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Development of an Orientation Program for New Nurse Employees at One Rural Hospital

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Running Head: ORIENTATION

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The nurse in the rural hospital needs to be a generalist, as nurses may be required to work in several, or even all, areas of patient care. This presents a challenge when orientating a new nurse employee, particularly if that nurse is a recent graduate or if the nurse's experience lies solely in one area of specialization, such as coronary care, obstetrics, or other clinical practice areas. Within just a few weeks, the nurse needs to learn how to independently function while caring for medical patients, surgical patients, pediatric patients, emergency patients, swing bed residents, and possibly obstetrical and newborn patients, as well as learning the routine of all shifts. Some nurses are also expected to function in the charge nurse role immediately upon hire.

Problem and Purpose

Based on her own experience and that of her nurse colleagues, the author has determined that the orientation program of one selected rural hospital requires modification. At that facility, the director of nursing schedules new nurse employees. These new employees are assigned by the charge nurse to any staff nurse who may be scheduled that particular shift, without any particular consistency. Checklists are used, but they were developed many years ago and are out of date. A supervisor or director does not consistently collect completed checklists, nor do they conduct formal or informal evaluations. Thus, the orientation for a new nurse is often incomplete and the nurse may feel incompetent. The purpose of this project was to develop an orientation program for new nurse employees that can be used consistently at this selected rural hospital.

Theoretical Framework

The theoretical framework for this project is based on Patricia Benner's "from novice to expert" model. In this model, the nurse experiences five different stages as he/she transitions from a novice to an expert (Mitre, Alexander, & Keller, 1998). In the *novice* stage, the nurse has no background experience from which to draw. This level usually applies to nursing students, but can also apply to nurses with limited clinical experience when assigned to new clinical settings.

The second stage is that of the *advanced beginner* (Mitre, Alexander, & Keller, 1998). According to Benner's theory, the advanced beginner has the ability to recognize recurring issues in situations. The advanced beginner is task-oriented and rule-guided, and sometimes has difficulty grasping the larger perspective. The advanced beginner is capable of managing patient care, yet still relies on the help of more experienced nurses. New graduate nurses often fall into this category, and so might nurses encountering new clinical settings.

The third stage in Benner's model is that of *competency* (Mitre, Alexander, & Keller, 1998). The competent nurse has learned from actual practice and from observing others. The competent nurse is able to manage patient care on his/her own, but only with "conscious and deliberate planning" (Mitre, Alexander, & Keller, p. 162). Mitre, Alexander, & Keller call this stage "pivotal in clinical learning" (p. 162), because it is at this stage that the nurse's focus turns from himself/herself and his/her own organization and efficiency to that of the patient, recognizing that each patient situation guides the nurse's response.

The fourth stage in this model is *proficiency* (Mitre, Alexander, & Keller, 1998). In this stage, the nurse is able to perceive a situation as a whole, rather than in terms of its aspects and tasks. Nurses at this level demonstrate increased confidence in their own knowledge and abilities.

The final stage of Benner's model is that of the *expert* (Mitre, Alexander, & Keller, 1998). The expert has a large background of experience from which to draw conclusions and interventions. This nurse is able to intuitively grasp a patient situation and identify the problem and solutions without having to spend time considering alternative problems and solution. It is hoped that the preceptor, or mentor, within this orientation program would be in the proficient or expert level in his or her nursing knowledge and ability.

Assumptions and Limitations

An assumption of this project was that there will be experienced staff nurses who will be willing to serve as preceptors. Another is that the director of nurses (DON) and other staff will intend to follow this orientation program as it was designed. A third is that the newly developed orientation policy and program components will be reviewed and appropriately updated over time. It was assumed that, when asked for their input, the DON and charge nurses thoroughly reviewed the program components and that their feedback was honest.

A limitation of this project was that a new director of nurses took over the position midway through completion of the project. While the new DON was continuously supportive and helpful throughout the process, it was the first DON who was originally consulted and who initially gave approval for the project. A second

limitation is that, in this small facility, new employees are infrequently hired; therefore, there was no opportunity to implement and evaluate the program while it was being developed.

