


2010

# Reorientation of the Experienced General Medical/Surgical Nurse to a Progressive Care Medical/Surgical Nurse Utilizing Benner's Novice to Expert Theory

Barbara Radford  
*Gardner-Webb University*

Follow this and additional works at: [https://digitalcommons.gardner-webb.edu/nursing\\_etd](https://digitalcommons.gardner-webb.edu/nursing_etd)

 Part of the [Nursing Administration Commons](#), [Occupational and Environmental Health Nursing Commons](#), and the [Perioperative, Operating Room and Surgical Nursing Commons](#)

---

## Recommended Citation

Radford, Barbara, "Reorientation of the Experienced General Medical/Surgical Nurse to a Progressive Care Medical/Surgical Nurse Utilizing Benner's Novice to Expert Theory" (2010). *Nursing Theses and Capstone Projects*. 188.  
[https://digitalcommons.gardner-webb.edu/nursing\\_etd/188](https://digitalcommons.gardner-webb.edu/nursing_etd/188)

This Thesis is brought to you for free and open access by the Hunt School of Nursing at Digital Commons @ Gardner-Webb University. It has been accepted for inclusion in Nursing Theses and Capstone Projects by an authorized administrator of Digital Commons @ Gardner-Webb University. For more information, please see [Copyright and Publishing Info](#).

Reorientation of the Experienced General Medical/Surgical Nurse  
to a Progressive Care Medical/Surgical Nurse  
Utilizing Benner's Novice to Expert Theory

by  
Barbara Radford

A thesis/project submitted to the faculty of  
Gardner-Webb University School of Nursing  
in partial fulfillment of the requirements for the  
Degree of Master of Science in Nursing

Boiling Springs

2010

Submitted by:

---

Approved by:

---

Date

---

Date

---

### **Abstract**

The decisive factor for this project was the Health Care Organization's decision to combine the medical/surgical units from two campuses into one department. This process required the Registered Nurses to reapply for their positions, merge into one unit, and transition to a different physical location. The next major process to occur will be the changing of patient acuity-levels from general medical/surgical to medical/surgical progressive care.

This project will provide a cost effective educational plan based on Benner's novice to expert theory which will ensure efficient transition for the expert medical/surgical nurse to an expert progressive care nurse. A structured orientation process has been developed which will provide lecture, blended-learning, and simulation presentations. The process will be flexible in order to include just-in-time education as required by the individuals. Patient safety and quality of care will be driving factors in the educational plan. Retention of the experienced general medical/surgical nurse will be a major goal of this reorientation process.

## Table of Contents

	Page
Chapter 1	
Introduction.....	1
Background.....	1
Theoretical Framework.....	3
Purpose and Rationale.....	5
Chapter 2	
Review of Literature.....	6
Novice to Expert.....	6
Expert to Novice.....	8
Benner and Nursing Orientation.....	11
Chapter 3	
Project Description.....	16
Chapter 4	
Outcomes and Evaluation Plan.....	22
Demographic Characteristics.....	22
Descriptive Statistics.....	24
Individual Progression.....	27
Chapter 5	
Discussion.....	29
Project Summary.....	29
Implication for Nursing.....	30
Limitations of Project.....	31
Implications for Further Study.....	31



Appendices	
Appendix A: Demographic Characteristics.....	33
Appendix B: ICU/Progressive Care Comprehensive Knowledge Assessment.....	34
Appendix C: Role Transition Survey.....	47
Appendix D: Unstable Med/Surg Patient Class.....	49
Appendix E: Project Coordinator Rounding Questionnaire.....	50
Appendix F: Novice to Expert Progression Worksheet.....	51
References.....	52

## List of Figures

	Page
Figure 1 – Role Transition Survey Academic Excellence .....	24
Figure 2 – Role Transition Survey Resources.....	25
Figure 3 – Role Transition Survey Simulation Training.....	25
Figure 4 - Projected Progression Timeline based on Patricia Benner's Theory of Nursing Education.....	28

## List of Tables

	Page
Table 1 –Demographic Characteristics.....	23
Table 2 –Additional educational needs identified based on results of Role Transition Survey.....	26

## **Chapter 1**

### **Introduction**

In today's healthcare environment, patients are presenting to the hospital with both acute and chronic illnesses which are manifesting symptoms that are more severe than the general medical/surgical nursing units are accustomed to handling. This is forcing Health Care Organizations (HCO) to change the level of nursing care provided. General medical/surgical beds are decreasing in number while progressive care beds are on the increase. This shift not only affects the physical layout of the nursing units; it also affects the nursing skill level required to provide safe quality care to these patients.

When determining how to provide nurses with the skill level required to care for these patients, HCO have two choices. They can recruit and hire new nurses or retrain the current general medical/surgical nursing staff. With the current economic downturn, HCO must look at the time commitment and expense of orientating new nurses. It is more cost effective to educate the current staff of expert general medical/surgical nurses to the role of progressive care nurse. Another possible issue with recruiting and hiring new nurses is the potential for decrease morale within the hospital after it is learned that the medical/surgical nurses were not given the opportunity to advance to the progressive care level.

### **Background**

With the increased medical complexity of admitted patients comes the need for more specialized care. One way to fill this need is to re-designate medical/surgical beds to progressive care beds. With this change comes the need for specialized education for medical/surgical nurses. According to Lorraine Steefel (2004), "PCU (progressive care unit) care is more high tech and includes treatments that require more intensive care and

monitoring than those on med/surg units”(para. 9). In 2008, the American Association of Critical-Care Nurses (AACN) provided the following definition.

Progressive care defines the care that is delivered to patients whose needs fall along the less acute end of that continuum. Progressive care patients are moderately stable with less complexity, require moderate resources and require intermittent nursing vigilance or are stable with a high potential for becoming unstable and require an increased intensity of care. Characteristics of progressive care patients include: a decreased risk of a life-threatening event, a decreased need for invasive monitoring, increased stability, and an increased ability to participate in their care (para. 4).

Nursing administration is placed in the position of providing advanced education to assist the expert medical/surgical nurse become a progressive care nurse within their established education budget. The goals of the advanced education are the provision of safe, quality patient care and to retain the nurses within the department. To retain these nurses, the education must provide the nurse with a feeling of proficiency with the more intensive monitoring and care required for this new patient population. Benner, Tanner, and Chesla (1997) state that “At the level of expert practice, you’ve developed intuitive links and are able to see salient issues in a situation and know how to respond to them. The links between a patient’s condition and your actions are strong” (p. 16BBB). Transitioning the expert general medical/surgical nurse to the level of a progressive care nurse requires the educational presentation to flow smoothly and quickly.

## **Theoretical Framework**

Patricia Benner's theoretical framework provides the direction for this project. Benner's model of novice to expert defines a process that nurses follow to become experts in their chosen area of nursing care. To define the process, Benner studied "...clinical nursing practice in an attempt to discover and describe the knowledge embedded in nursing practice..." (Tomey & Alligood, 2006, p. 142). Nursing knowledge comes from nursing practice. As new nurses interact with patients, co-workers, physicians, and other ancillary personnel, they acquire knowledge and skill sets that can be modified to various patient care situations. As they increase their skill sets, they not only see the anticipated symptoms but also the subtle signs that show the patient is going into clinical jeopardy. When the nurse gets to this stage, they are experts in their chosen field of practice.

Descriptions of Benner's major concepts are important information for nursing administration during this change process. An understanding of these concepts can guide the formation of advanced education and management support required for an effective transition from medical/surgical nursing to the more technical progressive care nursing. The following are descriptions of Benner's stages of advancing from novice to expert.

1. Novice: This is the time when new nurses acquire skill sets to provide basic nursing care with oversight from a preceptor. Benner's theory allows for nurses to be experts in some nursing care aspects while being a novice in others. In this project, the expert medical/surgical nurse becomes the novice progressive care nurse and must go through the growth stages again.

2. Advanced Beginner: “Nurses functioning at this level are guided by rules and are orientated by task completion” (Tomey & Alligood, 2006, p. 145). These nurses see task completion as their learning the system. They do not have the ability to see the completion “...in terms of the patient needs and responses” (Tomey & Alligood, 2006, p. 145). In this project, the expert medical/surgical nurses will be expected to focus on task completion, but should quickly obtain the ability to include the patient’s needs and responses in their care.
3. Competent: According to Tomey & Alligood (2006), at this level, nurses have the ability to utilize planning to get their patient care task completed. They can apply rules and prioritization in their daily routine. However, they still do not connect their actions with the patient’s needs and responses.
4. Proficient: At this level, nurses finally begin to recognize the patient’s needs and responses to care. “At the proficient stage, there is much more involvement with the patient and family. The proficient stage is a transition into expertise” (Tomey & Alligood, 2006, p. 146). In this project, this level may be combined with the competent level. In addition to the initial intensive care classes, this stage will see additional, higher-level, education presented.
5. Expert: “For the expert nurse, meeting the patient’s actual concerns and needs is of utmost importance, even if it means planning and negotiating for a change in the plan of care. There is almost a transparent view of the self” (Tomey & Alligood, 2006, p. 146). In this project, this level should be attainable within a much shorter time frame for the expert medical/surgical nurse than the new graduate nurse.

**Purpose and Rationale**

The purpose of this project is to provide an efficient transition from expert medical/surgical nurse to expert progressive care nurses utilizing a cost effective educational plan. Patient safety and quality of care will be driving factors in the educational plan.



## **Chapter II**

### **Review of the Literature**

The literature review revealed numerous studies utilizing Benner's novice to expert theory. However, studies are limited regarding the expert nurse becoming a novice again. Benner's novice to expert theory can be utilized to assist nursing administration and nursing education in the development of an orientation program that will provide a successful transition and remain cost effective. This program must be developed to provide the expert medical/surgical nurse with concentrations on new skill set acquisition and less time on developing patient interaction skills as these have already been obtained.

