CALIFORNIA STATE UNIVERSITY SAN MARCOS

PROJECT SIGNATURE PAGE

PROJECT SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE

MASTER OF SCIENCE

IN

NURSING

PROJECT TITLE: EASING PATIENT FLOW

AUTHOR: RODERICK M. DONATO

DATE OF SUCCESSFUL DEFENSE: APRIL 30, 2012

THE PROJECT HAS BEEN ACCEPTED BY THE PROJECT COMMITTEE IN
PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE IN NURSING

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PROJECT COMMITTEE CHAIR

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[Date]

DR. DENISE BOREN
PROJECT COMMITTEE MEMBER

[Signature]

[Date]

NA
PROJECT COMMITTEE MEMBER

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[Date]
EASING PATIENT FLOW

A Grant Proposal Project

Presented to the faculty of the School of Nursing

California State University, San Marcos

Submitted in partial satisfaction of
The requirements for the degree of

MASTER OF SCIENCE

In

Nursing

Adult Clinical Nurse Specialist

By

Roderick M. Donato

SPRING SEMESTER
2012
Abstract

Emergency department (ED) overcrowding has been a significant issue in the healthcare industry since about the early 80’s not only in the United States but also in other countries such as the United Kingdom, Australia, Canada, and even in Taiwan. Multiple research studies had been done about the causes and impacts of ED overcrowding; and interventions were suggested and tested, but it continues to be an overwhelming problem of the healthcare industry. The known major contributor to overcrowding in ED is the unavailability of inpatient beds to absorb intakes. This is brought about partly by a shortage in nursing staff and delay of discharging inpatients. The goal of the researcher is to explore ways to resolve ED overcrowding by making inpatient beds available for ED admissions. The assumption is that delay in the discharge of inpatients causes significant delay in admitting ED patients to acute of critical care beds. The purpose of this study is to investigate the causes of delay in the discharge process from the perspectives of the staff nurses compared to the perspectives of the nursing management. Result of this study will help in planning for future intervention or revising current program to help ease the flow of patients. Methodology involves conducting a semi structured survey to participants recruited for this study in the telemetry unit at Tri-City Medical Center. Data analysis will include comparison of the manager’s perception to staff perception using non-parammetrical statistical analysis or paired t-test. The outcome of this study is it serves as base for an interventional study in the future.

_________________________________, Committee Chair
Dr. JoAnn Daugherty

_________________________________
Date
Acknowledgements

This project would not have been possible without the kind support and help of many individuals.

I am forever grateful to Dr. JoAnn Daugherty and Dr. Denise Boren, my grant project committee chair and member respectively, for their knowledge, wisdom, patience and valuable comments.

I would also like to express my sincerest gratitude to my advisor, Dr. Susan Bowles, for her eternal patience, wisdom, encouragement, and support.

Special thanks to my colleagues at Tri-City Medical Center for their enthusiasm and cooperation.

And most importantly, I am highly indebted to my family for their understanding, love, and support.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title Page</td>
<td>i</td>
</tr>
<tr>
<td>Copyright page</td>
<td>ii</td>
</tr>
<tr>
<td>Abstract</td>
<td>iii</td>
</tr>
<tr>
<td>Acknowledgement</td>
<td>iv</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>v</td>
</tr>
<tr>
<td>I. Budget Request and Line Item Justification</td>
<td></td>
</tr>
<tr>
<td>A. Detailed Budget for Initial Budget Period, Direct Cost Only</td>
<td>1</td>
</tr>
<tr>
<td>B. Budget for Entire Proposed Project, Direct Cost Only</td>
<td>2</td>
</tr>
<tr>
<td>C. Budget Narrative</td>
<td>2</td>
</tr>
<tr>
<td>II. Biographical Sketch</td>
<td></td>
</tr>
<tr>
<td>A. Roderick Donato RN, BSN, CCRN, Principal investigator</td>
<td>4</td>
</tr>
<tr>
<td>B. Susan Bowles DNP, Research Data Analyst</td>
<td>7</td>
</tr>
<tr>
<td>C. Mary Floyd, Research Assistant</td>
<td></td>
</tr>
<tr>
<td>III. Research Plan</td>
<td></td>
</tr>
<tr>
<td>A. Background</td>
<td>11</td>
</tr>
<tr>
<td>1. Statement of the problem</td>
<td>12</td>
</tr>
<tr>
<td>2. Purpose of the Research</td>
<td>12</td>
</tr>
<tr>
<td>3. Research Question</td>
<td>13</td>
</tr>
<tr>
<td>4. Hypothesis</td>
<td>13</td>
</tr>
<tr>
<td>5. Research Variables</td>
<td>14</td>
</tr>
<tr>
<td>6. Assumptions</td>
<td>14</td>
</tr>
</tbody>
</table>
B. Review of Literature

1. The aging population..................................................15
2. The emergency care seekers...........................................16
3. Effects of ED overcrowding..........................................18
4. Interventions.............................................................19

C. Theoretical Framework...................................................20

D. Methodology

1. Research Design.........................................................21
   a. Setting.................................................................21
   b. Sampling.............................................................21
   c. Methods of Data Collection......................................22
   d. Analysis of data....................................................23
   e. Dissemination Plan................................................23
   f. Timeline...............................................................23

References............................................................................25

Protection of Human Subjects..............................................29

Appendices

A. Appendix A: Causes of Discharge Delay, Fish Bone Analysis by the
   Telemetry Management.................................................30

B. Appendix B: Causes of Discharge Delay, Fish Bone Analysis by the
   Telemetry Nursing Staff Focus Group............................31

C. Appendix D: Survey Instrument......................................32

D. Appendix C: Information Letter to Survey Participants......35
E. Initial Enquiry Letter to Tri-City Hospital Foundation……..36
F. Follow up letter to Tri-City Hospital Foundation……………37
G. Grant Application Form……………………………………..38
H. Comparison table of Potential Funders……………………..39
Chapter I

Chapters one and two of this grant research proposal present the budget request and line item justification and biographical sketches of the researcher and the research data analyst respectively. This format is the preferred grant application format of Tri-City Hospital Foundation which is the potential funder of this research project.

