

AN ORIENTATION PROGRAM FOR NEW GRADUATES WORKING IN THE EMERGENCY
DEPARTMENT: CURRICULUM DEVELOPMENT

By

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Abstract

Due to the global shortage of nurses it is not uncommon for health institution to hire new graduates to work in the emergency department; however, there are limited orientation programs to address the needs of new graduates in this highly challenging and stressful area of practice. New graduates who lack consolidation of their basic knowledge and skills after their BSN degree enter into an emergency specialty programs, and upon completion, they are expected to utilize a higher level of critical thinking they have not yet fully developed. The goal of this project is to develop a curriculum blueprint for new graduates to work in the emergency department following a foundational emergency specialty course. A thematic analysis of literature was performed to identify three major themes of the challenges new graduates face when transitioning into their professional role; socialization with subthemes of sociopolitical and socio cultural, skills and knowledge, and interpersonal conflict. The analysis was used to inform the development of an orientation program. A theoretical framework of constructivist learning theory, Benner's novice to expert, and Finks taxonomy were used to guide the process of curriculum development. The intent is to present nurse educators and managers an orientation program grounded in evidence informed knowledge, which would enable novice nurses in the emergency department to practice in a safe and competent manner.

Table of Contents

Supervisory Committee ,.....	2
Abstract	3
Table of Contents	4
Acknowledgements	7
Introduction	8
Background	10
Entry Level Competencies	11
NENA Competencies	11
BCIT Specialty	13
Financial Constraints	14
Nurse Turnover	16
Statement of Problem	17
Methodological Approach	18
Thematic Analysis	19
Overview	19
Socialization of New Graduates	21
Socio political	22
Socio cultural	26
Skills and knowledge	30
Interpersonal conflict	34
Summary of Literature Review	37
Review of Orientation Program.....	39

Curriculum Development	41
Theoretical Lens	42
Context Relevant	47
Internal Factors	48
External Factors	50
Curriculum Blueprint	52
Taxonomy	54
Teaching and Learning	57
Lectures	57
Case studies	58
Story telling	59
Mentorship	60
Evaluation	61
Evaluation Tools	64
Conclusion	65
References	67
Appendix A: Summary of Themes	78
Appendix B: John Hopkins Nursing Evidence Based Practice Appraisal Tool	79
Appendix C: Strength of Evidence	114
Appendix D: An Orientation Program for New Graduates Working in the Emergency Department: Curriculum Blueprint	117
Appendix E: Teaching and Learning Strategies for Each Dimension of Learning	118
Appendix F: Modules	119
Appendix G: Graphis Syllabus	141

Appendix H: Formal Summation Evaluation 145

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Emergency nursing is a specialty area of nursing, which requires specialized knowledge and skills to address the unpredictable evolving changes of patients in the emergency department. The National Emergency Nurses' Affiliation (NENA) of Canada mandates Registered Nurses to meet certain standards of care and core competencies to deliver safe patient care. Due to the worldwide nursing shortage, there is a trend that places new and inexperienced nurses in specialty areas that in the past were staffed by more senior and experienced staff. Cycles of nursing shortages have been reported throughout the United States and Canada throughout the 1970's, 1980's, and 1990's (Brodie et al., 2004). Retention issues in emergency departments are due to contributing factors such as lack of established limits to patient assignments, the unpredictable nature of emergency care, the increased responsibility of caring for admitted patients when beds are unavailable for admitted patients on other units, overcrowding, and increased violence against nurses (Sawatzky & Enns, 2012, p.697).

As seasoned nurses we acquired knowledge and skills from many years of practice and gained wisdom from expert nurses. Due to the nursing shortage, most new graduates who have just completed their BSN programs are being approved to enter into an emergency specialty program; however, many of these nurses are unable to solidify their baseline experience before taking the specialty emergency course and are often placed in situations that require critical thinking and sophisticated assessment skills to quickly act upon evolving and challenging situations (Loiseau, 2003). How can these new graduates be better prepared to practice effectively in the emergency department? For the purpose of this project, new graduates will be defined as nurses that have graduated from a specialty program of emergency nursing within one year of graduating from a BSN program.

Since the opening of the Abbotsford Regional Hospital and Cancer Center (ARHCC) new graduates continue to replace each other annually. While working alongside new graduates in my role as a clinical educator, new graduates revealed to me that they are inadequately prepared to work in specialty areas such as the emergency department. Nelson and Godfrey (2004) also support this as they state that new nurses are overwhelmed by juggling a multitude of tasks that they are ill-prepared to manage in the provision of patient care, and thus they claim that special attention to developing emergency (ER) nurse competencies is warranted to retain new nurses. In this paper, I present how I plan to design a curriculum blueprint for an orientation program targeting recent graduates of an emergency ER nursing specialty program.

A curriculum blueprint is an educational framework that outlines the essential elements of a curriculum and has set expectations as to what will be evaluated (Cumyn & Gibson, 2010). My curriculum blueprint has content (foundational knowledge) from which other previous content will build upon. In designing this curriculum a thematic analysis of the literature was conducted to elicit what is evident in the published literature about the challenges that new graduates face when working in the emergency department. This review was used to inform and critique the existing orientation curricula for new ER nurses that I found in the literature. Through a review of the literature on challenges faced by new graduates in ERs and a related critique of existing curricula, I decided on the final elements of a curriculum blueprint for an orientation program to support the transition of new graduates into practice in the emergency department. The curriculum blueprint consists of modules which will enable learners to access prior knowledge and help develop the competencies necessary for working in the emergency department (Appendix D). A unique

element of the curriculum that I designed is a mentorship period included to foster the ongoing professional growth and socialization of a new graduate.

I begin by providing a background of the how the global nursing shortage affected the hiring practices of institutions. Entry-level competencies and NENA standards are included to understand how competency level of novice nurses can restrict their ability to adapt to emergency practice environments. Financial constraints of organizations will provide an understanding of how mentorship periods are determined, which results in nurse turnover. A statement of the problem is provided and it is followed by a thematic analysis of the literature presenting the challenges of new nurse graduates in their professional role.

Background

As previous stated, there is a global shortage of nurses. According to the Canadian Nurse Association (2009) there was a shortage of 11,000 nurses in the year 2007. In the year 2022, there will be an estimated projected shortfall of 60,000 nurses in Canada (2009). The projected number of nurses retiring from the workforce will influence not only the overall shortage of nurses, but also decrease the availability of specialty care nurses (Winslow, Almarode, Cottingham, Lowry & Walker, 2009). Furthermore, as nurses retire from the workforce, there will not be enough experienced nurses to guide new graduates in the transition to the professional role. Areas identified that contribute to the nursing shortage include ageing RNs, declining enrolment in nursing studies, poor work conditions, low social value given to nurses, and an increase in consumer activism. (Basu & Gupta, 2012; Goodin, 2003; Sawatzky & Enns, 2012; Schriver, Talmadge, Chuong, & Hedges, 2003). In addition, nurses have cited personal reasons for leaving

the profession that included caring for young children or older parents, spouses' job responsibilities, return to school, better job opportunities for more money and better hours, moving, and physical and emotional illness (Strachota, Normandin, O'Brien, Clary, & Krukow, 2003, p. 115).

The causes of the nursing shortage are diverse, and in the past shortages were due to an increasing demand, or a decrease in supply (Oulton, 2006); however, Oulton states that today both factors contribute equally: a decreased supply cannot meet an increased demand (p. 34S).

Increased demands are due to more complex diseases which results in increased acuity of care; a shift from hospital to home and community care; new infectious diseases and re-emerging new ones, such as tuberculosis and malaria; an aging population; globalization and a growing private sector; high public trust in nurses, which sparked an increased demand for nurses as the primary entry point to health services (Oulton, p.35S).

Therefore, with the nursing shortage and the demands on the healthcare system, the hiring of new graduates into specialty areas like the emergency department is a common practice (Duchscher & Myrick, 2008). The multifaceted and dynamic environment of the emergency department and television series such as '*ER*' that dramatize and sensationalize this area of healthcare also promotes and attract new graduates into this high acute area. However, many are unprepared to manage the complexity of acute care patients in this stressful environment when graduating with entry level competencies.

Entry-Level Competencies

ARHCC opened in August of 2008, at which time nurse administrators initiated the hiring of many new graduates eager to work in the new emergency department. Prior to working in the

acute areas of the emergency department at ARHCC, nurses complete a foundational ER specialty course at the British Columbia Institute of Technology (BCIT) which aims to prepare nurses to work in this type of environment; a unique environment that requires nurses to handle unplanned situations requiring intervention, allocate limited resources, and provide emergent care (NENA, 2011, p. 2). However, new BSN graduates hired into ARHCC ER and who apply for this foundational ER specialty course usually have limited experience following BSN graduation to further consolidate basic nursing knowledge and skills.

New graduates are at a novice, or advanced beginner level and thus are at the early stages of developing their skills and applying critical thinking (Benner, 1984). The College of Registered Nurses of British Columbia (CRNBC) mandates specific competencies that are expected of a newly graduated registered nurse. Entry level registered nurses are aware of the Standards for Nursing Practice in British Columbia, which requires them to practice in a responsible and accountable manner based on their level of knowledge and experience (CRNBC). According to CRNBC, during the first 6 to 12 months of practice, entry level registered nurses focus on the details and rules of practice with limited attention to the broader picture (CRNBC, 2009, p.5). In addition, they are familiar with, and apply basic nursing knowledge and skills (CRNBC, p.5). CRNBC states that in the first six months of employment, a newly graduated registered nurse is in transition (CRNBC). Time is required to consolidate practice and gain depth in nursing practice knowledge and judgment (CRNBC). A transition period is important for new graduates to gain experiences outside of school where concepts are learned and internalized through personal experience; therefore, while the school prepares students with tools for professional practice, it is in the work environment that new nurses develop their ability to apply and use these tools (Santucci, 2004).

Due to the shortage of nurses, new graduates will often begin the foundational ER course prior to having completed six months of post-BSN practice. At my place of work when new graduates are hired in the ER they attend the next available intake of the emergency specialty course, which overlook the recommendations put forth by NENA ensuring competency to practice.

NENA Competencies

National nursing shortages and nursing retirement influences the availability of recruiting experienced emergency nurses (Winslow et. al., 2009, p. 521). Within the Standards of Emergency Department Nursing Practice, a specified qualification for employment in an emergency setting is a minimum of two years in an acute care, or medicine/surgery experience is preferred to adequately prepare new graduates to practice in a challenging environment (NENA, 2010, Standard 1, p. 3). The two years of nursing experience allow new graduates to develop the skills and confidence to manage clinical situations, which will prepare them to move to a more complex way of thinking and doing (CRNBC, 2000). Due to the shortage of nurses (CNA, 2002) the recommendation of two years experience prior to entry into a specialty program is being essentially disregarded. New graduates with limited experience will also have limited practice hours as a Registered Nurse in which to consolidate their basic skills. A foundational program like the BCIT emergency specialty course builds upon a nurses' prior knowledge and skills to work with the complex illness of patients.

BCIT Emergency Specialty Course

As previously stated NENA (2000) recommends that nurses have a minimum of two years acute care experience prior to entering a specialty course. However, BCIT emergency entrance

requirements are that applicants should have a minimum of 6 months to 1 year of relevant work experience in an acute care setting (BCIT, 2012). Within the BCIT emergency curriculum there are a total of 250 practice hours. These practice hours focus on the application of further new skills and knowledge (2012), which builds upon nurses prior experiences; however, as previously mentioned many of the nurses who currently enter the program have limited clinical experience to consolidate basic knowledge and skills, but are nevertheless expected to have the necessary critical thinking and psychomotor skills to deal with a complexity of patient illnesses. The average attrition rate of the emergency program is 7% (Fraser Health, 2013). Attrition is defined as the number of individuals and percentages of individuals sponsored by Fraser Health who withdrew from the emergency program, or did not successfully complete the program (Fraser Health).

When new graduates have limited experience to consolidate their skills and knowledge on a medical/surgical unit it can be overwhelming for novice nurses to work in an environment that is faster-paced and requires advanced skills and knowledge (Wolf, Everson, & Gantt, 2008). Orientation programs need to be developed with the consideration of inexperienced nurses, but yet remain cost effective for the organization (Santuci, 2004, p. 274). Although an additional mentorship period is implemented to provide consolidation of knowledge and skills provided by the ER foundational course, due to financial constraints of the organization an appropriate mentorship period based on individual need is often not realistic.

Financial Constraints

While most emergency department managers and clinical nurse educators will incorporate a period of mentorship to assist in the consolidation of critical thinking skills, this mentorship period

may be limited due to financial health care constraints (Heitlinger, 2003). Health care constraints are due to economic trends in Canada, which puts provincial governments in the position to economize on health spending (Varcoe & Rodney, 2009, p.125). Health care expenditures strain government budget when technological advances, pharmaceuticals, and equipment provide new medical treatment for patients creating more work and hospital care resulting in increased cost (Van Wyk, 1998). In addition, the health workforce dictated by demand and supply are affected by socio demographics such as age, as the aging of society increases demand for health services such as nurses for homecare (Zurn, Dal Poz, Stilwell, & Adams, 2004).

A review of the literature indicated that nurses have absorbed a disproportionate burden of cost containment in healthcare (Heitlinger, 2003, p. 37). For example, reduced government funding results in the closing of hospital beds, reducing length of patients' stay, laid off nurses, transforming full time nursing positions into casual, or part-time ones, contracting out staffing needs, and intensifying the work of remaining staff (Heitlinger, p. 39). Therefore, a restricted mentorship period due to cost containment of an emergency department will inadequately prepare the new graduate to develop the skills needed to become a competent practitioner. A mentorship period is needed to assist new graduates to develop skills, improve critical thinking, and learn how to make quick decisions, which will enable them to advance from novice to expert nurses (Nelson & Godfrey, 2004, p. 551). Hence, an appropriate mentorship period that meets the needs of new graduate will decrease nurse turnover in specialty care areas (Meyer & Meyer, 2002).

Nurse Turnover

Sophisticated assessment and critical thinking skills are needed “on the spot,” yet new graduates require time to practice new psychomotor skills as well as to develop critical thinking and assessment skills to guide their actions in the ER. An example of nurses using their critical thinking skills is deciding when and how to implement specific emergency policies and procedures such as the sepsis protocol. Emergency departments of Fraser Health, in the past two years, have introduced new patient-focused¹ policies to improve the care of those who present to the emergency department with high acuity and complex health issues.

Specific protocols are initiated by the emergency nurses based on pre-established patient criteria; therefore, it is the nurses’ assessment, skills, and judgments which will dictate whether a protocol is initiated. Sepsis is becoming one of the more prevalent diagnoses of patients presenting to the emergency department for which early intervention may save lives. Interventions such as the initiation of STAT laboratory (lab) work, the evaluation of the lab work, the initiation of intravenous therapy, and knowing when to contact the physician are needed in conditions of severe sepsis. Understanding the importance of early intervention for septic patients, without having the necessary experience of when to critically assess and intervene, can cause anxiety and stress for new graduates.

In my capacity as a clinical educator, it is often in these times that new graduates have told me that they felt ill prepared to work in an environment where patients’ lives depend on assessment and critical thinking skills that they have not yet fully developed. As a result, at the end of the first

¹ Policies that focuses on patient to ensure they are getting timely care and test results.

year after opening the new emergency department at ARHCC, 18 Registered Nurses, all of whom were new graduates transferred, or left the department due to dealing with the complexity of the work without having adequate resources. No exit interviews were provided to the new graduates who left. Financial consequences of this loss of nursing staff includes: loss of future returns from investment of hired nurses; productivity losses, costs of overtime for existing staff to replace vacant positions, cost of further orientation sessions and mentorship periods, and cost accrued from educational sessions, such as mandatory courses, which provide standards of care in an emergency department.

The impact of nurse turnovers has several potential financial consequences. Essentially, nurse turnover consumes resources that could potentially be deferred to other business activities that could be used to improve staff development (Jones, 2004; Waldman, Kelly, Arora, & Smith, 2004). In addition, Jones (2005) estimated it would cost between \$62,100 and \$67,100 to replace an RN, which represents 120% and 130% of an average Registered Nurses' salary (as cited in Uruh, 2008, p.68).

Statement of Problem

Due to the practice of hiring new graduates into the emergency department where I work, there is a concern that new graduates are being hired into a setting, which is inappropriate due to the evolving and challenging situations of health-related emergencies. As previously stated, new ER nurses lack the foundational competencies and experience which impacts their ability to manage the demands and workload of an emergency department. Competency is defined as "the integrated knowledge, skills, attitudes and judgment required to perform safely within the scope of an

individuals' nursing practice (CRNBC, 2000, p. 19). The Canadian Nurses Association also defines competency as an integration of the attributes that comprise competent nursing care, within a specific setting and context (CNA, 2000). For the purpose of this project, competency will be defined within the contextual situations of practice in emergency departments to be the capacity to integrate skills, knowledge, attitudes, and values according the minimally accepted competence level of the Registered Nurse practicing in emergency care.

Methodological Approach

This project included several steps as a basis for my orientation program. First, an integrative literature review was conducted to identify key articles focused on the challenges of new graduates working in the emergency department. An integrative literature review allows a cross section of data to inform nursing science and theory driven practices (Whittemore & Knafl, 2005). For the literature search, I used three electronic databases, The Cumulative Index to Nursing and Allied Health Literature (CINAHL), Google Scholar, and Health Source: Nursing/Academic Edition (EBSCO Host). Key words and phrases included, but were not restricted to, new graduates, challenges of new graduates, curriculum for orientation programs, specialty nursing, transition of new graduates, trends in nursing, and shortage of ER nurses. The dates of articles were within a 10 year period to keep with more current trends and the demographics of new graduates being hired to specialty areas. The reviewed articles included those about BSN new graduates and diploma program graduates, and excluded those involving nurse practitioners and LPNs as these nurses will have different education and clinical experiences. The articles were restricted to those from the U.S. and Canada due to differences within nursing programs and specialty education for nurses

(Rose, Goldworthy, O'Brien-Pallas & Nelson, 2008). Articles were reduced during initial reading of the article if the focus did not pertain to critical care areas or emergency departments. Article that focused on critical care were included as there were limited literature of new graduates in emergency departments. A thematic analysis of the reviewed literature was then conducted.

A thematic analysis is a qualitative analytical method in which to identify patterns of themes within data/articles, and from these, interpretations can be made (Braun & Clarke, 2006, p.79). Finally, I reviewed existing orientation programs for emergency departments within Fraser Health, and one from Royal Victoria Hospital in Montreal to compare difference in content and length of orientation programs.

In the following section of the paper, an overview of the thematic analysis that was conducted for this project will be presented. This will be followed by a discussion of the major themes.

Thematic Analysis of Literature

Overview

I reviewed 50 articles related to new graduates and I have selected 8 of those articles that provided more relevance within a critical care and emergency care context. The literature reviewed included the earliest article published in 2001 and the most recent in 2009. I explored a variety of appraisal tools for articles chosen, none of which proved to be a good fit for my project; therefore, upon consultation with my supervisor and peers, I selected the John Hopkins Nursing Evidence

Based Practice Appraisal Tool based on the fit with the articles chosen; being both research and non research based evidence.

The six phases of conducting a thematic analysis are: becoming familiar with the data, generating of codes, searching for themes, reviewing themes, defining and naming themes, and producing the report (Braun & Clark, 2006, p. 87). Within the context of new graduates, the aim of a thematic analysis is to gain a better understanding of the challenges experienced by new emergency nurses.

Phase 1 began by immersing myself in the data to become familiar with the depth and breadth of the content. This involved repeated readings of the data and the search for meaning and patterns. Phase 2 began when I read and familiarized myself with the data, and developed an initial list of ideas about what was in the data. This phase included the production of initial codes from the data. Codes identify a feature of the data that is interesting to the analyzer regarding the phenomenon of interest (Braun & Clarke, 2006, p.88). Phase 3 began when all data have been initially coded. This phase involved sorting the different codes into potential themes, and collating all the relevant coded data within the identified themes. This phase ended with a collection of preliminary themes. Phase 4 involved the refinement of the identified themes. This phase included two levels of reviewing and refining my themes. Level one involved reviewing at the level of the coded data extracts. In level two, consideration was given to the individual themes by re-reading the data set to ensure themes fit with the data and coded any additional data within the themes that may have been missed earlier. At this level, I considered the validity of individual themes in relation to the data set. I then gathered all the coded data, identified aspects of the data that

provided a basic pattern, and categorized them into potential themes. In phase 5 further definition and refinement of the themes was conducted. In defining and naming the themes, I identified the essence of what the theme captured and provided a name for the themes in the final analysis (Appendix A).

For each individual theme a written detailed analysis is provided. Phase 6 began when I had a set of fully developed themes, and involved the final analysis and write-up of the report. The final stage of producing the report included sufficient evidence of the phenomena of interest. Vivid examples captured the essence of the point that is being demonstrated without unnecessary complexity (Braun & Clarke, p. 93). Finally, I presented a comprehensive understanding of the challenges of new graduate in the emergency derived from this thematic review.

Appendix B provides a summary of the key themes or findings of each article as well as the identified strength and quality of evidence of the articles (Appendix C). Major themes that were analyzed are presented in three major categories: Socialization of new graduate nurses with two subthemes of sociopolitical conditions and socio cultural relations, skills and knowledge, and interpersonal conflict. Following a discussion of each of the themes, recommendations were made according to the theme presented. A proposal for an appropriate course of action under the heading of recommendations will follow. The intent of the thematic analysis is to provide a foundation of knowledge used to ground my curriculum blueprint.

Socialization of new graduates.

New graduates are commonly being recruited to specialty areas of nursing practice for a variety of reasons (Dyess & O'Sherman, 2009). The adjustment of new graduates transitioning into

their professional role can be stressful and present specific challenges. Specific challenges are related in part by their socialization into an environment that is significantly different than their experiences while in the academic setting, which they had grown accustomed to (Boychuk Duchscher, 2001; 2003; 2008; 2009; Boychuk Duchscher & Cowin, 2004; Casey, Fink, Krugman, & Propst, 2004; Dyess, & O'Sherman; Farnell & Dawson, 2004; Valdez, 2008). To better understand the challenges new graduates experience while working in the context of an emergency department environment, it is necessary to examine the socio political conditions of a practice area that is not only one of the most challenging and stressful environments to work in, but also influences the social culture of nurses working in this type of environment. A discussion of issues, dilemmas, and conflicts will promote an understanding of how our work environment can affect how we work, relate to our colleagues, and give care to our patients.

Socio political conditions. The term 'politics' constitutes all formal organizations including institutions of nursing education and the health care industry which sustain, hierarchical power structures and relations (Boychuk Duchscher, 2004). The social structure in an emergency department is unique. Specialized nurses save lives amidst the chaos generated by a system significantly underfunded (Boychuk Duchscher, in press). Space is limited as gurneys are tucked into every visible crevice. Patients are shuffled from place to place making room for the more critically injured. Human and material resources are limited and controlled by tight budgetary restraints (Dyess & O'Sherman, 2009). Staff do not walk in the emergency department of today...they run.

