTED SCENARIOS [Mix up presentation and modify based on region as needed]:

- The clinic is short-staffed and the nurse is on his fourth admission of the hour. He is not even done with the admission documentation from his first two patients, and now the physician is calling him needing extra lab work on the third. He left the room of his fourth admission before finishing taking the patient’s vital signs and documenting the patient’s allergies and home medications. [EXPECTED ANSWER: Stressed and not communicating; the nurse feels rushed, pressured, and has constant interruptions. HOW TO RESPOND: The nurse can be assertive and say that he needs to finish one thing first before he can move on to the next. The nurse can also prioritize his cares, anticipate next steps, and take things one step at a time].

- The nurse is on her seventh straight day of working because of covering other staff member’s shifts. She has missed several of her patient’s critical vital signs, lab values, and assessment results that were outside of baseline. [EXPECTED ANSWER: Preoccupied or “off”: the nurse is definitely fatigued. HOW TO RESPOND: Either another staff member or the nurse herself should follow a known procedure on how to take the nurse out of staffing, for her own safety and the patients’ safety].

- The nurse is performing a PICC dressing change for the first time, but forgot the steps, so in panic, he also confused the other nurse who was helping him and both contaminated the sterile field that was set up. [EXPECTED ANSWER: Unclear: the nurse is displaying ambiguity and deviating from normal procedure. HOW TO RESPOND: This is a good time to use Briefings and Callouts to make sure that both nurses are on the same page].

SAY: Let’s do some scenarios to help us understand Red Flags better.

SAY: We mentioned “Callouts” as a way to correctly respond to Red Flags. Let’s explore this further.

SAY: Callouts are the active sharing of information that is known by one team member for the benefit of others, often during urgent or emergency situations.

A good callout [you can choose to write these down for the class to see]:
- States the current status
- Verbalizes instructions
- Confirms completion of steps

DO: Ask for volunteers to role play the following suggested scenario about Callouts. Modify based on region where necessary. After the scenario, allow for a short class discussion to identify if the criteria for good Callouts were met, or if not, how the scenario can be made better.

SUGGESTED SCENARIO:
You are a nurse in an urgent care clinic seeing a pediatric patient whose mother says has been coughing badly for a couple of days. On exam, you see a three-year-old who is drooling, leaning forward to breathe, taking shallow breaths, and making a high-pitched sound when breathing. The mother said that the child had a fever and cold three days ago that she thought went away. You suspect epiglottitis with the child’s presenting symptoms.

You were finishing writing your assessment on the patient’s chart when the mother decided to look down her child’s throat because his voice was starting to get muffled. The child showed signs of worsening respiratory distress as his airway started swelling up. You started bag and mask ventilation right away and called for another nurse to help you. You briefly the second nurse on the situation, asked her to page the physician, and start an IV on the patient. The second nurse confirmed that you are continuing to bag the patient, and that she will start an IV since the patient has no IV access yet. She also stated that she had already paged the physician before going into the room.

EXPECTED ANSWERS:
Good example of using callouts:
- States current status – first nurse briefed the second nurse on the situation, second nurse confirmed.
- Verbalizes instructions – second nurse confirmed that you are continuing to bag the patient, and that she will start an IV since the patient has no IV access yet.
- Confirms completion of steps – second nurse stated that she had already paged the physician before going into the room.
SAY: In closing, being aware of our surroundings is very important in our profession. Especially as Residents, you are either inexperienced in Ambulatory Care, or still inexperienced as a nurse. Aside from that, the team members that you work with are not always on your same level, and your own astute observations can definitely help keep everybody practicing in a safe environment.

What you learned today, no matter how “simple”, are great concepts to practice with your leaders—your Preceptors, Validators, Mentors, or even Managers and Charge Nurses—especially when you are feeling overwhelmed when you start to take on that first patient assignment. Do not forget that you need to be briefed about what is expected of you, you need to learn to be confident when you do the cross-checking and verifying, you need to know how to handle red flags, and you need to build that good team work that will surely help when you are bouncing callouts back and forth.

DO: Ask the class if they have any more questions or clarifications about the topic and discuss them further if necessary. Thank the class for participating.

---

Clinical Learning

I. Procedural Competencies

This section contains the Procedural Competencies that are part of the RN Residency Program. All competencies will have an available Validator Guideline to assure consistency and quality between Validators.

The Procedural Competency Tool and Validator Guideline templates are available in the Forms and Evaluations section of this document to aid in the development of additional competencies. When developed locally, the locality is asked to forward a developed Competency Tool and Validator Guideline to the Program Director for review. The Program Director will send the competency out to the Competency Workgroup for review and subsequent Program adoption.

It is recommended that the Competency Tool be given to the Resident at least a week prior to the initial review. The Resident should come prepared to be validated on the competency. Most competencies will require a review process before the actual validation. The critical thinking questions are best asked before beginning the procedure. The Validator should expect complete answers that demonstrate the understanding of how to assure patient safety and quality.