Chapter one shows two tables that outline the cost of each item which the researcher is requesting grants for. The first table shows direct costs of the itemized budget for the first phase of the project or the initial budget period. The second table shows itemized budget for the entire project period.

**Budget request and line item justification**

**A. Detailed Budget for Initial Budget Period, Direct Costs Only**

<table>
<thead>
<tr>
<th>Line Item</th>
<th>Cost</th>
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</tr>
<tr>
<td>Personal Computer</td>
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<td>Computer software</td>
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</tr>
<tr>
<td>Pens</td>
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<td>Envelopes</td>
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<tr>
<td>Recliner chairs x 6</td>
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<td>$1,200</td>
<td>4,100</td>
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<tr>
<td>Bedside table with wheels x 6</td>
<td>$750</td>
<td>$750</td>
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</tr>
<tr>
<td>Television</td>
<td>$800</td>
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<td><strong>Total</strong></td>
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<td></td>
<td><strong>$7,650</strong></td>
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### C. Budget Narrative

1. Dr. Susan Bowles has agreed to donate her service as a research data analyst valued at $3,000 based on her normal per diem rate.

2. A research assistant will be provided by the unit directly benefitting from this project. Valued at $450 based on $18 per hour rate.

3. IRB application through WIRB – Tri-City Medical Center, the site of the project, is contracted with WIRB to approve application for research projects.

4. Personal computer is needed for the analysis of research data. The same computer is also needed when the proposed discharge lounge is already operational to be utilized by staff discharge RN in discharging a patient.

5. Computer software is needed for data analysis.
6. A printer with copier is needed in phase one of research project to print and copy survey instrument.

7. Papers, pens, and envelopes are needed in conducting the survey.

8. Six recliner chairs – Instead of beds, recliner chairs will be provided for patients while they are waiting in the discharge lounge. A total of six is needed. A double room in telemetry 2West was identified to be the ideal place for a discharge lounge. Hospital management has already agreed for the conversion of the said double room into a discharge lounge.

9. Six bedside tables with wheels and adjustable height for patients’ use during mealtime.

10. Television for patients pleasure

11. Automatic External Defibrillator is mandatory for any area with patient.
Chapter II

**Biographical Sketch**

Provide the following information for the senior/key personnel and other significant contributors in the order listed on Form Page 2. Follow this format for each person. **DO NOT EXCEED FOUR PAGES.**

<table>
<thead>
<tr>
<th>NAME</th>
<th>POSITION TITLE</th>
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<tbody>
<tr>
<td>Roderick M. Donato RN, BSN, CCRN</td>
<td>ASSISTANT NURSE MANAGER TELEMETRY</td>
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<table>
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<tr>
<th>eRA COMMONS USER NAME (credential, e.g., agency login)</th>
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**Education/Training** *(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable.)*

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**Personal Statement**

I am graduating with a Master of Science in Nursing degree this May 2012. I have held positions in clinical, academic, and administrative in nursing. I have 16 years of clinical experience in various specialties including acute medical-surgical unit, adult intensive care unit, acute rehabilitation unit, high dependency unit, and telemetry unit. I am currently an assistant nurse manager in a telemetry unit in north San Diego county, California. I previously worked at De Los Santos medical center in the Philippines for two years then he moved to Oxford, England and worked in AICU. I came to the USA in 2003 and have been working in a step-down cardiac care unit since. I assumed a Shift Supervisor position in 2005 and to my present position in
2007. Seventeen nurses report directly to me. As an assistant nurse manager, I am responsible for the shift operation of my unit.

**Positions:**

2007 – Present  Assistant Nurse Manager

Telemetry Unit, Tri-City Medical Center, Oceanside, CA.

- Responsible for shift operation of telemetry unit
- Ensure positive productivity through implementation of unit guidelines and policies
- Ensure that nursing staff follow the path to excellence
- Implements action plan for improvement of performance targets.
- Serve as a consultant for patients, nurses and other health team members
- Implements educational programs designed to convey specialized knowledge and skills to nursing personnel

2005- 2007 Shift Supervisor

Telemetry Unit, Tri-City Medical Center, Oceanside, CA

Duties as described above

2003- 2005 Staff Nurse

Tri-City Medical Center, Oceanside, CA

- Functioned as a staff nurse, charge nurse, a professional mentor
- Responsible for nursing care of four high acuity cardiac care patients.
1999-2003 Staff Nurse, Adult Intensive Care Unit
Oxford Radcliffe NHS Trust, Oxfordshire, England

- Staff Nurse
- Mentor to foreign trained nurses

1997-1999 Senior Staff Nurse, Intensive Care Unit
De Los Santos Medical Center, Quezon City, Philippines

- Staff nurse
- Mentor to nursing students and newly hired nurses.

C. Selected Peer-reviewed Publications

N/A

D. Research Support

Ongoing Research Support - N/A

Completed Research Support N/A
**Biographical Sketch**

Provide the following information for the Senior/key personnel and other significant contributors in the order listed on Form Page 2. Follow this format for each person. **Do not exceed four pages.**

<table>
<thead>
<tr>
<th>NAME</th>
<th>POSITION TITLE</th>
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<tr>
<td>Susan M. Bowles, DNP, RNC-NIC</td>
<td>Clinical Nurse Specialist</td>
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</table>

**eRA Commons User Name** (credential, e.g., agency login)

**Education/Training** *(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable.)*

<table>
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<th>INSTITUTION AND LOCATION</th>
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<td>University of San Diego, San Diego CA</td>
<td>DNP</td>
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</table>

**A. Personal Statement**

I am a doctorally-prepared registered nurse who has practiced in administrative, clinical, and academic roles for over 28 years. I am clinically prepared as a Clinical Nurse Specialist and experienced in patient care management of the neonatal critically ill client. I have served in both clinical and administrative management positions, as well as in executive leadership roles.

I am employed by Tri-City Medical Center, the hospital that serves the population of the Tri-City Health Care District in North County San Diego, an institution committed to providing safe quality care to all the residents of the district and I have been a member of the State Program Planning Committee for the California Chapter March of Dimes and have served in a volunteer and advocacy capacity, for over 6 years.
B. Positions and Honors

Positions:

2009- Present Clinical Nurse Specialist

Tri-City Medical Center, Oceanside, CA

- Coordinated the identification of patient care problems, implemented approaches to these problems and to evaluate the effectiveness of the approaches.
- Established goals for improvement of performance targets.
- Serve as a consultant for patients, nurses and other health team members throughout the hospital and community agencies.
- Coordinate the development and implementation of educational programs designed to convey specialized knowledge and skills to nursing personnel

2008 - 2009 Clinical Nurse Specialist

Rady Children’s Hospital, San Diego, CA

Duties as described above

2006- 2008 Clinical Nurse Specialist

Miller Children’s Hospital, Long Beach, CA

- Functioned as a leader, change agent, liaison, patient/family advocate, educator, and expert practitioner.
- Responsible for developing and implementing patient care standards for a defined patient population.
- Established goals for improvement of performance targets.
2006-2008 Adjunct Professor

- Clinical Instructor, Pediatrics Health Rotation
- California State University Long Beach
- Clinical Faculty member for a professional nursing program.
- Responsibilities included classroom, and clinical components.

2005-2006 Director, Care Management and Clinical Services

CareAssist, Irvine, CA

- Planned, organized, and coordinated the Care Management Department.
- Planned and developed annual staffing, capital equipment and expense budgets.
- Developed, reviewed, and implemented policies within the Care Management Department that reflected current Standards of Practice

2004-2005

Health Dialog, San Antonio, TX

Health Coach

- Provide health coaching to patients and families helping them to better manage medical conditions.
- Health coaching is provided telephonically to all patient populations using a research based internet database.

2003-2004 Faculty II

- Baptist Health System School of Professional Nursing, San Antonio, TX
- Faculty member for a diploma granting professional nursing program.
• Responsibilities included classroom, committee and clinical components.

1982-2003

Various Hospitals: CA, CO, HI, MO, NJ, and TX.

(A listing of each job, responsibilities and location is available upon request)

Director of Women and Children’s Services,

Education Coordinator

Learning Coach

Staff Nurse

C. Selected Peer-reviewed Publications

The Office of the National Nurse, December 2010, http://nationalnurse.blogspot.com


Neonatal Hospital Acquired Infection Prevention Tool Kit; California Perinatal Quality Care Collaborative, 2008

D. Research Support

Ongoing Research Support - N/A

Completed Research Support N/A
Chapter III

Research Plan

Background

Press Ganey (2010) on a Pulse issue reported that, according to the latest data of American hospital Association and the National Center for Health Statistics, from 1990 to 2008 the number of annual emergency department visits in the United States rose from 90 million to 123 million, amounting to about 41 visits per 100 people. While the number of hospitals operating emergency department declined from more than 5,000 in 1991 to fewer than 4,000 in 2006. In 2009, the average time spent in ED was four hours and seven minutes, an increased by four minutes compared to 2008 (Press Ganey Associates Inc., 2010). It was recognized that one of the reasons for this increasing wait time in the emergency department is the shortage of inpatient beds. “Bed blocking” is a concept which explains that inpatient beds are “available” but they are occupied by outgoing patients who are stuck due to delay in the discharge process by one reason or another. A Discharge lounge is a concept that helps in easing patients flow by providing a place for discharge patients who are otherwise stuck in an inpatient beds whilst waiting for transportation. This concept is widely popular in the United Kingdom but has yet to be adapted in the United States except by a few hospitals. At University of California Medical Center (UCLA), a discharge lounge is staffed by a registered nurse who helps patients with their follow up appointments; provide instructions on medications, and to address any of their concerns (University of California Los Angeles, Ronald Reagan Medical Center, 2012).

This research study will attempt to explore the causes of delay of discharging patients from inpatient units; first by analyzing the similarities and differences in the perspectives of the staff nurses and the nursing administrators and decision makers regarding the causes of the delay...
in discharging patients. Tri-City medical center, the second busiest emergency department in San Diego, attempted to address this problem by conducting two focus groups composed of telemetry’s management team, housekeeper supervisor, transportation supervisor, bed coordinator, and one telemetry staff nurse. Interventions were proposed and implemented to help ease the flow but delay in discharging patients persisted. This research study has two phases. In phase one, the researcher aims to investigate the causes of delay in discharging patients from inpatient units from the perspectives of the staff nurses and to compare their perspectives from that of the nursing management. The significance of this study is it provides data in which an interventional study can be based on. Literature shows that the discharge lounge concept is widely utilized in Europe and a few hospitals in the United States. The second phase of this research is to conduct and interventional study to explore if the discharge lounge concept will ease the discharge process and help relieve ED overcrowding.

Statement of the Problem

Phase one: The ED to floor wait time on average is about four hours. This causes delay in the provision of treatment and delay in the delivery of medical and nursing care.

Phase two: Discharged patients from telemetry unit continue to occupy inpatient beds due to multiple factors such as unavailability of patient’s own transport, and delay in dispensing discharge instructions. On average, a patient waits for 4 hours after discharge order was written before actually leaving the inpatient area.

Purpose of the Research

Phase one: The objective of this study is to identify the factors that cause the most delay in discharging telemetry patients and to compare the perspectives of the staff nurses and the nursing management. This information is essential to determine if the current interventions in
place are appropriate. Result of this study will also help in planning for future intervention or revising current program to help ease the flow of patients.

Phase two: The objective of phase two study is to investigate if discharge lounge will solve the problem of discharge delay in telemetry unit and to explore if this concept can be adapted as a permanent unit.

**Research Question**

Phase one: Are there similarities in the perception of the staff nurses and the perception of the nursing management as to the causes of delay in discharging patients from the telemetry unit? If Yes, are interventions in place that addresses these problems?

Phase two: Can discharge lounge helps resolve the problem of delay in discharging telemetry patients?

**Hypothesis**

Phase two: Discharge lounge eases the flow of patients by absorbing discharged telemetry patients who occupies inpatient beds due to delay in the discharge process by the primary nurse, lack of nursing support staff such as discharge nurse, and unavailability of patient’s own transport (Holdsworth, n.d.)

**Research Variables**

Bed block – is a term used in this study that defines a situation where discharged patient continues to occupy inpatient bed because of a delay in the discharge process or delay in the patient’s transport.