Literature Review

While there is much literature focusing on preceptors, mentors, and new graduates hospitals. Rural hos, no research was found specific to orientation for new nurse employees in rural pitals have special needs, including the necessity for the nurse to work in several or all clinical areas, and few resources available for use during this orientation time.

Orientation Studies

Reising (2002) conducted a study specific to the orientation of new critical care nurses. She studied the early socialization process of critical care nurses. She interviewed new critical care nurses and preceptors, and uncovered five phases of socialization: the prodrome, welcome to the unit, disengagement/testing, on my own, and reconciliation. These phases can be related to the first three stages of the novice to expert model.

The prodrome, according to Reising (2002), is the point at which the individual is choosing to enter nursing or a particular clinical practice area. Here the nurse is still in the novice stage. In the welcome to the unit phase, the new nurse is beginning the process of socialization within the unit. He/she may be taking some initial courses relevant to the practice area, meeting the nurses on the unit, and beginning to care for patients with preceptors. This phase is also consistent with the novice stage. In the disengagement/testing phase, the nurse is given increased responsibility and being

challenged more by the preceptor. The nurse is beginning to enter the advanced beginner stage. During the on my own phase, the nurse is "putting it all together," gaining confidence and organizational skills, and managing more difficult patients. The nurse is in the advanced beginner stage. Finally, in the reconciliation phase, the new nurse is breaking ties with the preceptor, and assuming more responsibility by taking his/her own case loads. He/she acknowledges that he/she is in a continual learning process. This is consistent with Benner's stage of competency. The nurse is able to manage patient care on his/her own but with deliberate planning and frequent guidance.

Oermann and Moffitt-Wolf (1997) studied the stresses, challenges, and threats experienced by new graduates in their initial orientation period to a hospital setting as well as the relationship of social support to these stresses, challenges, and threats. A sample of 35 new graduates in different clinical areas participated in the study. It was found that new graduates did experience a moderate level of stress during clinical practice, but that consistent preceptors facilitated their learning during orientation.

Clayton, Broome, and Ellis (1989) studied the effect of a preceptorship on the socialization of baccalaureate graduate nurses into their professional role. Sixty-six senior nursing students, half guided through their practicum by a faculty member, and half in a preceptorship experience, completed a pretest-posttest questionnaire (Schwerian's Six-Dimension Scale of Nursing Performance) at three different time intervals: prior to the senior practicum experience; immediately after the practicum experience; and six months after graduation. The findings of this study suggested that working with a practicing nurse enhanced the transition to staff nurse more than working with a faculty member.

Oermann and Garvin (2002) studied the stresses and challenges new graduate nurses face in their initial clinical practice in hospitals. Forty-six new graduates were surveyed regarding the stresses, challenges, and emotions experienced in their clinical practice. Stresses most frequently reported by the new nurses were not feeling confident and competent, making mistakes because of increased workload and responsibilities, encountering new situations, surroundings, and procedures, and inconsistent preceptors. The greatest challenges faced were applying the knowledge they learned in school to their patients' care and acquiring new skills.

An Australian study examined the amount of time spent by nursing unit managers in educational activities, including educating new employees (Duffield, Wood, Franks, & Brisley, 2001). The study found that nurse managers spend little time in educating nurses and suggested that education activities be delegated to the expert clinicians on the nursing units.

In the United Kingdom, Cameron-Jones and O'Hara (1996) studied the mentor role. This study listed 18 aspects of the mentor role and asked 87 nurse mentors and 39 student nurses to evaluate how much emphasis he or she put on each aspect. It was found that both groups emphasized the role of supporter for the nurse mentor. However, the mentors also thought an important part of their role was to be an "eye-opener," "door-opener," and a friend, while the students thought the most important role was that of problem-solver, assessor, and energizer.