Some competencies ask you to add site-specific information either to the tool or to the guideline; this should occur before the tools are given to the Validators.

At the completion of all the Procedural Competencies, the Resident will be able to:

- Apply the standards of ambulatory professional practice when either directly carrying out these procedures or overseeing their implementation
- Perform the skills safely and effectively in the clinical setting
- Rapidly assess and intervene when patients have reactions and/or suffer consequences from a specific procedure

II. Procedural Competency List

These are the Procedural Competencies that are required of the Residents in the Program:

- AED
- Arm Sling and Elastic (ACE) Wrap Bandage
- Bladder Scan
- Blood Glucose Monitoring (SureStepFlex)
- BP Manual
- BP Automatic
- Central Catheter Dressing Change, Peripherally Inserted
- Ear Lavage
- EKG 12 Lead
- Eye Drop Instillation
- Foot Exam
- Intramuscular Injection
Effective Observation requires the following:

- Immunizations
- Insulin Pen Patient Teaching
- Intravenous Starts
- Medication Administration
- Nasal Culture
- Nasal Pharyngeal Specimen Collection
- Nebulizer – Hand Held
- Occult Blood – Stool
- Oxygen Saturation Measurement (Pulse Oximetry)
- Pain Assessment/Management
- Peak Flow Meter
- Rapid Strep Test
- Splinting – Finger, Wrist, Ankle, Knee
- Spirometry
- Subcutaneous Injection
- Suture/Staple Removal
- Therapeutic Phlebotomy
- Throat Culture
- Tuberculin Skin Testing, Administration, and Reading
- Urinary Catheter, Insertion, and Removal for Special Procedures
- Urine Dipstick, using Bayer (Siemens Multistick 8SG or Uristick)
- Urine Pregnancy
- Visual Acuity using the Snellen Chart

III. Clinical Observation Guideline

Being able to observe what should be seen is a skill that requires the Resident to have Situational Awareness.

Five different Observation Grids are found in the section Forms and Evaluations. Each grid has questions that help the Resident to observe and think about what they are seeing, or perhaps not seeing. The questions are written to help Residents develop critical thinking skills. It is recommended that at least two observations take place during the course of the Program. An organization may want to add a site or use a tool in a different location.

Effective Observation requires the following:

- Review of the “Situational Awareness” topic (available as an eModule, with a follow-up classroom session if necessary), before the Residents conduct their first clinic observation.
- The Observation Grids that will be used should be reviewed so that all Residents understand that they need to complete the form.
- The Residents should bring their completed form to the next peer discussion meeting. A meeting immediately following their observation may be scheduled for optimal learning.
- The manager and/or RN leader in the clinic where the Resident will conduct their observation should be introduced to the concept of Situational Awareness and the Observation Grid.

With each Observation session, the Resident is expected to:

- Develop observational skills that help to differentiate what is actually happening in the environment from what should be happening.
- Mitigate assumptions about how care is being delivered.

The provided Observation Grids are for the following settings:
- Primary Care
- Ambulatory Care (general)
- Family Practice
- Pediatrics
- Immunizations

IV. Clinical Rotation Guideline

The Residency Program contains clinical rotations that provide a range of opportunities for the Resident to learn about different aspects of ambulatory practice. The rotations enable the Resident to engage in both observational and direct clinical practice.

The specific clinical rotations identified in this section are recommendations. An organization may choose to add or delete rotations, change learning experiences and/or objectives and the number of hours the Resident spends in each rotation. Any changes are expected to provide similar learning experiences and objectives.

To assure an optimal experience, the Resident should receive the identified curriculum content and/or competency review/validation prior to a specific clinical rotation. Relevant organizational policies and procedures can be added to the Resident Notebook.

The Nurse Educator should follow-up with the Validator and/or Preceptor in each clinical rotation to assure that learning experiences and objectives are being met. The appropriate evaluation tool should be provided to them for completion.

The Resident should be asked to share their learning experiences in the Peer Transition Sessions and explain how the objectives were achieved.

V. Sample Clinical Rotation Schedule

The following is a sample clinical rotation schedule for Residents which outlines learning experience/s and objective/s for each clinic/center. Please modify rotation as necessary to accommodate the Resident’s learning needs and fulfill Program requirements.

<table>
<thead>
<tr>
<th>GI Lab</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Experience – 4 hours</td>
</tr>
<tr>
<td>To attend a patient education class; to observe a colonoscopy by following a patient from admission to discharge.</td>
</tr>
<tr>
<td>Objectives – To explain the information that patients ought to know before having a GI</td>
</tr>
</tbody>
</table>
procedure; to learn assessment of a patient undergoing procedural sedation both during and post procedure.

Infusion Center

Learning Experience – 2 days for the experienced RN and 4 days for the New Graduate

To perform and be validated on central line care, accessing the central line; to observe PICC line insertion; to set up a sterile field; to access porta-caths (depending on job duties)

Objectives – To practice specifically defined competencies; to demonstrate and explain the adherence to strict sterile technique involving any central line procedures.