Discharged patients – patients who are going home or are being transferred to other departments.
Discharge Lounge – is a unit where discharged patients are accommodated while they are waiting for the discharge process to be completed or if they are waiting for transport. It is staffed by the discharge nurse and a care tech.

ED to Floor Wait Times – a term used to describe the length of time measured from the time admits order is written in ED to the time the patient arrived to the inpatient unit.

Discharge Wait Times – the length of time measured from when the discharge order is written at the actual time the patient left the inpatient bed.

Discharge delay – patients wait indefinitely after discharge order is written and continue to occupy inpatient telemetry beds due to the problem in the discharge process.

Frequency – how often a variable happens.

Severity – the impact of a variable to the delay in the discharge process.

Assumptions

Phase one: The major causes of delay in discharging telemetry patients have not been identified and, therefore, the current intervention program is inadequate in resolving this problem.

Phase two: Discharge lounge significantly reduces ED overcrowding by easing the flow of discharged patients out of telemetry unit, therefore, freeing acute beds and making them available for ED admissions.

Review of Literature

In reviewing literatures, three search engines were used by the researcher: CINAHL, PUBMED, and MEDLINE. Literature search was limited to the last ten years. This is a two part research project: The first part is to the similarities and differences in the bedside nurses’ and
nursing administrator’s perspectives as to the causes of discharge delay of inpatient telemetry patients. Like a domino, the effects of which causes delay in the admission of ED patients to the telemetry unit and eventually leads to ED overcrowding. The second part of this research study is about testing an intervention to the problems identified in the first part of this study. One such solution could be the utilization of a discharge lounge, which is widely utilized in the United Kingdom successfully to free inpatient telemetry beds for ED admits. To understand the causes and effects of overcrowding in the emergency department and to find out what solutions were recommended and attempted by researchers and decision makers to resolve this difficult healthcare problem, the phrase “Emergency department overcrowding” was searched applying search filters to the last ten years and which were peer reviewed. Almost all of the literatures reviewed were original research and some were editorials.

**The Aging Population**

The issue of overcrowding in the emergency department is not a new concept. It can be traced back to the early 1980’s (Gallagher, 1990). It has worsens in the last decade as more people are seeking emergency care (Derlet, 2002). And it is expected to get worse as the aging population of the United States reaches an alarming level in the next few years (Berger, 2008). The Sun Herald (2010) on its August 11, 2010 press release reported that from 1997 to 2007 the rate of emergency visit have increased at twice the rate of the growth of the US population as found by a new study of the American Medical Association (American College of Emergency Physicians, 2010). The older adult population aged 65 years and older accounted for 38.9 million in 2008 or 12.8% of the total US population. The number of Americans aged 45-64 who will reach 65 over the next two decades increased by 31% during this period 2008 (Administration on Aging, 2010). The projection by the US Census Bureau is that the United
States will experience rapid growth in its older adult population between the year 2010 and 2050. Baby boomers began crossing into the older adult category starting January 2011. The projected number of older adults in 2050 is 88.5 million which is more than double the current older adult population of 40.2 million (Grayson & Velkoff, 2010).

As the demand for emergency care increases, the supply of medical personnel such as doctors and nurses who provide this emergency care becomes stagnant. The Joint Commission stated that ED overcrowding is a symptom of staff shortages (Siegel, Wilson, & Sickler, 2007).

The Emergency care seekers

Berger (2008) wrote that the number of emergency room visits by the older adults will likely double by the 2013 as older adults will experience acute exacerbations of chronic illnesses (Berger, 2008). But some of this emergency room visits by the elderly are inappropriate (Bernstein & Asplin, 2006; Kaufman, 2005; George, Jell, & Todd, 2006)). Elderly patient gets nervous easily and requires a lot of reassurance, so a non-urgent complaint necessitates a trip to the emergency room. Lack of diagnosis due to the elderly’s cognitive impairment and forgetfulness takes a lot of the physician’s time and causes delay in seeing other ED patients (Kaufman, 2005). The combination of aging baby boom population and shortages of doctors, nurses, and inpatient beds placed greater demands on the healthcare system more so to the emergency department (Berger, 2008). The increasing number of critical patients presented to ED contributed significantly to ED overcrowding. In a ten year study of the ED use and capacity in California from 1990 to 1999 showed that critical care visits to ED increased by 59%, urgent visits increased by 36% and surprisingly a decline of the non-urgent visits to just eight percent. The increased in critical cases left little room for the non-urgent cases. It was also noted that when ICU or telemetry is filled, ED becomes the de facto ICU which led to a very limited ability
EASING PATIENT FLOW

of the ED to provide services to new patients presenting to ED triage (Derlet, 2002). ED is not intended to function as inpatient care unit; it is designed to provide immediate lifesaving care as well as assessment, diagnosis, and treatment of medical and surgical emergencies. The complex evaluation and treatment of critically ill patients in the ED means decreased in the turnaround for beds. One of the factors noted to be contributory to ED overcrowding is the unavailability of inpatient beds. This is true especially in the East coast. And until the insufficiency of inpatient beds is addressed there will be overcrowding in the ED (Derlet, 2002). Gardner and colleagues (2007) conducted a study that identifies the most common factors that are associated with longer ED length of stay. Their data came from the 2001-2003 National Hospital Ambulatory Medical Care Survey. They have concluded that Hispanic ethnicity was consistently associated with a longer ED length of stay in both admitted and discharged patients. Admitted Hispanic patients stayed an average of 20 minutes longer in ED and discharged Hispanic patients stayed about ten minutes longer. They have speculated that language barrier is directly related as it takes more time to conduct history taking, discussing diagnoses, procedures, and discharged instructions; and waiting for interpreters. Other factors they found that affects the duration of stay in ED include waiting for CT scan or MRI (Gardner, Sarkar, Maselli, & Gonzales, 2007). While the number of patients presenting to ED increases, the number of ED decreases. This discrepancy is mostly due to financial pressure brought about by the cuts in private and public insurance reimbursements and the mandated Emergency Medical Treatment and Active Labor Act (EMTALA) which is unfunded (Moskop, Sklar, Geiderman, Schears, & Bookman, 2009). ED overcrowding is also exacerbated by the increasing number of substance abusers, homeless, AIDS patients, and mentally ill in urban areas. Many of these patients are uninsured or underinsured and usually visit ED for non urgent cases; this is the cause of ED overcrowding
The greatest contributor to ED overcrowding, however, is the unavailability of inpatient beds (Bernstein & Asplin, 2006; Canadian Medical Association, 2004). Patients who have admission orders are forced to stay longer in ED while waiting for floor beds. These patients, collectively known as boarders or bed blockers require a considerable amount of nursing care, and medical resources. They also prevent patients from being seen and treated (Bernstein & Asplin, 2006).