Mentor/Preceptor Studies

Much of the literature discusses the concepts of mentor and preceptor. One author distinguishes a mentor from a preceptor in that a mentor is "an experienced nurse

who shares knowledge with less experienced nurses to help advance their careers" and that a preceptor is "a nurse who assumes responsibility for teaching a novice" (Fawcett, 2002, p. 950). Mentor implies a long-term relationship, whereas preceptor implies a teaching relationship that ends when the novice is considered educated. The end of a mentoring relationship, however, is undetermined and may extend over a longer period of time. Nurse mentors understand mentees and how they communicate, follow standards and policies, and are certain of the role of the professional nurse. By definition, a mentor cannot be assigned. Rather, the mentee selects the mentor. Fawcett (2002) states that mentors should possess certain characteristics including patience, enthusiasm, knowledge, a sense of humor, and respect. Mentors help in the socialization of new nurses. A mentor should facilitate a sense of belonging for the new nurse.

Shaffer, Tallarica, and Walsh (2000) defined a mentor as one who "listens, affirms, counsels, encourages, seeks input, and helps the novice develop expert status and career direction" (p. 33). The preceptor is defined as one who "performs a formal, structured task with a narrow focus" (Shaffer et al., 2000, p. 33). This definition also implies that the mentor relationship is long term, whereas the preceptor relationship is likely assigned by a manager and much more narrow in scope. Shaffer et al. further state that mentoring is a win-win relationship for all involved. The mentor gains new leadership and teaching skills, the learner learns diverse skills such as stress management and organization, and the organization benefits with better management-staff relations and greater nurse retention.

While there are defined differences, the concepts of mentor and preceptor are similar, and frequently used interchangeably. For the purposes of this project, the term preceptor will be used.

One issue regarding nurse orientation that emerges from the literature is that of having a consistent preceptor. Nurses frequently cite the lack of a consistent preceptor as a hindrance to their orientation experience, or having a consistent preceptor as a benefit to their experience (Kramer, 1993; Oermann & Garvin, 2002; Oermann & Moffitt-Wolf, 1997; Squires, 2002; Vandenberg, 1997). In a small rural hospital with fewer resources, this may not be as feasible as in a larger hospital, or larger department. However, it should be possible to have two consistent preceptors, perhaps one for different shifts, or one for acute care and one for "swing-bed" care.

Aspects of Orientation Programs

Vandenberg (1997) states that checklists are helpful in preceptor programs, particularly for the new graduate. She also suggests planning and feedback sessions at the beginning and throughout the orientation. Finally, she recommends that a review of the preceptor program be presented to all nurses on the unit in order that they are able to be supportive of the program and the orientee. Chosen preceptors should be experienced nurses with clinical experience in the area in which they will be precepting, they must demonstrate a desire to serve as a teacher, they should use the nursing process effectively, and they should have a positive professional attitude and interpersonal skills.

Kramer (1993) reported several criteria necessary for a preceptor to be selected. These nurses, to serve as preceptors, should have: nine to twelve months experience on the specific unit; should be proficient in clinical, teaching, and problem-solving skills;

communicate effectively in charting and shift report; and demonstrate interest in enhancing their professional growth. Preceptors need to be able to assess, plan, intervene, and evaluate the new staff member's learning needs. Skills checklists are beneficial in helping the preceptor and preceptee work together in developing and evaluating goals, and "informal feedback sessions are helpful for providing suggestions, sharing insights, and clarifying information" (Kramer, 1993, p. 276). Responsibilities of the preceptee are to communicate with the preceptor to develop goals and objectives. Responsibilities of the unit manager and the staff development personnel are to periodically evaluate the orientation methods, collaborate with all staff, and supply personnel with staffing and scheduling information and other unit-specific information.

As stated earlier, the nurse in the rural setting needs to be a generalist. This nurse also needs to be creative with his or her available resources. There are frequently no physicians or ancillary technicians available in the facility, and the nurse needs to know who to call, where to call, and what warrants a call (Shellian, 2002). Shellian also noted that rural nurses frequently look after the people they know, and that this instills a strong sense of accountability. The rural nurse is always the "nurse" in her community.

