

Development of a Self-directed Orientation Manual for Novice Registered Nurses in Long-term Care

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Abstract

Background: Newfoundland and Labrador (NL) has a rapidly aging demographic requiring increasingly advanced levels of nursing care in long-term care (LTC) facilities. There continues to be many challenges around the recruitment and retention of registered nurses (RNs) in this setting. This has been attributed to the broad range of roles and responsibilities, as well a lack of a clear definition of the RN role in the context of LTC, which can be challenging for the novice RN.

Purpose: The purpose of this practicum project was to develop an orientation resource manual for novice RNs in LTC. Using self-directed learning, the manual can supplement the current clinical orientation for RNs at St. Luke's Homes (SLHs) and improve resident health outcomes by increasing the RN's knowledge and confidence around geriatric nursing care.

Methods: Following the completion of the informal needs assessment at SLHs, it was determined that there was an educational need among the novice RN group for an improved comprehensive orientation program. An integrated literature review and consultations with several key stakeholders experienced in geriatrics were conducted.

Results: Based on the findings from the literary review and consultations, and using theoretical foundations from Knowles' Adult Learning Theory and Benner's Novice to Expert Model, an orientation resource manual was developed. The manual was divided into seven chapters detailing geriatric and leadership content for the RN to access.

Conclusion: For the purpose of this practicum project, while the resource has not been implemented or formally evaluated, "test your knowledge" questions and case-studies were included at the end of each chapter in the manual for the orientee to test their knowledge. Plans

for a qualitative review to examine if the manual assisted with increasing the confidence levels and eased the transition of novice RNs at SLHs have been discussed.

Key Words: registered nurse; novice nurse; geriatric; gerontology; senior; older adult; long-term care; nursing homes; residential care; orientation; preceptorship; orientation program; nursing; and nursing care.

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Table of Contents

Introduction	1
Background	1
Rationale	3
Practicum Project	3
The Resource	3
Contact Person	4
Ethics Approval	4
Practicum Goals and Objectives	5
Overview of Methods	6
Summary of the Literature Review	7
Summary of Consultations	12
Overview of the Orientation Manual	14
Self-directed Learning Component	14
Associated Theories	14
Knowles' Adult Learning Theory	14
Benner's Novice to Expert Model	15
Orientation Manual Content	16
Implementation Plan	17

Evaluation Plan	17
Advanced Practice Nursing Competencies	18
Clinical Competence	18
Research	19
Leadership	19
Consultation and Collaboration	20
Conclusion	21
References	23
Appendix A – Literature Review	30
Appendix B – Consultations	85
Appendix C – Permission Letter Winnipeg Project	110
Appendix D – Orientation Resource Manual	108

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Introduction

Due to the rapidly aging population in NL with complex health comorbidities, there is an increased need for recruiting and retaining RNs as key health care providers in LTC facilities. Historically in NL, there have been challenges around attracting RNs to the LTC setting. This has led to pronounced RN shortages and attrition concerns, as well as adverse health outcomes for seniors residing in LTC facilities (O'Brien, Ringland, & Wilson, 2010; Stuckless & Power, 2012). It has been suggested in the literature that the unique set of roles and responsibilities of the RN in LTC is often misunderstood, which has further attributed to decreased attrition rates among the RN group in LTC (Abbey et al., 2006; Leppa, 2004; McGilton, Bowers, McKenzie-Green, Boscart, & Brown, 2009). A key strategy in improving workplace commitment and satisfaction and enhancing leadership capacity has been the availability of a high-quality comprehensive orientation program for novice RNs entering the LTC environment (Burgess, 2007; McGilton et al., 2009; O'Gara, 2003). At Eastern Health (EH), while there is presently a generalized orientation program for all nursing staff beginning employment in LTC, the clinical orientation and preceptorship process is not structured enough to support the novice RN transitioning to the role as a nursing leader in the LTC environment.

Background

Given the fact that Canadians today are living longer with greater health care needs, there is a growing strain on LTC facilities and the present composition of professional nursing staff (College of Nurses of Ontario, 2007). As leaders and expert clinicians, the role of the RN in LTC is indispensable in the achievement and delivery of positive health outcomes for the geriatric

population. It is therefore imperative that the RN working in LTC has a strong understanding of the unique and broad set of roles and responsibilities required in this environment. The shortage of RNs choosing to work in LTC facilities and committing to geriatric nursing is an ongoing concern in Canada (ARNNL, 2013). This has been associated with several misconceptions around the working environment for RNs in LTC, in which LTC has been described as a workplace of convenience in which the RN's clinical skill sets and assessment skills are not utilized to their full scope of practice (Moyle, Skinner, Rowe, & Gork, 2003). This fact has been contrasted in the literature, where the LTC environment has been described as an exceptional learning environment that emphasizes the leadership, clinical, and coordination skills of RNs (Carlson & Bengtsson, 2014; Choi, Flynn, & Aiken, 2011; Prentice & Black, 2007; Robertson & Cummings, 1991). Both newly graduated RNs, as well as seasoned RNs transitioning their career to the LTC environment, are challenged with a demanding learning curve in order to fulfill the extensive list of roles and responsibilities required of the entry-level practitioner. It is therefore imperative for administration to focus on early interventions that demonstrate support and commitment to RN engagement and educational pursuits in LTC, such as a standardized comprehensive orientation program for RNs (Peltokoski, Vehvilainen-Julkunen, & Miettinen, 2016).

Saint Luke's Homes (SLHs) is a moderately sized 117-bed LTC facility of EH in St. John's, NL with a nursing staff that consists of personal care attendants (PCAs), licensed practical nurses (LPNs), and a smaller number of RNs (Eastern Health, 2015). The current orientation program consists of an organizational-wide orientation day for new hires at EH, followed by a general LTC orientation for all nursing staff. The clinical orientation entails the RN being assigned to a preceptor(s) for a set number of shifts depending on the experience level

of the RN, which is currently guided by a set of generalized entry-level competencies for graduate RNs. There is presently no orientation resource available to distribute to all RN orientees and their assigned preceptors to facilitate the learning process during the clinical orientation at SLHs.

Rationale

Since graduation, I have worked in LTC as a RN for the past three years, and had the opportunity to orientate to two LTC facilities in EH. During these years, I have been involved in precepting several novice RNs to the LTC setting, as well as mentoring many Bachelor of Nursing (BN) students and novice RNs. Through these experiences, I have found that the current orientation process can be challenging and not structured enough for novice RNs transitioning into this clinical environment. In preparing for this practicum project, an informal needs assessment was completed at SLHs. Unstructured conversations were conducted with clinical nursing staff, resident care managers (RCMs), and the clinical nurse educator at SLHs. It was discovered that their experiences supported my identification of the need for a standardized orientation resource manual that could be accessed and distributed to all novice RNs in an effort to enhance the clinical orientation for RNs at SLHs. Through this needs assessment, it was discovered that there are limited resources available provincially in which this type of learning manual has been developed and implemented.

Practicum Project

The Resource

In planning for this practicum project, it was decided to develop an orientation manual that could be readily distributed to novice RNs, as well as RN preceptors, educators, nursing

students, or any member of the interprofessional team at SLHs. In order to best supplement the current orientation and preceptorship program for RNs at SLHs, it was decided to compose the manual into individual chapters pertaining to important gerontological topics and RN leadership information that the novice RN could reference during this transition period. Regardless of the desired competencies to be met and any past experience in gerontology, it was recommended that each orientee complete the entire resource because of the inclusion of current educational material and up-to-date policies and procedures from EH.

Contact Person

Throughout the development stage of the proposed orientation manual for SLHs, Ms. Michelle Nawaz, one of the primary RCMs at SLHs was identified as the primary contact person within the organization. In her leadership role at SLHs, Michelle was instrumental in supporting the development of an orientation resource manual as a means to develop greater nursing leadership and empowerment among the novice RN group at SLHs. Over the course of creating this project, Michelle has been consulted and updated on all developmental processes.

Ethical Approval

The Health Research Ethics Authority (HREA) screening tool was utilized to determine if the proposed practicum project had to be submitted to the Health Research Ethics Review Board for approval. Reference to how the HREA screening tool was applied to this practicum project can be found in the attached consultation report. While pre-approval was sought and gained from administration at SLHs and the Professional Practice Division for LTC at EH, it was determined that this project did not have to be submitted to approval to the Health Research Ethics Review Board as it was not considered a research project.

Practicum Goal and Objectives

The overall goal of this practicum project was to develop a standardized orientation manual that is evidence-based, and that could be readily distributed to novice RNs beginning employment at SLHs. This goal was accomplished through the successful achievement of the following six practicum outcome objectives:

1. To conduct an informal needs assessment at SLHs and identify several key stakeholders that could be recruited to obtain data pertaining to their own experiences.
2. To complete an integrated literature review that included: the roles and benefits of the RN in LTC; the experiences of novice RNs orientating to LTC; any existing orientation programs that have been conducted provincially and nationally for RNs in LTC; and the benefits of comprehensive orientation programs on RN attrition rates in LTC.
3. To consult multiple key stakeholders with extensive experience in gerontology and RN leadership in order to develop a strong understanding of the types of topics that should be explored in an RN orientation resource manual.
4. To clearly define the roles and responsibilities of the RN employed in the LTC setting.
5. To enhance the self-efficacy and confidence levels of novice RNs orientating to SLHs through the development of a comprehensive orientation resource manual that incorporates several important topics designed to guide the novice RN transitioning to the LTC environment.

6. To demonstrate the utilization of the four advanced nursing practice (ANP) competencies: clinical, research, leadership, and consultation and collaboration (Canadian Nurses Association, 2008).

Overview of Methods

In order to achieve the proposed outcome objectives for this practicum project and better understand the needs of novice RNs transitioning to the work environment in LTC, several different methods were applied. In the beginning, an informal needs assessment was employed at SLHs which assisted with the planning stage of the orientation resource manual. Next, an integrated literature review was completed which included search topics such as: the experiences of novice RNs orientating to LTC; the complexity of the roles and responsibilities of the RN in LTC, the importance of preceptors and comprehensive orientation program in influencing positive workplace satisfaction and commitment to the LTC environment. Two relevant learning theories were included in the literary search: Knowles' Adult Learning Theory and Benner's Novice to Expert Model. The completed integrated literature review and the core themes discovered throughout this process can be found in appendix "A" of this report.

Another integral methodology that was incorporated in the development stage of this practicum project was the consultation process. This involved leading a series of interviews with key stakeholders that were identified in the needs assessment as having considerable experience in gerontology and orientating novice RNs to LTC. This process was integral in gathering rich data through the insight and experiences of the selected participants, as well as comparing the resultant themes to the research obtained in the literary review. The finalized consultation report and associated content analysis can be found in appendix "B." The completed orientation resource manual for novice RNs new to LTC can be found in appendix "D."

Summary of Literature Review

Search Methods

A variety of research articles were reviewed throughout the integrated literature review process, which first encompassed a comprehensive electronic search that used PubMed health databases, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), as well as Google Scholar. A variety of search terms that were related to “long-term care”, “nursing”, and “orientation programs” were included. A variety of qualitative and quantitative research were discovered, and efforts were made to focus on articles that had been published within the last ten years. While many of the articles generated were of qualitative methods due to the nature of the topics being researched, a few quantitative research studies were critiqued using the Public Health Agency of Canada’s (PHAC) Critical Appraisal Tool Kit (2014). All of the qualitative studies were analyzed and critiqued for scientific merit, clarity, methodology, and rigor. Upon critiquing the relevant articles, three core themes were identified: the complexity of the RN role in LTC, the benefits of orientation programs, and the process of designing nursing orientation programs.

The Complexity of the RN Role in LTC

There were a number of research studies discovered through the literature review that emphasized the continued misunderstandings of how the RN role in LTC is defined, as well as the types of assumptions and concerns among the RN group working in the LTC setting (Boscart & Brown, 2009; Leppa, 2004; McGilton, et al., 2007). The LTC environment continues to be avoided by novice RNs and nursing students seeking placements due to concerns that the environment is depressing, less physically demanding, and that they will lose their skills when

compared to other clinical areas in the acute care setting (Abbey et al., 2006; Carlson & Bengtsson, 2014; Dellasega & Curriero, 1991; Leppa, 2004). These misconceptions have been challenged in the research when LTC has been compared to RN work in the intensive care unit (ICU), and LTC has demonstrated similar levels of uncertainty and variability required to work in the environment (Leppa, 2004).

With the growing number of Canadian seniors requiring advanced nursing care in residential settings, there needs to be a greater emphasis on retaining and recruiting RNs in LTC (The Canadian Federation of Nurses Union, 2011). NL has a lower average than the number of Canadian nurses choosing to work in LTC, with only approximately 8.2 percent of RNs in this province employed in the LTC setting (Government of NL, 2014). The role of RN leadership and how it impacts the internal working environment in LTC settings and resident-centered care was a consistent theme in the literature (McGilton et al., 2009; Phelan & McCormack, 2016). While the RN leadership role in LTC is complex and demonstrated through many responsibilities, it continues to be poorly understood and recognized among RNs (McGilton et al., 2009; McGilton et al., 2012). Although more experienced RNs may have greater confidence in delegation and leadership skills than novice RNs, O’Gara (2003) emphasized the orientation and mentorship periods as the opportune time to provide all RNs with education around leadership development. Going forward it is essential that administrators invest resources into educational and mentoring initiatives that aim to enhance RN leadership capacity in order to strive for greater job satisfaction and commitment to the LTC setting early among RNs (McGilton et al., 2009).

The Benefits of Orientation Programs

The literature supports the use of evidenced-based comprehensive orientation programs designed for RNs that emphasize the novice employee feeling empowered at the new

organization, supported by staff and administration, and valued as a key member of the leadership team (ARNNL, 2003; Burgess, 2007; Winter-Collins & McDaniel, 2000; Wong, 2000). When orientation programs are structured appropriately, there can be profound positive effects on RN role transition and overall workplace satisfaction and morale levels, with decreased attrition rates at the organizational level (Baxter, 2010; Morris et al., 2009; Puntill, 2005; Tanner, 2002). In planning for the development and implementation of an orientation program, it is imperative to clearly define the job description, list of roles and responsibilities, and a core-competency framework for novice RNs (California Health Care Foundation, 2006).

While limited research has been conducted on the role of orientation programs on RN turnover rates in the LTC setting, the phenomena has been well studied in acute care. Morris and colleagues (2009) examined the role of a competency-based orientation program in the critical care setting. After the study participants completed the new orientation program, there was a statistical improvement in recruitment and retention rates, as well as the orientation process going forward. Within the LTC setting, research has been conducted in which high RN turnover has been associated with higher rates of adverse resident outcomes including increase physical and chemical restraint use, and increased catheterizations of residents (Castle & Engberg, 2005). These findings and correlations to quality resident outcomes and RN workplace satisfaction emphasize the importance of orientation programs and early educational initiatives as top priorities among organizational leaders in LTC.

The Process of Designing Nursing Orientation Programs

Multiple studies from the literature review emphasized the challenges faced by novice RNs transitioning to the clinical environment, and the positive effects of the availability and completion of a comprehensive orientation program within the organization ((Almanda Carafoli,

Flattery, French, & McNamara, 2004; Burgess, 2007; Gavlak, 2007; Marcum & West, 2004). In congruence with the principles of adult learning, the orientation program should include a variety of learning delivery methods that best correspond to the individual learning needs of the orientee. This could potentially include a written manual, self-directed learning packages, e-technology, simulations, and assigned preceptors or mentors (Butt et al., 2002; California Health Care Foundation, 2006; Peltokoski et al., 2016). The unique learning needs and preferences of the orientee need to be considered during the development stage of an orientation program, as well as the content of the manual being inclusive of both organizational-level and site-level educational material (Miettinen, Kaunonen, & Tarkka, 2006; Peltokoski et al., 2015).

The inclusion of an established list of core competencies that the novice RN can achieve, in addition to the assignment of a clinical preceptor or mentor in the new workplace are key approaches that are recommended in the literature (ARNNL, 2003; Burgess, 2007; Winter-Collins & McDaniel, 2000; Wong, 2000). In considering any previous career experience of the orientee and that LTC is a clinical speciality area, the RN should be encouraged to view the orientation process as dynamic and assess their own learning needs through the use of the established competency framework at the beginning of the clinical orientation period. The current orientation program at SLHs for novice RNs includes a one-day general orientation to the EH and a three to five day general nursing orientation to LTC, followed by a the novice RN being assigned to one or more preceptors for a period of two to six weeks at SLHs (Eastern Health, 2016).

Based on the set list of core competencies, the novice RN is expected to be able to demonstrate proficiency and identify which competencies were not met at the end of their orientation and probationary period (Sandau & Halm, 2010). While the recommended time frame

in completing the orientation program varies in the literature, it is indicated that new graduates can take up to six or seven months in a new clinical area to feel competent (ARNNL, 2003). It is suggested that the orientation timeframe be viewed as flexible, and that the employer value the individual RN's learning needs and past career experience. These key considerations will be emphasized in the proposed comprehensive orientation program for SLHs (Butt et al., 2002; Peltokoski et al., 2016). Benner's (1982) novice to expert model can be applied when designing comprehensive orientation programs in order to guide all orientees throughout their expected set of clinical competencies.

Another important phase when considering orientation programs is the evaluation process, and the literature revealed that this area of the planning process for the LTC setting required improvement. In one research study by Peltokoski and colleagues (2015), the participants revealed that throughout the orientation program at the LTC site they were employed, their learning and competence levels were never formally assessed by the employer. From the literature, it is important that the evaluation process be integrated as an ongoing component of all orientation programs in both the development and implementation stages (Billings et al., 2006). When evaluating a novice RN's performance, the process should be a combined effort between the employer and the preceptor which is assessed throughout the orientation so that remediation and an individual action plan can be formulated if required (College of Nurses of Ontario, 2003). By obtaining ongoing feedback from the novice RN, preceptor, and the employer, and through the utilization of well-established evaluation tools throughout the orientation program, the long-term sustainability and transferability of the orientation program can be established (Schub & Heering, 2016).

Summary of Consultations

The consultation process was an integral phase of planning the orientation resource manual for novice RNs new to LTC, and revealed an extensive set of rich data that greatly supplemented the research obtained in the integrated literature review. Purposive recruitment was used to gain insight into the diverse experiences of a large set of key stakeholders with extensive experience in gerontology and the RN orientation process. Individualized semi-structured interviews were conducted with all participants, both in-person when possible, and over the telephone or through email correspondence, in early March, 2017. The script for the interviews were pre-designed using a number of leading questions to encourage open-style dialogue, and the data from the interviews was transcribed in note form and later transferred verbatim to Microsoft word. The results from the consultation process assisted in confirming the findings from the literature review, as well as contributing to the types of topics that could potentially be included in the proposed orientation resource manual.

By completing a thorough content and thematic analyses of the data that emerged through all interviews, there were a variety of themes discovered. The consultations further emphasized the rationale for developing an orientation resource manual for distribution to novice RNs orientating to SLHs. One consistent finding among all of the key stakeholders was the low confidence levels of novice RNs beginning employment in the LTC setting, and the attribution of the variety of roles and responsibilities of the RN in this environment. The present orientation program for RNs in LTC was described as being too broad for RNs, and the inclusion of an orientation resource manual in addition to the present orientation program at SLHs was considered a valuable resource in guiding the transition process.

The participants felt that the addition of an established preceptorship throughout the program, as well as well-established feedback and evaluation components were integral to the success of any comprehensive orientation program. With regard to the current preceptorship program, the participants expressed concern that the assignment to multiple preceptors at SLHs during the orientation was frustrating due to the variance in leadership styles and clinical skills among the senior RN group. This was also articulated among senior RNs who participated in the consultation process, in which concerns were raised around the lack of time to adequately prepare the novice RN before they were re-assigned to another preceptor at SLHs. Other components that were emphasized around the design of the orientation program were the importance of ongoing feedback and evaluation components, as well as a self-paced and flexible timeframe to meet the needs of the learner in relation to the principles of adult learning. Important data concerning the evaluation and accessibility plans of the proposed resource were used, with permission, from the developer of the Winnipeg pilot project (O'Rourke, 2016) (Appendix C).

Inquiries into the potential content of the resource manual to ensure that the guide would be beneficial in supplementing the current orientation program were discussed with all key stakeholders. Many of the topics that emerged throughout the consultation process were consistent among the participants, and this was an important finding as this subject was not well covered in the literature review. The significance of thorough geriatric assessment skills, and providing the residents and their families with concrete information around those assessments was acknowledged. The role of consulting the interprofessional team in LTC, and the coordinated approach in improving resident outcomes was mentioned as well. Several of the participants expressed an additional explanation of the monthly critical indicators that are

examined by the RN in LTC, as well as education around conflict management and RN leadership.

Overview of the Learning Resource Manual

Self-directed Learning Component

Through the literature review and consultation processes, the role that an orientation resource manual has on meeting the learning needs and improving confidence levels among novice RNs in LTC was emphasized. Both new graduates and nurses new to the LTC setting require significant support and education to assist with making a smooth transition. By implementing and distributing the resource manual in a print format to the orientee and assigned preceptor at the beginning of the clinical orientation, the novice RN is directed to analyze and study the content in a self-directed manner. The use of “test-your-knowledge” and case-study style questions were incorporated at the end of each chapter as ongoing evaluation components for the orientee and preceptor to complete. Knowledge acquisition of the material and the ability to move onto the next chapter were evaluated through the obtainment of 80 percent or higher on each chapter test.

Associated Theories

Knowles’ adult learning theory. In order to adequately meet the needs of novice RNs orientating to the LTC setting and in correlation to the principles of self-directed learning, Knowles’ Adult Learning Theory (1984) was used to throughout all developmental phases of this resource. According to this theory, adults are autonomous, self-directed, intrinsically motivated, and contribute unique life experiences and build upon these experiences with every learning opportunity (Candela, 2015; Knowles, 1984). All of these principles are important to consider

when creating an educational resources in order to maximize participant involvement and achieve targeted learning outcomes.

In the introduction of the orientation resource manual, the purpose and objectives of the manual were clearly described for the orientee. The chapters were divided into sections based on the educational needs identified by the participants in the consultation process, and all orientees will be encouraged to complete the entire manual regardless of their educational needs and past experience in geriatric nursing. Internal motivation of the participants was considered through the inclusion of “test-your-knowledge” and case-study style evaluation components that were incorporated at the end of each chapter. All orientees participating in the comprehensive orientation program will also be encouraged to provide ongoing feedback and reflection on the resource as an additional measure to maximize participant involvement in the learning process.

Benner’s novice to expert model. In order to demonstrate support for both new graduates and more experienced RNs orientating to LTC, Benner’s Novice to Expert Model (1982) was chosen as another appropriate theoretical lens. This framework defines five levels of competence in nursing: novice, advanced beginner, competent, proficient, and expert (Benner, 1982). The newly graduate nurse enters the orientation program at a novice level, and throughout the comprehensive orientation program strives to move towards an advanced beginner stage (Almanda et al., 2004). In contrast, while the more experienced RN may be considered an expert in their past clinical environment, they would still have access and benefit from a comprehensive orientation program that educates them on geriatric-specific topics. All orientees, regardless of past experience, should be encouraged to complete a self-assessment using the set of core-competencies established by EH for novice RNs to determine their learning needs in the LTC environment. By assigning all orientees to a clinical preceptor, the RN will be supervised and

exposed to regular clinical experiences which also fits under Benner's (1982) theoretical lens. The RN in partnership with their assigned preceptor should set clear learning goals that are mutually accepted, and work together to build confidence and overall knowledge level on geriatric nursing care in the LTC setting.

Orientation Manual Content

The content of the orientation resource manual was based on the literary findings in the literature review, as well as the data obtained from the key stakeholders through the consultation process. The finalized manual was composed of seven chapters:

- Completing Geriatric Assessments;
- The Admission Process in LTC;
- The Role of the Interprofessional Team;
- The Critical Indicators;
- Completing an Environmental Scan;
- Conflict Management; and
- RN Leadership Development

The manual begins with an introduction and instructions around accessing EH's policies and procedures from home or at work. A summary of the types of common geriatric assessments used by the RN in LTC was provided, as well as the stages of how to complete a thorough admission process for a new resident at SLHs. The following chapters introduce and detail the consultation process for the various interprofessionals at SLHs, as well as the monthly critical indicators that the RN will be responsible for tracking in relation to resident care outcomes. The last three chapters feature the importance and responsibility associated with completing an

environmental scan, models and strategies for dealing with conflict in the workplace, and resources and education around RN leadership development in LTC. Important reminders and educational points that are highlighted for the RN to read are included throughout the chapters in the form of “Notes” and “Did You Know” sections. Recommended readings and the inclusion of relevant EH policies and forms are included at the end of each section in the respective chapter for the RN to review prior to completing the assessment at the end of the chapter.

Implementation Plan

At the end of this practicum project, the completed orientation resource manual will be presented to management and administration at SLHs for revision and approval. Upon approval from the administrator and clinical nurse educator at SLHs, the resource will be distributed to all nursing units as a hard copy, as well as to the nurse educator to present to all prospective RN orientees and preceptors at SLHs in an electronic format. The orientation resource manual will also be presented to the nursing staff at SLHs in the form of a lunch-and-learn session to make them aware of the availability of the resource. The manual could also be used by senior RNs at SLHs, nursing students, the interprofessional team, or any individual seeking additional education and information around geriatric nursing. Future modifications can be made to the manual to convert it to an electronic format and an interactive workshop for nursing staff, as well as modify and adapt the resource for use among other LTC sites in EH.

Evaluation Plan

Ongoing evaluation components in the form of “test your knowledge” and case-study style questions were provided throughout the orientation resource manual for the learner to complete. In building on these components following the implementation stage, a qualitative

review to formally evaluate novice RN satisfaction level and confidence post-orientation will be completed. This will be accomplished using an anonymous survey of novice RNs immediately following the completion of the orientation program, and repeated at the six month interval post-orientation. The survey will seek to determine whether the orientees, who completed the orientation resource manual feel confident through the knowledge obtained to care for residents in the LTC setting, as well as supported in their transition to LTC as a novice RN. As a part of this formative evaluation plan, the RCM and clinical nurse educator will be interviewed to discover how the orientation resource manual has impacted the organization and resident care outcomes.

Advanced Practice Nursing Competencies

The Canadian Nurses Association (CNA) outlines four main competencies that act to guide the RN in any designated role or clinical environment to practice safe and ethical nursing care. These four competencies include: clinical competence, research, leadership, and consultation and collaboration (CNA, 2008). The application of all four competencies has been instrumental in the planning and development of this practicum project.

Clinical Competence

My professional experience as a RN working in LTC was influential in identifying the need to create this resource, as well as throughout the planning and development stages of this practicum project. My overall clinical competence and interest in gerontology assisted me greatly in the development of an orientation resource manual that will be readily distributed to novice RNs in the LTC setting. This resource will contribute greatly to generating and integrating nursing knowledge relating to geriatrics, and transferring it to the novice nurse

population beginning employment in LTC. Through the integrated literature review and consultation process, as well as through my own expertise, I was able to design the content of the manual around pertinent gerontological topics in order to assist novice RNs with feeling better supported and prepared for their new role in LTC.

Research

The background research for this practicum project was essential in ensuring that the resource manual was constructed from evidence-based knowledge and current literature pertaining to gerontology and the RN orientation process. These research methods included an integrated literature review and consultation process which captured several themes and rich data that were successfully incorporated into this practicum project. This advanced competency was met by critically evaluating and interpreting multiple qualitative and quantitative research studies for their strengths, limitations, and overall study design and quality in the literary summary tables presented in the integrated literature review. It was also met through the collection and analyses of the data obtained from all of the key stakeholders in the consultation process. Both research methodologies were integral in demonstrating how evidence-based research can contribute to ANP efforts in the LTC environment, and further validated the importance of developing and piloting this resource manual at SLHS among the novice RN group.

Leadership

The leadership role of the RN in LTC is widespread, and incorporates the coordination of the larger interdisciplinary nursing team, resident care outcomes, as well as the dissemination of evidenced-based research and quality nursing practice to others (ARNNL, 2013). Through the informal needs assessment and consultation process, as well as my experience in mentoring

many novice RNs, it was determined that there were concerns around the current orientation program for RNs at SLHs. By completing this practicum project based on an identified need that is aimed to positively affect the nursing team at SLHs, leadership has been demonstrated by developing a learning resource manual that will improve the current orientation program and professional growth for novice RNs, and the subsequent nursing care of the geriatric population at SLHs.

Consultation and Collaboration

Both the consultation and collaboration competencies have been integral throughout all stages of the practicum project. Consultations with my faculty advisor, Dr. Ann Noseworthy, have been conducted over the telephone or in-person on a weekly basis for guidance and feedback through the practicum process. Initial consultations with the RCM and administration at SLHs were held during the informal needs assessment process to determine the aim and contributions of the proposed practicum project on the nursing team and resident care outcomes. Targeted changes have been made through a collaboration partnership with management at SLHs to have future novice RNS orientating to SLHs assigned to one preceptor for the duration of their clinical orientation when feasible. Key stakeholders with extensive experience in gerontology and the RN orientation process were identified early in the project, and provided rich data throughout the consultation process that greatly benefited the content of the final orientation resource manual. The combination of these collaborations with faculty, staff at SLHs, and the stakeholders who participated in this project, have been central in the production of a targeted and valuable resource.

Conclusion

The completion of the primary goal of this practicum project was illustrated through the process of planning and developing an orientation resource manual that could be readily distributed to novice RNs orientating to SLHs. Additional goals of the project were met; an informal needs assessment was conducted, an integrated literature review was completed, key stakeholders with experience in gerontology and the RN orientation process were consulted, and all four ANP competencies were demonstrated. Throughout the research and consultation components of this project, additional insight was gained into the educational and support needs of novice RNs orientating to SLHs, as well as the extensive scope of practice of the RN in LTC and how it contributes to positive resident outcomes. The process of developing this practicum project have assisted with strengthening my professional ANP competencies, particularly in RN leadership, research, and collaboration and consultation. Having a strong awareness and appreciation for these competencies are invaluable going forward as a nurse leader in the LTC environment, in order to meet the needs of the geriatric population, and positively contribute to the nursing profession (CNA, 2008).

RNs employed in the LTC setting require a high degree of clinical autonomy, as well as strong leadership skills to coordinate the larger nursing team and care delivery for all residents (ARNNL, 2013). The contribution of an evidence-based comprehensive orientation program is instrumental in increasing the knowledge of novice RNs, and demonstrating support for RNs undergoing the transition to working in LTC (O’Gara, 2013). In this final report, a background and rationale have been provided for this practicum project, as well as the practicum objectives. An overview of the research methodology that was used throughout the practicum project has been included, as well as results of the thematic and content analysis from the integrated

literature review and consultation process. These finalized reports can be found in appendices “A”, and “B” respectively. The content of the orientation resource manual has been outlined, as well as the relevant theories were applied throughout all aspects of the project. The plans for implementation and evaluation have been discussed, as well how the ANP competencies were demonstrated throughout the practicum process. The completed orientation resource manual has been included in appendix “D.”

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Appendix A: Integrated Literature Review

Introduction

On a global scale, the nature and complexity of the aging population is changing. In Canada, the number of older adults being admitted to residential facilities with high acuity rates and complex co-morbidities are placing an unprecedented strain on our National health care system (The Canadian Federation of Nurses Unions, 2011). Within the LTC environment, there are ongoing challenges around the recruitment and retention of qualified nursing staff. Given the increased complexity and care needs of residents in the LTC setting, there is a constant need for RNs because of their increased knowledge and high-quality approach to resident-centered care (Canadian Nurses Association, 2008).

Due to the unique set of roles and responsibilities that the RN encompasses in the LTC environment, it is essential that the administrative team develop successful strategies on how to effectively approach the orientation process of RNs new to the LTC (Association of Registered Nurses of Newfoundland and Labrador (ARNNL), 2003). The goal of implementing a standardized and evidenced-based orientation program is to improve the workplace conditions for RNs by fostering a sense of commitment and job satisfaction within the context of LTC, thereby increasing the recruitment and retention of RNs (O’Gara, 2013). The purpose of this integrative literature review is to examine the available research on the learning needs of novice RNS new to the LTC environment, the unique roles and responsibilities of the RN in LTC, and the experiences of new RNs that have orientated to LTC. Applicable learning theories associated with developing orientation programs for the adult learner and measuring the expertise of nurses will also be discussed. Literature summary tables will be provided to display pertinent research studies in reference to the purpose of this integrated literature review.

Integrated Literature Review

Background Information

Given the global increase in life expectancy and anticipated requirements for residential care, there is an urgent emphasis on the need for quality health care and adequate human resources. In fact, according to Statistics Canada (2016), while one in seven Canadians is 65 years or older today, by 2036 it is predicted that one in four Canadians will be considered seniors. Overall Canadians are living longer with higher acuity and co-morbidity rates, and due to the demand for residential care they are having an unprecedented impact on the current human and financial resources in the LTC environment (College of Nurses of Ontario, 2007). There is a particular need to increase the capability of the professional nursing staff to address this challenge, with RNs being identified as valuable leaders in the context of the LTC environment.

It has been identified that there is an ongoing shortage of nurses choosing to work in LTC (Canadian Federation of Nurses Union, 2011), making it imperative that health care administrators determine ways to recruit RNs which may work towards increasing retention rates through job satisfaction and overall commitment to the LTC environment. Historically, within and outside the profession there have been many existing misconceptions that LTC is a boring and unchallenging working environment (Robinson et al., 2008). There was a tendency to believe that nurses sought out LTC as a workplace of convenience, and that their clinical skill set and knowledge would not be tested (Moyle, Skinner, Rowe, & Gork, 2003). The literature consistently reveals that this is not the case, and in fact LTC has been described to be an excellent learning environment that encompasses RNs to demonstrate a high degree of autonomy, creativity, and leadership abilities (Carlson & Bengtsson, 2014; Choi, Flynn, & Aiken, 2011; Prentice & Black, 2007; Robertson & Cummings, 1991).

