Executive Summary and Evidence-Based Recommendations

- **Executive Summary:** The evidence promotes the development of a philosophical framework of education to fit the needs and cultures unique to each organization and medical center. Once created, this educational philosophy can be used to design individualized educational models, structures and processes for hospital-based educational programs. Critical elements of the evidence include the following:
  - A philosophy of hospital wide education, rather than a single rigid educational model, allows a more holistic approach to organizational learning.
  - High performing education departments play an essential role in creating an organizational culture of learning.
  - A combination matrix for an educational and development model maximizes the benefits and minimizes the limitations of centralized and decentralized structures.
  - Varying degrees of centralization may be appropriate.

Based on the reviewed evidence, the following recommendations are offered for consideration:

- Rethink the hospital-wide education as a philosophy rather than as an organizational model.
- Ensure the educational mission and outcomes are carefully aligned with all aspects of the organizational strategic plan.
- Develop a holistic educational program that is responsive to the educational needs of the entire organization, including nonclinical areas.
- Embed the systems, processes, resources, and time needed to support the educator’s role, responsibilities, delivery of quality hospital wide education, and maintenance of a documentation repository of educational offerings.
- Maximize resources and meet organizational/personal learning needs by creating hospital wide educational programs that use an integrated systematic approach and incorporate the following components:
  - Develop a strategic plan to market and expand visibility.
  - Seek, recognize, embrace, and respond to forces of change.
  - Maintain a realistic perspective.
  - Create the infrastructure needed for organizational and personal learning.
  - Identify new and existing hospital-wide customers and respond to their educational needs.
  - Determine functional responsibility and provide support to personnel with educational functions, with a description of their range of authority and responsibility.
  - Identify and effectively use formal and informal communication networks from all levels of the organization.
  - Establish credibility by supporting the strategic priorities of the organization.

**Conclusions:** An educational philosophy provides the vision, meaning and goals needed to develop an education delivery model that meets learning needs from the nursing staff to organizational leadership while also supporting the strategic plans of the institution. This philosophical vision will guide the development of quality educational delivery programs regardless of health care system, size, or culture.
## PHILOSOPHY OF EDUCATION

### Definition:
A hospital-wide education program.
- Achieves organizational learning through research and development; evaluation and improvement cycles; work force, patient, and other stakeholder ideas and input; best practice sharing; benchmarking; and evidence-based practice.
- Promotes individual learning and growth through education, training, and developmental opportunities while also updating skills in all jobs.

### CONCEPTS

#### Rethink the hospital-wide education as a philosophy rather than as an organizational model.
- Develop a holistic educational program that is responsive to the educational needs of the entire organization.
- A combination matrix for a educational and development model maximizes the benefits and minimizes the limitations of centralized and decentralized structures:
  - Varying degrees of centralization may be appropriate.
  - One person does not necessarily direct all educational activities.
  - Education and development models de-emphasize territory, power plays, and reporting issues by demonstrating how to best get the work done.

#### New hospital wide education programs maximize resources and meet organizational/personal learning needs by addressing the following areas:
- Seek, recognize, embrace, and respond to forces of change.
- Maintain a realistic perspective.
- Create the infrastructure needed for organizational and personal learning.
- Identify new and existing hospital-wide customers and respond to their educational needs.
- Determine functional responsibility and provide support to personnel with educational functions.
- Outline the range of authority and responsibility.
- Identify and effectively use formal and informal communication networks from all levels of the organization.
- Establish credibility.
- Develop a strategic plan to market and expand visibility.

### PROCESS

Philosophy of hospital wide education does not solve all problems of reorienting educational programs.
- There is a lack of agreement among those describing the new function as inevitable because organizations facing differing kinds of needs must respond to them with differing types of programs.
- Diverse forms of managerial processes are needed to respond to diverse organizational needs, which are influenced by facility size, dissimilar types of communication, variable accountability mechanisms, and different manpower issues.

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Created by Jasper Diaz, RN, BSN and Cecelia L. Crawford, RN, MSN, DNP(c), Kaiser Permanente SCAL Nursing Research Program, April 2012
**RECOMMENDATIONS**

<table>
<thead>
<tr>
<th>Ensure education mission and outcomes are carefully aligned with all aspects of the organizational strategic plan(^2,4,5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use the forces of change to survive and thrive(^5,6)</td>
</tr>
<tr>
<td>o Identify global organizational needs by regularly meeting and communicating with departmental directors, committees, QI department, and accreditation administrator(^5,6)</td>
</tr>
<tr>
<td>o Develop relationships with existing and new customers in the organization(^5,6)</td>
</tr>
<tr>
<td>o Spend time implementing effective programs rather than drawing lines in territorial power plays(^6)</td>
</tr>
<tr>
<td>• Base programs on reliable communications from all levels of the organization(^3,6)</td>
</tr>
<tr>
<td>• Exploit problem areas as opportunities to create better educational programs(^5)</td>
</tr>
<tr>
<td>• Enable educators to maximize the equipment and resources from both the nursing and education departments(^2,6)</td>
</tr>
</tbody>
</table>
CLINICAL EDUCATION DELIVERY: AN INTEGRATIVE REVIEW

TOPIC SUMMARY OF THE EVIDENCE

“What is the quantity, quality, and consistency of the evidence for standardized clinical education delivery in the acute care hospital setting?”

<table>
<thead>
<tr>
<th>Centralized Educational Delivery Model</th>
<th>Decentralized Educational Delivery Model</th>
</tr>
</thead>
</table>
| **Definition:** A centralized hospital-wide education program exists whenever the education and training functions of an institution are centralized under one director and departmental lines are crossed in a collaborative effort to identify and meet educational needs:  
  - Responsibility for continuing education and updating skills in all jobs is lodged in a central office rather than in various departments  
  - Central accountability and functional responsibility for education that is clearly defined allows the coordinating and combining of institutional education resources to afford maximum benefits to the entire institution |
| (Reviewers were unable to locate literature describing a decentralized unit-based education model based solely within clinical specialties. The evidence in this table describes decentralized educational delivery models that are hybrids. These hybrids consist of a centralized education department incorporating the use of decentralized clinical educators who support various clinical areas) |
| **Characteristics** of effective educators working in centralized hospital education departments:  
  - Flexibility  
  - Openness  
  - Creativity  
  - Friendliness  
  - Communication  
  - Enthusiasm  
  - Visibility  
  - Consultative  
  - Facilitative  
  - Expert in systems thinking, program development, project design, and management  
  - Willingness to challenge old ways |
| **Structures:**  
  - Formalized, centralized, and coordinated hospital wide education and training that is directed toward the needs of the total organization and provides orientation, in-service, training, and CE for all employees  
  - Centralized education department focuses on centralized classes such as:  
    - New employee orientation  
    - CPR  
    - CE seminars  
    - Broad topics such as disaster planning  
  - Some functions may need to be centralized |
| **Processes:**  
  - When a major reorganization such as decentralization is in progress, flexibility is the key to success  
  - Lines of communication must remain open, with clarity of role responsibility  
  - “When everyone is responsible, then usually no one is.”  
  - Address specialized learning needs in various patient care areas  
  - All people involved in staff education should know what others are planning |

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CLINICAL EDUCATION DELIVERY: AN INTEGRATIVE REVIEW

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“What is the quantity, quality, and consistency of the evidence for standardized clinical education delivery in the acute care hospital setting?”

Centralized

- Central education department to keep a central calendar of ALL classes given in the hospital
- Any educational materials, text, equipment, manikins, etc., should be approved for purchase by a central committee to control duplication and inappropriate resource use
- All forms to be reviewed and approved by ONE committee before use; forms to be used in the same way on all units

Centralized education uses standardized structures such as:

- Standardized templates to provide continuity across multiple nurse planners
  - Planning documentation
  - Participant materials
  - Faculty forms
  - Checklists for documentation retained in file
  - Class outline, set of behavioral objectives, and a sign-in sheet filed
  - Easily requested by reviewing bodies such as The Joint Commission
  - Provides quality assurance

