Professional development

Project management tips to develop staff leaders
Florida educator helps students become effective planners

From reshaping the customer service department to planting a serenity garden, your staff members likely have a plethora of project ideas swimming in their heads. But to bring these plans into fruition, nurses must be trained in the steps of project management. This skill set is essential for your staff members to grow and develop into effective leaders.

Jo-Ann C. Byrne, RN, MHSA, director of healthcare education at Wuesthoff Health System in Rockledge, FL, realized the importance of relaying project management skills to her students and has developed a class focused on helping individuals envision, craft, manage, and, ultimately, complete a hospital-centered project.

“We needed to be teaching more organizational skills and answer the question of ‘How do you appropriately plan and ensure that you’re not going to miss any steps?’” Byrne says.

William Perry, MA, RN, adjunct instructor at Wright State University in Dayton, OH, says staff members, particularly nurses, need to be adept in these skills.

“While some academic programs include project management in their curriculum, nurses in practice can benefit from project management tools and techniques,” Perry says.

The project management class at Wuesthoff, “Managing Your Projects Effectively: The Basics,” is interdisciplinary and offered several times per year as a full-day session.

Class in session

A typical project management class at Wuesthoff will draw about 18 students and last from 8 a.m. to 6 p.m. To begin, students share their project ideas and what they would like to accomplish.

Some initial time is spent discussing exactly what project management is and how it can help nurses stay on track while working on their projects. Then comes one of the most crucial steps, says Byrne: defining the
Project management < continued from p. 1

project. An AAACN Viewpoint article states, “This phase is critical for the startup of any project. During this phase, the problem must be clearly identified, stated, and understood to be a true problem before a project proposal can be made.”

The scope of the project (deciding what will be done and when it will be accomplished) should be defined at this point, and Byrne says the best strategy for doing this is laying out the ultimate goal you wish to accomplish.

Next comes the planning phase of the project, when students plan using the dimensions of quality, time, and cost. “These three dimensions are the cornerstones,” says Byrne. “And as they work through this planning, everyone has time to share their project ideas with the group to get objective feedback.”

When determining a timeline during this planning phase, Byrne recommends prioritizing the tasks necessary to complete the project and mapping out the prioritized tasks in a project schedule. This ensures that the most crucial steps are given an adequate time estimate.

The next step is discussing project implementation. “We discuss what the implementation plan looks like and talk about how you control the work, provide feedback, negotiate for what you need, and so on,” Byrne says.

The class will also discuss conflict resolution and how to head off conflicts that can occur when people are working on projects together. Byrne adds that it is important to emphasize the following conflict resolution tactics:

➤ Providing a better understanding of the goal at hand
➤ Developing cohesion in a group through mutual respect
➤ Keeping the people and the problems separate
➤ Exploring options collaboratively

The final piece of the discussion is about completing the project. “We look at how to make sure you get to a successful conclusion,” Byrne says. The class has also been offered as part of the health system’s leadership development program, she adds, as leaders “have to understand project management.”

Projects that students have come up with include:

➤ Redesigning the traffic flow in the ED
➤ Efficiently labeling products in the central supply room
➤ Improving the method for conducting exit interviews

Creating ease for project managers

Perry notes that “there are also several free or open-source online resources available that may make the job of the nurse project manager a bit less hectic.” Byrne makes it clear in the class that there are software tools available to students, such as Microsoft Project, which helps them make charts and develop time schedules.

Reference


Source

The Staff Educator, July 2008, HCPro, Inc.
Quality improvement

Rounding cuts number of call lights by 3,000

Six months after the telemetry unit at Sts. Mary & Elizabeth Hospital in Louisville, KY, implemented hourly nurse rounding, the number of patient falls decreased, patient satisfaction increased, and call light usage dropped by more than 3,000 per month.

“The managers round on all of the patients every day,” says Amy Robinson, RN, a nurse manager at the 200-bed facility. “One of the questions we ask the patient is, ‘Does someone always come in as soon as you use your call light?’ And we often hear, ‘Oh, I never use my call light because they’re in here all the time.’ ”

The hospital began hourly rounding on Robinson’s 25-bed telemetry unit in March 2007 as part of an effort to reduce patient falls. In February 2007, the unit had five falls. That number dropped to one in April 2007, although it took six months before the program was really hardwired. The director of patient care excellence, Lisa Benner, organized the project.