Obstetrics & Gynecology – (Preceptor CNM or NP preferred)

Learning Experience – 16 hours

To be validated on POCT competencies: Urine pregnancy and UA/chlamydia screening; to observe a normal stress test (NST), PAP smear, breast exam, and an endometrial biopsy; to observe birth control education.

Objectives – To describe specific issues related to the care of woman; to articulate the role of an advanced nurse practitioner.

Pediatrics

Learning Experience – 2-4 days dependent on the Resident’s assigned clinic

To be validated on immunizations and POCT testing for strep; to observe identified pediatric specific procedures such as PKY collection and catheterization; to gain skills in message management; to gain skills in phone and walk in triage; to expose the Resident to a variety of childhood illnesses such as: URI, GI, fever and rashes.

Objectives – To understand the differential diagnosis and treatments for common pediatric illnesses; to understand how to provide comfort, safety, and appropriate communication for children of different ages.

Surgical Clinics: General Surgery Clinic and/or Surgical Outpatient Center

Learning Experience – 16 hours

To set up a sterile field; to observe the informed consent process; to perform wound care and be validated on the competency; to practice staple & suture removal; to observe message management.

Objectives – To understand a variety of pre/post-surgical procedures; to educate pre and post-surgical patients.

Orthopedic Clinic

Learning Experience – 8-16 hours dependent on the Resident’s assigned clinic

To perform wound evaluation, removal of sutures & staples, crutch education, placement of slings, circulatory check and application of ACE bandage & splints.

Objectives – To describe a variety of orthopedic procedures; to explain the difference between performing wound assessment on the phone versus face to face; to educate pre and post-surgical patients.

Patient Education Classes – Ones that might be selected include: asthma, COPD, CHF, weight management, diabetic, hypertension and cholesterol management

Learning Experience – Each Resident should attend a minimum of 2 classes, one health focused and one disease focused

Objectives – To understand the process to refer patient to the classes; to understand the variety of educational methods used to assist patients; to understand the importance of adequate health literacy.

Teen Clinic

Learning Experience – 8 hours

To observe in teen clinic & expose Residents to the unique health care needs of adolescent females and males.

Objectives – To gain understanding about the following: adolescent confidentiality laws, the treatment of sexually transmitted diseases, and birth control options.

Geriatrics Clinic

Learning Experience – 16 hours

To be validated on the bladder scan competency; to provide a safe environment for the older adult population; to perform medication reconciliation.

Objectives – To state and discuss the assessment and treatment of a variety of problems unique to the older adult population such as changes in cognition, residual urine testing and mobility issues.
**Lactation Clinic**

**Learning Experience** – 8 hours

To observe the challenges and successes of new mothers breastfeeding their infants.

**Objectives** – To observe lactation support strategies, newborn assessment and evaluation of lactation effectiveness.

---

**Adult Primary Care/Internal Medicine-Family Medicine Clinics**

**Learning Experience** – 16 hours at the clinic that will not be the Resident’s assigned clinic

Validation of IM injections and adult immunizations; Medication education and learning to understand to do a thorough assessment and prioritize.

**Objectives** – To demonstrate the assessment and treatment of a variety of problems unique to the patient population; to practice rapid assessment skills and message management.

---

**Nurse Clinics**

**Learning Experience** – 8-24 hours per nurse clinic (dependent on availability)

To practice skills specific to the role of registered nurses in Ambulatory Care; to review and reinforce the concept of standardized procedures.

**Objectives** – To practice procedural competencies learned in a Preceptor setting; to articulate the roles of the Registered Nurse in ambulatory care.

---

**Emergency Department**

**Learning Experience** – 40 hours

To observe emergency situations that may occur in the ambulatory setting.

**Objectives** – To demonstrate procedural skills that have been learned; to learn rapid assessment skills on patients whose clinical presentation rapidly deteriorates; to learn priority skills in assessment and intervention in acute situations; to explain the role of RN in the Emergency Department; to practice the use of SBAR.

---

**Urgent Care**

**Learning Experience** – 3 days split between adult and pediatrics as appropriate for each

---

**Resident**

**Objectives** – To practice rapid assessment skills; to observe delegation skills, to practice procedural competencies, to identify triage questions, to provide patient education and observe patient education; RN/MD collaboration

---

**Wound Care Clinic**

**Learning Experience** – 1 day

To practice assessment skills; to perform dressing changes; to educate patients.

**Objectives** – To develop assessment skills that focus on differentiating different types of wounds; to learn wound care assessment methodology, to teach patients about signs and symptoms of healing wounds and wounds that need to be seen by the wound care nurse.

---

**Immunization Clinic**

**Learning Experience** – 1 day

To practice giving a variety of immunizations to people of different ages; to educate patients and parents using the guidelines provided by the; to confirm medications given by MA.

**Objectives** – To assess patients’ pre immunization for appropriateness of medical order; to immunize patients using the 5 rights of medication administration; to provide patient education post immunization.