Generally, when employees enter a new organization, they bring with them a positive and dedicated attitude. Going forward, the experiences they encounter and engage in over the first three to six months in their new workplace is considered a critical period (O'Brien, Ringland, & Wilson, 2010). One critical component in assisting to prepare RNs who are new to the LTC environment to better understand and apply their roles and responsibilities in the new clinical context is the delivery and availability of an organized and standardized orientation program (Peltokoski, Vehvilainen-Julkunen, & Miettinen, 2016). From the orientation guidelines established by the Association of Registered Nurses of Newfoundland and Labrador (ARNNL) (2003) and an existing orientation program that was developed by the Winnipeg Regional Health Authority (O'Rourke, 2016), successful high-quality orientation programs consistently involves self-directed learning principles, as well as the opportunity to learn from a preceptor in the clinical environment. In order to improve resident outcomes and promote quality health care in the future, it is imperative to develop evidenced-based resources that can be distributed and adapted for new RNs to reference and guide the orientation process (O'Rourke, 2016). This will aid in presenting foundational knowledge on geriatric nursing and the associated roles and responsibilities of the RN in LTC, with a goal of positively impacting their transition to LTC.

Search Terms and Databases

The research articles reviewed for the purpose of this integrative literature review were acquired by conducting a comprehensive electronic search using the Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed health databases, as well as an initial search of Google Scholar. The search terms included: *geriatric; gerontology; senior; older adult; long-term care; nursing homes; residential care; hospital; orientation; preceptorship; orientation program; orientation process; mentor; mentorship; nursing; nursing care; and*

novice nurse. Several articles pertaining to the experience of novice RNs transitioning to LTC, the unique roles and responsibilities of the RN in LTC, and the impact of preceptors and orientation programs on the workplace satisfaction of nursing staff were found and included in this literature review. While one successful orientation program has recently been implemented on a national level and included in this review (O'Rourke, 2016), limited research was found that involved the evaluation of any provincial or national orientation programs designed for the LTC environment.

All relevant research articles were accessed through the CINAHL and PubMed health databases, and an effort was made to include the most recent and applicable research in this integrated literature review. Through the literature scan, there were a few quantitative research studies that were critiqued using the Public Health Agency of Canada's (PHAC) Critical Appraisal Tool Kit (2014). Due to the nature of the topic being researched and plans for the development of a learning resource, the majority of the literature was of qualitative nature. The qualitative studies were evaluated for scientific merit, clarity, methodology, and rigor. Literature summary tables describing several of the research studies used to formulate this integrative literature review were developed, and are available in the appendices for review. From the process of reviewing the applicable literature, three consistent themes were identified: the complexity of the RN role in LTC, the benefits of orientation programs, and the process of designing nursing orientation programs.

The Complexity of the RN Role in LTC

The role of the RN in LTC is a vital component in the delivery of evidenced-based quality health care that is resident-centered. The ARNNL (2008) maintains that due to the broad number of roles that the RN fulfills in the LTC setting, it is critical that the RN has a strong

awareness of the job description and the roles and responsibilities they are accountable for. Unfortunately, the absence of a clear definition and understanding of the RN role within the context of the LTC environment is a central concept in the literature (Boscart, & Brown, 2009; Leppa, 2004; McGilton, Bowers, McKenzie-Green, 2007).

There are a number of assumptions that exist about the culture of working as an RN in the LTC environment. Conventionally, LTC has been described as a workplace that is predictable, boring, less physically demanding, and requiring fewer skills when compared to acute care clinical settings (Leppa, 2004). Unfortunately the LTC environment continues to be avoided by both novice nurses and nursing students due to the continued belief that it is depressing and not intellectually challenging (Abbey et al., 2006; Carlson et al., 2014; Dellasega & Curriero, 1991; Leppa, 2004). In addition to concerns about a lack of sufficient funding for staffing and essential supports for staff, these presumptions have led to shortages of qualified professionals pursuing gerontological nursing (The Canadian Federation of Nurses Unions, 2011). When compared to the national average of approximately 9.6 percent of RNs choosing to work in LTC, 8.2 percent of RNs in Newfoundland and Labrador are employed in LTC (Government of NL, 2014). In fact, the Canadian Nurses Association (CNA) (2008) maintained that 54 percent of Canadian nurses working in LTC indicated that there is not enough staff to complete the work, of which 47 percent attributed a decline in quality of resident care to chronic understaffing. With the current statistics signifying that the number of aging Canadians requiring LTC services is going to drastically increase, it is evident that there has to be more emphasis on retaining and recruiting RNs in LTC (The Canadian Federation of Nurses Unions, 2011).

With rising levels of resident acuity and complexity, addressing the current and projected RN shortage in LTC is at the forefront of gerontological research. In attempting to understand

what contributes to a favorable work environment in LTC, RNs have indicated that the inclusion of better benefits and the presentation of LTC as a challenging front are important factors that lead to workplace satisfaction (Robertson & Cummings, 1991; Robertson & Cummings, 1996). When compared to nursing work in the intensive care unit (ICU), LTC has been found to be similar in terms of the level of uncertainty and variability. This challenges the preconceptions about LTC as a nursing work environment, and suggests that LTC is in fact a complex, demanding, and intellectually stimulating area of nursing (Leppa, 2004).

There has been a variety of research completed that has explored the internal environment of working in LTC from the perspective of RNs. One important theme is the leadership requirements of RNs in LTC, and the role of RN leadership in impacting quality resident-centered care (McGilton et al., 2009; Phelan & McCormack, 2016). RN leadership is multifaceted and includes: managing the care for all residents and their families, coordinating the team of nursing staff, providing education and enabling nursing staff, and having an awareness of the organization's policies and services to ensure a quality health care environment (Heath, 2010). While leadership skills are embedded into the role of the RN in LTC, there is poor recognition and mention of the importance of the leadership role and development specifically from the RNs themselves (McGilton et al., 2009; McGilton et al., 2012; McKenzie-Green, 2004).

The past portrayal of the RN in LTC has primarily focused on quantifying clinical tasks and categorizing nursing interventions, rather than the contribution to resident-centered care, clinical expertise, and leadership (McGilton et al., 2009). This idea has been the center of skill mix initiatives for the LTC environment, resulting in decreasing RN numbers and replacing them with other health care providers who have assumed a broader scope of practice (McGilton et al., 2012; The Canadian Federation of Nurses' Union, 2011). In meeting the sophisticated health

care needs of today's seniors, it will be imperative to better articulate the RN leadership role and both the visible and non-visible contributions that the RN delivers to resident-centered care in the LTC setting (CNA, 2008). One method to address the RN shortage and professional image in LTC is to invest a greater amount of time and funding into education and mentoring around increasing RN leadership capacity, with the overall goal of creating a greater sense of job satisfaction and commitment to LTC from the RN group (McGilton et al., 2009).

Evidence demonstrates that older RNs with greater amounts of clinical experience are more competent and confident in delegating and performing leadership responsibilities when compared to novice RNs (Yoon, Kim, & Shin, 2016). O'Gara (2003) maintained that one critical time to implement educational opportunities pertaining to leadership development is during the orientation and mentorship phase, when novice RNs are transitioning into the LTC environment. By empowering RNs and educating them on the leadership requirements of working in LTC early in the recruitment process, RNs will feel supported and prepared to fulfill these roles and responsibilities going forward (O'Gara, 2003).

The Benefits of Orientation Programs

The role of empowerment has been documented in the literature as a paramount strategy in retaining RNs and increasing workplace satisfaction in all clinical environments. Access to a quality orientation program that has ample resources and the inclusion of positive support systems is one key method to demonstrate an empowered work environment to new employees (Burgess, 2007). When organizations commit resources and improve access to professional development and educational opportunities for RNs, it assists in enhancing the RN's commitment and sense of belonging to the organization (Lavoie-Tremblay et al., 2002). As discussed earlier, research studies indicate that effectively structured orientation programs have

the potential to assist in positive role transition, improve workplace satisfaction, develop employee confidence and morale, and thereby reduce attrition rates within an organization (Baxter, 2010; Morris et al., 2009; Puntil, 2005; Tanner, 2002).

An essential starting point when designing and implementing orientation programs for novice RNs is to provide a clear outline of the job description, roles and responsibilities, and competency framework (California Health Care Foundation, 2006). One consistent finding in the literature that acted as an initial determinant for orientees entering the LTC environment was a lack of dependable leadership from the management team surrounding staff learning opportunities (Castle et al., 2005; Moyle et al., 2003; Puntil, 2005; Sandau et al., 2010). Addressing this issue will require the organization and management team to recognize the importance of an effective orientation program that is based on an existing framework, and devote the necessary time and resources to partake in the implementation and evaluation process (Baxter, 2009). Looking forward, the consequences of nursing staff turnover have been associated with a decreased continuity of care for residents in the LTC setting and higher operational costs (Aaron, 2011). This emphasizes the importance of comprehensive orientation programs as an effective strategy for recruiting and retaining novice RNs.

While there is a limited body of research that has examined the result of orientation programs on RN attrition rates in LTC; research has been conducted on these indicators following the completion of hospital orientation programs. Participants in the research study by Morris and colleagues (2009) completed a competency-based orientation program in the critical care setting which utilized a variety of learner-centered modalities based on the concepts of adult-learning theory. Feedback from the study demonstrated a significant improvement in recruitment and retention rates, and overall satisfaction with the entire orientation program

(Morris et al., 2009). Another critical consideration that emerged from the research is how RN attrition rates affect the residents themselves and their families. Interestingly, high rates of RN turnover have been linked to adverse resident outcomes such as an increase in restraint use, catheterization, and psychoactive medications in the LTC setting (Castle & Engberg, 2005). These findings strengthen the importance for organizational commitment in embracing the role that orientation programs can have on empowering novice RNs and subsequent quality resident outcomes in the LTC setting.

One of the most significant findings in the literature is the role that an assigned preceptor can have on influencing the orientation process. Sandau and Halm's (2010) literature review examined twelve existing research evaluation reports that examined preceptor-based learning. Overall, the research demonstrated that preceptor-supported orientation programs increased overall orientee satisfaction and retention, and reduced turnover costs (Sandau & Halm, 2010). Such enhanced orientation programs have been developed and implemented on a national level. While the exact effects on nurse retention and recruitment have not been measured up to this date, preliminary evaluations demonstrated that the study participants gained sufficient foundational knowledge surrounding gerontology, enhanced their leadership skills, and had a positive effect on their transition into LTC (O'Rourke, 2015). It is important to note that this style of orientation program is beneficial to RNs undergoing job change, as well as new RNs. This is due to the fact that experiencing job change can result in expert RNs in one clinical area feeling like novice RNs in the new clinical area (Butt et al., 2002). When feasible, another important consideration for employers is to assign nurses with one consistent, or a couple of consistent preceptors. This was demonstrated in a study by Roche and colleagues (2004), in which RNs that were assigned to fewer than four preceptors expressed higher satisfaction with

the orientation program as a whole, rather than RNs that were assigned to several different preceptors. From this research, when considering how to design a comprehensive orientation program for the LTC setting, it is imperative to integrate a preceptor-based model as a fundamental step in successfully guiding all RNs.

The Process of Designing Nursing Orientation Programs

The experiences and education requirements of RNs undergoing job change or transitioning from the role of student to graduate nurse is well documented in the literature. The difficulties encountered during these transition periods are diverse, and it has been estimated that as many as 60 percent of new graduate nurses will leave the profession during their first year of employment based on these types of challenges (Baxter, 2010). One prominent strategy that has been demonstrated to positively enhance the transition into all clinical environments is the completion of a comprehensive and supportive orientation program offered through the organization (Almanda Carafoli, Flattery, French, & McNamara, 2004; Burgess, 2007; Gavlak, 2007; Marcum & West, 2004).

The orientation program for RNs can include a variety of learning delivery methods depending on the needs of the individual and specific clinical area (Butt et al., 2002). While it is expected that some clinical skills will be transferable to the new specialty area, there is a definitive need for high-quality orientation programs to be designed to ensure that RNs feel competent in assuming their new roles and responsibilities when undergoing job change (Abruzzese & Quinn-O'Neil, 1996; Peltokoski et al., 2016; Sandau & Halm, 2010). The ARNNL (2003) maintained that orientation programs that are designed to encourage new nurses to feel welcomed to the organization, supported in the process, and valued as employees will assist with diminishing the stress of the transition and facilitate a greater sense of workplace satisfaction.

The literature supports a collaborative approach to orientation that is inclusive of core competencies that can be completed in a self-directed style in combination with a clinical preceptorship. This approach will ensure a vital linkage between education and clinical practice (ARNNL, 2003; Burgess, 2007; Winter-Collins & McDaniel, 2000; Wong, 2000). These considerations are of particular importance in the LTC environment due to the shortage of RNs choosing to work in gerontological nursing, and the unique roles and responsibilities of RNs in LTC.

The current orientation program offered by EH for novice RNs entering the LTC program is based on a three-stage competency-based process. This is a routine structure of nursing orientation programs and consists of a one-day general orientation to the organization, a universal three to five day nursing orientation to LTC, and then the novice RN being assigned to a more senior RN preceptor for a period of two to six weeks (EH, 2016; Sandau & Halm, 2010). At the conclusion of the orientation period, the novice RN is expected to be able to demonstrate proficiency based on the achievement of a set of established core competencies at a novice level (Sandau & Halm, 2010). While the orientation program should be designed as a dynamic timeframe, due to ongoing fiscal challenges and RN shortages, there continues to be considerable pressure from the internal system for the novice RN to transition quickly and reduce professional development costs (ARNNL, 2003; Peltokoski, Vehvilainen-Julkunen & Miettinen, 2016). While many existing orientation programs focus on the first year of nursing practice, the literature maintains that an orientation program should be structured to meet the professional development needs of all nurses, regardless of their career experience (Peltokoski et al., 2016).

While individual preferences exist around the delivery methods of orientation programs, it is important to consider both the viewpoints of experienced nurses' and new graduates' when

planning orientation frameworks (Peltokoski et al., 2016). Although many of the existing research studies have examined the implementation of orientation programs from the perspectives of novice RNs or more experienced nurses, there is limited research that has highlighted the experience of orientation as a comprehensive process (Peltokoski, Vehvilainen-Julkunen, & Miettinen, 2015). Collectively, it is essential that the content of the orientation program is standardized and inclusive of both organizational and site-specific educational content (Miettinen, Kaunonen, & Tarkka, 2006; Peltokoski et al., 2015).

In strengthening the comprehensive orientation process into the nursing practice environment, the role of an assigned preceptor cannot be understated. High-quality preceptors should be competent in the clinical area and be willing to teach and support the novice RN as role models and ambassadors for the organization (Baxter, 2010). Some research suggests the importance of formalized preceptor development education. Such education would introduce the principles of adult education, promote critical thinking, and provide the resources for preceptors to demonstrate applicable skills and the roles and responsibilities of the new clinical environment to the orientees (Halfer, 2007; Lewis & McGowan, 2014; Ragsdale & Mueller, 2005). Management and clinical administration should maximize and support the use of quality preceptors in order to enhance the comprehensive orientation process, improve nurse retention rates, and contribute to overall workplace satisfaction in the clinical environment (Sandau et al., 2010).

In recognizing economic restraints and the utilization of organizational resources in planning a standardized approach to orientating RNs to LTC, it is important to consider the use of various learning pathways and integrate theoretical frameworks to accommodate diversity. The literature supports the use of several learning modalities including: written information, self-

directed learning packages, online e-technology, hands-on simulations, and the use of preceptors (Butt et al., 2002; California Health Care Foundation, 2006; Peltokoski et al., 2016). In recognizing the principles of adult learning theory, the orientation program can be tailored to the individual needs of the novice RN regardless of prior career experience. Given that LTC is considered a clinical specialty area, while new graduates may require additional time to complete the orientation program; experienced nurses who are undergoing job change may require a shortened version of the orientation program which can be completed independently (Peltokoski et al., 2016). Through the careful design and planning of a comprehensive orientation program that incorporates existing theoretical frameworks, successful integration to new workplace and associated retention benefits for the organization can be achieved.

The suggested time frame to conduct an orientation program for the novice RN entering the LTC environment varies extensively in the literature. In fact, when considering the learning needs of 1,826 new graduates entering the LTC environment, approximately 50 percent expressed that their orientation program was too short (Burgess, 2007). Findings from the literature indicate that RNs generally require orientation programs that are of longer periods than they are presently receiving from their organization, and new graduates can take up to six or seven months to feel comfortable in a clinical area (ARNNL, 2003). The duration of orientation programs has consistently been positively correlated to the attainment of a comprehensive orientation process, and those RNs who receive longer orientations tend to achieve a higher level of satisfaction with their workplace (Peltokoski et al., 2016). Instead of describing the orientation program as an established timeframe, it has been suggested that organizations view the process as dynamic, in which the RNs learning needs and prior career experience are embraced (Butt et al., 2002; Peltokoski et al., 2016). Suggestions to guide this process in the LTC setting include

the consideration of the RNs experience working in LTC, their experience working in an autonomous role, and the preceptor's evaluation of the RN based on the defined set of core competencies (Aaron, 2011).

One integral phase in the planning and implementation of a learning resource is to consider the evaluation process. This helps to determine if any gaps exist between the stated learning outcomes and what was actually achieved by the learner (Meek et al., 2013). A key finding in the literature pertaining to the development of an orientation program for LTC nursing staff requiring significant improvement is how organizations can systematically complete orientation program evaluations. Participants in the study by Peltokoski and colleagues (2015) reported that their overall learning needs and competence level were not accessed at the beginning, during, or following the completion of the orientation program. The evaluation process should be an ongoing component of the orientation program development and implementation phases (Billings et al., 2006).

In considering the unique learning needs of both graduate RNs and more experienced RNs entering the LTC environment, an initial learning assessment can be completed by the development of a competency checklist to guide the RN throughout the orientation process (Marcum et al., 2004). Other tools that exist in the literature consist of preceptor evaluation forms, workplace satisfaction indicators, focus group interviews with participants, retention and recruitment rates, and pre and post-tests to examine attained knowledge as a result of completing the orientation program (O'Rourke, 2016; Lavoie-Tremblay et al., 2002; Marcum et al., 2004; O'Brien et al., 2010). It is also critical that individualized feedback is provided by the preceptors, colleagues, and management to the RN throughout the orientation process to assist with guiding

the orientee throughout the workplace transition and ensuring the orientee has the support and resources to succeed in the new workplace (Peltokoski et al., 2015; Twibell & St. Pierre, 2012).

The evaluation of the novice RNs' performance is a complex process, and the measurement of competence should encompass the cognitive, affective, and psychomotor fundamentals of learning (Giro, 1993). Should the results of the clinical competence assessment reveal deficits during and following the completion of the orientation period, an individualized action plan that is reviewed by the individual and management should be prepared to address the weaknesses. This can include additional knowledge-based education and time with an assigned preceptor in the clinical area, paired with ongoing feedback and support provided by management and senior administration (Schub & Heering, 2016). The formal review of competencies should be a joint effort between the management team and the preceptor, and by providing evaluation as an ongoing process the novice RN has the opportunity to acknowledge and take action pertaining to their learning needs (College of Nurses of Ontario, 2003). Due to the dynamic nature of orientation programs, it is critical to consider the types of evaluation tools that can be employed throughout the process in order to support the continuation and transferability of a comprehensive orientation program for RNS in LTC.

Guiding Theoretical Frameworks

Benner's Novice to Expert Model

In designing an orientation manual for novice RNs to access in the LTC setting, it is imperative to consider existing theoretical frameworks in order to guide the process. Benner's Novice to Expert Model (1982) is particularly relevant to self-directed learning and professional development initiatives that promote recruitment and retention in nursing (Aaron, 2011). In

supporting both the graduate RN and more experienced RN populations orientating to LTC, this framework outlines five levels of competence in nursing: novice, advanced beginner, competent, proficient, and expert (Benner, 1982). This is important to consider in relation to transition experiences and knowledge acquisition in nursing orientations, as each specific competency builds on the previous stage which expert nurses developed through clinical experience (Butler & Hardin-Pierce, 2005).

In considering the graduate RN, the individual begins the orientation program at a novice level with the goal of progressing to the advanced beginner stage (Almanda et al., 2004). By incorporating a defined set of core competencies, education, and assigned preceptors into the orientation program, the novice RN is supported and gains a set of clinical experiences and skills on which to build (Benner, 1982). In comparison, a more experienced RN may have been considered at an expert level in their previous clinical environment. In transitioning to the LTC setting, RNs with prior clinical experience will still benefit from a standardized orientation program due to the description and experiences of geriatric specific content.

By incorporating a preceptorship dimension into the orientation program, the RN is provided with regular clinical experiences and knowledge acquisition which is consistent with Benner's (1982) model. Of interest, the literature recommends that nurses who have between two to four years of experience in a specific clinical area should be considered in fulfilling the preceptor role. These advanced beginner RNs have been found to explain the rationale behind clinical tasks and behaviors in a more efficient way that expert RNs therefore reducing workplace strain and potential burnout of the more senior group of RNs (Baxter, 2010). In conducting a preliminary learning needs evaluation for all RNs orientating to LTC, the establishment of entry-level competencies can be evaluated using Benner's (1982) framework as

an effective approach. Continued learning and goal setting can then be established by the orientee and preceptor, with an overall goal of instilling comfort in the novice RN and improving recruitment and retention rates in the LTC setting.

Adult Learning Theory

In considering the needs of the novice RN orientating to LTC when designing this orientation program, the principles of Knowles' Adult Learning Theory will be used. Knowles (1984) termed the process of adult learning as andragogy, and highlighted the importance of reflecting on the unique assumptions pertaining to adult learners when developing educational resources. This theory is constructed on the belief that adult learners are autonomous, self-directed, intrinsically motivated, and bring a unique set of life experiences to every learning endeavor (Candela, 2015; Knowles, 1984). It is crucial to consider all of these assumptions when designing educational resources to increase participant involvement and in achieving learning outcomes

When planning for the development and implementation of this orientation manual, the prior experiences and knowledge of the RNs will be considered on an individual basis by conducting a learning needs assessment that is based on a defined set of clinical competences relevant to the LTC setting. Internal motivation for the need to complete a comprehensive orientation program would be strengthened through the use of this ongoing evaluation tool with the goal of progressing through the program through the achievement of the core competencies. In considering generational differences and differences in clinical skills sets and experiences, a variety of learning modalities will be encompassed within the orientation program to maximize accessibility for all participants (Morris et al., 2009). The RNs completing the orientation

program will be asked to give progressive feedback and an overall evaluation of the resource which further increases their involvement and participation in the process.

Summary of Key Themes and Concepts

In completing this integrative literature review, a number of key themes and concepts were identified. Firstly, there is an ongoing shortage of RNs being recruited and retained in the LTC setting. This has been attributed to multiple preconceptions concerning the culture of nursing work in LTC, as well as the absence of a clear definition of the RNs' roles and responsibilities. The clinical environment for nurses working in the LTC sector is unique, and demands a specialized skill set and confidence (O'Brien et al., 2010). Going forward, it is essential for management to devote resources in building on the leadership capacity and the empowerment of RNs as a strategy in attracting and retaining a stable workforce of professionals to care for the growing number of geriatric clients requiring residential care.

The impact of offering a comprehensive orientation program in hospital settings has been demonstrated to improve RN satisfaction with transitioning to a new clinical environment, and therefore decrease overall attrition rates. While there has been limited evaluative studies completed on orientation programs that have been designed for the LTC setting, high RN turnover in LTC has been attributed to an increase in negative resident outcomes. A key aspect of this literature review is the various dimensions to consider when designing and implementing an effective nursing orientation program. The program should be introduced and implemented in a dynamic nature, and encompass a variety of learning modalities that are complete using a flexible time frame. Consideration of prior nursing experience and clinical skills should be accounted for, and the utilization of Benner's (1982) novice to expert model can be incorporated to guide all orientees.

In order to maximize learner satisfaction and success in the program, the orientation should be structured to encompass both a competency-based and preceptorship dimension. While the timeframe of what constitutes an effective nursing orientation program varies extensively in the literature, longer orientation programs have been connected to increased RN satisfaction in the new workplace and decreased attrition rates. As an important dimension of any educational resource, core evaluation tools should be established as ongoing throughout the orientation program to encourage feedback and generate support for the potential continuation and transferability of the resource.

Conclusion

In completing this integrative literature review, a number of important implications were revealed that impact the development of an orientation program for novice RNs orientating to LTC. To begin, the significance of developing a learning resource for new graduates and experienced RNs alike entering a new clinical environment has been reinforced. Several research studies support the design of such a resource in the form of a comprehensive orientation program, that encompasses both a competency and preceptor based framework. These considerations will be especially important going forward, due to the changing global demographic and shortage of RNs choosing to work in geriatric residential care settings. The literature also supported that orientation programs of adequate length are an effective way to improve RN satisfaction and commitment to the workplace, and therefore effectively attribute to organizational strategies to increase recruitment and retention rates of RNs in LTC. A collective emphasis should be placed on improving RN access to leadership and professional development opportunities such as through the completion of a comprehensive orientation program, and emphasizing the vitality of the RN role in the LTC setting.

Whether the RN is entering the LTC environment as a new graduate or experienced nurse, the importance of having an effective orientation program that is evidenced-based is critical in fostering a supportive learning environment and successful transition to the LTC setting. In this paper, I have provided an integrative literature review that describes the complexity of the roles and responsibilities of RNs in the LTC setting, and the impact that a comprehensive orientation program can have on overall workplace satisfaction and resident outcomes with the contribution of a stable RN workforce. The inclusion of Benner's Novice to Expert Model and Knowles' Adult Learning Theory were integrated due to their validity in designing an orientation program for nurses new to gerontology. The inclusion of several literature summary tables of relevant research studies that have been completed on this topic can be located below in the appendices.

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Appendix A-I

Study Name, Author, & Study Objective	Sample and Setting Characteristics	Design and Methodology	Key Results and Findings	Strengths and Limitations	Conclusion and Rating
<p>-Views Of Job Satisfaction and Dissatisfaction in Australian Long-term Care.</p> <p>-Moyle, W., Skinner, J., Rowe, G., & Gork, C. (2003).</p> <p>-To examine the factors that lead to workplace satisfaction and dissatisfaction</p>	<p>-Purposive Sample of 9 RNs, 5 ENs, and 13 AINs.</p> <p>-Participation was voluntary.</p> <p>-Average age was 46 years, and only one male participant.</p> <p>-2 Long-term Care (LTC) facilities in Brisbane, Australia under the same organization.</p>	<p>-Explorative Study. Qualitative Design.</p> <p>-10 focus group interviews conducted by external principal investigator until data saturation was met.</p> <p>-Interviews were audio taped.</p> <p>-Data from the interviews was transcribed verbatim, and emerging themes were noted.</p>	<p><u>-7 central themes emerged:</u></p> <ol style="list-style-type: none"> 1) LTC is a convenient workplace 2) Resident care and interaction promotes staff satisfaction 3) Resident gratification leads to staff satisfaction 4) Team work leads to job satisfaction, whereas staff members that are identified as inappropriate to work in LTC leads to staff dissatisfaction. 5) Time restraints and task centered care leads to job dissatisfaction 6) Un-recognized tensions in the workplace leads to job dissatisfaction 7) Overtime can create both job satisfaction and dissatisfaction <p>-RNs and ENs identified coming to LTC because they felt they didn't need many skills or enhanced knowledge in this setting.</p>	<p><u>Strengths:</u></p> <p>-Confirms findings of other job satisfaction studies</p> <p>-Offers strong support for nursing recruitment and retention in the LTC environment.</p> <p>-Participants commented on the benefits of having opportunity to discuss their concerns and feelings of empowerment about the workplace.</p> <p><u>Limitations:</u></p> <p>-Small number of participants.</p>	<p>-Overall, there was evidence to support the importance of LTC management understanding the factors that lead to job satisfaction among nursing staff in order to enhance overall recruitment and retention efforts, and positive resident outcomes.</p>

<p>n among a group of Registered Nurses (RNs), Enrolled Nurses (ENs), and Assistants in Nursing (AINs) in caring for the geriatric population.</p>	<p>-Recruitment completed through advertisements in newsletters and letter with pay stub.</p> <p>-Approximately half of the sample was from each facility.</p>	<p>-Demographic data about the participants were also analyzed.</p> <p>-27 Quotations were included from the participants to enhance the thematic analysis.</p>	<p>-Upon entering LTC they recognized that LTC was a complex setting requiring specialized skills.</p> <p>-Levels of satisfaction and dissatisfaction were similar among all three nursing groups.</p> <p>-It remains difficult to attract nursing staff into LTC due to presumptions about the nursing skills required.</p> <p>-In order to promote staff recruitment and retention through job satisfaction, management should encourage learning opportunities for staff and emphasize benefits to new nursing graduates of working in LTC.</p> <p>-Nursing workforce in LTC is ageing, potential for further staffing crisis.</p>	<p>-Lack of transferability of the results.</p> <p>-Potential bias towards one organization.</p>	
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Appendix A-II

Study Name, Author, & Study Objective	Sample and Setting Characteristics	Design and Methodology	Key Results and Findings	Strengths and Limitations	Conclusion and Rating
<p>-The Uniqueness of Elderly Care: Registered Nurses' Experiences as Preceptors During Clinical Practice in Nursing homes and Home-based Care.</p> <p>-Carlson, E., & Bengtsson, M. (2014).</p> <p>-The aim was to describe the experiences of a group of RNs who had preceptored undergraduate nursing students</p>	<p>-Convenience sampling employed.</p> <p>-N= 30 RNs divided into 7 groups (4 groups of rural RNs, and 3 groups of urban RNs).</p> <p>-Setting was in Southern Sweden.</p> <p>-Mean age of participants was 46 years, and mean clinical experience was 20 years.</p> <p>-Preceptored nursing students</p>	<p>-Qualitative, explorative design.</p> <p>-Focus group interviews were used to capture the individual experiences of the participants, as well as their shared experiences and perspectives.</p> <p>-Interviews were conducted by the first author using open-ended questions, lasting between 57-96 minutes.</p> <p>-7 interviews were considered to be enough with this population.</p> <p>-The interviews were transcribed by the first</p>	<p>-Used a socio-cultural perspective to describe the findings.</p> <p>-Oftentimes, the LTC environment is one of the nursing students' first clinical placements.</p> <p>-It is essential that preceptors convey a supportive attitude to the students in order to reduce anxiety and stress associated with the transition process.</p> <p>-When preceptorship experiences in LTC are presented in a creative way, it can successfully stimulate students'</p>	<p><u>Strengths:</u></p> <p>-Focus group interview sessions were described as being lively, in which participants felt comfortable and open in the group setting.</p> <p>-Sample included preceptors employed in nursing homes and home-based care, as well as rural and urban centres.</p> <p><u>Limitations:</u></p> <p>-Limited to the context of Swedish health care system, and transferability of</p>	<p>-Overall, this research study demonstrated that the LTC environment can facilitate unique learning experiences for nursing students. The consensus among the participants was that by including the students at the centre of learning and encompassing a creative and person-centered approach to geriatric nursing, the hope would be to change the perceptions of the students and stimulate interest in pursuing a career in geriatric nursing.</p>

in the LTC clinical setting.	between years 1-3 of their program.	<p>author, in which 3 subcategories emerged.</p> <p>-All authors were involved in the interpretation process, and peer review was also used in the analysis of the transcribed text.</p>	<p>interest in geriatric care.</p> <p>-Important that education surrounding end of life care is offered to nursing students, and experience is gained during the preceptorship.</p>	<p>the results is therefore limited.</p> <p>-Group-based focus groups can present the risk of certain participants being influenced by others, and not voicing opinions.</p>	
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Appendix A-III

Study Name, Author, & Study Objective	Sample and Setting Characteristics	Design and Methodology	Key Results and Findings	Strengths and Limitations	Conclusion and Rating
<p>-How Do Charge Nurses View Their Roles in Long-term Care?</p> <p>-McGilton, K.S., Bowers, B., McKenzie-Green, B., Boscart, V., & Brown, M. (2009).</p> <p>-The aim is to explore how RNs in LTC define and perceive their supervisory role.</p>	<p>-All nursing homes in Ontario were invited to participate (N=520).</p> <p>-30 expressed an interest, and of those 30, 8 were purposively selected to ensure variation in the sample.</p> <p>-Of the 8 facilities, 2 charge nurses were invited to participate (n=16 charge nurses). Of these 16, 2 did not provide demographic information, so the data was collected from 14 participants.</p>	<p>-Qualitative, exploratory design. Employed dimensional analysis.</p> <p>-One interview was conducted with each participant of an approximate length of 1.5hr.</p> <p>-Interviews were structured, but open-ended.</p> <p>-Audio-taped interviews were conducted by one researcher, and the transcription and review was</p>	<p><u>-3 dimensions were revealed from the data analysis:</u></p> <p>1) Against all odds, getting through the day.</p> <p>2) Stepping in work</p> <p>3) Leading and supporting unregulated care workers.</p> <p>-Overall, the participants experienced their work as complex and unpredictable.</p> <p>-Reduced attention is paid to the defined role of leadership in the charge nurse position.</p> <p>-Charge nurses need to be made aware of the leadership requirements during the recruitment process for LTC.</p>	<p><u>Strengths:</u></p> <p>-Adds to a growing body of literature on clarifying the role of the charge RN in LTC.</p> <p>-Each interview was individually analyzed to control for biases.</p> <p>-A variety of LTC facilities were included to capture different sizes.</p> <p>-Consistent dimensions arouse from the individual interviews.</p> <p><u>Limitations:</u></p> <p>-Exploratory methods employed, limiting</p>	<p>-Despite capturing the chaotic and demanding role of the charge RN in LTC, it is imperative that the management/administrative team consider methods to support the RNs within their leadership role.</p> <p>-In order to guide the development of the leadership role in LTC, efforts should be made to implement concrete orientation and mentorship programs that prioritize this vital role that the RN must fulfill to</p>

	<p>-On average, the charge nurses had worked in LTC for 7 years.</p> <p><u>-Eligibility criteria:</u></p> <p>-Being an RN</p> <p>-Employed part-time or full-time as a charge nurse at one of the selected LTC facilities.</p>	<p>conducted by the research team.</p> <p>-For transcription purposes, each interview was assigned a code number and all identifiers were removed.</p> <p>-Line by line dimensional analysis was used to analyze the data and form concepts.</p> <p>-Saturation was reached after 16 interviews when no new dimensions were generated from the participants' descriptions.</p>	<p>-Proper orientation and a thorough mentorship process are important in assisting novice RNs in the essential areas of leadership, time management, and conflict management.</p> <p>-It is important that the management team understands and supports the turbulent nature of the charge nurse position in LTC.</p>	<p>the transferability of the findings.</p> <p>-Potential that the participants were pre-selected by the administrations at each site which could introduce bias.</p>	<p>flourish in the LTC environment.</p>
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Appendix A-IV

Study Name, Author, & Study Objective	Sample and Setting Characteristics	Design and Methodology	Key Results and Findings	Strengths and Limitations	Conclusion and Rating
<p>-The Positive Impact of Preceptors on Recruitment and Retention of RNs in Long-term Care. A Pilot Project.</p> <p>-Aaron, C. S. (2011).</p> <p>-The purpose of this research study was to utilize a systems approach to discover the culture of LTC to improve the</p>	<p>-Four Heritage nursing homes that are part of the greater Expanding Teaching-Nursing Home Project</p> <p>-Setting: Central Illinois.</p> <p>-Participants included the administration, director of nursing, and assistant director of nursing at the 4 nursing homes.</p> <p>-Sample=12 Caucasian women, 8 of which were RNs.</p> <p>-One facility agreed to be the site of the pilot</p>	<p>-Qualitative, descriptive design.</p> <p>-Two parts: Feasibility study and pilot-project.</p> <p>-Semi-structured focus groups at each nursing home were held by a trained research assistant with the 3 participants.</p> <p>-Interviews were audio-taped, and confirmation of the responses was completed at the end of each interview.</p> <p>-All audio-tapes were transcribed by the research assistant, and reviewed by the research assistant, investigator, and co-</p>	<p>-The participants revealed that the orientation program routinely lasted 1-2 weeks, but could be reduced if there was a staffing shortage.</p> <p>-Of the 10 nurses orientated under the new preceptor program at the pilot-site, all 10 were successfully retained.</p> <p>-Annual positive indicator testing revealed that resident/family/and staff satisfaction had improved the year after the implementation of</p>	<p><u>Strengths:</u></p> <p>-Two aspects were explored: current practices around retention and recruitment, and then a re-evaluation following the implementation of a preceptor program at one of the sites.</p> <p><u>Limitations:</u></p> <p>-The initial focus group for the feasibility aspect of the study consisted of participants that were of administrative status only.</p> <p>-Only one of the nursing homes in the</p>	<p>-By establishing a preceptor program to orientate new nurses' to the pilot LTC site, recruitment and retention efforts of RNs were effective.</p> <p>-The orientation program was useful in improving new nurses' confidence and competence surrounding their roles and responsibilities of practicing in the LTC environment.</p> <p>-Organizations need to embrace individualized orientation for new</p>

<p>overall retention and recruitment of RNs in LTC.</p>	<p>project (164 bed facility).</p> <p>-One preceptor was chosen at the pilot-site to orientate each new nurse to the site.</p> <p>-The preceptor program was implemented on September 1st, 2006 and involved the orientation of 10 nurses.</p>	<p>investigator to discover themes relating to recruitment and retention.</p> <p>-All responses were kept confidential, and locked in a secure location by the research team.</p> <p>-Benner's (1984) novice to expert framework was used as the conceptual model for the preceptor program at the pilot-site during 2005-2006.</p> <p>-Data was collected from the pilot-site on nurse agency use, turnover rate, overtime, and advertising costs.</p> <p>-Other data from the pilot-site included resident/family satisfaction, annual survey results, recruitment methods, and staff development.</p>	<p>the preceptor program.</p> <p>-MDS measurements noted that resident measures improved the year after implementation of the preceptor program.</p> <p>-The pilot-site experienced reduced costs of overtime and advertising.</p>	<p>study participated in the pilot-study portion.</p> <p>-Focus group style-interviews may have introduced bias, as participants may have with-held information or been influenced by the other responses.</p>	<p>nurses in LTC, which can lead to professional growth and commitment to the organization by the new employee.</p>
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Appendix A-V

Study Name, Author, & Study Objective	Sample and Setting Characteristics	Design and Methodology	Key Results and Findings	Strengths and Limitations	Conclusion and Rating
<p>-Enhanced Orientation for Nurses New to Long-term Care.</p> <p>-O'Rourke, D. (2016).</p> <p>-The project aim was to provide novice RNs entering LTC with a better overview of the nature of the resident population in order to improve resident outcomes, and foster a positive work environment. Another project</p>	<p>-Setting: 3 LTC sites in the Winnipeg Regional Health Authority.</p> <p>-Mentorship program included 11 mentors experienced in LTC, and 12 novice nurses new to LTC.</p> <p>-9 of the novice nurses were new graduates, 3 had worked in other settings.</p> <p>-8 were LPNs, and 4 were RNs.</p>	<p>-Pilot-project design.</p> <p>-Project planning began in February, 2009.</p> <p>-The 12 novice nurses were paired with an experienced nurse from their LTC site.</p> <p>-In September, 2009 the mentors participated in a one-day work-shop with a goal of enhancing their mentorship skills.</p> <p>-One week later, the novice nurses and mentors attended a one-day orientation workshop in order to meet each other and set expectations.</p>	<p>-The entire project was evaluated as part of the national RTA evaluation.</p> <p>-The effects of this project on nurse retention and recruitment has not been evaluated at this point.</p> <p>-The novice nurses emphasized that the enhanced orientation program was positive in assisting in the transition into their new positions and confidence levels in LTC.</p> <p>-The mentor group revealed that the opportunity and education had been positive in advancing their</p>	<p><u>Strengths:</u></p> <p>-In order to expand the number of novice nurses available, the participant sample was increased to include nurses new to LTC who had been hired up to six months before the project began.</p> <p><u>Limitations:</u></p> <p>-At the 3 sites, the number of recently hired nurses to LTC was lower than anticipated (proposal had anticipated for 30 novice nurses).</p> <p>-Small sample size overall.</p>	<p>-This pilot project was successful in having a positive effect on both the transition of novice nurses to LTC, as well as building the capacity of the mentor group.</p> <p>-Due to the complexity of the residents being admitted to LTC, the novice nurse requires a consistent high-quality orientation, and the</p>

aim was to provide a consistent LTC orientation program in Manitoba.	<p>-Within the mentor group, 2 were LPNs and 9 were RNs.</p> <p>-6 clinical workshops were arranged and held, with a total of 390 participants attending.</p>	<p>-The mentoring process transpired between September, 2009-April, 2010.</p> <p>-Between October, 2009-April, 2010, the novice nurses and mentors attended a series of six day-long workshops pertaining to LTC.</p>	<p>leadership abilities and mentoring skills.</p> <p>-Multiple-choice tests were administered to all workshop participants following the clinical workshop, and measurable improvements were noted relating to the key concepts pertaining to LTC.</p>	<p>-Management was not involved in the mentorship education, and this limited their ability to support and understand the process for both the mentor and novice nurse.</p>	support of a qualified mentor in the workplace.
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Appendix A-VI

Study Name, Author, & Study Objective	Sample and Setting Characteristics	Design and Methodology	Key Results and Findings	Strengths and Limitations	Conclusion and Rating
<p>-Staff Turnover and Quality of Care in Nursing Homes.</p> <p>-Castle, N. G., & Engberg, J. (2005).</p> <p>-The aim of this research study was to examine the association between nurse aide (NA), LPN, and RN turnover on six quality indicators in the LTC environment.</p>	<p>-The questionnaire was mailed to administrators of 526 nursing homes from facilities located in Missouri, Texas, Connecticut, and New Jersey in March, 2003.</p> <p>-The facility sample was selected randomly from a pool of selected facilities from the 4 states (n=529).</p> <p>-354 (response rate=67%) was received from the nursing home sample, which varied across all 4 States.</p>	<p>-Quantitative, empirical design (Descriptive).</p> <p>-Negative binomial regression was used to complete a multivariate analysis in order to examine the effect of staff turnover on 6 quality indicators.</p> <p>-The six quality indicators consisted of: physical restraint use, catheter use, contractures, pressure ulcers, psychoactive drug use, and certification survey quality of care deficiencies.</p>	<p>-The 1 year turnover rates from this study were 98.6% for NAs, 66.8% for LPNs, and 55.4% for RNs.</p> <p>-Of the facilities in the study, 23% of them had low RN turnover (0-20%), 31% had medium turnover (21-50%), and 46% had high turnover (>50%).</p> <p>-Among the RNs, moderate to high levels of turnover are associated with lower quality of care.</p> <p>-A stable RN workforce in the</p>	<p><u>Strengths:</u></p> <p>-There are few existing empirical studies that have demonstrated the relationship between staff turnover and quality indicators in the LTC environment.</p> <p>-Large number of participating sites.</p> <p><u>Limitations:</u></p> <p>-The OSCAR data has limitations, and in future the use of MDS data may produce a more accurate set of results.</p>	<p>-Overall, this quantitative research study demonstrated that there is an association between high nursing staff turnover and quality indicators affecting resident care.</p> <p>-Efforts need to be made to enhance retention rates of nursing staff within the LTC environment, in order to prevent adverse outcomes for the residents.</p> <p><u>Rating:</u></p> <p>-Study Design: Weak</p>

	<p>-Information on staff turnover was collected from an ongoing study that is examining the accuracy of turnover reporting by nursing homes.</p> <p>-The questionnaire asked administrators to indicate their turnover rates as a self-reported measure.</p> <p>-Information on staffing levels was also collected.</p> <p>-The information on quality indicators was collected from OSCAR.</p>		<p>LTC environment leads to the highest quality of care as measured by the six quality indicators.</p>	<p>-Cross sectional results are only able to demonstrate an association between staff turnover and the quality care of the geriatric population in nursing homes.</p>	<p>-Study Quality: Medium</p>
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Appendix A-VII

Study Name, Author, & Study Objective	Sample and Setting Characteristics	Design and Methodology	Key Results and Findings	Strengths and Limitations	Conclusion and Rating
<p>-The Learning Needs of Nurses Experiencing Job Change.</p> <p>-Butt, M., Baumann, A., O'Brien-Pallas, L., Deber, R., Blythe, J., & DiCenso, A. (2002).</p> <p>-This study aimed to explore the learning and orientation needs of nurses when they experience job change.</p>	<p>-All nursing staff (N=3408) from two large, tertiary care teaching hospitals.</p> <p>-Setting: Ontario, Canada</p> <p>-Nursing staff included RNs and LPNs.</p> <p>-A list of all nursing staff at both hospitals was generated.</p> <p>-The questionnaire, information sheet, and consent form were mailed to each nurse.</p> <p>-Post-card reminder was sent as well 2 weeks after</p>	<p>-Quantitative Design.</p> <p>-Questionnaire entitled the Nursing Job-Change Survey was developed.</p> <p>-The survey explored themes relating to job change such as: work environment, quality of care, organization and professional commitment, learning needs, and orientation.</p> <p>-Feedback from expert nurse researchers established the questionnaire's content-related validity.</p>	<p>-Of the nurses who experienced job change, 85.1% were provided a clinical orientation of 1-37 shifts.</p> <p>-The orientation included several types of learning modalities including: written information (89.9%), self-directed learning packages (73.2%), trained preceptors (83.5%), and a unit introduction (86.5%).</p> <p>-The majority of the nurses experiencing job change identified they needed further knowledge around policies and procedures, patient protocols, technical procedures, and nursing interventions.</p>	<p><u>Strengths:</u></p> <p>-Large sample size from two large teaching hospitals.</p> <p><u>Limitations:</u></p> <p>-Due to the nature that the study was conducted in two large teaching hospitals, the findings may not be applicable to non-teaching hospitals</p> <p>-While the learning needs of the job-change group</p>	<p>-Overall, this study demonstrated that it is important for educators to create competency-based orientation programs that are sensitive to the needs of the nurse experiencing job change.</p> <p>-The program should ideally explore the nurses' past experience, and build on existing knowledge and</p>

	<p>the questionnaire was distributed.</p> <p>-Response rate to the questionnaire was 50.7% (n=1728).</p> <p>-Useable data was completed on a final data set of 1662 nurses, of which approximately 49.8% had experienced job change.</p> <p>-Data for this analysis was based on n=828.</p> <p>-69.1% of the sample had a RN diploma, 15.3% had a BN or higher, and 14.6% were LPNs.</p> <p>-54.9% of the sample had experienced job change in the past 4 years.</p>	<p>-Questionnaire was pre-tested for face validity and reliability with a group of nurses who had undergone job change.</p> <p>-Consisted of 72 questions using reliable and valid questionnaires, and included categorical response questions and items with answers based on a 7-point Likert scale.</p> <p>-SPSS used to conduct statistical analysis.</p> <p>-Nurses divided into two categories: job change, or not experienced job change.</p> <p>-Analysis only completed on the job-change group.</p>	<p>-The learning needs were specific to the type of job change experienced.</p> <p>-Job change can make experienced nurses feel like novice nurses due to the unique knowledge and skill set required in different clinical areas of nursing.</p>	<p>were explored, it was not compared to a control group of non-job change nurses.</p>	<p>skills in order for the novice nurse to feel competent in their new position.</p> <p><u>Rating:</u></p> <p>-Moderate Design</p> <p>-Medium Quality</p>
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Appendix A-VIII

Study Name, Author, & Study Objective	Sample and Setting Characteristics	Design and Methodology	Key Results and Findings	Strengths and Limitations	Conclusion and Rating
<p>-Exploring Nursing Expertise in Residential Care for Older People: a Mixed Method Study.</p> <p>-Phelan, A., & McCormack, B. (2016).</p> <p>-The aim of the study was to explore the knowledge of a group of RNS employed in LTC on the nursing care of the geriatric population.</p>	<p>-Setting: Ireland in 2012.</p> <p>-At time of the study, there were 526 facilities for LTC, 75% were privately operated, and 20.5% were run by the state.</p> <p>-Recruitment occurred through advertisements in Health Service Executive networks, emails to the All Ireland Gerontological Nurses' Association, and Nursing Homes Ireland's membership listings.</p>	<p>-Empirical, Mixed Methods Design (Qualitative and Quantitative).</p> <p>-6 data collection methods were used.</p> <p>-5 data collection methods were used with each of the 23 case study nurses: shadowing, interview with a colleague, interview with a resident, a demographic profile, and a director of nursing survey.</p> <p>-The study also employed a modified focus group.</p>	<p>-35% of the participants were between 22-30 years.</p> <p>-7 themes emerged from the data analysis: transitions, context of the nursing home, saliency, holistic practice knowledge, knowing the resident, moral agency and skilled know how</p> <p>-There is an imminent need to support and recognize the important of nursing expertise in geriatrics.</p>	<p><u>Strengths:</u></p> <p>-Several data collection methods, in which rigor was maintained through a thorough discussion and preparation of each method by the research team.</p> <p>-Triangulation was used between all data methods to increase dependability as the individual data methods strengthened each other.</p> <p><u>Limitations:</u></p> <p>-Hawthorne effect may have been a factor during the shadowing aspect of the data collection.</p>	<p>-Overall, the findings of this mixed methods study demonstrated that due to the growing population of older people it is essential that residential care and staff composition is focused on levels of the unique expertise required, and not only on task assignments and cost containment.</p> <p>-Further research needs to explore how to reduce the invisibility of the geriatric nurses'</p>

	<p><u>Inclusion Criteria:</u></p> <ul style="list-style-type: none"> -Registered with the Irish Nursing and Midwifery board -Minimum of 1 year experience in LTC for older people. -23 sites agreed to participate, of which 6 were public, 14 were private, and 3 were voluntary run. -Each site recruited a RN to participate who met the inclusion criteria. -23 case study nurses participated from nursing homes. 	<ul style="list-style-type: none"> -Qualitative data was analyzed using directed content analysis that stemmed from a conceptual framework that was created from the literature on nursing expertise. -Central themes emerged from the qualitative data analysis using deductive directed content analysis. -Coding was discussed by all researchers, until inter-rater agreement was reached. -Quantitative data was analyzed using SPSS. 	<ul style="list-style-type: none"> -There were multiple and complex elements of expertise that were demonstrated by each case nurse in this study, which emphasizes the importance of the RN in LTC. -Contrary to Benner's (1984) theory that nurse expertise involves a minimum practice experience of 5 years, this study demonstrated that expertise may not be time bound and can occur in a shorter time frame. 	<ul style="list-style-type: none"> -Gender bias, all participants were female. -Resident interviews were arranged by the director of nursing, may have been pre-selected due to cognitive ability and independence. -The participant nursing homes utilized self-selection. 	<p>level of expertise and continue to promote the professional status of gerontology.</p>
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Appendix A-IX

Study Name, Author, & Study Objective	Sample and Setting Characteristics	Design and Methodology	Key Results and Findings	Strengths and Limitations	Conclusion and Rating
<p>-Newly Qualified Nurses' Experiences of Preceptorship.</p> <p>-Lewis, S., & McGowan, B. (2015).</p> <p>-To explore into the experience of a group of newly qualified nurses who had recently finished their preceptorship.</p>	<p>-Purposive sampling.</p> <p>-n=8 RNs working in the trust who had completed their preceptorship period.</p> <p>-All participants were working in the inpatient setting.</p> <p>-All participants were RNs who had completed their preceptorship period less than 18 months ago.</p>	<p>-Qualitative research methods.</p> <p>-Utilized Newell and Burnard's (2011) Pragmatic Approach to Qualitative Data Analysis to guide data collection and analysis process.</p> <p>-Data collection involved one-to-one and semi-structured interviews lasting approximately 1 hour.</p> <p>-Interviews were recorded, and field notes were also taken.</p>	<p>-Two main categories emerged: support requirements and expectations of preceptorship.</p> <p>-One of the main goals of the preceptorship period is confidence building which was important to all participants.</p> <p>-Most of the participants felt that the preceptorship period enabled them to develop their confidence levels, as well as their knowledge and skills to the clinical area.</p> <p>-One emergent concern from the interviews was that the novice RN felt unclear about what the expectations would be of them once the preceptorship period was completed.</p>	<p><u>Strengths:</u></p> <p>-Offered data on the experience of the preceptorship period from the insight of a group of novice RNs.</p> <p><u>Limitations:</u></p> <p>-Small sample size.</p> <p>-The sample came from the same trust, with similar clinical facilities.</p> <p>-Limited transferability to other clinical contexts.</p>	<p>-From the findings of this qualitative study, the preceptorship experience offers the novice RN a key opportunity to develop their confidence in the transition from a student to a novice RN.</p> <p>-It is imperative that the roles and responsibilities for both the novice RN and the preceptor be developed and maintained initially and throughout the relationship.</p>

		<p>-Transcripts were typed and analyzed by each researcher separately.</p> <p>-The researcher's interpretations were compared to strengthen the validity and rigor.</p>	<p>-There were some discrepancies in the way that the novice RNs were preceptored. Some worked alongside their preceptor, while others shadowed for a few days and then worked independently.</p> <p>-Some of the participants felt that their preceptor was unclear of what was expected of them as a preceptor as they hadn't acted in that role before.</p> <p>-From this theme, it can be determined that there was confusion by both the novice RNs and the preceptors around their roles and responsibilities in the process.</p>		<p>-Merit can be gained from a consistent approach in organizing a preceptorship program for novice RNs entering new clinical areas in nursing.</p>
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Appendix A-X

Study Name, Author, & Study Objective	Sample and Setting Characteristics	Design and Methodology	Key Results and Findings	Strengths and Limitations	Conclusion and Rating
<p>-Attracting Nurses to Long-term Care.</p> <p>-Robertson, J. F., & Cummings, C. C. (1996).</p> <p>-The purpose of this research study was to examine factors that would contribute to RN recruitment in the LTC setting.</p>	<p>-N=604 RNs from nursing homes in the United States.</p> <p>-The majority of the respondents were female, with an RN diploma. They had worked in LTC on average for 5 years.</p>	<p>-Qualitative, ethnographic content analysis using the Ethnograph Program to analyze the data.</p> <p>-The data collection instrument was developed in the original quantitative study.</p> <p>-Data collection occurred over a 4 month period.</p> <p>-All participants were asked to respond to one open ended question concerning how to make LTC a more attractive place to work.</p> <p>-The ethnographic manuscript was analyzed</p>	<p>-There were 2259 suggestions offered from the 604 participants.</p> <p>-Content analysis revealed 9 major conceptual categories offering recruitment recommendations: staffing, salary, nursing practice, bureaucracy, environment, benefits, education, quality, and image.</p> <p>-It was noted that LTC is often weighed down by negative misconceptions both within and outside the nursing profession.</p> <p>-91% (n=155) of the participants identified education as an important</p>	<p><u>Strengths:</u></p> <p>-Large sample size.</p> <p>-Multiple suggestions on how to improve RN recruitment in the LTC setting.</p> <p><u>Limitations:</u></p> <p>-No mention of recruitment tactics.</p> <p>-Setting is not well defined, vague description of across the Country but no demographic analysis noted.</p> <p>-Potential bias because nurses that respondent had chosen to remain in</p>	<p>-The findings of this research study indicate the importance of recognizing methods to decrease the longstanding shortage of nurses in the LTC setting.</p> <p>-Educational opportunities including a consistent and organized orientation program that encompasses topics specific to gerontology and the role of leadership in the LTC setting are</p>

		<p>by both researchers several times and themes and codes were identified.</p> <p>-The themes that were identified were consistent with themes that had been revealed in the literature review around improving nursing recruitment in LTC.</p> <p>-Inter-coder agreement was estimated to be 95-98%.</p>	<p>factor for recruiting RNs to LTC.</p> <p>-Under the education category, orientation was recommended to be more intense and effective. There was also mention of the importance of on-going educational opportunities for RNs in the workplace including geriatrics, leadership and management, attitudes, and clinical practice.</p>	LTC and not left this clinical area.	key in recruiting and retaining RNS in LTC.
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Appendix A-XI

Study Name, Author, & Study Objective	Sample and Setting Characteristics	Design and Methodology	Key Results and Findings	Strengths and Limitations	Conclusion and Rating
<p>-Attracting Students to Aged Care: The Impact of a Supportive Orientation.</p> <p>-Robinson, A., Andrews-Hall, S., Cubit, K., Fassett, M., Venter, L., Menzies, B., & Jongeling, L. (2008).</p> <p>-To gain insight into the clinical experiences of a group of undergraduate nursing students in</p>	<p>-Involved 6 LTS facilities.</p> <p>-Participants included nurse preceptors (n=37) in the 6 facilities, as well as 3 groups of second year nursing students (n=20/21/stage) who were completing 3-week clinical over three successive semesters of the school year.</p> <p>-Setting: Tasmania, Australia</p>	<p>-Qualitative and Quantitative methods were completed for certain stages of the research study.</p> <p>-Study was conducted from 2003-2006.</p> <p>-Utilized informed by action research methods to improve the quality of aged care clinical placements and to involve the RNs working in aged care to critique their work and work setting.</p> <p><u>-3 Stages:</u></p> <ol style="list-style-type: none"> 1) Scoping study to clarify issues impacting the students' clinical placements. 2) Collaborate with preceptors 	<p><u>Stage 1:</u></p> <p>-A week prior to the first group of students beginning their placement, the preceptors identified the importance of welcoming and supporting the students.</p> <p>-The student group expressed a desire for a formal orientation that would make them feel welcome in the LTC facilities.</p> <p>-The preceptors did not address several important areas with the students. Feedback was provided to the preceptors.</p>	<p><u>Strengths:</u></p> <p>-Qualitative and quantitative methods were employed.</p> <p><u>Limitations:</u></p> <p>-The recruitment method is not mentioned by the authors for the preceptor group. This may introduce biases as those RNs that volunteered as preceptors may be more engaged in the LTC setting and preceptor opportunities.</p> <p>-Focus group style interviews with the students may</p>	<p>-Overall, the orientation process needs to be considered a critical dimension of student nurses' experiences during the clinical placement within the LTC environment.</p> <p>-It is paramount to consider the role of the preceptor in the orientation process, with the collaborative goal of fostering enthusiasm and a positive attitude towards gerontology.</p>

LTC facilities, and how the orientation experience influenced their attitude towards LTC as a career choice in the future.		<p>3) Follow-up stage to assess the sustainability of any improvements.</p> <p>-Involved 45 one-hour meetings with preceptors, and 27 meetings with the three student groups.</p> <p>-Meetings facilitated by research assistants who were familiar with the methodology.</p> <p>-Thematic analysis, clustering of concepts, and generation of themes relating to the students' quality of experience were completed.</p> <p>-Quantitative data included an orientation checklist to evaluate induction procedures which was administered at the end of the first week of the students' placement. Also included two survey tools that assessed students' career intentions and experiences on placement.</p> <p>-Microsoft excel was used, and descriptive statistical analysis was performed in this program.</p>	<p><u>Stage 2:</u></p> <p>-A 3 stage orientation process was developed based on the feedback in stage 1.</p> <p>-There was a drastic improvement in the students' orientation experience. The practicum was viewed as a positive encounter and a positive shift occurred in the students' attitudes about working in LTC.</p> <p><u>Stage 3:</u></p> <p>-Sustainability of the improvements made to the orientation program in stage 2 was sustained in 4 of the 6 LTC facilities.</p> <p>-78% of the students felt welcomed on arrival.</p>	<p>introduce participant bias. The responses of other students may intimidate or influence other students' attitudes and opinions.</p> <p>-No long-term follow up to demonstrate the quantity of students that chose LTC as a career choice following graduation.</p>	<p>-Parallels can be drawn between the student-groups in this study and the novice-RN group new to the clinical LTC environment.</p> <p><u>Rating:</u></p> <p>-Study Design: Weak</p> <p>-Study Quality: Medium</p>
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Appendix A-XII

Study Name, Author, & Study Objective	Sample and Setting Characteristics	Design and Methodology	Key Results and Findings	Strengths and Limitations	Conclusion and Rating
<p>-Outcome Evaluation of a New Model of Critical Care Orientation.</p> <p>-Morris, L. L., Pfeifer, P., Catalano, R., Fortney, R., Nelson, G., Rabito, R., & Harap, R. (2009).</p> <p>-To examine the effect of a new model of orientation in the critical care setting on workplace satisfaction, retention,</p>	<p>-145 nurses participated during the first 22 months, at end of the 34 months, a total of 197 had participated in total.</p> <p>-Setting: Northwestern Memorial Hospital</p> <p>-109 of participants had less than 1 year experience, 36 had 1-2 years, 17 had 5-10 years, and 3 had more than 20 years.</p>	<p>-Prospective, quasi-experimental design.</p> <p>-Qualitative and Quantitative methods.</p> <p>-Used Benner's Novice to Expert Model, and Adult Learning Theory as frameworks.</p> <p>-Used a learner-centered model with preceptor—assignment.</p> <p>-Program implemented in 2005 with all new hires in the ICU setting.</p> <p>-Data was collected before, during, and after implementation using several outcome measures: satisfaction, preparedness to manage assignment, retention, vacancy,</p>	<p>-Prior to the program, the overall retention rate for nurses in the ICU was 91.2%.</p> <p>-By the end of the first year, the retention has increased to 93.7%.</p> <p>-Before the new program, annual turnover was 8.77% of ICU nurses. After one year, this rate had decreased to 6.29%.</p> <p>-Increased recruitment emerged from the program.</p> <p>-The new program cost \$24,810 more than the</p>	<p><u>Strengths:</u></p> <p>-Multidimensional design and large sample size.</p> <p>-Offers a strong framework to be transferrable to other clinical settings when designing orientation programs.</p> <p><u>Limitations:</u></p> <p>-No mention of recruitment methods.</p>	<p>-Overall, this hospital based orientation program that included both competency and preceptor-based frameworks was effective in improving RN retention and satisfaction rates.</p> <p>-Can be considered for other areas, as a template in designing orientation programs.</p>

turnover, vacancy, preparedness, length of orientation, and overall cost.	-87% were female, 13% were male.	<p>turnover, recruitment and costs and length of orientation.</p> <p>-Before the new model was started, questionnaires evaluating the program sent to panel of experts to confirm content validity.</p> <p>-Orientees were asked to rate their level of experience, time spent in classroom, and clinical education, length of orientation.</p> <p>-3 months into program, and several times during the year direct feedback was obtained from the participants.</p> <p>-Following implementation, management were asked to evaluate the program based on anxiety and burnout, time spent in orientation. Orientees rated overall satisfaction.</p> <p>-Human resources provided data on length of orientation, cost, and rate of retention.</p>	<p>old program. Important to note that the new orientation program added value through due to retention savings.</p> <p>-Length of the orientation program remained unchanged.</p>	-Study only conducted at one hospital.	<p><u>Rating:</u></p> <p>Study Design: Weak</p> <p>Study Quality: Moderate</p>
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Appendix A-XIII

Study Name, Author, & Study Objective	Sample and Setting Characteristics	Design and Methodology	Key Results and Findings	Strengths and Limitations	Conclusion and Rating
<p>-Newly Hired Nurses' and Physicians' Perceptions of the Comprehensive Health Care Orientation Process: a Pilot Study.</p> <p>-Peltokoski, J., Vehvilainen-Julkunen, K., & Miettinen, M. (2015).</p> <p>-To explore the perceptions of a group of newly hired nurses' and physicians' in relation to their</p>	<p>-n=145 nurses, and n=37 physicians working in two Finnish hospitals in specialized hospital settings.</p> <p>-One of the hospitals was a university-based, and one central based.</p> <p>-Both had similar orientation programs.</p> <p>-2009-2010.</p> <p><u>-Inclusion criteria:</u></p> <p>-All RNs and physicians that were employed in May 2009 or later</p>	<p>-Pilot study.</p> <p>-Cross-sectional, descriptive questionnaire.</p> <p>-Data collected by mailed questionnaires. Mailed to nurses and physicians work units 3 months after employment.</p> <p>-Comprehensiveness of the orientation program was measured using the Orientation Process Evaluation (OPE). This was collected from a study conducted by Miettinen et al (2006,</p>	<p>-Half of the respondents stated that the orientation was 4 days or under, a quarter said 5-10 days, and 13% said over 25 days.</p> <p>-Satisfaction with the orientation was moderately low.</p> <p>-Results show some evidence that the orientation program was not properly implemented in the two study studies.</p> <p>-The role of the preceptor is critical, and has a major influence on the comprehensive orientation.</p>	<p><u>Strengths:</u></p> <p>-Moderate response rate achieved.</p> <p>-Reliability of the OPE instrument was considered good.</p> <p><u>Limitations:</u></p> <p>-Small sample size limit the generalizability of the findings.</p> <p>-Self-selection of participants</p>	<p>-This pilot study emphasizes the importance of a comprehensive orientation program on meeting the needs of nurses and physicians transitioning into a complex health care system.</p> <p>-Orientation programs should be evidenced-based, and obtain full support from the organization and unit-preceptor levels.</p> <p>-Strategies should be implemented to develop any hospital orientation program</p>

orientation process.	<p>-In permanent or temporary positions</p> <p>-Present in position for at least 3 months of longer</p> <p>-Of the 401 questionnaires mailed, 182 were returned. Response rate= 45%.</p>	<p>2009) and previous literature.</p> <p>-Instrument was composed of 55 items, and adjusted based on commentary from nursing experts, nurses, directors of nursing, and university lecturer.</p> <p>-Instrument was pre-tested with a convenience sample of 16 nurses and 2 physicians from both study hospitals.</p> <p>-Responses were on a five-point likert-type scale.</p> <p>-Cronbach's alpha was 0.87.</p> <p>-Data analyzed using SPSS.</p>	<p>-Preceptor programs decrease a hospital's turnover cost.</p> <p>-There was a low level of patient and work safety culture. Difficult to determine if this is due to the orientation, or the reliability and validity of the questionnaire.</p> <p>-Duration of the orientation is critical.</p> <p>-Improvements need to be made around the evaluation of the orientation process.</p>	<p>may introduce bias.</p> <p>-OPE instrument used for the first time in this study.</p>	<p>into a comprehensive process.</p> <p><u>Rating:</u></p> <p>Overall Design: Weak</p> <p>Overall Quality: Moderate</p>
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Appendix B: Consultation Report

Introduction

Consultations are included as one of the advanced nursing practice competencies (ANP) as proposed by the Canadian Nurses Association (CNA) (2008). The consultation process is an essential skill in assisting with the development of an orientation resource manual for novice registered nurses (RNs) new to long-term care (LTC) as proposed for the practicum project in fulfillment of N6660. The addition of this learning resource will be critical in supporting the transition of novice RNs to the LTC setting, with the added collaborative goal of improving the continuity of nursing care for the geriatric population. In developing and implementing research-based projects, the joint knowledge sharing and support of the larger inter-disciplinary team, colleagues, and key stakeholders are an essential aspect to the process. In completing this practicum project, the clinical nurse educator, resident care manager (RCM), a senior and novice RN at St. Luke's Homes (SLHs), the president of the Newfoundland and Labrador Gerontological Nurses' Association (NLGNA), the clinical nurse educators for the LTC programs for the four regional health authorities in Newfoundland and Labrador (NL), a human resources (HR) representative with EH, and the coordinator of the Winnipeg LTC orientation pilot project were all consulted to gain additional insight from their experiences and perspectives on the benefit and need for a comprehensive orientation program for RNs in the LTC setting. In this paper, I will discuss the purpose of the practicum project, provide a rationale for the consultation process, explain the key stakeholders' experience and contributions to the process, clarify how the interview data was managed and analyzed, summarize what was learned through the consultation process, and, finally, how the data obtained from the consults will contribute to the overall practicum project.

Background of the Practicum Project

The setting for this practicum project is at SLHs, which is a moderately-sized LTC facility within EH. This agency employs a large inter-disciplinary team that consists of numerous personal care attendants (PCAs) and licensed practical nurses (LPNs), and a smaller ratio of registered nurses (RNs). Looking forward at the rapidly aging population in NL that will require residential care, it is imperative to examine and develop strategies to adequately meet their health care needs. Within this population, residents entering LTC facilities often require more advanced nursing care due to the complexity and acuity of their health statuses. While the contribution of the RN to this setting is indispensable, there continues to be a number of negative connotations affecting the internal culture of nursing work in LTC, as well as organizational mandates to reduce the number of RNs as a cost-saving measure. Both of these factors have led to ongoing and projected shortages of RNs in the LTC setting, and affected recruitment and retention rates.

A review of the literature demonstrates that the RN in LTC is a fundamental component to the nursing team, and that due to the complexity of their leadership position in this setting there continues to be a variance in the understanding of the defined roles and responsibilities (Leppa, 2004; McGilton, Bowers, McKenzie-Green, Boscart, & Brown, 2009). RN shortages have been further exacerbated by the belief among nursing students and graduate nurses that the LTC environment does not promote the RN to utilize their clinical skills, and that caring for the geriatric population is both predictable and boring (Abbey et al., 2006; Carlson et al., 2014; Dellasega & Curriero, 1991; Leppa, 2004). From the literature, evidence indicates that one effective way to enhance the overall workplace satisfaction of the RN group in LTC is for employers to invest more into education and professional development initiatives (CNA, 2008; McGilton et al., 2009). An optimal time to expose novice nurses to evidence-based education relating to gerontology is during the orientation period (O’Gara, 2003). A comprehensive orientation program that consists of competency-based education and a preceptorship

period is a prominent method identified by RNs in all clinical areas to positively assist with the transition into a new environment (Almanda et al., 2004; Burgess, 2007; Gavlak, 2007; Marcum & West, 2004). In considering the education needs of newly graduate RNs versus RNs with considerable clinical experience, the literature supports a dynamic timeframe for the orientation program that consists of various delivery modalities (Miettinen, Kaunonen, & Tarkka, 2006; Peltokoski et al., 2016). The role of RN empowerment in enhancing an individuals' commitment and satisfaction in the workplace, and therefore decreasing attrition rates has been linked to the availability of successful comprehensive orientation programs (Morris et al., 2009; O'Rourke, 2016; Sandau & Halm, 2010). Therefore, all RNs transferring to the LTC clinical setting would benefit from the availability of a comprehensive orientation program to assist with easing the transition to this dynamic environment and varied roles and responsibilities.

Through the completion of the integrated literature review, it was determined that an orientation resource manual for novice RNs new to LTC would be a relevant topic in completing this practicum project. Applicable theoretical frameworks such as Knowles' Adult Learning Theory and Benner's Novice to Expert Theory will be utilized in the development phase of this manual. As an available resource for orientees at SLHs in addition to an ongoing preceptorship, the manual will describe the roles and responsibilities of the RN in LTC, managing and preventing common geriatric health issues, leadership training, conflict management, expectations of the orientee during the preceptorship period, common policies and procedures unique to LTC, and the clinical management of palliative care residents.

This resource manual will be in addition to the one-week long generalized nursing orientation that the entire nurse team receives through the LTC program, and will be pertinent to the RN group to guide and in coordination with the defined preceptorship period at SLHs. The manual will be provided to all resident care managers (RCMs) at SLHs, as well as the clinical nurse educator who conducts the

nursing orientation program for all orientees. During the site-wide orientation program, the resource manual can be provided to all RNs as an additional resource to enhance their knowledge in gerontology, and assist with easing the transition period. Assigned preceptors can also be made aware of this resource, and utilize it as a guide in assisting the orientee to receive the best experience possible during the orientation period. In meeting any diversity among learners, the manual will be made available in print format as well as electronically on all nursing units at SLHs.

Purpose of the Consultation Process

The consultation process offers the ideal opportunity to gain insight into the expertise of the identified participants with diverse experience in gerontology and orientating novice RNs to LTC. The literature review revealed a gap in the research surrounding orientation programs that have been completed specifically in the LTC environment, and evaluative studies that have been conducted in this clinical setting to determine if a comprehensive orientation program has affected the recruitment and retention rates of RNs. Having recently completed the current orientation program at SLHs and identifying the need for an additional learning resource to be available to novice RNs, it is important to gather additional information surrounding the experiences and opinions of gaps within the current program from the participants. Through this process, if the participants agree that this type of resource would be beneficial, the data obtained will be valuable in formulating the learning resource and the type of education material that should be included.

The Participants

In meeting the requirements of this practicum project, several participants were selected to be consulted: the clinical nurse educator at SLHs, the RCM at SLHs, a senior RN who has been involved in the preceptorship process at SLH, a novice RN who recently orientated to SLHs, the president of the NLGNA, a representative with the human resources (HR) department with EH, the clinical nurse

educators with all four regional health authorities in NL with the LTC program, and the lead researcher of the Manitoba pilot project. Purposive recruitment techniques were utilized, and the individuals were notified of the aim of the practicum project through verbal conversation and in writing. All individuals agreed to partake in an interview in order to provide information relevant to this practicum project. The majority of the interviews were completed in person at SLHs, and the prospective interviews with the clinical nurse educators with the four regional health authorities, as well as the interview with the coordinator of the Manitoba pilot project were completed over the phone and through email correspondence.

The clinical nurse educator at SLHs was selected to gain insight into the current orientation program and supports that are offered to novice RNs arriving at SLHs, as well the types of education needs and topics that potentially could be included in the resource manual. One of the RCMs at SLHs was included due to her involvement with recruiting and retaining RNs to SLHs, and the types of feedback received by novice RNs about the current transition process to this clinical environment. Both a novice and senior RN at SLHs were chosen due to their hands-on participation in the preceptorship and site-level orientation process, and potential insight that could be gained to complement the content of the resource manual from these rich experiences. The perspective of the current president of the NLGNA was integral in offering data on a provincial and national level surrounding RN recruitment and retention rates, and the types of professional development activities to support these initiatives. Following this interview, connections were made with an HR representative with the LTC program at EH and the clinical nurse educators with the LTC program at the four regional health authorities. HR offered key statistics on current and past recruitment and retention rates of RNs at SLHs, and the four clinical nurse educators of the varying provincial health authorities provided information on their individual orientation programs for RNs in LTC which could be compared and contrasted. Finally, the coordinator with the Manitoba Pilot Project (O'Rourke, 2016) was selected due to her expertise in the

design and implementation of an enhanced orientation program in the LTC setting. In consulting this key stakeholder, I was able to capture the experienced benefits and challenges of this provincial project, and gather additional insight into the types of things she would change in future and include as resources for novice RNs orientating to LTC.

Methods, Data Management, and Analysis

All of the interviews were completed in early March 2017 using a semi-structured questionnaire based methodology. The majority of the interviews were completed in-person in the boardroom at SLHs, while a couple of the interviews with key stakeholders in other parts of the province and country were completed over the phone and through email correspondence. The interview process was led by a pre-set number of leading questions for the participants, which were designed around key findings and themes discovered through the integrated literature review. There was some allowance set for participants to expand on their responses using open-style dialogue in order to obtain rich data through the philosophical lenses of the participants. All of the interviews lasted between 30 to 45 minutes, and each interview was captured in the form of notes that were later transcribed verbatim using Microsoft Word on my personal computer. In order to ensure the accuracy of the data, each response was read back to the participant during the note taking process, and corrections were made to the data set as necessary during the interview. While a core set of the interview questions can be found in appendix “B-I”, additional questions were added to the transcript for certain participants to capture the relevance of their expertise and contributions to the proposed practicum project. These additional questions can be found in appendix “B-II”.

All of the participants’ verbatim responses were examined for thematic significance and content analysis, and comparisons and similarities were noted. Due to the fact that the purpose of the interviews were to capture raw data from the key stakeholders, the approach was based on conventional content

analysis in which each of the captured data sets from the participants were coded before and during the data analysis through the assignment of key words (Hsieh & Shannon, 2005). A table was designed using Microsoft Word to organize and sort the various data sets to promote visual clarity. All of the data was stored and managed on my personal lap top computer which is password-protected and electronically secure.

Ethical Considerations

In order to determine if the proposed practicum project required a formal review by the Health Research Ethics Review Board, the Health Research Ethics Authority (HREA) Screening Tool was referenced. A breakdown of how the HREA Screening Tool was utilized in reference to this proposed practicum project can be viewed in appendix “B-III”. In reference to the criteria required for submission (See Appendix “B-IV”), this practicum project did not have to be submitted to the Research Ethics Board for approval as it was not considered a research project. In the initial planning stages of this practicum project, permission to move forward with the interviews and formal consultation process was first obtained by the administration at SLHs and Professional Practice Division for EH. All proposed participants were selected using purposive sampling techniques, which can be considered a convenient sample (Streubert & Carpenter, 2011).

In an effort to reduce any bias, all participants were informed prior to beginning the interview process of the overall purpose of developing the orientation resource manual, and the benefit of obtaining their experiences and expertise in producing a meaningful product for the LTC setting. Verbal consent was obtained from all of the participants prior to beginning the interview process. The participants that completed in-person interviews at SLHs were made comfortable in the private boardroom, and were counseled to answer all of the questions honestly based on their own unique experiences in the content area. As the project developer, it was imperative to remind the participants

that in the event they felt uncomfortable or uncertain of how to answer a question during the interview, that there was no obligation to provide an answer or complete the interview. In order to maintain the privacy and confidentiality of the participants, it is important to note that no participant identifiers were attached to the data, and all participants were made aware of the efforts made to protect their confidentiality throughout the project. For the purpose of this practicum project there was no resident data or identifiers obtained, and all of the participants were strongly encouraged to not reveal any resident identifiers in their responses in order to safeguard the security and confidentiality of all residents at SLHs.

The Consultation Results

In analyzing the results of the data obtained through the interviews with all of the participants and completing a content analysis, there were a variety of themes that emerged. Several of the themes were recurrent amongst all participants, while a few of them revealed unique responses which have the potential to expand greatly on the content area for the proposed resource manual. All of the participants had considerable experience in the content area being explored. Many of the themes that were discovered in the research through the integrated literature review were reinforced further by the individuals who participated in the interviews.

In keeping with the research by Baxter (2010) the participants reported the initial confidence levels of novice RNs entering the LTC environment as low, and many attributed these resulting feelings due to a lack of previous experience in the clinical area and the large set of roles and responsibilities required by the RN in the LTC setting. While the current general and departmental orientation programs was described as adequate in preparing the nursing team on a broad level for some of the disease pathologies and resources available in the LTC setting, many felt that the content area was not unique to the RN group transitioning to this new role.

Participants were in agreement that while the RNs entering the LTC environment may have completed some entry-level clinical time in LTC during their gerontology course early in the Bachelor of Nursing (BN) program, it is often not sufficient in exposing the future RN to the complexity and diversity of the RN role in LTC. Two participants indicated that recruiting undergraduate level BN students to complete clinical placements in LTC continues to be problematic, and that with the exception of the gerontology course in the BN program it was difficult to determine how much of the content was focused in gerontology. This is consistent with the research by Burgess (2007) in which the challenges associated with graduate RNs beginning employment in LTC were discussed. One participant stated that four to five novice RNs are hired each year at SLHs with EH, with many of the orientees having limited to no prior experience in this clinical setting. Given the large number of new hires annually, it is imperative that they become comfortable and confident in their new positions. The availability of a learning resource manual to guide the orientation process upon arrival at SLHs would greatly assist with this goal. The novice and senior RN interviewees both indicated that the orientation manual would further improve the current orientation process and offer a strategic plan in guiding the transition of the novice RN into the LTC environment upon arrival at SLHs.

The current preceptorship assignment was described as frustrating by the novice RN. This was due to the fact that during the site orientation period the individual was assigned to multiple senior RNs, which limited the ability to form a concrete mentorship or consistency in the transition process. The novice RN had received a site-orientation of two weeks, and due to the leadership role of the RN in LTC felt unprepared and isolated at the completion of the orientation period. Feelings were described of being unsure of who to consult for advice on shift as the orientee had been exposed to several senior RNs with varying styles of leadership and clinical skills. The collective need for a guide that could be accessed at SLHs and completed as a self-development tool was mentioned by both RNs as a positive measure. The senior RN described the current preceptorship dimension of the orientation as inadequate,

as it does not allow for sufficient time to properly orientate the novice RN to the unit before they are assigned to another senior RN on subsequent shifts. Both participants described the current program as closed and non-interactive, in which feedback and evaluation were not strong components by both the participant and the assigned preceptor. The ability to access and complete the program independently as a self-paced and independent endeavor were noted by both individuals in being key components to empower future orientees and preceptors in the workplace.

The current support system for present and future orientees entering the LTC setting was described by both the RCM and clinical nurse educator at SLHs. Both participants described the first day of the site orientation as being an introduction to the building, staff, and resources available for all employees at SLHs. The current preceptorship was mentioned, but due to low numbers of senior RNs at SLHs the preceptorship program has not been formalized. This was consistent with how the senior and novice RN described this component of the orientation program. In agreement with the HR representative from EH, the RCM described the recruitment and retention rates as challenging at this LTC site, with five novice RNs being hired in the previous fiscal year. No formal evaluation of the site orientation process was available to reference, but the utilization of a competency-based evaluation and progress report by the RCM for all new employees upon completion of the orientation program was described. The RCM specifically stated the importance of novice RNs having the opportunity to discuss any improvements that could be made to the program or if any additional orientation time was required in the new clinical area. Both interviewees agreed that the addition of a supplementary resource manual to guide the site-orientation process for novice RNs would be beneficial in improving the transition to LTC by not only guiding the novice RN, but the assigned preceptor as well. With additional efforts to empower and build the capacity of the novice RNs through an improved and more structured orientation program, the perceived benefit would also encompass improved recruitment and retention rates of RNs in LTC.

The president of the NLGNA specifically spoke to the importance of reviewing the orientation programs within the four regional health authorities in this province, as well as nationally if applicable. Interviews were successfully conducted over the phone with three clinical nurse educators, with the Eastern, Central, and Labrador Grenfell Health regions of NL, as well as the lead researcher and developer of the Winnipeg Regional Health Authority's pilot project that developed an enhanced orientation program for LTC. All participants mentioned the limited research and lack of availability of existing enhanced orientation programs both nationally and provincially. The developer of the Winnipeg pilot project created the curriculum for her project from scratch. While the program is now in place provincially, the evaluation component on recruitment and retention rates of RNs in Manitoba is currently being completed by the core funder of the program and is not available for referencing at this time. The contact information of the individual conducting the evaluation component was provided by the lead developer of the project in her interview, and while contact has been made through email correspondence the information has not been provided at this time. All participants described the role of preceptorship as a component of any orientation program for RNs entering LTC as being considered essential.

The principles of adult learning such as accessibility and the unique learning needs of each orientee have to be accounted for when developing and implementing the resource. While the Winnipeg pilot project was initially only made available for novice RNs and interested preceptors to attend in a workshop format, challenges were found in the evaluation component around accessibility and the time required from individuals to commit to attending. As the program was offered to additional LTC centers in rural areas, it was increasingly difficult for the participants to attend. The need for the program to be made available as an on-line module based component was a key finding from the participants' that completed the Winnipeg enhanced orientation program. Provincially, the participants stated that while their individual orientation programs are not based on any particular

framework, when possible they do endeavor to assign the novice RN to one preceptor for the duration of the orientation period. Oftentimes, while an entry-level competency list is made available to the orientee, it is the responsibility of the novice RN to interpret and complete the competencies throughout their orientation period. Preceptors are not formally provided a list of the competencies, and the direction of the site-level orientation is a joint effort between the orientee, preceptor, and management.

There were a variety of consistent topics that emerged throughout the interviews by all participants as important to include in the orientation resource manual. Participants felt that geriatric assessment skills and an explanation around why each type of assessment is important should be included. This could encompass the roles of consulting the interdisciplinary team within the LTC setting, such as physiotherapy, speech language, occupational therapy, and the dietitian. Critical indicators such as pain management, fall and pressure sore prevention, and environmental safety were also suggested. Several of the participants agreed that in relevance to the advanced RN role in LTC, that conflict management and leadership development were important learning points for the novice RN to be exposed to during the orientation program. This could encompass basic strategies and models available for the novice RN to follow, in addition to the types of resources available through the larger organization for the RN to access if interested initially and throughout their career in LTC.

Implications and Conclusion

From the collection of extensive data describing the professional opinions and experiences of several experts in gerontology, it is evident that there is a need to develop an orientation resource manual for novice RNs beginning employment at SLHs. The rich data obtained through all of the interviews will be influential in the creation of a beneficial and accessible learning tool for novice RNs. A wide variety of interviews with participants were captured, and all interviewees were confident in the merit of such a resource being made available. The challenges depicted in the Winnipeg pilot project

were important to learn about and reflect on in order to expand on the future accessibility of the resource for adult learners. The educational content was an important topic that was addressed as well, and many of the suggested topics were collaboratively agreed on by all participants indicating the importance and relevance of the RN role in LTC. All of the goals listed in the consultation plan were accomplished through the consultation process, and with the addition of the completed integrated literature review it is clear that the creation of an orientation resource manual for the novice RN entering LTC would be valuable for SLHs.

The consultation process was beneficial in emphasizing many of the themes that were found through the integrated literature review. It is important to note that by interviewing a group of experts with extensive experience in the field of gerontology, the data identified several important realizations to further grow the body of research supporting the development of this practicum project. The confidence levels of novice RNs entering the LTC setting was described as being generally low, and this was attributed to the extensive set of roles and responsibilities of the RN in LTC. Although the limited clinical experience that BN students receive in gerontology was highlighted in the literature review, the interviews assisted in connecting this factor to the ongoing issues with RN retention and recruitment in the LTC setting. The current general and departmental-level orientation programs organized by EH were described as being adequate on a broad nursing scale. However, the relatively high number of novice RNs beginning employment at SLHs annually highlights the importance of an additional resource being available for the RN group to access to guide in this transitional period. The accessibility of the resource and using multiple modalities to meet the needs of all learners was highlighted, as well as the importance of incorporating a preceptorship dimension into the site-level orientation program. Lastly, the current orientation program at SLHs was described as being closed and non-interactive, stressing the importance of ongoing feedback and participation through a strong evaluation plan. These emerging findings will be imperative to reflect on in the planning and

implementation of the proposed orientation resource manual, and highlight the importance of the consultation process in building this practicum project.

This consultation report clearly describes the group of participants that were interviewed in meeting the goals of my practicum project, and a rationale of why they were purposively selected. An explanation of the proposed practicum project, description of the consultation process, and the data collection and management strategies was referenced. Finally, the key themes and content that emerged through the consultation process have been included in connection to the importance of such a resource manual being available for novice RNs orientating to SLHs. The implications of these findings on the development and implementation of the resource manual have been included. A list of the questions utilized during the interviews with participants, as well as an explanation of how the HREA toolkit was referenced have been included in the appendices of this report.

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Appendix B-I: Interview Questions

- What experiences have you had with novice RNs orientating to LTC? How would you describe their confidence level at the beginning, during, and following completion of the orientation program?
- Would you consider the orientation program a beneficial time to invoke leadership training to novice RNS entering LTC? Do you feel that novice RNs are empowered through the current orientation process?
- What types of concerns have the orientees brought forward during the orientation process? Have they had multiple preceptors during their site-orientation, or were they assigned to one senior registered nurse? Would you describe the current RN orientation as adequate?
- How would you describe the roles and responsibilities of the RN in LTC? Do you feel that the RN has the opportunity to positively affect resident care outcomes? Give me an example.
- Do you feel that novice RNs would benefit from an additional orientation resource manual to guide the orientation process? Do you feel it would assist with the transition process to LTC?
- What types of education do you feel would be important to include in an orientation resource manual for novice RNs undergoing the orientation process at SLHs?

Appendix B-II: Additional Interview Questions

Additional Interview Questions for Resident Care Manager

- What types of supports does management have for assisting in the transition of novice RNs into practicing within the LTC environment? How long is the current orientation?
- Approximately how many RNs are hired at SLHs per year? Could you comment on current retention and attrition rates among the RN group at SLHs? Do you feel that additional resources such as a comprehensive orientation resource manual would be beneficial in contributing to workplace satisfaction and commitment to LTC at SLHs?

Additional Interview Questions for the President of the NLGNA

- Are you familiar with any provincial or national-level orientation programs that have been implemented for novice RNs entering the LTC setting? Do they contain competency-based education and preceptorship components? Have they been evaluated? Have retention and recruitment rates been compared to any former programs?
- Do you feel that the availability of an orientation resource manual would be beneficial for RNs undergoing the transition process to LTC?

Additional Interview Questions for the Clinical Nurse Educator at Eastern Health

- Can you comment on the types of entry-level competencies that are expected of novice RNs finishing the orientation program?

- In developing the site-level orientation program for LTC nursing staff, did you come across any other provincial or national-level orientations programs that have been conducted and evaluated in this clinical area?
- Can you comment on the types of feedback that you receive from participants of the current site-level orientation program? Would you say they feel prepared to enter the clinical area and fulfill their new set of roles and responsibilities?

Additional Interview Questions for Human Resources Representative

- Can you provide me with the recruitment and retention rates of RNs for SLHs over the past year? What about for the entire LTC program at EH?
- When you are involved in the recruitment process for RNs entering LTC, can you explain what type of job description is given to the prospective RN? How is the orientation process explained?

Additional Interview Questions for Research Coordinator with the Manitoba Pilot Project

- Can you describe your experience with developing and implementing the pilot project within the LTC program in Manitoba? What types of challenges were there?
- Has there been a formalized evaluation completed following the implementation of this program in 2016? Has it been adopted by any other LTC facilities, or provinces?
- In planning an orientation resource manual for novice RNs entering the LTC environment, what would you describe as key items to be included?
- Do you feel that the orientation process plays an integral role in recruiting and retaining RNs in the LTC environment?

Appendix B-III: HREA Screening Tool

	Question	Yes	No
1.	Is the project funded by, or being submitted to, a research funding agency for a research grant or award that requires research ethics review		X
2.	Are there any local policies which require this project to undergo review by a Research Ethics Board?		X
	IF YES to either of the above, the project should be submitted to a Research Ethics Board. IF NO to both questions, continue to complete the checklist.		<input type="checkbox"/> X
3.	Is the primary purpose of the project to contribute to the growing body of knowledge regarding health and/or health systems that are generally accessible through academic literature?	<input type="checkbox"/>	<input type="checkbox"/> X
4.	Is the project designed to answer a specific research question or to test an explicit hypothesis?	<input type="checkbox"/>	<input type="checkbox"/> X
5.	Does the project involve a comparison of multiple sites, control sites, and/or control groups?	<input type="checkbox"/>	<input type="checkbox"/> X
6.	Is the project design and methodology adequate to support generalizations that go beyond the particular population the sample is being drawn from?	<input type="checkbox"/>	<input type="checkbox"/> X
7.	Does the project impose any additional burdens on participants beyond what would be expected through a typically expected course of care or role expectations?	<input type="checkbox"/>	<input type="checkbox"/> X
LINE A: SUBTOTAL Questions 3 through 7 = (Count the # of Yes responses)		0	
8.	Are many of the participants in the project also likely to be among those who might potentially benefit from the result of the project as it proceeds?	X <input type="checkbox"/>	
9.	Is the project intended to define a best practice within your organization or practice?	X <input type="checkbox"/>	
10.	Would the project still be done at your site, even if there were no opportunity to publish the results or if the results might not be applicable anywhere else?	X <input type="checkbox"/>	
11.	Does the statement of purpose of the project refer explicitly to the features of a particular program, organization, or region, rather than using more general terminology such as rural vs. urban populations?	X <input type="checkbox"/>	
12.	Is the current project part of a continuous process of gathering or monitoring data within an organization?		X
LINE B: SUBTOTAL Questions 8 through 12 = (Count the # of Yes responses)		4	

Appendix B-IV: Interpretative Guidelines for the HREA

Interpretation:





- ☐ If the sum of Line A is greater than Line B, the most probable purpose is **research**. The project should be submitted to an REB.
- ☐ If the sum of Line B is greater than Line A, the most probable purpose is **quality/evaluation**. Proceed with locally relevant process for ethics review (may not necessarily involve an REB).
- ☐ If the sums are equal, seek a second opinion to further explore whether the project should be classified as Research or as Quality and Evaluation.

These guidelines are used at Memorial University of Newfoundland and were adapted from

ALBERTA RESEARCH ETHICS COMMUNITY CONSENSUS INITIATIVE (ARECCI). Further information

can be found at: <http://www.hrea.ca/Ethics-Review-Required.aspx>

Appendix C: Permission Letter Winnipeg Project

 **Deanne O'Rourke** <2definesolutions@mymts.net> Jun 5 ☆  
to me 

Hi Claire,

I am glad that the materials helped in the development of your resource. I am the original author and was functioning as the Project Coordinator of the Manitoba arm of the Research to Action initiative at the time of the Enhanced Orientation program's development. The program materials were developed in the spirit of sharing and (hopefully) broader use beyond the project and province. We would just ask that the Research to Action initiative and the national and provincial partners/funders (see below) be acknowledged in any materials that have referenced or used the Enhanced Orientation Program content.

If you have any other questions, please let me know.

Thanks,

Deanne

The Manitoba Research to Action project Enhanced Orientation for Nurses New to Long Term Care is a joint initiative of the Canadian Federation of Nurses Unions (CFNU), the Canadian Nurses Association (CNA), the Canadian Healthcare Association (CHA) and the Dietitians of Canada as national partners, and Manitoba Health, the Manitoba Nurses Union (MNU) and the Winnipeg Regional Health Authority (WRHA) as provincial partners. Funding from Health Canada has contributed to the development of the materials in the Program Guide.

Appendix D: Orientation Resource Manual

Orientating to Long-term Care as a Registered Nurse

***A learning resource manual for
novice Registered Nurses
undergoing clinical orientation at
Saint Luke's Homes***

Margaret Claire Penton
RN BN BSc



INTRODUCTION

Who is the target for this resource manual?

- Saint Luke's Homes (SLHs) is a 117-bed long-term care (LTC) facility with Eastern Health (EH) that is located in St. John's, Newfoundland.
- This learning resource manual is intended for all novice Registered Nurses (RNs) and their preceptors undergoing the preceptorship component of clinical orientation at SLHs.
- Novice RNs can refer to newly graduated RNs, as well as RNs with experience in other clinical areas outside of LTC.
- The manual can also act as a reference for RN preceptors, Bachelor of Nursing (BN) students, management, and nurse educators at SLHs.

Why is this type of learning resource important?

- To supplement the current RN orientation process at SLHs, and function as a self-learning tool and learning guide for RNs and their assigned preceptors.
- Due to the unique clinical leadership role of the RN in LTC, it is imperative to have a standardized learning resource that is evidence-based and readily available to all new RN hires at SLHs.
- The overall goal of this resource manual is to bridge the gap between the generalized orientation and site-level orientation at SLHs using an individualized approach to learning. The entry-level competencies expected of the RN at the completion of their orientation period are also recognized.
- The resource will include a number of important geriatric-related topics that can be referenced throughout the clinical orientation including:
 - How to complete a geriatric assessment
 - The admission process in LTC
 - The role of the interdisciplinary team in achieving resident care outcomes

- Monthly critical indicators
 - Completing environmental safety scans
 - Conflict management
 - RN leadership development
- All of the above topics were identified through the completion of a thorough integrated literature review and by consulting a number of key stakeholders with extensive experience in geriatrics.

How can this resource manual be used effectively?

- Depending on your LTC experience, the manual can be used to guide the orientation process, or as a useful clinical reference tool. Although you may have past experience in other clinical areas or in geriatric nursing, it is recommended that each novice nurses complete the entire orientation manual to enhance your knowledge based on current resources and policies and procedures.
- The manual is designed to be a self-learning tool, and a quiz or case-study can be found at the end of each chapter to test your knowledge.

Phase One: Completion of the entire self-study manual during the first two weeks of the generalized LTC orientation. A copy will also be provided to your assigned preceptor(s) as a reference and for their reflection in guiding you towards the achievement of all beginning competencies.

Phase Two: Consolidation of the learning outcomes achieved throughout the manual and clinical practice with your assigned preceptor(s) over the duration of the clinical orientation period. This orientation resource manual will be used in combination with EH's list of core competencies for novice RNs and the preceptorship experience. Depending on your past nursing experience, your clinical orientation may span between two-six weeks at SLHs. You will be assigned to your preceptor for the duration of this period, and are encouraged to follow up with your preceptor weekly to share reflections and feedback concerning your clinical experiences and learning needs. Your preceptor will be provided with a copy of the orientation resource manual and core-

competencies for novice RNs as well to review and familiarize themselves with the content areas.

Phase Three: The evaluation component will be ongoing after each individual chapter of the manual following the completion of the case-study or test your knowledge component. All novice nurses will be expected to score 80% or higher on each of the components. Your preceptor or clinical educator at SLHs can review your responses with you, and answer any questions you may have pertaining to the material in the manual.

- Following the completion of your preceptorship, you will have the opportunity to review how you have met the beginning competencies with your preceptor or clinical nurse educator. In the event that you do not score 80% or higher on a component in the manual, you will be asked to repeat the readings and section of the manual, and follow-up with your assigned preceptor(s) for feedback and assistance, this will assist with you achieving a successful transition as a novice nurse following your orientation and probationary period. A formalized learning plan will be discussed and arranged between you and your preceptor at that time. A copy of the learning plan template is located in Appendix D-VII.
- It is imperative to reference EH's policies and procedures on the Intranet when caring for all residents at SLHs. Relevant recommended readings to the respective policies and forms will be provided in each section of the chapters throughout the manual. How to reference EH's policies and forms both from home and at work will be explained at the beginning of this manual. Questions pertaining to EH's policies and procedures will be included in the chapter evaluations.
- The employer will provide you with a list of competencies to achieve throughout your orientation program. This competency checklist for LTC can be found in Appendix D-II. This manual will aid you to continue to work towards meeting many of the entry-level RN competencies.

ACCESSING EASTERN HEALTH POLICIES AND FORMS

- There are a number of EH policies and forms that will be referenced for you to access and read throughout this manual. Using your Outlook email address and password, you can access any of the policies or forms from work or home.



From <https://www.pexels.com/photo/computer-desk-electronics-indoors-374074/>

Note: *As a new RN at SLHs, you should receive username/password information for your outlook email account. This is the primary communication method between management and RNs at SLHs. If you have not received your log-in information, please contact your RCM or the IT helpdesk at EH.*

Accessing From Home:

- Go to www.easternhealth.ca
- Click in the top right hand corner on the link **for health professionals**
- Click on the link towards the bottom on the screen under the section **For Our Staff** on **Webmail – Access your EH email from home!**
- Click on **Intranet**
- Login with your Outlook email and password, press continue
- Click on the gold button **Policies** or **Forms** which will direct you to a search option. You can search for any EH policy or form by name here

Accessing From Work:

- Click on the **Intranet**
- Click on the gold button **Policies** or **Forms** which will direct you to a search option. You can search for any EH policy or form by name here

TABLE OF CONTENTS

CHAPTER ONE: COMPLETING GERIATRIC ASSESSMENT	116
Section 1.1 – Normal Aging Process	117
Section 1.2 – Lab Values in the Elderly	120
Section 1.3 – The Nursing Assessment	123
Section 1.4 – Presentation of Infection/Illness in the Elderly	126
Section 1.5 – Palliative Care	129
Section 1.6- Test Your Knowledge	134
CHAPTER TWO: THE ADMISSION PROCESS IN LTC	135
Section 2.1 – Medication Reconciliation in LTC	136
Section 2.2 – The Admission Form and Documentation	139
Section 2.3 – The Kardex	143
Section 2.4 – Advance Care Planning	145
Section 2.5 – Emergent Issues	149
Section 2.6 – Test Your Knowledge	151
CHAPTER THREE: THE ROLE OF THE INTERPROFESSIONAL TEAM	153
Section 3.1 – The Charge RN’s Assignment Record and Shift Report	154
Section 3.2 – Assigned LPNs and PCAs	158
Section 3.3 – The Referral Process	160
Section 3.4 – The Attending Physician	162
Section 3.5 – Test Your Knowledge	164
CHAPTER FOUR: THE CRITICAL INDICATORS	165
Section 4.1 – Infection Control	166
Section 4.2 – Vaccines	170
Section 4.3 – Monthly Critical Indicators	172
Section 4.4 – Test Your Knowledge	174
CHAPTER FIVE: COMPLETING AN ENVIRONMENTAL SCAN	176
Section 5.1 – Shift Rounds and Expectations	177
Section 5.2 – Bed Rails and Restraint Use	182
Section 5.3 – Bed Entrapment	186

Section 5.4 – Case Study	191
CHAPTER SIX: CONFLICT MANAGEMENT	192
Section 6.1 – Conversation Styles & Strategy	193
Section 6.2 – Effective Delegation	197
Section 6.3 – Conflict Resolution Model	200
Section 6.4 – Case Study	204
CHAPTER SEVEN: RN LEADERSHIP DEVELOPMENT	205
Section 7.1 – Staff Mix Changes in LTC and Professional Practice	206
Section 7.2 – RN Leadership Network	211
Section 7.3 – RNUNL Involvement	213
Section 7.4 – Test Your Knowledge	216
REFERENCES	218
APPENDICES	
Appendix D-I: Test your Knowledge Quiz and Case-Study Answers	225
Appendix D-II: LTC Competency Checklist	231
Appendix D-III: McGeer Criteria Pathways for Identification of UTI	238
Appendix D-IV: Dementia Observational Tool Form	241
Appendix D-V: Influenza-like Illness (ILI) Mandatory Surveillance	242
Data Collection Form	
Appendix D-VI: Gastrointestinal Outbreak Line Listing Form	243
Appendix D-VII: Learning Plan/Contract for Remediation	244

CHAPTER 1

COMPLETING A GERIATRIC ASSESSMENT

This chapter includes:

Section 1.1 – The Normal Aging Process

Section 1.2 – Common Laboratory Values

Section 1.3 – The Nursing Assessment

Section 1.4 – Common Diseases and Infections in the Elderly

Section 1.5 – Palliative Care

Section 1.6 – Test Your Knowledge

Learning objectives:

- ✓ Participate in completing a geriatric assessment using the head-to-toe method under the supervision of your assigned preceptor.
- ✓ Describe four kinds of diseases/disease states that are common in the elderly.
- ✓ Recognize the common lab values and the ranges relevant to geriatric health maintenance.



SECTION 1.1

THE NORMAL AGING PROCESS



From https://en.wikipedia.org/wiki/Old_age#/media/File:Altenpflege_02.jpg

- The normal aging process involves a gradual decline in physiologic function that is typically not connected to any one specific disease process (Elsawy & Higgins, 2011). These normal changes can have pronounced effects on one's functional ability, as well as their generalized appearance.
- **Gerontology** is defined as a field of science that studies the aging process, and the types of challenges that the older population face. As a gerontological nurse, there is an ongoing responsibility to assist the older adult in achieving the highest level of health and wellness despite the potential for chronic illnesses, and any associated functional or cognitive decline (Touhy, Jett, Boscart, & McCleary, 2012).
- The present generation of Canadian seniors, or adults 65 years or older, are living longer and healthier lives than all of the previous generations. In fact, it is predicted that by 2036, seniors will compose approximately 25 percent of the total population in Canada (Canadian Institute for Health Information, 2011).

Did You Know?

According to the Association of Registered Nurses of Newfoundland and Labrador (ARNNL) (2013), 7 percent of seniors residing in Newfoundland and Labrador (NL) live in LTC facilities, assisted living facilities, or retirement homes.

- According to the Merck Manual (2017) the most commonly affected systems and organs, and the effects on these systems/organs due to the aging process include the:
 - ❖ **Central Nervous System:** *A decrease in brain weight, reduction of up to 20% of total cerebral blood flow, and an overall decrease in neurotransmitters, dopamine receptors, synapses, and neurons).*
 - ❖ **Cardiovascular System:** *Blood vessels and valves thicken, less elasticity of the main arteries and aorta, and a decrease in the intrinsic heart rate and maximum heart rate.*
 - ❖ **Gastrointestinal System:** *Increased pH, increased transit time, increased rates of constipation and incontinence, decreased nutritional absorption, and numerous oral and dental changes.*
 - ❖ **Kidneys:** *Decreased glomeruli and glomerular filtration rate, decreased renal blood flow, and decreased overall renal mass.*
 - ❖ **Liver:** *Decreased hepatic blood flow and hepatic weight, and an increase of free drug levels that are metabolized in the liver.*
 - ❖ **Immune System:** *The older adult is more prone to illness and infection due to an increase in DNA destruction, and decrease in T-cell and B-cell function.*
 - ❖ **Endocrine System:** *A decrease in sex hormones, increase in insulin resistance and glucose intolerance.*

Note: *The rate of normal aging of the main organs and bodily systems varies greatly among the older-adult population. Healthy aging does not have to imply a perfect health status (Government of Newfoundland and Labrador, 2007).*

- When a client is reviewed for admission to a LTC facility, the client is assigned a level of care which is based on a holistic assessment completed by the office of placement services (Eastern Health, 2016). While this assignment is done prior to admission to SLHs, you may hear the criteria mentioned in reference to the newly admitted resident and should be familiar with the definition of each level as defined in the Eastern Health (2012) policy on Levels of Care in LTC.

Recommended Readings:

- 1) Eastern Health. (2012). Levels of care- long term care. Long-term care LTC 050.
- 2) Government of Canada. (2006). Healthy aging in Canada: A new vision, a vital investment from evident to action. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2006/Healthy_Aging_A_Vital_latest_cop_October_2006.pdf
- 3) Government of Newfoundland and Labrador. (2007). Provincial healthy aging policy framework. Retrieved from <http://www.releases.gov.nl.ca/releases/2007/health/0711n04HA%20Policy%20Framework>
- 4) Ragsdale, V., & McDougall, G. J. (2008). The changing face of long-term care: Looking at the past decade. *Issues of Mental Health Nursing*, 29(9), 992-1001. doi: 10.1080/01612840802274818
- 5) Touhy, T. A., Jett, K. F., Boscart, V., & McCleary, L. (2012). Chapter 1: Introduction to healthy aging. In T. A. Touchy & K. F. Jett (Eds.). *Ebersole and Hess' Gerontological Nursing and Health Aging* (1st Canadian Edition). Toronto, Canada: Elsevier.

SECTION 1.2

COMMON LABORATORY VALUES



From https://en.wikipedia.org/wiki/Blood_test#/media/File:Vacutainer_blood_bottles.jpg

Note: At SLHs, the physician orders annual blood work for each resident in August. While this is tailored to the individual resident, it typically includes a CBC, glucose, and renal function test.

- While normal reference ranges are offered by EH laboratories, it is important to understand that results that fall outside of the given range are increasingly more common in the older adult population. While there is limited evidence to support additional normal range-sets for the elderly, it is important to know how to interpret and understand laboratory values for this population (Edwards & Baird, 2005).
- In referencing laboratory values, discrepancies and ranges outside the traditional normal can be attributed to increased disease processes and co-morbidities in this population, polypharmacy, and the normal aging process (Blann, 2014). See Table 1 on the following page.

Note: Blood collection at SLHs is the responsibility of the RN and is done at the end of Night Shift at 0700. Ensure that each resident is well hydrated prior to blood collection. All SST (yellow top) tubes must be spun for 10 minutes on the centrifuge located on Pleasant view prior to sending via courier.

Table 1: Common Laboratory Values and the Aging Effect (Beers & Berkow, 2000)

Laboratory Test	Aging/Disease Effect on Test	Expected Value
<i>CBC – Hemoglobin</i>	<ul style="list-style-type: none"> Can decline with age and anemia status. No pronounced difference between sexes. 	<ul style="list-style-type: none"> Greater than 100.
<i>CBC – WBC</i>	<ul style="list-style-type: none"> Elevation could indicate a dehydrated state or infection. Elevation has been correlated to a higher risk of having a MI or CVA. 	<ul style="list-style-type: none"> Due to slower immune response, monitor for other signs of infection in addition to the WBC count. Normal range: 4,500-10,000 WBC/mcL of blood
<i>CBC – Erythrocyte sedimentation rate (ESR)</i>	<ul style="list-style-type: none"> Increases with age. Elevated levels can indicate an infection. 	<ul style="list-style-type: none"> Males: 40 mm/hour Females: 45 mm/hour
<i>Renal Function – Na</i>	<ul style="list-style-type: none"> High levels could suggest dehydration. 	<ul style="list-style-type: none"> Greater than 125, treatment required.
<i>Thyroid Function- TSH</i>	<ul style="list-style-type: none"> Slightly higher values are normal in the elderly. Hard to diagnose in the elderly, as the symptoms are similar to the normal aging process. 	<ul style="list-style-type: none"> Target serum of TSH should be 4-6mIU/L If treatment is indicated, titrate medications slowly based on serum TSH levels.
<i>Glucose –HgbA1C</i>	<ul style="list-style-type: none"> Lower values are common among the elderly. 	<ul style="list-style-type: none"> Greater than 5. If less than 5, treat for hypoglycemia.
<i>Urinalysis – Routine and Microbiology, Culture and Sensitivity</i>	<ul style="list-style-type: none"> High incidence of asymptomatic bacteriuria in the elderly. If bacteria is in the urine, but no symptoms of infection present, this does not indicate a urinary tract infection (UTI). 	<ul style="list-style-type: none"> Follow the McGeer and colleagues (1991) Surveillance Definitions of UTI for LTC facilities (See Appendix D-III).

Recommended Readings:

- 1) Edwards, N., & Baird, C. (2005). Interpreting laboratory values in older adults. *Medsurg Nursing*, 14(4), 220-229. Retrieved from <http://www.medsurnursing.net/cgi-bin/WebObjects/MSNJournal.woa>
- 2) Luggen, A. (2004). Laboratory values and implications for the aged. In P. Ebersole & P. Hess (Eds.), *Toward healthy aging: Human needs and nursing response* (6th ed.) (pp. 115-135). St. Louis: Mosby.
- 3) World Health Organization. (2010). WHO guidelines on drawing blood: Best practices in phlebotomy. Retrieved from http://www.who.int/injection_safety/phleb_final_screen_ready.pdf

SECTION 1.3

THE NURSING ASSESSMENT



From <https://www.pexels.com/photo/man-hands-waiting-senior-33786/>

Note: *The key steps in approaching every comprehensive geriatric assessment is to determine if there are any changes, examine the functional status and quality of life, and communicate to the entire family and interdisciplinary unit involved in the care of the resident (Research to Action, 2016).*

- The main approach to any initial nursing assessment with a newly admitted resident involves a Review of Systems approach. As per the suggestions proposed by Research to Action (2016) this broadly encompasses the following components and can be adapted to meet the needs of the residents and their families:
 - Any Past Medical History
 - General Appearance: *height and weight*
 - History and Current Smoking and Alcohol Use
 - Vision and Hearing Status (use of hearing aids or glasses): *PERRLA, and determine if there are any deficits*
 - Sleep history
 - ADLs
 - Pain: *PQRST*
 - Current Medication Review
 - Dietary Needs and Preferences: *Including oral hygiene and use of dentures*
 - Ambulation Status

- Sexuality
- Vaccination History
- Gastrointestinal System: *Indigestion, bowel history, bowel medication use, and continence*
- Kidneys: *Continence, normal patterns, infection history, and use of catheter*
- Skin: *Any skin breakdown, texture, rashes, existing pressure sores*
- Neurological: *Any existing numbness or sensation loss, and strength*
- Cardiovascular: *Check for pedal pulses, any edema, and breath sounds*
- Musculoskeletal: *Check range of motion, feet assessment, postural condition, and coordination*

Note: *The Admission process will be covered in more detail in Section 2 of this manual.*

- In completing an initial nursing assessment with the older adult, there are a number of known challenges that can emerge that are unique to this population. According to Elsayw and Higgins (2011) these are known broadly as the “**Five I’s of Geriatrics**” and includes:
 - Intellectual Impairment (*changes or delirium state*)
 - Immobility
 - Instability (*falls*)
 - Incontinence
 - Iatrogenic Disorders
- In preparing to overcome these types of challenges, it is important for the RN to be familiar with and access common geriatric assessment tools/assessment forms that are available through the EH Intranet. These can include the following:
 - ❖ **Intellectual Impairment:**
 - Standardized Folstein Mini Mental Exam (Available on EH Intranet)
 - Dementia Observational Scale (See Appendix D-IV)
 - Record of Surveillance (Available on EH Intranet)
 - ❖ **Immobility:**
 - Morse Fall Scale (MFS) Risk Assessment Tool (Available on EH Intranet)
 - Numeric Pain Rating Scale
 - “Get up and Go” Test (Elsawy & Higgins, 2011).

- PQRST Self-Report of Pain
- ❖ **Instability:**
 - Tinetti Balance and Gait Evaluation (Elsawy & Higgins, 2011).
- ❖ **Incontinence:**
 - Braden Scale (Available on EH Intranet)
 - Katz Activities of Daily Living (ADL) (Katz, 1983). (Available on EH Intranet).

Note: *Based on the use of the above assessment tools, interdisciplinary referrals should be initiated by the RN for the respective professional. This process will be discussed in Chapter 3.*

Recommended Readings:

- 1) Eastern Health. (2017). Fall risk assessment, prevention, and intervention: Acute and long-term care (in patient units) policy. Safety 204(NUR)-2-030
- 2) Eastern Health. (2017). Fall risk assessment tool (part 1). (AS1990 0211 08 2012).
- 3) Eastern Health. (2016). Screening and assessment of pain policy. General Therapeutics 204(NUR)-6-010
- 4) Eastern Health. (2014). Braden scale- for predicting pressure sore risk. (AS2090 0391 02 2013)
- 5) Eastern Health. (2013). Folstein mini mental status examination (part 1). (AS1770 0088 08 2012).
- 6) Eastern Health. (2012). Skin integrity risk assessment (Braden scale) policy. Patient Care 295-PC-230
- 7) Touhy, T. A., Jett, K. F., Boscart, V., & McCleary, L. (2012). Chapter 13: Assessment tools in gerontological nursing. In T. A. Touchy & K. F. Jett (Eds.). Ebersole and Hess' Gerontological
- 8) Nursing and Health Aging (1st Canadian Edition). Toronto, Canada: Elsevier.

SECTION 1.4

COMMON DISEASES AND INFECTIONS IN THE ELDERLY



From <https://www.pexels.com/photo/black-and-white-blood-pressure-kit-220723/>

Note: *Disease states and infections tend to affect the elderly differently than younger populations. Therefore the need for early assessments and interventions are integral!*

- As mentioned in Section 1.3, the “Five I’s of Geriatrics” can be the first indicators that the older adult is being affected by a disease or infection (Beloosesky, Weiss, HersHKovitz, & Grinblat, 2000). With a new onset or change in any of these five indicators, the RN should implement additional assessment and medical interventions in coordination with the physician and interdisciplinary team.
- The acronym tool **SPICES** as first described by Fulmer (1991) is a useful and quick assessment tool for the RN to implement when the new onset of a disease or infection is predicted.

Sleep Disorders

Problems with Eating or Feeding

Incontinence

Confusion

Evidence of falls

Skin Breakdown

Did You Know?

The existence of environmental hazards can be attributed to over 50 percent of all falls that occur in LTC facilities (World Health Organization, 2012). The importance of a thorough environmental safety scan will be discussed in Chapter 5.

- Although there are many types of diseases and infections that can affect the geriatric population, only a few common disease states and atypical presentation indicators will be discussed in this section (Belooseky et al., 2000).

Table 2: Common disease processes in the elderly.

Disease/Infection	Atypical Presentation Indications	Important Notes
<i>Urinary Tract Infections</i>	<ul style="list-style-type: none"> • New onset of incontinence • New onset of delirium • Increase in fall occurrences 	<ul style="list-style-type: none"> • Follow the McGeer and colleagues (1991) Surveillance Definitions of UTI for LTC facilities (See Appendix D-III).
<i>Pneumonia</i>	<ul style="list-style-type: none"> • New onset of delirium • Change in respiratory rate • Increased feelings of fatigue • Marked decrease in ADLs • Increase in falls 	<ul style="list-style-type: none"> • Prodromal phase may include an absence of the typical respiratory symptoms: cough, sputum production, and temp.
<i>Influenza</i>	<ul style="list-style-type: none"> • New onset of delirium • Increase in falls • Ongoing weakness • Non-productive cough 	<ul style="list-style-type: none"> • See the Eastern Health Influenza Like Illness Guidelines and Tracking Form (See Appendix D-V).
<i>Myocardial Infarction (MI)</i>	<ul style="list-style-type: none"> • Vague description of non-localized chest pain • Marked shortness of breath • Increase in anxiety • New onset of delirium • Isolation 	<ul style="list-style-type: none"> • If suspected MI, call MD immediately. • Check if resident is ordered standing orders. There is an order for the administration of O2, as well as Nitro 0.4mg SL spray.

Recommended Readings:

- 1) Canadian Nurses Association. (2011). Chronic disease related to aging. Retrieved from https://www.cna-aiic.ca/~media/cna/page-content/pdf-en/hesa_brief_on_chronic_disease_and_aging_e.pdf?la=en
- 2) Lee, P. G. (2009). The co-occurrence of chronic diseases and geriatric syndromes: The health and retirement study. *Journal of the American Geriatrics Society*, 57(3), 511-516. doi: 10.1111/j.1532-5415.2008.02150.x
- 3) Touhy, T. A., Jett, K. F., Boscart, V., & McCleary, L. (2012). Chapter 9: Hydration and continence. In T. A. Touchy & K. F. Jett (Eds.). *Ebersole and Hess' Gerontological Nursing and Health Aging* (1st Canadian Edition). Toronto, Canada: Elsevier.

SECTION 1.5

PALLIATIVE CARE



From <https://www.pexels.com/photo/bright-burn-burnt-candle-278823/>

- **Palliative Care** is a holistic approach to health care that incorporates the whole-person with the goal of alleviating suffering and pain, as well as promoting quality of life and dignity for all individuals diagnosed with a life limiting illness (Brodtkorb, Skisland, Slettebo, & Skaar, 2017).
- The majority of residents admitted to SLHs reside there until the end of their life, making palliative care an important focus for the nursing and larger interprofessional team. A major goal upon admission to LTC is for the RN to assess and plan in advance with the resident (or SDM) and their family their knowledge and wishes around palliative and end-of-life care. This will be discussed in detail in Section 2.4 in this manual.
- **End-of-Life Care** is an important aspect of palliative care, and generally refers to the period of illness in which the resident is progressively declining (Research to Action, 2016).

Eight Common Symptoms during the End-of-Life Phase (Research to Action, 2016):

<i>Pain</i>	<i>The most common end-of-life symptom. Commonly described as “total pain” or “total suffering”, and “pain all over.” It is important for the RN and family to look for signs of grimacing, facial tension, tachycardia, and other signs of distress.</i>
<i>Confusion & Delirium</i>	<i>Common at the end-of-life stage, and may lead to increased agitation in the elderly. It may present as restlessness or agitation, and education should be provided to the family about symptom management.</i>

Loss of Appetite	<i>Common long before the end-of-life stage. Families often worry that their loved one will “starve to death.” It is important for the RN to offer reassurances, and look for signs of the resident resisting food (clenching teeth, nauseated, and weight loss).</i>
Dehydration	<i>The reduction or elimination of fluid intake is also common long before the end-of-life stage. Families and loved ones will need support that this is to be expected. Urine output will also decline as kidney function diminishes.</i>
Constipation	<i>Often related to decreased oral and nutritional intake, decreased mobility, and palliative medications.</i>
Nausea & Vomiting	<i>Nausea and vomiting can be distressing for both the resident and family during the end-of-life process. Attention should be paid by the RN on the nutrition and hydration status of the resident, medications being received, and treatments should be made available on a PRN basis.</i>
Shortness of Breath	<i>Prevalence of symptoms can be as high as 80 percent in the geriatric population. It is important for the RN to offer relaxation therapy (elevate head of bed, use of a fan, open window, reduce room temperature), and oxygen therapy as needed.</i>
Urgent Syndromes	<i>Emergency situations such as spinal cord compression, superior vena cava syndrome, hemorrhage, hypercalcemia, pathological fracture, and drug toxicity.</i>

Important Assessment Findings for the RN that Indicate Impending Death

(Research to Action, 2016)

- ❖ Mottling or discolouration of the skin, and cool extremities
- ❖ Decreased urinary output
- ❖ Swallowing impairment
- ❖ Increased secretions
- ❖ Cheyne-stokes respirations
- ❖ Periods of apnea

Note: *If the resident wishes to reside at SLHs for end-of-life care, there is a special palliative room located on the Inglewood unit that is private and larger to meet the needs of the residents and their families.*

- The role of the interprofessional team is paramount in the delivery of quality palliative care for all residents at SLHs.

Table 3: Common palliative medications.

Symptom	Medication	Route
<i>Shortness of breath</i>	<ul style="list-style-type: none"> • Opioids (morphine or dilaudid) • Oxygen 	<ul style="list-style-type: none"> • Subcutaneous or oral
<i>Pain</i>	<ul style="list-style-type: none"> • Opioids (the gold standard for end-of-life pain management). 	<ul style="list-style-type: none"> • Oral (if swallowing not impaired) • Subcutaneous
<i>Increased Secretions</i>	<ul style="list-style-type: none"> • Scopolamine (<i>be aware that due to the sedation effects of this medication, it is common for it to cause delirium in a resident that is awake</i>). 	<ul style="list-style-type: none"> • Subcutaneous or intranasal
<i>Agitation</i>	<ul style="list-style-type: none"> • Ativan • Nozinan • Haloperidol 	<ul style="list-style-type: none"> • Sublingual, subcutaneous • Subcutaneous or oral • Subcutaneous or oral

Adapted from: Harlos, M., Brown, S., & Embleton, L. (2013). *Supporting palliative care in long-term care facilities*. Retrieved from <http://www.ltcam.mb.ca/2013conference/Mike%20Harlos%20Lori%20Sarah%20Brown%2013.pdf>

***Note:** Eastern Health (2017) has developed a policy that lists commonly approved off label use subcutaneous medications for palliative patients. This has been included as a recommended reading as it is important for the RN to be aware of these medications. For repeated subcutaneous injections, the RN can obtain an order from the physician for the insertion of a subcutaneous butterfly.*

- **Anticipated/Expected Death** is when the death of an individual is expected/anticipated by the physician and is documented due to an irreversible terminal illness in which no treatment options were available, or the individual declined treatment (Eastern Health, 2016).
- In end-of-life situations in which the death is anticipated and expected, the RN can certify the death and complete the Medical Certificate portion of the Registration of Death form. This is detailed in the Eastern Health (2016) policy *Certification of Anticipated and Expected Death by Registered Nurses*.
- When expected death occurs, it is important for the RN to shift their focus to the family. Encourage the family to take their time with their good-byes, and assist with the facilitation of the grieving process. When the family is ready, inquire about any funeral and burial arrangements that have been made for their loved one. The RN must contact the funeral home to arrange transport of the body once the death certificate has been signed by the appropriate professional. Most funeral homes in the metro area are available 24 hours a day.
- **Medical Assistance in Dying (MAID)** is a current National health care topic, and as a health care provider you may be part of the interdisciplinary team caring for a resident that has requested MAID. The Association of Registered Nurses of Newfoundland and Labrador (ARNNL) (2016) released a document regarding the position and role of NPs and RNs practicing in Newfoundland and Labrador around MAID, and it is important to be familiar with the language and content of this document.
 - At this time, in assisting with MAID, the RN or NP may be asked to provide information around MAID to residents and their families, insert an intravenous line, provide nursing care and support, and assist with the preparation of MAID medications for the physician (ARNNL, 2016).

Recommended Readings:

- 1) Association of Registered Nurses of Newfoundland and Labrador. (2016). *Registered nurses and nurse practitioners – aiding in medical assistance in dying*. Retrieved from https://www.arannl.ca/sites/default/files/RD_RN_and_NP_Medical_Assistance_in_Dying.pdf
- 2) Brodtkorb, K., Skisland, A. V., Slettebo, A., & Skaar, R. (2017). Preserving dignity in end-of-life nursing home care: Some ethical challenges. *Nordic Journal of Nursing Research*, 37(2), 78-84. doi: 10.1177/2057158516674836
- 3) Canadian Nurses Protective Society. (2016). *Physician-assisted death: What does this mean for nurses?* Retrieved from <http://www.cnps.ca/index.php?page=327>
- 4) Eastern Health. (2017). Off label use subcutaneous medications for palliative patients. Patient/Resident/Client Care PRC-200.
- 5) Eastern Health. (2016). Certification of anticipated and expected death by registered nurses. Death and Dying 204(NUR)-5-010.

SECTION 1.6

A CASE STUDY

Ms. X.

Mrs. X. is a 90-year-old woman who was admitted to SLHs 3 months ago. Her husband resides in a personal care home, and Mrs. X. was admitted because she had recently had a left-sided CVA that resulted in mild ambulatory deficits. She is cognitively well, and scored 27/30 on her MMSE on admission at SLHs. Mrs. X. is typically orientated to person, place, and time, and is usually continent. While Mrs. X. requires 1-person assistance with her ADLs, she ambulates well with her walker for short distances and attends meals in the dining room with the other residents. Her secondary diagnoses on admission included: mild pain to her lower back due to degenerative disk disease, HTN, and T2DM. Mrs. X. had bloodwork completed yesterday, and the results are as follows: Hgb 88, Na 140, and WBC 17.

This morning, the PCA attending to Mrs. X. came to you reporting that “Mrs. X. is not herself, can you assess her?” When you inquired, the PCA reported that Mrs. X. was confused about where she was, and what month it is. Mrs. X. requested to stay in bed this morning, and reported mild pain to her right side. She appeared pale, and was incontinent of urine. The PCA reported a strong smell of urine in the room, and that Mrs. X. would not take any breakfast this morning.

Please refer to the questions below and answer them based on the case study provided. The answers are available in Appendix D-I.

- 1) How would you approach Mrs. X. with your nursing assessment? What tools would you use to assist you?
- 2) In analyzing the laboratory values, what values would trigger you to contact the physician?
- 3) Which “5 I’s of Geriatrics” are evident in this case study that could be affecting Mrs. X’s well-being?

CHAPTER 2

THE ADMISSION PROCESS IN LONG-TERM CARE

This chapter includes:

Section 2.1 – Medication Reconciliation in LTC

Section 2.2 – The Admission Form and Documentation

Section 2.3 – The Kardex

Section 2.4 – Advanced Care Planning

Section 2.5 – Test Your Knowledge

Learning objectives:

- ✓ Complete a medication reconciliation form under the supervision of your assigned preceptor(s).
- ✓ Describe the purpose of and how to accurately update the resident kardexes.
- ✓ Participate in an advanced care planning meeting with a resident and their family under the supervision of your assigned preceptor(s).



SECTION 2.1

MEDICATION RECONCILIATION IN LONG-TERM CARE



From <https://www.pexels.com/photo/colors-colours-health-medicine-143654/>

- **Medication reconciliation** is the formal and systematic process of reviewing all medications with the resident and their family on admission or transfer from other healthcare settings to LTC. The primary goal is to reduce any adverse drug events or harm to our residents due to potential miscommunication or changes made to existing medications during the transfer to LTC (Accreditation Canada, 2012).

Did You Know?

The geriatric population takes on average four-times more medications that are available over the counter when compared to other age groups (Accreditation Canada, 2012).

- As part of Eastern Health's 2014-2017 strategic plan, in committing to an improved culture of quality and safety for all populations through its programs and services, the increased rate of medication reconciliation processes was identified as a key indicator (Eastern Health, 2014).
- In one LTC survey completed by Earnshaw and colleagues (2007) among a group of Alberta RNs and pharmacists on the medication reconciliation process, it was found that:
 - The medication information provided was not fully completed or unclear 75% of the time
 - 90% of the time there was not enough information provided to support the use of the prescribed medications and the actual diagnoses

- 40% of the time the prescribed medications did not arrive on the same day as the admitted resident to the LTC facility

Did You Know?

Internationally, the Beers list identifies a list of drugs that are inappropriate for use among the geriatric population when an alternative medication is available. In 2009, 1 in 10 Canadian seniors were taking one or more drugs from the Beers list on a regular basis (Canadian Institute for Health Information, 2011).



From <https://www.pexels.com/photo/writing-notes-idea-class-7103/>

- Within LTC, medication reconciliation includes 3 important steps:
 - i. The **Best Possible Medication History (BPMH)**. It is crucial to identify “what the patient is actually taking.” The accuracy of the list must be checked by at least two sources. The primary source should be the resident or a reliable family member (next-of-kin), but other sources can include the medication vials, previous medical records, blister packs, family physician, pharmacy records, or personal list of medications.
 - ii. Check for discrepancy vs no-discrepancy for each medication. The BPMH is compared to the physician’s medication orders on admission.
 - iii. Work with the Physician or NP to resolve any discrepancies. If any changes are made, the rationale for the change must be identified and the new medication order must be completed on a medication order sheet.

- A copy of Eastern Health's Medication Reconciliation Record can be found on the Intranet in the forms section. It is important to fill in all components of this form including:
 - ✓ Height and weight of the newly admitted resident
 - ✓ Any known allergies
 - ✓ All medications including regular, PRN, puffers and inhalers, vitamins, and herbal supplements. Identify the correct unit of measure for the dosage
 - ✓ Tick the appropriate sources of information that you used to complete the BPMH
 - ✓ Sign the form and initial as required

Recommended Readings:

- 1) Accreditation Canada. (2012). Medication Reconciliation in Canada: Raising the Bar. Retrieved from <https://accreditation.ca/sites/default/files/med-rec-en.pdf>
- 2) Eastern Health. (2015). Medication reconciliation record admission (part 1). (MD1420 1208 06 2015).
- 3) Feldman, L. S., Costa, L. L., Feroli, E. R., Nelson, T., Poe S. S., Frick, K. D., ... & Miller, R. G. (2012). Nurse-pharmacist collaboration on medication reconciliation prevents potential harm. Journal of Hospital Medicine, 7, 396-401. Retrieved from [http://onlinelibrary.wiley.com/journal/10.1002/\(ISSN\)1553-5606](http://onlinelibrary.wiley.com/journal/10.1002/(ISSN)1553-5606)
- 4) Pronovost, P., Weast, B., Schwarz, M., Wyskiel, R. M., Prow, D., Milanovich, S. N., . . . Lipsett, P. (2003). Medication reconciliation: a practical tool to reduce the risk of medication errors. Journal of Critical Care 18(4) 201-205. Retrieved from <http://www.jccjournal.org/>

SECTION 2.2

THE ADMISSION FORM AND DOCUMENTATION



From <https://www.pexels.com/photo/architecture-buildings-center-clinic-263399/>

- The Admission process at SLHs is completed by the RN, in conjunction with the interdisciplinary team.
- The application for the potential resident will be reviewed with the RN and the Social Worker (SW) at SLHs. If the file is deemed appropriate and the resident is accepted for admission to SLHs, the SW will notify the RN of a unit meeting for all nursing staff to discuss the upcoming admission. This typically occurs on the day of the admission.
- The ward clerk will deliver the chart to you, and create the resident data sheet that will serve as a reference for the resident's health information, insurance, and next-of-kin.

Did You Know?

The transition experienced during the admission process to LTC for the resident and their family has been termed "relocation stress syndrome" due to the overwhelming surge of emotions that have been associated with the process (Verbowski, Chan, Kalkat, Kurji, MacPhee, 2013).

- The findings in the qualitative research study by Verbowski and colleagues (2013) revealed the importance of the following considerations during the admission process:
 - Involving the family unit and valuing their input
 - Using effective and positive communication techniques

- Welcoming and valuing the resident and their family
- Using an interdisciplinary approach to care delivery
- Demonstrating respect and listening to the specific interests of the resident



From <https://static.pexels.com/photos/302083/pexels-photo-302083.jpeg>

- EH piloted a Nursing Admission Checklist Tool in 2010 that was made available for all LTC facilities in the St. John's metro region. The tool was introduced with the objective to create consistency and timely documentation among all RNs during the admission process. This tool is still in circulation and used to guide the RN in conducting the admission process, and could be found on the EH Intranet under forms.
- The admission process should always be completed within 72 hours of the resident arriving at the LTC facility. This will assist in reducing any errors of omission.
- In scanning this admission checklist, the following steps should be completed by the RN during the admission process:
 - ✓ Obtain consent for **Examination and Treatment**
 - ✓ Obtain consent for the **Pneumococcal** and **Influenza vaccine**
 - ✓ Complete the **Advanced Health Care Directive** (this will be completed in more detail in Section 2.4).
 - ✓ Email the interdisciplinary team to welcome the new resident to SLHs
 - ✓ Email the ward clerk to add the proper identification stickers associated to the resident's code status on the sleeve of the chart, as well as take the resident's photo.

- ✓ Complete the **Medication Reconciliation Process**
- ✓ Notify the physician and obtain the order for medications and treatments. Fax the Resident Admission Report to Lawtons Pharmacy
- ✓ Complete all interdisciplinary consults as identified
- ✓ Ensure that the proper **Positive Patient Identifiers (PPI)** are in place: *resident photo, resident name, arm band*
- ✓ On the Magic Computer System (EMR): Add **ADL Basic Care** (flowsheet) to the resident's care plan and other nursing diagnoses as required. This will allow the staff to document their shift assessments and interventions on that particular resident.
- ✓ Document the allergies or NKDA into the EMR
- ✓ Complete the following interventions and document on the EMR: **Admission Assessment, Foot-care Assessment, Morse Falls Risk Assessment, Braden Scale Assessment, Pain Assessment, and Vaccination Assessment**
- ✓ Add the resident's name to all lists: *Weekly bath list, MDS, work list, treatment list*
- ✓ Write an admission progress note in the EMR
- ✓ Enter information into the electronic **Kardex**. Print a copy for the reference binder.
- ✓ Complete the **Musculoskeletal Injury Prevention-Safe Patient/Resident Handling Patient/Resident Handling Assessment Acute Care & Long Term Care** form to determine activity level. This can be found on the EH Intranet under forms.

Note: *In order to gain confidence around the admission process in LTC, it will be important to seek out the opportunity to complete an admission under the supervision of your preceptor(s) during the orientation period.*

Recommended Readings:

- 1) Eastern Health. (2017). Nursing admission checklist (part 1). (AS3130 1664 06 2017).
- 2) Eastern Health. (2015). Musculoskeletal injury prevention – safe patient/resident handling patient/resident handling assessment acute care & long term care. Occupation Health, Safety & Rehabilitation (AS46900048052015).

- 3) Reuss, G. F., Dupuis, S. L., & Whitfield, K. (2004). Understanding the experience of moving a loved one to a long-term care facility. *Journal of Gerontological Social Work*, 46, 17-46. Retrieved from <http://www.tandfonline.com/loi/wger20>
- 4) Verbowski, V., Chan, K., Kalkat, P., Kurji, K., & MacPhee, M. (2013). Exploring resident, family and staff perceptions of the admission process to long-term care. *Canadian Nursing Home*, 24(4), 13-18. Retrieved from <http://www.nursinghomemagazine.ca/>

SECTION 2.3

THE KARDEX



From <https://www.pexels.com/photo/books-126345/>

- The **Kardex** is an electronic communication tool designed for staff to quickly reference in order to access important information on each resident.
- The RN will initiate the Kardex and input data during the admission process under three different headings:
 - **Standard Fields**
 - **Custom Queries:** there is a section for Nursing Communications in which the RN can enter information important for the staff to know pertaining to the resident
 - **Allergies/Adverse Reactions**

***Note:** The Kardex will automatically update as data is entered on Meditech pertaining to the resident.*

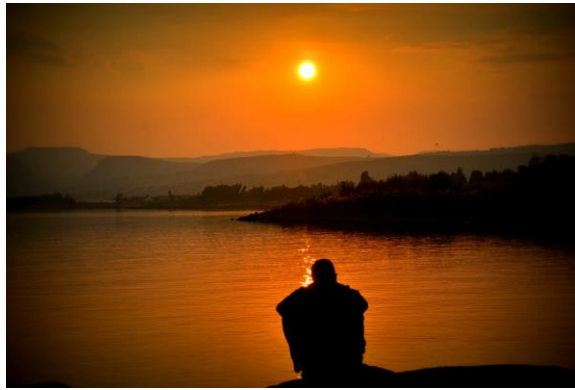
- The Kardex must be updated monthly by the RN or assigned LPN, and printed to place in a reference binder on each unit at SLHs.
- Nursing staff should be encouraged to reference the binder on each shift, and the RN can update staff on any changes in the kardex pertaining to the residents.

- Should any changes be identified throughout the month, the staff may write the information on the printed kardex in pencil. Changes will be entered when the RN or assigned LPN updates the electronic version of the kardex monthly.
- Items such as annual bloodwork, upcoming appointments outside SLHs, and resident preferences can be included on the kardex for easy access for all nursing staff.

***Note:** It will be important to initiate and update a resident's kardex with your preceptor during the orientation period in order to be familiar with the type of resident information that is included.*

SECTION 2.4

ADVANCE CARE PLANNING



From <https://www.pexels.com/photo/sunset-love-lake-resort-54379/>

- **Advance Care Planning (ACP)** can be defined as the voluntary process of reflecting and communicating about one's values and needs around end-of-life care (Speak Up, 2017).
- This process includes:
 - **Communicating** with family, friends, and the health care team
 - Assigning a **Substitute Decision Makers (SDM)**
 - Completing an **Advanced Health Care Directive (AHCD)**
 - Reflecting on one's **values and wishes** around end-of-life care
- It is important to note that when each resident is admitted, they will chose a next-of-kin and person-to-notify to place as contacts on their chart. These individuals may be different than the **SDM** and **power-of-attorney**.
- The **Substitute Decision Maker** is an individual appointed by the resident to make health care decisions on behalf of the individual, should they not be physically or mentally able to communicate themselves (Eastern Health, 2016).
- If the individual does not appoint an SDM, and they are unable to communicate their health care wishes, the SDM is appointed in accordance to Newfoundland and Labrador's Advance Health Care Legislation (Eastern Health, 2014).

Note: *The process of completing ACP is voluntary. If the resident decides not to partake in this conversation and there is no documentation indicating otherwise, the health care professional needs to remind the resident and their family that CPR will be administered by default in the case of cardiac arrest (Eastern Health, 2017).*



From <https://static.pexels.com/photos/339620/pexels-photo-339620.jpeg>

- Eastern Health (2017) developed a recent policy around ACP in LTC with a goal of supporting residents and their families in decision making around end-of-life care in a standardized way.
- This policy in addition to the **Advance Care Planning (ACP) – Advanced Care Directive Long Term Care form** (ACP/AHCD LTC form) can be initialized by any member of the health care team and must be witnessed by a second member. This form can be found on the EH intranet under forms.
- In reviewing the ACP/AHCD LTC form, you will find that it details three types of health care intervention designations:
 1. **Resuscitation (R):** the resident will receive, and is in agreement with any appropriate interventions or assessments such as attempted CPR, life support, and transfer to acute care.
 2. **Medical Care (M):** the resident will receive and is in agreement with any appropriate interventions or assessments except CPR and life support. There are two separate options under Medical Care:
 - a. **M1:** Transfer to acute care for diagnosis of treatment will be considered

- b. **M2:** Transfer to acute care for diagnosis or treatment will not be considered outside of what can be provided by the health care team at SLHs.
- 3. **Comfort Care (C):** medical care will consist of comfort measures and palliative care measures at SLHs.
- The assigned physician must then sign the form and it is placed on the chart so that the care team can easily recognize the end-of-life wishes of the resident.
- It is important for the health care team to begin the ACP conversation with the newly admitted resident/SDM within **72 hours** of arrival at SLHs. The ACP/AHCD LTC form is then reviewed annually, with any significant change to the health status of the resident, should the resident be transferred to acute care, and if the resident/SDM requests to review the form.

Did You Know?

All communication pertaining to ACP must be documented by the RN in Meditech, and during any transition of care (change of shift, transfer to another facility, and transfer to another unit within SLHs).

- Upon completing the ACP/AHCD LTC form, the RN should communicate to the ward clerk so that the resident's armband and photograph on the chart can be updated. A **blue dot** on the outside of the chart signifies that the resident wishes to receive CPR.

Tips for Health Care Professionals:

- Initiating ACP conversations can sometimes present as challenging for certain residents and their families, as well as staff. This conversation is vital to have as it is important for the nursing team to be aware of the care needs of the resident and their wishes around end-of-life.
- The Quality Palliative Care in Long Term Care Alliance (2014) outline a number of key tips for nurses preparing to undergo these types of conversations with residents and their families:
 - Get to know the resident and their family by obtaining their personal, medical, and social history prior to beginning ACP
 - Create a safe and quiet environment to have the conversation

- Be familiar of the policies and procedures surrounding ACP, as well as where the forms are located
- Begin the conversation by asking the resident/SDM if they have ever discussed their wishes/care needs around end-of-life
- Ensure the resident and their family that the nursing staff are in a supportive role
- Include the resident, SDM, and family members in the discussion
- Discuss any fears or worries the resident/SDM may have about their current condition and prognosis
- Discuss spiritual needs if applicable
- Be aware that the admission process can be a stressful time. While the information can be presented to the resident/family, allow them time to process the information and re-visit as necessary
- If the resident/family require additional time, follow-up with them and schedule a time to have a conversation again

Recommended Readings:

- 1) Abele, P., & Morley, J. E. (2016). Advance directives: the key to a good death? JAMDA, 17(4), 279-283. Retrieved from <http://www.jamda.com/>
- 2) Eastern Health. (2017). Advance care planning (ACP) – advance health care direction long term care. (PO3180 1265 01 2015).
- 3) Eastern Health. (2017). Advance care planning: Long term care. Long Term Care 307-RC-140
- 4) Gilissen, J., Pivodic, L., Smets, T., Gastmans, C., Stichele, R., Deliens, L., & Van de Block, L. (2017). Preconditions for successful advance care planning in nursing homes: A systematic review. International Journal of Nursing Studies, 65, 47-59. Retrieved from <https://www.journals.elsevier.com/international-journal-of-nursing-studies/>

SECTION 2.5

EMERGENT ISSUES



<https://www.pexels.com/photo/ambulance-architecture-building-business-263402/>

- There will be emergent medical situations that arise when you will determine that the best course of action is to send the affected resident to acute care for treatment and diagnosis. If possible, communication should be made with the resident and family prior to initiating the transfer.
- If the physician has not assessed the resident in person, a telephone order must be received from the attending physician on call to transfer the resident to acute care.
- If a family member is not available to accompany their loved one in ambulance to the emergency room, a staff member will have to accompany until a decision is made if the resident will be admitted to hospital.
- Reference should always be made to the resident's AHCD. In cases of cardiac arrest, residents who wish to receive full resuscitation at SLHs by the health care team should have a blue dot on their chart, and it should be indicated on their positive patient identification bracelet and on the ACHD.

Did You Know?

*All communication for appointments and emergent transfers is completed on a **Share Form**. For transfers to the emergency department in the acute care setting, an **Adult Share Form for Permanent Transfer from unit** should be used as this requires more detailed information on the resident. For routine appointments and dialysis standing appointments, the RN should fill in a **Share Form for Temporary Transfer from unit**. All of these forms can be found on the Eastern Health Intranet under Forms.*

Tips for Health Care Professionals:

- When filling in the Adult Share Forms, the RN should include the following information:
 - Any critical information pertaining to the health status of the resident
 - Last glucose reading for those residents with diabetes
 - If the resident is a high fall risk
 - Code status
 - If the resident is receiving antibiotics
 - Ambulatory status

Recommended Readings:

- 1) Eastern Health. (2014). Transfer of information – client patient resident transfer- temporary or permanent transfer (non-physician). Patient/Resident/Client Care (PRC-175).

SECTION 2.6

TEST YOUR KNOWLEDGE

1) Fill-in the missing boxes in the table below with the correct term or definition:

Term:	Definition:
a.	An electronic communication tool designed for staff to quickly locate information on a resident
b. Substitute Decision Maker	
c.	The intervention on the ACHD that includes comfort care measures that will be provided by the care team at SLHs.
d. Advanced Care Planning	
e.	The formal and systematic process of reviewing medications on admission to a health care facility.
f. Beers List	
g.	A term that has been connected to the stress associated with transitioning to LTC.
h. Best Possible Medication History	

2) True or False?

- a. ____ The process of advance care planning is voluntary.
- b. ____ The geriatric population takes on average two times as many over-the-counter medications as other populations.
- c. ____ The admission process should be completed within 24 hours of the residents arrival at SLHs.
- d. ____ The medication reconciliation process requires 3 sources to compare the medication history.
- e. ____ When completing ACP with a resident and their family, the RN requires a witness and physician signature on the ACP/AHCD LTC form to finalize it.

CHAPTER 3

THE ROLE OF THE INTERDISCIPLINARY TEAM

This chapter includes:

Section 3.1 – The Charge RN’s Assignment Record and Shift Report

Section 3.2 – Assigned Licensed Practical Nurses and Personal Care Attendants

Section 3.3 – The Referral Process

Section 3.4 – The Attending Physician

Section 3.5 – Test Your Knowledge

Learning objectives:

- ✓ Complete the unit assignment record and shift report under the supervision of your assigned preceptor(s).
- ✓ Participate in physician rounds and take off the medication and treatment orders under the supervision of your assigned preceptor(s).
- ✓ Communicate where to locate an interdisciplinary referral form and how to properly fill it out for the associated professional.



SECTION 3.1

THE CHARGE RN'S ASSIGNMENT RECORD AND SHIFT REPORT



From <https://images.pexels.com/photos/237675/pexels-photo-237675.jpeg?w=940&h=650&auto=compress&cs=tinysrgb>

- The **Assignment Record** and **Shift Report** are two different documents, and are the responsibility of the RN or designate LPN-unit liaison to fill in on each shift.
- The **Shift Report** or **Transfer of Accountability (TOA)** is the official handover of information that occurred on one shift to the oncoming shift of health care providers (WHO, 2007). It is imperative that nursing staff in LTC facilities are consistent and organized with the way that the shift report is carried out and managed.
- The TOA lists all of the names of the residents for each nursing unit, and at the end of the shift a tick by the resident's name indicates that the shift was uneventful for that particular resident. If there is no tick, a commentary should be provided below to detail the event.
- These reports are stored in a binder on each unit at SLHs for 30 days, and may be shredded in the iron mountain bin after this time period.
- Upon arrival on the unit, the oncoming RN will receive a verbal report from the RN going off-shift of vital information. All of this information plus additional pertinent information may be included on the TOA.
- In accordance with Eastern Health's (2010) policy on the TOA at change of shift in a nursing home environment, the RN or LPN unit liaison will sign the form at the end of the shift.

- Before the RN reads the shift report to oncoming staff, a **bedside safety check** round should be performed to ensure resident safety is upheld. This will be discussed in greater detail in Section 5.1 in this manual.
- For oncoming nursing staff at various intervals during the day, they should seek out the RN to gain insight into the shift report and any pertinent information that has occurred throughout the day.
- In order to communicate and promote team building with the entire nursing staff throughout the day, the RN should endeavour to have a group safety huddle at 1400 daily in which an exchange of information can transpire effectively (Dunbar, 2008).



From <https://www.pexels.com/photo/colleagues-cooperation-fist-bump-fists-398532/>

Did You Know?

The RN has been referred to as the “cheerleader” of the nursing team in the literature, due to their valuable role in boosting morale and expectations around resident care (Dunbar, 2008).

Tips for What to Include in the Shift Report:

- ✓ Abnormal bloodwork findings
- ✓ New onset of illness or critical incidents pertaining to any resident
- ✓ Family concerns
- ✓ The new occurrence of falls or pressure injuries
- ✓ Notification of appointments
- ✓ Medication changes and whether or not the family has been notified
- ✓ Infection control issues such as isolated residents
- ✓ PRN medication administrations
- ✓ Any safety concerns

- There is a miscellaneous section on the TOA for information that is outside of resident care, but pertains to the nursing team. Information on the unit, memos, or upcoming meetings for staff can be communicated in this section by the RN.
- At 0730 daily, the RN going off from night shift photocopies the completed TOA, and places a copy of the TOA on the respective unit. The original copy is placed in the mail box for management located on Trinity Square.

***Note:** Routine information that can be found on other sources does not need to be included on the TOA.*

- The **Assignment Record** is completed at the beginning of each shift, and updated by the Charge RN or LPN unit liaison. This is where the formal documentation of which nursing are present on the unit for the given shift, and their respective assignment to resident care is placed.
- Each LPN and PCA are assigned a certain number of residents that they are responsible to care for, and document on in Meditech throughout their assigned shift. The nursing staff are also assigned their breaks and break relief duties on this document.
- The RN signs at the top of the page as the completer of the record, and if the record is updated the respective RN or LPN unit liaison must sign the record as well at the bottom.
- Other items that may be assigned to certain staff members on this record include:
 - Medication assignments
 - Dressings and catheters
 - Glucose checks
 - Safety checks
 - Dining room surveillance
 - Code assignments (fire, **code 6**, code white).
 - Enteral feeds

Note: *If you hear “Code 6” called overhead at SLHs this can refer to any emergent situation requiring the attention of the RN and assigned LPN. The AED is located next to the front entrance, and backboards/CPR resuscitation mask is at the nursing desk on each unit.*

Recommended Readings:

- 1) Dunbar, S. (2008). Safety huddles. Advance for Nurses. Retrieved from <http://nursing.advanceweb.com/Article/Safety-Huddles-1.aspx>
- 2) Eastern Health (2010). Transfer of accountability at change of shift in a nursing home environment. Long Term Care 307-DOC-190
- 3) Eastern Health. (2017). Resident assignment-nursing-long term care. Long Term Care 307-RC-300

SECTION 3.2

ASSIGNING LPNs AND PCAs



From <https://www.pexels.com/photo/hands-people-friends-communication-45842/>

- As the leader of the nursing team, the RN at SLHs has the responsibility to provide direction and support for the LPNs and PCAs on each respective unit. While this encompasses the delegation and assignment of nursing staff to resident care and nursing tasks, it also includes the verbalization and understanding of certain expectations from the nursing team (Association of Registered Nurses of Newfoundland and Labrador, 2013).
- With respect to the TOA and Shift Reporting process the LPNs and PCAs are expected to:
 - Arrive on time for shift report at the beginning of the shift (0750 for the 0800-2000 shift, and 1950 for the 2000-0800 shift)
 - Refer to the assignment record and complete a safety round of their assigned residents prior to beginning their shift and receiving report
 - Listen to shift report and report to their assigned units
 - Review the kardexes of all assigned residents to seek out important information pertaining to their resident that may of not been included in verbal report
 - Update the kardex as necessary by adding to the communication section in pencil
 - Update the kardex on Meditech with any information that has been added to the kardex, and print them in collaboration with the RN

- Communicate to the RN with any necessary information throughout the shift
- Participate in a team huddle at 1400 to receive and give important information pertinent to resident care

Recommended Readings:

- 1) Association of Registered Nurses of Newfoundland and Labrador. (2013). Registered Nurse Roles in Long Term Care. Retrieved from https://www.arannl.ca/sites/default/files/PS_Registered_Nurse_Roles_in_Long_Term_Care.pdf
- 2) Eastern Health. (2017). Resident assignment-nursing-long term care. Long Term Care 307-RC-300

SECTION 3.3

THE REFERRAL PROCESS



From <https://www.pexels.com/photo/people-coffee-meeting-team-7096/>

- The **interprofessional team** is composed of many members of various health disciplines working together towards the same goals or needs of the geriatric population (Canadian Health Services Research Foundation, 2012). Due to the complexity and individual circumstances of each resident we may encounter, it is imperative to be aware of the types of resources and expertise available at SLHs.
- The process of completing an interprofessional referral at SLHs is standardized by completing an **Interprofessional/Referral for Assessment/Service** form. This form can be found on the EH intranet under forms. The form will ask for the resident's medical information, contact information and reason for referral. At SLHs this can be placed in the professional's mail box at the front desk, and the RN should endeavour to follow up with a phone call or email to notify them of the new referral.
- Some of the more common interprofessional referrals that are completed by the RN on behalf of our residents and their families include:
 - **Dietician:** *malnutrition, weight gain, enteral feeds, and dietary preferences*
 - **Occupational therapy:** *seating options, wheelchair adjustments, ADL evaluation, and equipment needs*
 - **Physiotherapy:** *ambulation assessment, strength training, and exercise regimes*

- **Speech Language Pathology:** *swallowing assessments and dietary texture suggestions*
- **Geriatric Psychology:** *counselling needs and mental health assessments*
- **Social Work:** *transition concerns, end-of-life planning, and substitute decision assignment*
- **Pastoral Care:** *spiritual needs, end-of-life care, and counselling*
- **Ethics:** *family and resident conflict, and end-of-life care*
- **Wound Care Nurse:** *wound assessments, wound product use, and education*
- **Infection Control Coordinator:** *assessment, staff and resident education, and any vaccination needs*
- **Behaviour Management Specialist:** *challenging behaviours, education, and distraction resources for residents*
- **Recreation Therapy:** *Distraction activities for residents, outings, event planning at SLHS*
- **Music Therapy:** *group or individual music preferences at SLHS*

Note: *If you are unsure of which professional to consult, ask any member of the interprofessional team!*

Recommended Readings:

- 1) Boorsma, M., Frijters, D. H. M., Knol, D. L., Ribbe, M. E., Nijpels, G., & Hout, H. P. J. (2011). Effects of multidisciplinary integrated care on quality of care in residential care facilities for elderly people: a cluster randomized trial. *Canadian Medical Association Journal*, 183(11). doi: 10.1503/cmaj.101498
- 2) Canadian Health Services Research Foundation. (2012). Interprofessional collaborative teams. Retrieved from http://www.cfhi-fcass.ca/Libraries/Commissioned_Research_Reports/Virani-Interprofessional-EN.sflb.ashx
- 3) Eastern Health. (2015). Interprofessional referral for assessment/service (part 1). (CL1720 1293 01 2015).
- 4) Galvin, J. E., Valois, L., & Zweig, Y. (2015). Collaborative transdisciplinary team approach for dementia care. *Neurodegenerative Disease Management*, 4(6), 455-469. doi: 10.2217/nmt.14.47
- 5) Government of Newfoundland and Labrador. (2005). Long term care facilities in Newfoundland and Labrador operational standards. (pp. 28-37). Retrieved from http://www.health.gov.nl.ca/health/publications/long_term_care_standard.pdf

SECTION 3.4

THE ATTENDING PHYSICIAN



From <https://www.pexels.com/photo/healthy-clinic-doctor-health-42273/>

- At SLHs, there are two attending physicians who complete weekly rounds with the RN. Each resident who resides at SLHs is under the care of one of these physicians as referenced on their individual chart.
- As per the Government of Newfoundland and Labrador's Operational Standards for Long-term Care Facilities (2005), each resident in LTC has access to an attending physician to assess their medical needs on a 24 hour basis.
- While certain LTC facilities within EH have a **Nurse Practitioner (NP)** on staff as a member of the primary health care team, at this time the NP role has not been implemented at SLHs.
- There is a black calendar agenda on each unit at the nursing desk which is referred to as the physician's book. Should you have any concerns about the resident or any item for review, it can be written on the physician's scheduled round day to be addressed at that time.
- The monthly on-call schedule is listed on each nursing unit at SLHs. This refers to the physician to call after 5pm each day of the week. During 0800-1700, the RN should call the in-house physician that is assigned to that particular resident.

- All telephone orders for medication changes should be transcribed by the RN or LPN on the blue **Prescriber's Orders** for Lawtons. The physician should be asked to call this order into Lawtons Pharmacy on behalf of the resident, and it can be signed by the physician when he/she attends rounds during the week.
- For non-related medication orders, such as bloodwork or vital signs, the RN or LPN should transcribe the telephone order on the yellow **Patient's Order Sheet** on the chart. The physician should also be encouraged to write non-medication orders on this sheet.

***Note:** If a resident returns from an outside appointment or is admitted with orders from another prescriber, the RN should telephone the attending physician at SLHs to obtain a telephone order that he/she agrees with the medication change/order.*

Recommended Readings:

- 1) Canadian Nurses Association. (2013). Nurse practitioners in long-term care. Retrieved from https://www.cna-aiic.ca/~media/cna/page-content/pdf-en/fact_sheet_nurse_practitioners_2013_e.pdf
- 2) Eastern Health. (2013). Medication transcription and administration. Medications 204(NUR)-8-140
- 3) Government of Newfoundland and Labrador. (2005). Long term care facilities in Newfoundland and Labrador operational standards. (pp. 28). Retrieved from http://www.health.gov.nl.ca/health/publications/long_term_care_standard.pdf

SECTION 3.5

TEST YOUR KNOWLEDGE

1) Name the interprofessional team member that you should consult in the situations below:

- a) ____ The critical indicators indicated that a resident lost 12lbs this month.
- b) ____ You note the presence of new eschar in a resident's pressure ulcer.
- c) ____ Your resident requires a gel cushion for their wheel chair.
- d) ____ A resident just returned from acute care after having surgery due to a fractured hip.
- e) ____ A resident returned from an appointment with the ophthalmologist and has a new prescription for eye drops.
- f) ____ You notice that a particular resident is always coughing after he drinks thin fluids.

2) There is a new PCA orientating to your unit today. In meeting them this morning, they ask what is expected of them around shift reporting throughout the day. Make a list of what is expected.

3) True or False:

- a) ____ The Shift Report is also known as the TOA.
- b) ____ Shift Reports are to be kept in a binder at the nursing desk for 30 days before discarding.
- c) ____ Interprofessional referrals should be written on a Patient Order Sheet.
- d) ____ All medication related orders should be written on the Prescriber's Order sheet.
- e) ____ The hours to call the in-house Physicians at SLHs is 0800-2000 daily.
- f) ____ As soon as the verbal shift report is given to oncoming staff, a bedside safety check must be performed.
- g) ____ A resident has been admitted to SLHs, and has a prescription for their medications from acute care. There is no need to call the Physician on call.
- h) ____ A "Code 6" is called for the dining room overhead on the paging system. Only the assigned LPN should respond.
- i) ____ When residents are transferred from acute care to long-term care, transfer orders are not required.

CHAPTER 4

THE ADMISSION PROCESS IN LONG-TERM CARE

This chapter includes:

Section 4.1 – Infection Control

Section 4.2 – Vaccinations

Section 4.3 – Monthly Critical Indicators

Section 4.4 – Test Your Knowledge

Learning objectives:

- ✓ Describe the steps that are taken in accordance with infection control if a gastrointestinal outbreak case is suspected on your unit.
- ✓ Participate in the immunization consent and administration process for a newly admitted resident under the supervision of your assigned preceptor(s).
- ✓ Complete the monthly critical indicators sheet on one unit at SLHs under the supervision of your assigned preceptor(s).



SECTION 4.1

INFECTION PREVENTION AND CONTROL



From <https://www.pexels.com/photo/short-red-hair-woman-blowing-her-nose-41284/>

- **Infection Prevention and Control (IPAC)** refers to routine evidenced-based practices and procedures that are carried out in health care environments to prevent or decrease the spread of microorganisms to staff, other residents, and the public (Infection Prevention and Control Nova Scotia, 2015).
- At SLHs, there is a designate IPAC RN that oversees the facility and provides guidance and education to staff to implement the proper IPAC practices and procedures.
- All RNs beginning employment at SLHs should be familiar with the content and where to access the following Eastern Health policies:
 - Eastern Health. (2017). *Hand hygiene*. Infection Prevention and Control IPC-150
 - Eastern Health. (2016). *Routine practices*. Infection Prevention and Control IPC-200
 - Eastern Health. (2016). *Droplet precautions*. Infection Prevention and Control IPC-140
 - Eastern Health. (2016). *Contact precautions*. Infection Prevention and Control IPC-120
 - Eastern Health. (2016). *Airborne precautions*. Infection Prevention and Control IPC-100

- Eastern Health. (2013). *Personal protective equipment (PPE) donning and removal of PPE*. Infection Prevention and Control IPC-190
- Eastern Health. (2012). *Outbreak management for acute and long term care*. Infection Prevention and Control IPC-185
- The **Point-of-Care Risk Assessment (PCRA)** is a process that should be performed by every health care worker as a routine practice before any interaction occurs. This determines the potential risk for exposure to microorganisms (Infection Prevention and Control Nova Scotia, 2015).
 - ✓ Assess the resident's condition
 - ✓ Assess the resident's environment
 - ✓ Assess the type of care and interaction that will be provided

Two important forms and processes that the RN at SLHs should be familiar with are:

- i. Influenza-like Illness (ILI) Mandatory Surveillance Data Collection Form (Appendix D-V)
- ii. Gastrointestinal Outbreak Line Listing Form (Appendix D-VI)

Influenza-like Illness (ILI) Mandatory Surveillance Data Collection Form (Appendix D-V)

- The **ILI Mandatory Surveillance Data Collection Form** is filled in daily by the RN on each shift from October 1st-April 30th, and weekly on Wednesdays from May 1st-September 30th. This form is faxed by the ward clerk to the IPAC RN daily to track the number of ILI on each unit.
- If the resident is displaying new onset of the following symptoms you should suspect the resident is symptomatic of an ILI:
 - ✓ Temperature above 38 degrees C
 - ✓ Cough
 - ✓ Sore Throat
 - ✓ **Arthralgia** or joint pain
 - ✓ **Myalgia** or muscle pain
 - ✓ Exhaustion or weakness

- The following steps should be taken if you suspect a resident on any unit at SLHs is symptomatic of ILI:
 - Contact the IPAC RN
 - Complete the ILI Surveillance Data Collection Form daily
 - Place the resident on **contact-droplet precautions**
 - Put up the proper signage and an isolation cart outside the resident's room
 - Notify the dietary department and order all meals downstairs
 - Notify the ward clerk to stock the isolation cart
 - Collect any specimens as dictated by the IPAC RN (Nasopharyngeal swab)

Gastrointestinal Outbreak Line Listing Form (Appendix D-VI)

- The **Gastrointestinal (GI) Outbreak Line Listing Form** should be initiated by the RN if gastrointestinal illness is suspected. This may include:
 - ✓ Two or more episodes of loose watery stool
 - ✓ Two or more episodes of emesis
 - ✓ Ongoing abdominal pain and nausea
 - ✓ Temperature
 - ✓ Myalgia
- The following steps should be taken if you suspect a resident on any unit at SLHs is symptomatic of GI illness:
 - Contact the IPAC RN
 - Complete the GI Outbreak Line Listing Form every 24 hours
 - Place the resident on **contact precautions**
 - Put up the proper signage and an isolation cart outside the resident's room
 - Notify the dietary department and order meals downstairs
 - Notify the ward clerk to stock the isolation cart

- Collect any specimens as dictated by the IPAC RN (Stool specimen for Clostridium Difficile, Norovirus, and rotavirus).
- Contact housekeeping to initiate a private garbage and laundry for the affected resident's room
- If there are more than two cases, shut down the entire unit. All residents must eat on the unit, signage must be placed on the outside door of the unit to notify visitors, and all outside appointments must be limited during the outbreak period.

Note: If you have any concerns following the completion of your PCRA, contact the IPAC RN for additional advice.

Recommended Readings:

- 1) Infection Prevention and Control Nova Scotia. (2015). Infection prevention and control: Guidelines for long-term care facilities. Retrieved from [https://ipc.gov.ns.ca/sites/default/files/IPCNS%20Infection%20Prevention%20and%20Control%20LTC%20Final\(1\).pdf](https://ipc.gov.ns.ca/sites/default/files/IPCNS%20Infection%20Prevention%20and%20Control%20LTC%20Final(1).pdf)
- 2) Infection Prevention and Control Canada. (2014). Seasonal influenza, avian influenza and pandemic influenza. Retrieved from <https://ipac-canada.org/influenza-resources.php>
- 3) Ministry of Health and Long-Term Care/Public Health Division. (2013). Control of gastroenteritis outbreaks in long-term care homes. Retrieved from http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/guidance/gd_control_gastroenteritis_outbreaks.pdf

SECTION 4.2

VACCINATIONS



From <https://www.pexels.com/photo/white-and-clear-glass-syringe-161628/>

- Vaccination tracking and administration is part of the IPAC program.
- As RNs completing the admission process in LTC, a thorough vaccination history must be obtained from each resident admitted to SLHs.
- Two types of vaccines that can be offered to newly admitted residents are the:
 - **Pneumococcal vaccination:** a one-time vaccine against **streptococcus pneumoniae** that causes **invasive pneumococcal disease**. If the resident is unsure if they have received the vaccine in the past, it is recommended to repeat this vaccination.
 - **Influenza vaccination:** an annual vaccine that is typically administered in the fall.
- Both vaccines require informed consent from the resident/SDM, and these contents may be kept on the resident's chart for future use. As per Eastern Health's (2013) policy on the *Administration of Influenza Vaccine in Long Term Care Facilities*, once

the consent for the influenza vaccination is obtained, it will be valid for subsequent years during influenza season.

- At SLHs, both the pneumococcal vaccine and the influenza vaccine are included among the standing orders. If the physician has ordered standing orders for the resident, the RN can refer to the standing orders for the directions on administering both vaccines.
- Once either vaccine is administered by the RN at SLHs, it must be properly documented in the Meditech system under **Vaccination History**. Monthly tracking of pneumococcal vaccines will also be submitted to management on the critical indicator sheet. This will be discussed in more detail in Section 4.3.

Recommended Readings:

- 1) Association of Registered Nurses of Newfoundland and Labrador. (2004). Influenza vaccination by registered nurses. Retrieved from [http://arnnl.com/documents/publications/Influenza Vaccinations by Registered Nurses.pdf](http://arnnl.com/documents/publications/Influenza_Vaccinations_by_Registered_Nurses.pdf)
- 2) Eastern Health. (2013). Administration of influenza vaccine in long term care facilities. Infection Prevention and Control IPC-081
- 3) Eastern Health. (2013). Administration of pneumococcal vaccine in long term care facilities. Infection Prevention and Control IPC-085
- 4) Newfoundland and Labrador Immunization Manual. (2011). Pneumococcal immunization program, section 5.4. Department of Health and Community Services. Retrieved from http://www.gov.nl.ca/health/publichealth/cdc/im_section5_sept26.pdf

SECTION 4.3

MONTHLY CRITICAL INDICATORS



From <https://www.pexels.com/photo/black-calendar-close-up-composition-273011/>

- Performance or **critical indicators** are utilized in the LTC environment to monitor and evaluate how the quality of resident care is upheld at a given facility (Frijters et al., 2013).
- At the end of every month, the RN on each unit at SLHs is responsible for completing the Monthly Critical Indicators and submitting the paperwork to management.

This paperwork consists of the following:

- **Pneumococcal Vaccine Tracking Sheet:** *tracks the administration of the pneumococcal vaccine to all new admissions*
- **Weight Loss:** *to identify residents that have more than 5% weight loss in the given month*
- **Pressure Injuries:** *to identify residents with pressure injuries, and the stage and location of the injury*
- **Monthly Infection Control Report:** *to name the residents who have had an infection in the given month, the type of infection, date of onset, date of culture if*

applicable, if the resident had been administered an antibiotic, and the signs and symptoms encountered

Note: *The paperwork for this documentation is available in a binder marked “Critical Indicators” on each nursing unit at SLHs.*

Did You Know?

In assisting with the prevention and management of pressure injuries among residents in LTC, the RN or LPN is responsible to complete a head to toe assessment within 8 hours of admission. Additional measures include the completion of the Adult Braden Scale within 48 hours of admission. It is then repeated weekly for the first four weeks and quarterly, and upon any change in the resident’s condition (Eastern Health, 2017). This can be written on the calendar on each unit as a reminder for all RNs to complete.

Recommended Readings:

- 1) Eastern Health. (2017). Pressure injury prevention- long term care. Long Term Care 307-RC-200
- 2) Eastern Health. (2012). Skin integrity risk assessment (Braden scale). Patient Care 295-PC-230
- 3) Frijters, D. H. M., Roest, H. G., Carpenter, I. G., Finne-Soveri, H., Henrad, J., Chetrit, A., & Bernabei, R. (2013). The calculation of quality indicators for long term care facilities in 8 countries (SHELTER project). BMC Health Services Research, 13(138). doi: 10.1186/1472-6963-13-138
- 4) National Pressure Ulcer Advisory Panel. (2014). Prevention and treatment of pressure ulcers: Quick reference guide. Retrieved from <http://www.npuap.org/wp-content/uploads/2014/08/Quick-Reference-Guide-DIGITAL-NPUAP-EPUAP-PPPIA-Jan2016.pdf>

SECTION 4.4

TEST YOUR KNOWLEDGE

1) Fill-in the missing boxes in the table below with the correct term or definition:

Term:	Definition:
a) Arthralgia	
b)	The type of bacteria that causes invasive pneumococcal disease.
c) Point-of-care Risk Assessment	
d)	Muscle pain.
e)	The type of precautions required for suspected GI illness.

2) A resident on your unit has had three episodes of loose watery stool and two episodes of emesis on your shift. List the procedures that you will follow.

3) True or False:

- a) ____ The consent obtained on admission for the influenza vaccination has to be obtained annually prior to vaccination.
- b) ____ Number of falls are part of the monthly critical indicators.
- c) ____ A point-of-care assessment should only be completed by the health care worker if there is a suspected infection.

- d) ____ The ILI Mandatory Surveillance Data Collection Form is filled out daily from May 1st- September 30th.
- e) ____ If you suspect a resident is symptomatic of ILI-like-illness you should place the resident on contact-droplet precautions.
- f) ____ The vaccination history will be completed by the IPAC RN upon admission of a new resident to SLHs.
- g) ____ The Adult Braden Scale is completed within 72 hours of a newly admitted resident to LTC, then repeated for 2 weeks, quarterly, and with any change in the overall condition.

CHAPTER 5

COMPLETING AN ENVIRONMENTAL SCAN

This chapter includes:

Section 5.1 – Shift Rounds and Expectations

Section 5.2- Bed Rails and Restraints

Section 5.2 – Monitoring Systems

Section 5.3 – Bed Entrapment

Section 5.4 – Test Your Knowledge

Learning objectives:

- ✓ Describe the steps in completing a bedside safety round in the LTC setting.
- ✓ Locate and be familiar with the principles of the least restraint policy at SLHs
- ✓ Implement preventative strategies to protect residents that are at risk of bed entrapment under the supervision of your assigned preceptor(s).



SECTION 5.1

SHIFT ROUNDS AND EXPECTATIONS OF STAFF TO PREVENT ADVERSE EVENTS



From <https://www.pexels.com/photo/sign-slippery-wet-caution-4341/>

- Increased safety and quality initiatives are part of Eastern Health's (2017) mission statement, and therefore the safety of our residents should be a top priority for all health care employees at SLHs.
- In creating a safe environment, the Agency for Healthcare Research and Quality (2012) outlines the following strategies for the nursing team providing direct care to our residents to uphold at all times in the LTC environment:
 - ✓ Be Responsive
 - ✓ Share and Work as a Team
 - ✓ Report and Support
 - ✓ Be Aware
- **Staffing** and the **Organization of Care** has been identified as one of the primary environmental risk factors leading to falls and other adverse events among the geriatric population in the LTC environment (Hill et al., 2009).
- As outlined in Section 3.1 and as the leader of the nursing team, in upholding the safety of the residents, the RN is responsible to assign a PCA or LPN to complete a

bedside safety check prior to beginning shift report for the oncoming shift. This is outlined clearly in Eastern Health's (2010) policy *"Transfer of accountability at change of shift in a nursing home environment"*.

Did You Know?

Falls account for 85 percent of all injury-related acute care hospitalizations, and are the primary cause of injury among the geriatric population (Accreditation Canada, 2014).

- While there is not one single cause that leads to adverse events relating to falls, there are a number of interventions that should be communicated and initiated clearly by the RN. The Agency for Healthcare Research and Quality (2012) describes this as **HEAR ME**:

Hazards: in the immediate environment should be noted and removed by nursing staff.

Educate: the residents and their families about interventions that can be implemented to assist with the resident maintaining quality of life while remaining safe.

Anticipate: the needs of the resident. This can be accomplished by getting to know the resident, and updating the kardex frequently. The RN should complete the Morse Fall Scale on admission, if the condition of the resident or environment changes, after a fall, and routinely every three months (Eastern Health, 2017).

Round: routinely or closely if initiated by the RN.

Materials: and equipment should be monitored and checked that they are working correctly.

Exercise: and fitness levels need to be assessed and monitored for all residents. It can be useful to send referrals to occupational and physical therapy.

- In maintaining a high regard for quality of life and the needs of all residents at SLHs, there will be incidences of falls that occur. In keeping with Accreditation Canada's (2014) standards is imperative that the nursing team at SLHs puts forth preventative and quality strategies to reduce the seriousness of injuries that occur from resident falls.
- Eastern Health (2017) outlines several interventions and documentation that should transpire with a fall. These are described in the table on the following page.

Post-Fall Interventions and Documentation (Complete by RN or LPN)
<ul style="list-style-type: none"> • Complete a physical assessment of the resident (<i>level of consciousness, appearance, pain, signs of injury, and baseline vital signs</i>). • Determine the cause of the fall. • Determine the most appropriate route to transfer the client from the fall-position to a safe position. • Implement environmental safety precautions: <i>bed in lowest position, side rails down if applicable, bed or chair alarm if applicable, call bell within reach, footwear, equipment within reach, bedside clutter, lighting, and the needs of the resident (toileting, dietary, pain)</i>.
<ul style="list-style-type: none"> • Complete the CSRS occurrence report and document the fall on Meditech using a progress note. • This should include: <i>date/time of the fall, if the fall was witnessed/unwitnessed, location of the fall, activity at time of the fall, pain/injury, assessment findings, environmental factors that could have contributed, and any interventions completed by the nursing team</i>. • Notify the Physician.
<ul style="list-style-type: none"> • Complete the updated Morse Fall Scale on Meditech. Analyze the resident's numerical rating. Consider updating the care plan accordingly based on the score the resident receives. • Ensure that fall risk is communicated clearly on all transfers of care, and on the SHARE form.

<ul style="list-style-type: none"> • If the resident is a high fall risk as per Morse Fall Scale, ensure that the CAP: High Falls Risk is added to the plan of care for that resident. Review the care plan.
<ul style="list-style-type: none"> • Contact the SDM/NOK where applicable.
<ul style="list-style-type: none"> • Update the staff on what occurred and any interventions that have been implemented.
<ul style="list-style-type: none"> • If resident is considered a high-fall risk or has had multiple falls, consider placing the resident on Q15 surveillance. Update the nursing staff.
<ul style="list-style-type: none"> • Update the kardex as applicable.

Note: The link to complete a **CSRS occurrence report** can be found on the right hand side of the EH Intranet homepage. It is important to complete the entire CSRS report promptly within 24 hours for all identified occurrences of close calls. This is outlined in Eastern Health's (2015) policy **Occurrence Reporting and Management**.

Recommended Readings:

- 1) Accreditation Canada. (2014). Preventing falls: From evidence to improvement in Canadian health care. Retrieved from <https://accreditation.ca/sites/default/files/falls-joint-report-2014-en.pdf>
- 2) Agency for Healthcare Research and Quality. (2012). Improving patient safety in long-term care facilities. Retrieved from http://www.nursinghomehelp.org/AHRQ_RAND_Module3.pdf
- 3) Akyol, A. D. (2007). Falls in the elderly: What can be done? International Nursing Review, 54, 191-196. Retrieved from [http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1466-7657](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1466-7657)
- 4) Eastern Health. (2010). Transfer of accountability at change of shift in a nursing home environment. Long Term Care 307-DOC-190
- 5) Eastern Health. (2015). Occurrence reporting and management. Quality, Patient Safety and Risk Management QRM-080.

- 6) Eastern Health. (2017). Fall risk assessment, prevention, and intervention: Acute and long-term care (in-patient units). Safety 204(NUR)-2-030
- 7) Hill, E. E., Nyuyen, T. M., Shaha, M., Wenzel, J. A., DeForge, B. R., & Spellbring, A. M. (2009). Person-environment interactions contributing to nursing home resident falls. *Research in Gerontological Nursing*, 2(4), 287-296. doi: 10.3928/19404921-20090527-02

SECTION 5.2

BED RAILS AND RESTRAINTS



From <http://www.publicdomainpictures.net/view-image.php?image=22618&picture=wheelchair>

- A **restraint** can be defined as any method or intervention that intentionally limits the movement or behaviour of a resident. In other words, the resident has no control over the intervention being implemented. This includes: **physical, environmental, and chemical restraints** (Advocacy Centre for the Elderly, 2003).
- Within the LTC setting, and in accordance with the organizational guidelines at Eastern Health, all residents have the right to live comfortably in a restraint-free environment (Government of Newfoundland and Labrador, 2005). Both the residents and their families are informed of the least restraint policy upon admission to LTC.
- At SLHs, restraints of any form are used as a last-resort only when other least restrictive interventions have been implemented and exhausted. Eastern Health's (2012) policy entitled *Least Restraint* details EH's position on a **least restrictive restraint approach**.

Common Myths around Restraints in LTC:

1. Physical restraints such as seatbelts, chair trays, and geriatric chairs will prevent falls.

- **The Truth:** *Physical restraints are not a good practice to be used by nursing staff for fall prevention, and in fact have been proven in the literature to actually increase the number of injuries sustained from falls due to the resident trying to escape from the restraint (Agens, 2010).*

2. Physical restraints assist with stopping aggressive behaviours and associated injuries among the geriatric population.

- **The Truth:** *Residents that are restricted have been found in the literature to suffer a higher prevalence of confusion, falls, pressure injuries, decrease in ADLs and ambulatory independence, a decrease in cognitive function, and even death (Agens, 2010).*

3. Bed rails are not a form of physical restraint and are a useful method by staff to reduce resident falls.

- **The Truth:** *Bed rails are a form of physical restraint and have been demonstrated to not prevent falls. Alternative fall prevention interventions should be considered as a fall from the height of a bed rail or entrapment between the bed rails can lead to increased severity of injuries sustained by residents (Gastmans & Milisen, 2006). If the resident is insistent on using the bed rails for comfort/safety measures when in bed, this should be well documented on the resident's chart.*

The Least Restraint Policy:

1. If you are faced with an emergent situation in which danger to the resident, other residents, and staff is imminent, and other least restrictive interventions have been attempted, the RN must complete a comprehensive assessment of the resident immediately.

2. **Consent** must be obtained from the resident or SDM prior to initiation in situations in which there is a **potential risk** identified, and restraint initiation may be considered by the health care team **without consent** if there is an **emergent/actual/imminent** risk to the resident and others (Eastern Health, 2012).
3. An order must be obtained by the physician or NP, and reviewed quarterly by the physician in LTC.
4. In terms of mechanical restraints, the restraint must be released every two hours for nursing staff to address range of motion, psychological status, and toileting. This release must be documented on the EMR.
5. Thorough documentation by nursing staff in Meditech and on the health record must be completed. This is outlined in the Eastern Health (2012) policy *Least Restraint*.

Did You Know?

In residents living in LTC facilities diagnosed with dementia, both the use of anti-psychotic medications and physical restraints increases the rate of functional and cognitive decline (Foebel et al., 2016).

Alternative Least Restrictive Safety Measures:

- Initiating bed and chair alarms
- Close surveillance (Q 15 minutes)
- Elpas security system for residents that are at risk of eloping
- PT/OT referrals for ambulation and fall-risk advice
- Hip protectors when applicable
- Bed in lowest position when the resident is unsupervised
- Position the resident close to nursing desk if possible

Recommended Readings:

- 1) Agens, J. E. (2010). Chemical and physical restraint use in the older person. *British Journal of Medical Practitioners*, 3(1). Retrieved from <http://www.bjmp.org/>
- 2) Eastern Health. (2012). Least restraint. Patient-Resident-Client Care PRC-080
- 3) Gastmans, C., & Milisen, K. (2006). Use of physical restraints in nursing homes: Clinical-ethical considerations. *Journal of Medical Ethics*, 32(3), 148-152. Retrieved from <http://jme.bmj.com/>
- 4) Government of Newfoundland and Labrador. (2005). Long term care facilities in Newfoundland and Labrador operational standards (pp. 80-82). Retrieved from http://www.health.gov.nl.ca/health/publications/long_term_care_standard.pdf

SECTION 5.3

BED ENTRAPMENT



From <https://www.pexels.com/search/hospital%20bed/>

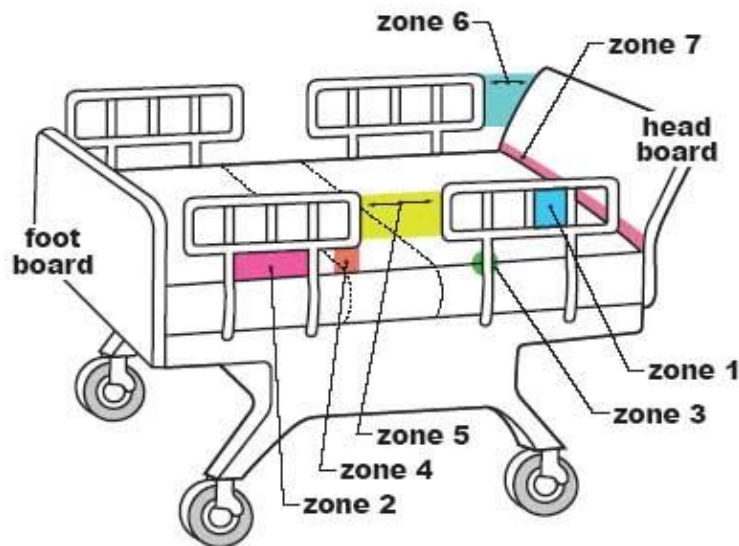
- **Bed Entrapment** is defined as any accidental occurrence that results in a resident becoming stuck, migrating, or entangled in the bedrails, bed mattress, or bed frame of their hospital bed (Health Canada, 2017). It is important to note that while certain populations are more at risk, bed entrapment can happen to anyone in any type of health care environment.
- This safety issue is complex and has far reaching consequences for bed manufacturers, administration, nursing staff, residents, and families. It is important to note that protecting residents and minimizing the risk of bed entrapment for all residents at SLHs involves a multifaceted approach (Health Canada, 2008).

Did You Know?

Between the years 2012 to 2017 there have been 58 adverse incidents reported to Health Canada due to bed entrapment, 11 of which resulted in patient death (Health Canada, 2017).

Identifying the Residents at Highest Risk of Bed Entrapment (Government of Canada, 2008):

- Residents with cognitive and communication impairments
 - Frail and underweight residents
 - Agitated or delirious residents
 - Those in pain
 - Those with uncontrolled body movements (Parkinson's disease)
 - Those with bladder or bowel dysfunction
- There are **seven** identified **Bed Entrapment Zones** (Eastern Health, 2017) that every health care professional should be aware of. **Zones 1-4** have been determined by Health Canada (2008) to be the greatest risk for all populations for entrapment.



From <https://www.canada.ca/en/health-canada/services/drugs-health-products/medical-devices/application-information/guidance-documents/guidance-document-adult-hospital-beds-patient-hazards-side-rail-other-hazards.html>

Zone 1: Within the rail itself

Zone 2: Under the rail, between the rail supports, or next to a rail support

Zone 3: Between the bed rail and the mattress

Zone 4: Under the rail or at the ends of the rails

Zone 5: Between the split bed rails

Zone 6: Between the end of the rail and the side of the foot/head board

Zone 7: Between the head/foot board and the mattress end

Role of the Registered Nurse Concerning Bed Rail Usage:

- Assess the resident for bed safety on admission, with any change in condition, and with any bed-safety incident including: *a medical history, sleeping patterns, medications, acute conditions, delirium, toileting, cognition, communication, mobility, and fall risk*. This assessment should assist the RN in determining if the resident is at risk for climbing over the rails, high fall risk, ambulatory issues and weaknesses in strength and balance, and cognitive status.
- Assess the resident's bed and mattress for the zones of entrapment and eliminate any gaps that could potentially lead to bed entrapment.
- Any potential risks for bed entrapment and concerns with the bed mattress, bedframe, and rails should be reported to biomedical at Eastern Health. These requests can be entered on the **Eastern Health Intranet** under **Tools > Business Tools > Biomedical Service Request**.
- Educate the nursing staff on the importance of environmental safety scans: *lowering one or more sections of the bedrail, ensure the bedrail latches are secured before leaving to room, routine and close surveillance, and assessing the resident's needs. The environmental safety scan should encompass the 4 P's: **pain, position, personal hygiene, and presence**.*
- Document on the electronic medical history of the affected resident any decisions around bed rail use
- Update the care plan quarterly on Meditech
- Communicate to the team any changes concerning bed safety and bed rail use
- Update the kardex

- Consider any additional bed safety interventions: *Toileting schedule, turning and positioning schedule, surveillance, head-of-bed positioning, dietary and hydration needs, bedtime habits, seizure precautions, distractions, and pain*
- Document any potential risks that a resident may have for bed entrapment in the electronic medical record
- If a bed entrapment incident does occur, the RN is to complete a CSRS occurrence report and **Health Canada's (2008) Bed-related Entrapment and Fall Report Form**. This can be located on the Government of Canada's website:
<https://www.canada.ca/en/health-canada/services/drugs-health-products/medical-devices/application-information/forms/bed-related-entrapment-fall-report-form.html>

***Note:** If bedrails are used to limit the range of movement of the resident and not to assist with the daily ADL's, it is considered a physical restraint (Region of Peel, 2013).*

- Any decision for the continued or discontinued use of bed rails should be completed on an **individualized resident basis**. This includes conversing with the nursing team, resident, SDM, and interdisciplinary team or health professionals.

When Bed Rails are Beneficial for Residents and Staff (Health Canada, 2017):

- To assist nursing staff with turning and repositioning a resident in bed
- To assist residents to get out of bed independently when appropriate
- For the resident to feel supported and secure in bed, and to protect their personal items in bed

***Note:** If bed rail usage is determined to be necessary, the RN should identify the minimal number of rails to implement to ensure bed safety and reduce the risk of entrapment.*

Recommended Readings:

- 1) Eastern Health. (2017). Bed entrapment prevention – long-term care. Retrieved from <https://connect.easternhealth.ca/dana/home/launch.cgi?url=http%3A%2F%2Fpulse.easternhealth.ca>
- 2) Health Canada. (2008). Adult hospital beds: Patient entrapment hazards, side rail latching reliability, and other hazards. Retrieved from <https://www.canada.ca/en/health-canada/services/drugs-health-products/medical-devices/application-information/guidance-documents/guidance-document-adult-hospital-beds-patient-hazards-side-rail-other-hazards.html>
- 3) Health Canada. (2017). Hospital beds: Risk of patient entrapment. Retrieved from <http://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2017/62960a-eng.php>
- 4) Hospital Bed Safety Workgroup. (2003). Clinical guidance for the assessment and implementation of bed rails in hospitals, long term care facilities and home care settings. Retrieved from <http://www.fda/goc/cdrh/beds/>
- 5) Region of Peel. (2013). Bed entrapment prevention program. Retrieved from <https://www.peelregion.ca/ltc/pdfs/bed-entrapment-prevention-program.pdf>

SECTION 5.4

A CASE STUDY

Mrs. Y.

Mrs. Y. was admitted to Trinity Square at SLHs yesterday from a personal care home. Her medical history is complex, and upon review of her chart you note that she has dementia, depression, type two diabetes, and is incontinent of urine and stool. Mrs. Y is non-ambulatory, and requires the nursing staff to assist her with her ADLs, feeding, and toileting. Her daughter who is identified as her NOK is visiting this afternoon and you are in the process of finalizing the admission paperwork.

On the share form, the nursing staff at the personal care home have identified that Mrs. Y does not sleep well during the night, is a high fall risk, and tends to try to get out of bed during the night. You also note that at the personal care home, the staff used bedrails x 4 to keep Mrs. Y in bed during the night, and a geriatric table top during the day time when she is in her Broda chair.

Please refer to the questions below and answer them based on the case study provided. The answers are available in Appendix A.

- 1) In utilizing the acronym HEARME, please describe how you would document your safety assessment of this new resident?
- 2) In your assessment of Mrs. Y, you find her in bed with all 4 bed rails up. What type of conversation should you have with her next-of-kin and the nursing staff?
- 3) Is this resident at risk of bed entrapment? What type of interventions could be initiated by you to protect her against bed entrapment in consideration of the least restraint policy?

CHAPTER 6

CONFLICT MANAGEMENT

This chapter includes:

Section 6.1 – Communication Styles and Strategies

Section 6.2 – Delegation

Section 6.3 – Conflict Resolution Model

Section 6.4 – Case Study

Learning objectives:

- ✓ Describe four effective strategies to assist with establishing trust among the nursing team as an assertive leader.
- ✓ Define the 7 Crucial Conversations that healthcare leaders should be having with frontline staff.
- ✓ Practice using the 5 Step Negotiation Model for Conflict Resolution with your assigned preceptor(s) in a case-study format.



SECTION 6.1

COMMUNICATION STYLES AND STRATEGY



Figure 25: From <https://www.pexels.com/search/talk/>

- Effective communication among nursing leaders has been considered in the literature the most valuable of all leadership skills, and is therefore a vital component in the delivery of safe and effective health care to all residents (Hicks, 2011).
- The RN in LTC is in a key leadership position, and is therefore responsible for the coordination and oversight of resident care and the nursing team. While effective communication skills are a valuable skill and imperative aspect of the RN's role in LTC, this often gets overlooked in orientation and mentorship training (Canadian Nurse, 2011).
- **Lateral violence** is prominent among all nursing environments, and as nursing leaders it is imperative that the RN leads and strives for a culture of respect and a healthy work environment for all nursing staff (Ceravolo et al., 2012).

Communication Tips for Effective Nurse Leaders (Gifford et al., 2007):

- ✓ Ask the team for ideas. Communication should be a two-way process

- ✓ Communicate directly, and ideally face-to-face
 - ✓ Provide opportunities for growth
 - ✓ Listen to the team and gain insight into what they think they should do. Use exploring style questions for the team such as “what, how, and when.”
 - ✓ Express your expectations and visions honestly
 - ✓ Be aware of your non-verbal cues and body language during conversations
 - ✓ Respond and deliver to any requests or complaints in a timely manner
 - ✓ Lead by example
- **Assertive Communication** is a style of communication that involves the individual being able to express their feelings and rights, while continuing to respect the feelings and opinions of others. In other words, it is based on mutual respect (Okuyama, Wagner, & Bijnen, 2014).
 - This style of communication is a learned skill that requires practice, reflection, reinforcement, and support from others
 - It is different from an aggressive or passive communication style
 - When used effectively, this style of communication assists with creating effective nursing team relationships
 - An essential aspect of positive team-building that is based on negotiation and collaboration is the establishment of **trust** (Healthy Workplace, 2011).



From <https://www.pexels.com/photo/black-and-white-connected-hands-love-265702>

Strategies for Building Trust:

- **Establish expectations:** *Identify the “unwritten rules”*
 - **Lead:** *Model trustworthy behaviour to the team*
 - **Build trust over-time:** *Expect trust building to be a gradual process*
 - **Establish the limits of your trust:** *Internally you need to be aware what your limits are and what actions will be taken if another individual on the team breaks your trust*
-
- As a novice RN and new employee, the process of developing assertive communication skills and connecting with the larger nursing team may seem daunting. Research to Action (2016) recommends the following core tips to remember.
 - ✓ Deliver the right signals
 - ✓ Select the proper attitude
 - ✓ Encourage them to communicate and keep the lines of communication open
 - In one large research study completed in the United States, the authors identified Seven Crucial Conversations that health care professionals are failing to have which can lead to safety concerns in the system (Maxfield, McMillan, Patterson, & Switzler, 2005). It is important for the RN in LTC to be aware of and practice having these crucial conversations with the nursing team to promote positive work environments and a culture of safety.
 1. **Broken Rules:** *Address any shortcuts in care practices that could jeopardize resident safety*
 2. **Lack of Support:** *Assisting other colleagues with tasks, questions, etc.*
 3. **Mistakes**
 4. **Incompetence**

5. **Poor Teamwork**
6. **Disrespect**
7. **Micromanagement:** *Abusing authority*

Recommended Readings:

- 1) Ceravolo, D. J., Schwartz, D. G., Foltz-Ramos, K. M., & Castner, J. (2012). Strengthening communication to overcome lateral violence. *Nursing Management*, 20(5), 599-606. doi: 10.1111/j.1365-2834.2012.01402.x
- 2) Okuyama, A., Wagner, C., & Bijnen, B. (2014). How we can enhance nurses' assertiveness: A literature review. *Nursing and Care*, 3(5), 1-9. doi: 10.4172/2167-1168.1000194
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SECTION 6.2

EFFECTIVE DELEGATION



From <https://www.pexels.com/photo/colleagues-cooperation-fist-bump-fists-398532/>

- **Delegation** is a skill that involves any action in which the responsibility and authority for a certain nursing intervention or task is referred and entrusted to another staff member (Research to Action, 2016).
- In the position of nurse leader and overseer of many units and residents, it is imperative to learn how to delegate certain tasks to others. In fact, by learning to delegate effectively, there can be increased job satisfaction, growth and empowerment, balanced workload, and positive resident health outcomes for all nursing staff (Yoon, Kim, & Shin, 2016).
- The process of delegating to nursing staff is a shared responsibility between the RN as the delegator and the staff member being delegated (Lightfoot, 2011). The RN should endeavour to document the delegation such as on the **Assignment Record** or residents' chart.
- When determined to be appropriate, by delegating to the regulated and unregulated care providers the RN can focus on:
 - Care plan review and updates
 - Advanced nursing skills and unstable residents
 - Medication changes

- Resident and family education and needs
- Physician rounds and resident orders
- Closer observation of the assigned units, residents, and staff

Did You Know?

Delegation is not often included in the BN curriculum. Novice RNs require practice in delegation skills, and should endeavour to participate in role-playing and case-study activities during the preceptorship period pertaining to delegation competence (Yoon et al., 2016).

Tips for Successful Delegation (Research to Action, 2016):

- Only delegate tasks that are within the individual's scope of practice (*the RN should have a working knowledge of the regulated and non-regulated employees' scope of practice*).
- Be aware of education vs competency (*The individual may have the education to perform the task, but may not identify themselves as competent*).
- Assess the resident to determine if they are medically stable
- Assess the strengths and weaknesses of the individual you are delegating to
- Be clear in the objectives and outcomes expected of the delegated task
- Offer to supervise, observe, or educate the employee if they are uncomfortable or unsure
- Provide feedback and time for reflection, and suggestions to adjust in the future if necessary
- Document as necessary

Note: *There are “five rights” to successful delegation: the right task, the right circumstances, the right person, the right communication, and the right supervision (Lightfoot, 2011).*

Recommended Readings:

- 1) Lightfoot, R. J. (2011). Nurse delegation in LTC and assisted living. I Advance Senior Care. Retrieved from <https://www.iadvanceseniorcare.com/article/nurse-delegation-ltc-and-assisted-living>
- 2) Yoon, J., Kim, M., & Shin, J. (2016). Confidence in delegation and leadership of registered nurses in long-term-care hospitals. Journal of Nursing Management, 24, 676-685. doi: 10.1111/jonm.12372

SECTION 6.3

CONFLICT RESOLUTION MODEL



From <https://www.pexels.com/photo/man-couple-people-woman-343/>

- **Workplace Conflict** is any disagreement that involves an individual or party that is of the understanding that another individual or parties' actions and needs conflicted with their own interests.
- This involves a disruption in workplace efficiency and flow (Healthy Workplace, 2011). As leaders at SLHs, there will be situations in which you will have to resolve your own conflicts, or intervene in other staff conflicts to work towards creating a positive work environment for everyone.

Note: *Conflict is a reality of working with other individuals. Ideally it should be viewed as a natural process which is both neutral and normalized (Kupperschmidt, 2008).*

Primary Causes of Workplace Conflict (Psychometrics, 2008):

- Clash of personalities and the balancing of egos
- Lack of leadership

- Communication issues, especially honesty and openness
 - Workplace stressors
 - Difference in personal values
- Conflict in any health care environment is commonly due to the complexity of the organization, and the range of individuals and staff interacting to promote positive health outcomes for consumers. While the prevention of conflict is important, sometimes it is inevitable. As the RN in LTC, gathering strategies in managing conflict in the workplace, Kupperschmidt (2008) recommended implementing the concepts of **Carefronting**.
 - Carefronting= Care + Front (caring enough about one's self and other individuals to confront others using a self-assertive professional manner.
 - Incorporates respect for yourself and others
 - Involves being honest and open
 - Take courage
 - Principles of forgiveness
 - Using "I" statements
 - Equal responsibility for enhancing positive work environments

<u>Constructive Conflict</u>	<u>Destructive Conflict</u>
<ul style="list-style-type: none"> ➤ New ideas and information are formulated and accepted by both parties for a mutual discussion and reflection ➤ New and improved solutions emerge from the presentation of both parties involved 	<ul style="list-style-type: none"> ➤ The individuals care more for themselves than demonstrating respect for the other party involved ➤ The individuals value their opinions over the opinions of others

- | | |
|--|--|
| | <ul style="list-style-type: none"> ➤ Both parties do not agree over the objectives of the conflict resolution ➤ Both parties use “you” instead of “I” statements when presenting facts |
|--|--|

Adapted from Research to Action (2016).

- **The Five Step Negotiation Model to Conflict Resolution** is a useful framework that RNs should be aware of to assist with negotiating solutions that incorporate your own needs, and the needs of the other individual (Research to Action, 2016).
 - 1) **Opening:** Introduce the concern or issue that you have, and your intentions. It is important to use open body language and tone of voice.
 - 2) **What? Facts and Feelings:** Using a question-style format, you are inquiring about the other individual’s viewpoint and their feelings of the issue.
 - 3) **So What? Implications and Interests:** What are the implications from both viewpoints of what has been happening and how a mutual outcome could be facilitated?
 - 4) **Now What? Options & Actions:** The resolution and identified steps to achieve a resolution.
 - 5) **Closure:** Always end on a positive note and discuss what has been learned through the process and conversation.

The Role of the Leader in Managing Workplace Conflict:

- Endeavour to create and maintain a positive workplace for all employees
- Encourage and utilize open and constructive communication that is respectful of different opinions
- Use an interest-based approach to work towards conflict resolution
- Attempt to resolve conflicts with as little escalation as possible
- Monitor and manage disruptive and deconstructive interpersonal behaviour among staff members

Did You Know?

Eastern Health offers conflict management training opportunities for all frontline employees. Watch for the next opportunity to attend!

Recommended Readings:

- 1) Kupperschmidt, B. R. (2008). Conflicts at work? Try carefronting. Journal of Clinical Nursing, 25(1), 10-17. Retrieved from [http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1365-2702](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1365-2702)
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SECTION 6.4

A CASE STUDY

Conflict Scenario

It is a busy day on your assigned nursing units, and the physician will be arriving shortly to complete resident rounds. One of the PCAs approaches you at the desk as you are gathering the charts for rounds and lets you know that one of the residents on Cabot Square just fell in their bathroom.

You assess the resident on Cabot Square promptly, and no injuries have been sustained. You assist the staff with safely transferring the resident back to her wheelchair and ensure that a chair alarm is in place as a least restrictive fall safety measure.

As part of the fall protocol, you know that a CSRS report has to be filed, a set of vitals needs to be conducted, the family needs to be notified, a Morse Fall Scale needs to be completed, and a note needs to be written on Meditech detailing the fall and assessment.

In gathering the supplies to complete the vitals, you see that the physician has arrived on the unit for rounds. You gather one of the assigned LPNs and the PCA that witnessed the fall for a quick conversation. You decide to delegate the vital signs to the PCA and incident report, and the Morse Fall scale to the LPN. You let them know that you will chart on Meditech and notify the family after rounds.

You overhear the PCA saying to the LPN, “Why can’t she do it, she doesn’t look very busy.”

- 1) How could you have more effectively applied the **5 principles of successful delegation** in this scenario?
- 2) What **crucial conversations** need to occur with the LPN/PCA?
- 3) How could you apply the 5 Step Negotiation Model to negotiate a solution for this conflict scenario?

CHAPTER 7

RN LEADERSHIP DEVELOPMENT

This chapter includes:

Section 7.1 – Staff Mix Changes in LTC

Section 7.2 – RN LTC Leadership Network

Section 7.3 – RNUNL Support

Section 7.4 – Test Your Knowledge

Learning objectives:

- ✓ Define the types of practice situations that can be communicated using the RNUNL Professional Practice Form;
- ✓ Differentiate between the scope of practice of the RN, LPN, and PCA;
- ✓ Name the types of leadership and additional educational resources for RNs working in LTC.



SECTION 7.1

STAFF MIX CHANGE IN LTC AND PROFESSIONAL PRACTICE



From <https://www.pexels.com/photo/black-pen-on-white-book-page-159621/>

- **Staff or Skill Mix** is the ratio or combination of regulated and unregulated health care personnel that provide both direct and indirect care to a group of residents (Canadian Nurses Association (CNA), 2012). In the context of LTC facilities in Newfoundland and Labrador, this would consist of the ratio of RNs, LPNs, and PCAs.
- **Scope of Practice** is the services and activities that the health care employee has been educated and authorized to complete as governed by a set of professional standards and code of ethics (CNA, 2012).
- While all nursing staff are integral members of the larger interdisciplinary team, the respective responsibilities and staff hierarchy in LTC is due to differing levels of education, training, and scopes of practice.
- Since 2005, the Government of Newfoundland and Labrador has challenged the four health authorities in the province to become more fiscally efficient in terms of staff ratios and working all staff to their full scope of practice while continuing maintaining positive resident health outcomes (Kennedy, 2009). In response to this

mandate, a Staff Mix Committee was formed to research and implement the proposed skill mix and new staffing ratios in LTC facilities in 2006 (Kennedy, 2009).

Resultant Skill Mix Changes That Have Been Made to LTC (Kennedy, 2009):

- Lowered the RN ratio to 14-20%, lowered the LPN ratio to 40-50%, and increased the PCA ratio to 33-40% of total interdisciplinary team members in LTC facilities
 - Widened the scope of practice of the RN to include the following roles: practitioner, leader, educator, and advocate. The RN is in-charge of multiple units at SLHs and the coordination of both the care of all residents and staff assignments on both assigned day and night shifts.
 - Upskilled the LPNs with the following courses: Health assessment, medication administration, catheterization, medication transcription, enteral feeds, and wound care. Many of these courses were mandated by the College of Licensed Practical Nurses of Newfoundland and Labrador to be completed by April, 2012.
 - In response to recruitment challenges for LPNs and RNs in LTC in NL, PCAs were implemented as resident care providers in LTC facilities in conjunction with the larger interdisciplinary team of nursing staff.
-
- Since the implementation of skill mix in LTC facilities in NL, RNs make up an increasingly smaller percentage of the interdisciplinary nursing team. The literature advocates for higher ratios of RNs in LTC due to the association of higher RN ratios with positive health outcomes of the geriatric population such as: fewer infections, fewer restraints used, less catheterizations, less pressure ulcers, and less admissions to acute care (Lyons, Specht, Karlman, & Maas, 2008).



From <https://www.pexels.com/search/blood%20pressure/>

- As RNs employed in LTC in Newfoundland and Labrador, we are accountable to the public and our profession through our licensing and regulatory body, the ARNNL. The four standards of practice for practicing RNs is detailed in the ARNNL (2013) document entitled *Standards of Practice for Registered Nurses (2013)*.
- The ARNNL (2013) has developed a secondary document for the roles of the RN specifically in LTC. This document has been referenced in separate chapters. In guiding the RNs ethical practice, the Canadian Nurses Association (CNA) (2008) developed the *Code of Ethics for Registered Nurses* which clearly outlines the values and ethical conduct expected of all RNs practicing in Canada. This document is currently being updated by the CNA.
- The ARNNL (2006) developed a document that listed the RN Entry to Practice Nursing Competencies that can be applied to any practice setting. This list of competencies is listed below in Appendix D-II.

Overview of RN-LPN-PCA Scope of Practice:

<u>Role of the PCA in LTC</u>	<u>Role of the LPN in LTC</u>	<u>Role of the RN in LTC</u>
<ul style="list-style-type: none"> • Providing personal care to assist the resident is accomplishing ADLs. • Basic nail and foot care • Vital signs 	<ul style="list-style-type: none"> • Practitioner • Leader • Assessment and management of medically stable and predictable residents. • Medication administration 	<ul style="list-style-type: none"> • Practitioner • Leader • Educator • Advocate • The RN is in charge for all residents and staff assignments/supervision on one or more units • Coordinator of care, and associated care planning • Communicates to and educates families

<ul style="list-style-type: none"> • Colostomy care 	<ul style="list-style-type: none"> • Direct resident care and associated ADLs including weights, heights, vital signs, glucose checks, and associated documentation 	<ul style="list-style-type: none"> • Resident assessment and health outcome planning, implementing, evaluating, and documenting.
<ul style="list-style-type: none"> • Weights and heights 	<ul style="list-style-type: none"> • Catheterization and catheter care • Non-tunnelling wound care 	<ul style="list-style-type: none"> • Attends resident care meetings
<ul style="list-style-type: none"> • Escorting residents to appointments 	<ul style="list-style-type: none"> • Enteral feeds • Basic and advanced foot care 	<ul style="list-style-type: none"> • Advanced foot care • Venipuncture and IV/PICC therapy when required • Oxygen therapy
<ul style="list-style-type: none"> • Documentation 	<ul style="list-style-type: none"> • Oxygen therapy • Colostomy care 	<ul style="list-style-type: none"> • Assessment, care, and management of medically unstable or unpredictable residents • Physician rounds • Admission screening and admission procedure • Resident assignment and TOA procedures

- As you can visualize in the chart above, there is some overlap between the scope of practice of the RN and LPN. This is referred to as **Shared Competencies**, in which a skill or task is within the scope of more than one health care professional. In this case, the skill may be completed by either health care professional in agreement with the organizational/workplace agency policy (ARNNL, 2006).
- As self-regulated professionals, both the RN and LPN are responsible and accountable for their own practice as guided by their Standards of Practice and Code of Ethics.

Recommended Readings:

- 1) Association of Registered Nurses of Newfoundland and Labrador. (2013). Standards of practice for registered nurses (2013). Retrieved from [https://www.arannl.ca/sites/default/files/Standards of Practice for Registered Nurses.pdf](https://www.arannl.ca/sites/default/files/Standards_of_Practice_for_Registered_Nurses.pdf)
- 2) Association of Registered Nurses of Newfoundland and Labrador. (2006). Scope of nursing practice: Definition, decision-making, and delegation. Retrieved from [https://www.arannl.ca/sites/default/files/RD Scope of Nursing Practice.pdf](https://www.arannl.ca/sites/default/files/RD_Scope_of_Nursing_Practice.pdf)
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- 5) Kennedy, A. (2009). Evaluating nursing staff mix in long-term care: A comprehensive framework for decision-makers. *Healthcare Quarterly*, 12(4), 46-53. doi: 10.12927/hcq.2013.21125

SECTION 7.2

RN LEADERSHIP NETWORK



From <https://www.pexels.com/photo/close-up-photography-of-yellow-green-red-and-brown-plastic-cones-on-white-lined-surface-163064/>

- The **LTC RN Leadership Network** is an Eastern Health wide group of RNs and advanced practice RNs (ANP) who are employed in LTC. This includes: RNs region wide working in LTC, clinical educators, clinical nurse specialists (CNS), and resident care managers (RCM).
- The network was formed to promote and provide leadership development and education, mentoring, RN support, and promote positive change and healthy resident outcomes at the unit level within LTC facilities.
- All RNs employed in LTC within EH are invited to join, and are made aware of the network during the orientation period. Upcoming educational opportunities and communication is completed through your Outlook email account.

Other Nursing Leadership Interest Groups and Education:

- **Newfoundland and Labrador Gerontological Nurses Association:** *special interest group of gerontological nurses, and the Newfoundland chapter of the*

Canadian Gerontological Nurses Association (CGNA). Membership information can be obtained through: <http://www.nlgna.ca>

- **Canadian Gerontological Nurses Association:** *National organization that promotes gerontological nursing, education, and research across Canada. Member information can be obtained through: <http://www.cgna.net/>*
- **Canadian Nurses Association:** *Offers speciality credentials in Gerontological Nursing through the CNA certification program. More information can be obtained through: <https://www.cna-aiic.ca/en/certification>*
- **Advanced Foot care Course:** *Offered through the Centre for Nursing Studies. More information can be found at http://www.centrefornursingstudies.ca/programs/continuing_education/RN_LPN_Advanced_Footcare.php*
- **Post-Basic BN Gerontological Course:** *Offered through the Centre for Nursing Studies. More information can be found at http://www.centrefornursingstudies.ca/programs/continuing_education/RNGerontologyProgram.php*

SECTION 7.3

RNUNL SUPPORT



From <https://www.pexels.com/search/test/>

- The **Registered Nurses Union of Newfoundland and Labrador (RNUNL) (2017)** represents over 5,500 RNs as the governing labour relations and trade union in Newfoundland and Labrador. The RNUNL is committed to its members through the following types of services:
 - Negotiating the collective agreement
 - Assists RNs with filing grievances, mediation, and arbitration
 - Educational opportunities for members
 - Research to improve the current health care system
 - Advocating and media relations for members

Did You Know?

Our local branch number at SLHs is #37, and there are currently three shop stewards that can represent you, or answer any questions around the collective agreement.

- **Professional Practice (PP)** is a quality process of identifying and reporting any situation in which the RN feels they are unable to practice safely in accordance to the professional standards and ethics (RNUNL, 2016).
- The RNUNL developed a toolkit to assist members with reporting and dealing with PP issues. This was released in 2016, and a copy of the toolkit is available on each unit at SLHs for reference.
- As an issue arises, the affected member should complete a **professional practice form**, and submit the completed form to the RCM within 24 hours.
- It is important to detail which Professional Nursing Standard has been compromised on the form.
- The form will be submitted at a monthly Professional Practice Committee meeting. This meeting is conducted between Branch #37, management, and human resources. Three appointed RNs volunteer on this committee from branch #37. Follow up will be provided to the affected member. The minutes from each meeting are made available to all members of Branch #37.
- Remember to document an issue each time it occurs on a new PP Form.

Examples of Professional Practice Issues (RNUNL, 2016):

- Baseline staffing levels not met
- Necessary equipment not available
- Ineffective communication and leadership
- Inadequate education or orientation
- Environmental concerns (*noise, renovations*)
- Non-Nursing Duties

***Note:** Branch meetings are held quarterly, and all members are invited to attend. Information for upcoming meetings and events will be posted on our bulletin board in the lunchroom.*

- Additional information can be obtained on the RNUNL through their website: <http://rnunl.ca/>. If you wish to have your own copy of the Professional Practice Toolkit, you can request one through the website.

Recommended Readings:

- 1) Harris, M. (2016). Professional practice toolkit. Registered Nurses' Union of Newfoundland and Labrador. St. John's: The Hub.

SECTION 7.4

TEST YOUR KNOWLEDGE

1) Fill-in the missing boxes in the table below with the correct term or definition:

Term	Definition
a) Professional practice form	
b)	The overlap between scopes of practice of two separate health professionals.
c) Skill Mix	
d)	The licensing and regulatory body for RNs practicing in Newfoundland and Labrador.
e) RNUNL	

2) You have a resident returning from hospital tonight with a new Kangaroo pump and orders for enteral feeds. When you go to get the equipment that you require to receive the resident, the last IV pole and Kangaroo pump are in use for another resident. Is this a professional practice issue? List the procedure for reporting, and what Professional Standard(s) have been violated?

3) True or False:

- a) ____ The Professional Practice Committee branch #37 meets quarterly to present any PP forms submitted from members.
- b) ____ All completed PP forms need to be submitted to a resident care manager within 48 hours of completion.
- c) ____ All RNs working in LTC in the Eastern Health region are invited to join the LTC RN Network.

- d) ____ If skill mix is being implemented, the LPN can assess and care for medically unpredictable residents.
- e) ____ The PCA in LTC is primarily responsible for resident care and the assistance in achieving the resident's ADLs.

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APPENDIX D-I

TEST YOUR KNOWLEDGE AND CASE STUDY ANSWERS

Section 1.6

- 1) In approaching Mrs. X, it would be important to consider SPICES to assess this resident. The SPICES assessment tool would reveal that she is having problems with eating/feeding, incontinence, and new onset of confusion. Some tools that you could use to further assess Mrs. X based on her symptoms would include: the McGeer and colleagues (1991) Surveillance Definitions of UTI in LTC facilities, the Standardized Folstein Mini Mental Exam, the Morse Fall Scale, the Numeric Pain Rating Scale, and the Katz Activities of Daily Living. It would also be important to get a set of baseline vitals on Mrs. X.
- 2) All of the lab values are outside of the normal range and should be reported to the attending physician.
- 3) By incorporating the Five I's of Geriatrics, your assessment would reveal that Mrs. X has undergone an intellectual impairment, and incontinence.

Section 2.6:

- 1) a) Kardex
- b) Substitute Decision Maker: an individual appointed by the resident to make health care decisions on behalf of the resident should they not be physically or mentally able to communicate themselves.
- c) Comfort Care
- d) Advance Care Planning: the voluntary process of reflecting and communicating about one's values and needs around end-of-life care.

- e) Medication Reconciliation
 - f) Beers List: an international list of drugs that are inappropriate for use among the geriatric population when an alternative medication is available.
 - g) Relocation Stress Syndrome
 - h) Best Possible Medication History: a list of current medications that the resident is “actually taking.”
- 2) a) True
b) False
c) False
d) False
e) True

Section 3.5:

- 1) a) Dietician
b) Wound Care Nurse
c) Occupational Therapy
d) Physiotherapy
e) Physician
f) Speech Language Pathology
- 2) In speaking to the new PCA, as the team leader it will be important to remind them of the expected start time of each shift and when nursing report is given. You can reference the Eastern Health (2017) policy on *Resident assignment-nursing-long term care* in which the safety round is done prior to the beginning of the shift/receiving nursing report. The RN should show the new PCA where the kardex binder is located on the unit, and the importance of updating both the RN and the kardex with any changes that may occur with any given resident throughout the day. It is also important to set expectations for the daily team huddle that occurs at 1400 as per policy guidelines.
- 3) a) True
b) True
c) False

- d) True
- e) False
- f) False
- g) False
- h) False
- i) False

Section 4.4:

- 1)
 - a) Arthralgia: joint pain
 - b) Streptococcus pneumoniae
 - c) Point-of-care Risk Assessment: the process that should be performed by every health care worker as a routine practice before any interaction occurs in order to determine the potential risk for exposure to microorganisms.
 - d) Myalgia
 - e) Contact precautions

- 2) Recognize that these type of symptoms could be a gastro-related illness. First, contact the IPAC RN coordinator for your unit for advice on sample collection. Initiate contact precautions, and isolate the resident. This includes: signage, an isolation cart outside the door, and a garbage/linen collection bins for the individual resident inside the room. The family and dietary department should be notified. Initiate and complete the GI Outbreak Listing form every 24 hours. Send an email to the ward clerk to stock the isolation cart. Monitor the remainder of the unit for symptoms.

- 3)
 - a) False
 - b) False
 - c) False
 - d) False
 - e) True
 - f) False
 - g) False

Section 5.4:

1) In applying HEARME to Mrs. Y's case study,

H: Mrs. Y is non-ambulatory, and staff will need to frequently attend to her care needs when she is in bed. All hazards in the immediate environment will need to be removed by the nursing staff.

E: Education will need to be provided to the nursing staff about the use of bedrails, as well as to the family about the bedrails and geriatric table top as safety measures. Reference can be made to the Least Restraint Policy.

A: The RN is to complete the Morse fall scale on admission, and anticipate any care needs that the resident may have when she is in bed. This can be done by interviewing the resident/family and reviewing the past history from the personal care home.

R: Assign the nursing staff to complete frequent safety rounds

M: Assess the type of bed, mattress, and side rail latch being used for safety. Complete a biomedical referral if required.

E: Consult PT and OT to assess exercise and fitness levels, and establish any reasonable goals with the resident/family pertaining to strength and mobility in coordination with the PT/OT.

2) You will need to investigate the reasons that the nursing staff at her last personal care home has used the four side rails up, as well as the geriatric table top. If it is not determined to be necessary and no other least-restrictive interventions can be applied, it will be important to communicate the risk of such restraints to the family/nursing staff. The RN should also communicate this on the resident's kardex.

3) This resident is at risk for bed entrapment. She is cognitively impaired, and is frequently incontinent of urine/stool. Other least restrictive safety measures that could be implemented by the RN could include: initiating bed/chair alarms, putting the resident on close surveillance, positioning the bed in the lowest position, removing clutter from the bedside, and positioning the resident close to the nursing station if possible.

Section 6.4:

- 1) In order to effectively apply the 5 principles of successful delegation to this case study, the RN could:

Risk Task: ensure that the PCA is competent to complete the vital signs and the incident report, and the LPN is competent to complete the Morse Fall Scale.

Right Circumstances: Explain that you are needed to complete bed rounds with the physician, and that their assistance with these tasks would be greatly appreciated.

Right Person: Ensure that the delegated tasks fall under the LPN's/PCA's scope of practice, and that they are not only educated, but competent in the delegated tasks.

Right Communication: Ensure that you are using assertive communication. Ensure that you are clear in the objectives of the delegated tasks and outcomes.

Right Supervision: If they require assistance or education with either of the delegated tasks, offer your assistance and feedback.

- 2) The Crucial Conversations that need to occur with the LPN/PCA are: lack of support, potentially incompetence, poor teamwork, and disrespect.
- 3) In negotiating a solution for this conflict scenario, it is important to apply the 5 step negotiation model:

Opening: In a private area, communicate your concern to the LPN/PCA. Use open body language and tone of voice.

What: Inquire about the LPN/PCA's feelings on the delegation scenario, and why they felt like you didn't look busy.

So What: Identify the implications from your point of view, and the point of view of the LPN/PCA of how the conflict unfolded. Explore how a mutual outcome could be facilitated. For example; did the LPN/PCA understand that you had rounds to complete with the physician? Were they unsure on how to complete the delegated tasks? Was your tone of voice elevated?

Now What: Negotiate a resolution. If they are unsure on how to complete a task, such as the vitals or Morse Fall Scale, offer your supervision and assistance. Offer constructive feedback.

Closure: Close the conversation on a positive note, and address that you have all learned from the process and open conversation.

Section 7.4:

- 1)
 - a) Professional practice form: the form used to detail and report any practice situation that arises that violates the ARNNL professional standards.
 - b) Shared Competencies
 - c) Skill Mix: the ratio or combination of regulated and unregulated health care personnel that provide both direct care and indirect care to a group of residents.
 - d) ARNNL
 - e) RNUNL: the governing labour relations and trade union for RNs in Newfoundland and Labrador.
- 2) This is a professional practice issue, the necessary equipment was not readily available for resident use. In reporting this issue, you will complete a professional practice form and submit it to your RCM within 24 hours. You should also speak to a member of the PPC. Some of the standards of practice that could have been violated in this case study include: Responsibility and Accountability and Client Centered Practice.
- 3)
 - a) False
 - b) False
 - c) True
 - d) False
 - e) True

APPENDIX D-II

LTC COMPETENCY CHECKLIST



This form is applicable for the following sites:
Rural Avalon/Peninsulas/Long Term Care – St. John's

Generic Competencies Self-Assessment Tool For Registered and Graduate Nurses

Name:	Date:
Program:	Years of Experience:
Clinical Unit:	Years of Experience in Clinical Area of Related Area:

The following is a list of competencies and functions for which you, as a Registered or Graduate Nurse, are responsible to self-assess. Please complete the list by initialing and dating the appropriate column and return to your Manager at the end of your probationary period. The opportunity to review any learning needs will be provided at the end of clinical orientation and your probationary period. If follow up with the Clinical Educator is required, learning plans will be developed to assist in areas where further education is needed. The completed form will be forwarded to your employee file in the Department of Human Resources at completion of the probationary period. Following clinical orientation, the Registered/Graduate Nurse is responsible to seek appropriate education and clinical guidance to perform competencies not available during the orientation period.

Comments: Additional information and follow-up action can be included here. Please indicate in this section if you have not received any education theory and practical for any of the skills listed below.

Skill	Theory/ Lab only	Knowledgeable but Requires Practice	Able to Perform Independently	Comments
Admission/Discharge/Transfer				
• Admits a patient/resident				
• Transfers a patient/resident				
• Discharges a patient/resident				
Assessment: Performs/Completes				
• Physical assessment				
• Performs mental status assessment				
• Fall Risk Assessment				
• Braden Assessment Scale				
• Neurovascular Assessment Flowsheet				
• Neurological Assessment-Glasgow Coma				
• Confusion Assessment Method (CAM)				
• Alcohol Withdrawal Protocol				
• Pain Assessment				
• Foot Assessment				
• Oral Health Assessment				
• RAI-MDS 2.0 Assessment				
Plan of Care				
• Initiates and individualizes a plan of care				
• Completes Care Plan review				
• Completes Client Assessment Protocol (CAPs) summary				
Skin and Wound Care				
• Packings				
• Irrigations				
• Compression therapy				
• Removal of sutures/staples				
• Negative Pressure Wound Therapy				
• Removes drains				

Skill	Theory/ Lab only	Knowledgeable but Requires Practice	Able to Perform Independently	Comments
<ul style="list-style-type: none"> • Completes wound assessment record 				
Respiratory				
<ul style="list-style-type: none"> • Initiates oxygen therapy • Titrates oxygen therapy • Performs pulse oximetry • Performs oropharyngeal suctioning • Performs tracheostomy care • Cares for patient/resident with a chest tube • Cares for patient/resident on NIPPV (e.g., CPAP) 				
Cardiovascular				
<ul style="list-style-type: none"> • Initiates or discontinues telemetry • Performs 12 Lead EKG 				
Gastrointestinal				
<ul style="list-style-type: none"> • Inserts nasogastric tube (NG) • Verifies NG placement • Gastrostomy/Jejunostomy exit site care • Changes balloon gastrostomy tube (established tract) • Administers an enema • Ostomy care (change appliance) • Initiates parenteral nutrition • Uses feeding pump • Administers gastric tube feeds 				
Genitourinary				
<ul style="list-style-type: none"> • Inserts urinary catheter: <ul style="list-style-type: none"> - Male - Female • Changes suprapubic catheter (established tract) • Applies external urinary drainage (condom) catheter • Bladder Scanner 				
Specimen Collection				

Skill	Theory/ Lab only	Knowledgeable but Requires Practice	Able to Perform Independently	Comments
<ul style="list-style-type: none"> • Body fluids specimens(e.g., urine/stool) • Obtains swabs from wounds • Obtains blood specimen by: <ul style="list-style-type: none"> - Lancet - Venipuncture - CVAD - POCT - glucose - Blood cultures 				
Perioperative Care				
<ul style="list-style-type: none"> • Completes preoperative checklist • Receives patient/resident from the operating room • Patient Controlled Analgesia (PCA) • Epidural 				
Blood and Blood Products				
<ul style="list-style-type: none"> • Administers blood and/or blood products 				
Resident/Patient Safety				
<ul style="list-style-type: none"> • Uses mechanical lifts • Cares for the patient/resident with restraints • Completes surveillance records • Cares for client on isolation precautions • Dons and doffs personal protective equipment • Uses Safe Patient/Resident Handling (SPRH) Techniques • Performs Positive Patient/Resident Identification (PPI) • Utilizes electronic surveillance systems: <ul style="list-style-type: none"> - Wanderguard - Bed check - Chair check - TABS 				
End of Life Care				
<ul style="list-style-type: none"> • Provides care to the dying resident/patient and their family 				

Skill	Theory/ Lab only	Knowledgeable but Requires Practice	Able to Perform Independently	Comments
<ul style="list-style-type: none"> Provides support to family after death Provides postmortem care Pronouncement and certification of death (expected and anticipated death) Completes death certificate 				
Venous/Arterial/Subcutaneous				
<ul style="list-style-type: none"> Inserts a peripheral IV Inserts a subcutaneous indwelling catheter Care and maintenance of: <ul style="list-style-type: none"> Short term CVP <ul style="list-style-type: none"> Peripherally inserted central catheter (PICC) Tunneled catheter (e.g. Hickman) Implanted infusion port (Port a Cath) Subcutaneous Indwelling catheter Removes CVAD <ul style="list-style-type: none"> Short term CVP PICC Uses an infusion pump 				
Medication Administration				
<ul style="list-style-type: none"> Performs independent double check Knowledge of hazardous medication list and required PPE Administers medication by: <ul style="list-style-type: none"> Oral Intramuscular Subcutaneous Subcutaneous indwelling catheter Direct injection Intermittent infusion Continuous infusion Vaccination Suppository Inhalation (inhalers, nebulizer mask) 				

Skill	Theory/ Lab only	Knowledgeable but Requires Practice	Able to Perform Independently	Comments
- Topical				
- Enteral tube				
Medication Orders				
• Transcribes orders				
• Obtains telephone orders				
• Obtains verbal orders				
• Recopies medication administration record (MAR)				
• Performs best possible medication history				
• Performs medication reconciliation				
Leadership				
• Staff mix/EH Acute model of care				
• Coordinator of patient/resident care/ in charge role				
• Delegation of function/tasks				
• Method of patient/resident assignment				
Communication				
• Gives and obtains handover report				
• Utilizes Focus Charting				

Specialized Competencies (completed):				
1. Gentle Persuasive Techniques (GPA)	Date:	2. Advanced Foot Care	Date:	
3.		4.		
5.		6.		
7.		8.		
9.		10.		

Comments:	
Signature:	Registered/Graduate Nurse:
Date	

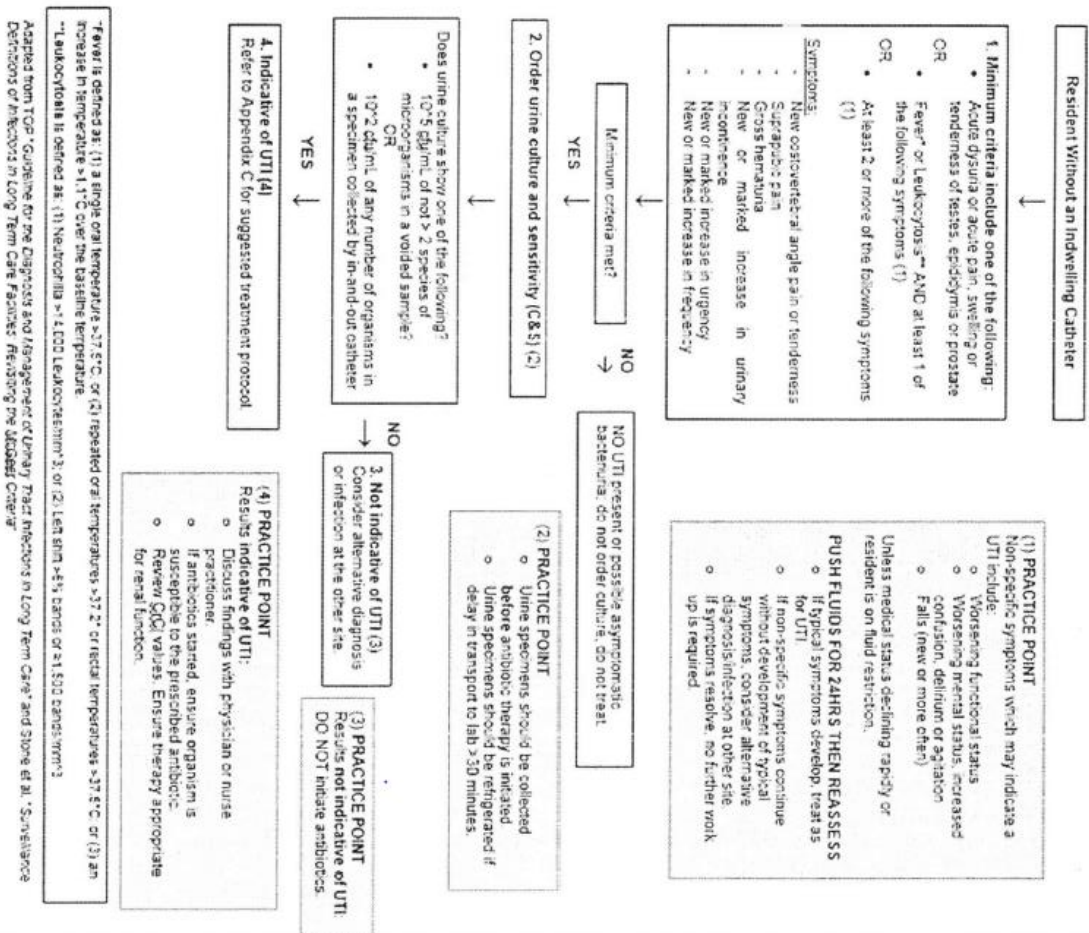
Comments:	
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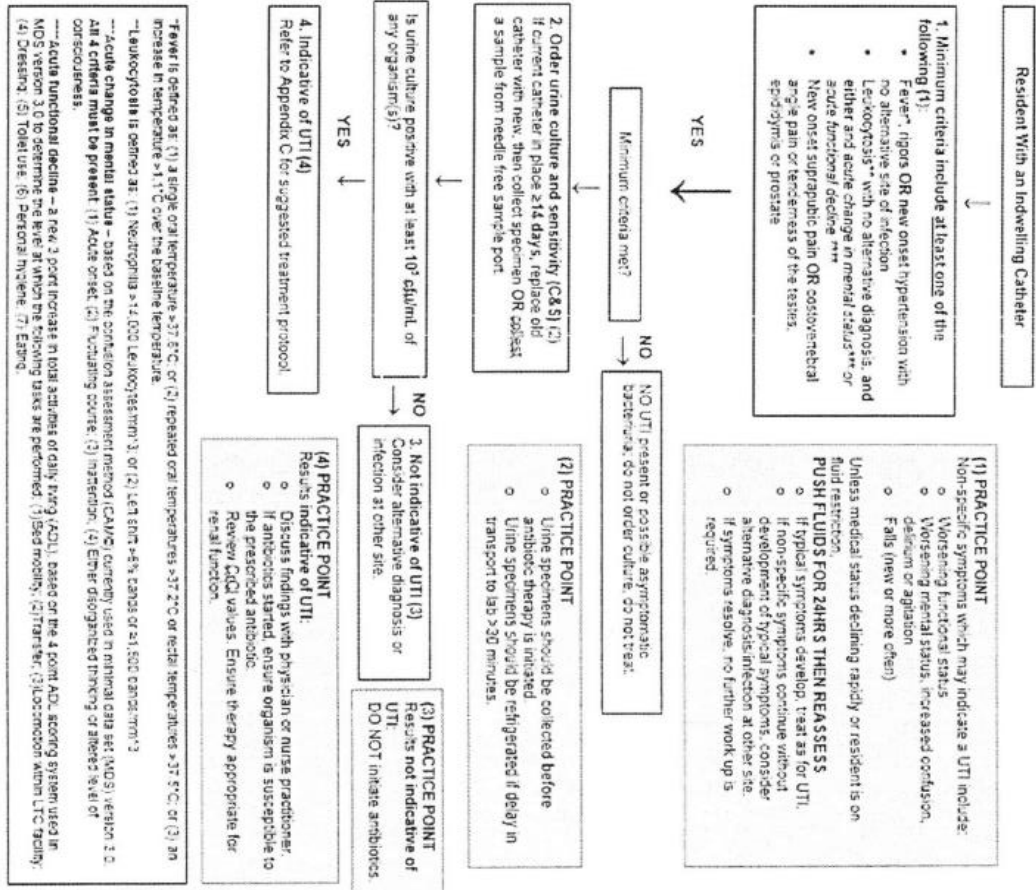
APPENDIX D-III

McGEER CRITERIA PATHWAY FOR IDENTIFICATION OF UTIs

Appendix A: Suggested Pathway for Identification of Symptomatic UTI



Appendix B: Suggested Pathway for Identification of Symptomatic CA-UTI



Appendix C: Suggested Treatment Protocols for Symptomatic Urinary Tract Infections in Long Term Care Settings

Management Issues related to Treatment of UTIs

- 1/3 of prescriptions for presumed UTI in the population are for asymptomatic bacteriuria or the presence of bacteria in the urine in the absence of urinary symptoms.
- Making a diagnosis of asymptomatic bacteriuria and deciding not to prescribe antibiotic is challenging.
- UTIs are *overprescribed* and *over-treated* in LTC.
- Older adults have decreased renal function, which needs to be considered when selecting an antibiotic.
- Generally a minimum of 7 day treatment is required. For women with lower tract symptoms, 3 days of Cipro 250mg BID is as effective as 7 days of therapy with fewer adverse effects.
- Modify antibiotic therapy if necessary once culture and sensitivity (C&S) results are available.

Treatment of Uncomplicated Symptomatic UTIs in Adults

First Line	TMP/SMX	2 tabs BID or 1 DS tab BID (1 dose if CrCl <30 mL/min)
	Trimethoprim	100mg BID or 200mg once daily
Line	Nitrofurantoin	50-100mg QID or Macrobid 100mg BID (AVOID if CrCl <40-50mL/min)
	Amoxicillin	500mg TID (500mg BID if CrCl <50 mL/min)
Second Line	Ciprofloxacin	250mg BID or 500mg XL* once daily (1 dose if CrCl <50 mL/min)
	Levofloxacin*	250mg once daily <i>250mg once daily</i>
Line	Amoxicillin/Clavulanicate*	500mg TID or 875mg BID (500mg BID if CrCl <50 mL/min)

*May require Special Auth.

Complicated Urinary Tract Infections

- Includes residents with structural or functional abnormalities such as: obstruction, chronic catheter, spinal cord injury, etc., or any UTI in men and immunosuppressed, diabetes, renal transplantation.
- Are characterized by mixed culture bacteriology and generally more resistant types of organisms.
- Recurrent infection is common (50% by 6 weeks post therapy). Consider the need to investigate any underlying abnormalities.
- Generally require longer treatment duration compared to uncomplicated UTI (10-14 days).
- Residents with catheters should not be treated unless there is evidence of systemic disease.

Treatment of Complicated UTIs in Adults

First Line	TMP/SMX	2 tabs BID or 1 DS tab BID (1 dose if CrCl <30mL/min)
	Trimethoprim	200mg BID
Line	Nitrofurantoin	50-100mg QID or Macrobid 100mg BID (AVOID if CrCl <40-50mL/min)
	Ticarcillin	400mg BID
Second Line	Ciprofloxacin	500mg BID or 1g XL* once daily (1 dose if CrCl <50mL/min)
	Levofloxacin*	500mg once daily or 750mg BID (500mg BID if CrCl <50mL/min)
Line	Amoxicillin/Clavulanicate*	500mg TID or 875mg BID (500mg BID if CrCl <50mL/min)

*May require Special Auth.

Adapted from TCP* Guidance for the Diagnosis and Management of Urinary Tract Infections in Long Term Care* and Stone et al. Surveillance Definitions of Infections in Long Term Care Facilities: Revisiting the IACSFIL Criteria*

APPENDIX D-IV

DEMENTIA OBSERVATIONAL TOOL



**LTC
Program**

DOS - Dementia Observation System

Name: _____

Use corresponding numbers to record in ½ intervals. Record all numbers that apply in each block. For example: (3,15) or (5,7). Enter additional behaviours or activities of interest. Record across all shifts for a 24 hour period for 7 days. See BPSD Glossary.

- | | | | |
|----------------------|----------------------------|--|---------------------------|
| 1. Sleeping in Bed | 5. Restless or Pacing | 9. Resists Care - Specify Type of Care | 13. _____ |
| 2. Sleeping in Chair | 6. Pain – Signs & Symptoms | 10. _____ | 14. Outing – |
| 3. Awake/Calm | 7. Aggressive - Verbal | 11. _____ | 15. Engaged in Recreation |
| 4. Noisy | 8. Aggressive - Physical | 12. _____ | 16. Visitors - |

Day/ Month/Year							
Time - hrs							
0730							
0800							
0830							
0900							
0930							
1000							
1030							
1100							
1130							
1200							
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APPENDIX D-V

INFLUENZA-LIKE ILLNESS (ILI) MANDATORY SURVEILLANCE DATA COLLECTION FORM

**Influenza-like Illness (ILI)
Mandatory Surveillance Data Collection Form**
Daily 00:00 – 24:00 Hrs

Saint Luke's
Date _____

Nursing Unit _____

Total # Patients on Unit _____

	Name	Fever > 38°C	Cough	Sore throat	Arthralgia (joint pain)	Myalgia (muscle pain)	Prostration (total exhaustion, weakness)	Antivirals	Isolation		Culture	
									Yes	No	Yes	No
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

Definitions: Fever >38°C; Arthralgia: joint pain; Myalgia: muscle pain; Prostration: total exhaustion/weakness; Obese: >30lbs overweight

Signature 0800-1600 _____

1600-2400 _____

2400-0800 _____

October 1 – April 30: complete report DAILY
May 1 – September 30: complete report WEEKLY on Wednesday

APPENDIX D-VI

GASTROINTESTINAL OUTBREAK LINE LISTING FORM

Gastrointestinal Outbreak Line Listing From

Site: _____

Nursing unit: _____

ICP: _____

Unit Contact & Phone Numbers

Manager: _____

PCC: _____

Name	Case Identification			Diarrhea			Symptoms			Specimens		Comments
				Age			Gender (M/F)			Date Onset of Symptoms (d/m/y)		
				Room #			Watery Stool			Frequency in 24 hours		
							Vomiting					
							Abdominal pain					
							Temperature					
							Myalgia					
							Other-Please Specify					
							Stool Specimen (specify date)					
							Result					

Directions for completion: Nurse in charge to complete daily during outbreaks and to include all cases on the unit. Scan or fax to ICP by 0800 hours daily.

Revised May 2015

APPENDIX D-VII

LEARNING PLAN/CONTRACT FOR REMEDIATION

What do I want to learn?	What am I going to learn?	How will I know I have learned it?	Timelines:	Impact on my practice:

Adapted from Saskatchewan Registered Nurses' Association. (2013). *Continuing competence program*. Retrieved from https://www.srna.org/images/stories/Nursing_Practice/Continuing_Competence_Program_Manual_2013_01_09.pdf

Orientee Name:

Preceptor Name:

Orientee Signature:

Preceptor Signature:

Date:

Date: