Creating a Unit-Based Resource Nurse Program

A hospital program develops clinical experts to foster best practices on every unit.

Holy Name Medical Center is a 361-bed Magnet-designated community hospital in northern New Jersey. Having knowledgeable experts available to guide nursing practice is integral to our model of care and is consistent with the guiding principles of the Magnet program. The chief nursing officer and other nurse leaders use the input of nurses at all levels, as well as organizational and departmental goals, to define what resources are needed and to develop a plan to acquire them.

Recognizing that not all nurses are specialists in every aspect of nursing care, Holy Name established a resource nurse program to address specific needs that had been identified in different practice areas. Here, the resource nurse is considered a clinical leader; the role is designed to enhance clinical expertise and to provide peer support and peer review. The resource nurses support other providers in clinical problem solving, clinical decision making, and critical thinking. They assist in the implementation of evidence-based practice, exemplify the role of the nurse as teacher, and serve as mentors to both patients and colleagues. They also help Holy Name meet Joint Commission quality requirements, American Nurses Credentialing Center Magnet requirements, and requirements of other quality initiatives related to various specialties.

In 2001, Holy Name initiated its first resource nurse role: pain resource nurse. Since then, the hospital’s resource nurse program has grown to include skin care and diabetes resource nurses. There are now over 80 resource nurses. Each clinical area has one pain and one diabetes resource nurse, and each unit has one skin care resource nurse per shift.

The resource nurses are expected to develop increased expertise in their specialty areas to both improve their own practice and mentor their colleagues. Each resource nurse’s practice is determined according to the needs of her or his specific unit and is supported by both hospital-wide and unit-based education, walking rounds, development of educational materials, and evaluation of outcomes. Because their practice isn’t dictated by others, the resource nurses know that when they identify an issue, they have the authority to act on it.

The long-term success of their initiatives is partly because they have taken on the responsibility for integrating the best practices of their specialties into their respective units.

The financial constraints of a community hospital provided another rationale for the adoption of this model. We’ve been able to implement a program that’s met the needs of our patients and increased the satisfaction of our staff—all by making a cost-effective investment in developing the expertise of current staff members rather than adding new staff members; and resource nurses receive financial support from the administration for ongoing in-service education, attendance at conferences, and work time spent managing quality initiatives. Not only have the quality outcomes been impressive, but the investment has paid off in staff retention and satisfaction. As measured by the National Database of Nursing Quality...
Indicators (NDNQI; for more information, visit www.nursingquality.org), staff satisfaction has been in the “high satisfaction” range for the last three years, with an overall job enjoyment T score of 60.63 and a response rate of 76%.

THE LITERATURE
The literature on resource nurses is limited. While mostly reflecting positive experiences with resource nurse models, it is largely anecdotal or descriptive. In general, the literature describes resource nurses as unit-based staff nurses who are trained and recognized as resources for certain complex, discrete, and common medical and nursing problems. The use of resource nurses to prioritize care for specific patient populations may improve patient outcomes and is widely seen as providing professional growth and job satisfaction for the staff nurses who function in this role. These staff nurses are direct care nurses who, because they have the most contact with patients, may be better able to improve processes and outcomes related to complex nursing issues. A description has been published of this model’s use with diabetes patients,1 and the model was also adopted in the early 1990s to train oncology nurses in managing pain in cancer patients.2 The use of geriatric resource nurses was a well-received component of the Nurses Improving Care for Healthsystem Elders (NICHE) initiative.3 And the Visiting Nurse Service of New York has demonstrated cost savings related to wound care after implementing a wound care team that comprised interested staff nurses (not called “resource nurses” but having a similar role) who received training and guidance from a certified wound, ostomy, and continence nurse (CWOCN).4

Anecdotal reports in the literature state that continuing education and support for the resource nurse role have been shown to increase nurse competence and improve patient outcomes in geriatric patients,3, 4 facilitate the implementation of evidence-based practice protocols through collaboration with advance practice nurses and academic partners,5 and improve nursing satisfaction by promoting increased autonomy.6

IMPLEMENTATION
Resource nurses are direct care RNs who are on staff. They carry a regular patient assignment on their unit and provide side-by-side consultation to their...
peers. Seen as the “go to” nurse for their specialty, each resource nurse receives intense education (described below) in a specific content area and ongoing support from nursing administration. There is no formal educational requirement to be a resource nurse; at Holy Name, resource nurses range from diploma graduates to those with a master’s degree. The key requirement is a high level of interest in developing and expanding not only their professional expertise, but also that of their peers.