---

**Laboratory**

**Learning Experience** – 2 hours

To observe the laboratory environment within the MOB that a specific Resident will work.

**Objectives** – To introduce the Residents to key personnel; to identify where different types of specimens are taken; to visualize the processing for specific lab tests.

---

**Interventional Radiology**

**Learning Experience** – 2-4 hours

To tour the facility; to observe a procedure.

**Objectives** – To introduce the Residents to key personnel; to identify types of procedures performed; to understand pre procedural & post procedural follow-up.
## Cardiology Procedures

<table>
<thead>
<tr>
<th>Learning Experience – 2-4 hours</th>
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</thead>
<tbody>
<tr>
<td>To tour the facility; to observe a procedure.</td>
</tr>
</tbody>
</table>

**Objectives** – To introduce the Residents to key personnel; to identify types of procedures performed; to understand pre procedural & post procedural follow-up.

## Flu Clinic

<table>
<thead>
<tr>
<th>Learning Experience – 3 days</th>
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<tbody>
<tr>
<td>To participate in the set-up of the clinic if possible; to practice immunization skills and patient/family education about the flu</td>
</tr>
</tbody>
</table>

**Objectives** – To be able to explain the benefits of having a flu vaccine; to be able to answer questions from patients about the current flu vaccine safety and efficacy.

## Policies and Procedures

### I. Policies and Procedures List

Some Policies and Procedures and related content and/or Procedural Competencies may be region/organization-specific. Use this table to add these to better keep track of the Resident’s progress.

<table>
<thead>
<tr>
<th>Title</th>
<th>Associated Lecture/Procedural Competency</th>
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</table>
Forms and Evaluations

In this section you will find various forms, checklists, and evaluation tools that are needed in the Residency Program. Please make copies as necessary.

I. Validator Competency Guideline and Competency Tool

<table>
<thead>
<tr>
<th>Competency Validator Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency Title: __________________________</td>
</tr>
<tr>
<td>Developed by: ___________________________</td>
</tr>
</tbody>
</table>

Step Information:  
☐ NA  
If none, put X in the NA box.

Critical Thinking/Problem Solving Questions:  
☐ NA  
If none, put X in the NA box.

Interpersonal Question/s and Answer:  
☐ NA  
If none, put X in the NA box.

Curriculum Content:  
☐ NA  
If none, put X in the NA box.  
If there is curriculum content, state if it is a PowerPoint, online, etc.

Competency Tool

Name: ___________________________  Job Title: ______________________
Department/Work Area: _______________  Employee #: ___________________
Subject: ____________________________  Date: ______________________

Rationale for Selection (check appropriate):  
☐ high-risk  ☐ low-volume  ☐ problem-prone  ☐ new equipment/technology

Job Category:  
☐ RN  ☐ LVN/LPN  ☐ MA  ☐ Able to validate others (may only be checked by an RN Validator)

Complete by date: ____________________  
(Arrange time with approved Validator to perform competency/return demonstration and turn in completed form by date indicated).

NOTE: Validator is expected to use guideline to provide consistency in the Validation Process. Other notes may be added here.

<table>
<thead>
<tr>
<th>Behavior/Skill</th>
<th>MSE</th>
<th>Unable to Perform</th>
<th>Performs with Coaching</th>
<th>Performs without Coaching</th>
</tr>
</thead>
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</table>

<table>
<thead>
<tr>
<th>Critical Thinking (LVN/MA – Problem Solving Question)</th>
<th>MSE</th>
<th>Unable to Perform</th>
<th>Performs with Coaching</th>
<th>Performs without Coaching</th>
</tr>
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</tr>
<tr>
<td>Interpersonal</td>
<td>MSE</td>
<td>Unable to Perform</td>
<td>Performs with Coaching</td>
<td>Performs without Coaching</td>
</tr>
<tr>
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</tr>
<tr>
<td>(Diversity, Cultural, Age-Specific, Customer Service – may or may not be present within a specific competency)</td>
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</tr>
</tbody>
</table>

**MSE: Method of Skill Evaluation**
RD (Return Demonstration); O (Observation); WA (Written Assignment); V (Verbalization); CR (Chart Review)

**References** (at least one complete citation of evidence-based practice):

**Resources** (any KP regional or national resources, e.g. AED Use and Maintenance Guideline, 2009):

**Validated by** (print name/signature/department):
Date: ________________________________

**Demonstrator** (print name/signature/department):
Date: ________________________________

**Outcome:**
☑ satisfactorily completed competency
☐ needs to complete action plan and revalidate (fill in action plan)
II. Clinical Observation Grid

### Observation Grid – Primary Care

<table>
<thead>
<tr>
<th>Name:</th>
<th>Observation Site:</th>
<th>Date:</th>
</tr>
</thead>
</table>

Complete each question and bring to your next peer group meeting.