Squires and McGinnis (2001) discussed critical care orientation in a rural community hospital. In their program, newly hired nurses received formal instruction in performance improvement areas, such as pain management, restraint use, medication errors, pressure ulcer prevention, and cardiopulmonary arrest management. They were provided an orientation to pharmacy, respiratory care, intravenous therapy, and the various equipment used in the facility. They also tried to schedule new nurse hires that

had completed their orientation on the same shifts as their preceptor for the next two to three weeks.

Squires (2002) discussed new graduate orientation in a rural community hospital. In this program the new graduate nurse completed "an eight-week program centered around providing social support and integrating theoretical content into clinical practice" (Squires, 2002, p. 204). This program consisted of weekly three-hour sessions in which the new graduates were given the opportunity to vent, examine case study modules, and complete a computer-based training. Throughout the program the nurses had a chance to evaluate their clinical practice readiness through a questionnaire. It was found that what the new graduate nurses liked best about the program was the venting time. What they liked least were the case studies as homework.

While no literature was found specific to general nurse orientation in a small rural hospital, several themes can be taken from the literature while developing this orientation program. First, insofar as possible, consistent preceptors should be used. These preceptors should be the clinical experts on the unit as well as individuals who enjoy teaching and value professionalism. Secondly, frequent feedback sessions and evaluation periods are helpful. Thirdly, skills checklists are helpful in evaluating what the new nurse employee and learned and planning for needs the new nurse still has.

Procedure

Included in this orientation program were the development of an orientation policy, a sample schedule that can be used for orientation, updated skills checklists for new nurse employees, and an evaluation tool for evaluating each new nurse employee's individual orientation. The policy (see Appendix A) that was developed was primarily

based upon the literature findings. Similar policies from other facilities were reviewed, and feedback of the current orientation program was obtained from nurses who had recently (within the past 1-2 years) begun employment at the facility. The DON reviewed the policy and gave input based upon her expectations. The policy will be finalized by the DON and added to the current policy and procedure manuals. All policies at this hospital are reviewed and updated periodically.

Checklists (see Appendix B) were designed that can be utilized by both registered nurses (RNs) and licensed practical nurses (LPNs) for acute care, special care unit, and the emergency department. The current swing bed checklist will continue to be used, as it has been more recently updated and does fit the needs of the department. Since obstetrics (OB) is a highly specialized area and not all nurses are trained to work in that area, the orientation for that department will be managed by the OB supervisor. A checklist was also designed for charge nurse orientation.

The checklists that were currently in use were reviewed. Additions and deletions were made based on current needs of the department. The DON and charge nurses were given opportunity for input; items were added and deleted based upon their thoughts and what they saw as needed skills and knowledge of a new nurse employee.

The checklists were designed with three columns for check off on each skill: Information Given; Done with Supervision; and Done Independently. The rationale behind this is that in a nurse's given orientation period, there may not be opportunity to witness or perform each skill. For example, there are certain things that are only seen on the unit once every several months, such as parenteral nutrition, portacath access, or a code blue, for example. This format gives the new employee opportunity to receive

information on and discuss certain skills that he or she may not get a chance to perform during the orientation. Conversely, there may be skills that an experienced nurse can do independently without extensive information or supervision, such as AM and PM care, or medication administration, for example.

While every skill may not have been done independently by the new employee at the conclusion of the orientation period, the employee will at least have received information on everything included. He or she can continue to work on completing the checklists throughout the first several months of employment. The final completion of the checklists can be one component in assessing the employee's readiness for further leadership responsibilities on the unit, for example, second RN or charge nurse.

The new nurse employee will be given copies of all checklists at the beginning of his or her orientation period. He or she will also be given a tentative schedule at the beginning of orientation. This will give the employee an opportunity to begin formulating objectives for this learning period. The employee and his or her preceptor will review the checklists and mark items completed on an ongoing basis throughout the orientation. This will be used as direction for guiding the remainder of the orientation period.