#### **Novice to Expert**

A study was conducted by Haag-Heitman (2008) on the expert nurse's perceptions of factors that influenced their attainment of expert status. This study looked at deliberate practice, risk taking, social models and mentors, and external rewards as influences that impact the attainment of expert status. To attain expert status, education and practice must be deliberately focused on the development of advanced skill sets that assist the nurse in providing high-quality patient care. "These highly focused engaged and concentrated training activities are associated with consistent improvements in practice and help move performance beyond its current level" (Haaf-Heitman, 2008, p. 204). Dreyfus & Dreyfus (1996) state that "Success at moving beyond the mid or competent stage...requires a departure from the status quo" (p. 30). Learner must take risk to advance their skill level. The type and consequences of the risks taken by the RN will either empower them to go forward and attain expert status, or will prevent the RN from progressing along the novice to expert continuum.

Social models and mentors assist in the development of expert nurses by providing a practice area that performs in the expert domain. “Expert role models and mentors also help create a supportive learning environment shown to be critical to the engagement of the learner across and throughout the developmental continuum” (Haaf-Heitman, 2008, p. 204). To attain the required skill sets to become an expert, those within the novice to proficient domains watch and imitate those expert nurses around them. External rewards can be a motivating factor in the attainment of expert status. Salary increases, individual recognition and promotions are a few external rewards that can be utilized. For this study, ten practice expert nurses were selected based on

...(a) validation by the internal nursing review process as practicing at the expert stage; (b) recommendation by a Clinical Nurse Specialist or nursing leader for participants’ superior expert nursing performance as compared to other experts practicing in the same environment; and (c) availability of participants’ narratives used for determination of their expert stage of skill acquisition. (Haaf-Heitman, 2008, p. 205)

The results of this study showed that all four of the study defined influences were important in the attainment of expert status in nursing. The study participants were involved in deliberate life-long learning, which increased their ability to attain expert status.

Schoessler and Farish (2007) conducted a study to “...describe the evolution of skills acquisition required for nurses to develop expertise within their clinical specialty” (p. 170). A random selection of nurses with seven or more years of nursing experience in one department were utilized. Three main influences were focused on during the

interview process: What assisted them in attaining expert status, what specific person(s) influenced their development, and what characteristics of that person(s) influenced them the most. The results of the study showed that the participant's quest for self-learning was a major factor in attaining expert status. Results also showed that "Support people included family and friends, managers, nurse colleagues, physician colleagues, and staff educators" (Schoessler & Farish, 2007, p. 172). According to the participants, the most influential characteristics of their support people were the abilities to "...put essential emotional, intellectual, and physical resources into the reach of the individual..." (Schoessler & Farish, 2007, p. 172). According to this study, providing educational reinforcement and support are major influences in nurses attaining expert status.

Benner, Tanner, and Chesla (1997) conducted a six-year study on the expert nurse's use of clinical experiences and textbook information to care for their patients. Benner, et al. concluded that getting to the expert level is a gradual process that progresses with each clinical experience that a nurse encounters. The expert nurse gains the ability to see beyond the visible clinical signs and symptoms displayed by the patient. They are able to use past clinical experiences to assist in the determination of possible problems that might occur based on this patient's clinical presentation. The expert nurse pulls together past and present clinical experiences, understanding of the patient, a positive relationship with the patient's family, and textbook knowledge to care for, and prevent decline of, the patient's current clinical condition.

### **Expert to Novice**

A qualitative study conducted by Cusson and Strange (2008) looked at the transition of seventy (70) expert neonatal nurses into the Neonatal Nurse Practitioner

(NNP) role. The researchers understand that role transition comes with a universal set of difficulties. “Successful role transition results in an APN (Advanced Practice Nurse) who is competent and confident and who relishes the challenges that the new role brings” (Cusson & Strange, 2008, p. 329). This study utilized an open-ended question survey tool that focused on “...educational preparation, integration into the new role, barriers encountered, and factors helping or hindering the transition process...” (Cusson & Strange, 2008, p. 332). Study results indicated that the novice domain was filled with both excitement and fear of the challenge to become an expert NNP. Having gone through the novice to expert continuum as a neonatal nurse, the participants were aware of what each domain would focus on. During this transition, some of the new NNPs wanted to return to the bedside nursing role because it was a comfortable place, others were critical of the bedside nurses, and a few found the transition very difficult. Cusson and Strange found that

The expert to novice phenomenon was a pervasive experience that participants had not expected and found particularly upsetting. Accustomed to feeling competent and being in charge, participants described the humbling experience of becoming a novice again. The journey back to expert status was long and arduous and often took years of practice to achieve. (2008, p. 336)

Barbara Blaich (2004) documents her transition from an expert in nursing administration to a novice entrepreneur. During the practicum, Ms. Blaich decided to plan for and build a nursing consulting company. She found that she was lacking skill sets to make this happen. Without these skill sets, Ms. Blaich reverted back to the novice requirement of rules and guidelines to assist in getting through this domain. As her

knowledge and experience matured, the type of assistance needed changed from basic to more challenging concepts. During the practicum, she connected with experts and mentors who continue to assist with the growth of her company.

Gershenson, Moravick, Sellman, and Somerville (2004) describe how important mentoring, good communication, and constructive feedback are to an expert nurse when they become a novice nurse manager. At the time of the change from expert nurse to nurse manager, the nurse does not realize how different the role change will be. Instead of looking at the patient's current clinical condition, the nurse manager must look at what is best for the department in the long-term. When treatment and care of a patient does not produce positive results, the expert nurse steps back to look at the clinical picture again, communicates with the physician and institutes the new plan of care. This process is rewarding when positive results are seen. On the other hand, when the novice nurse manager makes a decision or plan that does not provide positive results, they see themselves as incompetent. Their ability to step back and look at the entire picture is non-existent. In order to continue through Benner's novice to expert domains, mentoring is vital.

Peter Moran moved from being an expert Emergency Department (ED) Case Manager to a novice case manager for complex medical patients (Moran, 2010). He went from knowing all the services available for the ED patient, to learning how little he knew about the unique needs of the complex medical patient and the very limited resources available. Mr. Moran (2010) states

It has been a rough ride and difficult adjustment as I have transitioned into my new role. What I can say is I am being challenged to grow and to learn. I am

being forced to think of creative solutions because for some of my clients, there are not right answers, and we need to just do the best we can (Moran, 2010, p. 101).

Ms. Thomes (2010) links career changes to the changing healthcare environment, average age of registered nurses, and the physical demands of current bedside nursing such as shift rotation, working holidays and working short staffed. As with the other expert to novice articles listed in this chapter, Thomes concludes that adequate mentoring is a very important tool for the expert nurse who has moved back to the novice domain. Mentors must be honest with the novice nurse regarding the differences in the nurses past position and the new one. This honesty is not to discourage the novice, but to help them understand that they will not be an expert in their new position for a period of time. This knowledge will assist the novice when they fail to meet their expectation to be an independent expert within a very short period of time. “The new novice has a wealth of knowledge and experience from which to draw. The novice brings unique talents and skills to the new position. Soon, the novice will once again become the expert” (Thomes, 2010, p. 334).

### **Benner and Nursing Orientation**

When looking at the transition from general medical/surgical to progressive care medical/surgical nurses, we can link their orientation needs to the new graduate on several levels. Anna Valdez (2008) conducted a literature review regarding the transitioning of graduate nurses from novice to competent in the emergency room. Ms. Valdez divided her review into two sections: “...*culture shock* (barriers to success) and *assimilation* (facilitators of success)” (Valdez, 2008, p. 437).

The graduate nurses were functioning within an unfamiliar area and were “...being asked to assume increasing levels of responsibility” (Valdez, 2008, p. 437). The barriers documented in Valdez’s review will be directly related to the individuals of this project. Culture shock for these individuals will be the transition to progressive care nursing and advanced educational requirements. Valdez’s elements of stress, frustration, and inadequate preparation will be manifest related to the fact that these individuals will not have the opportunity to rely on a preceptor who has experience in the department they will be working. They will have access to the system’s Rapid Response Team which will offer some stress relief.

Schoessler and Waldo (2006) conducted a research study on the new graduates first eighteen month of practice. Schoessler and Waldo utilized Benner’s Novice to Expert theory, Bridges’ transition management theory, and Kolb’s experiential learning cycle. Bridges’ transition management theory defines transition as “...the psychological reorientation needed to adapt successfully to the change” (Bridges, 1980, p. 48). Bridges also divides this process into three parts which include endings, neutral zone, and new beginning.

The creation of an orientation process for new graduate hires involves long hours and many participants. According to Gomes, Higgins, Butler, Farzaneh and Everson (2009), the orientation of a new graduate hire requires “...the unit educator, unit manager, preceptor, and a staff member” (Gomes, et al., 2009, p. 575). The inclusion of a staff member in the planning, implementing, and evaluation of new graduate hires orientation process is very unique. Most HCO utilize preceptors only.

Knowledge Management (KM) is a concept born in the corporate world in the 1980's. Anderson and Willson (2009) reviewed KM in relationship to nursing practice.

The authors state that

A key attribute applied throughout the KM literature is that knowledge is a quantifiable asset to which a multitude of actions may be applied. Knowledge can be managed, leveraged, mobilized, shared, transferred, accessed, captured, represented, and created. Knowledge assets are identifiable within an organization as either explicit (written) or tacit (know-how). Organizational knowledge is embedded in routines, procedures, practices, and the minds of people. (Anderson and Willson, 2009, p. 3)

During the novice to expert transition, knowledge management is a critical component that nursing educators must navigate with skill and precision. Each phase of the transition requires specific sharing and transference of knowledge. Since each phase builds on the one before, knowledge deficits will produce negative consequences throughout the remaining transition. “*Good KM* [knowledge management] is defined as “getting the right knowledge to the right place, at the right time” (Anderson and Willson, 2009, p. 2). Good KM is a goal of this project.

In an article discussing the integration of the electronic medical record into their nursing orientation classes, Harton, Borrelli, Knupp, Rogers, and West (2009) discussed the process utilized to change their initial nursing orientation process from lecture and paper to lecture, paper, and electronic. This blended process resulted in greater satisfaction scores with the orientation process. Bastable (2003) states that the role of the educator is to create and implement classes and simulations that guide the novice



nurse through activities that enhance learning. Nursing educators no longer simply give out information.

The facilitation of learning will be a major component of this project. Providing visual and tactical images regarding the differences between general and progressive care nursing will be critical to the orientation process for the individuals. Educational offerings must be developed with the safety of the patients and the advancement of the individuals as a guide.

Lyneham, Parkinson, and Denholm (2008) conducted a study looking at the fifth stage of Benner's novice to expert theory. Specifically they studied the role of intuition by emergency room nurses. It is well known that Benner utilized the work of Dreyfus and Dreyfus as the foundation for her theory. Addressed in the article are the differences between "knowing that" and "knowing how".

The first distinction that Dreyfus and Dreyfus (1986) made was the difference between *knowing that* and *knowing how*. To know *that* is to be able to know the rules relating to a task, and knowing *how* is the performance in context. The development of knowing how assists in the movement through the stages of practice development; however, knowing that forms the theoretical foundation for the progression. (Lyneham et al., 2008, p. 381)

Utilizing the concept definitions of knowing that and knowing how when planning and providing advanced skill sets education, nursing educators can ensure that the knowledge is presented in a sequence that assists the learners in their transition. One must know the rules, procedures, and processes of any patient care activity prior to actually performing the activity. Since this project's participants will be new to

progressive care nursing, time must be spent educating the knowing that concept. A majority of this information will be provided during the ICU/Progressive Care Orientation series. The department nurse educator must be observant to recognize those concepts that were missed.

Cathcart's 2008 article addressing the role of the Chief Nursing Officer's (CNO) in leading nursing practice within an HCO utilizes Benner's theory of obtaining nursing expert status. Cathcart states that the CNO must be able to present nursing as more than "...countable and measurable tasks and procedures..." (p. 87). The CNO must

...come to appreciate that they are leading and developing a practice community rather than a workforce. The paradigm shifts to one where the clinical nurse is understood to be doing the mission-critical work and is, thus, perceived as the most important nurse in the organization. That position gives the clinical nurse the right and the responsibility to speak to issues of patient care and the environment in which care is delivered. (p. 89)

With the multitude of changes that these individuals have endured within the last year, it is very importation that nursing management, from the CNO to the nurse manager, acknowledge the daunting process that is ahead. They must also be visible and available to assist as needed and requested. Having the full support of all levels of nursing management will make the transition more meaningful for everyone.

## **Chapter III**

### **Project Description**

This project will be conducted in a natural setting. The project coordinator will not manipulate the environment in which the transition will take place. The setting will be a fifteen-bed medical/surgical unit that will be transitioning from a general medical/surgical unit to a medical/surgical progressive care (MSPC) unit in a Level II trauma center.

As this author's HCO reorganized to remain financially viable in today's economy, units were combined, staff were required to reapply for a position, and those lucky enough to be rehired had to deal with the frustrations that come with multiple change processes. After these changes, the staff was informed that they will no longer be working in a general medical/surgical unit, but a progressive care unit. For these expert medical/surgical nurses, this unexpected change was a source of professional distress. They are aware of the increased educational needs that have been forced upon them. Knowing about the cuts to the educational budget, concern for how they will obtain the required education is a source of distress that can, and must, be relieved by nursing administration. Opportunities to acquire the needed education can come from several different sources within the HCO. This HCO provides critical care level classes aimed at the orientation of new Registered Nurse (RN) hires who will be working in one of the many intensive care and progressive care units within the system. Departmental nursing management must determine the best way to get the RNs to these classes and maintain adequate coverage on the unit during the initial transition stage. Additional advanced education can be provided by the clinical nurse specialists (CNS) and/or the

department nurse educator. Another consideration is the advanced education that may be required by the CNS and department nurse educator. They may need to attend the intensive care/progressive care orientation classes as well.

The major goal of this project is to provide the required education, currently established and just-in-time, required to ensure an efficient transition from general to progressive care acuity level patient care. An additional goal is to retain the current RN staff.

When staff changes their work location by choice, they are ready to go through the leaning process again. The individuals in this project were informed that their patient type would be changing. In today's economic climate, only a small portion of the population can make the decision to change jobs on short notice. These nurses had a difficult year with the combining of two medical/surgical units, having to reapply for a position, changing physical locations, some changing twice, and the change in their patient population. With the orientation of new hires costing more than the re-education of existing staff, it is in nursing administration's best interest to provide appropriate educational opportunities for the current staff.

Benner's theory and the literature review provided guidance in the decisions and development of this project. Bridges' (1980) divisions of the transition process, endings, neutral zone and new beginning, will be utilized in this project. This author would define endings as the movement from an expert general medical/surgical nurse to a novice medical/surgical progressive care nurse. The neutral zone would be defined as the period of time when the nurses are going through the ICU/Progressive Care Orientation series

and learning about the new telemetry monitors. The day they are assigned their first progressive care patient will be the definition of new beginnings.

The individuals will be selected utilizing the purposive sampling method. Inclusion criteria for this project include (a) registered nurses, (b) employed on the general medical/surgical unit prior to the initial processes of transition to a MSPC unit, and (c) willingness to participate in this project utilizing a demographic characteristics tool, role transition survey, and participation in an Unstable Progressive Care Patient class at six months and one year. Exclusion criteria include: (a) functioning in roles other than a bedside Registered Nurse and (b) employed after the initial processes of unit transition to a MSPC unit. The individuals will be given a Demographic Characteristics Tool (see Appendix A) developed by this author for use in this study. Completion of this tool will constitute consent to participate in this project.

Prior to caring for the progressive care patient population, the selected general medical/surgical registered nurses will complete the four-week ICU/Progressive Care Orientation process already established by the Nursing Practice, Education and Research department. This process offers advanced level didactic, on-line, and simulation sessions related to the following topics: (a) Respiratory (b) Electrocardiogram (ECG) (c) Acute Coronary Syndromes (d) Heart Failure (e) Critical Care Pharmacology (f) Heparin, Insulin, Potassium/Magnesium, Orthopedic/Neurological Pain, Geriatric Pain, and Coumadin Protocols (g) utilization of the Patient Controlled Analgesia (PCA) pump (h) Mock Code (i) Neuroscience (j) advanced Renal (k) Hemodynamics and (l) Shock. The nurses will also be required to successfully complete the ICU/Progressive Comprehensive Knowledge Assessment (see Appendix B) which will be administered several weeks after

the orientation classes are completed. The pre-determined criterion for passing is a minimum score of eighty-five percent (85%).

After successful completion of the ICU/Progressive Care Orientation classes and comprehensive knowledge assessment, each individual will be given a Role Transition Survey (see Appendix C) to complete. This survey will be repeated at six months and one-year after the first progressive care patient is admitted to the unit.

Given the fact that this is a new unit designation and there are no experienced progressive care nurses on the unit to provide guidance, the individuals will be assigned clinical time with a staff RN on other progressive care units within the organization. With the limited number of qualified preceptors on each unit, and the amount of RN turnover, these individuals will be assigned to observe with a staff nurse if no qualified preceptor is available. When assigned with a staff nurse, the individuals will observe and participate in patient care at a general medical/surgical level.

Six months, and again at one year, after the department admits its first progressive care patient, an Unstable Progressive Care Patient Class (see Appendix D) will be offered. This class will utilize case based simulation scenarios. These scenarios will be developed with the assistance of the Rapid Response Team (RRT) and their encounters with the newly formed MSPC unit. The three most challenging progressive care patient scenarios will be selected for utilization in this class. Each simulation will be sixty minutes in duration followed by a thirty-minute debriefing session and have a maximum of three participants per scenario. Participants will be assigned roles of primary nurse, staff RN, and nursing assistant. Along with assessing the patient care decisions and group dynamics, the facilitator will be assessing the delegation techniques of the primary

and staff RN to the nursing assistant. No roles outside the RN's scope of practice will be assigned. Facilitators will function in the physician role for needed orders and the RRT role should questions arise that need that expertise. At the beginning of the scenario, the facilitator will give the primary nurse report utilizing the Situation, Background, Assessment, Recommendation (SBAR) technique. After this point, the facilitator will step back and only intervene when providing physician or RRT assistance as requested by the patient care RNs. Scenarios will be paused if actions selected by the participants would cause patient harm. After focused debriefing, the scenario will resume.

Individuals will be informed when they register for the class that each scenario will be video taped. This information will not be repeated at the beginning of class in order to decrease the stress level of the participants. The tape will be utilized during the facilitator lead debriefing session at the end of the scenario and could be evaluated by a team of experts. All participants will be expected to participate in the debriefing discussions which will focus on patient care decisions with outcomes and group dynamics. The video evaluation by the team of experts will focus on facilitator techniques, group interactions and patient outcomes. This information will be shared with the participants involved in the scenario.

The Unstable Progressive Care Patient class will be offered multiple times based on the number of individuals in this project. The same three scenarios will be utilized for each class presented at both the six month and 12 month classes. The class, facilitator and participant guidelines will be the same for both class. Also, the facilitators, simulation operator, and classroom locations will remain the same for all the classes unless unforeseen changes are unavoidable. Following participation in the Unstable

Progressive Care Patient class at six months and one year, the individuals will be required to complete the role transition survey.

In the event that one, or more, of the individuals do not progress through this process in an acceptable manner, the project coordinator will take direction from department management and education regarding the amount of time to spend with remedial education and practice. Due to the fact that all individuals must have successfully completed the comprehensive knowledge assessment to become part of this project, this will require subject specific planning. With department management's approval, the project coordinator will provide one-on-one sessions with the subject (s) to determine the specific educational requirements and develop an educational plan. The project coordinator will communicate with department management and education weekly during any remedial education processes.

During this one year project, this author would be rounding on the participants at least twice a month. The expected outcome of this rounding will be to maintain contact with the individuals, assess additional learning needs, and assess the individual's ability to go from expert general medical/surgical nurse-to novice MSPC nursing-to expert MSPC nurse. Standard questions will be asked during each rounding utilizing the Project Coordinator Rounding Questionnaire created by the author for this project (see Appendix E). Rounding will also show the individuals that this author is available if they need assistance; they are valued as more than a project subject and their success in the novice to expert continuum is important.