1. Did you observe team collaboration? Explain.

2. State one thing that you noticed and appreciated about the team.

3. Did you observe the RN performing a leadership role? Explain.

4. Did you observe the act of caring by a staff member? Explain.

5. What are some ways an RN can make a difference in the care being delivered?

6. How is the RN role different than other staff members? Did you notice a difference? Explain.

7. What skills did you observe that you are comfortable performing?

8. How can we improve care in the Ambulatory Setting?

### Observation Grid – Ambulatory Care

<table>
<thead>
<tr>
<th>Name:</th>
<th>Observation Site:</th>
<th>Date:</th>
</tr>
</thead>
</table>

Complete each question and bring to your next peer group meeting.

1. What are some ways an RN can make a difference in the care being delivered?

2. What is different in the way an RN should provide care from any other staff member?

3. Did you observe an act of caring by a staff member? If so, explain.

4. What skills did you observe that you are comfortable performing?

5. How would you explain the type of team collaboration that you observed?

6. State one thing that you noticed and appreciated about the team.

7. What does it mean to be an RN leader?

8. How can we improve care in the Ambulatory Setting?
## Observation Grid – Family Practice Clinic

<table>
<thead>
<tr>
<th>Name: _______________________________</th>
<th>6a. How was safety assured for the child and/or the adult patient?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation Site:_______________________</td>
<td>6b. Would you have done anything differently?</td>
</tr>
<tr>
<td>Date: ________________________________</td>
<td></td>
</tr>
<tr>
<td>Complete each question and bring to your next peer group meeting.</td>
<td></td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. As the RN, what do you do differently in the performance of your role vs. the LVN or the MA?</td>
<td></td>
</tr>
<tr>
<td>2a. When administering vaccines or any treatment to pediatric patients, how was comfort provided to the child?</td>
<td></td>
</tr>
<tr>
<td>2b. What would you have done differently?</td>
<td></td>
</tr>
<tr>
<td>3a. When performing any procedure, did the staff member communicate to the parent or the pediatric patient, or both?</td>
<td></td>
</tr>
<tr>
<td>3b. Was the communication age-appropriate? Explain.</td>
<td></td>
</tr>
<tr>
<td>4. Did the staff members introduce themselves with their name and position?</td>
<td></td>
</tr>
<tr>
<td>5a. Did the staff members wash their hands at appropriate times?</td>
<td></td>
</tr>
<tr>
<td>5b. If not, when should you wash your hands?</td>
<td></td>
</tr>
</tbody>
</table>
Observation Grid – Pediatric Clinic

<table>
<thead>
<tr>
<th>Name: _______________________________</th>
<th>6. Were discharge instructions given clearly and appropriately as it relates to content and scope of practice?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation Site:_______________________</td>
<td></td>
</tr>
<tr>
<td>Date: ________________________________</td>
<td></td>
</tr>
<tr>
<td>Complete each question and bring to your next peer group meeting.</td>
<td></td>
</tr>
</tbody>
</table>

1. As the RN, what do you do differently in the performance of your role vs. the LVN or the MA?

2a. When administering vaccines or any treatment to pediatric patients, how was comfort provided to the child?

2b. What would you have done differently?

3a. When performing any procedure, did the staff member communicate to the parent or the pediatric patient, or both?

3b. Was the communication age-appropriate? Explain.

4a. Did the staff members introduce themselves to both child and parent with their name and position?

4b. If not, what would you do?

5. State two things that you learned about pediatric care.
**Observation Grid – Immunizations**

Name: _______________________________
Observation Site: ___________________
Date: ______________________________

Complete each question and bring to your next peer group meeting.

<table>
<thead>
<tr>
<th>1a. What is the role of the RN?</th>
<th>6a. What vaccines were given?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1b. What is the role of the LVN?</td>
<td>6b. Did the staff adhere to vaccination standards?</td>
</tr>
<tr>
<td>1c. Should there be a difference? Explain.</td>
<td>6c. If not, what could they have done differently?</td>
</tr>
</tbody>
</table>

| 2a. When administering vaccines to the members, how did the nurse ensure safety? |  |
| 2b. What could he/she have done differently? |  |

| 3. What about the workflow process worked well? Why? |  |

| 4. Did the staff demonstrate age-appropriate care during the visit? Explain. |  |

| 5a. How effective was the staff in comforting members? |  |
| 5b. What could have been different? |  |
III. Residency Program Completion Checklist