“We have a high population of elderly patients, so [telemetry] seemed like a good place to start, and, indeed, we did find that our falls went way down,” Robinson says. “Patient satisfaction went up, which we saw as a bonus. But the biggest thing was patient safety.”

Some nurses initially feared that it would add to their workload. “One of the things that we tried to really get across to the staff is that this isn’t something extra; you’re already doing this,” Robinson says. “All we’re doing is giving you the verbal tools for what you’re already doing to help your patients feel more comfortable.”

Before mandating hourly rounding, nurses were most likely in the patient’s room every hour anyway. But instead of asking patients about specific needs, nurses would most likely ask, “How are you doing? Is there anything you need? Okay, I’ll check on you in a little bit.”

Now, staff members ask patients whether they’re in pain, whether they need to use the restroom, whether they are in a comfortable position, and whether they have everything they need within arm’s reach. Staff members also tell patients, for example, that they’re moving the call button or wastebasket closer to the patients because they’re concerned about their safety and they don’t want them to fall getting out of bed. That message has led to increased patient satisfaction, Robinson says. Many patients who were in the hospital several years ago now tell her how much the facility has changed.

The success of hourly rounding on the telemetry unit prompted administrators to roll it out hospitalwide. The facility began rounding in the ED and the ED waiting room. “We found it really reduced anxiety for patients and for their families,” Robinson says. The hospital has nurses round on the even hours, and aides check in with patients on the odd hours. The hospital has forms in all patient rooms, which nurses or aides initial every hour to show they have checked in with the patients.

After reading this article, you will be able to:

➤ Identify the benefits of implementing an hourly nurse rounding policy

Source

Quality Improvement Report, July 2008, HCPro, Inc.
Medication reconciliation

Designing a successful medication reconciliation process

Questions about responsibilities, the process, and knowing where to start can be stumbling blocks in the design of a medication reconciliation program. But following the principles below can help any hospital overcome the challenge of designing a successful process.

Essential principles for med rec process design

The following guiding principles should be considered as you design your medication reconciliation process:

- Develop a single medication list shared by all disciplines (such as the “Sample paper-based one-source-of-truth form” on p. 5), for documenting the patient’s current medications.
- Define roles and responsibilities clearly for each discipline involved in medication reconciliation.
- Standardize and simplify the medication reconciliation process throughout your organization and eliminate unnecessary redundancies.
- Recognize and understand the nuances that might exist within various practice settings. Modify them to minimize variations and integrate them into your design.
- Integrate medication reconciliation into existing work flow.
- Make the right thing to do the easiest thing to do within the patterns of normal practice.
- Develop effective prompts or reminders for consistent behavior.
- Evaluate the potential for work-arounds, which includes assessing whether new process steps introduce unintended sources of error.
- Educate patients and their families or caregivers on medication reconciliation
- Ensure that process design meets all pertinent local laws or regulatory requirements.

Building the foundation for your process

Process design should center on the concept of a single list to document the patient’s current medications. This list should be shared and used by all physicians, nurses, pharmacists, and other disciplines caring for the patient—allowing a team approach to medication reconciliation.

It is important that all disciplines caring for the patient are working off the same medication list regardless of whether it is in an electronic or paper-based format. The list should be centrally located and easily visible within the patient’s medical record as it becomes the reference point for ordering decisions and reconciliation, screening medications to be administered during a procedure/episode of care, and determining the patient’s medication regimen upon discharge. Each discipline should have the ability to update the home medications as new or more reliable information becomes available.

In a paper-based format, old or modified information can be crossed out, new information can be added, and each change can be dated, time-stamped, and signed. In an electronic system, changes are date- and time-stamped and the discipline’s name is captured automatically.

If the patient’s medication list requires changes at discharge, updated information can be stored for review and modification for future admissions.

Sample paper-based one-source-of-truth form

Customize this form to document and verify patients’ current medications upon admission to your organization.

[Insert hospital logo]  Insert patient’s nameplate/stamp:
Patient name: ____________________________________________  
Date: ___________________________________________________  
Medical record number: ___________________________________  
Account number: _________________________________________  

Allergies: None _________ (please check none) or list below.

<table>
<thead>
<tr>
<th>Source</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Penicillin</td>
<td>Hives</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication</th>
<th>Strength</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
<th>Last dose taken</th>
<th>Information source</th>
<th>Date/time/signature of entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>List names of medications the patient is taking. Include any over-the-counter medicines (e.g., vitamins, minerals, herbal supplements). Also include any medications held for a procedure.</td>
<td>List the strength of each tablet, capsule, etc.</td>
<td>List the number of tablets, capsules, units, etc.</td>
<td>List how often the patient takes the medication (e.g., daily, twice per day).</td>
<td>List how the patient takes the medication (e.g., orally, injection, patch).</td>
<td>Indicate the date and time of the most recent dose taken.</td>
<td>Indicate the source of the information (e.g., patient, family, caregiver, past medical records, pharmacy, patient’s medication bottles or list, primary care physician).</td>
<td>Date/time/signature of entry</td>
</tr>
<tr>
<td>Example: Cardizem CD</td>
<td>180 mg</td>
<td>One capsule</td>
<td>Every day</td>
<td>Orally</td>
<td>8/10/08 @ 9:30 a.m.</td>
<td>Patient</td>
<td>8/10/08 @ 14:30/Dr. Jones</td>
</tr>
</tbody>
</table>

Source: Northwestern Memorial Hospital, Chicago, IL.
Infection control

Stare disaster in the face: Testing and perfecting your emergency system

Imagine this scenario: a norovirus outbreak hits your hospital’s psychiatric unit, prompting an emergency evacuation of multiple units and taking weeks to clear the infection out of the facility.

Although you might not consider an event such as this as an emergency situation on par with a pandemic flu outbreak or a flood, it certainly feels like a crisis for the facility involved, says Peggy Luebbert, MS, MT (ASCP), CIC, CHSP, owner of Healthcare Interventions, Inc., in Omaha, NE.

And because situations such as this require some of the same strategies and coordination as a full-scale emergency, it’s the perfect opportunity for a facility to roll out its hospital incident command system (HICS).

By using the HICS, hospitals can make improvements in areas of emergency management planning, response, and recovery capabilities. The HICS also allows hospitals to work more efficiently with community response agencies during a disaster.

The HICS, which specifically lists the individuals that will handle various roles during the incident, is typically designed for major events, such as large-scale infectious outbreaks or bioterrorism attacks, but can be extremely useful in managing everyday infectious disease outbreaks such as the one described above.

Practice makes perfect

Using your HICS not only helps you organize your response to the outbreak, it also helps ensure that the system is working well and lets members hone their response skills, says Kristine Sanger, hospital exercise coordinator at the Center for Biopreparedness Education, a joint venture between Crighton (NE) University Medical Center and the University of Nebraska Medical Center in Omaha.

The Center for Biopreparedness Education is currently working on HICS response plans and scenarios for norovirus and scabies outbreaks, which will be available on the organization’s Web site at www.bioprepare.org.

Calling the HICS into play makes sense in situations that affect a lot of people and when an infection can spread easily, Sanger says. For example, a norovirus outbreak in a psychiatric unit—where patients may not have full control of vomiting or diarrhea—is even more difficult to get under control than it normally would be, Luebbert says.

In these situations, hospitals need to know how to treat staff members who may be carriers and prevent them from spreading the organism. Because the initial response is critical in determining how effectively the hospital will manage the incident, it is the perfect time to use the incident command structure. Doing so helps the response team move rapidly because everyone is trained to handle different aspects of the crisis.

Don’t miss practical opportunities

Luebbert recalls a pertussis outbreak at a facility she previously worked for and the opportunity that was lost by not activating the HICS. Staff members in multiple departments were exposed to the disease and had to miss work for a period of time. If the facility’s HICS had been activated, it could have helped the staff members more smoothly manage the staffing shortage that

After reading this article, you will be able to:

➤ Recognize how you can use your hospital incident command system (HICS) to manage everyday infectious disease outbreaks
➤ Describe some of the incidents in which your HICS system might come into play
➤ List at least two ways you can use your facility’s emergency preparedness system to improve your infection control program
resulted. Staff shortages aren’t just a reality during a major event; as much as 20% of a hospital’s staff can be out during a pertussis outbreak, or even during seasonal influenza, Luebbert says.

Another benefit of the HICS is that the team includes a media officer who can provide an organized response to the media during an emergency. “If you think about it from the infection control perspective, [HICS is] the perfect setup to use for responding to a public health outbreak inside the hospital walls,” Luebbert says. It also gives your HICS experience in managing a longer-term emergency. It can take weeks to get a norovirus outbreak under control and months to control scabies, which has a long incubation period, she says. In these cases, your HICS team might meet for an hour per day to check in and manage the situation.

Small crises can serve big purposes

Other aspects of your hospital’s emergency plans can also be applied to more common occurrences, says Luebbert. For example, The Joint Commission (formerly JCAHO) requires facilities to perform an emergency exercise twice annually to test their systems. It’s a good idea to perform this test using a more routine infectious disease outbreak as an element of your event, she says.

Greenville (SC) Hospital System is doing just that this fall. “One of the things we’re already planning for our fall emergency drill is to test a mass vaccination scenario using seasonal flu vaccine,” says Sue Boeker, RN, BSN, CIC, an infection control professional at Greenville. The drill will help test the facility’s readiness to roll out a mass vaccination in an emergency situation, such as a pandemic flu outbreak, but it’s also meeting an everyday need: helping the hospital get ready for its regular influenza season. Although the facility already has good influenza vaccination compliance, planners hope that this drill will further boost the number of staff members who are vaccinated this year, Boeker says.

You can use other aspects of your emergency preparedness systems on daily basis, as well, Boeker says. Facilities should have active and passive systems for detecting disease threats. For example, an active system would include syndromic surveillance to detect disease clusters, whereas a passive system would monitor health alerts and listservs to derive information about potential threats from other sources, she says.

But don’t only use these systems to look for rare threats. They can also spot more common infections that could affect your facility on a local level. “We’ve been able to identify some small local clusters. For example, we identified a Group A strep cluster,” Boeker says. The systems have also helped Boeker’s facility react quickly when the 2007–2008 influenza season started earlier than usual. By monitoring these systems, Greenville was able to get ahead of the seasonal influenza influx. ■

Source
Adapted from Briefings on Infection Control, July 2008, HCPro, Inc.
Patient care

Reducing the danger of medication errors for children

Concern surrounding medication errors is heightening in healthcare facilities across the country, and attention is particularly being focused on the neonatal and pediatric population.

A 2008 study in *Pediatrics* found that one in 15 hospitalized children experience a medication error, and The Joint Commission (formerly JCAHO) recently issued a Sentinel Event alert warning healthcare providers about the prevalence of dangerous medication errors with pediatric patients.

Medication errors can happen for several reasons, such as lack of communication, drug mislabeling, technology malfunctions, or frequent distractions, which are all components of human error. “Technology dictates many different things, but much of this has little to do with technology because it’s the human piece that is still a part of everything,” says Lisa Graper, RNC, BSN, manager of the neonatal ICU (NICU) at The Western Pennsylvania Hospital in Pittsburgh.

Ten years ago, the NICU at The Western Pennsylvania Hospital discovered an increasing number of neonatal medication errors occurring on different levels: physicians writing an order, the secretary transcribing the order, the pharmacy dispensing the dose, or the nurse delivering the medication. The nursing and pharmacy leadership team took its medication error concerns to the hospitalwide nursing/pharmacy committee but was unable to find a resolution due to the unique requirements involved when delivering medication to newborns.

Thus, the team looked at its primary focus, quality of care, and created an interdisciplinary neonatal pharmacy task force to reduce medication errors.

Focusing on an interdisciplinary team

The neonatal pharmacy task force looked for solutions by including nursing and pharmacy staff members, a clinical secretary, a physician, a neonatal nurse practitioner, an information systems specialist, and a respiratory therapist.

The task force examined the NICU’s seven-step medication delivery process to see where improvements could be made. The steps were:

1. The physician writes the order
2. The clinical secretary/RN enters the order into the computer
3. The RN signs off on the entered order
4. The order is faxed to the pharmacy
5. The pharmacist screens the order for appropriateness
6. The pharmacist verifies the order in the computer and dispenses the dose to the unit
7. The dose is administered

After researching improvement ideas, the neonatal pharmacy task force members decided to design a new medication delivery system by going to the origin of medication orders—physicians.

Checking references twice

When administering medication dosages to infants, NICU physicians reference sources such as NeoFax®, an online application that provides drug-dosing information. But nurses and pharmacists did not have access to this reference system to check the physician’s orders for accuracy.

Therefore, the neonatal pharmacy task force gave the pharmacy and NICU nurses a copy of NeoFax®.
The consideration of reference checking prompted the task force to establish an independent double-checking system as part of the new medication delivery process, which holds pharmacists and NICU nurses individually responsible for medication delivery to infants.

The new double-checking system requires one pharmacist to dispense the medication while another pharmacist double-checks the dosing and mixing for accuracy. From there, a NICU nurse receives the medication dosage from pharmacy and checks references for accuracy, and another nurse rechecks references to catch any errors. Once the double-checking is complete, the medication can be delivered. Nobody moves forward with the medication delivery without these independent double checks, Graper says.

Identifying a new system

The following 18 steps represent the new medication delivery system physicians, nurses, and pharmacists adhere to for the NICU:

1. The physician verifies drug dosing by using a reference such as NeoFax®
2. The physician writes the patient’s order
3. The clinical secretary/RN enters the patient’s order into the computer
4. The RN verifies the drug dose with references
5. The RN signs the order if the drug dose is accurate
6. The clinical secretary faxes the order to the pharmacy
7. The pharmacist screens the order for appropriateness with references
8. The pharmacist prompts NICU via e-mail to complete the dosage
9. The pharmacist enters the dosing recommendation and reference source
10. The pharmacist verifies the order in the computer and confirms all information is correct (if there is a question, the pharmacist will call the neonatologist)
11. The verification request prints in pharmacy and the dose is dispensed
12. The dosage verification sheet prints directly to the NICU
13. The RN compares reference dosing with pharmacy documentation
14. The dose is delivered to the NICU
15. Two RNs perform an independent check of the label, dose per reference, and written order for accuracy
16. If correct, both RNs initial the IV bag or syringe label as well as a copy of the new medication order or medication administration record
17. The dose is administered and documented
18. A copy of the medical order or medication administration record is given to the nurse manager at the end of each shift

And to get nurses into the mind-set that double-checking medication orders is mandatory, Carmen Stauffer, RN, clinical nurse-III says nurses also have a patient care summary—a computer printout of a patient’s diagnosis, medication needs, and physician orders—that has to be double-checked and initialed by another nurse.

Responding to resurgence

After implementing the new medication delivery process in 1999, the NICU saw a decrease in medication errors. But by 2004, there was a resurgence. The task force found that the increase in errors was due to staff members becoming relaxed about the process and not diligently following every step.

To solve the problem, the task force made the 18-step medication delivery process the NICU’s primary performance improvement indicator and introduced yearly educational training related to the process. The pharmacy and education committee designed a nursing educational training course as a dry run for how nurses should proceed once they have received a medication order. During the education course, nurses are given a medication order and must follow the new medication delivery process and demonstrate each step correctly.

Overall, the NICU has seen a more than 50% decrease in medication errors since implementing the 18-step medication delivery process.

Source

Adapted from HCPro’s Advisor to the ANCC Magnet Recognition Program®, July 2008, HCPro, Inc.
Patient safety

Fighting medical identity theft at your facility

Educate your staff to protect your patients and yourself

Continuing Education | Learning Objectives

After reading this article, you will be able to:

- Define medical identity theft
- Discuss the differences between traditional and medical identity theft
- Recall three strategies that can help hospitals minimize the chance of medical identity theft

It’s a hot topic everywhere—in television commercials, movies, and on the nightly news. Identify theft is a growing concern to consumers across the country.

Traditional identity theft is a familiar problem in the United States. Victims of identity theft brace for its effect on their finances and credit ratings. Medical identity theft is less well known, but it is just as problematic for patients, hospitals, and insurers. Protecting against medical identity theft is a tall order for overburdened and understaffed hospitals, but its importance can’t be overstated. Medical identity theft has significant short-term and long-term implications for everyone involved. That’s why it’s essential to educate staff members on what medical identity theft is, whom it affects, how it affects them, and how to fight it.

Defining medical identity theft

Medical identity theft is “the theft of any information that is personally identifiable with a patient,” says Bill Roach, a healthcare attorney at McDermott Will & Emery, LLC, in Chicago. “HIPAA defines protected health information to include many identifiers, the theft of any of which I would consider medical identity theft,” Roach says.