The sample schedule (see Appendix C) was based upon the written policy as well as ideas from the DON. The DON will be the individual, at least initially, coordinating orientation for new employees, so it is important that she agrees with the format and plans for implementing this program.

The final component of this orientation program is the evaluation (see Appendix D). This is the tool that will be completed by the new nurse employee at the conclusion

of his or her orientation period. The development of this tool was based upon the written policy. The orientation program can be changed and/or updated based on new employees' responses over time.

These components were done with the collaboration and input of the DON. Upon completion, the program was reviewed with the director of nursing, the medical-surgical supervisor and the charge nurses on the unit before implementation. All components were reviewed by the DON as well as several charge nurses from the unit. These individuals were given opportunity to share their input which was taken into consideration throughout the development of each component. Based upon this input, it is hoped that this orientation program will be of the most benefit to the new employee as well as easily integrated into the current routines of the department and hospital. Because it will become part of the departmental policies and procedures, the program will be reviewed periodically and updated as needed.

Recommendations for Nursing Practice, Education, Research and Policy

A recommendation for nursing practice is that facilities incorporate and utilize structured methods that are based upon the nursing literature into their orientation programs for new employees. This will help to ensure a consistent orientation experience among employees as well as assist in tailoring the orientation to each employee's needs.

It is recommended that nursing education programs include a rural health component into their curricula. Rural health settings have appreciably different needs than larger health settings, and it is important for nurses to have an understanding of these needs. Even nurses that work in larger health care settings will benefit from an understanding of rural health as there are often close ties between a rural facility and a

larger facility. Rural facilities rely on larger clinics and hospitals to offer to patients what they cannot, and it is helpful that nurses understand the limitations, yet abilities of rural facilities.

Recommended for research include studies that research how a nurse employee's orientation experience relates to his or her job satisfaction and how a facility's orientation program relates to its retention rates. In particular studies are needed that focus on new nurse employees and experiences within rural hospitals.

Finally, for nursing policy, it is recommended that facilities make every attempt to have an orientation program in place and that it is routinely reviewed and updated. A well planned and structured orientation should facilitate learning for the new employee, ease the department's or facility's burden of training new nurses, and ultimately improve patient care.

It is hoped that with a consistent and planned orientation program, new nurse employees will be able to help guide their own experience, feel more prepared for the particular clinical setting, and that the program will ultimately increase nurse retention.

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Appendix A

St. Aloisius Medical Center
Harvey, ND

STANDARD POLICY

Title: ORIENTATION, MEDICAL-SURGICAL

Date:

1. Each nurse employee receives an individually tailored orientation to the facility and the department (medical-surgical floor). The departmental orientation will consist of actively working in the department as extra staffing under the direct and indirect supervision of the preceptor, sessions with the preceptor regarding policy and procedures, and independent information gathering regarding hospital policy and procedure.

2. Either the employee or the preceptor may request additional orientation time for any employee who may require it. New graduate nurses particularly may require additional time.

3. The employee will spend the duration of the orientation period under the supervision of one or two primary preceptors. When it is not possible to work with the primary preceptor, either the primary preceptor or the charge nurse may assign another nurse for the employee to work with for that shift.

4. The primary preceptor(s) will be chosen by the director of nursing based upon experience in the department, proficiency in clinical, teaching, and problem-solving skills, communication skills, and an interest in teaching and enhancing professional growth.

5. The employee is expected to communicate to the supervisor and/or preceptor his/her special needs and/or desires regarding expectations of orientation.

6. The employee will receive an orientation to pharmacy, respiratory care, infection control, laboratory, and safety procedures as they relate to nursing by the pharmacist, respiratory therapist, infection control nurse, lab techs, and safety director respectively.

7. An informal evaluation will be completed mid-way through the orientation period with the employee, preceptor, and director of nursing. Both the employee and the preceptor may offer feedback on how the orientation is progressing and develop goals for the remainder of the orientation period.