<table>
<thead>
<tr>
<th>Subject</th>
<th>Date and Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-related care</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Nursing Practice</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Nursing Standards of Practice</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Care – Nursing Rides</td>
<td></td>
</tr>
<tr>
<td>Arm Sling Elastic Wrap</td>
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<tr>
<td>Blood Glucose Monitoring</td>
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<tr>
<td>Chronic Care Model</td>
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<tr>
<td>Educational Resources</td>
<td></td>
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<tr>
<td>Communication – SBAR</td>
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<tr>
<td>Communication – RNMD</td>
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<tr>
<td>Communication – Crucial Conversations</td>
<td></td>
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<tr>
<td>Critical Thinking</td>
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<tr>
<td>CSGC</td>
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<tr>
<td>EKG – 12 Lead</td>
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<tr>
<td>Emergency Response</td>
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<tr>
<td>End of Life Care</td>
<td></td>
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<tr>
<td>Ethics Code for Nursing</td>
<td></td>
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<tr>
<td>Foot Exam</td>
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<tr>
<td>Healthcare Team</td>
<td></td>
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<tr>
<td>HIPAA</td>
<td></td>
</tr>
<tr>
<td>Immunizations</td>
<td></td>
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<tr>
<td>Infection Control</td>
<td></td>
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<tr>
<td>Integrity</td>
<td></td>
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<tr>
<td>Intramuscular Injection</td>
<td></td>
</tr>
<tr>
<td>IOM Report – The Future of Nursing</td>
<td></td>
</tr>
</tbody>
</table>

Residency Program Completion Checklist

Name: ___________________________________________
Department: ______________________________________
Program Start Date: ______________________________

Please return completed checklist to Nurse Educator at the end of Residency Program.

I have reviewed the attached checklist for completion:

Resident Signature: _______________________________      Date: _________________
Clinical Manager Signature: _________________________     Date: _________________
Nurse Educator: __________________________________     Date: _________________

Curriculum

IV Access, adding medication, dressing change – ports, Broviacs, hep locks, dialysis shunts
KP Vision, Values, and Models
Leadership
Medication Administration, Medication Safety and Reconciliation
Message Management
Nasopharyngeal Specimen
Oxygen Administration
Patient Education/Self-Management
POE/POS
Point of Care Testing
PPE
Professional Portfolio

Rotations

Adult Primary Care
Cardiology Procedures
Emergency Department
Family Medicine Clinic
Flu Clinic
Geriatric Clinic
GI Lab
Hypertension Clinic
Infusion Center
Interventional Radiology
Internal Medicine Clinic
Laboratory
Lactation Clinic
Nurse Clinic (specify)
Obstetrics/Gynecology Clinic
Orthopedic Clinic
Patient Education Classes (specify)
Pediatric Clinic
Pulmonary Clinic
Population Health
Surgery Clinic (specify)
Teen Clinic
Urgent Care
Wound Care Clinic

Curriculum

Professional Work Behavior
Scope of Practice
Secure Messaging – Email Etiquette
Situational Awareness
Skin and Wound Assessment
Splinting
Tuberculin Skin Testing (TST), Administration, and Reading
Walk-in Patients – Triage Scenarios
<table>
<thead>
<tr>
<th>Competencies</th>
<th>Review</th>
<th>Performed</th>
<th>Date Initials</th>
<th>Review</th>
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<th>Date Initials</th>
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<tr>
<td>AED</td>
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<td>Arm Sling Elastic (ACE) Wrap</td>
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<td>Bladder Scan</td>
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<td>Blood Glucose Monitoring (SureStrepFlex)</td>
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<td>Blood Pressure Manual</td>
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<td>Central Catheter Dressing Change, Peripherally Inserted</td>
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<td>Ear Lavage</td>
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<td>EKG 12 Lead</td>
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<td>Eye Drop Instillation</td>
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<td>Foot Exam</td>
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<td>Intramuscular Injection</td>
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<td>Immunizations</td>
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<td>Insulin Pen – Patient Education</td>
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<td>Intravenous Starts</td>
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<td>Medication Administration</td>
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<td>Nasal Culture</td>
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<td>Nasal Pharyngeal Specimen Collection</td>
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<td>Occult Blood – Stool</td>
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<td>Oxygen Saturation Measurement (Pulse Oximetry)</td>
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<td>Pain Assessment/Management</td>
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<td>Peak Flow Meter</td>
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<td>PPE – Donning and Doffing</td>
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<tr>
<td>Rapid Strep Test</td>
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<tr>
<td>Splinting – Finger, Wrist, Ankle, Knee</td>
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<tr>
<td>Spirometry</td>
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<td>Subcutaneous Injection</td>
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<td>Suture/Staple Removal</td>
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<td>Telephone Advice</td>
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<td>Therapeutic Phlebotomy</td>
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<tr>
<td>Throat Culture</td>
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<tr>
<td>Tuberculin Skin Testing</td>
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</table>

<table>
<thead>
<tr>
<th>Policies and Procedures</th>
<th>Initials</th>
<th>Policies and Procedures</th>
<th>Initials</th>
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</thead>
<tbody>
<tr>
<td>(TST) – Administration &amp; Reading</td>
<td></td>
<td>Urinary Catheter Insertion and Removal, Special Procedures</td>
<td></td>
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<td></td>
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<td>Urine Dipstick, using Bayer (Siemens Multistick 8SG or Uristick)</td>
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<td>Urine Pregnancy</td>
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<td>Visual Acuity – Snellen Chart</td>
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<table>
<thead>
<tr>
<th>Residency Program Checklist Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident: _____________________________</td>
</tr>
<tr>
<td>Clinic Site: __________________________</td>
</tr>
<tr>
<td>Date: _________________________________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Area Needing Development</th>
<th>Goal</th>
<th>Target Completion Date</th>
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<tbody>
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</table>
### IV. Evaluation Forms

