Attachment A
Johns Hopkins Health System
Departments of Nursing

Approval of Research Involving Nursing or Nursing Resources

Instructions: This form is to be completed for any research requiring the use of Johns Hopkins Health System (JHHS) Departments of Nursing resources or if JHHS nursing staff will be study participants. Please complete Sections I-IV, obtain signatures for Section V, and upload completed form **with required Department of Nursing signatures** into the eIRB application.

**Approval checklist (in order of completion):**

- Study team member completes Sections I-IV
- Completed form and eForm A/study protocol sent to:
  - Departmental Director of Nursing (JHH/JHBMC)
  - CAPRES Divisional Coordinator (HCGH, Sibley Memorial, Suburban)
- Departmental Director of Nursing/Designee approval obtained
- Form and eForm A/protocol sent to:
  - Nurse Scientist, then Director of Nursing Practice, Education, and Research (JHH)
  - Senior Director Hospital Capacity Management and Emergency Nursing (JHBMC)
  - CNO/Designee (HCGH, Sibley Memorial, Suburban)
- Signed, completed form returned to Principal Investigator and/or other study contacts
- Form uploaded into eIRB

For questions, please contact:

- Elizabeth Scala, MSN/MBA, RN, Research Program Coordinator, escala1@jhmi.edu or 410-502-4613 (JHH)
- Cynthia Walters, DNP, RN, NE-BC, Senior Director Hospital Capacity Management and Emergency Nursing, cwalter2@jhmi.edu or 410-550-0183 (JHBMC)
- Jackie Lobien, RN, CAPRES Divisional Coordinator, jlobien1@jhmi.edu or 301-896-3122 (HCGH, Sibley Memorial, Suburban)
Section I
STUDY INFORMATION

1. Study Title: _________________________________________________________________

2. Principal Investigator: _______________________________________________________

3. Address: __________________________________________________________________

4. Telephone Work: _______________ Email: ________________________________

5. Additional Study Contact(s): ________________________________________________

6. Study length (anticipated start and end dates) From:_________ To:____________

7. Site(s) where JHHS nursing staff will be involved:

- The Johns Hopkins Hospital (JHH)
- Johns Hopkins Bayview Medical Center (JHBMC)
- Howard County General Hospital (HCGH)
- Sibley Memorial Hospital
- Suburban Hospital
- All Children’s Hospital

For Students Only
Advisor’s Name: ___________________________ Advisor’s Phone: ________________
Advisor’s Institution: ________________________________
Degree Pursued: _______________________________________

Section II
NURSING AND CLINICAL RESOURCES REQUIRED

1. Type(s) of activities that nursing staff will be responsible for within research study protocol:

- Study participants
- Specimen collection
- Data collection
- Documentation
- Direct care
- Study recruitment
- Data analysis
- Other

2. Time required of each nurse (hours per week or specify):

<table>
<thead>
<tr>
<th>Activity</th>
<th>For Orientation</th>
<th>During Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study participants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data collection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Will there be any equipment involved in this protocol? ☐ YES ☐ NO
If not included above, how much time, if any, will be required for nursing staff to learn use of equipment?
3. Type(s) and number of nurses sought: ____________________________________________

4. Department where research will occur (ex. Surgery, Medicine, Oncology) ______________

5. Clinical area(s) or unit(s) to be involved: __________________________________________

6. Type(s) and number of patients sought: ____________________________________________

7. Time(s) of day when nursing resources will be required:
   - [ ] Day Shift (7a – 3p)
   - [ ] AM Shift (7a – 7p)
   - [ ] Evening Shift (3p – 11p)
   - [ ] PM Shift (7p – 7a)
   - [ ] Night Shift (11p – 7a)

Section III
FEEDBACK AND COMPENSATION

1. Plan(s) for acknowledging contribution of nursing staff in subsequent publications:
   - [ ] Credit to unit for service
   - [ ] Acknowledgement naming nurse contributors
   - [ ] Opportunity to participate in writing papers
   - [ ] Other ________________________________

2. Plan(s) for feedback of study results:
   - [ ] Discuss findings at nursing staff meetings on request
   - [ ] Send abstract of completed study to unit(s)
   - [ ] Other ________________________________

3. Compensation for participation:
   - [ ] Grant or stipend to unit
   - [ ] Direct payment or gift
   - [ ] No payment or compensation will be provided
   - [ ] Other ________________________________

Upon study completion, please provide to the Departmental Director of Nursing or CNO/Designee:
- Notification of study closure or ending of required nursing resources
- Written summary of the study findings
- Summary of nursing resources required (ex. total number of nursing hours needed)
- Description of feedback and compensation provided to nursing staff

This summary will be sent on or about (date): ________________________________
Section IV
PERMISSION FOR RELEASE OF PROPOSAL & REQUIRED SIGNATURES

May copies of this proposal be provided to nurses or students who are learning the research process?
☐ YES  ☐ NO

I certify that the above information is correct:

__________________________________________  ______________________
Principal Investigator                              Date

__________________________________________  ______________________
Signature of Advisor, if student                      Date

Section V
NURSING ADMINISTRATIVE APPROVAL

☐ The Johns Hopkins Hospital

__________________________________________  ______________________
Departmental Director of Nursing                     Date

__________________________________________  ______________________
Nurse Scientist                                       Date

__________________________________________  ______________________
Director of Nursing, Practice, Education and Research Date

☐ Johns Hopkins Bayview Medical Center

__________________________________________  ______________________
Departmental Director of Nursing                     Date

__________________________________________  ______________________
Senior Director Hospital Capacity Management and Emergency Nursing Date

☐ Howard County General Hospital    ☐ Sibley Memorial Hospital    ☐ Suburban Hospital

__________________________________________  ______________________
CNO/Designee                                           Date

__________________________________________  ______________________
CAPRES Divisional Coordinator                       Date

☐ All Children’s Hospital

__________________________________________  ______________________
CNO/Designee                                           Date