## **Chapter IV**

### **Outcomes and Evaluation Plan**

#### **Demographic Characteristics**

It is anticipated that there will be approximately seventeen medical/surgical registered nurses involved in this project. Each RN will complete the demographic characteristics tool upon completion of the ICU/Progressive Care Orientation classes and successful completion of the ICU/Progressive Care Comprehensive Knowledge Assessment. Demographical characteristic frequencies and percentages will be summarized (see Table 1).

It is projected there will be a higher number of females and the associates degree level RN will be predominate. Since nursing in this HCO has just begun to encourage bedside nurses to become nationally certified in their area of expertise, it is projected that the number of certified nurses will be low.

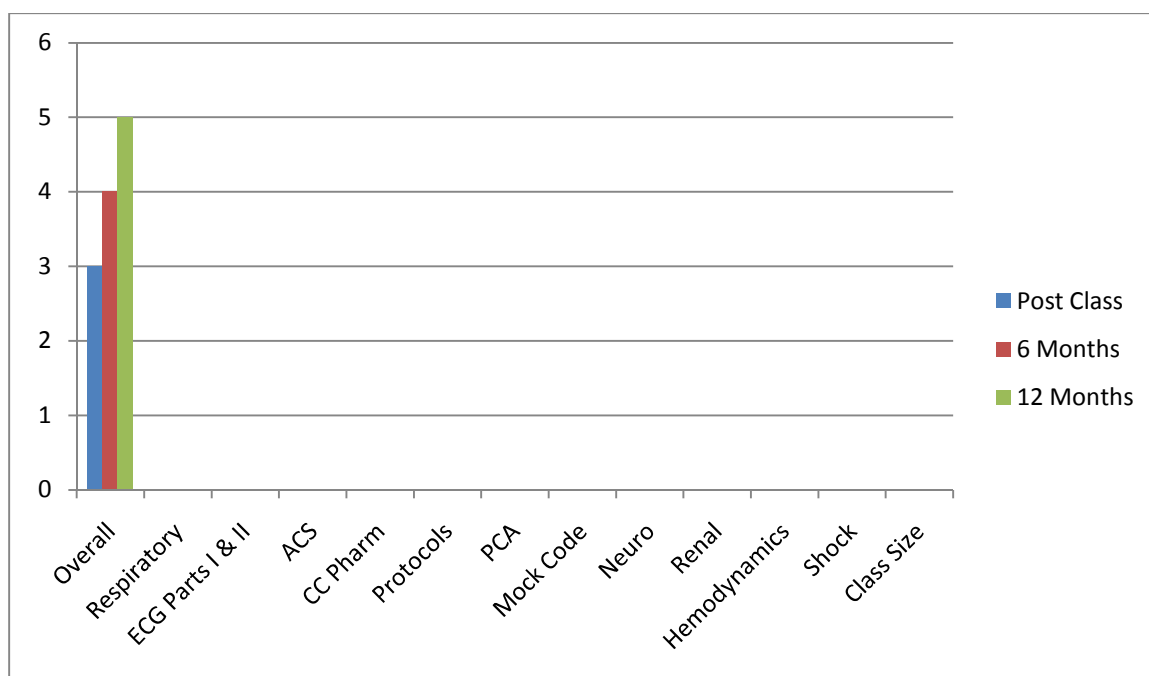
Table 1

*Demographic characteristics of individuals by frequency and percent.*

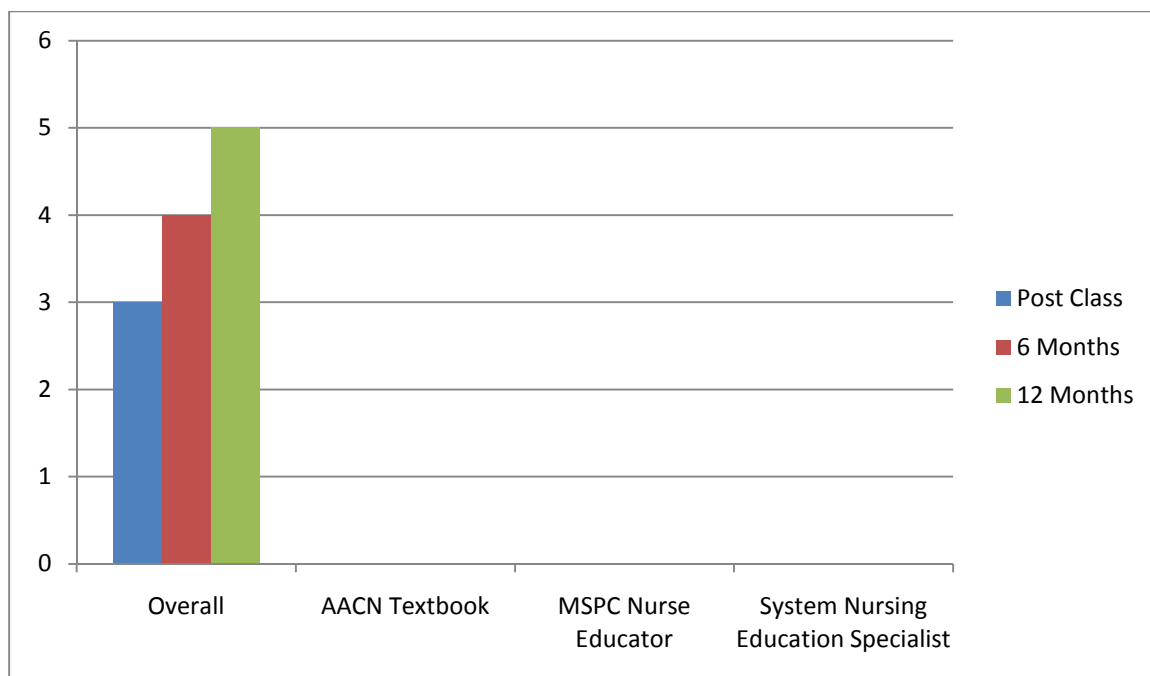
	Frequency	Percent
Gender		
Male		
Female		
Ethnic Background		
African-American		
Caucasian		
Mexican-American		
Asian		
Other		
Years as a Registered Nurse		
Highest Nursing Degree		
Associates Degree		
Diploma		
Bachelor		
Master's/Graduate		
Doctorate		
Years of General Medical/Surgical Nursing		
Management Position		
Yes		
No		
National Certifications		
Yes		
No		

## Descriptive Statistics

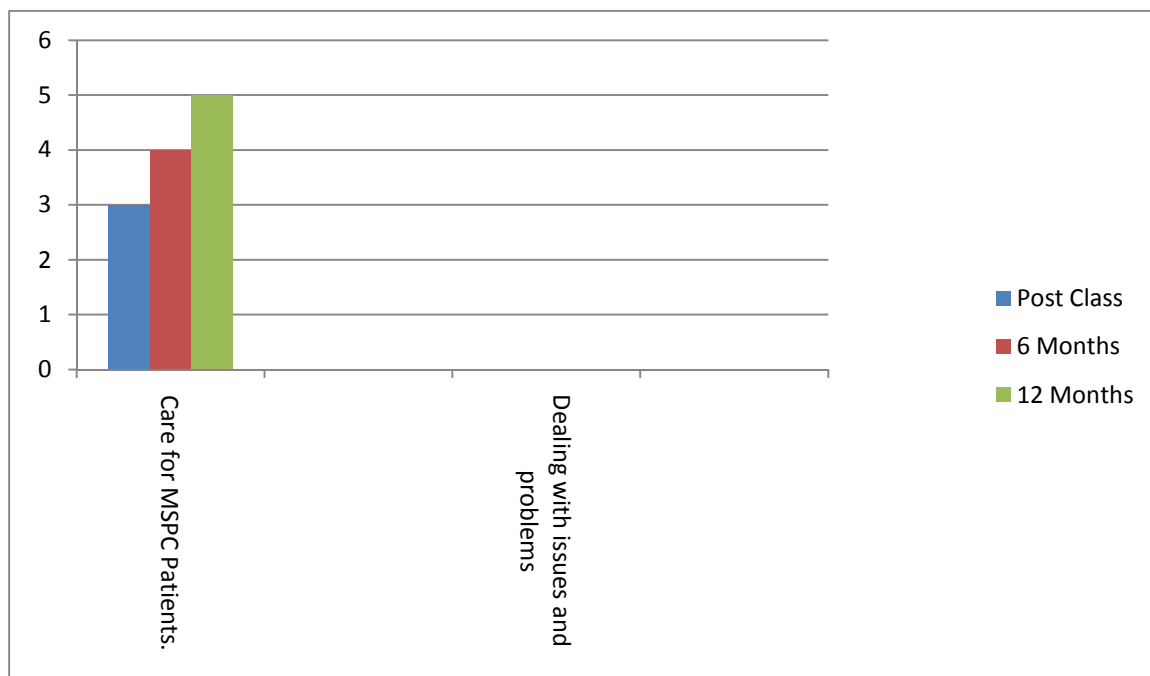
Descriptive statistics will be utilized to summarize survey results. Upon successful completion of the ICU/Progressive Care Orientation classes and comprehensive knowledge assessment, each individual will be required to complete the Role Transition Survey. This survey will also be completed after the final debriefing session at the end of the Unstable Progressive Care Patient class at six and twelve months. Criteria included in this tool include academic excellence, resources, simulation training, and additional educational needs. The information retrieved from the compiled surveys will be utilized to improve the ICU/Progressive Care Orientation series and to enhance the assistance offered from the system nursing education specialists. See Figures 1-3 and Table 2 for the format that will be utilized in presenting these results.



*Figure 1.* Role Transition Survey Academic Excellence: Summative evaluation of ICU/Progressive Care classes. Results post initial class, at six months and twelve months.