**Preceptor Evaluation – Resident**

<table>
<thead>
<tr>
<th>Preceptor Evaluation - Resident</th>
<th>Ratings: 1=Never; 2=Rarely; 3=Sometimes; 4=Usually; 5=Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Preceptor:</td>
<td></td>
</tr>
</tbody>
</table>

1. Demonstrated professionalism. | 1 2 3 4 5 NA |
2. Facilitated my ability to assess and manage the working environment. | 1 2 3 4 5 NA |
3. Listened attentively to my concerns. | 1 2 3 4 5 NA |
4. Observed my clinical performance. | 1 2 3 4 5 NA |
5. Provided me with learning opportunities. | 1 2 3 4 5 NA |
6. Encouraged me to directly resolve or advocate for the concerns of patients. | 1 2 3 4 5 NA |
7. Provided resources and assistance when I did not ask for them. | 1 2 3 4 5 NA |
8. Facilitated my critical thinking abilities. | 1 2 3 4 5 NA |
9. Provided timely, respectful feedback when my practice needed improvement. | 1 2 3 4 5 NA |
10. Encouraged, coached, and motivated me. | 1 2 3 4 5 NA |

**Comments:**

Resident: __________________________ Date: ________________

Preceptor: __________________________ Date: ________________

---

**Final Signatures**

Clinical Manager Signature and Date

Nurse Educator Signature and Date

RN Resident Signature and Date
Resident Evaluation – Preceptor

Ratings: 1=Never; 2=Rarely; 3=Sometimes; 4=Usually; 5=Always

My Resident:

1. Demonstrated professionalism. 1 2 3 4 5 NA
2. Utilized critical thinking. 1 2 3 4 5 NA
3. Listened attentively to my feedback and utilized it to improve their practice. 1 2 3 4 5 NA
4. Initiated opportunities to advocate for patients. 1 2 3 4 5 NA
5. Independently sought out resources (staff or written) to improve own practice. 1 2 3 4 5 NA
6. Worked collaboratively with the team. 1 2 3 4 5 NA
7. Was motivated to learn. 1 2 3 4 5 NA

Comments:

Preceptor: ___________________________________ Date: ________________
Resident: ___________________________________ Date: ________________
## Part B

**Circle the Degree of Confidence and Competence You Think You Have in the Following Areas:**

<table>
<thead>
<tr>
<th>Area related to Ambulatory Nursing Practice</th>
<th>Confidence</th>
<th>Competence</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical thinking</td>
<td>0 None</td>
<td>1 Minimal</td>
<td>2 Moderate</td>
</tr>
<tr>
<td>Time management</td>
<td>0 Never done</td>
<td>1 Require moderate supervision</td>
<td>2 Require minimal supervision</td>
</tr>
<tr>
<td>Organizational skills</td>
<td>0 Never done</td>
<td>1 Require moderate supervision</td>
<td>2 Require minimal supervision</td>
</tr>
<tr>
<td>Patient assessment</td>
<td>0 Never done</td>
<td>1 Require moderate supervision</td>
<td>2 Require minimal supervision</td>
</tr>
<tr>
<td>Rapid patient assessment</td>
<td>0 Never done</td>
<td>1 Require moderate supervision</td>
<td>2 Require minimal supervision</td>
</tr>
<tr>
<td>Communication with physicians</td>
<td>0 Never done</td>
<td>1 Require moderate supervision</td>
<td>2 Require minimal supervision</td>
</tr>
<tr>
<td>Communication with peers</td>
<td>0 Never done</td>
<td>1 Require moderate supervision</td>
<td>2 Require minimal supervision</td>
</tr>
<tr>
<td>Communication with patient and families</td>
<td>0 Never done</td>
<td>1 Require moderate supervision</td>
<td>2 Require minimal supervision</td>
</tr>
<tr>
<td>Use of SBAR communication</td>
<td>0 Never done</td>
<td>1 Require moderate supervision</td>
<td>2 Require minimal supervision</td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td>0 Never done</td>
<td>1 Require moderate supervision</td>
<td>2 Require minimal supervision</td>
</tr>
<tr>
<td>Fall prevention</td>
<td>0 Never done</td>
<td>1 Require moderate supervision</td>
<td>2 Require minimal supervision</td>
</tr>
<tr>
<td>Triage patient calls on phone</td>
<td>0 Never done</td>
<td>1 Require moderate supervision</td>
<td>2 Require minimal supervision</td>
</tr>
<tr>
<td>Triage walk-in patients</td>
<td>0 Never done</td>
<td>1 Require moderate supervision</td>
<td>2 Require minimal supervision</td>
</tr>
<tr>
<td>Provide leadership for a team</td>
<td>0 Never done</td>
<td>1 Require moderate supervision</td>
<td>2 Require minimal supervision</td>
</tr>
<tr>
<td>Provide leadership in emergency situations</td>
<td>0 Never done</td>
<td>1 Require moderate supervision</td>
<td>2 Require minimal supervision</td>
</tr>
<tr>
<td>Refer patients/families to Kaiser resources</td>
<td>0 Never done</td>
<td>1 Require moderate supervision</td>
<td>2 Require minimal supervision</td>
</tr>
<tr>
<td>Provide a caring environment</td>
<td>0 Never done</td>
<td>1 Require moderate supervision</td>
<td>2 Require minimal supervision</td>
</tr>
<tr>
<td>Provide patient care with consideration for cultural, religious, gender, race, ethnicity, lifestyle, socioeconomic status, age, and spiritual differences</td>
<td>0 Never done</td>
<td>1 Require moderate supervision</td>
<td>2 Require minimal supervision</td>
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</tbody>
</table>