Nurses provide care to patients within this organizational structure, but the standard of that care is suspect. This often leads to feelings of discontent, dysfunctional behavior, frustration, and anger (Boychuk Duchscher, 2001; 2004; 2008; 2009; Casey et al., 2004; Dyess & O'Sherman, 2009; in press; Farnell, & Dawson, 2004; Valdez, 2008). But the voices of emergency room nurses often remain unheard and the challenges are left to fester. These challenges include additional workload due to shortage of staff, lack of autonomy, misappropriation of nursing human resources (increased patient to nurse ratio, elimination of continuing professional education funds, and decreased clerical support on night shifts), which threaten standards of care (Boychuk Duchscher, in press). Powerless to contest the conditions, or the care, emergency room nurses survive in this chaotic world, but why? Why are the voices of those providing the care silent? The sociopolitical structures of health care industries influence, and in many cases, sustain hierarchical power structures and relations (Boychuk Duchscher & Cowin, 2004, p. 289).

According to Lynam et al., factors which influence the power dynamic in this setting include corporate ideologies in which Canadian health care reforms guide inequities in the distribution of human resources along with the acceptance of certain actions to save money in health care (as cited in Varcoe & Rodney, 2009). Hospital budgets set by provincial authorities dictate the development of new policies which will increase efficiency and productivity in emergency departments and thus healthcare has become a corporation. Corporate ideologies based on efficiency and standard guidelines from a biomedical model marginalize nurses and patients and can contribute to social and ethical problems (Boychuk Duchscher, 2004). Policies and guidelines that dictate how a patient is to be cared for based on specific indicators are created from a biomedical model. For example, guidelines and policy initiate certain interventions based on

presenting symptoms at triage. Guidelines and policies help to process, treat, and discharge patients through the emergency department quicker.

Emergency nurses must adhere to rules being governed by corporate ideology and the biomedical model; therefore, nurses who work in the emergency department work in a system driven by organizational directives where efficiency and productivity are stressed. Furthermore, overcrowding in emergency departments and a shortage of staff increases the intensity of nurses' work. Nurses advocate to increase staffing levels, but there are budget constraints. Nurses who work in the emergency department are met with the challenge of meeting the needs of patients and at the same time adhering to organizational goals (Boychuk Duchscher, in press). Therefore, nurses are expected to maintain the flow of the patients in an emergency department functioning at beyond 100% capacity with limited human resources.

Mohr (1995) states, "the hospital environment tends to move the new graduates away from their ideal of professional nursing practice by emphasizing productivity, efficiency, and the achievement of institutionally imposed social goals" (as cited in Boychuk Duchscher, 2004, p.292). New graduates are overwhelmed with the responsibility of providing quality care, which address the physical and psychosocial needs of patients once they are immersed in an organizational culture entrenched in dominant behaviors (Boychuk Duchscher, 2001; 2004; 2008; 2009; Casey et al., 2004; Dyess & O'Sherman, 2009; Farnell & Dawson, 2004; Valdez, 2008), and have been described as *prescriptive, intellectually oppressive and cognitively restrictive* (Kramer 1966, Crow, 1994, Boychuk Duchscher, 2001, as cited in Boychuk Duchscher, 2009, p.1104).

Policies and protocols are established norms in the emergency department, which increases efficiency and productivity (Boychuk Duchscher, 2009). Emergency nurses must adhere to rules being governed by corporate ideology and the biomedical model, and nurses are sacrificed for maintaining efficiency of a system. In addition, as the emergency department personnel are under enormous pressure to perform tasks at increasing speed, the accessibility of resources can be frustrating. At my place of work, multiple resources regarding procedural care, skills, and policies are electronically based; however, there will be times when nurses are unable to access these resources due to the urgency of the situation. Dyess and O'Sherman (2009), acknowledges that due to the pace of practice environments new nurses are expected to make independent clinical decisions, but the resources for policies and procedures on which they rely on for guidance are not always quickly accessible (p.409). "Having to use multiple references and resources made task and caring for patients take 3 times as long as it should" (Casey et al, 2004, p. 308).

New graduates are overwhelmed in their new professional responsibilities; organizational expectations, standards of care, and workload are common stressors (Boychuk Duchscher, 2002; 2009; Boychuk Duchscher & Cowin, 2004; Dyess & O'Sherman, 2009; Farnell & Dawson, 2004; Valdez, 2008). Nurses who are expected to adhere to organizational constraints commonly experience moral distress when they are not able to fully enact their professional role (Boychuk Duchscher, 2001; 2004; 2009; Casey, et al., 2004; Dyess & O'Sherman, 2009; Valdez, 2008). Consequently, hospital administrators use the nurses' values, beliefs, and dedication to patient care to maintain the efficiency.

Recommendations. The incongruent values of practicing nursing within an academic setting and those of organizational expectations continue to be major stressors for new graduates (Boychuk Duchscher, 2001; 2002; 2009; Casey et al.; Dyess & O'Sherman, 2009; Farnell & Dawson, 2004; Valdez, 2008). Studies have shown that new graduates need assistance socializing into their professional role to be safe practitioners as well as decrease the attrition rates of nurses due to burnout (Boychuk Duchscher, 2001; 2004; 2008; 2009; Casey et al., 2004; Farnell & Dawson; Valdez, 2008).

Further education is needed to provide emergency nurses and nurse managers about experiential learning and experiences of new graduates (Boychuk Duchscher, 2009; Valdez, 2008). Other strategies to minimize marginalization can include promotion of tolerance; acceptance and mutual respect; end oppressive nursing actions by utilizing liberating practices; consistently present nurses as a 'sea of possibilities' (enjoy individualism while promoting collective of nursing); and explore work-based rituals and routines by encouraging discussion and debates on best practices (Boychuk Duchscher, 2004, p.294).

Sociocultural relations. Culture encompasses the characteristics of a group of people defined by customs, mores, and rules for behavior considered acceptable for the inclusion in a social community united by a shared aim, interest, or principle (Boychuk Duchscher, 2004, p. 290). New graduates transitioning into their professional role are met with certain expectations by senior nurses with whom they work with (Boychuk Duchscher, 2001; 2004; 2008; 2009; Casey et al., 2004; Dyess & O'Sherman, 2009; Farnell & Dawson, 2004; Valdez, 2008;). Boychuk Duchscher (2001) explored participant's transition experiences in a qualitative phenomenological study:

The sense of responsibility inherent in their new nursing practice was overwhelming and they afforded accountability for this disparity in the lack of preparation by their nursing education. They believed they had never been conferred with the full weight of responsibility for patient care as students, and therefore could not cope with such responsibility as nurses. (p.429)

New graduates struggle with the realistic expectations of professional practice and experience a number of moral dilemmas when they have been acclimatized to nursing within an academic context (Boychuk Duchscher, 2001; 2008; 2009; Boychuk Duchscher & Cowin, 2004; Casey et al., 2004; Valdez, 2008). New graduates are faced with the challenge of enacting their profession role while functioning in an unfamiliar and unsupportive culture (Valdez, p. 437). Studies have shown that completing tasks was an important criteria to successfully meet expectations of an orientation period (Boychuk Duchscher, 2001; 2008; 2009; Boychuk Duchscher & Cowin, 2004; Casey et al., 2004). High levels of stress were associated with multitasking with events such as answering phones, speaking with physicians, processing orders, and dealing with multiple patients and family issues while providing direct care patient care (Boychuk Duchscher, 2008, p. 445). Completing tasks on time allowed the new graduates to be part of the team and was an indicator of their capability (Boychuk Duchscher, 2001). Furthermore, new graduates are driven by their desire to belong, and as a result went to great lengths to concealed their anxieties and feelings of inadequacy (Boychuk Duchscher, 2008, p. 444).

Senior nurses who have long been assimilated and accustomed to this type of social culture have adapted; therefore, they have unrealistic expectations from new graduates who are accustomed

to their academic standards (Boychuk Duchscher, 2004). In the emergency department, new graduates are judged by senior nurses to be good nurses if they are able to manage the workload they are given and at the same time assess the changing status of critically ill patients. In addition, if new graduates ask for help, they risk exposing themselves to be incapable and incompetent (Boychuk Duchscher, 2001; 2004; 2008; 2009); thereby adding to their moral dilemma. “Not knowing” was perceived as a weakness rather than an expected state of their professional orientation; therefore the need to stop questioning and manage on their own was strong” (Boychuk Duchscher, 2001, p. 427).

New graduates exposed to a practice environment with corporate ideologies that emphasizes the importance of efficiency and productivity may socialize them to work in a way that diminishes ethical and moral practices, thereby causing moral distress and workplace burnout (Boychuk Duchscher, 2004). Guidelines and policy which initiate certain interventions based on presenting symptoms can limit autonomy and the development of critical thinking for new graduates. One of new graduates at my place of work commented:

I know I have to treat this patient’s symptoms according to protocol, but there were other factors to consider.... she didn’t need the nitro because....but according to protocol...so how do I question that?

Similarly, Boychuk Duchscher (2004) states that “new graduates advocating for patients self determination were polarized with maintaining a powerfully fixed organization structure and ordered routine” (p. 292). It oppresses the true nature of nursing...that of caring, and this further increases the new graduate’s moral distress. The prevalence of moral distress is prevalent when

there is lack of decision-making autonomy in their practice which gives rise to the belief that ethical compromise is unavoidable (Boychuk Duchscher, 2004, p.292). When the art of nursing is lost to the science inherent in the biomedical script the power to practice ethically is limited.

Recommendations. It is clear from the literature that the differences in academic setting and institutional expectations play a major role in the transition of new graduates in their professional role (Boychuk Duchscher, 2001; 2004; 2008; 2009; Casey et al., 2004; Dyess & O'Sherman, 2009; Farnell & Dawson, 2004; Valdez, 2008). Recommendations include a closer partnership with academic institutions to improve integration into a new graduate's professional role (Boychuk Duchscher, 2004; 2009; Casey et al., 2004; Valdez, 2008). In addition, academic institutions should provide opportunities for new graduates to discuss and explore the structure of socialization into professional practice before they leave their academic institution (Boychuk Duchscher, 2004, p. 294). In my experience, post conference periods during clinical rotations may offer such discussion surrounding the social structure of institutions; however, the discussions were short lived and were mere reflections of our clinical day.

Furthermore, by providing a link to leadership new graduates would have the opportunity to express their challenges and allow nurse leaders and managers to gain a better understanding and address these challenges (Boychuk Duchscher, 2001; Dyess & O'Sherman, 2009; Valdez, 2008). Finally, a transition program would enable new graduates to ease into their professional role while addressing their anxieties (Boychuk Duchscher, 2001; Casey, et al.; Valdez, 2008).

Skills and Knowledge.

Due to the current global shortage of nurses there is a rapid deployment of new graduates into the nursing profession (Boychuk Duchscher 2001; in press; 2008; Casey et al.; 2004; Dyess & O'Sherman, 2009; Valdez, 2008). There is sufficient evidence which supports new graduates are ill prepared to transition into the realities of their professional practice (Boychuk Duchscher, 2001; 2004; 2008; 2009; in press; Casey et al.; in press; Dyess & O'Sherman, 2009; Farnell & Dawson, 2004; McKenna, Smith, Pool, & Cloverdale, 2003; Valdez, 2008). Del Bueno (2005) and Li and Kenward (2006) state "although new licensed nurses have achieved the legal and professional requirements of minimal competence to enter practice, studies indicate that many new nurses lack the clinical skills and judgment need to provide safe, competent practice" (as cited in Dyess & O'Sherman, 2009, p.404).

New graduates lack confidence in their first year of professional practice when they begin to realize that the expectations of their practice environment are significantly different than the expectations of their academic role, and thus, feel unprepared for the unexpected challenges they are faced with (Boychuk Duchscher, 2004; 2008; 2009; Casey et al.; 2004). In a non-experimental study, a descriptive, comparative design using a survey questionnaire Casey et al. found that only 4% of new graduates were comfortable performing skills and procedures (p. 305). Boychuk Duchscher (2001) states new graduates attempt to rigidly apply context free concepts to clinical situations and were naturally confused when they discovered that this did not work, and that they could not modify or manipulate their knowledge (p.429). In addition, predominant stressors were related to a lack of organizational skills, unfamiliar clinical situations and nursing procedures, and

expectations of making advanced clinical judgments and decisions for which they felt minimally qualified for (Boychuk Duchscher, 2009, p.433). Our political and economic climate often affects the new graduate's ability to practice, and therefore, nursing leaders today face the challenge of achieving practice environments that can be conducive in providing competent practices.

We are seeing a trend that places new and inexperienced nurses in specialty areas that in the past were staffed by more senior and experienced staff (Boychuk Duchscher in press; Dyess & O'Sherman, 2009; Valdez, 2008). Senior nurses have acquired knowledge and skills from many years of practice experience and therefore, are able to apply critical thinking skills to different situations in acute care settings such as the emergency department and critical care units (Boychuk Duchscher, 2003a, as cited in Boychuk Duchscher, 2009; Boychuk Duchscher, in press; 2001; 2008; Casey et al., 2004; Dyess & OSherman, 2009; Farnell & Dawson, 2004; Roberts & Farrell, 2003; Taylor, 2002; Valdez, 2008; Welk, 2002). Boychuk Duchscher (in press) states "historically nurses working in emergency department considered the intellectual and skill demands were beyond those of inexperienced, or 'beginning' practitioner" (p.3). New graduates who have minimal, or no experience in which to consolidate their knowledge and skills that they have acquired in their academic setting limits their ability to provide care in a manner equivalent to senior nurses (Boychuk Duchscher, 2001, 2004, 2008, 2009, in press; Dyess & O'Sherman, 2009; Valdez, 2008; Farnell & Dawson, 2004; Casey et al., 2004).

New graduates working in acute care areas and specialty settings require a higher level of critical thinking, but have not yet mastered their baseline knowledge and skills, which is required as a base of developing critical thinking skills; therefore, they feel unprepared to meet the challenges

these areas present (Boychuk Duchscher, 2001; 2004; 2008; 2009; in press; Dyess & O'Sherman, 2009; Farnell & Dawson, 2004; Valdez, 2008). In a systematic review Valdez (2008) examined new graduates in the emergency setting and specific skills new graduates felt unprepared for included specific nursing procedures, death and dying, organizational skills and time management, inability to recognize subtle changes in patient condition, and communication with physicians and patient families (p. 438). In addition, specific procedures that were challenging included cardiopulmonary arrest management, caring for patients with chest tubes, and the insertion and maintenance intravenous, central and epidural lines (438). According to Casey et al., feelings of inadequacies and deficits in both skills and knowledge are common experiences, and at least 12 months are needed to feel comfortable practicing in acute care environment (p. 309).

Recommendations. Collaboration with academic institutions can support new graduates to develop their clinical competencies through the development of initiatives such as internship, specialty education, structured mentoring, and one year residency programs (Boychuk Duchscher, 2001; 2009; Casey et al., 2004; Dyess & O'Sherman, 2009; Farnell & Dawson, 2004; Valdez, 2008). A one year residency program can provide an opportunity for new graduates to transition into professional practice with ease and help to develop nurses who can provide safe and competent care (Casey et al., 2004). In addition, implementation of summer programs can enhance clinical experiences in new graduates to be acclimatized to the acute care setting (Valdez, 2008, p. 439). At Fraser Health, this would be similar to the employed student nurses role. Employed student nurses are student nurses hired in units under the supervision of the registered nurse to work in a restricted capacity. In the emergency department at ARHCC they are placed in medical/surgical areas.

A foundation program such as the BCIT emergency specialty can be helpful in preparing new graduates to work in specialty areas. Farnell and Dawson (2004) state a foundation program was important and provided a framework for structured learning as well as prepare new graduates to their roles and responsibilities on the unit (p.325). Furthermore, new graduates should be assisted to explore and discuss the structure of socialization into professional practice during their academic period (Boychuk Duchscher, 2004, p.294).

Clinical nurse educators can advocate for an improved orientation program, which may better support nurses in their transition role (Boychuk Duchscher, 2001; 2008; 2009; Casey et al., 2004; Dyess & O'Sherman, 2009; Valdez, 2008). It is necessary for new graduates to repeatedly practice skills that are required by their units, this can be included within an orientation program (Boychuk Duchscher, 2008). Response from a survey questionnaire revealed new graduates appreciated a longer orientation period to connect with other graduates who can offer moral support (Casey et al., 2004, p. 308). Boychuk Duchscher (2009) states orientation programs should include knowledge of role transition as well as have content which includes unit specific skills such as special nursing and medical procedures and emergency protocols (p. 1110).

Practicing in an environment with clinically stable patients prior to practicing in specialty areas like the emergency department or critical care areas can provide a better consolidation of knowledge and skills learned in the academic setting, and as a result, enables new graduates to socialize with lesser difficulty in specialty practice environments (Boychuk Duchscher, 2001; 2008; 2009; in press; Farnell & Dawson). Boychuk Duchscher (2001) emphasizes specialty areas such as emergency settings and critical care areas require advanced skills and knowledge to address

unanticipated events; however, new graduates have not attained the confidence and experience to manage these situations; therefore, they should not be floated to other wards until they have at 1 year of experience in a consistent environment in order to practice safely (p. 437). In addition, Boychuk Duchscher (2009) explains new graduates should practice in stable clinical areas in order to be exposed to various clinical situations; be given feedback to reinforce and redirect learning; be offered opportunities for sharing work experiences; and be encouraged to collaborate on development of approaches that optimize their learning environment and quality work experience (p. 1111).

Interpersonal Conflict.

In the first year of practice, new nursing graduates are subjected to a various interactions with peers which can affect their self confidence (Boychuk Duchscher, 2001; 2004; 2008; 2009; in press; Casey et al., 2004; Farnell & Dawson, 2004; Mckenna et al., 2003; Valdez, 2008). In Casey et al. 's (2004) study of new graduates' experiences, the findings revealed new graduates experienced a lack of respect or acceptance from senior nurses which included a lack of positive support and verbal feedback. They expressed frustration with their preceptors due to their insensitivity of understanding their challenges as a new nurse. Many were fearful about speaking out, while others feared retribution if they reported poor treatment by the preceptor (p. 307). Often poor treatment of staff or preceptors went unreported for fear of repercussions (Casey et al., 2004; McKenna et al., 2003).

In a literature review by Boychuk Duchscher (2009) new graduates described interactions with *dominant* nurses who intentionally challenged their practice foundation and as a result reduced

their confidence level. New graduates reported being given overwhelming responsibilities without adequate supervision and feeling unable to ask for help due to the perception of being incompetent (Boychuk Duchscher, 2001; 2009; Casey et. al., 2004; Dyess & O'Sherman, 2009, McKenna et al., 2003). Valdez (2008), reports that new graduates are introduced to professional practice "within an unfamiliar and unsupportive organizational culture while being asked to assume increasing level of responsibility" (p. 437). Similarly, Boychuk Duchscher (2004), states that there is increasing evidence that "managers and senior nursing staff are antagonistic, unwelcoming, and abusive to new graduates (p. 292). Within the prior academic environment new graduates were used to, instructors advocated on their behalf when there were interpersonal conflicts; however, inexperience and lack of instructor support provided stress and anxiety for new graduates when having to deal with interpersonal conflict on their own in their professional role.

The experiences of interactions with physicians that are disrespectful were also found to be challenges for new graduates (Boychuk Duchscher, 2001; 2009; Casey et al., 2004; Dyess & O'Sherman, 2009). Boychuk Duchscher (2009) states interaction with senior nurses and physicians reinforced a hierarchical rather than a collegial relationship (p. 1108). Casey et al. state that due to inexperience new graduates lack the skills to communicate what is needed to physicians, and when calling physicians to confirm or clarify orders physicians were perceived by new graduates to be disrespectful (p. 308). Rude responses such as 'gruff tone or expressed disgust' can be factors contributing to patient safety due to new graduates avoiding contact with physicians when necessary (Dyess & O'Sherman, p. 407). Due to lack of experience dealing with interpersonal conflicts, new graduates expressed stress and anxiety when communicating with physicians who

questioned their judgment to call, which can prevent new graduates from communicating with physicians to advocate for their patients.

Recommendations. Strategies to support new graduates with interpersonal conflict include developing educational activities to inform senior staff and management of the new graduates' stressors (Boychuk Duchscher, 2001; 2004; 2009; McKenna et al., 2003; Valdez, 2008). Boychuk Duchscher (2009) suggests:

A program would encompass knowledge (theory taught in creative and interactive ways) and practice (role playing involving novice and seasoned practitioners) related the stages of transition and the experience of transition shock (what to expect and when); generational and inter/intraprofessional communication (work ethics and style differences as well as role distinction; workload delegation and management (delegating to more experienced than oneself and prioritizing the competing demands of a full workload) (p. 1110).

Along the same lines Dyess and O'Sherman (2009) recommends education about horizontal violence should be included into transition programs and that role playing would provide opportunities for new graduate to reflect and practice resolving conflict. Recommendations to management include examination into the cause and effect of interpersonal conflict should be undertaken as well as an enforcement of a zero-tolerance for disrespect in the workplace (Boychuk Duchscher, 2001).

Summary of the Literature

A review of the literature provided sufficient evidence to indicate that there are common themes in regards to the challenge experienced by new nurse graduates. There is limited research for the specific area of new graduates in the emergency setting; therefore, the literature used presented the challenges of new graduates in general. It is evident from the literature that new graduates are unprepared to practice in a realistic ER environment (Boychuk Duchscher, 2001; 2002; 2009; Casey et al., 2004; Dyess & O'Sherman, 2009; Farnell & Dawson, 2004; Valdez, 2008). In addition, senior nurses may have unrealistic expectations of the novice level nurse. According to Benner's five levels of proficiency "new graduates start at a novice level in which they have had no previous experience in situations in which they are expected to perform tasks;" therefore, the difficulty is using discretionary judgment in performing tasks in situations and circumstances that they are unfamiliar with (Benner, 1982, p. 403). This is especially relevant to the emergency setting as there are unanticipated events that require discretionary judgment in which to base nursing actions.

In the initial stages of practice new graduates apply a linear model of thinking in which the objective is one of completing tasks rather than thinking through a skill performance (Boychuk Duchscher, 2001, p. 430). Senior nurses who work in the emergency department performs with *certainty, fluidity, and flexibility*" (p. 436). Experience allows expert nurses to assess a situation and respond in an appropriate manner using fully developed critical thinking skills. It is this experiential knowledge which provides the confidence to manage a variety of situations in the emergency department (Boychuk Duchscher, in press). Field (2004), "the learning that takes place

is ‘situated’ within real life contexts and the learners were allowed to participate legitimately as learners” (p. 562).

Farnell and Dawson state the ability for new graduates to transition into an acute care setting may be influenced by pre-requisites such as “post-registration experience, life experience, and clinical areas previously worked, which may enable them to progress from a novice to advanced beginner” (p. 329). New graduates who have experience in other clinical environments may have exposure to various situational contexts in which to develop the skill to respond appropriately to situations; therefore, the transition to an emergency setting may not present the same challenges as it does for new graduate who do not have prior experience.

Findings from the reviewed literature indicate that most new graduates require 6 to 12 months to feel comfortable and confident in an acute care setting (Boychuk Duchscher 2008; 2009; Casey et al., 2004; Dyess & O’Sherman, 2009; Valdez, 2008). Socialization of new graduates in the emergency department presents certain challenges. The emergency setting is considered a specialty area of nursing which focuses on the performance of clinical competencies necessary for critical care. Therefore, it is necessary to develop an orientation program from a framework of competency based, which will focus on clinical competency within a constructivist perspective of learning. Knowledge and skills will be introduced in a linear fashion of simple to complex. Providing an orientation period that has continuing supportive measures in place can help ease the transition into their professional role. A curriculum blueprint that will incorporate an appropriate mentorship period will ensure the ease of socialization into this highly stressful area.