The quality of an RN’s relationships with colleagues also influences whether she or he will be chosen for this designation. It’s important that participation be considered an honor, not a burden. The program depends on unit leaders allowing these candidates adequate time to complete the required educational programs and to participate in the evaluation of quality outcomes. Each resource nurse program is designed to include specialty-related education, mentoring, and participation in quality outcomes directed at the needs of specific patients on the individual units. Each program has a sponsor from either nursing management or the clinical practice specialty itself (for example, a wound care nurse or a certified diabetes educator). The sponsors meet with the resource nurses quarterly, or more often if necessary. They assess the continuing learning needs of the resource nurses, present clinical updates, and review outcomes data.

The resource nurses use the sponsors as mentors when developing individual unit projects. One skin care resource nurse developed a PowerPoint presentation for her unit on preventing pressure ulcers and subsequently copied the presentation onto a CD-ROM for the other skin care nurses to use in their unit education. The hospital evidence-based practice council sponsors an annual “Day of Inquiry.” This is a two-day poster symposium for which each unit is invited to submit abstracts and create posters outlining research- or evidence-based practice changes. Resource nurses from each specialty submit several posters highlighting their roles and accomplishments.

First steps: pain management. The resource nurse program at Holy Name was initiated to provide more effective pain management–related care. In 2001, the integration of pain as the fifth vital sign focused attention on nurses’ roles in pain management. Struggling to gain staff compliance with an evolving approach to pain management and with required changes in the documentation of pain reassessment, the directors of clinical education and oncology developed a comprehensive plan to address these shortcomings. This led to the inception of the pain management resource nurse program. A two-day course was scheduled that included staff education related to pain, teaching skills, and outcome evaluation, the goal of which was to prepare the resource nurses to participate in data collection, evaluate the practice on their respective units, and share their knowledge with their colleagues. The education component also included a review of the changes in documentation and an increased awareness of the nature of pain and of patient rights in relation to pain management. The participants were provided with outlines to use for unit-based education and a pain-related performance-improvement plan. Regular meetings were held with the resource nurses following the course to help mentor their work and to promote networking among unit experts to share ideas and pitfalls.

Next steps. Following an evaluation of the pain resource nurse program and its success in improving compliance with documentation and increasing unit-based education related to pain management, we identified additional areas requiring focused attention.

Skin care. Analysis of outcomes data related to pressure ulcers led us to expand the use of resource nurses to skin care. This expansion of the model of unit-based experts and peer education was a perfect fit. The skin care program was developed by a CWOCN in 2003 in collaboration with nursing administration, medical staff, and pharmacy. At that time, the prevalence rate of hospital-acquired pressure ulcers at Holy Name averaged 10 per 1,000 patient-days, a figure that was higher than the national benchmark and certainly not within the parameters of excellence that the hospital wished to attain. The staff expressed a need for additional expertise in managing skin care, and nursing administration supported the designation of a nurse from each shift on each unit as the skin care resource nurse. These nurses function as an extension of the CWOCN and consult.
with their colleagues on pressure ulcer prevention, identification, and treatment. They also participate in the quarterly prevalence and incidence measurements on their respective units and take personal ownership of the outcomes.

**Diabetes care.** The next area for the expansion of the model was in the care of patients with diabetes. The need for a diabetic resource nurse program was determined during the annual assessment of staff educational needs. Additional education on diabetes, a comorbidity that affects many patients, was needed across all specialties. Since their inception, diabetic resource nurses at Holy Name have implemented a consistent approach to patient teaching, especially of newly diagnosed patients. Sponsored and mentored by RNs who are certified diabetes educators, the diabetic resource nurses have helped to increase the number of referrals to the diabetes self-management outpatient program. They also work in collaboration with physicians to ensure that patients are referred for follow-up care. Most recently, the diabetic resource nurses on one unit presented comprehensive education for their annual skills day. It included posters, education material for both staff and patients, and a demonstration of the insulin pens used by some outpatients.

**Skin care outcomes.** The skin care resource nurses collaborate with the CWOCN in prevention and treatment of pressure ulcers. They lead the quarterly skin care incidence and prevalence initiative and collect, analyze, and evaluate the data to measure their performance. They participate in skin care rounds with the patient care technicians to help them recognize the importance of proper positioning and frequent turning of their assigned patients. They make weekly rounds with the CWOCN and with education specialists on units whose patients are at high risk for skin breakdown, and based on the outcomes of these rounds they’re able to assist their peers in planning care for these patients. The mean prevalence rate of hospital-acquired pressure ulcers on medical–surgical units went from 10 per 1,000 patient-days before implementation of the skin care resource nurse program to the current NDNQI prevalence rate of 2.17 per 1,000 patient-days. Although some areas of the hospital have seen a spike in pressure ulcer prevalence due to patient acuity, no hospital-acquired pressure ulcers have been seen in many parts of the medical–surgical division.

The wound care resource nurses’ most recent initiative is the evaluation of equipment, with a focus on choosing new mattresses for the inpatient units. Since the cost of rental beds has increased, they’ve been working with the CWOCN to establish criteria for the use of specialty mattresses. In addition, the resource nurses in the ICU are working on an evidence-based project to further reduce the incidence of hospital-acquired pressure ulcers. The ICU is also participating in a research study on early mobility of ventilator patients and its effects on improving patient outcomes, including the prevention of skin breakdown.

**Pain management outcomes.** In 2008, the pain resource nurses were challenged by the issue of nurses not documenting pain reassessment after the administration of pain medication. The issue was discussed at a meeting

Outcomes of resource nurse programs reported in the literature, such as increased nurse competence and improved patient outcomes, have also been seen at our facility.
of the professional practice council, which grasped its significance and agreed to work with the pain resource nurses to increase compliance with documentation. Both groups suggested that the hospital investigate the possibility of using an automatic prompt from the electronic medication administration record (eMAR) system to remind nurses to reassess the patient after the administration of pain medication. This issue was brought to the attention of the hospital’s information technology department, which was working on the development of a clinical task manager system as a component of the electronic clinical support system.

Based on nurse input, the information technology department developed a pain reassessment system. Prior to administering medication, the eMAR system prompts the nurse to enter the pain score, pain location in the body, and pain quality. An alert is automatically set, displaying a “pre-due” pain reassessment icon. The nurse can access the reassessment screen through the icon and record the patient’s pain score. If a pain reassessment isn’t recorded within 55 minutes, a reminder page is sent to the nurse’s pager to reassess the patient. At the beginning of the pain resource nurse program, the reassessment compliance rate was an unacceptable 44%; now it’s over 95%, and has been sustained at this level for more than two years, thanks to the efforts of the pain resource nurses.

**Patient education.** The pain resource nurses also worked with their colleagues to create and evaluate new patient education materials. The need for new materials was championed by a resource nurse who’d observed that the pain handouts given to patients upon admission contained insufficient information about pain, perceptions of pain, and pain relief. She recognized the importance of making information concise and easily understandable to both patients and their families. She revised the handouts and worked with the patient education council on the format. The new pain handout now included in the welcome folder every Holy Name patient receives. The pain resource nurses also participate in chart review to measure their unit’s progress in reaching the hospital’s goals. This form of peer review enables them to communicate results directly to their peers in a nonthreatening, collaborative way.

The pain resource nurses continue to be an active group. They present their unit outcomes at quarterly meetings and have helped to improve patient satisfaction scores related to pain management. The oncology unit, for example, embraced a patient satisfaction project led by the unit director and the pain resource nurses. Nurses had been responding quickly to patients’ needs for pain medication, but patient satisfaction scores didn’t reflect their efforts. In response, nurses designed an evidenced-based tool to assess patients’ expectations about postintervention pain levels; this tool allowed both nurses and patients to subsequently determine whether or not they’d met their pain goal.

**Choosing a pain assessment tool.** The pain resource nurses’ most recent achievement has been the adoption of a new evaluation tool for the pain assessment of nonverbal patients, a project initiated by the pain resource nurses and two administrative directors, who received help from a doctoral student at a nearby university. The pain resource nurses decided which assessment tools to pilot and on which units to do so. They eventually chose the stroke unit, the geropsychiatric unit, and two medical–surgical units where the staff was passionate about the project. Once a tool had been decided upon because of its reliability, ease of use, and fit with existing pain measurement procedures, it was implemented throughout the hospital. The staff looks forward to its subsequent evaluation.

**Diabetes education outcomes.** The diabetes resource nurses have increased referrals to the outpatient diabetes self-management
program by 37%. This improvement suggests that the staff’s emphasis on patients and the importance of follow-up has been effective. The opinions of the staff are one of the best measures of the success of the resource nurses. Linda Toth, RN, a diabetic resource nurse on one of our units, puts it this way:

The role of the diabetic resource nurse is woven into the fabric of our daily practice. Every communication with patients is an opportunity for teaching and a step toward disease prevention through education. As a diabetic resource nurse, I take great satisfaction in the learning my patients achieve and see it as progress toward our goal of prevention through education. My peers come to me often as the content expert on diabetes. I am able to mentor them and help them hone their diabetes teaching skills. I see it as a win–win; I’m able to help both my patients and my peers.

In an initiative on one unit, the diabetic resource nurses presented clinical skills days on diabetes. Using evidence-based literature, they designed an educational poster, distributed a series of articles to each staff member, and had insulin pens available so the staff could familiarize themselves with them. The pens aren’t typically used in this hospital, but the staff on this unit had seen an increase in patients using them at home. Such training enables the staff to be more knowledgeable if patients have questions about any equipment they might use after discharge.

The diabetes resource nurses also provide crucial input to the certified diabetes educator during her participation in failure modes and effects analysis of hospital-wide insulin safety procedures.

REWARD AND RECOGNITION
Resource nurses receive no differential or additional pay; however, they cite their activities as one component of the achievements they demonstrate in the division of nursing’s five-level professional excellence program (career ladder). This program provides nurses added incentive to engage in organizational initiatives and quality outcomes—and financial rewards for those who meet the requirements. The resource nurses demonstrate real-time peer review and mentoring as they develop their clinical expertise.

Reflection of hospital focus on nurse autonomy. In addition to the clinical outcomes realized by the nurse resource program, the consistently high nursing satisfaction scores for all nurses (including resource nurses, who are approximately 15% of nurses at the hospital) reflect the professionalism and level of autonomy at Holy Name. Staff nurse satisfaction scores in all categories continue to be at or above the national NDNQI mean. Evidence of nursing staff autonomy beyond the resource nurse program was demonstrated recently when there was a vacancy in the CWOCN position. The staff on the surgical unit did “traveling rounds,” complete with posters, handouts, and colostomy care equipment, to their colleagues on other units. They took responsibility to teach their peers about wound care and to maintain the care, comfort, and skin integrity of patients with colostomies.

GOING FORWARD
The resource nurse program, which started in 2001, has now shown 10 years of progressive, sustained improvement. While the structure of the program provided its foundation, the autonomy and commitment of the nursing staff are the keys to its continued success. The model has become so much a part of the culture at Holy Name that several units are developing their own programs. The resource nurse role supports staff RNs in practicing with evidence-based knowledge and skills. Resource nurse areas of concentration provide a foundation for practice, quality improvement initiatives, and ultimately, nursing research. ▼

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