**Effects of ED overcrowding**

A study by Michael Schull and colleagues (2003) regarding ED overcrowding and ambulance transport of patients with chest pain found that a period of greater ED overcrowding was associated with significant delays in the ambulance transport of patient with chest pain. When these patients are presented to an overcrowded ED, delays in the multiple steps of the AMI treatment because of overcrowding may have a cumulative effect in overall time to complete the process. (Kulstad & Kelly, 2009) Delay in transport and delay in the process of investigation and treatment may lead to poor outcome. This is true especially in patients who are presenting with cerebrovascular accident and myocardial infarction. Overcrowding can also lead to unintentional inhumane and inappropriate treatment. Rick Mah (2009) warned that emergency department overcrowding is a threat to patient’s dignity. He based this observation based on the taxonomy of four types of dignity violation by Mann: 1. being ignored or insufficiently acknowledge; 2. being seen but only as a member of a group; 3. Having one’s personal space transgressed involuntarily; and 4. Humiliation. Dignity is a foundational concept of human rights, with overcrowding two rights are threatened: The right to health and the right to be free from torture or cruel, inhuman, or degrading treatment and punishment. Overcrowding in itself is not a torture but the conditions that exist in overcrowded ED like sensory bombardment
with noise and bright lights; uncomfortable, narrow and hard stretchers; sleep deprivation; and
denial of privacy may be considered cruel, degrading and inhumane (Mah, 2009). Another
untoward outcome of ED overcrowding is the increased in the incidence of medication errors as
found by a limited study that was conducted by Kulstad and colleagues in 2010 (Kulstad, Sikka,
Sweis, Kelley, & Rzechula, 2010). The shortage of staff combined with an increased in the
number of high acuity patients in ED could be overwhelming to staff nurses, and because of this
they can easily commit errors in medication administration. Medication error includes missed or
delayed dose especially time sensitive medications like thrombolytic.

**Interventions**

In 2003, The Joint Commission on the Accreditation of Healthcare organizations
(JCAHO) issued landmark guidelines on crowding (Bernstein & Asplin, 2006). This voluntary
body recognized that crowding impacts hospital work condition, quality, and patient’s safety
(The Joint Commission, 2007). Without specific guidelines, the joint commission mandates that
patients who are boarded in ED receive the same quality care that they would receive in inpatient
units (Bernstein & Asplin, 2006). The solution to crowding in ED is complex and multifactorial.
The amount of measures taken is more effective in reducing waiting times in ED than the
individual interventions (Munro, Mason, & Nicholl, 2006). Senior leadership’s support is a key
factor (Olshaker, 2009). Improving patient flow is essential. This can be achieved by effectively
managing inpatient beds availability. The influx of patients is not random. It can be charted and
planned. During the peak period ED, inpatient units and the support system could be staffed up
to ease the patient’s flow (Greene, 2007). Hoot and Aronsky (2006) presented in the American
Medical Informatics Information (AMIA) 2006 symposium that an early warning system for
overcrowding maybe helpful in alleviating the problem before reaching a crises state. The
creation of an acute medical admissions unit has been effective in alleviating ED overcrowding by immediately taking referrals from the ED. A study in Ireland showed that the number of ED patients waiting for an inpatient beds were significantly shorter compared to the time before the creation of the acute medical admissions unit (Maloney, Bennet, O'Riordan, & Silke, 2005). A discharge lounge is a place in the hospital, which accommodates patients who have planned discharged, where the discharge process can be completed. It has the capability to discharge patients any time of the day; it can be used as a holding area for patients who are waiting for a care home. Discharge lounge was developed to free up acute beds for incoming admissions from emergency department, thus, reduces “bed blocking”. In England, discharge lounge are used increasingly across hospitals to meet government policy on delayed discharges and have links to intermediate care (Holdsworth, n.d.).

**Theoretical Framework**

In doing this research study, the researcher was guided by the Queuing theory which was first introduced by David Kendall. In queuing theory, a queuing model is used in the mathematical approximation and analysis of a real queuing situation or system (Encyclopedia Britannica, 2011). Emergency department is a queuing system with both a single server as in the case of nurse triage and a multiple server system such as when patients are transported from the triage to ED rooms. Philippe Nain (1998) stated that in queuing model, “customers from a population or source enter a queuing system to receive some service. Upon arrival, a customer joins the waiting room if all servers in the service center are busy. When a customer has been served, he leaves the queuing system” (p.16). Queuing model showed that a queuing system can be predicted. It allows analysis of useful steady state performances such as the average number in the queue, or the system; the average time spent in the queue, or the system; the statistical
distribution of those numbers or times; the probability the queue is full, or empty, and the probability of finding the system in a particular state. These performance measures are significant in the hospital business as issues or problems caused by queuing situations in the emergency department often lead to delay in treatment and customer dissatisfaction with the service. Likewise in a telemetry unit, patients waiting to be discharge wait for the primary nurse to do the discharge process. Oftentimes, discharging patients are not on top of the nurse’s priority list. This delay brought about by the queuing situations may be the cause of economic losses in a business. Analysis of the relevant queuing models allows the cause of queuing issues to be identified, and the impact of proposed changes to be assessed (Nain, 1998).

Methodology

Research Design

Setting

This study will be conducted in the 60 beds telemetry unit at Tri-city Medical Center (TCMC), a 360 bed capacity district hospital in Oceanside, California which is providing services to three cities within the district. It is the second busiest emergency department in San Diego County. At Tri-City Medical Center, 2009-2010 data showed that the average wait time in ED was 4.5 hours.