The following section presents my findings on various orientation programs and how they are structured. They include ER orientation programs from the Fraser Health Authority, an orientation program from the emergency department at Vancouver General Hospital, and one from the emergency department at the Royal Victoria Hospital in Montreal, Quebec.

Reviewed ER Orientation Programs

There are various lengths of orientation periods and nursing literature does not provide a clear answer as to how long an orientation period should change to be; however, the time average time frame ranges from 8 weeks to 18 months (Baxter, 2010). The structure of orientation periods for the ER's at Fraser Health emergency department appear similar in that 1-2 days are given to review protocols, guidelines, equipment, and define roles and responsibilities of nurses and support staff within the department, mentorship is not included within this period. Following the unit orientation a series of mentorship period ranges from one set of shifts to a minimal required for learning the routines of the department. Although there are no defined set number of shifts provided for mentorship and is directly based on individual needs; budget is front and foremost in determining how many shifts can be used for the mentorship period. When mentorship ends, added clinical support are provided by peers, charge nurses, clinical nurse educators, and manager. An emergency department within the Vancouver Coastal Health Authority has a similar orientation period as Fraser Health (R. Dhillon, personal communication, January, 2013).

Loiseau (2003) developed a 4 month comprehensive orientation program to transition new nurses to work in their emergency department at the Royal Victoria Hospital site of the McGill University Health Center in Montreal. New nurses who were hired to work in the emergency

department had no foundational ER specialty program before commencing this orientation period; therefore, the orientation period involved nurses learning advanced knowledge and skills to develop the ability to work within the emergency nurse's role. A former pre-requisite for this orientation program was to spend the first 3 months on a medical unit providing patient care with a preceptor (Loiseau). In 2001, this orientation program was modified so that nurses would not need the pre-requisite of working on a medical unit, but instead, spend their first 12 weeks in the emergency department where a cardiology course, heartsaver CPR course, and lectures on physical assessment and topics pertinent to the department were provided (Loiseau).

The orientation program developed by Loiseau used formative and summation evaluations using tools such as questionnaires and surveys, which provided knowledge for revisions of the orientation program for improvement, rated abilities and professional identity, and measured productivity of new nurses (Loiseau, 2003). According to Loiseau, a nurses' success in the orientation program were influenced by maturity and previous nursing experience. The orientation program developed by for the emergency department at the Royal Victoria Hospital Loiseau had been reduced to 6 weeks, and will be reduced further to 5 weeks due to budget constraints (P. Chaisse, personal communication, January, 2013).

At ARHCC, our orientation program consists of a 6 week period for new graduates of an ER foundational program. Based on my experience, 6 weeks is insufficient to orientate new nurses to work independently. New nurses are not used to the routines and fast pace of an ER environment and will need time to develop and utilize their new skills, knowledge, and critical thinking in unplanned situations. An organized and structured orientation program of 12 weeks, which is an

added 6 weeks, will provide time to develop these skills in a supported environment. Less time is dedicated to didactic material in classroom, rather an overview of commonly presented symptoms in the ER, review of focused assessments, and teaching strategies that will help develop critical thinking will provide an orientation that new nurses can exercise during their mentorship period. Within the modules created for the orientation program it will also include an aspect of cultural safety, and provide opportunities to discuss ethical issues that are commonly experienced in the ER.

Factors which will dictate an implementation of an orientation program will be greatly influenced by budget constraints, resources such as availability and use of high-fidelity simulation, and human resources (Keating, 2011). However, if future nurses need the knowledge, skills, and attitudes necessary to improve quality and safety of the health care system in which they work (Sullivan, 2010), then institution need to prioritize funding to facilitate nurses to do so.

Curriculum Development

A curriculum is a formal plan of study that provides the philosophical underpinnings, goals, and guidelines for the delivery of a specific educational program (Keating, 2011, p.1). Identification of beliefs about teaching and learning is one of the earliest activities when developing a curriculum (Keating, p. 47). My philosophical view of learning is provided in the following section of this paper. Philosophy has historically been viewed as an expression of the “art of living” (Hadot, 1995 as cited in Brown & Hartrick Doane, 2007, p.99). The philosophical position behind the creation of this curriculum can then be seen as an expression of our ‘art’ of teaching and learning. In the next section I will review my theoretical lens. This will be followed by the internal

and external framework, which will provide for a context relevant curriculum. In addition, a taxonomy of learning will be used to guide and evaluate learning objectives.

Theoretical Lens

A philosophical view of learning based on social constructivism and Benner's model of novice to expert guided the development of my curriculum. I approach nursing education using a social constructivist lens, which can interface with many pedagogical approaches. The tenets of social constructivist theory states students can learn from and with each other, not just from the environment (Young & Maxwell, 2007). Therefore, this theory can be used to enable students to apply theory to practice in the clinical settings as well as come up with solutions collectively.

Teaching and learning are not separate processes in the emergency department, but are interactive, dynamic, and engaging. Each learning opportunity in the emergency department is embraced by nurses with a spirit of collaborative inquiry and critical reflection. Traumatic experiences can provide nurses with opportunities to de-construct and re-construct using a case study, or storytelling approach to facilitate new learning in an environment that is free of coercion, is engaging, interactive, and inspiring. In-house courses create opportunities for engagement through discussions of ethical issues, and allow participants to be challenged by simulated real life situations. For example, in the emergency department teaching is about engaging the learner in those moments when unexpected situations arise. Situations such as multiple traumas, 'do not resuscitate' (DNR) orders, or comfort care only, provides opportunities for the learner to reflect on his/her own beliefs and values concerning practice. Engaging learners in new and challenging

experiences will construct meaning for the individual. Therefore, knowledge is socially constructed in the emergency department as it is a relational process.

Constructivism is both a philosophy and a teaching theory and is foremost in student-centered learning (Young & Maxwell, 2007). Foundational to understanding my overview of teaching is to appreciate that knowledge is a process being created, experienced, and acquired through interaction with the students past experiences and the context in which it is being used (Ackermann, 2001; Young & Maxwell, 2007). Magnussen (2008) argues that teaching from a constructivist lens better prepares nurses to transition to practice, which is an essential component of orientation of new graduates.

It is important to note that these new nurses entering the ER can be novice, advanced beginners, or even competent in their previous areas of practice. Benner (1984) argues however, that whenever nurses enter a new area of practice there will always be a period of returning to a novice state. These needs will be taken into account within my curriculum design in order to make learning objectives attainable for the level of learner. According to Benner (1984) novice learners are linear thinkers and govern their practice based on rules, and in order to become advanced beginners they must be able to identify the salient features of situations.

Although various kinds of knowledge are important for nursing care, empirical knowledge appears to be dominant and is derived from an empirical base that guides safe nursing practice in the ER. Learners must access the scientific knowledge in order to manage complex situations in the ER. For nurses working in critical care areas, competence requires not only possessing the knowledge and skills to perform certain tasks in any given clinical situation, but also to integrate

certain empirical knowledge (scientific knowledge), skills, and personal attributes consistently in the context of practice to meet established standards (Fey & Miltner, 2000). For example, knowledge of pain management in the ER requires certain pharmacological interventions (type and doses) that may not be appropriate in medical/surgical areas; clinical problem solving which requires relevant facts related to the problem such as cardiac physiology, pathophysiology, and etiology for symptoms of the condition are important for understanding interventions for treatment; and appropriate nursing care for invasive procedures such as intubation requires pharmacological interventions that are needed to perform the procedure. In the emergency department where I work, the science of empirical knowledge is necessary in moments of crisis, such as recognizing algorithms that treat dysrhythmias, or trending vital signs that provide information about a patient status. Considering the complexity, ambiguity, and acuity level of the patients seen in the ER, ensuring that nurses meet certain standards of competency are essential to patient safety. When competency is defined as the ability of the nurse to perform a task with desirable outcomes under the varied circumstances integrating knowledge, skills, values, and attitudes into their practice (Benner, 1982; Cowan, Norman, & Coopamah, 2005); a curriculum framework which will link concepts of competency-based learning will be used. Competency-based orientation has shown to aid in narrowing the gap between education and practice leading to “improved patient outcomes, clinical judgment, and accountability of the learner” (Scott-Tilley, 2008, p. 63), and is therefore an obvious choice to aid in the development, implementation, and evaluation of an orientation (Fey & Miltner, 2000 as cited in Baxter, 2010, p.14).

“NENA believes the nature of emergency nursing mandates a competency-based orientation to a wide spectrum of patient population and conditions, policies, procedures,

equipment, supplies, and nursing processes” (2010, p. 1). Competency-based education focuses on outcomes and is different than traditional learning as it uses problem-based learning, involves critical thinking and considers experiential knowledge, which allows for individualized progression toward expected outcomes (Gurney, 2002, p. 509). As previously defined, for the purpose of this curriculum, competency is defined as the capacity to integrate skills, knowledge, attitudes, and values according the minimally accepted competence level of the Registered Nurse practicing in emergency care.

Competency based orientation is the structure of my curriculum used to identify the new graduates progression from a novice practitioner in the ER to becoming an advanced beginner. I have based competencies on the NENA’s statement on *Professional Practice Core Competencies for Emergency Nurses* (2010). Although there is not a separate section that addresses cultural competence in NENA’s approach, it is important to acknowledge the diversity of our population. In order for nurses to provide holistic care that addresses the physical, psychological, social, emotional and spiritual needs of people, we must recognize various cultural orientations. If nurses are to practice nursing that involves a quality of care that takes into consideration beliefs, values, and culture, then nurses can care in a way that would profoundly affect the outcome of health. Therefore, I have included an application of cultural competence within the modules created.

Rashotte and Thomas (2002) argue that orientation alone cannot prepare new graduates for competence in the “indeterminate zones of critical care practice” (p. 131). Ongoing education is necessary and flows in a logical and sequential order, and as a result I have chosen to create stages within the curriculum beginning with orienting new graduates to acute care areas that will initially

exclude the trauma room and triage. The intention is; once the nurses have mastered the competencies at this stage, they will return for continuing education such as the Trauma Nurse Core Course (TNCC), Advance Cardiac Life Support (ACLS), and the Canadian Triage and Acuity Scale (CTAS) to prepare for competencies related to the more critically ill patients in the trauma room and develop their assessment skills for triage. Time is needed to master competencies before continuing education for more complex areas. This will aide in decreasing the stressors nurses experience as novices and facilitate their growth into advance beginners and beyond. However, due to the shortage of experienced staff, there are times that new graduates find themselves assigned to areas like the trauma room and triage. When they are not ready to move into these areas, it can add to their stress. This is also in agreement with the belief that educators tend to “teach too much too fast” (Rashotte & Thomas, p. 131), which could lead to frustration on the part of the new nurse and affect retention.

Lenburg (1999) developed a competency outcome and performance assessment model in collaboration with a nursing college program, educational, and organizational entities. It is a focus model that requires integration of practice-based outcomes, interactive learning methods, and performance assessment of competencies. The framework used to organize the model utilized responses to four major questions from faculty members and those responsible for program development:

1. What are the essential competencies and outcomes for contemporary practice?
2. What are the indicators that define those competencies?
3. What are the most effective ways to learn those competencies? And,

4. What are the most effective ways to document that learners and/or practitioners have achieved the required competencies?

The result was the creation of eight core competencies; assessment and intervention, communication, critical thinking, teaching, human caring relationships, management, leadership, and knowledge integration skills (Lenburg, 1992 – 1995; 1998; 1999). These core competencies are applicable in any practice environment and can be adapted to fit specific nursing settings, clients, students, and practitioners. In addition, each competency category can be used to specify required practice abilities for particular levels in diverse settings (Lenburg, 1999). Therefore, as the emergency department is composed of many sub areas such as pediatrics, medical/surgical/ first aid to critical care illness and has a diverse clientele, it is appropriate to apply the core competencies to this context of practice. These competencies also align with the competencies put forth by NENA that focus on assessment, intervention, and monitoring. The sub areas of the ER will enable new graduates a good grounding of skills due to the unknown nature of patient illness that is presented. Therefore, the curriculum will be context-relevant and adhere to the current goals of the health care institute (Iwasiw, Andrusyszyn, & Goldberg, 2009).

Context-relevant curriculum

I conducted a needs assessment for curriculum development that included the internal and external factors of ARHCC. A needs assessment for curriculum development is defined as, “the process for collecting and analyzing information that contributes to the decision to initiate a new program or revise an existing one” (Keating, 2001, p. 91). The internal frame factors include the description and organizational structure of ARHCC: mission statement and purpose, internal economic situation and its influence on a curriculum blueprint, resources within the institution and

potential faculty and staff characteristics (Keating, 2011). The external frame factors are factors that influence the development of curriculum in its environment and outside of the parent institution (Keating, 2011, p. 91).

Internal Factors.

The vision of ARHCC as part of Fraser Health is 'Better health, and best in healthcare' with an internal philosophy of being a 'patient/family centered care' facility. Family centered care is an approach to planning, delivery, and evaluation of healthcare that recognizes and honors patient and family perspective of choices. Health care providers recognize the important role families have in ensuring the social, mental, and developmental needs of their loved one and are encouraged in participating in delivery of care and share decision making processes (Fraser Health, 2013).

The vision of ARHCC is a foundation which provides a goal for all health professionals who work in the region to improve the health of the population and the quality of life of the people served. ARHCC offers a supportive environment that has various programs within nursing in which to thrive professionally. Some examples are sponsorship of formal education, leadership programs, and values-based culture that encourages employee recognition. In addition, it also has a focus of employee health and safety that addresses ergonomics, equipment, immunizations, health fairs, and return to work programs.

ARHCC and the Fraser Health region have also acknowledged the need to foster the new graduate into the professional role and promote this transition with a variety of teaching and learning workshops. While the new graduate transition program supports new staff into general nursing roles; the programs have not been used to support new graduates in specialty areas such as

the ER. Education at ARHCC is also supported with environmental resources that include: three large conference rooms and two lecture rooms for use by various educators. Internet and a web-based library assist educators in providing ongoing education by facilitating communication around new policies, protocols, or development of new programs as well as provide information for evidence-based practice.

Current staff in the emergency department of ARHCC consists of new graduates and nurses with less than a year of nursing experience. The goal is to implement a program in which new graduates from a foundational ER specialty course, such as the BCIT ER course, can transition into this specialty area with a competence to practice and have decreased psychological stress associated with nursing practice in a very challenging environment. The current population of nurses within the ARHCC ER is 275. After the new opening of ARHCC in 2008, new hires for the new ER had no prior professional experience. A better orientation program is needed in order to prepare new graduates to ease into the challenges of this dynamic practice environment. Prior consultation and communication with key people can help with the initiation of a proposed program. However, as educators, we need to be mindful of the feasibility of a curriculum that can be based on financial limitations of the institution (Keating, 2011).

Presently only one Clinical Nurse Educator (CNE) exists in the emergency department of ARHCC. An additional CNE, or the utilization of a community of experts may be needed to be able to deliver teaching and learning sessions to support a curriculum such as the one presented in this paper. ARHCC's mission statement in regards to its employees is to offer a supportive environment in which to thrive professionally (Fraser Health, 2010). A curriculum that helps new

nurses gain confidence and competence will also support nursing practice that upholds the institution's vision statement of 'Better health, and best in healthcare' (Fraser Health, 2010).

External Factors.

Health care trends and cost containment will predict future nursing workforce needs. To uphold ARHCC's vision of providing the best in healthcare, it is equally important to examine the external factors of ARHCC to support the development of a curriculum which will prepare new graduates in their role and expectations of the organization. "External frame factors are defined as the factors that influence curriculum development in its development and outside of the parent institute" (Keating, 2011, p. 91).

Keating (2011) argues that prior to starting any new curriculum development, or revision, an assessment of needs must be done. In the case of planning for orientation and continuing education programs for nursing staff, educators must consider external frameworks such as the description of the community, demographics of the population, characteristics of the academic setting, political climate, healthcare system and health needs of the populace, need for the program, financial support systems, and a regulation and accreditation standards (Keating, 2011). All of these factors can potentially influence, or precipitate the need for revision to current educational strategies.

ARHCC is one of 12 acute care hospitals in the Fraser Health region that supports a community of 5.3 million people (Fraser Health, 2010). It is a level 3-trauma center situated in the 5th largest municipality in BC that boasts the 3rd largest proportion of visible minorities in Canada (Fraser Health). Fraser Health region contains 32 bands of First Nations people as well as a diverse

culture including Asian, Indo-Canadian, Korean, and Filipino (Fraser Health). In planning for the preparation of nurses to work within this community, these cultural factors must be taken into account and any associated determinants of health that may also affect the health needs of this population (Bushe & Norena, 2012).

Along with the multicultural needs of this community, it has been documented in the last few years, that Fraser Health has had “unprecedented growth... with the largest capital expansion in history of healthcare in BC” (Fraser Health, 2010). The population growth has put demands on the healthcare system leading to congestion and service challenges and there is an expected population growth of 35.9% between now and 2036 with a projected increase of 58% in those aged 65-74 before 2021 (British Columbia Ministry of Statistics, 2011). Healthcare centers in the region can expect an increased demand on services leading to congestion that directly affects the care ER nurses can provide. In response to widespread congestion in hospitals, many communities across Canada have implemented overcapacity protocols to manage the insufficient resources to meet the demands of the increasing volumes of patients requiring care. CNA (2009) expressed concern on how these protocols may affect the safety of patients and nurses and the integrity of nursing practice including concerns over: inadequacy of staffing to meet patient needs; lack of privacy and dignity for patients and families; compromise of therapeutic relationships between nurses and patients; increase in the number and severity of adverse events; lack of essential equipment; increase in violence and tension; and concerns regarding control of infectious disease (Bushe & Norrena, 2012). Increase in the stressors being experienced by ER nurses in this time of overcrowding, boarding of patients in the ER, and prolonged wait times along with the aging population and the

increasing acuity and volume of patients makes nursing today challenging on many levels. What does this mean to the preparation of nurses to work in the ER?

Traditionally only experienced nurses were allowed to transfer to the ER. At that time they would get a few days of orientation regarding the paperwork and then be given a number of buddy shifts to get them prepared to work. It was expected that experienced nurses would be able to transfer their skills, critical thinking capacity, and organizational abilities into this new environment. This form of orientation is no longer effective and the Fraser Health region has become aware of the importance of specialty education in supporting experienced staff to attend an emergency specialty course in order to be prepared to work in the ER. However, given the increasing volume of patients, overcapacity protocols, and shortage of experienced nurses to work in the ER, management has been forced into a position to hire new graduates to attend the specialty course and start their professional practice in the ER. The question remains, how best can we prepare new graduates to work in this challenging environment?

Curriculum Blueprint

As earlier defined, a curriculum blueprint is an educational framework as to the essential elements of a curriculum and set expectations as to what will be evaluated (Cumyn & Gibson, 2010). Nurses are working in an environment that is an “uncontrolled, unpredictable environment in which patient assessment, analysis, and intervention is performed within a limited time frame and often with minimal patient data (NENA, 2010). The ER nurse must be able to distinguish stable patients from unstable patients, provide appropriate interventions based on findings, and prioritize care.

As nurses, we often look at disease based medicine where nurses are orientated to treatment of diseases. Instead, a better way is to look at patient presentation. This also relates to triage where we try to get nurses to not diagnose at triage but assess and identify the chief complaints and base decisions on these. The Canadian Triage and Acuity Scale (CTAS) (Canadian Association of Emergency Physicians, 2012) is a tool used in the ER to triage patients according the type and severity of their presenting signs and symptoms. CTAS modifiers are used at triage to help ER nurses differentiate between types of symptoms that need urgent care versus non urgent care. For example, for patients presenting with respiratory distress, CTAS modifiers are used to determine the level of acuity and what that looks like, it distinguishes between cardiac and non-cardiac chest pain; therefore, modifier help determine the type of intervention that is needed. So instead of discussing each diagnosis and what you might expect to see, nurses need to think about what we need to know about presenting symptoms. For example, if patients present with abdominal pain, nurses will need to know about this pain (location, timing, associated symptoms etc.) and what significance do each of these findings have to the acuity of the patient and necessary interventions.

Nurses work in a biomedical world, regardless of context of practice; however, we need to take it from a nursing perspective because ultimately, it is how we interact with these patients in a holistic manner that makes what we do stand out. In order to help new graduates in thinking past the concept of disease based nursing care, I have created 11 modules for part one of the new graduate orientation to the ER (Refer to Appendix F). Each module begins with a brief overview of the topic and the overall goal of the learning session. Assumptions and pre-requisites are also stated within each module so that each learner is aware of what knowledge they are expected to bring into the discussion for each module. Each module is created around the most common patient

complaints as identified in the CTAS (Canadian Association of Emergency Physicians), and although these new nurses will not be involved with triaging in the ER until they have much more experience and have taken the CTAS course, introducing them into the department's underlying philosophy is an important step in making each new staff member feel part of a larger team. This concept of needing to educate nurses to learn more than just skills to work in the ER will be considered in the over-all objectives of this curriculum. Development of critical thinking skills is an important aspect of working in the ER. Keating (2011) states "the role of critical thinking is applicable to educational taxonomy" (p. 71); therefore, the use of Fink's taxonomy of learning will provide the learning objectives.

Taxonomy of Learning

According to Candela (2011), an educational taxonomy provides a framework for the development, execution, and evaluation of a course, level, objectives, and outcomes (p.83). I utilized Fink's (2006) taxonomy of learning in the curriculum blueprint to develop, communicate, and evaluate learning objectives. Fink's taxonomy builds from the traditional taxonomy of Benjamin Bloom et al (1956); however, as Bloom's taxonomy is hierarchical in nature and centers on the cognitive level of learning, Fink's taxonomy is circular rather than hierarchical (Levine et al., 2008). Fink's taxonomy provides elements that align with a view of nursing that is dynamic, interpersonal, generative, and caring (Bergum, 2003; Bevis & Watson, 1989; Young, 2002). Nurse educators embrace student centered learning, a theory of learning known as constructivism, to prepare nursing student to practice competently. Constructivism maintains that learning is a process of meaning making, or knowledge building in which learners integrate new knowledge into

a pre-existing network of understanding (Mawell & Young). Student centered learning provide opportunities to think critically, practice reflectively, work in groups, and access new information to support practice (Young & Maxwell, p. 6). Fink's taxonomy has added components related to human interaction and motivation that are important in constructing learning which will change learners in significant ways (Levine et al.). It describes a new kind of significant learning that is guided by a definition of learning in terms of change.

According to Fink (2003), "for learning to occur, there has to be some kind of change in the learner, therefore, significant learning requires there be some kind of lasting change that is important in terms of the learners life" (p.3). The six kinds of significant learning include: foundational knowledge, application, integration, human dimension, caring, and learning how to learn.

1. Foundational knowledge is the basic understanding of concepts and ideas that is necessary for other kinds of learning (Levine et al.).
2. Application provides the learner to engage in action and thinking and can also include the development of new skills. This is reflective of critical, creative, and practical thinking (p. 247).
3. Integration refers to the ability of the learner to make the connections between different things and ideas (p. 247).
4. Human dimension enables learners to learn something new about themselves and others and helps learners understand others behaviors shaping new self descriptions or ideals (p. 247).