Chris Apgar, CISSP, president of Apgar & Associates, LLC, in Portland, OR, offers a more detailed explanation of medical identity theft:

The theft of medical information that is used for the gain of another. Specifically, to fraudulently obtain medical treatment or treatment-related medication (such as individuals seeking drugs for recreational/abuse purposes), obtain medical treatment and avoid paying for treatment, use medical identity to obtain insurance coverage (generally individual) that could not otherwise be obtained or would be too expensive because of a preexisting condition, and to hide a medical condition that may prohibit seeking certain types of employment (such as pilot, police officer, etc.).

Traditional identity theft more often refers to the theft of a Social Security number with the intent to commit fraud, Roach says. And the focus of traditional identity theft is financial gain, not clinical.

The specific crimes include using another person’s identity to obtain a credit card or loan, purchase property, avoid paying taxes, and/or fraudulently obtain identification, Apgar says.

Perpetrators of medical identity theft use a variety of methods to steal patient information. For example, they hack into electronic health information systems and take advantage of employee error or misconduct. There haven’t been a substantial number of criminal cases involving healthcare staff members who intentionally commit medical identity theft, Roach says. Medical identity theft generally occurs when staff members inadvertently publish protected health information—employee error being far more common than intentional misconduct.

However, the potential for medical identity theft to occur as the result of malicious intent exists, and it is a huge risk for providers, Roach says. “As more covered providers move to [electronic health records] for their patients, the risks of inadvertent disclosures and of intentional theft of information increase,” he says.

Why you need to be concerned

A hospital’s ultimate concerns are its reputation and its bottom line. Medical identity theft can adversely affect both. For example, a hospital may inadvertently provide services...
to people using a false identity and have little chance of receiving reimbursement for them. And the hospital—particularly if it is directly at fault—faces a PR nightmare.

“The theft of any protected health information, whether it is personal identifiers, health information, or financial information, is a serious problem for providers subject to HIPAA and state health information laws, both of which carry legal sanctions,” Roach says.

If a disclosure leads directly to an incidence of stolen identity, immediate action—such as revisiting and rewriting current privacy policies pertaining to patient identification—is necessary to prevent further unlawful disclosures.

Hospitals also should contact their legal counsel for advice on the best method of notifying affected patients, Roach says.

The real victim

Your organization will face problems if it experiences a breach that leads to medical identity theft for one or more of your patients. But the patients, not you, are the real victims.

Apgar says a victim of identity theft could face the following problems:

➤ Potential civil and criminal action if an insurance company tries to collect bad debt associated with fraudulently obtained medical treatment and/or fraudulent claims payment

➤ Creation of a medical record that is incorrectly associated with patients

➤ Potential labeling as someone who exhibits drug-seeking behavior

➤ Potential, although not necessarily obvious, employment discrimination if certain conditions such as alcohol and/or chemical dependency and mental illness incorrectly become part of a patient’s record

What you can do

Hospitals should consider adopting the following big-picture strategies to minimize the likelihood that medical identity theft will affect their organizations:

➤ Initiate comprehensive training that explains what medical identity theft is and the extent of potential damage to affected hospitals and victimized patients

➤ Conduct routine reviews of employee performance to discover potential wrongdoing

➤ Reinforce an internal culture of compliance that originates with the board of directors and CEO

Training should focus on fine-tuning patient identification tasks that staff members already perform.

Teach your staff to recognize potential warning signs, such as a frequent visitor who uses different names, and to report suspicious situations to supervision or administration.

Source
Health Information Compliance Insider, August 2008, HCPro, Inc.

Save the date!

Shared Governance Symposium
Join us September 24 in Chicago at the Hyatt Regency to hear practical strategies from Tim Porter-O’Grady, DM, EdD, APRN, FAAN, senior partner at Tim Porter-O’Grady Associates in Atlanta, and Kim Hitchings, RN, MSN, manager of the Center for Professional Excellence at Lehigh Valley Hospital in Allentown, PA, on building a culture that supports shared governance. The seminar will teach you how to implement a model of shared governance, as well as valuable tips and strategies to sustain it over time.

Nursing Leadership Summit
Stay in Chicago for our Nursing Leadership Summit September 25–26, which will provide nurse leaders with proven, practical solutions to the biggest leadership and management challenges they face. Hear from renowned industry experts on topics such as professional nursing environments, leadership, education, communication, and quality improvement.

To register or for more information, call 800/801-6661 or visit www.greeley.com.
Tip of the month
Building your support system

Every manager/leader needs what I call “pillars of support.” We all need support, consistent columns to lean on, to give us strength and keep us upright. The challenge for most of us is where to find those pillars.