Sampling

Three inclusion criteria will be considered in the recruitment of participants. Criterion one is working full time or part time staff nurse in telemetry unit at Tri-City medical center; Criterion two is Fluent in English language, and criterion three is working for more than a year. The first group of participants shall be known as the nursing group. Per Diem, float pool, and
registry nurses will be excluded in the study because their limited exposure to telemetry unit may generate inaccurate data. Target population for this group is about 57 participants. The second group of participants consists of the telemetry management, house supervisors, and bed coordinators. Target population for the management group is about 12 participants.

**Methods of Data Collection**

A fishbone analysis with the nursing staff focus group composed of six randomly chosen nurses was conducted as part of a performance improvement initiative of the telemetry unit to determine the variables that cause delay of admitting patients to telemetry unit from the nursing staff perspectives. After all the possible variables are identified, the focus group was asked to rate each variable according to frequency and severity. A rate of five means most frequent/most severe; a rate of three means frequent/severe; and a rate of one means less frequent/less severe. The researcher then classified the variables according to the headings People, Process, Equipment, and Environment. Results of which was compared to the fishbone analysis that was facilitated by the Performance Improvement department conducted with the telemetry management composed of the operation manager and seven clinical managers. Research instrument in the form of a structured survey questionnaire was developed based on the comparative results of the two fishbone analysis. The research instrument was reviewed by a panel of three nurses for content validity; a nurse educator at California State University San Marcos School of Nursing, a bed coordinator, and a house supervisor from TCMC. After the approval of the research instrument, recruitment of participants will follow. Research participants both from the nursing group and the management group will be recruited via a batch email. Signed consents will be waived because participants will not be asked to reveal their identity and the risks involved are very minimal. Participants will be provided with an
information sheet about the study. After IRB is obtained, the questionnaires together with an information sheet will be placed to each participant’s mailbox. An email from the researcher will be sent to each participant informing them about the availability of the questionnaire and the return date. A dedicated drop box will be provided in the assistant nurse manager’s office in the telemetry unit second floor. The research assistant will have the only drop box key which provides exclusive access. Participants will be given two weeks to accomplish the survey. The research assistant will be responsible in assuring that there are no identifying data written in the questionnaires before they will be turned in to the researcher.

Analysis of Data

Data analysis will include comparison of the manager’s perception to staff perception using non-parametrical statistical analysis or paired t-test.

Dissemination Plan

It is the intent of this project to disseminate its findings both in the descriptive study or phase one and interventional study or phase two. The principal researcher will be featured in a Nursing Leadership Seminar and monthly staff meeting of all nursing departments to discuss the findings of phases one and two studies. A summative report will be produced after phase two study to be disseminated to nursing leadership. An online version of the findings will also be made available to the hospital’s intranet.

Timeline

<table>
<thead>
<tr>
<th>Exploratory research</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposal development</td>
<td>Completed</td>
</tr>
<tr>
<td>Proposal defense</td>
<td>Completed</td>
</tr>
<tr>
<td>Task</td>
<td>Date</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Field Work</td>
<td>June, 2012</td>
</tr>
<tr>
<td>Data analysis and transcription</td>
<td>August, 2012</td>
</tr>
<tr>
<td>Writing of draft chapters</td>
<td>September, 2012</td>
</tr>
<tr>
<td>Research defense</td>
<td>November, 2012</td>
</tr>
<tr>
<td>Final approval and Completion</td>
<td>December, 2012</td>
</tr>
</tbody>
</table>
References


Protection of Human Subjects

1. Participants may expect immediate intervention based on the findings. It is possible that they may feel frustrated or disappointed if they do not see intervention right away after the study.

   Researcher will inform participants at the start of the study that this study is independent and not tied to the organization. They will be informed that a final report will be made available to the leadership team of Tricity but they are not required to intervene in any way. However, the organization can use this data in planning for future intervention or revising current intervention.

2. Participants may find answering the questionnaire to be stressful.

   Participants will be encourage to answer the questionnaire at home. They are given ample time, one month, to return back the questionnaire to the research assistant. It made clear to participants that they can stop answering the questionnaire and withdraw from the study anytime.

3. Potential to feel pressured or coerced

   Research assistant will receive the completed questionnaire back or direct the participants to place the questionnaire in a dedicated drop box located in the monitor tech room and make sure that no identifying data are written in the questionnaire before those questionnaires are handed to the researcher.
APPENDIX A: Causes of discharge delay in telemetry unit: Fish Bone Analysis by the telemetry unit management team.
Appendix B: Causes of discharge delay in telemetry unit. Fish bone analysis of the nursing group.

Fish Bone Analysis
Nursing staff

- GEORGHIASET UP, BIPAP AND VENTS LIMITED TO 2ND FLOOR
  - ELEVATOR MALFUNCTION 1/5
  - BLOCKED ROOMS DUE TO PLUMBING ISSUES 3/5
- UNAVAILABILITY OF WHEELCHAIR 3/3
- CERNER ISSUES 3/5
- ROOM IS AVAILABLE BUT NO BED 5/1

EQUIPMENTs

- INAPPROPRIATE ADMISSIONS 5/5
  - HIGH ACUITY PATIENTS OF DISCHARGING NURSE 3/3
  - INADEQUATE STAFFING, IMMATURE FLEXING OF STAFF 1/1

PROCESS

- SLOW FLOW
  - MULTIPLE CALLS WHEN TRANSFERRING TO ACS 5/3
  - CASE MGT. ISSUES 3/5
  - PRIORITIZATION OF OUTPATIENT VS INPATIENT RE: DX PROCEDURES 5/5

BATCH ADMITS 5/5

PEOPLE

- INADEQUATE # OF PM HOUSEKEEPERS 5/5
- PHYSICIAN'S LATE ROUNDS (HOSPITALISTS) 5/5
- TRANSPORTER'S AVAILABILITY? DISPATCHER 5/1
- RN'S VARIABLE CAPABILITY 1/1
- NO DISCHARGE NURSE/ANM NOT AVAILABLE TO HELP 3/3

INAPPROPRIATE ADMISSIONS 5/5

INADEQUATE STAFFING, IMMATURE FLEXING OF STAFF 1/1
Appendix C: Survey Instrument

CAUSES FOR DELAY IN DISCHARGE
SURVEY QUESTIONNAIRE

AGE Range:  21 to 30 ________31 to 40_________ 41 to 50__________51 to 60 _________ 61 to 70________
Number of years as a nurse____________
Number of years at current position__________
Do you work as a relief charge nurse? YES_______ NO_________
Demographics: White _____ African American _______ Asian ________
Hispanic _________

PLEASE RATE THE FOLLOWING VARIABLES AS TO THEIR INFLUENCE IN DELAYING A PATIENT BEING DISCHARGED FROM THE TELEMETRY UNIT. ALSO RATE THE SEVERITY OF EACH.