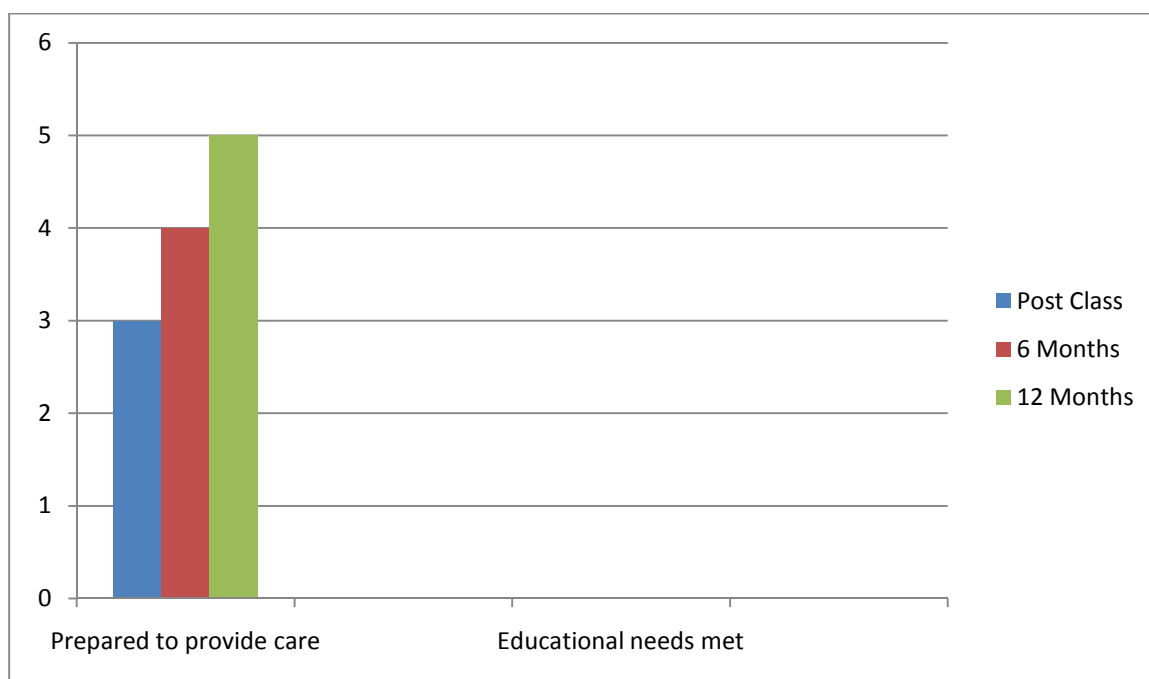
*Figure 2.* Role Transition Survey Resources: Summative evaluations of selected textbook and nursing education. Results post initial class, at six months and twelve months.



*Figure 3.* Role Transition Survey Simulation Training: Summative evaluations post initial class, at six months and twelve months.

Table 2

*Additional educational needs identified based on results of Role Transition Survey*



Data gathered from the academic excellence section of the Role Transition Survey will be utilized to modify class presentations in the areas of topics, material presented, and order of class presentations. This author will also look at the evaluation of the critical care pharmacology class as it is the only blended learning class offered. If the summative evaluation of this class is a one or two, this author will propose to change ECG Parts I and II to a blended learning format for future ICU/Progressive Care Orientation sessions.

Data from the resources section will be analyzed to determine if the selected textbooks are appropriate. Currently the classes utilize a progressive care textbook promoted as a study guide for a national progressive care certification examination. The MSPC nurse educator and the system nursing education specialists will revise their

interactions with the individuals based on the information provided by the survey. The goal is for MSPC nurse educator and the system nursing education specialists to be visible on the unit and spend quality communication time with the individuals.

Simulation training results will be reviewed with the purpose of making revisions in the case based scenarios. These revisions may include moving to more advanced progressive care case based scenarios.

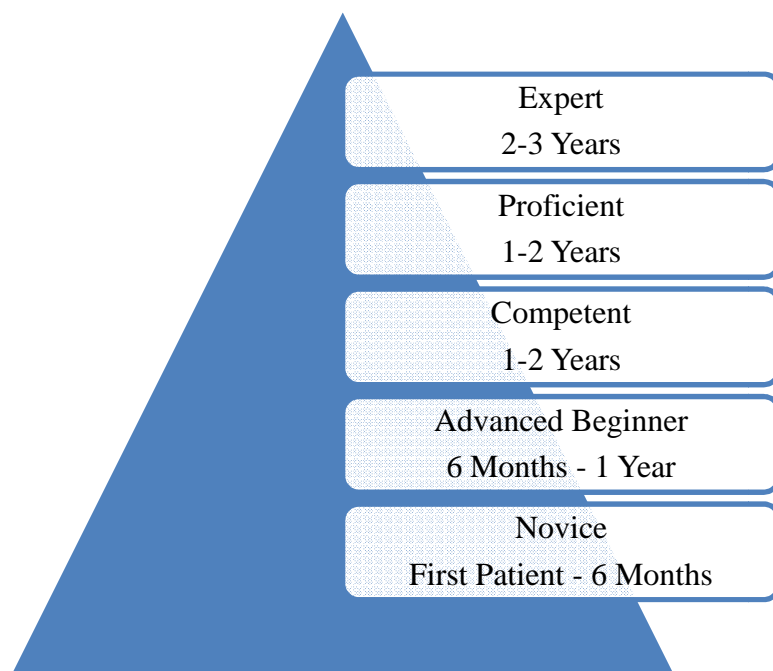
The additional educational needs section will provide information that can be utilized in progressive care orientation classes and to provide advanced education to all progressive care staff. All additional education offered during this one year project will be evaluated on an individual bases at the end of each session.

Starting the week of the first progressive care patient admission, the project coordinator will round on the individuals every two weeks to include day, night and weekend shifts. The rounding questionnaire consists of open-ended questions and the results will be subjective. The purpose of rounding is to determine additional educational needs of the individuals, to plan for the case based patient scenarios that will be presented in the Unstable Progressive Care Patient class, and provide educational support during the transition.

### **Individual Progression**

During this one-year project, progression along Benner's novice to expert continuum will be evaluated to ensure that the individuals are gaining needed skills and confidence in their progressive care role. Utilizing Benner's definitions of novice, advanced beginner and competent, the individuals will be evaluated as a group. The evaluation process will be completed by holding scheduled meetings with the HCO's

Rapid Response Team members. An author created worksheet will be utilized during these meetings (see Appendix F). Figure 4 shows a projected timeline for the individuals to progress through the levels of Benner's novice to expert continuum.



*Figure 4.* Projected Progression Timeline based on Patricia Benner's Theory of Nursing Education

## **Chapter V**

### **Discussion**

#### **Project Summary**

This project is to provide orientation to expert general medical/surgical nurses as they transition to progressive care medical/surgical nurses utilizing Patricia Benner's novice to expert theory. This orientation project will be cost effective and will support the nurses during the transition. The expected outcomes will be as follows:

1. The nurses will excel through the novice to expert stages based on the fact that they are experts in general medical/surgical nursing.
2. Retention of these experienced nurses will be greater than ninety-five percent, with a goal of one-hundred percent retention.

The nurses are currently going through the ICU/Progressive Care Orientation classes. Their unit is in the process of installing cardiac monitors. Education on these monitors is occurring at the same time. Because of this education overload, the MSPC nurse educator must be visible and available to assist with this transition process.

Additional continuing education will be provided as required, or requested, by the nurses and evaluated independently. This education will be provided as classroom, blended, or on-line, as required by the learners and the material to be presented.

In this particular project, the department nurse educator's background is in progressive care which limits the amount of education required for that position. This will give the nurse educator more time to work with the individuals as they progress through the process. Utilizing information from Schoessler and Farish's 2007 study, nursing education should emulate the influential characteristics identified by the study's



subjects. These characteristics are putting “...essential emotional, intellectual, and physical resources into the reach of the individual...” (Schoessler & Farish, 2007, p. 172). Other characteristics that must flow throughout this project are good communication and positive constructive feedback. The individuals will not know how different this patient population is until they begin providing direct bedside care. They will be overwhelmed in the beginning and providing positive constructive feedback will be essential for growth through the novice to expert continuum.

### **Implications for Nursing**

Staff education is a continual process in all Health Care Organizations. The process of providing education must change based on the learning needs of the staff. This project will become a foundation on which educational projects designed to transition nurses from a lower acuity-level patient population to a higher acuity-level patient population can be built. A positive impact for the nurses in this project will be the fact that they are the trendsetters for all other transitions of this nature within the system. Recognition of these nurses must be system wide as well as individual.

The outcomes of this project will also impact the ICU/Progressive Care Orientation classes. Currently individual classes are evaluated by participants. These evaluations allow the speakers to revise their information and presentation styles. This project will require the ICU/Progressive Care Orientation process to be evaluated in its entirety by a single group of nurses. This condensed evaluation from expert nurses will assist with the refinement of the entire orientation process.

Playing on the current trend in healthcare to plan and initiate a process to obtain national recognition as a center of excellence for care provided to specific patient

populations such as chest pain or stroke, the HCO should initiate a process where internal departments could become system recognized departments of excellence. This process would encourage nursing to participate in a deliberate learning process that would increase the quality of patient care. This process would be an excellent way for this project's department to grow and be rewarded for their efforts.

### **Limitations of this Project**

A limitation of this project is the small number of individuals participating in the project. With the limited number of individuals completing the Role Transition Survey, the data will be affected by the bond that was in place between the individuals prior to the initiation of this project.

Another limiting factor for this group of individuals is the absence of expert role models to watch and imitate. Without these experts, the individuals will have to rely on the knowledge they have obtained from the classes, simulation lab and assistance from nursing education. Their department nurse educator will need to be visible and assist the novice nurses in critical thinking as it relates to this new patient population.

### **Implications for Further Study**

Outcomes of this project should be reviewed and the nurses involved interviewed to determine the positive and negative aspects of this change process. Specific focus on barriers and factors that either helped or hindered the individuals navigate the transition process would provide information that could be utilized in the development of future nursing projects. A focused study on the retention of these nurses can provide insight into the qualities of the orientation classes, the availability of nursing education support, and the recognition of both the individual nurses and the group as a whole, to determine

which aspects of the project were most important to these nurses. Retention of experienced nurses is the key to making a transition of this nature happen smoothly.