- Resource manual with in-depth policy and procedural information
- Competence workbook with topic areas based on identified assessed learning needs and audit results
- Secure website with resources readily accessible to all nurse educators located and the administrative staff who support the activities
- Data management systems for data storage, management, and analysis
  - Learning management system to track class and participant data
  - Other local-level tools

Outcomes

- Development and maintenance of clinical competence is imperative in the delivery of high-quality health care

Advantages

Management:

- Facilitates mentorship with maximization of central leadership, educational specialists, and resources
- Increased autonomy of individual practitioners
- Identification of and timely response to individual unit needs
- Increased flexibility and coordination of efforts
- Enhanced support for education
- Educators grasp the “corporate picture” that brings perspective to their work
- Unit-based clinical experts assisting in the implementation of new knowledge at the practice level

Format:

- Fulfill corporate priorities amidst significant change
- A positive, growth-producing experience which is kept productive by constant system evaluation and its outcomes
- Efficiencies with projects that cross several clinical areas and the entire organization
- Customization and implementation at the program level
- Identification of knowledge and skill needs of nonclinical areas
- Reduced silo effect
- Structures and processes to manage and support educators

Collaboration:

- Improves communication, sharing of ideas, collaboration with other staff educators, and use of organizational education resources
- A valuable resource in the continual improvement of technical, thinking and interactive skills
- Increased learning, involvement and teaching at the bedside
- Increased use of expertise

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CLINICAL EDUCATION DELIVERY: AN INTEGRATIVE REVIEW

TOPIC SUMMARY OF THE EVIDENCE

“What is the quantity, quality, and consistency of the evidence for standardized clinical education delivery in the acute care hospital setting?”

<table>
<thead>
<tr>
<th>Processes:</th>
<th>Disadvantages:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Standardized and defined processes to provide continuity across multiple nurse educators providing organizational orientation and educational activities, such as:</td>
<td>• Change may not be what its planners anticipate</td>
</tr>
<tr>
<td>o Organizing and ongoing mentoring of staff educator RNs</td>
<td>o Leadership may not have the background in education</td>
</tr>
<tr>
<td>o Maintaining the competence of nurse educators</td>
<td>o Communication breakdown or loss of contact between centralized educators and decentralized clinicians</td>
</tr>
<tr>
<td>o Ensuring that all people involved in staff education know what others are planning</td>
<td>o Confusion and disagreements over responsibility of specific vs. general learning needs</td>
</tr>
<tr>
<td>o Take the initiative to establish and maintain lines of communication with regular meeting between educators and clinicians</td>
<td>o Lack of clarification of the educator’s, clinical nurse specialist’s and clinical manager’s role</td>
</tr>
<tr>
<td>• Data management system for data storage, management, and analysis can:</td>
<td>o Some directors feel that they have to be in control of the educators’ activities</td>
</tr>
<tr>
<td>o Guide provider unit operations as well as internal and external reporting</td>
<td>o Lack of advanced warning re: policy and procedural changes</td>
</tr>
<tr>
<td>o Allow the provider unit to identify trends and make data-driven decisions to maintain and enhance provider unit operations</td>
<td>o Lack of dedicated resources to nonclinical programs</td>
</tr>
<tr>
<td>• Lead nurse planners proactively identify essential requirements within organizational and local data management systems to collect, aggregate, and analyze data</td>
<td>o Total number of staff, patient type, patient complexity, staff learning needs must be considered in the allocation of educators-to-clinical programs</td>
</tr>
</tbody>
</table>

Effective centralized education departments incorporate the following elements: 5,6

• Credibility: 6
  o Bonafide educational requests are given top priority
  o Conduct a periodic systematic assessment of how the education department is perceived by others and deal with the perceived weaknesses
  o Maintain competencies in clinical patient care so educators are seen as clinical experts, change agents, innovators, resource people, and people who help you learn on the job
  o Professional contacts
  o Keeping up with the literature

• Increased creativity and job satisfaction 8
• Contributes to new employee success 8
• Seeing peers excited about learning 8