5. Caring can result from a learning experience and as a result is reflected in a change in feeling, interests, or values. When students care more, they are more interested in learning (p. 247).
6. Learning how to learn occurs when the learner discovers the process of learning itself. This type of knowledge provides for a more effective learning (p. 247).

The objectives of each module brings together aspects of Fink's significant learning including foundational knowledge, integration, application, human dimension, caring, and learning to learn as appropriate for each module. The important aspect of the structure for the assessment/planning/intervention section is that it shows the staff/ students that being part of the ER orientation is more than just memorizing content and skills, but involves them in understanding who they want to be as an ER nurse. Each module ends with statements of learner outcomes again addressing multiple aspects of significant learning.

Fink's taxonomy is not hierarchal in nature, but is relational and interactive. Interactive is defined to mean that various kinds of learning are synergistic; one kind of learning can enhance students' achievements in other kinds of learning (Levine et al., 2008). My curriculum design according to Fink's principles will extend over a 12 week period in which active learning strategies are used to engage, enhance motivation, and provide reflection and retention of knowledge (see Appendix E).

Teaching/Learning Strategies

"Effective teaching is not a set of generic practices, but instead is a set of context-driven decisions about teaching. Effective teachers do not use the same set of practices for every lesson . . . Instead, what effective teachers do is constantly reflect about their work, observe whether students are learning or not, and, then adjust their practice accordingly (Glickman, 1991, p. 6).

Certain teaching approaches can be barriers for learning, but can also facilitate learning in others to promote development of knowledge that will yield confident and competence nurses. For effective teaching to occur, the teaching and learning sessions need to acknowledge the diversity of learners and their learning styles. While this section includes student -centered approaches to teaching, it will also incorporate a conventional didactic approach to measure learner's outcomes. Therefore, creative teaching strategies to promote active learning will include: lectures, cases studies, story- telling and narratives, peer led sessions, simulation practices, and situated coaching such as mentorship to foster a collaborative and engaging environment to develop knowledge.

Lectures

Lectures are considered a conventional didactic approach to teaching that is more teacher-centered (Oermann, 2007). A conventional pedagogy assumes that learning progresses in a sequential process and reinforces the adding to cognitive gains and acquiring specific skills (Ironsides, 2001). In competency based orientation, pre-specified measurable learning outcomes are identified with-in the curriculum that direct new graduates to important parts of the course and provide a standard against which learning can be measured (Baxter, 2010). While traditional

lectures remain to be the most commonly used approaches to teaching, an integrated approach, in which active learning can be incorporated within lectures, can provide for an engaging and collaborative learning environment as well as promote critical thinking (Oermann, 2007). Creative strategies such as humor or stories incorporated within lectures, is one way to connect the content of the lecture with students' interests (Oermann, 2007). In addition, short cases introduced within lectures can be a valuable way to bridge the gap between theory and practice. Case reviews can contribute to rich discussions and can engage students to reflect on their own assumptions, values, and beliefs (Brown & Rodney, 2007).

Case Studies

Case studies are in-depth analysis of a real life or simulated situations that can develop nurses' critical thinking skills (Tomey, 2003). New graduates will apply theories or content from classroom lectures to assess, plan, implement, and evaluate nursing care based on a specific case presented. Working in small groups, content from the classroom can be combined with personal knowledge to determine solutions collaboratively. In addition, group discussions provide sharing of assumptions, values, and address issues in which to construct new knowledge (Brown & Rodney, 2007).

Case studies can be presented in a variety of ways; role-playing, using personal experience, and cases from journals are some examples that can be used (Tomey, 2003). Case studies in the teaching and learning session of our curriculum blueprint will consist of smaller groups of 2-4. An advantage of small group discussions is that they benefit the more passive learner who finds active learning in large groups, such as the classroom, more distressing. Case studies involving teamwork

can increase confidence and self esteem of nurses in their professional role, especially when their personal experiences contribute to the applicability of the case.

Engaging students in active learning strategies like case studies can provide for rich discussion that constructs new knowledge through sharing of assumption, beliefs, and values. Case studies involving patient experiences will provide new nurses to explore perspectives of patient and families lives and will engage students in reflective thinking, writing, and learning activities in the classroom setting (Davidson, 2003). Traditional case studies, however, can be limiting in their use for teaching and learning nursing ethics. When case studies are created to provide for opportunities to develop interrelationship between theory and practice, their use for exploring human experience and complexities of sociopolitical context of a case is limited (Brown & Rodney, 2007, p.146). Additional information may be needed to require nurses to see relevant contextual meaning and experience beyond objective facts (Brown & Rodney). Story telling and narratives as approaches to teaching and learning attends to the lived experiences of nurses and patients and can provide context that can engage learners to promote discussions of ethical issues and related policy (Brown & Rodney).

Story Telling and Narratives

The most salient features of narratives and stories are their ability to attend to the emotional dimensions of moral situations (Nortvedt 2004; Scott, 2000; Thayer-Bacon, 2003 as cited in Brown & Rodney, 2007). As nurses, we often hear personal narratives or stories being told by patients, so that nurses may understand and find meaning in their self-stories (Gaydos, 2003). The inclusion of patient experiences in case studies can provide a stronger platform to address ethical

issues that were previously overlooked (Brown & Rodney). The use of story- telling and narratives for teaching and learning is valuable to convey suffering of patients and their desire to be understood. The meaning of a story is dependent on how we hear them and is based on our moral values by which we live (Brown & Rodney, p. 157). Stories can be utilized in case studies, through role playing, showing pictures, and performing skits to enhance learning. Story- telling and narratives are a meaningful approach to encourage the development of caring empathy, compassion, and promotes the development of cultural competencies (Davidson, 2003, p188).

A mentorship period incorporated into the 12 week orientation program will facilitate the integration and application of skills and knowledge learners received from the first part of their orientation program. In addition, socializing with other staff members will enhance teamwork with the ER staff which can support ease of transition into professional practice.

Mentorship

Mentoring is a process where there is a planned relationship between a nurse who is experienced with one who is inexperienced to promote personal and professional development (Barker, 2005). Mentorship in the emergency room bridges the gap between inexperienced and experienced nurses. ‘In the moment’ teaching is invaluable, and in the emergency department, as in all areas, multiple approaches to teaching and learning are required. In some instances, narrative pedagogical approaches such as storytelling provide a venue to de-construct challenging situations and focus learning (such as in the case of a multiple trauma, respiratory arrest, or a patient with abdominal pain). Stories shared between and among colleagues provide a safe environment for learning. In addition, stories provide an avenue for experienced nurses to teach young and inexperienced

graduates. In planning this curriculum, it is important to incorporate time to hear stories from our experienced staff for novice nurses to reflect upon.

Opportunities for critical reflection can also be facilitated in formal education conferences, leadership forums, meetings, and assigned education days. Duchscher and Myrick (2008) state, “The key to critical reflection in any work setting rests upon a willingness on the part of management and staff to create and sustain an environment that is open to challenge, invites creativity, and opposes coercion (p.201). The mentor provides opportunities for engagement in activities that develop critical thinking, provides constructive feedback, and give support to build professional confidence (Baxter, 2010, p. E14). Matching personalities is important when considering the pairing of mentor and mentee (Baxter, p. E13). Providing a mentor who is overly confident and assertive may impede learning for the mentee who assumes a quieter disposition. Conversely, providing a mentor who assumes a more passive role can be frustrating for the more self assured mentee.

Finally, an evaluation will be used to evaluate the effectiveness of an orientation program. It is crucial to provide an orientation program which meets the needs of new graduates, which can overall decrease the attrition rates among new graduates and also result in reducing costs for the organization (Baxter).

Evaluation

“Evaluation is the process by which information about an entity is gathered to determine its worth” (Keating, p. 298). It is an important to evaluate the orientation program for its effectiveness and efficiency as well as the ability of the curriculum to meet the objectives (Santucci, 2004, p.

278). Curriculum evaluations are important for appraising information about a nursing program (Iwasiw, Goldenburg, & Adrusyszyn, 2005), and can include approaches which can be formal or informal, systematic or occasional, and formative or summative (Young, Maxwell, Paterson, & Wolf, 2007).

A formal evaluation can be conducted internally by faculty members to expose strength and weaknesses of a curriculum as well as monitors students learning, or externally, which include an outside agency conducted by accreditation bodies (Young et al., 2007). An example of a formal evaluation is a systematic approach to evaluation involving professional standards to investigate the worth or merit of a program (Tan, Lee, & Hall, 2010). Although there are various types of models used for evaluation, Sing (2004) proposes the context, input, process, and product model (CIPP) to be used in the evaluation of nursing program due to its alignment of a constructivist approach. It also allows for formative and summative evaluation of nursing education elements: context, inputs, process, and products (Young et al.). The evaluation criteria are based on “an interactive relationship between the evaluator and the clients and is operated on a foundation of trust, showing respect to stakeholders regardless of gender, power, and cultural background” (Tan et al., p. 2). Formal evaluation can also be episodic or occasional in the form of a onetime evaluation of his or her teaching by a colleague, a request of students likes or dislikes about a teaching strategy, or peer evaluation, which can be valuable indicators of knowledge in assessing student preferences and as source of interpersonal knowledge informing decisions about teaching (Young et al.). Verbal and nonverbal feedback are examples of informal feedback, which can provide educators with factors that may influence students’ learning as well as provide educators with about teaching styles that have negative effects (Young et al., 2007).

Formative evaluation is defined as the assessment that occurs during implementation of a program or curriculum, but can also be viewed as process evaluation (Keating, 2011). Formative evaluations are used as “intended - by the evaluator - as to provide a basis for improvement” (Keating, p. 298). For example, in this orientation program, the evaluators can compare students’ grades in the various courses taken in the ER specialty program to determine if certain levels of achievement influences their ability to comprehend what they learn and are able to apply. Some strategies used for formative evaluation include “course evaluations; student achievement measures; teaching effectiveness survey; staff, student, administration, and faculty satisfaction measures (Appendix H); students’ critical thinking development; standardized tests such as gains in knowledge and skills; and cost-effectiveness of the program “(Keating, p. 300). Various tools are used to measure these processes; however, caution is recommended that a literature review is needed to demonstrate reliability and validity of these tools.

Summation evaluation is defined as “taking place at the end of the program and measures final outcome” (Keating, 2011, p. 385). Summative evaluations provide for a more holistic approach to the assessment of a program and can utilize results from the formative evaluation (Keating, p. 298). Following the example provided from a formative evaluation of nursing, clinical nurse educators can evaluate the development of critical thinking skills in graduates as a product of the orientation program; however, Keating states a “measurement of skills before and after the orientation program would be needed to determine if there was an increase in skills” (p.298). The various tools used to measure outcome of programs include follow-up surveys of success rates of graduates; overall satisfaction of programs; graduates’ performance; accomplishment in leadership

roles as change agents, professional commitment , continuing education rates; graduation rates; program approval status , rating of program by external evaluation and public opinion surveys.

Evaluation Tools

To enable the orientation program to be successful in preparing new graduates to practice competently within a given time frame, there are several tools that can be used during and after the orientation program. The performance based development system (PBDS) was developed to assess an individual's competency skills and is used to assess critical thinking, interpersonal relations skills, and technical skills (Whelan, 2006). PBDS can be used to individualize the orientation plan for new graduates. Use of weekly preceptor evaluation forms can provide ongoing feedback to determine if goals and objectives are being met. Registered Nurse Competency assessments tools are used by new staff to dictate core competencies in the emergency department. At ARHCC, this tool is the Competency Assessment Planning and Evaluation tool (CAPE) and is utilized by new graduates during the first year to validate independent performance in providing competent care.

For any program a measurement of success is important to prove effectiveness of the program. The American Society of Training and Development Evaluation (ASTD) tool can be helpful to determine if the objectives and goals of the program were met from the perspective of new graduates (Marcum & West, 2004). The Professional Judgment Rating Form is one tool that can be used one year post orientation to classify critical thinking into categories. The tool uses measurement methods such as multiple choice questions generating solutions to problems and evaluating the quality of the solution (Facione & Facione, 2008); Likert-style measures to measure

critical thinking habits of mind (Facione & Facione, 1992; Giancarlo); and rubrics can be constructed to assess and obtain ratings of critical thinking skills and dispositions (Facione & Facione, 2008, p.7). As there are multiple tools used for collecting and analyzing data to measure outcomes, a literature review is needed to utilize the best tools for outcomes of educational programs.

Conclusion

Our political and economic climate, technological changes, demographics, and increased public expectations can often affect the nurse's ability to practice. Seasoned nurses in the emergency department influenced by ongoing organizational constraints are socialized to ritualistic practices at the expense of the needs of patients (Maben, Latter & Clark, 2006). New graduates introduced in this environment are then influenced by these nurses to be socialized in the same manner.

The shortage of nurses and retirement of the seasoned nurse bring about new nurses mentoring newer nurses or graduates who are practicing at a novice level and lack the necessary skills to manage unanticipated events, or have communication skills to deal with interpersonal conflict. For new graduates hired to work in the emergency setting, most are unable to solidify their baseline experience beforehand on a medical/surgical unit and are often placed in situations that require some life experiences to cope with the demands of the area.

According to Hibberd and Smith (2006), education opportunities are important when new graduates are being recruited to specialty units. This can help nurses gain the skills they need to perform competently. An orientation program that is responsive to the new nurse employee is an

important factor for retention as well as having a significant impact on patient outcomes. In my experience these programs are short lasting leaving new nurses unsure of their new knowledge and skills. With the ever increasing technology in health care, patient acuity, and shortage of nurses it is paramount nurse leaders of today provide an orientation program that is supportive, provides guidance, and enhances the recruitment and retention of professional nurses. This will improve quality of care for our patients, reduce nurse turnover rate, increase attraction, provide job satisfaction, and lower the degree of job stresses that in the end will burn out our nurses.

Competency-based orientation works to assist new nurses integration of knowledge and skills needed to meet established standards of care within their area of practice. The shortage of nurses continues to be problematic and vacancies of nursing position in specialty areas remain evident. If we are to provide an orientation whereby new graduates are supported in their learning, then perhaps the new nurses of today may be inspired to 'pay it forward' to yet another new generation of nurses and provide a new culture of learning that will eventually revolutionize nursing education in the ER.

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Appendix A

Summary of Themes

	Boychuk Duchsch er & Cowen	McKen na et al	Case y et al.	Boychuk Duchsch er	Farnel l & Dawso n	Dyess & O'Sherm an	Boychuc k Duchsch er	Valde z
Marginalizati on & strategies to prevent		X		X				
Role expectation	X		X	X	X	X	X	X
Professional Identity	X			X		X	X	X
Distressing incidences	X	X		X		X		X
Transition experiences	X		X	X	X	X	X	X
Confidence and fear	X	X		X	X	X	X	X
Critical care decisions	X				X	X		
Competence	X	X	X			X	X	X
Critical knowledge				X	X	X	X	

Appendix B

Johns Hopkins Nursing Evidence Based Practice

Appraisal Tool

Non- Research Evidence Appraisal

Author title: BSN, MN, PhD	Number:
Author (s): Boychuk Duchscher, J.E., Cowin L.S.	Date: 2004

Journal: The experience of marginalization in new nursing graduates
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<input type="checkbox"/> Systematic Review	<input type="checkbox"/> Clinical Practice Guidelines	<input type="checkbox"/> Organizational (QI, financial data)	<input checked="" type="checkbox"/> Expert opinion, Case study, literature review
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Does review/expert opinion address my practice question?	X <input type="checkbox"/> Yes	<input type="checkbox"/> No
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If the answer is no, stop here unless there are similar characteristics

Systematic Review		
Is the question clear? • Are search strategies specified, and reproducible? • Are search strategies appropriate to include all pertinent studies? • Are criteria for inclusion and exclusion of studies specified? • Are details of included studies (design, methods, analysis) presented? • Are methodological limitations disclosed? • Are the variables in the studies reviewed similar, so that studies can be combined	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
Clinical Practice Guidelines		
• Were appropriate stakeholders involved in the development of this guideline? • Are groups to which guidelines apply and do not apply clearly stated? • Have potential biases been eliminated? • Were guidelines valid (reproducible search, expert consensus, independent	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No

review, current, and level of supporting evidence identified for each recommendation)? • Are recommendations clear?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
Organizational Experience		
• Was the aim of the project clearly stated? • Is the setting similar to setting of interest? • Was the method adequately described? • Were measures identified? • Were results adequately described? • Was interpretation clear and appropriate?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
Individual Expert Opinion, Case Study, Literature Review		
• Was evidence based on the opinion of an individual? • Is the individual and expert on the topic? • Is author's opinion based on scientific evidence? Review of Literature places variable within a conceptual framework. • Is the author's opinion clearly stated? • Are potential biases acknowledged?	X <input type="checkbox"/> Yes X <input type="checkbox"/> Yes X <input type="checkbox"/> Yes X <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No X <input type="checkbox"/> No
PERTINENT CONCLUSIONS AND RECOMMENDATIONS		
<p>Relational factors as well as organizational constraints alienate the new graduates within the context of their nursing practice environment. These factors include unrealistic expectation of the new grad, role expectation (student vs RN), professional identity, socio political conditions.</p>		
Were conclusions based on the evidence presented	X <input type="checkbox"/> Yes	<input type="checkbox"/> No
Will the results help me in caring for my patients?	X <input type="checkbox"/> Yes	<input type="checkbox"/> No

Quality Rating (Scale provided)

Basic quality rating of the study under review (check one)	X <input type="checkbox"/> High (A)	<input type="checkbox"/> Good (B)	<input type="checkbox"/> Low/major flaws(C)
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Summary: The concept of marginalization was used as a framework for understanding the transitional challenges of new graduates. Marginalization in the context of new nursing graduate is a time limiting process of transitioning from student nurse to practicing nurse (RN). The marginalization of new graduates will be focused on their vulnerability and alienation which exists for new graduates when they

are transitioning to their professional role. Socio-cultural relations, role expectations, and professional identity are examined. Strategies are recommended to minimize

marginalization of new nursing graduates. Decreasing the effects of marginalization may help nurses transition into the practice environment more smoothly and are more likely to be retained by the workplace.

Themes/Recommendations:

- Socio-Cultural Relations
 - Reality shock – there is a distinctness of differences between being a student nurse and the role of a professional nurse.
 - Role expectations – Unrealistic expectations from management and nursing colleagues. Scrutiny of nursing skills and coping abilities erodes the new graduate’s self-confidence.
 - Professional identity – The use of the terms ‘new grad’, ‘new nurse’, ‘newbie’ can create a hierarchical system among senior nurses ‘marking’ of an outsider within a larger group (p. 291).

Socio-Political Conditions

- Role Socialization – New graduates are often conflicted between what has been taught to them and adhering to the institution’s practice standards of the ‘real world’ (productivity and efficiency).

Reflections – Strategies aimed at supporting integration of new graduates are provided.

- Promote tolerance
- Utilize liberating practices
- Promote collectivity of nurses
- Encourage greater collaboration
- Develop understanding of generational issues in workplace
- Explore work-base rituals and routines.

Strengths: Examines the transitional experiences of new graduates by exploring issues from the framework of marginalization as a concept and as an experience. Explanation of concepts are well provided. Specific strategies are well laid out and described in a Table. This was a Canadian literature review, which provided the context environment from a Canadian nursing program as well as a Canadian Institution.

Limitations: Author does not provide data bases used for literature search. Does not examine the specific context of nursing environment, but context of new graduates in general regardless of type of practice environment.

STRENGTH OF EVIDENCE

LEVEL 4

SYSTEMATIC REVIEW

- Research review that compiles and summarize evidence from research studies related to a specific clinical question
- Employs comprehensive search strategies and rigorous appraisal methods
- Contains an evaluation of strengths and limitations of studies under review

CLINICAL PRACTICE GUIDELINES

- Research and experiential evidence review that systematically develops statements that are meant to guide decision-making for specific clinical circumstances
- Evidence is appraised and synthesized from three basic sources: scientific findings, clinician expertise, and patient preferences.

LEVEL 5

ORGANIZATIONAL

- Review of quality improvement studies and financial analysis reports
- Evidence is appraised and synthesized from two basic sources: internal reports and external published reports.

EXPERT OPINION, CASE STUDY, LITERATURE REVIEW

- Opinion of a nationally recognized expert based on non-research evidence (includes case studies, literature review, or personal experience).

QUALITY RATING (SUMMATIVE REVIEWS)

A High quality: well-defined, reproducible search strategies; consistent results with sufficient numbers of well-designed studies; criteria-based evaluation of overall scientific strength and quality of included studies, and definitive conclusions

B Good quality: reasonably thorough and appropriate search; reasonably consistent results, sufficient numbers of well-designed studies, evaluation of strengths and limitations of included studies, with fairly definitive results

C Low quality or major flaws: undefined, poorly defined, or limited search strategies; insufficient evidence with inconsistent results, conclusions cannot be drawn

QUALITY RATING (EXPERT OPINION)

A High quality: expertise is clearly evident.

B Good quality: expertise appears to be credible.

C Low quality or major flaws: expertise is not discernable

JHNEPH Research Evidence Appraisal

Author Title: : B.A. MHSc. RCpN, RGON, RPN, MB, ChB, FRANZCP				Number:	
Author (s):): McKenna, B.G., Smith, A.A., Poole, S.J., & Cloverdale, J.H.				Date: 2003	
Journal: Journal of Advanced Nursing 42(1) Horizontal violence: experiences of Registered Nurses in their first year of practice					
Setting: Registered Nurses in their first year of practice			Sample (Composition size): 1169 questionnaires mailed , 584 returned		
<input type="checkbox"/> Experimental	<input type="checkbox"/> Meta analysis	<input type="checkbox"/> Quasi experimental	<input checked="" type="checkbox"/> Non experimental	<input type="checkbox"/> Qualitative	<input type="checkbox"/> Meta synthesis
Does this study apply to my patient population?				<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
If the answer is no, stop here (unless there are similar characteristics)					
Strength of study design					
Was sample size adequate and appropriate? Convenience sample (non random)				<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
• Were study participants randomized? Non random				<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
• Was there an intervention?				<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
• Was there a control group? Only one group				<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
• If there was more than one group, were groups equally treated, except for the intervention?				<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
• Was there adequate description of the data collection methods				<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Study Results					
Were results clearly presented?				<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
• Was an interpretation/analysis provided?				<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Study Conclusions					
Were conclusions based on clearly presented results?				<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
• Were study limitations identified and discussed? Limitations identified, but not all discussed. 47% return rate a bit low				<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

PERTINENT STUDY FINDINGS AND RECOMMENDATIONS			
<ul style="list-style-type: none"> - The need to provide support services - Education and training of staff - Development of programmes to reduce horizontal violence. 			
Will the results help me in caring for my patients?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Evidence Rating (scales on back)			
Strength of Evidence Rating		Level 3	
Quality Rating (check one)		<input type="checkbox"/> High A	<input type="checkbox"/> Good (B) <input type="checkbox"/> Low/major flaws(C)

Quality between B & C

Target population was first year graduates, 1169 surveys sent out and 584 were returned indicating 47% of response rate of eligible participants, not high; however author indicates that it was a favorable response given the low response rate of 30% associated with anonymous mailed survey (Lobiondo-Wood & Haber, 2009, p.93). I am thinking this is more like a convenience sample? (convenience sample is use of readily accessible persons as subjects in study, (p.256). Convenience sample are a type of non probability sampling. Non experimental designs often use non probability sampling strategies. It is the weakest form of sampling strategy in terms of generalizability and risk of bias is greater than any other form of samples. Researcher obtains information from only people who returned the survey, so representativeness is questionable (p257). Non probability sampling strategy is less generalizable because it tends to produce less representative samples. However, the author does state "it was possible to determine the representativeness of sample in relation to ethnicity, gender...with Nursing Council data." (p.93).