*Appendix A***Demographic Characteristics**

**Completion of this tool constitutes consent to participate in this project.**

Age: \_\_\_\_\_ Gender: M\_\_\_\_ F \_\_\_\_

Ethnic background (optional):

- ☐ African-American
- ☐ Caucasian
- ☐ Mexican-American
- ☐ Asian
- ☐ Other

Years as a Registered Nurse: \_\_\_\_\_

Please select the highest nursing degree held:

- ☐ Associates Degree
- ☐ Diploma
- ☐ Bachelor
- ☐ Master's/Graduate
- ☐ Doctorate

Number of year's in general medical/surgical nursing: \_\_\_\_\_

Do you work in a management position? Yes \_\_\_\_ No \_\_\_\_

Do you hold any national certifications? Yes \_\_\_\_ No \_\_\_\_

If yes, please list certifications: \_\_\_\_\_

*Appendix B***ICU/Progressive Care Comprehensive Knowledge Assessment**

Name: \_\_\_\_\_

Unit: \_\_\_\_\_

Date: \_\_\_\_\_

**Respiratory:****Select the best answer for the following multiple choice questions.**

1. Interventions to prevent ventilator acquired pneumonia:
  - a. Good hand hygiene
  - b. Oral care performed at least every 2 hours
  - c. Sedation drug holiday
  - d. All of the above
  
2. A patient has just been intubated. You auscultate breath sounds. Air movement appears to be minimal in both lung fields. The ET tube was probably placed in the:
  - a. Esophagus
  - b. Right mainstem bronchus
  - c. Left mainstem bronchus
  - d. Trachea
  
3. Your patient is in acute respiratory failure and hypoventilating. You would expect your ABGs to show:
  - a. Increased pH, increased pCO<sub>2</sub>
  - b. Decreased pH, increased pCO<sub>2</sub>
  - c. Increased pH, decreased pCO<sub>2</sub>
  - d. Decreased pH, decreased pCO<sub>2</sub>
  
4. You receive the following ABGs on your patient. They are in acute respiratory failure and about to code. Your actions will include:  
pH 7.15  
pO<sub>2</sub> 50  
pCO<sub>2</sub> 80  
HCO<sub>3</sub> 28  
SaO<sub>2</sub> 82
  - a. Administer bicab, increase ventilation and O<sub>2</sub>
  - b. Increase ventilation and O<sub>2</sub>
  - c. Administer bicarb, increase O<sub>2</sub>
  - d. Increase O<sub>2</sub>

5. All patients with a tracheostomy should have the following at the bedside:
  - a. Extra trach with obturator of the same size in its box
  - b. Communication tool
  - c. Ambu-bag with mask
  - d. All of the above
  
6. ABG's are drawn on your patient and you receive the following results:  
pH 7.24  
pCO<sub>2</sub> 80  
pO<sub>2</sub> 54  
HCO<sub>3</sub> 24  
What is your patient experiencing?
  - a. Metabolic Acidosis
  - b. Respiratory Acidosis
  - c. Metabolic Alkalosis
  - d. Compensated Metabolic Acidosis
  
7. NPPV is appropriate for which of the following patient conditions?
  - a. Patients with pneumothorax
  - b. Patients with copious secretions
  - c. Patients with obstructive sleep apnea
  - d. Patients with increased intracranial pressure

### **Renal**

**Select the best answer for the following multiple choice questions.**

8. Your patient is in pre-renal failure. You would expect their serum Creatinine level to be
  - a. Normal
  - b. Greater than 1.2
  - c. Less than 1.2
  - d. Greater than 3.0
  
9. Your patient is in Acute Renal Failure (ARF) secondary to a recent hospitalization. You recognize the patient to be in the second phase (Oliguric/Anuric) of ARF due to all of the following complications **EXCEPT**:
  - a. Shortness of breath
  - b. Hyperkalemia
  - c. Hypokalemia
  - d. Increased urine output

**Trauma:**

**Select the best answer for the following multiple choice questions.**

10. A 48 year-old male is involved in a motor vehicle crash (MVC) car vs. tree at high speed. His chest impacted the steering wheel. Shortly after arriving to the ER, he becomes unresponsive and has no palpable pulse although his ECG shows sinus tachycardia. What are the 3 most likely causes of pulseless electrical activity (PEA) in this patient?
  - a. Acidosis, drug overdose, acute coronary syndrome
  - b. Drug overdose, hypothermia, pulmonary embolus
  - c. Hyperkalemia, hypothermia, pulmonary embolus
  - d. Hypovolemia, hypoxia, cardiac tamponade
11. Due to his large, firm abdomen the patient's breathing is shallow. Which lab value is the best indicator of poor ventilation and impending respiratory failure?
  - a. Oxygen saturation of 97% on 2 liters of oxygen
  - b. PaO<sub>2</sub> of 130 on 100% non-rebreather
  - c. pCO<sub>2</sub> of 64 on 4 liters of oxygen
  - d. pH of 7.55
12. An important intervention to prevent delirium in 78 year-old patient with multiple rib fractures is:
  - a. Increase sensory input such as leaving television on
  - b. Minimize activity
  - c. Pain management
  - d. Restraints

**Heart Failure:**

**Select the best answer for the following multiple choice questions.**

13. Heart Failure describes a set of signs/symptoms that result from any structural or functional cardiac disorder that impairs the ability of the ventricle to fill with and/or eject blood.
  - a. True
  - b. False
14. The most frequent patient symptom (complaint) of acute HF is
  - a. Worsening Shortness of Breath
  - b. Pain in abdomen
  - c. Swelling in legs
  - d. Poor appetite

15. Diuretics remain the mainstay of treatment in acute heart failure because they can relieve acute symptoms by
- reducing intravascular fluid volume and therefore afterload
  - reducing intravascular fluid volume and therefore preload
  - reducing intravascular fluid volume and increase the SNS stimulation
  - reducing extravascular fluid volume and swelling

**Neuro:**

Select the best answer for the following multiple choice questions.

16. A change in the pts level of consciousness (LOC) is the most sensitive indicator of neurologic dysfunction
- True
  - False
17. Which of the following statements about acute stroke management are correct
- Acute stroke is an emergency
  - Public education is effective in reducing the interval of time from symptom onset to presentation in the emergency room
  - Ischemic stroke causes a focal injury to the brain which progresses over time
  - All of the above

**ECG Strip Interpretation:**

18.



Rate:

Rhythm:

PR Interval:

QRS Duration:

QT Interval:

**Interpretation**



19.



Rate:

Rhythm:

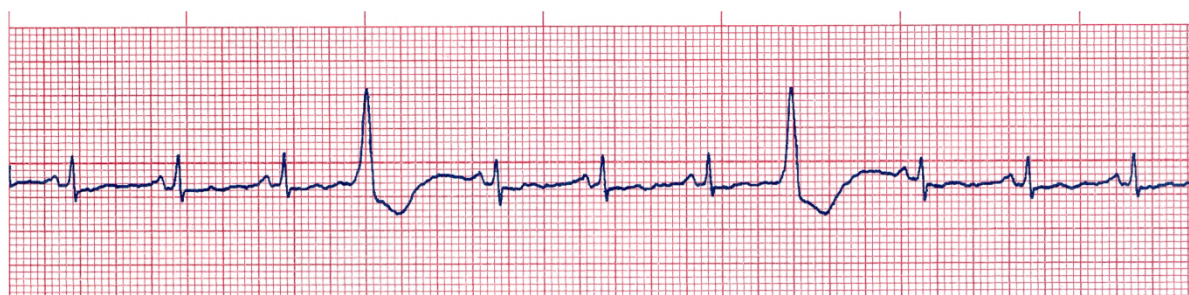
PR Interval:

QRS Duration:

QT Interval:

**Interpretation**

20.



Rate:

Rhythm:

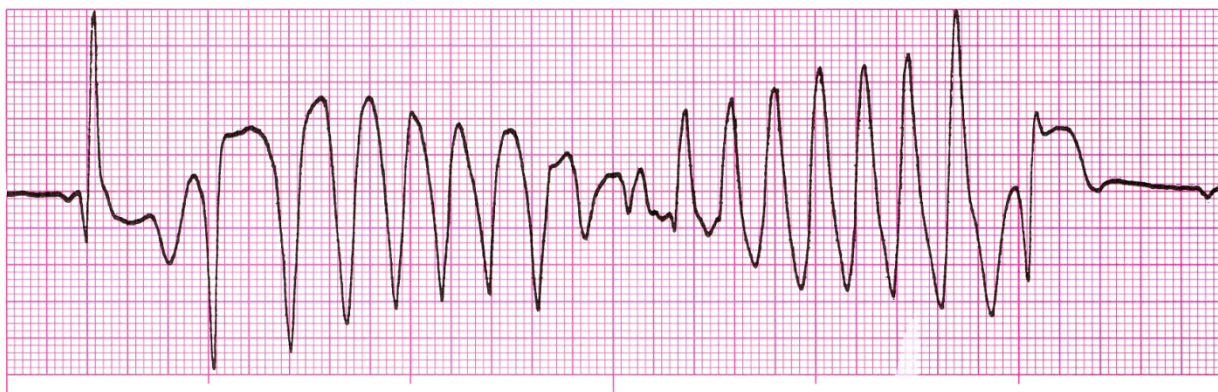
PR Interval:

QRS Duration:

QT Interval:

**Interpretation**

21.



Rate:

Rhythm:

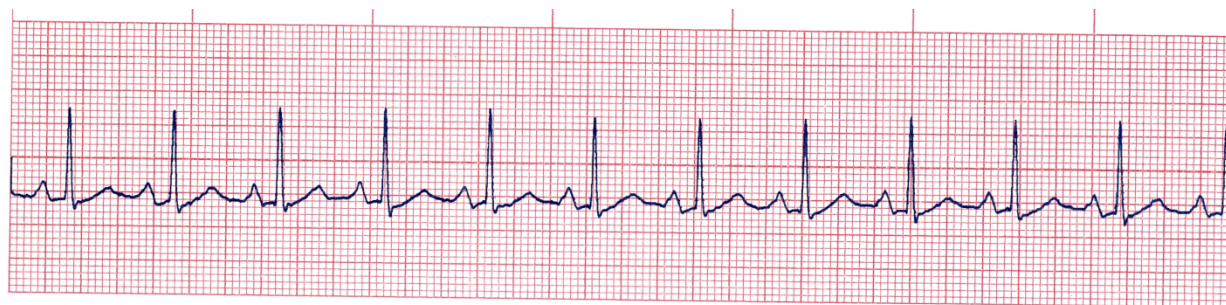
PR Interval:

QRS Duration:

QT Interval:

**Interpretation**

22.



Rate:

Rhythm:

PR Interval:

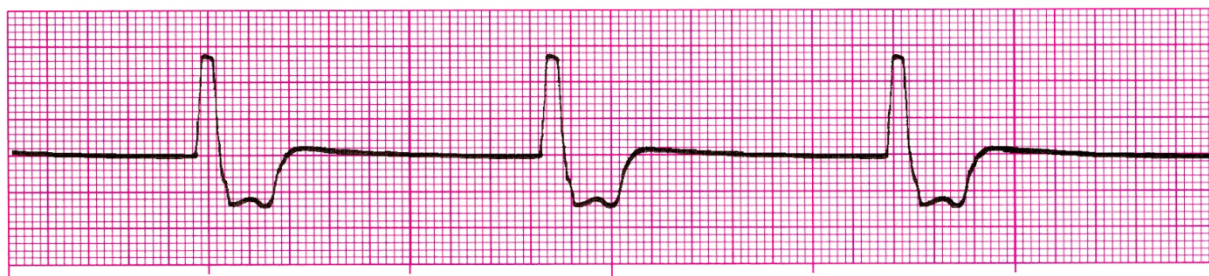
QRS Duration:

QT Interval:

**Interpretation**



23.



Rate:

Rhythm:

PR Interval:

QRS Duration:

QT Interval:

**Interpretation**

24.



Rate:

Rhythm:

PR Interval:

QRS Duration:

QT Interval:

**Interpretation**

25.



Rate:

Rhythm:

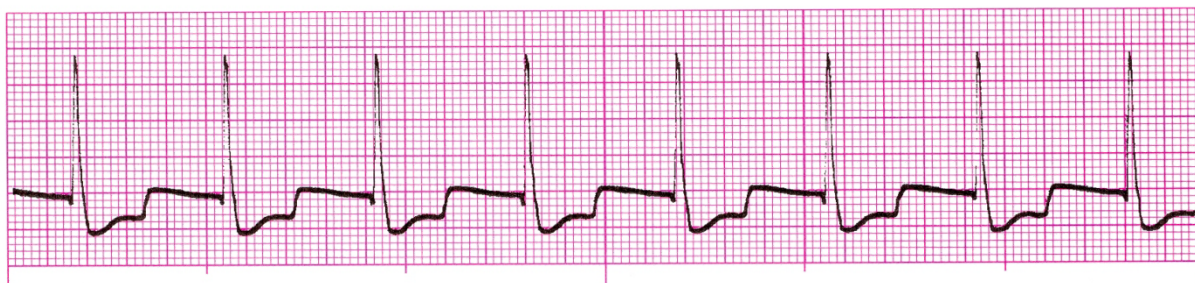
PR Interval:

QRS Duration:

QT Interval:

**Interpretation**

26.



Rate:

Rhythm:

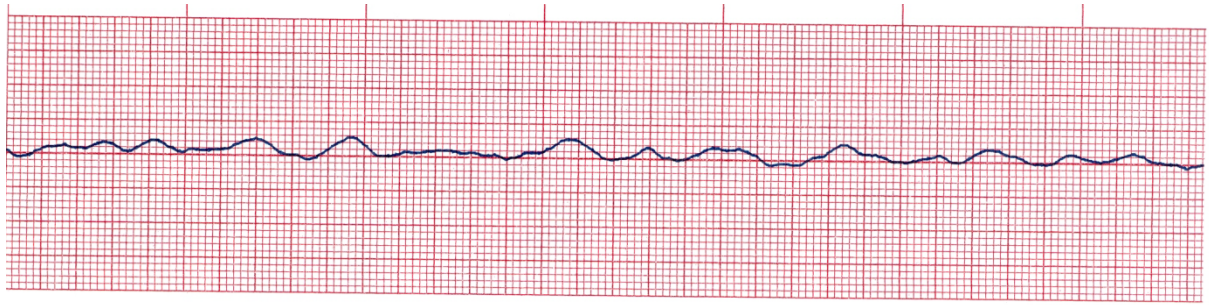
PR Interval:

QRS Duration:

QT Interval:

**Interpretation**

27.



Rate:

Rhythm:

PR Interval:

QRS Duration:

QT Interval:

**Interpretation****Pharmacology:****Select the best answer for the following multiple choice questions.**

28. The patient is in Ventricular Tachycardia with a pulse, is alert and oriented, skin warm and dry, and denies chest pain or dyspnea.

**According to the Adult Emergency Treatment Protocol, treatment should include:**

- A. Atropine 1 mg slow IV push
- B. Lidocaine 10 mg rapid IV push
- C. Synchronized cardioversion
- D. Amiodarone 150 mg/100 ml D5W over 10 minutes

29. Moderate doses (5mcg/kg/min-10mcg/kg/min) Dopamine results in which of the following responses:

- a. Increased urine output
- b. Peripheral vasoconstriction
- c. Increased heart rate and contractility
- d. Decreased heart rate and contractility

30. A patient admitted four hours ago with an anterior myocardial infarction suddenly goes into Ventricular Fibrillation:

**According to the Adult Emergency Treatment Protocol, the best sequence for initial treatment should be:**

- a. CPR, Defib 120 J, CPR, Epinephrine 1 mg IV
  - b. Defib 120 J, Defib 150 J, Defib 200 J, Epinephrine 1 mg
  - c. CPR, Epinephrine 1 mg IV, Defib 120 J, CPR
  - d. Defib 120 J, Amiodarone 150 mg IV, CPR, Defib 120 J
31. Treatment of pulseless electrical activity per the Emergency Treatment Protocol includes:
- a. Epinephrine 1mg (1:10,000) IV
  - b. Normal saline 500 ml IV bolus
  - c. Atropine 1 mg IV with heart rate < 60
  - d. All of the above
32. Which of the following medications is appropriate to be given via rapid IV administration for the treatment of supraventricular tachycardia (SVT)?
- a. Sodium Bicarbonate
  - b. Epinephrine
  - c. Adenosine
  - d. Nitroglycerin
33. As essential treatment element for polymorphic ventricular tachycardia (Torsades de pointes) is:
- a. Calcium
  - b. Potassium
  - c. Magnesium
  - d. Heparin
34. The monitor technician reports that the patient has developed new onset PVC's that are increasing in frequency. What initial action should be taken?
- a. Amiodarone 300 mg IV push
  - b. Amiodarone 150 mg IV push
  - c. Assess patient for hypoxia and electrolyte imbalance
  - d. Have the patient cough vigorously

35. The patient has new onset confusion, blood pressure 70/40, heart rate 45, skin cool and clammy and is in Third Degree Heart Block.

**According to the Adult Emergency Treatment Protocol, treatment may include:**

- a. Transcutaneous pacemaker
- b. Atropine 0.5 mg IV while awaiting pacer
- c. DOPamine 5 mcg/kg/min if B/P remains less than 80 after pacer is on
- d. A and C only

36. The patient is 6 hours post op and has an epidural infusion, blood pressure 68/42, heart rate 110. Which of the following may be used to treat the hypotension?

- a. Milrinone 0.375 mcg/kg/min
- b. Cardizem 10 mg/min
- c. Neo-Syneprine 30 mcg/min
- d. DOPamine 2 mcg/kg/min

37. Atrial Fibrillation is noted on the monitor; the patient is alert and oriented, skin warm and dry, blood pressure is 90/60, heart rate 150.

For new onset, what would you expect the MD to order?

- a. Cardizem
- b. DOPamine
- c. Atropine
- d. Epinephrine

**Please select True or False for the following statements.**

**True False** 38. Morphine sulfate is effective in reducing preload by vasoconstricting the venous system.

**True False** 39. The initial dose of Atropine for symptomatic bradycardia is 2 mg rapid IV push.

**True False** 40. Volume status should be optimized prior to starting a vasoactive agent in the treatment of decreased cardiac output and hypotension.

**True False** 41. Transient hypotension may occur following Cardizem bolus dose.

**True False** 42. Vagal nerve stimulation will produce tachycardia.

**Answer the following short essay questions:**

43. The patient is in Ventricular Fibrillation. Describe initial actions and any pharmacological and non-pharmacological treatment options as ordered in the Adult Emergency Treatment Protocol.

**DRUG CALCULATIONS:**

**The patient goes into atrial fibrillation with rapid ventricular response. The order is received to administer a Cardizem bolus and start an infusion (the infusion is mixed 125 mg/125 ml). The patient weight 100 kg and is 62 inches.**

44. What is the initial bolus?
45. The infusion is started at 5 mg/hr. What is the rate?

**The Cardizem is titrated up to 15 ml/hr and has been infusing four hours, the patient remains in atrial fibrillation, heart rate is 50, and blood pressure is 80/50.**

46. The Cardizem infusion should be **increased/decreased/stopped**. (*Circle correct answer*).



**You are caring for a 60-year-old-male, admitting diagnosis of ischemic stroke. The patient's blood pressure is 70/40; heart rate is 110, resp rate 32. He has received a fluid challenge. An order is written to start DOPamine at 5 mcg/kg/min. The infusion is mixed 800 mg in 500 ml of D5W. The patient weighs 90 kg and is 72 inches.**

47. What is the rate for 5 mcg/kg/min?
48. The DOPamine is increased to 8 mcg/kg/min, what is the rate for this dose?

**The next day during report while checking the infusion dose/rate with the night nurse, the DOPamine is noted to be infusing at 40.5 ml/hr.**

49. What dose is being delivered at this rate?
50. DOPamine infusing at this dose/rate is in the **beta/alpha** range. (*Circle the correct answer*).
51. What is the antagonist for DOPamine if a peripheral site infiltrates?