LEGENDS:
FREQUENCY (how often it happens) SEVERITY (has the most impact to delay in the discharge process)
5 – MOST FREQUENT CAUSE 5- MOST SEVERE
3 – FREQUENT CAUSE 3 - SEVERE
1 – LESS FREQUENT CAUSE 1 – LESS SEVERE
DK – Don’t know

PEOPLE

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<tr>
<th>VARIABLES</th>
<th>Frequency</th>
<th>Severity</th>
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<tbody>
<tr>
<td></td>
<td>5 3 1</td>
<td>5 3 1</td>
</tr>
<tr>
<td>Family not available to pick up pts who are discharge from telemetry.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inadequate # of PM EVS to clean rooms in telemetry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inadequate# of transporter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Late discharge orders of tele pts. due to late rounding of MD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN’s variable capability in the discharge process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No ANM for ACS to orchestrate the flow of transfer from tele to ACS.</td>
<td></td>
<td></td>
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<tr>
<td>No discharge nurse</td>
<td></td>
<td></td>
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<tr>
<td>Inadequate staffing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANM not available to help</td>
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</tbody>
</table>
### PROCESS

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<tr>
<th>VARIABLES</th>
<th>FREQUENCY</th>
<th>SEVERITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple calls when transferring tele pts. to ACS</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Prioritization of outpatient vs. inpatient re: Dx Procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Batch admits (multiple admissions at the same time)</td>
<td></td>
<td></td>
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<tr>
<td>Inappropriate admissions</td>
<td></td>
<td></td>
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<tr>
<td>High acuity patients of the discharging nurse</td>
<td></td>
<td></td>
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<tr>
<td>Case management issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immature Flexing of staff</td>
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### EQUIPMENTS

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<th>VARIABLES</th>
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<tbody>
<tr>
<td>Cerner issues</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Unavailability of wheelchair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unavailability of bed in the room of receiving dep’t.</td>
<td></td>
<td></td>
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</tbody>
</table>

### ENVIRONMENT

<table>
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<tr>
<th>VARIABLES</th>
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<tr>
<td>Geographical set up. Vents and Bipap limited to 2nd floor</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Elevator malfunction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blocked rooms due to plumbing issues</td>
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</table>
EASING PATIENT FLOW

<table>
<thead>
<tr>
<th></th>
<th>FREQUENCY</th>
<th>SEVERITY</th>
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</table>

Please write on this section any other factors that are not on the list, that you think causes delay in the discharge of patients from the telemetry unit.

1. ______________________________________________________________

2. ______________________________________________________________

3. ______________________________________________________________

4. ______________________________________________________________
Appendix D: Information Letter to survey participants

Easing Patient Flow

I, Roderick Donato RN, am conducting a study regarding the causes of the slow flow of patients from emergency department to telemetry unit as a partial fulfillment of the requirement for Masters of Science in Nursing at California State University San Marcos (CSUSM). As a registered nurse working full time in the telemetry department at Tri-City Medical Center you are invited to participate in this study because you have experienced delays in the discharge process and I am interested to know your perspective as to the causes of those delay.

The objective of this study is to identify the true causes of delay in the discharge process of telemetry patients from the perspectives of the bedside staff nurses. This information is important to determine if the current interventions are appropriate. Result of this study will also help in planning for future intervention or revising current program to help ease the flow of patients.

If you agree to participate in this study, you will be asked to answer survey questions which will take not more than 15 minutes of your time. You will not be asked to reveal your identity. The responses to this study will be kept confidential and only available to the research assistant and the researcher. The returned questionnaires will be destroyed at the end of spring semester. The California State University San Marcos Institutional Review Board may inspect study records as part of its auditing program to make sure they are safe for participants.

There are no risks involved in this study. Although this study was approved by Tri-City telemetry management, this is an independent study by the researcher. Participants of this study should not expect that an immediate intervention based on the final outcome of this study. However, outcome of this study may provide bases for future intervention.

Participation on this study is voluntary and will not affect your continued employment at Tri-City Med. Center. You can stop answering the questionnaire anytime and withdraw from this study and you will not be penalized. Should you need counseling you will be referred to the employee health.

If you have any questions, please call the researcher at 760-6724880. Questions about your rights as research participants should be directed to CSUSM Institutional review board at (760) 750-4029.

Thank you
Appendix E: Initial Enquiry Letter, Tri-City Hospital Foundation

December 13, 2011

Tobi Ferguson
Chief Development Officer
Tri-City Hospital Foundation
4002 Vista Way
Oceanside, Ca
92056

Dear Ms. Ferguson:

I am writing to see if you would consider a proposal to investigate the causes of slow flow of admitted patients from the emergency department to the telemetry unit. My goal is to conduct a descriptive study that explores the causes of delay in the discharge process of telemetry patients which contributes significantly to ED overcrowding.

Telemetry unit is the largest unit at Tri-City Medical Center with 60 beds. The average admissions on a daily basis are approximately 14 patients. Patients bound to be admitted to telemetry wait longer than the national average of 4 hours and 15 minutes. Interventional studies were conducted in the past but the problem continues.

I will be calling shortly to seek an appointment to discuss this project. In the meantime would you please email me your guidelines and instructions for preparing a completed request.

Sincerely,

Roderick Donato
Asst. Nurse Manager
Telemetry
Appendix F: Follow up Letter to Tri-City Hospital Foundation

January 22, 2011

Tobi Ferguson
Chief Development Officer
Tri-City Hospital Foundation
4002 Vista Way
Oceanside, Ca
92056

Dear Miss Ferguson:

I am pleased to present this proposal for your review. My proposal is in line with Tri-City’s goal of moving towards excellence and will be helpful in achieving the vision of the organization which is to be in the top 10% in patient care nationally by 2015.

I am going to investigate the slow flow of patients from the emergency department to telemetry unit. Through my experience as an assistant nurse manager and occasional house supervisor for night shift, I personally experience the sluggish flow of patients being admitted from the ED to telemetry. This causes overcrowding in ED and backlog in the waiting room. The national average of ED wait time is about 4 hours. At Tri-City medical center, I see patients waiting for more than four hours, sometimes seven or eight and even more than ten hours. This delay in admitting patients to inpatient care areas causes delay in the provision of medical and nursing care and leads to dissatisfaction to the whole organization. The number one cause of ED overcrowding is the unavailability of inpatient beds. This is brought about by multiple factors such as staffing issues, and delay in the discharge process. Interventions were put in place after a focus group meeting a few years ago but ED overcrowding continues to be an overwhelming problem. My proposal is to investigate the causes of delay in the discharge process of patients in telemetry unit as perceived by telemetry managers group and the nursing group. The outcome of my investigation will serve as bases for an interventional study in the future. My proposal requests $4,000 in funding to obtain IRB approval of the study, to hire a statistician, and to obtain necessary materials for the survey.

I appreciate Tri-City Hospital foundation taking an interest in resolving the chronic problem of ED overcrowding. Please give me a call at 760-6724880 if you require any further information or have any questions regarding this proposal.

Thank you.

Roderick Donato RN, BSN, CCRN
Assistant Nurse Manager
Telemetry Department
Appendix G: Grant Application form

TRI-CITY HOSPITAL FOUNDATION
PROJECTS AND ALLOCATIONS
REQUEST FOR FUNDING

Department or Individual
Submitting Request _______________________________________________________
Department Phone (Ext.) ________________________________________________

Nature of Request. Please provide an appropriate description of the program to be funded, equipment request for funding, or the nature of any other request. Please attach any appropriate support materials.
Note: If you are requesting equipment, program supplies, etc., a minimum of two competitive bids is required.

Amount of Request: __________________

Department Director's Signature: ______________________________ Date
(PLEASE SIGN & PRINT YOUR NAME)

Vice President's Signature: ______________________________ Date
(PLEASE SIGN & PRINT YOUR NAME)

☐ Requests $5,000 and under: Return your completed request, including the above signatures, to the Foundation office.
☐ Requests over $5,000: Return your completed request, including the above signatures, to the Foundation office. Your request will then be placed on the bi-monthly Executive Council agenda for review.

Tri-City Medical Center, Executive Council Review & Recommendation:
Item is:
☐ Capital Expense
☐ Replace Existing Asset
☐ New Asset
☐ Operating Expense

Executive Council Recommendation:
☐ Request Foundation Support
☐ TCMC unable to fund due to budget constraints this fiscal year
☐ Present for Foundation Interest / Funding Opportunity (Current TCMC funding available)
☐ Currently not a TCMC priority – hold for future year funding

______________________________________ Date _________________
Larry Anderson, President/CEO
## Appendix H: Comparison Table of Potential Funders

<table>
<thead>
<tr>
<th>Funders</th>
<th>Areas of Inquiry</th>
<th>Requirements</th>
<th>Available Funding</th>
<th>Contacts</th>
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</thead>
<tbody>
<tr>
<td>AACN- Phillips Medical System</td>
<td>Improving specific patient care outcome: clinical, safety, financial</td>
<td>-Cover letter</td>
<td>Up to $10,000</td>
<td><a href="mailto:research@aacn.org">research@aacn.org</a></td>
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<tr>
<td>Clinical Outcomes Grant</td>
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<td>(800)899AACN</td>
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<td>Medical System</td>
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<td></td>
<td></td>
<td>-Biosketch</td>
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<tr>
<td></td>
<td></td>
<td>-Research proposal, (limit sections on abstract, specific aims, significance, methodology and timetable to 12 pages excluding references and appendices)</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>-Letters of support</td>
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<td></td>
<td></td>
<td>-Approval from IRB</td>
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<tr>
<td>Tri-City Hospital Foundation</td>
<td>-“What is your wish” programs.</td>
<td>-Request for funding application form</td>
<td>Any Amount</td>
<td>Tobi Ferguson,</td>
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<tr>
<td></td>
<td>-Equipments</td>
<td>-Appropriate support materials (research proposal)</td>
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<td>Chief Development Officer</td>
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<td></td>
<td>&quot;Out of the box&quot; things.</td>
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<td>-Signature from TCMC Vice-President</td>
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<td></td>
<td></td>
<td>-Executive Council review and recommendation</td>
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<td>American Nurses Foundation. Chow/Togaski/Breitenbach</td>
<td>Advancement of nursing science and improving patient's outcomes.</td>
<td>Online application (deadline 5/1/12) - Applicant's</td>
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<td>Total Project Budget</td>
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<tr>
<td>Sigma Theta Tau Int'l Research Grant/Midwest Nursing Research Society</td>
<td>Promotion of healthy communities through health promotion, disease prevention and recognition of social, economic and political determinants; implementation of evidence-based practice; targeting the needs of vulnerable populations such as the chronically ill and poor; and capacity development for research by nurses</td>
<td>-Online application</td>
<td>-Abstract (limit 200 words)</td>
<td>-Research proposal</td>
</tr>
<tr>
<td>Tonna M. Thomas</td>
<td>888-634-7575</td>
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</table>
| Clinical Nurse Specialist Foundation | - Advance nursing science through nursing scholarship and research.  
- Disseminate nursing knowledge and evidence based practice within the three spheres of CNS influence - Patient/Client, Nursing Personnel and Organization/Network  
- Educate the public about the unique contribution of the clinical nurse specialist within health care delivery services  
- Support professional development of Clinical Nurse Specialists  
- Preserve the history of Clinical Nurse Specialist Practice |
| ENA Foundation (Emergency Nurses Assoc.) | To advance the specialized practice of emergency nursing. All relevant research topics will be considered. Priority will be given to research studies relating to the ENA research initiatives. |