### Delegate patient care
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

### Provide a safe environment for patient care
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

### Advocate for patients/families
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

## Part C

**Skills: Indicating Your Actual Experience, Rate How Confident and Competent You Think Your Skill Level is in Performing the Following:**

<table>
<thead>
<tr>
<th>Skill performance related to Ambulatory Nursing Practice</th>
<th>Confidence</th>
<th>Competence</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical thinking</td>
<td>0 None</td>
<td>1 Minimal</td>
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<tr>
<td>Time management</td>
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<td>1 Require moderate supervision</td>
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</table>

### Use of AED
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

### Performing a 12-lead EKG
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

### Recognition of ventricular fibrillation
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

### Recognition of ventricular tachycardia
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

### Recognition of elevated ST segment
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

### Sterile dressing change
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

### Urinary catheter insertion
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

### Using standard precautions
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

### Performing a foot exam
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

### Peak Flow Meter
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

### Spirometry
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

### Use of glucometer
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

### Pain assessment
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

### Wound care
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

### End of life care
- 0 Never done
- 1 Require moderate supervision
- 2 Require minimal supervision
- 3 Independent
- 4 Can teach others

### Blood Pressure
- **Manual**
  - 0 Never done
  - 1 Require moderate supervision
  - 2 Require minimal supervision
  - 3 Independent
  - 4 Can teach others
- **Automatic**
  - 0 Never done
  - 1 Require moderate supervision
  - 2 Require minimal supervision
  - 3 Independent
  - 4 Can teach others
- **Orthostatic**
  - 0 Never done
  - 1 Require moderate supervision
  - 2 Require minimal supervision
  - 3 Independent
  - 4 Can teach others
### IV Therapy
- **Insertion**
  - 0 1 2 3 4 0 1 2 3 4
- **Regulation**
  - 0 1 2 3 4 0 1 2 3 4
- **Central line access**
  - 0 1 2 3 4 0 1 2 3 4
- **Blood administration**
  - 0 1 2 3 4 0 1 2 3 4
- **Use of infusion pumps**
  - 0 1 2 3 4 0 1 2 3 4
- **Central line dressing change**
  - 0 1 2 3 4 0 1 2 3 4
- **Verifying medication given by medical assistant**
  - 0 1 2 3 4 0 1 2 3 4

### Physical Assessment
- **HEENT**
  - 0 1 2 3 4 0 1 2 3 4
- **Cardiac**
  - 0 1 2 3 4 0 1 2 3 4
- **Pulmonary**
  - 0 1 2 3 4 0 1 2 3 4
- **Neurological**
  - 0 1 2 3 4 0 1 2 3 4
- **Musculoskeletal**
  - 0 1 2 3 4 0 1 2 3 4
- **GI**
  - 0 1 2 3 4 0 1 2 3 4
- **GU**
  - 0 1 2 3 4 0 1 2 3 4
- **Integumentary**
  - 0 1 2 3 4 0 1 2 3 4
- **Recognition of a heart attack**
  - 0 1 2 3 4 0 1 2 3 4
- **Recognition of respiratory distress**
  - 0 1 2 3 4 0 1 2 3 4
- **Recognition of a stroke**
  - 0 1 2 3 4 0 1 2 3 4

### Medication Administration
- **PO**
  - 0 1 2 3 4 0 1 2 3 4
- **Intramuscular**
  - 0 1 2 3 4 0 1 2 3 4
- **Subcutaneous**
  - 0 1 2 3 4 0 1 2 3 4
- **Intravenous**
  - 0 1 2 3 4 0 1 2 3 4

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**BHMT Nurse Residency Program Playbook | 125**

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**Ambulatory Nurse Residency Program**

(Insert Dates Here)

(RN Resident Name)

Has Successfully Completed the Requirements of the Ambulatory RN Residency Program through

(Service Area Name)

_____________________________                                     _____________________________
Nurse Educator                                                                 Other Signature