**A 50 year-old-female is in sustained ventricular tachycardia, heart rate 150, blood pressure 100/50. She denies chest pain or dyspnea. A decision is made to treat this dysrhythmia by administering an Amiodarone bolus and start an infusion. The infusion is mixed 450 mg/250 ml D5W.**

52. What is the bolus dose?
53. If the infusion is started at 1 mg/min, what is the rate?

**8 hours after starting the infusion, the rate is 17 ml/hr.**

54. What dose is being delivered at this rate?
55. The patient goes into complete heart block, the Amiodarone infusion should be **titrated up, turned off immediately, titrated down**. (*Circle the correct answer*)

## Appendix C

### Role Transition Survey

Medical/Surgical Progressive Care (MSPC) Registered Nurse:

The education staff at Mission Hospitals values your feedback. Please fill out the following survey and return it to Barbara Radford in department Nursing Practice, Education & Research. Your identity is completely anonymous. We appreciate your participation!

Date:      Fall 2010

Area of Service	QUALITY RATING					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Applicable
<b>ACADEMIC EXCELLENCE</b>						
Overall, the ICU/Progressive Care Orientation classes were helpful.	1	2	3	4	5	6
On the basis of preparing you for the role of MSPC nurse, please rate each of the following topics presented during the orientation classes:						
Respiratory	1	2	3	4	5	6
Electrocardiogram (ECG) Parts I & II	1	2	3	4	5	6
Acute Coronary Syndromes	1	2	3	4	5	6
Heart Failure	1	2	3	4	5	6
Critical Care Pharmacology	1	2	3	4	5	6
Protocols	1	2	3	4	5	6
Patient Controlled Analgesia (PCA) pump	1	2	3	4	5	6
Mock Code	1	2	3	4	5	6
Neuroscience	1	2	3	4	5	6
Renal	1	2	3	4	5	6
Hemodynamics	1	2	3	4	5	6
Shock	1	2	3	4	5	6
The size of classes did not affect your ability to learn.	1	2	3	4	5	6
Please add any comments in this area.						
<b>RESOURCES</b>						
Overall, the resources available to me are helpful in keeping me competent to care for MSPC patients.	1	2	3	4	5	6
On the basis of preparing you for the role of MSPC nurse, please rate each of the following resources:						
AACN Essentials of Progressive Care Nursing textbook	1	2	3	4	5	6
Nurse Educator for MSPC	1	2	3	4	5	6
Nursing Education Specialist for System	1	2	3	4	5	6

Please add any comments in this area.						
<b>SIMULATION TRAINING</b>						
The case based simulation lab prepared me to care for MSPC patients.	1	2	3	4	5	6
The simulation lab training assisted me in dealing with issues and problems I could face with the MSPC patients.	1	2	3	4	5	6
Please add any comments in this area.						
<b>ADDITIONAL EDUCATIONAL NEEDS</b>						
I am prepared to provide safe, quality care to the MSPC patients.	1	2	3	4	5	6
All my current educational needs have been met.	1	2	3	4	5	6
Please add any comments in this area.						

## *Appendix D*

### **Unstable Progressive Care Patient Class**

1. Class process: Simulation and debriefing
  - a. Simulation (60 Minutes): Select three (3) of their most challenging progressive care patient scenarios
    - \*Maximum of three (3) participants per scenario = class max at nine (9) participants (will require two (2) classes to send everyone through)
    - \*Assignment of a primary nurse, RN, and nursing assistant (to check delegation skills with patient type). No roles outside the RN's scope of practice will be assigned. Having three (3) participants per scenario will allow each to function in the three roles.
    - \*Facilitator will function as MD for needed orders and/or RRT should questions arise that need that expertise.
    - \*Facilitator gives the primary nurse report (SBAR) and then steps back only to intervene when providing MD or RRT information. Scenarios will be stopped if care decisions would cause patient harm. After discussion/questions/answers completed, the scenario will be resumed.
    - \*Some mechanism to provide group with a listing of their decisions w/associated patient outcomes. (Plan to video sessions. Video will be reviewed during debriefing session at end of scenarios. At 12 months, videos will be compared to determine critical thinking growth and further educational needs)
  - b. Debriefing (30 minutes): Facilitator lead and keep discussion moving only.
    - \* All participants are expected to participate in discussion.
    - \* Discussion will focus on patient care decisions w/outcomes, nursing assistant delegation decisions and group dynamics
2. Proposed class agenda: No major introduction required since this will be introduced in another part of the project design
 

0900-1030	Simulation/Debriefing
1030-1045	Break
1045-1215	Simulation/Debriefing
1215-1300	Lunch
1300-1430	Simulation/Debriefing
3. Plan to have same facilitators, same person running Sim-Man, same scenarios, same location, and same participant groupings for all Unstable PC Classes as possible.

*Appendix E***Project Coordinator Rounding Questionnaire**

1. Most rewarding aspect about this patient population (MSPC patients).
2. Most challenging aspect about this patient population (MSPC patients).
3. What is your current educational needs/refresher?  
How many individuals voiced the same need(s)?
4. What is your most pressing educational/refresher need?
5. Other than education, what concerns/issues need to be addressed?
6. Rotation of questions related to the ICU/PC Orientation topics.
  - Respiratory
  - ECG
  - Acute coronary syndrome
  - Heart failure
  - Critical care pharmacology
  - Protocols
  - Neuro
  - PCA pump
  - Mock code
  - Renal
  - Hemodynamics
  - Shock

*Appendix F***Novice to Expert Progression Worksheet**

1. Nursing actions during a crisis:
  - a. Task oriented
  - b. Advancing knowledge regarding the patient's clinical picture
  - c. Considering potential problems before they happen.
2. Decision making ability:
  - a. Needs rules to function
  - b. Bringing the patient into the clinical picture
  - c. Utilized critical thinking skills when dealing with patient situations.
3. Critical thinking abilities:
  - a. None
  - b. Beginning to pull actual clinical picture together with appropriate plan of care
  - c. Consistent use of basic critical thinking skills.

### *References*

- American Association of Critical-Care Nurses (2008). Progressive care fact sheet.  
Retrieved from [www.aacn.org](http://www.aacn.org)
- Anderson, J. A., & Willson, P. (2009). Knowledge management organizing nursing care knowledge. *Critical Care Nursing Quarterly*, 32(1), 1-9.
- Bastable, S.B. (2003). *Nurse as educator: Principles of teaching and learning for nursing practice* (2<sup>nd</sup> ed.). Subury, MA: Jones and Bartlett Publishers.
- Benner, P., Tanner, C.A., & Chesla, C.A. (1997). Becoming an expert nurse. *American Journal of Nursing*. 97(6). Retrieved from <http://ovidsp.tx.ovid.com/sp-2.3/ovidweb.cgi>
- Blaich, B. S. (2004). Expert to novice a journey from administrator to entrepreneur. *Clinical Nurse Specialist*, 18(5), 235-237.
- Bridges, W. (1980). *Making sense of life's changes*. Menlo Park, CA: Addison-Wesley Publishing.
- Brykczynski, K. (2006). Patricia Benner from novice to expert: Excellence and power in clinical nursing practice. In Tomey, A., & Alligood, M. (Eds.), *Nursing Theorists and Their Work* (pp. 140-166). St. Louis: Mosby.
- Cathcart, E. (2008). The role of the chief nursing officer in leading the practice lessons from the Benner tradition. *Nursing Administration Quarterly*, 32(2), 87-91.
- Cusson, R. M. & Strange, S. N. (2008). Neonatal nurse practitioner role transition the process of reattaining expert status. *Journal of Perinatal & Neonatal Nursing*, 22(4), 329-337.

- Dreyfus, H.L. & Dreyfus, S.E. (1996). The relationship of theory and practice in the acquisition of skill. In P. Benner, C.A. Tanner, & C.A. Chesla (Eds.), *Expertise in nursing practice: Caring, clinical judgment and ethics* (pp. 29-47). New York: Springer.
- Gershenson, T. A., Moravick, D. A., Sellman, E., & Somerville, S. (2004). Expert to novice: A nurse leader's evolution. *Nursing Management*, 35(6), 49-52.
- Retrieved from [www.nursingmanagement.com](http://www.nursingmanagement.com)
- Gomes, M. M., Higgins, A. L., Butler, R., Farzaneh, J. R., & Everson, F. P. (2009). Anatomy of a staged orientation process. *Journal of Emergency Nursing*, 35(6), 575-579.
- Haag-Heitman, B. (2008). The development of expert performance in nursing. *Journal of Nurses in Staff Development*, 24(5), 203-211.
- Harton, B., Borrelli, L., Knupp, A., Rogers, N., & West, V. (2009). Integrating traditional nursing service orientation content with electronic medical record orientation. *Journal for Nurses in Staff Development*, 25(5), 229-235.
- Lyneham, J., Parkinson, C., & Denholm, C. (2008). Explicating Benner's concept of expert practice: Intuition in emergency nursing. *Journal of Advanced Nursing*, 64(4), 380-387.
- Moran, P. (2010). From expert to novice. *Professional Case Management*, 15(2), 101-102.
- Schoessier, M. & Waldo, M. (2006). The first 18 months in practice a developmental transition model for the newly graduated nurse. *Journal for Nurses in Staff Development*, 22(2), 47-52.



- Schoessler, M. T. & Farish, J. (2007). Development at the bedside: Evolutionary development of the experienced registered nurse. *The Journal of Continuing Education in Nursing*, 38(4), 170-175.
- Steeffel, L. (2004). Step forward: Progressive care units allow nurses to provide more specialized care and help improve patient satisfaction. E-Nurse Week. Retrieved from <http://www.nurseweek.com/news/Features/04-10/ProgressiveCare.asp>
- Thomes, J. (2003). Changing career paths from expert to novice. *Orthopaedic Nursing*, 22(5), 332-334.
- Valdez, A.M. (2008). Transitioning from novice to competent: What can we learn from the literature about graduate nurses in the emergency setting? *Journal of Emergency Nursing*, 35(5), 435-440.