Processes: 1,3,8

• Data and additional provider unit metrics 1

Disadvantages: 3,7,8

• Management:
  o Change may not be what its planners anticipate 3,8
  o Leadership may not have the background in education 7
  o Communication breakdown or loss of contact between centralized educators and decentralized clinicians 3,8
  o Confusion and disagreements over responsibility of specific vs. general learning needs 3,7,8
  o Lack of clarification of the educator’s, clinical nurse specialist’s and clinical manager’s role 7
  o Some directors feel that they have to be in control of the educators’ activities 7
  o Lack of advanced warning re: policy and procedural changes 3
  o Lack of dedicated resources to nonclinical programs 8
  o Total number of staff, patient type, patient complexity, staff learning needs must be considered in the allocation of educators-to-clinical programs 7
  o Difficulty in identifying learning needs in order to motivate staff to attend educational offerings 8
  o Inadequate time allotment (e.g. meetings and paperwork), particularly when using educators for service 8

• Format: 3,7,8
  o Uneven or duplication of clinical program educators 3,7
    ➢ Decentralized and centralized educators all working on same class/seminar without knowing it 3
  o Inappropriate use and sharing of resources 3
    ➢ Central area for sharing of resources 3
    ➢ Separate resources for specialty areas and content 3
  o Unit variability and lack of standardization 3

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• **Visibility:**
  - Educators must be seen and heard by the people they are servicing
    - Regular unit rounds
    - Listening to daily report
    - Reviewing care plans & bulletin boards
    - Initiate informal discussion re: patient care
    - Alignment of Dept-Unit schedules
    - Active participation in nursing dept committees and professional organizations

• **Ongoing Support:**
  - Active support of the centralized department’s person assigned specialized functions
    - Nurses responsible for new employee orientation
    - Clinical nurse specialists providing CE educational offering
  - Centralized education department educational experts are responsible for providing training in adult education to others in the education role

• **Communicating Informally:**
  - Deliberate use of informal communication to establish an informal network and more comfortable relationships with potential learners or their supervisors
    - Identify educational needs to people they know
    - Be aware of situations involving personal problems or personality conflicts
    - Become aware of daily conditions affecting current programs or future planning

**Outcomes:**
- Orientation and activities to maintain competence have allowed the nurse planners to recognize dilemmas when planning educational activities
- Nurse planners identify best practices during peer review of files and self-adapt their practices when offering advice to their peers

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CLINICAL EDUCATION DELIVERY: AN INTEGRATIVE REVIEW

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“What is the quantity, quality, and consistency of the evidence for standardized clinical education delivery in the acute care hospital setting?”

- Nurse planner meetings foster collaboration and sharing of ideas for all phases of the educational design process
- Lead nurse planners have proved to be essential in this process to oversee the operations of the provider unit and deliver quality nursing education to meet the needs of learners within the organization and a larger community of nurses
- Ensure that nurse planners use orientation and activities to maintain competences in order to support the integrity of the accredited provider unit

**Advantages**

- **Management:**
  - One individual is accountable for coordinating and combining educational resources to afford maximum benefits to the institution
  - Structures and processes that support centralized education have proved successful in managing a large number of nurse educators

- **Format:**
  - Centralized education uses standardized structures
  - Providing training throughout rather than limiting it to individual departments like nursing service
  - Transitioning to a hospital wide education department allows for development of current educational activities and programs that are more multidisciplinary in nature

**Disadvantages:**

- **Management:**
  - Few educators can or want to be held accountable for coordinating and combining the entire institutions educational resources
  - Managers in some institutions question the value of placing all educational resources in one central department
  - Potential conflicts:
    - Nursing administrators may only be familiar with the traditional nursing service model within the nursing department
    - Deciding on the educational

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CLINICAL EDUCATION DELIVERY: AN INTEGRATIVE REVIEW

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“What is the quantity, quality, and consistency of the evidence for standardized clinical education delivery in the acute care hospital setting?”