Sample size is determined by type of design and type of sampling procedure used (p.269). The sample size is estimated with use of power analysis (p. 270), but states only with clients that are randomly assigned to experimental or control group. I think this was a non random sample with only one group, so power analysis was not used to determine sample size due to it being a non random sample?

Lobiondo-Wood, G., & Haber, J. (2009). Nursing research in Canada: Methods and critical appraisal for evidence-based practice. Toronto, Canada: Elsevier Canada.

CATEGORY: RESEARCH STUDY (SURVEY (descriptive) – NON EXPERIMENTAL)

- **Is nonexperimental design used in study?** **YES**
- **Is rational for type for design evident?** **NO**

How is design congruent with purpose of study?	Explores phenomenon
- Is design appropriate for research problem?	YES
- Is design suited to data collection?	YES
- Does researcher present findings in a manner congruent with design used?	YES
- Does research go beyond relational parameters of findings and erroneously infer cause-and effect relationship between variable?	YES
- Are alternative explanations for finds possible?	YES
- Does researcher discuss threats to internal and external validity?	NO
- How does author deal with limitation of study?	Unknown circumstances
that initiated horizontal violence, no inquiry as to why some incidents were not reported. Author quoted sample was representative of total population of graduate nurse in their first year of practice on all variable except ethnicity, but non random samples produce less generalizability because it produces less representative samples.	

Summary: Horizontal violence is a common experience for new graduates in their first year of practice. Most of the behavior were subtle and covert; however, verbal statement, which were rude, abusive, humiliating, or involve criticism were also found to be common. Aim of study was to 1). Determine prevalence of various interpersonal conflict in first year of practice 2) description of most distressing incident 3) measure psychological impact of event 4) determine consequences of experience 5) determine adequacy of training to manage horizontal violence.

Education of staff, conflict management and resolution need to be incorporated into educational development of undergraduate programs as well as in clinical workplace. The first year of practice is important for new graduate to acquire confidence, but new graduates who are subjected to a variety of confident – diminishing behaviours can produce psychological stress.

Themes/Recommendations:

Types of threats – Learning opportunities blocked

- emotional neglect
- Distressed by conflict of others
- Given too much responsibilities inappropriate support.
- Statements that was rude, abusive, humiliating, unjust criticism
- Verbal sexual harassment
- Inappropriate racial comments and gestures
- Harassment through formal complaint process

- Verbal threats
- Physical intimidation
- Property damage
- Physical assault
- stalking

Consequences of event – psychological which include fear, anxiety, sadness, depression, frustration, mistrust, nervousness

- Positive outcomes – ability to stand up for self
- support of other staff

- Training:
- Primary prevention – education of staff
 - Curriculum development of undergraduate programmes.

Strengths: Study sample represented new graduates in their first year of practice. An Impact of Event Scale was used to measure level of distress, a validated and reliable measure of subjective psychological distress (Horowitz et al.1979, Shalev et al. 1997, Sudin & Horowitz, 2002). Favorable response rate indicated. Included a table of percentage of new graduates in various practice areas.

Limitations: Study sample within the context of general new graduates. Limited by use of self-report and absence of collaborating information. Circumstance of violence is unknown. First year graduates may have perceive constructive criticisms as conflict. Under- representation of participants from pacific island cultures and Asian cultures. (random selection occurs when each element of population has equal and independent chance of being included in the sample).

STRENGTH OF EVIDENCE

LEVEL 1 (HIGHEST)

EXPERIMENTAL STUDY (RANDOMIZED CONTROLLED TRAIL OR RCT)

- Study participants (subjects) are randomly assigned to either a treatment (TX) or control (non-treatment) group.
- May be:
 - Blind: neither subject nor investigator knows which TX subject is receiving.
 - Double-blind: neither subject nor investigator knows which TX subject is receiving.
 - Non-blind: both subject and investigator know which TX subject is receiving; used when it is felt that the knowledge of treatment is unimportant.

META-ANALYSIS OF RCTS

- Quantitatively synthesizes and analyzes results of multiple primary studies addressing a similar research question
- Statistically pools results from independent but combinable studies
- Summary statistic (effect size) is expressed in terms of direction (positive, negative, or zero) and magnitude (high, medium, small)

LEVEL 2

QUASI-EXPERIMENTAL STUDY

- Always includes manipulation of an independent variable
- Lacks either random assignment or control group.
- Findings must be considered in light of threats to validity (particularly selection)

LEVEL 3

NON-EXPERIMENTAL STUDY

- No manipulation of the independent variable.
- Can be descriptive, comparative, or relational.
- Often uses secondary data.
- Findings must be considered in light of threats to validity (particularly selection, lack of severity or co-morbidity adjustment).

QUALITATIVE STUDY

- Explorative in nature, such as interviews, observations, or focus groups.
- Starting point for studies of questions for which little research currently exists.
- Sample sizes are usually small and study results are used to design stronger studies that are more objective and quantifiable.

META-SYNTHESIS

- Research technique that critically analyzes and synthesizes findings from qualitative research
- Identifies key concepts and metaphors and determines their relationships to each other
- Aim is not to produce a summary statistic, but rather to interpret and translate findings

QUALITY RATING (SCIENTIFIC EVIDENCE)

A High quality: consistent results, sufficient sample size, adequate control, and definitive conclusions; consistent recommendations based on extensive literature review that includes thoughtful reference to scientific evidence.

B Good quality: reasonably consistent results, sufficient sample size, some control, and fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence

C Low quality or major flaws: little evidence with inconsistent results, insufficient sample size, conclusions cannot be drawn.

JHNEPH Non- Research Evidence Appraisal

Author title: MN, PhD, RN	Number:
Author (s): Boychuk Duscher,J.E.	Date: 2009

Journal: Transition shock: The initial stage of role adaptation for newly graduated Registered Nurses

<input type="checkbox"/> Systematic Review	<input type="checkbox"/> Clinical Practice Guidelines	<input type="checkbox"/> Organizational (QI, financial data)	<input checked="" type="checkbox"/> Expert opinion, Case study, literature review
---	--	---	--

Does review/expert opinion address my practice question?	X <input type="checkbox"/> Yes	<input type="checkbox"/> No
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If the answer is no, stop here unless there are similar characteristics

Systematic Review		
Is the question clear? • Are search strategies specified, and reproducible? • Are search strategies appropriate to include all pertinent studies? • Are criteria for inclusion and exclusion of studies specified? • Are details of included studies (design, methods, analysis) presented? • Are methodological limitations disclosed? • Are the variables in the studies reviewed similar, so that studies can be combined	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
Clinical Practice Guidelines		
• Were appropriate stakeholders involved in the development of this guideline? • Are groups to which guidelines apply and do not apply clearly stated? • Have potential biases been eliminated? • Were guidelines valid (reproducible search, expert consensus, independent review, current, and level of supporting evidence identified for each recommendation)? • Are recommendations clear?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
Organizational Experience		

<ul style="list-style-type: none"> • Was the aim of the project clearly stated? • Is the setting similar to setting of interest? • Was the method adequately described? • Were measures identified? • Were results adequately described? • Was interpretation clear and appropriate? 	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
Individual Expert Opinion, Case Study, Literature Review		
<ul style="list-style-type: none"> • Was evidence based on the opinion of an individual? • Is the individual and expert on the topic? • Is author's opinion based on scientific evidence? • Is the author's opinion clearly stated? • Are potential biases acknowledged? 	Interest and commitment to transition of new graduates. Theoretical framework Inclusion criteria, description of Ongoing analysis and Interpretation of data. Dynamic interplay between inductive and deductive processes permitted fluid movement between data analysis and further data acquisition.	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
<p>PERTINENT CONCLUSIONS AND RECOMMENDATIONS</p> <p>Understanding the initial stage of role transition will assist managers, educators, and experienced nurses to support and facilitate new graduates to transition into the professional role.</p> <p>Developing programs to better assist the new grad transition period will help retain new nurses.</p>		
Were conclusions based on the evidence presented	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Will the results help me in caring for my patients?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No

Strength of evidence: Level 5

Quality Rating (Scale provided)

Basic quality rating of the study under review (check one)	<input checked="" type="checkbox"/> High (A)	<input type="checkbox"/> Good (B)	<input type="checkbox"/> Low/major flaws(C)
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Summary: Transition shock is used as theoretical framework which focuses on the roles and responsibilities of new graduate intensifying their transition experience from student to professional role. Transition shock is used to present the most immediate and dramatic stage in

the process of professional role adaptation. Transition shock is felt when the new graduate is taken from a familiar role of a student to the unfamiliar role as a professional nurse.

Themes/Recommendations: The period where transition shock is most prevalent is in the first 4 months post orientation. Expressions of transition shock are experienced as:

Emotional: words used to describe feelings were terrified, scared to death, and high anxiety, and exhaustion. Fears included: the exposure of clinical incompetence; failing the patient, and not being able to cope with responsibilities.

Physical: Personal and developmental changes include changes to established routines, modified living arrangements, adjusting to shift work (sleep changes), and stress and anxiety which increases their energy demands (expectation of making advanced clinical judgment at their place of work).

Sociocultural and Developmental: Sociocultural and developmental tasks include the understanding and acceptance of their professional role, the acceptance by other professionals around them, learning to balance their personal and professional lives, and learning the differences between what they learned in the educational system and the 'real world'. The development of maturity was a strong theme which emerged during the initial 4 months of their practice.

Intellectual: New graduates feel they were placed in assignment which were beyond their cognitive or experiential comfort level, but were unable to find anyone who had time to help them as other staff members had workloads that were just as demanding. New graduates would often not ask for assistance for fear of being seen as 'incompetent' and therefore not being accepted by their colleagues.

Implications: An orientation program which include knowledge about role transition would greatly benefit the transition of new graduates. Theory of role transition should also be made available to seasoned nurses to provide understanding of the stress and challenges involved. Specific strategies can used for modes of knowledge transmission such as role playing and context base learning scenarios that can be engaging for both novice and seasoned nurses related to experiences of transition shock of new graduates.

Strengths: Authors theoretical positions and assumptions were clearly stated. Long study period was used to gather and analyze data. : Data sources culminated generation of emerging theory

originating from 10 year programme of research. Experiences of graduates from a Canadian BScN programme were used. Practice environment was an emergency department.

Reviewed documents were from reliable databases: CINAHL plus, Nursing and Allied Health Collection, Medline, and PsycINFO. Opinion of author clearly states her stance on practice environment of new graduates.

Limitations Data and ongoing study were conducted during identical time periods, and originating from the same nursing program

STRENGTH OF EVIDENCE

LEVEL 4

SYSTEMATIC REVIEW

- Research review that compiles and summarize evidence from research studies related to a specific clinical question
- Employs comprehensive search strategies and rigorous appraisal methods
- Contains an evaluation of strengths and limitations of studies under review

CLINICAL PRACTICE GUIDELINES

- Research and experiential evidence review that systematically develops statements that are meant to guide decision-making for specific clinical circumstances
- Evidence is appraised and synthesized from three basic sources: scientific findings, clinician expertise, and patient preferences.

LEVEL 5

ORGANIZATIONAL

- Review of quality improvement studies and financial analysis reports
- Evidence is appraised and synthesized from two basic sources: internal reports and external published reports.

EXPERT OPINION, CASE STUDY, LITERATURE REVIEW

- Opinion of a nationally recognized expert based on non-research evidence (includes case studies, literature review, or personal experience).

QUALITY RATING (SUMMATIVE REVIEWS)

A High quality: well-defined, reproducible search strategies; consistent results with sufficient numbers of well-designed studies; criteria-based evaluation of overall scientific strength and quality of included studies, and definitive conclusions

B Good quality: reasonably thorough and appropriate search; reasonably consistent results, sufficient numbers of well-designed studies, evaluation of strengths and limitations of included studies, with fairly definitive results

C Low quality or major flaws: undefined, poorly defined, or limited search strategies; insufficient evidence with inconsistent results, conclusions cannot be drawn

QUALITY RATING (EXPERT OPINION)

A High quality: expertise is clearly evident.

B Good quality: expertise appears to be credible.

JHNEBP RESEARCH EVIDENCE APPRAISAL

Authur Title: : PhD, RN, EdD, NEA, BC, CNL				Number:	
Author (s):): Dyess, S.M. & O'Sherman, R.				Date: 2009	
Journal: Journal of Continuing Education in Nursing 40(9) The first year of practice: New Graduate Nurses' transition and learning					
Setting: Novice nurse transition program. Nurses from divers practice settings with 80% being acute care facilities.			Sample (Composition size) 81 participants		
<input type="checkbox"/> Experimental	<input type="checkbox"/> Meta analysis	<input type="checkbox"/> Quasi experimental	<input type="checkbox"/> Non experimental	X <input type="checkbox"/> Qualitative	<input type="checkbox"/> Meta synthesis
Does this study apply to my patient population?				X <input type="checkbox"/> Yes	<input type="checkbox"/> No
If the answer is no, stop here (unless there are similar characteristics)					
Strength of study design					
Was sample size adequate and appropriate? For a qualitative study, 34 participants is at the larger end of the continuum.			X <input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Were study participants randomized? A high potential for professional leadership contributions was an attribute that organizations were asked to use in selection process as well as a commitment to attend sessions and completion of an evidence based project.			<input type="checkbox"/> Yes	X <input type="checkbox"/> No	
• Was there an intervention?			X <input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Was there a control group? Focus group?			X <input type="checkbox"/> Yes	<input type="checkbox"/> No	
• If there was more than one group, were groups equally treated, except for the intervention? Involved pre- and post program focus groups using hermeneutic analysis.			X <input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Was there adequate description of the data collection methods semi-structured questions, session audio taped and transcribed, themes and merging patterns were coded from multiple reviews of data.			X <input type="checkbox"/> Yes	<input type="checkbox"/> No	
Study Results					
Were results clearly presented? Key points presented			X <input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Was an interpretation/analysis provided? Thematic analysis			X <input type="checkbox"/> Yes	<input type="checkbox"/> No	
Study Conclusions					
Were conclusions based on clearly presented results?			X <input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Were study limitations identified and discussed? : I identified limitation, but was not discussed. Participants excluded those who did not agree to commit to attend transition sessions, or completed an evidence			<input type="checkbox"/> Yes	X <input type="checkbox"/> No	

based project			
PERTINENT STUDY FINDINGS AND RECOMMENDATIONS - The need to provide support services - Education and training of staff - Development of programmes to reduce horizontal violence.			
Will the results help me in caring for my patients?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Evidence Rating (scales on back)			
Strength of Evidence Rating	Level 3		
Quality Rating (check one)	X <input type="checkbox"/> High A)	<input type="checkbox"/> Good (B)	<input type="checkbox"/> Low/major flaws(C)

C Low quality or major flaws: expertise is not discernable or is dubious

CATEGORY: QUALITATIVE RESEARCH STUDY (Hermeneneutic analysis)

Identify the phenomenon:

- Is the phenomenon focused on human experience?
- Is the phenomenon relevant to nursing, health, or both?
- Does question specify distinct process to be studied?
- Does question identify the context of process to be studied?

- Does choice of specific qualitative method fit with research study?
- Are biases reported?
- Is it clear selected sample living phenomenon of interest?
- Are data sources and methods specified?
- Is evident presented that participant’s consent is an integral part of gathering process?
- Can dimensions of data analysis be identified and logically followed?
- Does researcher paint a clear picture of participant’s reality?
- Is evidence presented that the researcher’s interpretation captured participants meaning?
- Other professionals confirm interpretations?
- Examples provided to guide reader from raw data to researchers synthesis
- Does researcher link the finds to existing theory or literature, or is a new theory generated?

Summary: During the first year as a new graduate nurse, there are certain challenges and experiences that are stressful when transitioning into their professional role. Knowledge deficits and

organizational expectations are some of the factors which can contribute to challenges for new graduates. Recommendations offering extended orientation program, especially for specialty units, can provide a smoother transition to the work environment as well as address retention issues.

Themes/Recommendation:

Confidence and Fear: The ability to be able to link their theory to practice can cause emotions that are exciting, but ‘scary’. New graduates anticipate challenging situation (unexpected events) and also hoped there is added support for clinical judgments that will help develop their knowledge base.

Communication: Physician communication skills can be intimidating and demeaning. This prevents the novice nurse from communicating to them to advocate for their patients. New nurses are also unprepared to delegate and supervise support staff, when support staff does not respond to their requests for assistance they often avoided conflict by managing the task themselves.

Horizontal Violence: Defined as ‘any act of aggression demonstrated by a colleague, and its is inclusive of emotional, physical, and verbal threats, as well as innuendo or criticism (Longo & Shermann, 2007, p. 407). Novice nurses express a common experience of horizontal violence. Developing a program that can provide information and strategies of coping with horizontal violence in the work place can be beneficial.

Personal Isolation: There is a need to have ongoing dialogue with colleagues. This promotes a place where constructive criticism can provide support and guidance in order to develop into safe and competent nurses.

Critical decision making: New nurses working in specialty areas require further knowledge and skills they have not fully developed yet. Working in a complex practice environment can provide opportunities for reflection, which increases knowledge base. Due to work load and complexity of patient illness in specialty areas, new nurses often do not have the time for the much needed critical reflection, which can be beneficial to their professional development. An orientation that focuses on continuing education with exposure to practice environment would promote quality of care, ensuring competence, and safe care.

Contradictory Information: Nurses seeking advice from other nurses will encounter contradicting information and guideline, policies, and procedural information are not easily

accessible. Having a consistent preceptor will provide consistency of information as well as build a relationship based on mutual respect and validation of the novice nurses' value.

Successful transition of novice nurses into their practice environment must include having the necessary support structures in place to promote a smoother transition to professional practice. An orientation program offering specific content related to transition into practice, providing mentors to develop self confidence, and having an extended orientation program that can connect them to their peers and nurse leaders is important in the first year of practice.

Strengths: Demographic table is included, participants were graduates from various educational programs and had less than 12 months practice experience, and 80% of participants were in acute care community facilities within a range of specialty areas. Semi structured questions are provided. Review board approval was evident.

Limitations: Participants excluded those who did not agree to commit to attend transition sessions, or completed an evidence based project.

STRENGTH OF EVIDENCE

LEVEL 1 (HIGHEST)

EXPERIMENTAL STUDY (RANDOMIZED CONTROLLED TRIAL OR RCT)

- Study participants (subjects) are randomly assigned to either a treatment (TX) or control (non-treatment) group.
- May be:
 - Blind: neither subject nor investigator knows which TX subject is receiving.
 - Double-blind: neither subject nor investigator knows which TX subject is receiving.
 - Non-blind: both subject and investigator know which TX subject is receiving; used when it is felt that the knowledge of treatment is unimportant.

META-ANALYSIS OF RCTS

- Quantitatively synthesizes and analyzes results of multiple primary studies addressing a similar research question
- Statistically pools results from independent but combinable studies
- Summary statistic (effect size) is expressed in terms of direction (positive, negative, or zero) and magnitude (high, medium, small)

LEVEL 2

QUASI-EXPERIMENTAL STUDY

- Always includes manipulation of an independent variable
- Lacks either random assignment or control group.

- Findings must be considered in light of threats to validity (particularly selection)

LEVEL 3

NON-EXPERIMENTAL STUDY

- No manipulation of the independent variable.
- Can be descriptive, comparative, or relational.
- Often uses secondary data.
- Findings must be considered in light of threats to validity (particularly selection, lack of severity or co-morbidity adjustment).

QUALITATIVE STUDY

- Explorative in nature, such as interviews, observations, or focus groups.
- Starting point for studies of questions for which little research currently exists.
- Sample sizes are usually small and study results are used to design stronger studies that are more objective and quantifiable.

META-SYNTHESIS

- Research technique that critically analyzes and synthesizes findings from qualitative research
- Identifies key concepts and metaphors and determines their relationships to each other
- Aim is not to produce a summary statistic, but rather to interpret and translate findings

QUALITY RATING (SCIENTIFIC EVIDENCE)

A High quality: consistent results, sufficient sample size, adequate control, and definitive conclusions; consistent recommendations based on extensive literature review that includes thoughtful reference to scientific evidence.

B Good quality: reasonably consistent results, sufficient sample size, some control, and fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence

C Low quality or major flaws: little evidence with inconsistent results, insufficient sample size, conclusions cannot be drawn.

JHNEPH Non- Research Evidence Appraisal

Author title RN, PhD, CEN	Number:
Author (s): Valdez	Date: 2008

Journal: Transitioning from Novice to Competent: What can we learn from the literature about graduate nurses in the emergency setting.

<input checked="" type="checkbox"/> Systematic Review	<input type="checkbox"/> Clinical Practice Guidelines	<input type="checkbox"/> Organizational (QI, financial data)	<input type="checkbox"/> Expert opinion, Case study, literature review
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Does review/expert opinion address my practice question?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
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If the answer is no, stop here unless there are similar characteristics

Systematic Review		
Is the question clear? How transition along the novice to expert continuum be facilitated utilizing existing theory, practice and research. • Are search strategies specified, and reproducible? Using Databasis CINAHL, SCOPUS, ProQuest Dissertation Database., key search terms included. • Are search strategies appropriate to include all pertinent studies? • Are criteria for inclusion and exclusion of studies specified? Author unable to locate any published studies that specifically address transition from novice to competent in emergency nursing practice. Are details of included studies (design, methods, analysis) presented? Qualitative, Quasi-experimental, Descriptive survey, or questionnaire, • Are methodological limitations disclosed? Author states article could not be classified as a meta-synthesis of research because non research related publications are included in the review. • Are the variables in the studies reviewed similar, so that studies can be combined	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
Clinical Practice Guidelines		
• Were appropriate stakeholders involved in the development of this guideline? • Are groups to which guidelines apply and do not apply clearly stated? • Have potential biases been eliminated? • Were guidelines valid (reproducible search, expert consensus, independent review,	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No

current, and level of supporting evidence identified for each recommendation)? • Are recommendations clear?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Organizational Experience		
• Was the aim of the project clearly stated? • Is the setting similar to setting of interest? • Was the method adequately described? • Were measures identified? • Were results adequately described? • Was interpretation clear and appropriate?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
Individual Expert Opinion, Case Study, Literature Review		
• Was evidence based on the opinion of an individual? • Is the individual and expert on the topic? • Is author's opinion based on scientific evidence? • Is the author's opinion clearly stated? • Are potential biases acknowledged?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
PERTINENT CONCLUSIONS AND RECOMMENDATIONS		
Provide effective mentors and preceptors, provide education for practicing nurse to understand challenges of novice nurses in acute care setting, provide a nurse residency program to increase job satisfaction and decrease attrition rates. Improve collaboration with academic and hospital settings to enhance clinical experience to better support development of competency in emergency nursing practice.		
Were conclusions based on the evidence presented	X <input type="checkbox"/> Yes	<input type="checkbox"/> No
Will the results help me in caring for my patients?	X <input type="checkbox"/> Yes	<input type="checkbox"/> No

Quality Rating (Scale provided)

Basic quality rating of the study under review (check one)	X <input type="checkbox"/> High (A)	<input type="checkbox"/> Good (B)	<input type="checkbox"/> Low/major flaws(C)
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Summary: The shortage of nurses initiated the hiring of new graduates into specialty care areas such as the emergency departments. A literature review revealed themes which are categorized into

two groups: culture shock, and assimilation. Implications for manager and educators showed; mentorship plays an important role to ensure the success of the novice nurse, there is a the need to understanding stressors, so there may be social support, a residency program will address educational and socialization needs of graduate nurses, and improved collaboration between academic and hospital setting is important to enhance clinical experience in acute care setting.

Themes/Recommendations:

Culture shock: New graduates are not ill prepared to transition into professional practice due to never having to assume full workload, therefore, will face challenges assuming full role and responsibility of patient care.

Work environment – Frustration with high nurse:patient ratio, unsupportive workplace culture, expectations of organization, and the inability to provide the kind of care that they have been taught.

Stress and Frustration – Other sources of stressors include: fear of independent practice, challenge of new situation, work schedule challenges, unclear expectations, and finances and student loans.

Inadequate Preparation – Feeling unprepared in situations which involve; unfamiliar nursing procedures, death and dying, organizational skills, and time management, inability to recognize subtle changes in patient condition, and communication with physician and families.

Assimilation – Major indicator of novice and advanced beginners success in clinical settings.

Mentoring – Effective mentorship and preceptorship are the defining factors in the development of self confidence and clinical competence. Care should be taken to ensure positive experience for the novice nurse.

Social support – Practicing nurses need education in understanding the needs of novice nurses. Recognition of the stress and challenges faced by novice nurses are important in creating a supportive environment for them to succeed in the acute care culture.

Orientation Process – A recognition of an orientation program based on individual needs will help support their transition into competent nurses. A nurse residency program may also decrease attrition rates, increase job satisfaction and produce confident nurses.

Strengths: Literature review was conducted utilizing a systematic review of literature. An adequate amount of scholarly literature were accessed using reliable sources such as CNAHL, SCOPUS, ProQuest Dissertations. Articles used were classified according to study methodology. Publications focused on new graduate experience. Analysis method is disclosed, method selected allows reviewer to compare and analyze text, creating new interpretations.

Limitations: Publications selected for review dated **1995** – 2007.

STRENGTH OF EVIDENCE

LEVEL 4

SYSTEMATIC REVIEW

- Research review that compiles and summarize evidence from research studies related to a specific clinical question
- Employs comprehensive search strategies and rigorous appraisal methods
- Contains an evaluation of strengths and limitations of studies under review

CLINICAL PRACTICE GUIDELINES

- Research and experiential evidence review that systematically develops statements that are meant to guide decision-making for specific clinical circumstances
- Evidence is appraised and synthesized from three basic sources: scientific findings, clinician expertise, and patient preferences.

LEVEL 5

ORGANIZATIONAL

- Review of quality improvement studies and financial analysis reports
- Evidence is appraised and synthesized from two basic sources: internal reports and external published reports.

EXPERT OPINION, CASE STUDY, LITERATURE REVIEW

- Opinion of a nationally recognized expert based on non-research evidence (includes case studies, literature review, or personal experience).

QUALITY RATING (SUMMATIVE REVIEWS)

A High quality: well-defined, reproducible search strategies; consistent results with sufficient numbers of well-designed studies; criteria-based evaluation of overall scientific

strength and quality of included studies, and definitive conclusions

B Good quality: reasonably thorough and appropriate search; reasonably consistent results, sufficient numbers of well-designed studies, evaluation of strengths and limitations of included studies, with fairly definitive results

C Low quality or major flaws: undefined, poorly defined, or limited search strategies; insufficient evidence with inconsistent results, conclusions cannot be drawn

JHNEBP Research Evidence Appraisal

Author Title: : unable to find				Number:	
Author (s): Farnell, S. & Dawson, D.				Date: 2006	
Journal: International Journal of Nursing Studies ‘It’s not like the wards’. Experiences of nurses new to critical care: A qualitative study					
Setting: Nurses starting in critical care practice Environment with experiences varying from 3 days to 6 weeks			Sample (Composition size): 14 participants		
<input type="checkbox"/> Experimental	<input type="checkbox"/> Meta analysis	<input type="checkbox"/> Quasi experimental	<input type="checkbox"/> Non experimental	<input checked="" type="checkbox"/> Qualitative	<input type="checkbox"/> Meta synthesis
Does this study apply to my patient population?				<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
If the answer is no, stop here (unless there are similar characteristics)					
Strength of study design					
Was sample size adequate and appropriate? Sample size typical of phenomenological studies have fewer than 20 participants. (p. 170) • Were study participants randomized? All nurses recruited to critical care unit were invited to participate. • Was there an intervention? One researcher conducted interview to mprove reliability of data, minor changes were require regarding phrasing the questions. • Was there a control group? • If there was more than one group, were groups equally treated, except for the intervention? Only one group • Was there adequate description of the data collection methods Audio taped semi-structured interviews at one, three, and six months.				<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
				<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
				<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
				<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Study Results					
Were results clearly presented?				<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
• Was an interpretation/analysis provided?				<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Study Conclusions					
Were conclusions based on clearly presented results?				<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
• Were study limitations identified and discussed?				<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No

PERTINENT STUDY FINDINGS AND RECOMMENDATIONS			
Educational support to provide skills and knowledge in critical care areas Strategies for socialization into critical care milieu Set realistic goals			
Will the results help me in caring for my patients?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Evidence Rating (scales on back)			
Strength of Evidence Rating		Level 3	
Quality Rating (check one)		X <input type="checkbox"/> High A)	<input type="checkbox"/> Good (B) <input type="checkbox"/> Low/major flaws(C)

QUALITY RATING (EXPERT OPINION)

A High quality: expertise is clearly evident.

B Good quality: expertise appears to be credible. **C** Low

CATEGORY: (RESEARCH, HERMENEUTIC QUALITATIVE STUDY)

Summary: The attractions of nurses who want to work in critical care areas include the desire to have more knowledge and skills and having a better nurse: patient ratio; however there many experiences which contribute to the challenges of working in these specialty areas. Experiences are related to four key themes and sub themes. Subthemes can be interrelated to other keys themes as well. Certain pre-requisites are required in order to be successfully socialized in the critical care practice environment. This study demonstrate the need for continual education and support for nurses to socialize into this type of practice environment so that they may have a positive experience and as a result provide quality care to their patient. In addition, supportive measure for socialization will decrease attrition rates.

Themes/Recommendations: Four key themes emerged from study:

Support: Support was a necessary key factor in the socialization of nurses new to critical care.

- Supernumerary period - This is the stage where the new nurse assumes the sole responsibility and care of the patient with the preceptor only as a resource person. The preceptor will not include herself in the management and care of the patient. This
- period is frightening and causes anxiety for nurses new to critical care. This experience of ‘going solo’ can provide confidence and is an important stage to becoming the team.

- Group – Friendship developed in the first three months allowed nurses to share experiences. Group cohesion allowed reflection on critical situations, which reduces feelings of isolation and improved socialization into the unit.
- Preceptorship – Effective preceptorship enhanced the socialization of nurse into the practice environment. The ability to “form a relationship between preceptor and preceptee can increase professional socialization over time” (p.324). There is a correlation between having a consistent preceptor and competency attainment. Competency ensures best practice and limiting ritualistic practice (p. 324).
- Staff – Treatment by other staff had a significant impact on experience and socialization. Positive experiences included staff being friendly and able to give constructive feedback. Staff treatment of new nurses contribute to the learning experiences of nurses new to this practice environment.
- Shift pattern - Providing consistent patterns of shifts (Days) would provide a better learning environment. This would reduce the stress levels of novice staff, so that novice staff would learn the routines of a specific shift rather than learning routines of multiple shifts at one time. Having consistent preceptors in this instance would present a challenge as regular staff remain to work their regular schedule of alternating shifts.
- Allocation – The choice of which patient assignment to take were challenging when asked because the knowledge and skills needed, based on patient illness , can sometime be unknown at the time.

Knowledge and skill: Experiences were related to the knowledge and skill of individual nurse.

- So much to learn – Foundational knowledge is important to have prior to starting in critical care areas. This can directly impact their confidence level and socialization into the practice environment. Specialty education is necessary to provide the theoretical frameworks and clinical skills needed for effective care; however, there should be realistic expectation of a novice nurse in specialty areas such as critical care.
- Foundation Programme – A foundation program is needed to provide a framework for structured learning and prepares participants for practice in critical care. Clinical

- supervision provided a 'safety net' to learn. Opportunities to share learning needs and discuss problems reinforced learning.
- Challenged - Increased knowledge challenged nurses to exercise their critical thinking abilities leading to a more autonomous nursing practice.

Socialization – Experiences of participants have an impact on their socialization to critical care environment.

- So different – 'Reality shock'. Participants discover how different it is than working on the ward, patients acuity of illness and expectations of roles and responsibilities can be overwhelming
- Deskilled – participants discover knowledge and skills are 'domain specific'. Nurses who function independently and with confidence in one practice environment, may not function the same way in another.
- High expectations – Participants reflected on their sense of guilt of not having the knowledge and skills within a short period of time. Ensuring participants understand realistic expectations are important when beginning practice in this environment.
- Labelling - Derogatory terms undermine novice nurses and novice nurses being socialized into the critical care environment need to be reminded that these terms impeded progression and development of learning of future novice nurses.

Moving on – Adapting to the culture of the unit facilitated socialization to the unit.

- Good days – Nurses experience good and bad days between the three and six months. Collegial support affects clinical performance and can ultimately affect the attrition.
-
- Confidence – The consolidation of skills and knowledge over time developed confidence in abilities.

-Conscious incompetence – This is the stage when novice nurses in practice area are able to discern between what they know and what they do not and the understanding to ask for help.

Strengths: Captures experiences of novice nurses in specialty care areas.

Description of Ethical approved was included (confidentiality and anonymity was maintained).

Researchers were experienced critical care nurses and were able to use previous experience to understand and interpret participant's experiences (Hermeneutic phenomenology).

The method of independent analysis was thought to improve objectivity of research findings.

Limitations: 20% attrition rate from new graduate nurse group, there was a variety of orientation programmes, and the limited length of service in experienced nurse group.

STRENGTH OF EVIDENCE

LEVEL 1 (HIGHEST)

EXPERIMENTAL STUDY (RANDOMIZED CONTROLLED TRIAL OR RCT)

- Study participants (subjects) are randomly assigned to either a treatment (TX) or control (non-treatment) group.
- May be:
 - Blind: neither subject nor investigator knows which TX subject is receiving.
 - Double-blind: neither subject nor investigator knows which TX subject is receiving.
 - Non-blind: both subject and investigator know which TX subject is receiving; used when it is felt that the knowledge of treatment is unimportant.

META-ANALYSIS OF RCTS

- Quantitatively synthesizes and analyzes results of multiple primary studies addressing a similar research question
- Statistically pools results from independent but combinable studies
- Summary statistic (effect size) is expressed in terms of direction (positive, negative, or zero) and magnitude (high, medium, small)

LEVEL 2

QUASI-EXPERIMENTAL STUDY

- Always includes manipulation of an independent variable
- Lacks either random assignment or control group.
- Findings must be considered in light of threats to validity (particularly selection)

LEVEL 3

NON-EXPERIMENTAL STUDY

- No manipulation of the independent variable.
- Can be descriptive, comparative, or relational.
- Often uses secondary data.

Findings must be considered in light of threats to validity (particularly selection, lack of severity or co-morbidity adjustment).

QUALITATIVE STUDY

- Explorative in nature, such as interviews, observations, or focus groups.
- Starting point for studies of questions for which little research currently exists.

- Sample sizes are usually small and study results are used to design stronger studies that are more objective and quantifiable.

META-SYNTHESIS

- Research technique that critically analyzes and synthesizes findings from qualitative research
- Identifies key concepts and metaphors and determines their relationships to each other
- Aim is not to produce a summary statistic, but rather to interpret and translate findings

QUALITY RATING (SCIENTIFIC EVIDENCE)

A High quality: consistent results, sufficient sample size, adequate control, and definitive conclusions; consistent recommendations based on extensive literature review that includes thoughtful reference to scientific evidence.

B Good quality: reasonably consistent results, sufficient sample size, some control, and fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence

C Low quality or major flaws: little evidence with inconsistent results, insufficient sample size, conclusions cannot be drawn.

JHNEBP Research Evidence Appraisal

Author Title: : MN, RN, FCCM				Number:	
Author (s): Duchscher, J.E.				Date Sept. 2001	
Journal: Out in the Real World: Newly graduated nurses in acute care speak out					
Setting: New graduates in acute care hospital			Sample (Composition size): 5 New graduates		
<input type="checkbox"/> Experimental	<input type="checkbox"/> Meta analysis	<input type="checkbox"/> Quasi experimental	<input type="checkbox"/> Non experimental	<input checked="" type="checkbox"/> Qualitative	<input type="checkbox"/> Meta synthesis
Does this study apply to my patient population?				<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
If the answer is no, stop here (unless there are similar characteristics)					
Strength of study design					
Was sample size adequate and appropriate? Recommendation of 6 participants for phenomenological studies • Were study participants randomized? Purposive sampling • Was there an intervention? Subjectivity of interviewer indirectly instilled conceptual bias into interview although rigorous attempt were made to ensure participants directed course of interview. • Was there a control group? • If there was more than one group, were groups equally treated, except for the intervention? Only one group • Was there adequate description of the data collection methods. It was a longitudinal study, which collects data from the same group at different points in time (2months commencing practice, and 6 months later). Data was obtained using a nonstandard, semistructured interview. Initial interview was audiotaped within 2 months of new grads commencing practice and final interview audiotaped 6 month after. Participants used reflective journaling, informal note taking and photos that embodied participant's experience.				<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> No <input type="checkbox"/> No
Study Results					
Were results clearly presented?				<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
• Was an interpretation/analysis provided?				<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Study Conclusions					

Were conclusions based on clearly presented results? • Were study limitations identified and discussed?	X <input type="checkbox"/> Yes	<input type="checkbox"/> No
	X <input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>PERTINENT STUDY FINDINGS AND RECOMMENDATIONS</p> <ul style="list-style-type: none"> - Recognition of intensity of new nurses experiences - Connect new graduates with 6 month mentor - Consider initiatives for nurse transition to be 6 months – 1 year - Orientation period of 2 weeks with ½ workload - Access to practice assistance 		
Will the results help me in caring for my patients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Evidence Rating (scales on back)		
Strength of Evidence Rating	Level 3	
Quality Rating (check one)	X <input type="checkbox"/> High A)	<input type="checkbox"/> Good (B) <input type="checkbox"/> Low/major flaws(C)

JHNEPH Research Evidence Appraisal

Author Title: MS, RN, PhD, FAAN, AOCN, BSN				Number:	
Author (s) : Casey, K., Fink, R., Krugman, M., & Propst, J.				Date 2004	
Journal: Journal of Nursing Administration, The Graduate Nurse Experience					
Setting: New graduates from 6 acute care facilities			Sample (Composition size): 270 new graduates		
<input type="checkbox"/> Experimental	<input type="checkbox"/> Meta analysis	<input type="checkbox"/> Quasi experimental	<input checked="" type="checkbox"/> Non experimental	<input type="checkbox"/> Qualitative	<input type="checkbox"/> Meta synthesis
Does this study apply to my patient population?				<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
If the answer is no, stop here (unless there are similar characteristics)					
Strength of study design					
<p>Was sample size adequate and appropriate?</p> <p>A total of 784 surveys were distributed; 270 respondents agreed to participate (34% response rate). Convenience sample (non random). Major disadvantage of a convenience sample is risk of bias is greater than in any other type of sample because it uses voluntary participation. Bias is related to information only from people who volunteer to participate (Lobiondo-wood & Haber, p. 259). Selection bias and low response rate makes one question how are the participants who chose to participate different from those who did not. Non random samples tend to have less generalizability of finding beyond the actual study sample.</p>				<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<p>Were study participants randomized? Convenience sample (non random) of new graduates from 6 acute care facilities, participants were recruited by asking all new graduate nurses to voluntarily complete a survey.</p>				<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<p>• Was there an intervention? Survey questionnaire</p> <p>• Was there a control group?</p> <p>• If there was more than one group, were groups equally treated, except for the intervention?</p> <p>• Was there adequate description of the data collection methods?</p>				<input type="checkbox"/> Yes <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
<p>A descriptive comparative study using a survey questionnaire was used to study graduate nurse experiences in 6 institutions during timed data periods in first of of practice. In phase 1, Surveys were</p>					

distributed to various cohorts of new graduates at 6 acute care facilities from June 1999 – July 2001. In phase 2, a revised survey (to better measure work environment issues) was distributed to graduate nurses at the academic teaching hospital who were entering an expanded graduate nurse residency program.				
Study Results				
Were results clearly presented?		X <input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Was an interpretation/analysis provided?		X <input type="checkbox"/> Yes	<input type="checkbox"/> No	
Study Conclusions				
Were conclusions based on clearly presented results?		X <input type="checkbox"/> Yes	<input type="checkbox"/> No	
• Were study limitations identified and discussed? Low response Rate (34%)		X <input type="checkbox"/> Yes	<input type="checkbox"/> No	
PERTINENT STUDY FINDINGS AND RECOMMENDATIONS				
<p>Recommendation: New graduates require consistent support and professional development during the first year of practice. Suggestions include close partnership between academic and practice institutions and formal nurse residency program to develop into their professional role.</p> <p>-</p>				
Will the results help me in caring for my patients?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Evidence Rating (scales on back)				
Strength of Evidence Rating		Level 3		
Quality Rating (check one)		<input type="checkbox"/> High A)	X <input type="checkbox"/> Good (B)	<input type="checkbox"/> Low/major flaws(C)

CATEGORY: RESEARCH STUDY (SURVEY – Descriptive, comparative design) NON EXPERIMENTAL)

Summary: It is not uncommon for new graduates to experience feeling of inadequacy when entering the profession. Role adjustment period for a new graduate is 6 months to 1 year. A descriptive comparative design using a survey questionnaire method presented challenges of a new nurse graduate.

Theme/Recommendations: Themes regarding challenges and the new graduates’ experience include:

Skills and procedure performance – Very few graduates were comfortable performing all skills and procedures even after one year of practice.

Comfort and confidence – New graduates were not confident communicating with interns and residents, but gained confidence between 6 months and 1 year. 100% of new graduates were uncomfortable caring for dying patients.

Job Satisfaction – New graduates are unhappy with items related to salary, benefits, and work schedules.

Open ended questions permitted the graduate nurse to voice personal experiences, 6 themes identified were: - Lack of confidence with skill performance, deficits in critical thinking and clinical knowledge.

- Relationships with peers and preceptors
- Struggles with dependence on others
- Frustration with work environment
- Organization and priority-setting skills
- Communication with physicians.

Strengths: Methods, sample and setting well laid out. A variety of clinical areas were included. The Casey-Fink Graduate Nurse Experience Survey was revised to measure the new graduate nurse's experience. Tool was piloted and tested for content validity using an expert panel in academic and private sector. Research was approved by the appropriate institutional review boards. Sample was obtained from 270 new graduated nurses from various acute care facilities, academic teaching hospital, and private facilities.

Limitations: Sample was only from the Denver metropolitan area. Surveys distributed only had 34% response rate which can affect validity of results. Tool was revised many times and the format/structure did not facilitate ease of administration and analysis. Quantitative and qualitative section intermixed, making the tool difficult

STRENGTH OF EVIDENCE

LEVEL 1 (HIGHEST)

EXPERIMENTAL STUDY (RANDOMIZED CONTROLLED TRIAL OR RCT)

Study participants (subjects) are randomly assigned to either a treatment (TX) or control (non-treatment) group.

• May be:

- Blind: neither subject nor investigator knows which TX subject is receiving.
- Double-blind: neither subject nor investigator knows which TX subject is receiving.
- Non-blind: both subject and investigator know which TX subject is receiving; used when it is felt that the knowledge of treatment is unimportant.

META-ANALYSIS OF RCTS

- Quantitatively synthesizes and analyzes results of multiple primary studies addressing a similar research question
- Statistically pools results from independent but combinable studies
- Summary statistic (effect size) is expressed in terms of direction (positive, negative, or zero) and magnitude (high, medium, small)

LEVEL 2

QUASI-EXPERIMENTAL STUDY

- Always includes manipulation of an independent variable
- Lacks either random assignment or control group.
- Findings must be considered in light of threats to validity (particularly selection)

LEVEL 3

NON-EXPERIMENTAL STUDY

- No manipulation of the independent variable.
- Can be descriptive, comparative, or relational.
- Often uses secondary data.
- Findings must be considered in light of threats to validity (particularly selection, lack of severity or co-morbidity adjustment).

QUALITATIVE STUDY

- Explorative in nature, such as interviews, observations, or focus groups.
- Starting point for studies of questions for which little research currently exists.
- Sample sizes are usually small and study results are used to design stronger studies that are more objective and quantifiable.

META-SYNTHESIS

- Research technique that critically analyzes and synthesizes findings from qualitative research
- Identifies key concepts and metaphors and determines their relationships to each other
- Aim is not to produce a summary statistic, but rather to interpret and translate findings

QUALITY RATING (SCIENTIFIC EVIDENCE)

A High quality: consistent results, sufficient sample size, adequate control, and definitive conclusions; consistent recommendations based on extensive literature review that includes thoughtful reference to scientific evidence.

B Good quality: reasonably consistent results, sufficient sample size, some control, and fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence

C Low quality or major flaws: little evidence with inconsistent results, insufficient sample size, conclusions cannot be drawn.

Appendix C

Strength of Evidence Table

Article Reference	Strength of Evidence (Research Articles Only)	Quality Rating
Boyчук Duchscher, J.E., & Cowin, L.E., (2004). The experience of marginalization in new nursing graduates, <i>Nursing Outlook</i> , 52(6), 289-296.	N/A	A
McKenna, B.G., Smith, N.A., Poole, S.J., & Coverdale, J.H. (2003). Horizontal violence: experiences of Registered Nurses in their first year of practice. <i>Journal of Advanced Nursing</i> , 42(1), 90-96.	3	B
Boyчук Duchscher, J.E. (2009). Transition shock: The initial stage of role adaptation for newly graduated Registered Nurses. <i>Journal of Advanced Nursing</i> , 65(5),	N/A	A

1103-1113.		
Dyess, S.M. & O'Sherman, R. (2009). The first year of practice: New graduate nurses' transition and learning needs. <i>The Journal of Continuing Education in Nursing, 40</i> (9), 403-410.	3	A
Valdez, A.M. (2008). Transitioning from novice to competence: What can we learn from the literature about graduate nurses in the emergency setting. <i>Journal of Emergency Nursing, 34</i> (5), 435-440.	N/A	A
Farnell, S., & Dawson, D. (2006). It's not like the ward: Experiences of nurses new to critical care: A qualitative study. <i>International Journal of Nursing Studies, 43</i> , 319-331.	3	A

<p>Boychuk Duchscher, J.E. (2001). Out in the real world: Newly graduated nurses in acute care speak out. <i>Journal of Nursing Administration</i>. 31(9), 426-439.</p>	<p>3</p>	<p>A</p>
<p>Casey, K., Fink, R., Krugman, M., & Propst, J. (2004). The graduate nurse experience. <i>Journal of Nursing Administration</i>, 34(6), 303- 311.</p>	<p>3</p>	<p>B</p>

Appendix D

AN ORIENTATION PROGRAM FOR NEW GRADUATES WORKING IN THE EMERGENCY DEPARTMENT: CURRICULUM BLUEPRINT

Curriculum Goal

The purpose of this orientation program is build upon prior knowledge, skills, and experiences of new graduates to prepare them to practice competent and safe nursing as a novice nurse in the emergency department.

Curriculum Description

This is a 12 week orientation program to prepare new graduates with a foundational program in emergency nursing to practice in the emergency department at a novice level. Facilitation of learning is provided in a theoretical framework grounded in constructivist learning theory and incorporates strategies that are interactive, engaging, and dynamic. Utilizing Finks taxonomy will provide the learner to understand theories and concepts which he/she can apply and integrate into practice.

Objectives

To prepare new graduates into their professional role as advance beginners in the emergency practice environment.

- Orientation provided for individual learning needs
- Orientation provided opportunities to practice new skills
- Staff and educators provided consistent feedback
- Selected patient assignment based on level of development
- Orientation provided a gradual ease into the structure of the emergency department
- Opportunities to socialize with staff to exchange perspective of challenges.

Content (See Appendix D)

Learner Outcomes

- Development of critical care thinking skills
- Ability to intervene during change of patient status
- Prioritize care based on patient presentation
- Application and integration of theory to practice
- Management of a full patient assignment in acute care areas

Appendix E

Teaching/Learning Strategies for Each Dimension of Learning

Foundational Knowledge (understanding, remembering)	Didactic lecture, power point presentation, guest speakers, group discussions, review knowledge and skills.
Application (critical thinking, performing skills)	Assessment and skill practice, simulations, case studies, role-playing, seek and find scenarios (PBL), guided practice of new skills, exposure to new skill experiences.
Integration (connecting ideas)	Simulation exercises, anticipation of lab work/ treatment/diagnosis of ER patient, case studies.
Human Dimension (Leadership, ethics, teamwork; social, cultural, political)	Ethical issues – Narratives, story telling, role play. Family witness resuscitation – Case studies, narratives, story- telling, small group discussions. Cultural safety - Narratives, story telling, role playing. Interpersonal conflict - - Guest speakers (staff), role play.
Caring (wanting to succeed, developing a keen interest, making a commitment).	Reflective writing, positive reinforcement, self selected learning activities, helping others succeed.
Learning to learn (becoming a better learner, inquiring & constructing knowledge, being self directed).	Self evaluations, peer feedback, reflective writing, formative assessments, self reflective exercises, develop own learning plan.

Appendix F

Modules

Module 1 – Assessment and management of nausea and vomiting related to ED patients

Module Overview:

Vomiting is a common presenting complaint in the emergency department and can be a symptom of more significant concerns, or be the primary issue. Regardless, it is distressing and can lead to many potential complications.

Module 1 provides new graduates with skills to do a thorough assessment of patients presenting with nausea and vomiting. The nurse will identify various disorders associated with nausea and vomiting, potential complications, anticipate, treat and evaluate patient care. A review of the triage history will help focus their assessment.

Assumptions/pre-requisites:

Basic knowledge of general disorders associated with nausea and vomiting.

Knowledge of common pharmacological intervention

Understanding of normal/abnormal lab values

Potential complications associated with nausea and vomiting.

Assessment/Planning/Interventions:

Focused assessment of patient, including history (ie pregnancy, head injuries, overdose, poisoning) and physical examination (vital signs, lethargy, level of consciousness)

Protocol for initiation of Intravenous fluids including cautions and complications

Complications associated with vomiting. Ie metabolic alkalosis, electrolyte depletion, esophageal or gastric bleeding,

Consideration given to families (involve in care, discussions, give info.)

Ethnic and minority considerations

Ethical/Moral Challenges

Learning objectives

Foundational Knowledge provides the basic understanding that is necessary for other kinds of learning (Fink, 2003).

Integration is the act of making new connections which gives learners a new form of power, especially intellectual power (Fink, 2003).

Assess patients for complications.

Recognize symptoms of fluid overload (elderly) Recognize the importance of ongoing communication to healthcare team in regards to patient condition.

Demonstrate comfort care

Involve family members in decisions of care regarding discharge planning and discharge instructions.

Module 2 – Assessment and Management of Abdominal Pain related to ED patients

Module Overview:

Patients presented with abdominal pain in the ER are the most challenging endeavors nurses and Emergency Room Physicians can undertake. A thorough abdominal pain assessment can identify potential life threatening conditions, but can be complicated by a diagnosis of non specific (abdominal pain not yet diagnosed). Chronic abdominal pain can be a frustrating experience for the patient and can require proper management.

Module 2 provides the new graduate with an understanding and awareness that abdominal pain can present with a diagnosis of life threatening to trivial. A review of the triage history will help focus assessment, management, and treatment.

Assumptions/Pre-requisites:

Basic knowledge of anatomy and physiology of abdomen and pelvis

Basic knowledge of pathophysiology in concepts of altered health states

Understanding of basic normal/abnormal lab values

Common causes of abdominal pain (appendicitis, renal colic, ectopic pregnancy)

Potential complications associated with abdominal pain

Assessment/Planning/Interventions:

Focus assessment of abdominal pain, including history taking using the mnemonic LOTARP (Location, Onset, Type, Aggravating factors, Relieving factors, Precipitating factors), or PQRST (Provoking factors, Quality of pain, Radiation of pain, Severity of symptoms, Timing or Triggers of pain) to assess origins of pain.

Begin critical thinking around assessment, history, and presentation of patients with abdominal pain to anticipate complications and identify life-threatening conditions.

Anticipate lab work based on assessment and significance of findings. Protocol for CT (Computerized Tomography), U/S (Ultrasound).

Protocols: CT, U/S, IV initiation

Policies of charting and vital signs in the emergency department.

Infection protocols + concerns: VRE (Vancomycin Resistant Enterococci) or MRSA (Methicillin Resistant Staphylococcus Aureus). contact isolation, C-Diff (C-Difficult bacteria)

Significant population considerations: Women of child bearing age: Assessment for potential of pregnancy and bleeding.

Policy regarding point-of-care

Assessment specifics related to determining gestational age.

Delivery in the emergency department.

-understanding role, responsibilities, initial care of the newborn

Begin process of critical thinking around presentation, assessment and care of women with potential miscarriage and ectopic pregnancies related to care, potential for deterioration and specific psychosocial needs.

Care of products of conception- aware of institutional policy based on the age of the fetus
Assessment and preparation of surgical candidate

Surgical preparation: Consent, pre-op meds, Large bore Intravenous

Consideration given to families in regards to care as well as discharge instructions.

Ethnic and minority considerations

Ethical/moral challenges

Learning Objectives:

Foundational knowledge provides the basic understanding that is necessary for other kinds of learning (Fink, 2003).

Application learning allows other kinds of learning to become useful (Fink, 2003).

Learning how to learn enables students to continue learning in the future and to do so with greater effectiveness (Fink, 2003).

Thorough assessment of abdominal pain, it can help to distinguish between acute and chronic conditions and predict potential complications associated with abdominal pain.

Demonstrate an understanding of policies and protocols in regards to imaging tests, lab work, charting, and consent for surgical cases.

Involve families in decision- making and share information to decrease fear and anxiety.

Recognize the importance of ongoing communication to health care team in regards to patient condition.

Module 3 – Assessment and management of chest pain as they relate to ER patients

Module Overview:

The complaint of chest pain is one of the most complex problems faced by physicians and nurses in the emergency department. Understanding cardiac vs non-cardiac presentation is essential to ensuring proper care. The evaluation of patient's chest pain can be complicated by multiple factors including anxiety of the patient and family.

The evaluation of which can be complicated by multiple factors.

Module 3 provides the nurse with knowledge that chest pains can have various diagnoses. Recognizing signs and symptoms that are potentially life-threatening can prevent poor outcomes. Concerns of patient and families must be addressed to decrease anxiety and apprehension.

This module will be part 1 of 2 modules on caring for patients with chest pain and will cover significant assessment findings, potential complications. Part 2 will be covered in the second stage of orientation that will cover more specifics around the care of life-threatening cardiac presentations and monitoring parameters for the critically ill.

Assumptions/Pre-requisites:

Knowledge of anatomy and physiology

Basic knowledge of pathophysiology in concepts of altered health states

Understanding of basic normal/abnormal lab values

Possible causes of chest pain: Myocardial Infarct (MI), pneumothorax, gastric reflux, strained muscle, pneumonia, fractured rib.

Risk factors associated with MI (hypertension, obesity, Cholesterol, Diabetes)

Assessment/Planning/Interventions:

Focus assessment of chest pain using LOTARP (Location, Onset, Type, Aggravating factors, Relieving factors, Precipitating factors, or PQRST(Provoking factors, Quality of pain, Radiation of pain, Severity of symptoms, Timing or Triggers of pain)

Discuss importance of thorough history taking

Protocols: Intravenous initiation, lab work, Oxygen initiation, Nitroglycerin/ASA protocol

Policies of charting and vital signs in the emergency department.

Begin development of critical thinking based on assessment of chest pain, history, comorbidities and presentation and relate to cardiac vs non-cardiac presentations. ,

Identify specific lab test, imaging test used for chest pain. (chest x-ray, computerized tomography (CT)

Consideration given to families in regards to care as well as discharge instructions**Ethnic and minority considerations****Ethical/moral challenges****Learning Objectives:**

Foundational knowledge provides the basic understanding that is necessary for other kinds of learning (Fink, 2003).

Application learning allows other kinds of learning to become useful (Fink, 2003).

Human Dimension informs students about the human significance of what they are learning (Fink, 2003).

Thorough assessment of chest pain differentiates between stable and unstable conditions. Demonstrate an understanding policies and protocols in regards to imaging tests, lab work, and charting.

Involve families in decision making, understanding fear of families and providing information to decrease fear and anxiety.

Recognize the importance of ongoing communication to healthcare team in regards to patient condition.

Module 4 – Assessment and Management of Dyspnea as they relate to ED patients**Module Overview:**

Assessment of dyspnea is considered according to the pathophysiologic origins of the symptoms. Differentiation between mild, moderate, and severe dyspnea are addressed. An awareness of potential complications associated with dyspnea can help new grads develop critical thinking skills for treatment and management.

Module 4 will provide new grads with the ability to assess mild and moderate dyspnea. The new grad will start to develop critical thinking skills and implement knowledge to situation bridging theory and practice.

Assumptions/Pre-requisite

Basic knowledge of anatomy and physiology

Basic knowledge of pathophysiology in concepts of altered health states

Understanding of basic normal/abnormal lab values

Common causes of dyspnea (asthma, pneumonia, allergies, injuries, congestive heart failure, pulmonary embolus)

Potential complications associated with dyspnea

Understanding and proficiency in basic life support.

Assessment/Planning/Interventions:

Focus assessment of dyspnea

Knowledge of underlying disorders and significant history findings

Recognition of urgent interventions: intravenous, oxygen, basic life support, basic airway management skills (Open airway, Jaw thrust, suctioning)

Protocols: Asthma and anaphylaxis

Infection control concerns: Droplet isolation, N95 masks, Influenza-like-illness (ILI) assessment, management and potential epidemics

Policies of charting and vital signs in the emergency department.

Consideration given to families in regards to care as well as discharge instructions

Ethnic and minority considerations

Potential ethical and moral challenges**Learning Objectives:**

Foundational knowledge provides the basic understanding that is necessary for other kinds of learning (Fink, 2003).

Application learning allows other kinds of learning to become useful (Fink, 2003).

Integration is the act of making new connections which gives learners a new form of power, especially intellectual power (Fink, 2003).

Assessment of dyspnea differentiates between stable and unstable conditions.

Understanding policies and protocols in regards to asthma, allergies, lab tests, imaging tests.

Involve families in decision making and providing information to decrease fear and anxiety.

Recognize the importance of ongoing communication to healthcare team in regards to patient condition.

Module 5 – Assessment and Management of Fever as they Relate to ED patients**Module Overview:**

Patients with a chief complaint of a fever are another common presentation in the emergency department. Evaluation and treatment of fever vary depending on onset and duration and nature of the fever. Fever can also be another underlying illness.

Module 5 will provide new graduate with an understanding of etiologies of fever. New trends and treatment will be discussed as well as evaluation and treatment that vary dramatically with patient age and weight.

Assumption/Pre-requisite:

Basic knowledge of anatomy and physiology

Basic knowledge of pathophysiology in concepts of altered health states

Understanding of basic normal/abnormal lab values

Common causes of fever

Potential complications associated with fever

Assessment/Planning/Interventions:

Focused assessment of fever, methods of measurement and importance of searching for potential source thru thorough patient assessment

Policies of charting and vital signs in the emergency department.

Red flags: Meningitis, rash, SOB, low BP, immunocompromised

Infection concerns: airborne isolation

Septic protocol

Nurse initiated protocols: Lab and intravenous initiation; Acetaminophen protocol

Consideration given to families in regards to care as well as discharge instructions

Ethnic and minority considerations

Potential ethical and moral challenges

Learning Objectives:

Foundational knowledge provides the basic understanding that is necessary for other kinds of learning (Fink, 2003).

Application learning allows other kinds of learning to become useful (Fink, 2003).

When students care about something, they then have the energy they need for learning more about it and making it part of their lives (Fink, 2003).

Determine between stable and unstable conditions. Understanding nurse initiated protocol for mild pain and fever.

Evaluation of fever after Tylenol po.

Discharge instructions including teaching to families in treatment of fever.

Recognize the importance of ongoing communication to healthcare team in regards to patient condition.

Identify ways to be able to help others fulfill their educational and other needs.

Module 6- Assessment and Management of Mental Health Concerns as they Relate to ED patients**Module Overview:**

The ED frequently encounters patients experience psychiatric concerns. The challenge lies in recognizing the subtle clues of underlying psychosocial distress, separating organic illness from functional illness or determining the complex role both play in an individual (Rosen, Barkin, Braen, Dailey, Hedges, Hockberger, Levy, Marx, & Smith, 1993).

Module 6 will provide new graduates with the understanding of mental health and mental illness and the role these problems play in the lives of patients. In addition the new grad will demonstrate an understanding of how mental health illness can affect patients and families lives.

Assumption/Pre-requisite:

Knowledge of anatomy and physiology

Knowledge of pathophysiology in concepts of altered health states

Basic knowledge of mental illness

Understanding of basic normal/abnormal lab values

Common mental disorders (depression, suicidal, agitation, anxiety)

Common pharmacological treatment for depression, suicidal, agitation, anxiety

Assessment/Planning/Interventions:

Essentials for establishing a rapport with patient and family

Importance of a full medical assessment: includes history (psych and medical), trauma, recent illness, inquiry regarding drugs and ethanol use.

Toxicology screens

Potential physical concerns that could mimic psychiatric illness (what you do not want to miss)

Recognize safety issues: contracts for safety with patient, safety of staff

Awareness of mental health policies

Mental health certificates

- Levels of observation and use of on site security
- Restraint policy, including specifics in their use

Importance of confidentiality

Consideration given to families in regards to care as well as discharge instructions

Ethnic and minority considerations

Potential ethical and moral challenges

Learning Objectives:

Foundational knowledge provides the basic understanding that is necessary for other kinds of learning (Fink, 2003).

Human Dimension informs nurses about the human significance of what they are learning (Fink, 2003).

To recognize, treat, and manage patient with mental disorders and to develop a rapport to understand how mental disorders can impact the lives of patient and families.

To advocate for patients, communicate with families, and share resources that families can access.

Collaborate with interdisciplinary teams rolls in providing care for patients with psychiatric illness

Explore issue of confidentiality in relation to caring for patients with psychiatric illness Explore challenges in caring for patients with psychiatric illness

Advocate for quality patient care and assist families in dealing with mental health concerns.

Give examples of discharge teaching that will be provided to the patient upon discharge.

Recognize the importance of ongoing communication to Healthcare team in regards to patient condition.

Module 7- Assessment and Management of Ocular injuries as they Relate to ED patients

Module Overview:

Ocular complaints and injuries are frequent cause of visits to the emergency department. Nursing staff need to be able to respond to the urgent nature of the complaint such as chemical

burns or loss of vision. At times therapeutic interventions must be simultaneously done with history taking to avoid complications.

Module 7 will provide the new graduate with the recognition of common ocular injuries, treatment and management.

Assumptions:

Knowledge of structure and function of the eye

Knowledge of common eye disorders (bruising, corneal abrasions, foreign body, pink eye, allergies)

Assessment/Planning/Interventions:

Assessment of visual acuity and pupil exams

Identifying significant history that could relate to eye injury: potential chemical exposure, welders, sports related

Infections concerns: Contagious eye infections

Nurse initiated protocols: irrigation, pH testing, eye drops

Therapeutic strategies -

cold compresses -

irrigation -

patching

Consideration given to families in regards to care as well as discharge instructions

Learning Objectives:

Application learning allows other kinds of learning to become useful (Fink, 2003).

Recognize common causes of ocular complaints, and be able to predict treatment and management options in the emergency department.

Differentiate between minor eye complaints and those requiring immediate treatment and medical intervention.

Describe and demonstrate how to assess eye injuries.

Provide examples of discharge teaching that will be provided to the patient upon discharge.

Recognize the importance of ongoing communication to healthcare team in regards to patient condition.

Module 8 – Assessment and Management of Sore throat as they relate to ED patients

Module Overview:

Sore throats are a frequent cause of visits to the emergency department. New graduates need to be knowledgeable of the common causes and treatment of sore throat and recognize potential complications that can be associated with sore throat.

Assumptions/Pre-requisite

Knowledge of structure and function of airway

Knowledge of pathophysiology in concepts of altered health states

Common causes of sore throats (viral, laryngitis)

Understanding of basic normal/abnormal lab values

Common pharmacological treatment

Assessment/Planning/Interventions:

Assessment of potential for airway compromise:- shortness of breath, Swallowing difficulties, Epiglottitis

Pain assessment and management

Thorough history taking regarding recent illness, surgery

Consideration given to families in regards to care as well as discharge instructions

Learning Objectives:

Foundational knowledge provides the basic understanding that is necessary for other kinds of learning (Fink, 2003).

Illustrate common causes of patient complaints of sore throat

Recognize symptoms indicating more serious conditions with the presentation of a sore throat

Describe treatment and management of sore throats.

Give examples of discharge teaching that will be provided to the patient upon discharge.

Recognize the importance of ongoing communication to healthcare team in regards to patient condition.

Module 9 – Assessment and Management of Nose Bleeds as they relate to the ED patients

Module Overview:

Nosebleed can present in ED caused by a minor localized trauma; however, some of the causes can be due to hypertension, atherosclerosis, coagulopathy, foreign body, tumor, atmospheric changes, or exposure to caustic material in the air.

Module 9 will provide the new grad with knowledge of common causes, treatment, and management of nose bleeds. Venous and arterial bleeds will be discussed and coagulation panels will be reviewed.

Assumptions/Pre-requisites

Knowledge of structures and functions of the nose/airway

Common causes of nose bleeds

Understanding of basic normal/abnormal lab values

Common pharmacological treatment

Assessment/Planning/Interventions:

Assessment of epistaxis in relation to duration and type of nose bleed

Nurse initiated protocols: ice packs, first-aid management

Significant patient history related to use of anticoagulants, ethanol abuse, cocaine abuse, recent surgery and history of previous epistaxis
Common strategies for addressing epistaxis: nasal packing (anterior vs posterior)

Pain management: narcotics, sedation, topical

Evaluation of treatment

Learning Objectives:

Foundational knowledge provides the basic understanding that is necessary for other kinds of learning (Fink, 2003).

Describe treatment and management of epistaxis

Differentiate between venous and arterial epistaxis and predict treatment options.

Identify contributing factors to epistaxis that can exacerbate condition

Give examples of discharge teaching that will be provided to the patient upon discharge.

Recognize the importance of ongoing communication to Healthcare team in regards to patient condition.

Module 10 – Assessment and Management of Musculoskeletal Injuries as they Relate to the ED patient**Module Overview:**

Patients with orthopedic and non traumatic musculoskeletal complaints represent a large portion of emergency visits. Management and treatment of common injuries will prevent potential complications.

Module 10 will provide the new grad with knowledge of common causes, treatment, and management of common musculoskeletal injuries. An overview of splinting techniques and acute pain management as well as assess circulation of limbs will prevent potential complication associated with these injuries.

Assumptions/Pre-requisite

Knowledge of anatomy and physiology

Knowledge of pathophysiology in concepts of altered health states

Common musculoskeletal injuries

Common pharmacological and surgical treatment

First Aid

Assessment/Planning/Interventions:

Focused assessment of limb injuries: CWMS (color, warmth, movement, sensation) CSMT (capillary refill, sensation, motor function, and temperature) 5 P's (pain, pallor, pulselessness, paraesthesia, and paralysis) and the determination of arterial vs venous bleeding

Nurse initiate treatment: Use of ice packs, slings, splints

Nurse initiated protocols: Analgesic, IV initiation, nurse initiated xrays, entonox

Use of sedation scale

Conscious sedation protocol: what it is used for, nurses roles and responsibilities

Discharge planning and instructions: Cast care, dressing and suture management, crutches

Basics of wound care and management

Special considerations: Chemical burns and treatment

-Importance of Decontamination protocol

Consideration given to families in regards to care as well as discharge instructions**Ethnic and minority considerations****Potential ethical and moral challenges****Learning Objectives:**

Application learning allows others kinds of learning to become useful (Fink, 2003).

This kind of learning informs students about the human significance of what they are learning (Fink, 2003).

Predict a plan of care based on the assessment of musculoskeletal injuries.

Assess what situations would require immediate intervention

Describe comfort measures that could be used to alleviate pain or distress

Explain situations requiring decontamination and nurses role in procedure

Formulate a plan to protect self and staff from potential contamination from toxic materials

Recognize the importance of ongoing communication to healthcare team in regards to patient condition.

Module 11 – Management of Death in the ED**Module Overview:**

Death is a traumatic event in the ED for emergency personnel, patients, and families. Our role as nurses in the emergency department is to alleviate suffering, but in times of unexpected death of patients, it is important to understand various responses of grief exhibited by different cultural and ethnic groups.

Module 11 will provide the new grad with the awareness that cultural differences, values, and beliefs play an important role in responding to grief. Providing dignity for the deceased and accessing resources for the families can decrease the impact of the stress.

Assumptions/Pre-requisites:

Knowledge of stages of grief

Psychosocial support of patients

Ethical issues and concerns

Assessment/Planning/Interventions:

Knowledge of Institutional policies

- Family witness resuscitation policy
- certification of death
- Code Status
- Organ and tissue donation

Providing families time with loved one

Respect cultural needs, beliefs

- provide privacy for religious prayer pastor

Be aware of impact on self

Consideration of families needs in regards to support services.

Ethnic and minority considerations

Potential ethical and moral challenges

Learning Objectives:

This kind of learning informs students about the human significance of what they are learning (Fink, 2003).

When students care about something, they then have the energy they need for learning more about it and making it a part of their lives (Fink, 2003).

Become aware of how cultural differences, values, and beliefs affect grief.

Discuss the importance of being culturally sensitive in interactions with family and providing time privacy for religious practices.

Examine own beliefs around death and dying.

Critically reflect on moral or ethical challenges associated with dealing with patients and families during crisis

Be aware of the interdisciplinary resources available to assist patient, family and staff during crisis

Recognize the importance of ongoing communication to healthcare team in regards to patient condition.

Module 12 – Assessment and management of elderly patient population**Module Overview:**

The elderly patient presented to the emergency department can present specific challenges due to the complex health profile of older adults. The Fraser Health philosophy that applies to elderly patient center around two main mandates which relate to individual needs expectations, hopes, and dreams; and how professional can best meet those needs (Fraser Health, 2010).

Module 12 will provide new graduates about common conditions of the elderly patient presented in the emergency department. The new graduate will anticipate potential needs of elderly patients to minimize functional decline during their stay and locate various tools and resources associated with the geriatric population for discharge planning.

Assumptions/pre-requisites:

An understanding of the specific needs and challenge of elderly patients.

Completion of the Geriatric emergency network initiative one hour online course (Fraser Health).

Assessment/Planning/Intentions:

Assess patients for need of specific protocol for elderly patients such as the hip fracture protocol (Fraser Health, 2013).

Assess patients for potential discharge needs.

Recognize the importance of ongoing communication to healthcare team in regards to patient condition.

Demonstrate comfort care

Involve family members in decisions of care regarding discharge planning and discharge instructions.

Knowledge of resources for elderly patients upon discharge which include: Senior clinic, Hospital pharmacists, Geriatrician, Geriatric clinicians, Social workers, Occupational therapy, Physiotherapy, home care, Chronic disease clinics and translation services

Consideration given to friends and families (involve in care, discussions, give info.)

Ethnic and minority considerations**Ethical/Moral Challenges****Learning objectives**

Foundational Knowledge provides the basic understanding that is necessary for other kinds of learning (Fink, 2003).

Integration is the act of making new connections which gives learners a new form of power, especially intellectual power (Fink, 2003).

This kind of learning informs students about the human significance of what they are learning (Fink, 2003).

Identify the challenges of elderly patients in the emergency department

Link resources to specific needs upon discharge for elderly patient.

Collaborate and communicate with interdisciplinary team to promote optimal health function.

Module 13 – Promoting Culturally Safe Practice**Module Overview:**

The emergency department presents unique challenges for patients of cultural and linguistic diversity. New immigrants have limited support and have difficulty accessing health services due to cultural barriers. Culturally responsive practices are required for providing the needs of a diverse population (Fraser Health, 2011).

Module 13 will provide the new graduates to integrate culturally safe care within ARHCC's philosophy of patient-centered care (Fraser Health, 2011). New graduates will access resources needed to ensure responsiveness to the diversity of patients presented to the emergency department.

Assumptions/Pre-requisites:

Completion of online cultural competency course (7.2 hours)

Attendance of workshops presented by Fraser Health (Partners in care: Embracing Diversity, spiritual care, celebration of various cultural events (Fraser Health, 2011).

Assessment/Planning/Interventions:

Access translation services for support with assessments of presenting complaints.

Communicate with friends and relatives to communicate concerns/issues of patient.

Respect cultural values and belief by being culturally sensitive in interactions with patient and families.

Consideration given to friends and families (involve in care, discussions, give info.)

Ethnic and minority considerations**Ethical/Moral Challenges****Learning Objectives:**

Foundational knowledge provides the basic understanding that is necessary for other kinds of learning (Fink, 2003).

Application learning allows other kinds of learning to become useful (Fink, 2003).

This kind of learning informs students about the human significance of what they are learning (Fink, 2003).

When students care about something, they then have the energy they need for learning more about it and making it part of their lives (Fink, 2003).

Give examples of ethnic and minority considerations in regard to diet, spiritual needs, and personal traditional medicine.

Recognition of ethical and moral challenges

Facilitate communication by using translation services

Advocate for patients by sharing resources that families can access such as the Aboriginal resource site (Fraser Health. 2010).

Awareness of own biases related to care and treatment of patient different than self.

Module 14 –Assessment and Management of Acute Pain as they relate to ED patients.

Module Overview:

Acute pain is the most common reason for seeking emergency care. Pain is often accompanied by anxiety, or the feeling of loss of control. Inadequate administration of analgesia in the ED is a widespread problem.

Module 14 will provide new graduate to assess and recognize patients with acute pain presented to the emergency departments. New graduate will advocate for patient with acute pain and use ER specific protocols related to pain control.

Assumptions/Pre-requisites:

Awareness of presenting complaints that may accompany acute pain.

Knowledge of anatomy and physiology

Knowledge of pathophysiology in concepts of altered health states.

Understanding of basic normal/abnormal lab values

Knowledge of factors associated with under treatment of pain

Assessment/Planning/Interventions:

Importance of a full medical assessment: includes history (psych and medical), trauma, recent illness, inquiry regarding drugs and ethanol abuse.

Begin critical thinking around assessment, history, and presentation of patients with acute pain to anticipate complications and identify life-threatening conditions.

Policies of charting and vital signs in the emergency department.

Protocols: computerized tomography (CT) , ultrasound (LT) ,intravenous initiation

Knowledge of common non pharmacological pain management regimens.

Knowledge of common pharmacological pain management regimens in the emergency department.

Knowledge of specific protocols to address types of pain in the emergency department (ie chest pain protocol)

Knowledge of common distribution of medications in the emergency department (nitrous oxide, intranasal, conscious sedation).

Consult physician to order use of the acute pain protocol if necessary.

Understand that chronic pain is addressed by the emergency physician in emergency settings.

Ethnic and minority considerations

Learning Objectives:

Foundational knowledge provides the basic understanding that is necessary for other kinds of learning (Fink, 2003).

Application learning allows other kinds of learning to become useful (Fink, 2003).

Integration is the act of making new connections which gives learners a new form of power, especially intellectual power (Fink, 2003).

Determine between stable and unstable conditions.

Recognize the use for nurse initiated protocol for mild pain and fever vs physician initiated protocol for acute pain.

Differentiate between mild pain and acute pain.

Determine when to use the acute pain protocol

Mentorship

Foundational knowledge provides the basic understanding necessary for other kinds of learning (Fink 2003, p. 4).

Application learning allows other kinds of learning to become useful (Fink, 2003, p. 4)

Integration provides new connections which gives learners a new form of power, especially intellectual power (Fink, 2003, p. 4).

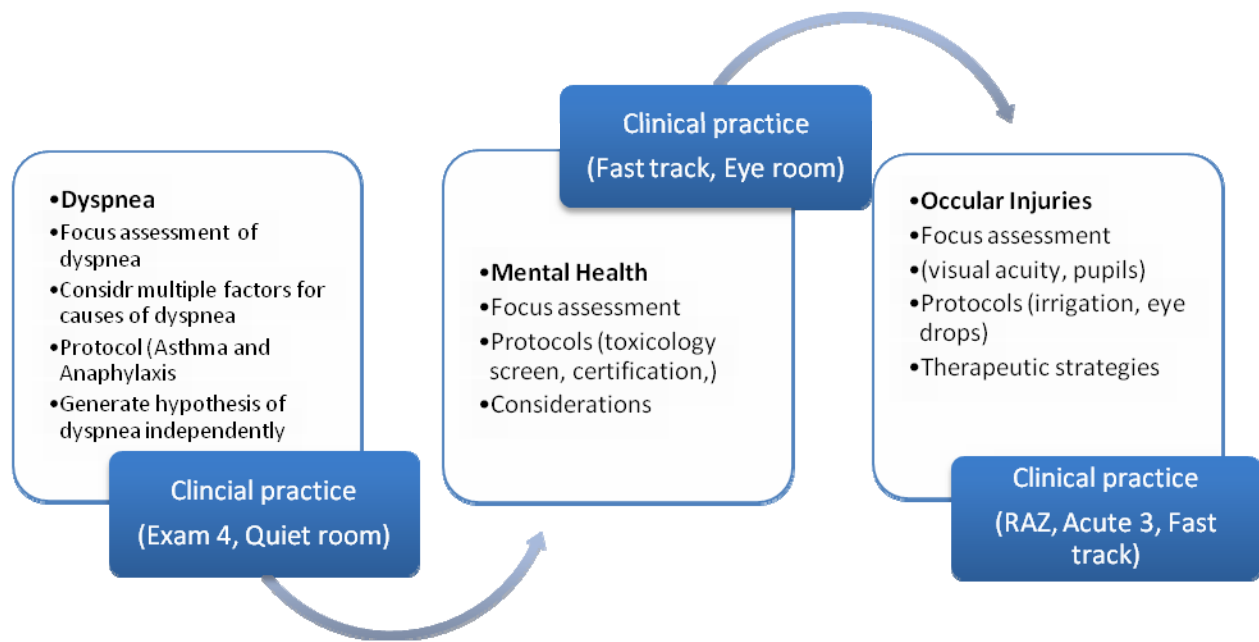
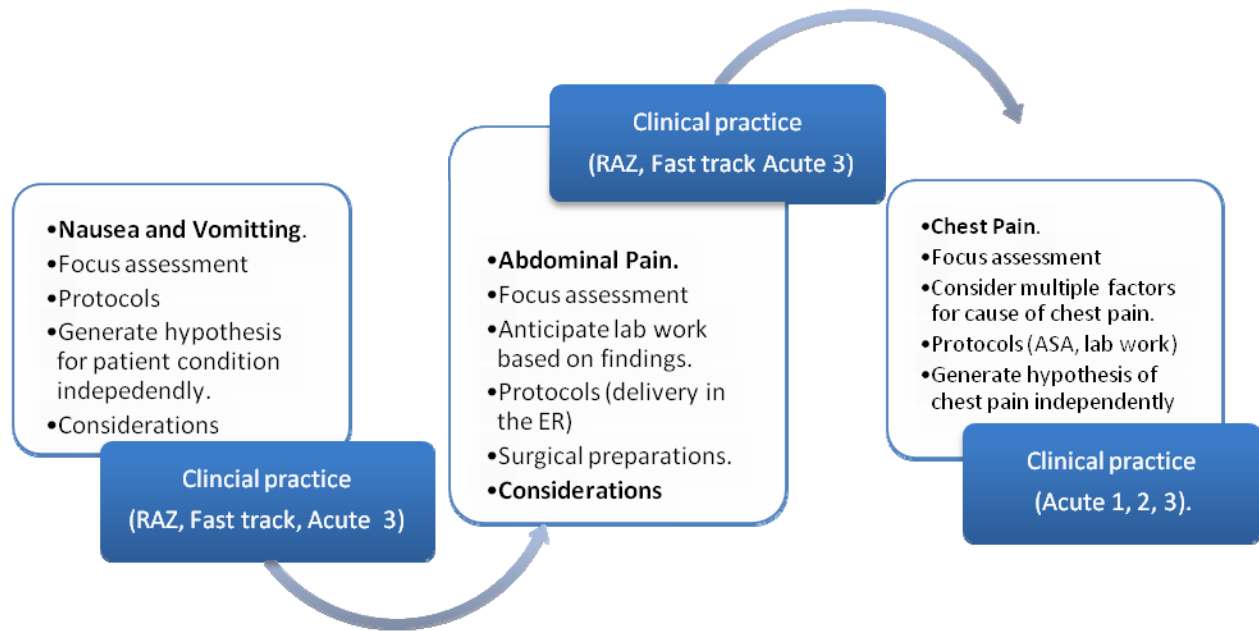
Caring provide learners to have the energy they need for learning, without the energy, nothing significant happens (Fink, 2003, p. 5).

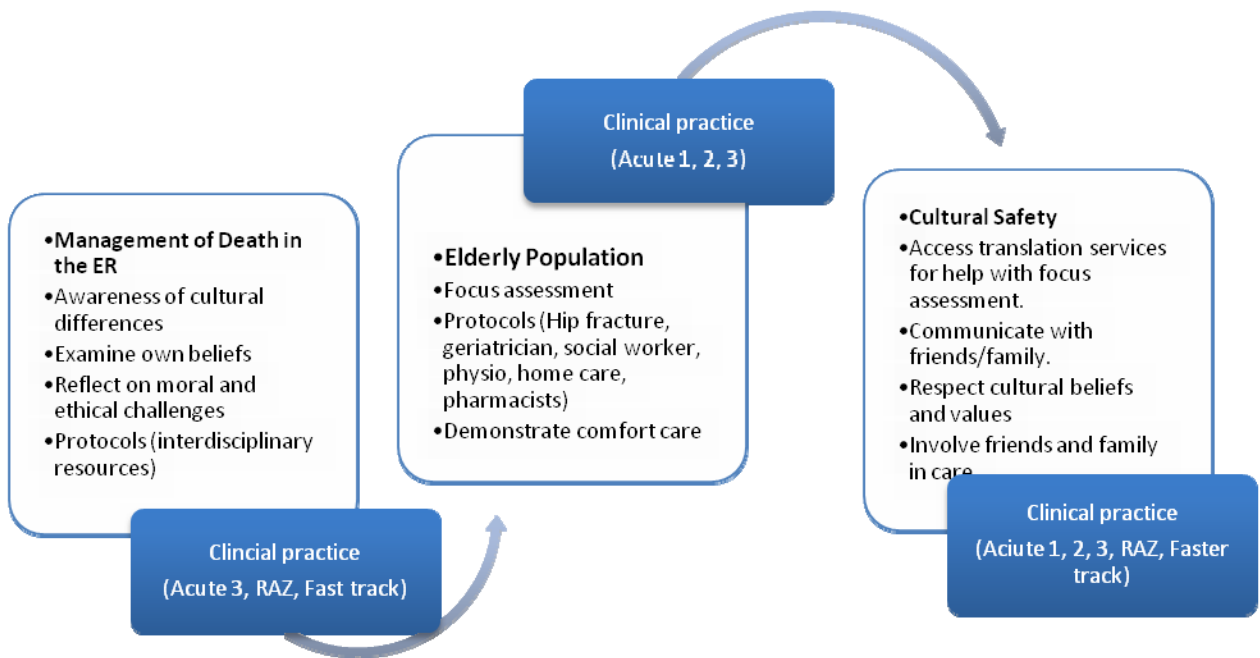
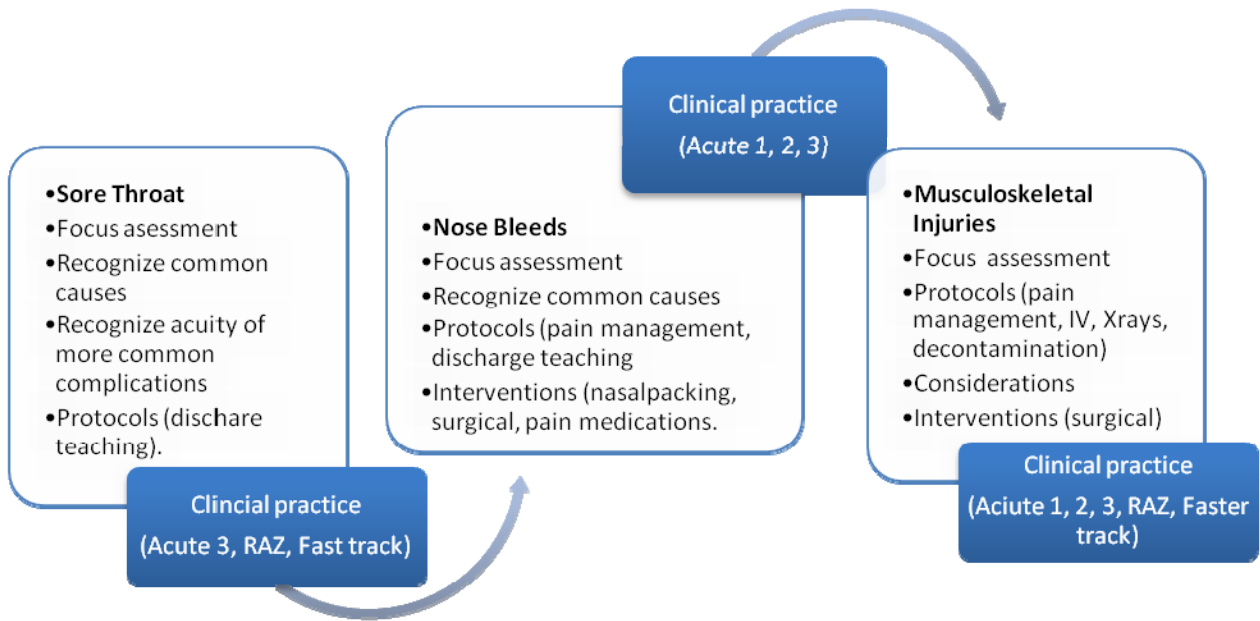
Learning how to learn enables learners to continue learning in the future with greater effectiveness (Fink, 2003, p. 5)).

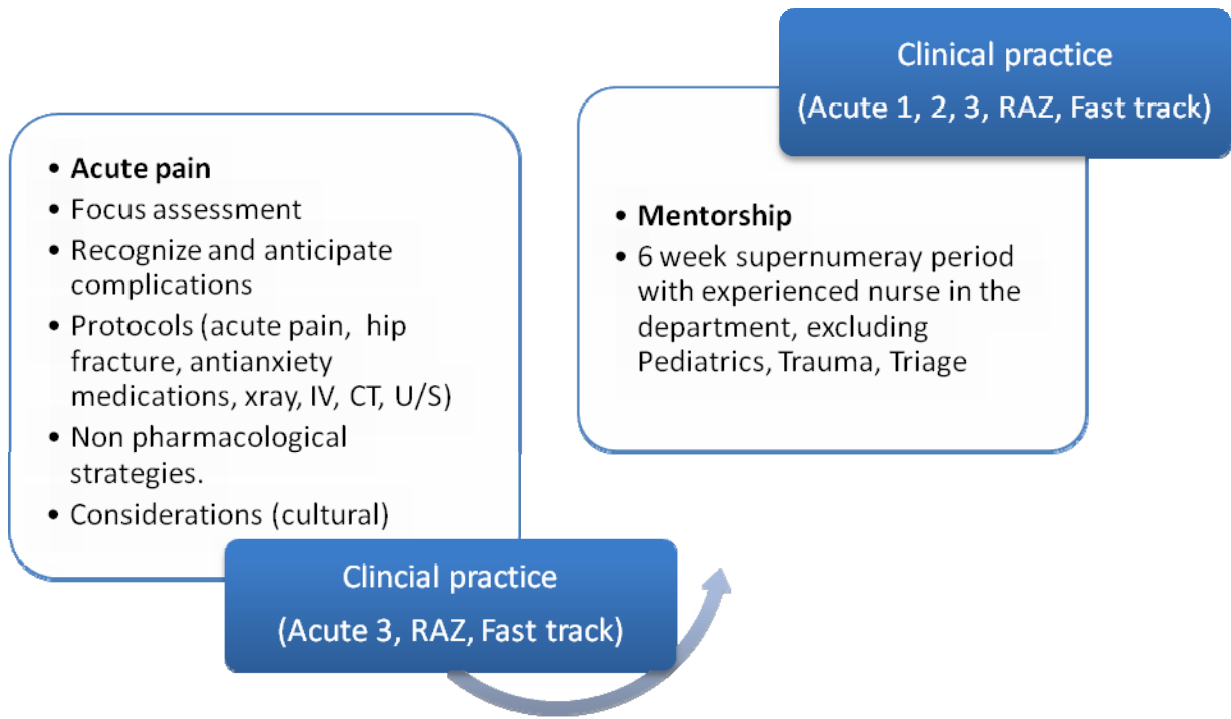
A period mentorship will consist of 6 weeks (24 shifts) in which the learners needs are evaluated. Longer periods of mentorship are supported by management/CNE if needed.

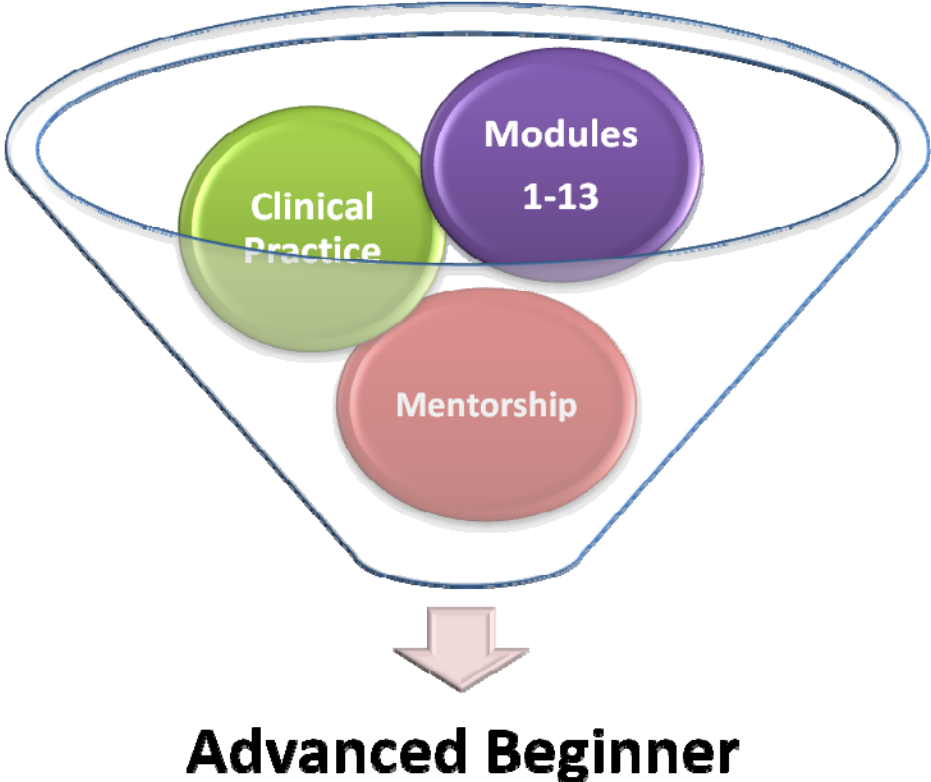
Note. Adapted from Educational Blueprint: Preparing Nursing Students to Care for Older Adults, by D. Gray-Miceli and M. Mezey, 2009, The John A. Hartford Institute for Geriatric Nursing, New York University, New York, NY.

Appendix G









Appendix H

Formal Summation Survey

Your name:

Preceptor:

Assessment of Preceptor	Most of the time	Some of the time	Rarely	Unable to evaluate
Evaluate your learning needs?				
Been someone you could trust?				
Provide opportunities for you to practice new skills?				
Ask questions to help you develop critical thinking?				
Provide clear explanations?				
Listen to your perspectives?				
Invite questions?				
Provide consistent feedback?				
Selected patient assignments based on your level of development?				
Treated you with concern and respect?				

Please describe your integration to the emergency department.

1. How did the orientation provide a structured and organized manner to assist your transition into your role?

2. What aspects of your orientation were especially helpful to you?

3. What would make the orientation better?

Orientation Program	Strongly Disagree 1	2	Neutral 3	4	Strongly Agree 5
Was the level of knowledge appropriate as a new ER learner?					
Were the teaching strategies appropriate for the content?					
Was the recommended time frame for this orientation sufficient to transition into professional practice?					

Please comment on the overall structure and content of the orientation program.