8. A formal evaluation will be completed with the employee, the preceptor, and the director of nursing at the conclusion of the orientation period. At this time, the orientation checklists will be reviewed. It will be the employee's responsibility to keep

the checklists updated until they are completed, at which time they will be given to the director of nursing to be kept in the employee's file.

9. Checklists to be completed include:
   - Orientation for RN/LPN
   - Orientation to Swing Bed
   - SCU Orientation (RNs only; may be completed at a later time unless the employee will be working in the 2nd RN or charge nurse position)
   - ER Orientation
   - Charge Nurse Orientation (if/when orientating to charge nurse position)

10. All department policies will be reviewed with special time set aside for review with the preceptor.

11. The attached sample orientation schedule can be used as a guideline for designing the employee's orientation. It should be modified based upon the employee's needs, the preceptor's schedule, and the availability of other staff and resources, i.e. pharmacist, respiratory therapist, DON, Education Days, etc.

Appendix B

Checklists

Orientation Checklist for RN/LPN

St. Aloisius Medical Center

SKILL	Information Given (Initial & Date)	Done with Supervision (Initial & Date)	Done Independently (Initial & Date)
AM and PM cares			
Admission procedure			
Discharge procedure			
Pre-operative care			
Post-operative care			
Dressings			
Dressing cart location and organization of contents			
Warm packs			
IV therapy (initiation and maintenance) See IV checklist			
Blood transfusions (view *Essentials of Blood Therapy* video)			
Platelet transfusions			
Nasogastric tube placement			
Nasogastric tube maintenance			
Tube feeding			
Wall suction			
Portable suction			
Catheterization (indwelling and intermittent)			
Foley catheter maintenance			
O2 equipment			
Respiratory treatments			
Weighing—standing/hoyer			
Bed operation			
IV pumps			
PCA pump			
Blood warmer			
Accuchecks			
Post-mortem care			
Portacath access			
Portacath maintenance			
Central and PICC line care			
TPN/PPN therapy and maintenance			
Blood pressure machines			
Telemetry			
Assessment			

Neurologic			
Cardiac			
Pulmonary			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Skin			
Medications			
Orientation to pharmacy (with pharmacist)			
Administration of medications (oral, rectal, intramuscular, subcutaneous, intravenous, ocular, topical)			
Charting medications			
Ordering and storing new medications			
Crediting medications			
Medications to be sent home with patients			
Patient's own meds			
72 hour narcotic and 5-day antibiotic orders			
Narcotic, stock, and emergency drug count and replacement			
Mixing medications (antibiotics, K-riders, cardiac drips)			
Medication errors			
Dietary			
Times meals served			
Requisitions for diets			
Snacks and supplements			
Recording meals			
Laboratory and X-ray			
Requisition forms			
Requisitions on evenings, nights, weekends, holidays			
Stat requisitions			
X-ray procedure preps			
Nuclear medicine requests and preparation			
Nuclear med and U/S notification when no other tests scheduled			
Blood bank			
Cultures			
Specimen collection and delivery			
Safety			
Restraints (wrist, geri-chair, posey)			
Personal alarms			
Location of fire alarm box, fire hoses, extinguishers, fire pillow			
Fire, tornado, and disaster plan (may be done with safety director)			

Charting			
Varied chart forms			
Errors in charting			
Assisting with transcription of doctor's orders			
End of shift chart/order verification			
24-hour verification of physician orders (night shift)			
Miscellaneous			
Code Blue			
Paging system			
Telephone system and courtesy			
Intercom			
Care of valuables			
Continuing education forms			
Nursing care plans and care conferences			
Shift report			
Staffing the next shift (when charge nurse unavailable)			
Occurrence reports			
Standing orders			
Physician notification Re: admits, discharge, incidents, deaths			
Patient education materials			
OB orientation (done with OB supervisor)			
Infection control (done with Infection Control Nurse)			
Isolation procedures (Infection Control Nurse)			

Employee_____ Date_____

Preceptor_____ Date_____

DON_____ Date_____

Emergency Room Orientation

Checklist for RNs and LPNs

St. Aloisius Medical Center

SKILL	Information Given (Initial & Date)	Done with Supervision (Initial & Date)	Done Independently (Initial & Date)
General tour			
Location of policy book and medical handbooks			
On-call physician schedule and routine			
Use of radio			
Mandatory reportables			
Admission of Patient:			
Report to front desk or ambulance entrance			
Consent to treat signed and witnessed			
Assessment, including VS and cardiac monitor if indicated			
Documentation/charting			
Notification of physician on call			
Notification of pastoral care, if required			
Required Forms:			
Lab, x-ray, and respiratory requisitions			
Procedure to turn on x-ray equipment			
Charge sheet for nursing services			
Charge sheet for supplies			
State department forms			
Vaccination forms			
Transfer sheets			
Code sheets			
Trauma sheets			
Release of information			
Autopsy, amputation permit			
Removal of remains and notification of LifeSource			
Privacy policy (HIPAA)			
Medications:			
Keys			
Ointments and OTC meds			
Narcotics			

Refrigerated medications			
TNKase			
Nitroglycerin			
Stock meds for prescriptions			
Contacting o/c pharmacy for OP prescription care			
General Supplies:			
Use of index for supplies			
Casting and splinting materials			
Linens			
Cold and warm packs—PT, one cold pack in ER fridge			
Specific care trays (eye, nasal, vaginal, ear, etc.)			
Central supply location and access			
IV supplies			
Suture supplies			
Dressing supplies			
Specimen collection			
Emergency Packs and Special Equipment			
Crash cart			
Monitor:			
1st ER			
2nd ER			
Intubation and airway supplies			
Wall suction			
Oxygen outlets			
Chest drainage tray			
Cut down tray			
Tracheostomy tray			
Sterile supplies and instruments			
Broselow bag			
Blood alcohol procedure			
Emergency OB pack			
Assault kit			
Communication with Switchboard:			
Call back for departments (lab, x-ray, resp.)			
Code blue			
Trauma code			
Emergency button			

Discharge of Patient:			
Documentation (time, mode, condition, pt. ed./instructions)			
Admit to inpatient status or 24-hr observation			
Equipment cleaning and servicing			
General ER facility cleaning			

Employee_____ Date_____

Preceptor_____ Date_____

DON_____ Date_____

SCU Orientation Checklist

St. Aloisius Medical Center

SKILL	Information Given (Initial & Date)	Done with Supervision (Initial & Date)	Done Independently (Initial & Date)
ACLS			
Monitors Set-up and Use:			
Central monitor			
SCU wall monitor			
Portable monitors			
Crash cart monitor			
Telemetry System:			
Electrode placement			
Nurse call button			
12-Lead EKG			
Rhythm strip print-out and documentation			
Tailor alarms to individual patients			
Suspend monitoring			
Admitting and discharging patients			
Crash Cart:			
Cardioversion			
Defibrillation			
Organization of cart/Location of contents			
Code sheets			
Chest tube:			
Insertion			
Maintenance			
CVP:			
Insertion/Supplies			
Monitoring			
Site care			
Arterial Line:			
Insertion/Supplies			
Monitoring			
Site care			
Zero and calibration of CVP and arterial line transducers			
Cut Down			

Suction, set-up			
Ventilator			
Thoracentesis			
Paracentesis			
Cardiac drips (Nitroglycerin, Dopamine, TNKase and other thrombolytics)			
External pacer			
Use of Beds			
Charting			

Employee_____ Date_____

Preceptor_____ Date_____

DON_____ Date_____

Charge Nurse Orientation Checklist

St. Aloisius Medical Center

SKILL	Information Given (Initial & Date)	Done with Supervision (Initial & Date)	Done Independently (Initial & Date)
Completion of RN orientation.			
Completion of ER orientation.			
Completion of SCU orientation.			
Understanding of facility's policies and procedures and where located.			
Displays self as a role model for nursing in attitude, behavior, and appearance.			
Staffs for the next shift according to facility policy, patient needs, and personnel capabilities.			
Makes assignments according to patient needs and personnel capabilities.			
Makes rounds on all patients.			
Makes rounds with physicians, depending on each physician's preference.			
Assigns new patients to appropriate rooms based on staffing needs and patient condition.			
Provides guidance to and assists nursing personnel with their duties.			
Uses appropriate channels for notification of physician in response to patient needs.			
Observes all physician orders and communicates appropriately for the order to be carried out.			
Reviews patient charts, checking for follow through of orders and appropriate documentation.			
Mediates immediate problems between personnel and/or between nursing and other departments.			
Communicates immediate patient needs and orders with other departments and/or switchboard, as indicated.			
Mediates visitation problems.			
Discusses difficult situations with director of nursing.			
Provides nursing care to ER patients or delegates other RN.			
Provides nursing care, including assessment and documentation to new admissions, or delegates to other RN.			
During off-hours, is available to nursing home units to assist with problems that may arise.			

Checks SCU crash cart (night shift).			
Checks ER (every shift).			
Locates needed supplies not available on med-surg floor: (central supply, purchasing, medical records, OR and recovery, physical therapy).			
Understands security systems, door bells, communicating with front desk and whom to notify in case of a security problem on the floor or within the facility.			
Understands Infection Control Procedures.			
Responsibility in event of disaster or fire.			
Understanding of swing bed policies and keeping swing bed charts updated.			
Safely obtains medication from pharmacy that are not available on the floor.			
Demonstrates working knowledge of specific procedures:			
Code Blue			
Chest tube insertion and monitoring			
Spinal puncture			
Transcutaneous pacemaker placement and monitoring			
Ventilator function			
Thoracentesis			
Paracentesis			
Tracheostomy			
Arterial line			
CVP line			

Employee_____ Date_____

Preceptor_____ Date_____

DON_____ Date_____

Appendix C

Sample Orientation Schedule 1

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Week 1		7-3 Tour of facility. Tour of unit. Intro to M/S routine and paperwork.	7-3 ER tour. Lab and x-ray orientation. Policy review.	7-3 Morning: Report and work on floor. Afternoon: Policy review.	Education Days	7-3 Floor. Pharmacy orientation	
Week 2		7-3 Floor. RT orientation. Safety procedures orientation. Policy review if needed.	7-3 Floor. Infection control orientation.	7-3 Orient with ward clerk. Afternoon: Complete policy review.		7-3 Floor	7-3 Floor
Week 3	7-3 Floor	7-3 Floor. Mid-orientation evaluation with preceptor and DON.	11-7 (or 3-11)	11-7 (or 3-11)	11-7 (or 3-11)		
Week 4		7-3 Take patients on floor. Preceptor will take her own lighter assignment; still available as a resource	7-3 Take patients. Preceptor available as a resource.	7-3 Floor. Final orientatation evaluation with preceptor and DON		11-7 On own.	11-7 On own.

Appendix D

St. Aloisius Medical Center

Med-Surg Orientation Evaluation

Date:

1. Are you a? RN LPN
2. How many weeks was your orientation period?
3. Did you have one or two consistent preceptors throughout your orientation?

   Yes No

   Name(s) of preceptor(s):_____

   Comments:

4. Was the length of your orientation period adequate enough to prepare you to work independently within the med-surg department? Was it too long?

   Comments:

5. Did your preceptor offer ongoing feedback on your progress throughout your orientation?

   Comments:

6. Did your preceptor allow you opportunity to express your own feedback regarding your orientation?

   Comments:

7. Was your schedule during orientation appropriate for your learning needs? For example, did you have sufficient opportunity to orient to all shifts? To weekends as well as weekdays?

   Comments:

8. Please comment on patient assignments during your orientation: (too few, too many, too complex, too simple, etc)

9. Were your expectations and/or objectives for the orientation met? If not, how could we have designed the orientation so that your expectations would have been met?

9. From your perspective, how could the orientation to St. Aloisius be improved?

10. Additional comments: