2.4 Describe how the CNO has enabled decentralized decision-making through education, facilitation, and support.

The Chief Nurse promotes professional nurse autonomy and clinical decision-making to enhance optimal patient care. The infrastructure within the Department of Nursing creates an environment that optimizes professional practice by empowering its nurses to be actively involved in decision-making. Nurses at all levels of the organization are encouraged to use their knowledge, clinical judgment and decision-making skills to improve patient outcomes.

The Patient Care Services (PCS) Professional Practice Model (PPM) supports nursing practice and clinical decision-making. The Collaborative Governance Model described in Force 2.3, provides the vehicle to facilitate decentralized decision-making bringing it closest to the bedside. The Norman Knight Nursing Center for Clinical & Professional Development provides nurses with the educational support needed to further develop and exercise their decision-making skills.

The Patient Care Services (PCS) Professional Practice Model

The PCS Professional Practice Model (PPM) as described in Force 1.1 has been developed to provide clinicians a comprehensive framework for knowledge-based practice. Developed around nine core elements: vision and values, standards of practice, narrative culture, professional development, clinical recognition and advancement, collaborative decision-making, research, innovation and entrepreneurial teamwork and patient-centeredness, it provides the structure and support to the interdisciplinary team to ensure the delivery of knowledge-based, seamless, high quality care to patients and families.

The PPM provides the foundation and direction for evaluating nursing impact on patient outcomes. It places the authority and accountability for patient care with the practicing clinicians, while linking to the strategic initiatives of the hospital, giving direct care nurses a strong role in the evaluation of patient care outcomes. Staff nurse decision-making and leadership in this process is the cornerstone of its success.

Collaborative Governance Model

Collaborative Governance is the vehicle for collaborative decision-making within the PPM. It provides a clearly defined structure for communication and collaborative decision-making processes with practicing clinicians. Its mission is: To integrate multidisciplinary clinical staff into the formal decision-making structure of Patient Care Services to stimulate, facilitate, and generate knowledge that will promote
professional leadership, improve patient care, and enhance the environment in which clinicians shape their practice. (Collaborative Governance Study, 2006)

Collaborative Governance is based on the beliefs that a shared vision and common goals lead to highly-committed and productive professionals, that participation is empowering, and that staff will make appropriate decisions when sufficient knowledge is known and communicated. Recognizing and relying on their knowledge, talent and creativity, the Chief Nurse places the authority, responsibility and accountability for patient care with the practicing clinicians who sit on the Collaborative Governance committees.

Collaborative Governance at MGH is operationalized by executive support of seven committees involving over 250 clinicians. While some committees are interdisciplinary, others are comprised solely of nurses. The following table shows the composition of each committee in 2006 and its percentage of nursing participation.

<table>
<thead>
<tr>
<th>Committee</th>
<th>RNs</th>
<th>Total Members</th>
<th>% Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversity</td>
<td>11</td>
<td>22</td>
<td>50%</td>
</tr>
<tr>
<td>Ethics</td>
<td>35</td>
<td>49</td>
<td>71%</td>
</tr>
<tr>
<td>Practice</td>
<td>50</td>
<td>54</td>
<td>92%</td>
</tr>
<tr>
<td>Patient Education</td>
<td>14</td>
<td>21</td>
<td>67%</td>
</tr>
<tr>
<td>Quality</td>
<td>25</td>
<td>27</td>
<td>93%</td>
</tr>
<tr>
<td>Research</td>
<td>22</td>
<td>23</td>
<td>96%</td>
</tr>
<tr>
<td>Staff Nurse Advisory</td>
<td>54</td>
<td>54</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>181</td>
<td>250</td>
<td>84%</td>
</tr>
</tbody>
</table>

While all of the committees engage nurses in the decision-making process, the directives of the Quality Committee and the Nursing Practice Committee highlights Staff Nurse involvement in the decision-making process. Members of the Quality Committee are responsible for reviewing findings and identifying and recommending strategies to improve patient care. The Nursing Practice Committee’s charge is to consult and approve standards of practice, approve clinical practice recommendations and approve selection of clinical products. Attachments 2.4.a and 2.4.b are minutes from a Quality and Practice meeting illustrating the decision-making process.

As Collaborative Governance has matured within the organization, an evolution has occurred with the advancement of service and unit-based collaborative governance committees. This development has helped to further support decentralized decision-making to optimize patient care.
• **Service-Based Collaborative Governance In Action**

The Medical Nursing Practice Committee, initiated in March 2005 by the Nursing Directors and Clinical Nurse Specialists from the General Medical Units, Medical Intensive Care Unit and Respiratory Acute Care Unit, is an example of nurses coming together to identify, discuss and resolve practice issues of mutual concern. Staff Nurses representing each of the above units are active members in the decision-making process of this committee. In May 2006, the committee finalized its vision, mission and guiding principles. Their vision and mission are as follows:

**Vision:** To create a professional practice environment that promotes medical nursing as a specialty through clinical excellence, research-based practice, a spirit of inquiry, and commitment to lifelong professional development.

**Mission:** To provide a forum to identify, discuss, and/or resolve issues related to nursing practice, quality improvement, and professional development.

Accomplishments of this group include the:

- Development of guidelines for giving nurse-to-nurse report between the ICU and general medical units,
- Development of guidelines for the behavioral management of patients with psychiatric and/or substance abuse problems who smoke,
- Development of one-day Medical/Surgical Certification Exam Review course for staff nurses,
- Development of 2006 Celebration of Practice - Caring for Medical Patients (attachment 2.4.c)

• **Unit-Based Collaborative Governance in Action**

In April 2005, MGH opened a four-bed Trauma Rapid Admission Care Unit (TRACU) within Ellison 7, a General Surgical Unit. This unique unit was created to assist the hospital with its capacity management efforts by helping to triage emergency room admissions. This unit provides intensive short-term observation and assessment to a select group of trauma and emergency surgical patients. Staff Nurses work directly with the Emergency Room Attending Physician to decide the appropriate patients to admit to the unit.
In 2006, as nursing practice on the TRACU evolved, a unit-based Collaborative Governance Practice Committee was formed. *Caring Headlines* (attachment 2.4.d) describes the training and orientation needs for the unit. Through the unit’s Practice Committee, the Staff Nurses organized to identify and create an orientation plan to meet their learning needs. Now, in its second year of operation, the Committee continues to meet weekly with service-based Nurse Practitioners to assess their continuing education needs that will be met through unit-based in-service programs. In 2007, the programs planned include Assessment of Pelvic Fractures, Neurological Assessment and Management and the Assessment of Delirium Tremors.

**The Norman Knight Nursing Center for Clinical & Professional Development (The Norman Knight Nursing Center)**

The Norman Knight Nursing Center collaborates with Staff Nurses and nursing leadership throughout Patient Care Services to promote clinical excellence and professional advancement by offering programs that integrate innovations in clinical practice; research, continuing education and training into patient care delivery. Under the direction of the Chief Nurse, The Norman Knight Nursing Center team are committed to creating an environment to support the *education and development* of direct care nurses and clinical staff.

Professional staff education opportunities are made available to nursing staff in an effort to advance knowledge and promote quality patient care, thus providing an atmosphere that enhances the nurse’s critical thinking and decision-making skills at the bedside. A monthly calendar of classes and grand round offerings are available to nurses throughout the year to support Staff Nurse continuing education needs. *Attachment 2.4.e* is a sample of course offerings for one month. The full calendar of classes for 2007 is in RD 8. Staff are made aware of course offerings through the on-line calendar on the Patient Care Services website, via a calendar listing in *Caring Headlines*, through electronic e-mail notices and by posted notices and announcements placed in main areas of the Hospital and on patient care units.

In addition to the many and varied continuing education classes, The Norman Knight Nursing Center has several programs designed specifically to support nurses to develop clinical decision-making skills. Two of these are the Preceptor Development Program and the Simulation Program.
• **Preceptor Development Program**

The Preceptor Development Program supports the development of critical thinking and decision-making skills for the adult learner. This program prepares professional and advanced practice nurses to serve as clinical preceptors for new nurses coming to work at MGH. The role of the preceptor is to work with a preceptee as a competent role model who is involved on a daily basis in decisions, processes and protocols of patient and unit management, and who is able to derive satisfaction from the work setting. As described in the instructor's training manual: *The program is an integral component of professional development and the Professional Practice Model at the Massachusetts General Hospital. The model supports adult learning theory within a creative learning environment as well as the development of role models for those involved in the program. New graduates, students, nurses, visitors and international guests will have clinical learning experiences facilitated by nurse preceptors who are experienced clinicians.*

Through the Preceptor Development workshop, preceptors explore the Staff Nurse roles of educator, role model, facilitator, and clinical “coach” as well as a partner in planning and guiding clinical experiences, professional socialization and role transition. Learning objectives of the program that relate to decision-making include:

1. Relate the preceptor role to the Professional Practice Model at MGH.
2. Identify five adult learning principles and their application to precepting experiences.
3. Describe strategies to facilitate critical thinking in the clinical setting.
4. Identify four critical elements of effective communication and feedback.
5. List strategies to assess competencies and learning needs of preceptees.

In 2006, 85 nurses completed the Preceptor Development workshop. Attachment 2.4.f provides the course overview described in the trainer's manual for the program. A copy of the full training manual is available on-site.

• **Clinical Simulation Program**

The Norman Knight Nursing Center’s Clinical Simulation Team has been providing educational programming for Massachusetts General Hospital (MGH) employees since 2004. The goal is to provide clinicians with opportunities to acquire knowledge and skills in a risk free, experiential learning environment in order to improve the quality of care and promote safety for the patient and clinician. Simulation is an effective tool that occurs in concert with other teaching and learning modalities. It provides the adult learner the opportunity to apply hands-on learning techniques to enhance the delivery of safe, efficient, competent, patient and family focused care.
Clinical Nurse Specialists and Nurse Educators from The Norman Knight Nursing Center partner with an interdisciplinary team of nurses, physicians and staff from Social Services, Chaplaincy, Respiratory Therapy, and Addiction Services to design and implement the currently offered programs. Each program addresses the overall themes of leadership, communication, teamwork, decision-making, and application of clinical knowledge and skills. Since its inception, 1,162 nurses have attended a simulation programming run by The Knight Nursing Center.

Programs currently offered through the Clinical Simulation Program include:

- **Simulated Bedside Emergencies for the New Nurse** - enhances the performance of the novice nurse when caring for patients who experience a medical emergency.

- **Code Blue: Simulated Cardiac Arrest for the Experienced Nurse** introduces the concepts of crisis resource management during simulated cardiac arrest.

- **Interdisciplinary Simulation: Assessment and Management of a Patient with a Change in Mental Status** fosters team communication and enhances the ability of physicians and nurses to identify, assess, diagnose, and treat patients who experience an acute change in mental status.

- **Interdisciplinary Code Team Training** introduces principles of critical event management and focuses on optimizing care for patients in cardiac arrest to participants from Medicine, Nursing, Anesthesia, Respiratory Therapy and Pharmacy.

- **New Graduate Critical Care Nurse** integrates simulation into the curriculum of the existing internship program for new graduate nurses in critical care. Scenarios are linked with lecture content and provide the opportunity to develop assessment, critical thinking and communication and teamwork skills.

In addition to these programs, special programs have been developed to address emerging organizational needs including a large influx of new graduate nurses on two general medical units and the opening of a new Trauma Observation Unit at MGH. Other programs in development will address the educational needs of staff caring for the critically ill adult, pediatric and obstetric populations at MGH.

It is clear that the Professional Practice Model and Collaborative Governance provides the infrastructure for a strong decentralized nurse-driven decision-making body at MGH. This framework along with the educational resources available through The Norman Knight Nursing Center provides and facilitates decentralized decision-making to support optimal patient care.
Nursing Practice Committee

Date: Excerpts of meeting minutes from: January 23, 2007
Time: 1:00 pm-2:30 pm
Location: Yawkey Building/ Satter Conference Room 2210
Presiding: J. Empoliti, RN; C. Mackinaw, RN; E. Riley, RN
Present: S. Ahmed, RPh; M. Bartholomay, RN; K. Boyle, RN; S. Burke, RN; C. Cain, RN; M. Callen, RN; E. Deirmendjian, RN; E. Clifford, RN; S. Cronin Jenkins, RN; E. Edwards, RN; J. Fahey, RN; S. Gavaghan, RN; J. Grana, RN; S. Haldeman, RN; M. Jeffries, RN; D. Jenkins, RN; S. Joyce, RN; S. Maginnis, RN; S. Mahoney, RN; S. Margardo, RN; C. Matthews, RN; C. McCarthy, RN; J. McCarthy, RN; S. McCarthy, RN; C. McKee, RN; N. Mermet, RN; S. Moran, RN; K. O'Grady, RN; L. Otis, RN; C. Ryan, RN; E. Salisbury, RN; M. Schaub, RN; C. Seguin, RN; N. Swanson, RN;
Absent: K. Anspach, RN; S. Ball, RN; M. Beaulieu, RN; K. Brescia, RN; M. Bryne Cabot, RN; C. Catone, RN; G. Cenzano, RN; M. Chernaik, RN; C. Cierpal, RN; G. Conklin, RN; S. Croteau, RN; L. Delisle, RN; M. Dever, RN; K. Egan, RN; K. Farrer, RN; K. Fillo, RN; F. Flaherty, RN; K. Flynn, RN; E. Gardner, RN; E. Gettings, RN; K. Gottbrecht, RN; K. Grealish, RN; M. Guanci, RN; J. Hardiman, RN; K. Hoffman, RN (Excused); K. Kalafatas, RN; C. Knauss, RN; D. Lawrence, RN; J. Lovett, RN; S. McCarthy, RN; L. Nichols, RN; E. Pelletier, RN; J. Ritzenthaler, RN
Guest: Carol Camosso, Dan Karl, Leann Otis

<table>
<thead>
<tr>
<th>Topic</th>
<th>Discussion</th>
<th>Action/Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minutes</td>
<td>Review minutes: 01/09/2007</td>
<td>The minutes were reviewed and approved with edits</td>
</tr>
<tr>
<td>Angel Slider</td>
<td>Joanne Empoliti give an overview on Angel Slider. This product is used for bed change and helps patient slide on and off the bed. It decreases the force needs to pull the patient up in bed. <em>The weight limit is approx 450 lbs</em> <strong>Important:</strong> The Angel Slider is not an incontinence pad. The goal is to improve patient and staff safety when moving patients in and out of bed.</td>
<td>Angel Slider will be used for trial. Samples are available. Joanne Empoliti at <a href="mailto:jempoliti@partners.org">jempoliti@partners.org</a></td>
</tr>
</tbody>
</table>
**Ceiling Portable Lifts**

Daniel Kerl discussed portable ceiling lifts. The use of ceiling lifts is currently being piloted on Ellison 12, Ellison 16, Blake 7. The lifts are used to help with difficult transfers of patients out of bed and decrease staff injuries sustained while lifting and transferring patients. The device comes with a sling and head holders and works with an electronic button. The sling comes in small, medium, and large.

There will be a sign out sheet on Ellison 16 available for the Portable Lift. For questions or training on this device, contact Daniel Kerl.

Dan Kerl will meet with nurse managers from each unit to discuss how the device would be shared on the units.

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**Obtaining Inpatient Weight**

- Leann Otis, RN Ellison 11. Discussed recommendations from the heart failure team regarding the inconsistency of obtaining daily weights on patients.
  - Same scale
  - Approx same time

Patient must be informed of their weight daily in comparison to their usual weight at home, goal weight, and change from the day before.

When complete, Leann will take to Cardiac Practice committee and let Nursing Practice committee know it’s complete. The Patient Weight Process will be placed in the nursing procedure manual under the guidelines section.

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Next Meeting - January 23, 2007 - 1:00pm-2:30pm

YAWKEY 2210 CONFERENCE ROOM

The full set of minutes is available for review on-site by request
~ A Celebration of Practice ~
Caring for Medical Patients

Wednesday, November 15, 2006

Featuring
Patricia Benner, RN, PhD, FAAN

“The Art and Science of Medical Nursing as Viewed Through the Clinical Narrative”
O’Keeffe Auditorium | 10:30 am - 12:00 pm
Contact Hours Awarded

“Managing Complex Patient Care: Through the Lenses of the Interdisciplinary Care Team”
O’Keeffe Auditorium | 12:45 pm - 2:00 pm

Poster Sessions
White One Corridor | 8:00 am - 2:00 pm

Massachusetts General Hospital (ONA 239) is an approved provider of continuing education by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation (OBN-001-91). Provider status valid through 10/01/08.
Innovative Care

The TRACU: making a difference one year later

—by Marian Wilson, RN, and Donna McKee, RN

In April of 2005, MGHI opened a four-bed Trauma Rapid Assessment Care Unit (TRACU) on Ellis 7. The TRACU is managed by Theresa Capodilupo, RN, nurse manager for the surgical units on Ellis 7 and White 7, and staffed by nurses from both units. Patients are referred to the TRACU from the Emergency Department (ED), from other units throughout the hospital, from community hospitals, and from other states and countries. Most admissions to the TRACU are planned, but trauma is not a predictable event so accommodating an influx of trauma patients can be challenging. Trauma patients require frequent monitoring and assessment. Once they're stabilized in the ED, they have to be moved to another venue to make room for other critically ill patients. That's where the TRACU comes in.

The concept of a trauma rapid assessment care unit is relatively new. Associate chief nurse, Jackie Somerville, RN, had heard about units in other hospitals created specifically to help decompress the ED and provide intensive, specialized care to trauma patients. Somerville and chief of Surgery, Andrew Warshaw, MD, enlisted the aid of George Velmahos, MD, a physician experienced in developing such units and met with him to strategize about how to create a TRACU at MGHI.

Space was allotted on Ellis 7; a budget was provided; new equipment was purchased; criteria and protocols were set; and training was initiated. Velmahos is the attending physician for the unit, which is now staffed 24 hours a day, seven days a week.

Staffing in the TRACU is determined by a number of factors, including patients' acuity levels, the experience of the nurses at the bedside, and the staffing needs on White 7 and Ellis 7. Training for nurses includes one year of nursing experience, training on a specialized computer program with follow-up testing; a four-hour mentoring session in the Surgical Intensive Care Unit (that includes care, monitoring, and setting up arterial lines) and a mentor orientation program in the TRACU. Mentoring can last from one to three days depending on the needs of the nurse.

Training includes orientation to the new telemetry system; travel monitors; vital sign protocols; neurological and CSM checks; and phlebotomy, admission, and traveling procedures. Traveling with patients is a frequent occurrence. Patients may need diagnostic, surgical intervention, or to be transferred to an ICU. Traveling protocols require patients to be moved with a nurse, telemetry, oxygen, Ambu bags, AED, and when necessary, a doctor.

Following is an example of a patient we might see in the TRACU. A 19-year-old young man with multiple gun-shot wounds is transferred from the ED. He has been shot 11 times and still has seven bullets in his body. One entry wound is in his face, four bullets are lodged in his thigh, one in his lower back, one in his groin, and one in his left buttock. He has numerous bullet fragments throughout his body. Remarkably, he sustained no major injury to his vital organs.

He arrives awake, alert, and able to move all extremities. He is breathing on his own and able to maintain good oxygen saturation. His vital signs are stable and after numerous CT scans, it's determined that he doesn't meet the criteria to be placed in an ICU, but he isn't stable enough for a patient care unit. This patient needs to be monitored closely for 24 hours for changes that could be life-threatening. Hemodynamic monitoring, including full-body and respiratory assessment, needs to be done.

continued on page 7
Clinical Narrative
continued from previous page

She had already received several blood transfusions and the bleeding was getting worse.

Amicar is a hemostatic agent that works to form clots. I’d learned about it during ECMO training. I thought amicar might be able to control, or at least decrease, the bleeding. Concerned about the amount of blood Abbie was losing and the number of transfusions she’d had, I paged the pediatric surgeon on call. We discussed auto-transfusing, which involves collecting the patient’s lost blood and re-infusing it back to the patient through sterile technique. Setting up an auto-transfusion takes time, so I suggested amicar. We discussed the risks and benefits. The physician agreed it could help the situation and we should try it in conjunction with auto-transfusing.

Keeping in mind the risks associated with amicar, we started the infusion at 9:00. By the end of my shift, Abbie’s bleeding was under control, and by the end of the next shift it has stopped completely.

With Abbie’s bleeding under control, we could focus on maintaining her ECMO support while her lungs hopefully healed. With the help of the clinical team—many doctors, ECMO specialists, and nurses—Abbie slowly improved and was soon able to come off ECMO. She remained on conventional ventilator support for several more days until her lungs were healthy enough to support her respiratory needs. Eventually, she was taken off the ventilator and gradually improved in her own time.

Though I took care of Abbie for more than a month, my only memory of her awake was when she first arrived. I learned about her through the countless hours I spent at her bedside with her and her parents. I grew to adore Abbie, often looking at her picture and wondering when she’d finally speak again. Sometimes, I wondered if she’d ever speak again. There were days when I would hug her parents, leave for the day, and pray and cry for her and her family.

My favorite memory of Abbie came about a week after the ventilator was removed. I would visit her every day when I worked, but she hadn’t spoken in over a month, and now that she could, she was afraid to. Still, I visited her, played games with her, and just tried to make her laugh. But still, no words. Until one day, I poked my head into her room, and her mother asked me, “Abbie, what do you have to say to Christine?”

She looked at me with those pigtails and big, beautiful eyes, and said, “Thank you.” Those were the most beautiful words I had ever heard.

Comments by Jeanette Ewen Erickson, RN, MS, senior vice president for Patient Care and chief nurse

Christine’s considerable knowledge and skill are as evident in this narrative as her compassion for Abbie and her family. Abbie’s respiratory status changed rapidly soon after her arrival and continued to change throughout her hospitalization. Christine’s knowledge of complex respiratory management and her intuitive grasp of Abbie’s changing status played a pivotal part in Abbie’s care.

Once Abbie was put on ECMO and had a chest tube placed, Christine provided vital input on how best to manage her bleeding issues. And amid all those critical decisions and interventions, Christine managed to provide support and reassurance to Abbie’s family.

Thank you, Christine.

The TRACU
continued from page 4

hourly for signs of bleeding, infection, airway distress, or cardiovascular shock. He is placed on spinal cord precautions with a C-collar and requires hourly neurological assessment to rule out spinal cord changes due to a displaced C1 fracture. The potential for compartment syndrome in his thigh is extremely high and requires hourly vascular checks including PVRs. The patient and his family have emotional and safety concerns so many disciplines are involved in his care including Police, Security & Outside Services, Case Management, Physical Therapy, and Social Services.

By admitting this patient to the TRACU, he has need for continuous observation and monitoring. Any subsequent need for immediate medical or surgical intervention can be implemented quickly. After 24 hours in the TRACU, he is transferred to a unit. His entire hospital stay is four days before being discharged home.

In this case, not only were the patient’s needs for intensive monitoring and stabilization met by being admitted to the TRACU, his length of stay in the ED and the hospital were reduced enabling the ED and the ICU to accommodate other patients.

The goal when we opened the TRACU in 2005 was to decrease the length of stay in the ED, decrease the length of stay in the hospital, provide quality care in the most appropriate setting, and save healthcare dollars. Based on TRACU statistics for the last year, we are meeting our quality-care goals and improving cost effectiveness.

Says Capodilupo, “The volume of patients in the TRACU has not changed dramatically over the past year, but the acuity level has—it’s much higher. That’s because clinicians are using our services appropriate and sending us only their most acutely ill patients.”

Currently, the Four-bed TRACU admits trauma patients who are cared for by a team of trauma residents, specialized trauma nurse practitioners, and specially trained nurses.

Capodilupo’s vision for the TRACU is to acquire more specialized equipment, train more ACLS-certified nurses, and offer training in adjunctive therapy, such as endotracheal ventilation, isotonic and sedative drug therapy. The goals remain the same: make beds available to help decrease the ED centralize expert trauma nursing care, and provide high-quality care with limited healthcare dollars. A year after its inception, the Trauma Rapid Assessment Care Unit is making a difference in the lives of our patients and in the quality of care provided at MGH.
<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>1) Assessment and Management of the Patient at Risk for Injury</td>
<td>2)</td>
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<tr>
<td>5)</td>
<td>6)</td>
<td>7) Greater Boston ICU Consortium Core Program Day 1</td>
<td>8) Norman Knight Preceptor of Distinction Award</td>
<td>9) ACLS Provider Course Day I</td>
</tr>
<tr>
<td>12)</td>
<td>13) BLS (CPR) Certification Healthcare Provider</td>
<td>14) Wound Care Education Day II</td>
<td>15) Pain Relief Champion Day I</td>
<td>16) Pain Relief Champion Day II</td>
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<td>26) Greater Boston ICU Consortium Core Program Day 6</td>
<td>27) ANCC Medical Surgical Nursing Certification Prep Course Day II</td>
<td>28) New Graduate RN Development Seminar II</td>
<td>29) BLS (CPR) Age-Specific Mannequin Demonstration</td>
<td>30) BLS (CPR) Heart Saver Certification, Coronary Syndromes, Basic Respiratory Nursing Care</td>
</tr>
</tbody>
</table>
Preceptor Instructor Manual

Program/Course Overview

**Morning**

- Introduction/Objectives
- Preceptor Survey
- Our Professional Practice Model
- Preceptor Roles and Responsibilities
- Preceptorship as a Process
- Adult Learning

**Afternoon**

- Learning Theories/Styles
- Determining the Preceptee’s Learning Needs
- Planning the Learning Experience
- Implementing Learning Plans
- Evaluating Performance
- Preceptor Development: Next Steps