<table>
<thead>
<tr>
<th>Priorities between nursing and rest of hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Format*</td>
</tr>
<tr>
<td>o It is difficult for centralized educators to remain consistent in delivering orientation and update content if each unit has separate “special” paperwork, charting, procedures, and processes</td>
</tr>
</tbody>
</table>

Other Models and Frameworks

• Alignment of education and work force development outcomes is an integral part of the strategic planning process*

• Hospital education departments can effectively prioritize work processes and focus on what matters most to improve organizational performance practices and achieve better outcomes by using an integrated systematic approach* (Baldrige Framework)*

• A combination matrix for an educational and development model maximizes the benefits and minimizes the limitations of centralized and decentralized structures*;4;6;7
  o The combination of centralized and decentralized educators is probably the most effective approach to education, especially in large institutions*
  o Unit-based and centralized educators must know what the other is doing and work together to decide how unit-based instruction can best complement centralized classes*

• Educators should focus their creative energies on the 20% of their work that matters most, which are the elements most strongly aligned with the strategic plan*
  o Apply the Pareto principle, or the 80/20 Rule, in the redesign of education*
    • In any situation, a few elements (20%) are vital and many (80%) are trivial*
    • 20% of work (first 10% and last 10%) consumes 80% of time and resources*
    • 20% of the education delivered then consumes 80% of available time*

Nursing Implications

• Members of the education department must change their concept of the instructor role*

• As long as educators can prove their value by positive outcomes, the education department will always be aligned with the strategic objectives of an organization*

• Organizations continue to have different concepts and methods on how to meet their educational needs; however, nurses wish to remain responsible for and in control of the continuing educational programs for their staff*;4
  o One political reality: educators serve as resource people, service providers, and occasionally scapegoats*
  o Decentralized models*
    • Emphasize that nursing staff must become used to turning to nurse clinicians as the primary resource person on the unit*
    • Nurse clinician must adjust her role from caregiver to caregiver/educator*
    • Nurse clinicians must provide follow-up for orientees, in-service new equipment and forms, updates staff on new practice developments, conducts patient conferences, conducts unit classes*
  o Centralized Models*
    • Educators must cope with feelings of isolation from nursing service, whether those feelings are justified or not*

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Further studies in other hospitals are recommended to demonstrate generalizeability of results for evaluating an education and development model in an academic health sciences center that combine centralization and decentralization.

The effect of staff educator RNs delivering unit-based education on healthcare outcomes is an area for further study:

- Healthcare outcomes (patient satisfaction with nursing care or nosocomial infection rates on specific units) can be compared to levels before implementation of the staff educator role.
- Satisfaction of nursing personnel may be measured by analysis of post-nursing orientation surveys, job satisfaction surveys, and recruitment and retention rates.
Appendix A

Structures, content, audience, functions, authority of Hospital Education Departments

<table>
<thead>
<tr>
<th>STRUCTURE</th>
<th>Separate department equal to other departments</th>
<th>Subsection within the personnel department</th>
<th>Special staff function not attached to any department</th>
<th>Subsection of community medicine or medical education</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Department within the organization along with an external consortium</td>
<td>Interdisciplinary committee</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROGRAM CONTENT</th>
<th>Broad range of topics that are of general interest</th>
<th>Development of specialized skills</th>
<th>Management development</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>AUDIENCE</th>
<th>All hospital employees</th>
<th>Interdepartmental groups</th>
<th>Any department that can demonstrate the need</th>
<th>Managerial personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All employees plus patients, prospective, patients, and physicians</td>
<td></td>
<td>Any department except those with their own instructors</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FUNCTIONAL RESPONSIBILITY</th>
<th>Provide consultative educational services</th>
<th>Provide all educational services</th>
<th>Provide administrative support to those who provide educational services</th>
<th>Coordinate the provision of all educational services</th>
<th>Directly provide some educational services and help others provide the balance of them</th>
</tr>
</thead>
</table>

| RANGE OF AUTHORITY | Control of all educational resources | Control over the use of staff assigned to the function | Cooperative control of all educational resources | | |
|-------------------|-------------------------------------|-------------------------------------------------|-------------------------------------------------| | |
|                    | No control of resources but veto power over programs | No control over the use of any resources (consultative style) | Control over the way in which program are developed | Control of resources used in connection with “new” programs |
|                    | Control of a select portion of the educational resources | | |

The above statements on structure, program content, audiences, functional responsibility, and range of authority can be put together in an endless number of combinations to explain the many ways in which hospital education based on a hospital wide educational philosophy can be organized and operated.

Clinical Question: “What is the quantity, quality, and consistency of the evidence for standardized clinical education delivery in the acute care hospital setting?”

Evidence Search Strategies: An integrative review on the selected question was conducted from March to April 2012 to determine the current state of the evidence. A review of the research evidence from 2002-2012 (reviewer) and 2000-2012 (librarian) was conducted via electronic databases (Google Scholar, Ovid/Medline, Proquest, PubMed), with the appropriate search terms used alone, mixed, or in combination (See Page 13). This review yielded 1885 relevant hits, with 32 articles were selected as relevant for inclusion. After careful examination, 24 articles were eliminated, as they did not answer the clinical question or targeted inappropriate clinical populations and/or institutional settings. Article inclusion and exclusion was confirmed by an independent reviewer. The remaining 8 articles pertained to the clinical area of inquiry and were reviewed in detail over a one-month period. The strength of the research evidence evaluated for this integrative review was insufficient. 7 articles were not research studies, but rather narrative descriptions of the implementation and examination of various types of educational programs and/or departments. Result limitations include a lack of quantitative/qualitative research studies and limited agreement on the standardized design and delivery of clinical education, as well as the inability to generalize the evidence results to the KP environment.

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>DESCRIPTION</th>
<th>RELEVANT ARTICLES</th>
<th>ARTICLE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Meta-analysis of multiple large sample or small sample randomized controlled studies, or meta-synthesis of qualitative studies with results that consistently support a specific action, intervention, or treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Well-designed controlled studies, both randomized and nonrandomized, prospective or retrospective studies, and integrative reviews with results that consistently support a specific action, intervention, or treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Qualitative studies, descriptive or correlational studies, integrative reviews, systematic reviews, or randomized controlled trials with inconsistent results</td>
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<tr>
<td>D</td>
<td>Peer-reviewed professional organizational standards, with clinical studies to support recommendations</td>
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<td></td>
</tr>
<tr>
<td>E</td>
<td>Theory-based evidence from expert opinion or multiple case reports, case studies, consensus of experts, and literature reviews</td>
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<td></td>
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<tr>
<td>MA</td>
<td>Manufacturer’s recommendation; Anecdotes</td>
<td>7</td>
<td>#1, #2, #3, #4, #5, #6, #8</td>
</tr>
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</table>

Total 8
**CLINICAL EDUCATION DELIVERY: AN INTEGRATIVE REVIEW**

*Topic Summary of the Evidence*

May 2012

**Electronic Database Search Methodology**

**Integrative review search topic:** "What is the quantity, quality, and consistency of the evidence for standardized clinical education delivery in the acute care hospital setting?"

**Date(s):** March-April 2012

<table>
<thead>
<tr>
<th>Database</th>
<th>Key Word(s) Used</th>
<th>Total References Identified (hits)</th>
<th>Relevant References</th>
<th>Total Duplicates</th>
<th>Articles Selected for Review</th>
<th>Articles Excluded</th>
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<td>Name: Proquest-Librarian Years: 2000-2012</td>
<td>Centralized Hospital Education</td>
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<td>Unit Based Education</td>
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<td><strong>24</strong></td>
<td><strong>8</strong></td>
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</table>

**Total Articles Included in Literature Review:** Database (8) + Contextual Links (0) = 8

**Inclusion Criteria:** Registered Nurse, Staff education, Professional development, Educational models in the U.S., acute care setting, all patient populations, hospital wide education department/program

**Exclusion Criteria:** Education models in the academic setting, longer term care, rehabilitation, allied health care professionals (LVN, MA), physicians, medical students, residents

Created by Jasper Diaz, RN, BSN and Cecelia L. Crawford, RN, MSN, DNP(c), ©Kaiser Permanente SCAL Nursing Research Program, May 2012


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