Although leadership development and education provides some of this to help sustain us, we need more. Managers need to look at what is closest to them—staff members—and build a team that includes members that have the qualities of a support pillar. The strength, resilience, and fortitude these people provide can become a great source of strength for you. Ask yourself the following questions as you review a roster of names of staff members who report to you:

➤ Do I ever feel threatened by someone with more skill or knowledge?
➤ Is there anyone on my list that has equal credentials scholastically to mine? If no, why not?
➤ Do I make an effort to mentor staff members to reach my level? Why not?
➤ How many of my staff members do I feel confident to delegate some appropriate daily functions?

Build some pillars to support your role and responsibilities. Start with existing staff members and expand to your interview process.

When hiring, seek out those with pillar qualities. And don’t toss aside those who you feel are competent enough to do your job. Nothing feels greater than knowing there are staff members supporting departmental goals and values.

Source
Shelley Cohen, RN, BSN, CEN, president, Health Resources Unlimited, www.hru.net. Adapted with permission.
Continuing Education Exam

July–September 2008

Accreditation statement:
HCPro, Inc., is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

This educational activity for three nursing contact hours is provided by HCPro.

Directions:
Fill out your contact information in the space provided.

Complete the exam by circling the letter that corresponds to the correct choice for each question. The questions are based directly on content from the July–September issues of SNM, and you may refer to them as you take the exam.

Return all four pages of the exam to us by October 1. To qualify for three nursing contact hours, you must answer at least 80% of the questions correctly—that’s 24 correct answers out of the 30 questions. Upon successful completion of the exam, we’ll e-mail you a certificate that you may use for display and documentation of three continuing education (CE) credits toward your nursing certification.

Name: ____________________________________________ License #: ________________________________

Facility name: ____________________________________________

Address: __________________________________________________

City, State, ZIP: ____________________________________________ Telephone: ____________________________

E-mail address: ____________________________________________

July 2008

1. According to Shelley Cohen, RN, BS, CEN, what is one example of a way to balance recruitment and retention efforts?
   a. Placing a newspaper ad for recruiting nurses, including a picture of a seasoned nurse to recognize him or her for what he or she has done at the organization
   b. Conducting staff satisfaction surveys among seasoned nurses
   c. Taking your staff members out for lunch regularly
   d. Praising staff members for their hard work

2. In regard to nursing leadership, what should be addressed at each facility?
   a. The level of clinical proficiency expected of nursing leaders as their roles expand
   b. The number of nursing leaders present
   c. The number of nursing leaders desired
   d. Strategies to recruit nursing leaders

3. When discussing nurse leader proficiencies, a beginner is described as a person who has ____________.
   a. acquired the essential knowledge and demonstrates the competency
   b. acquired the essential knowledge, demonstrates the competency, and is able to coach and mentor others
   c. acquired the essential knowledge but does not demonstrate the competency
   d. not acquired any essential knowledge

4. Why might healthcare facilities consider treating patients like guests?
   a. To enhance patient satisfaction
   b. To enhance employee satisfaction
   c. To speed up patient flow
   d. To lower fall rates

A service of Strategies for Nurse Managers
5. How did staff members at Owensboro (KY) Medical Health System ensure that patients’ heads were properly elevated?
   a. Asking each patient whether they were comfortable
   b. Placing a red mark on the beds indicating a 30° angle
   c. Consulting other staff members
   d. Consulting physicians

6. What strategies can help facilities prevent ventilator-associated pneumonia (VAP)?
   a. Focusing on oral care
   b. Assessing the VAP rate at surrounding facilities
   c. Providing training to staff members when possible
   d. Providing training to all patients

7. What tool do nurses at Owensboro (KY) Medical Health System use to assess ventilator patients every morning?
   a. A timeline
   b. A medication documentation form
   c. A diagram
   d. A checklist

8. According to Lydia Ostermeier, MSN, RN, CHCR, what should nurse managers think about when recruiting new nurses?
   a. Retention as a recruitment tool
   b. The candidate’s communication skills
   c. The candidate’s qualifications
   d. The candidate’s personality

9. What is usually the first step in the development of a nurse leader?
   a. Defining competencies
   b. Developing internal, existing resources
   c. Self-assessment
   d. Curriculum development

10. According to Jan Fitzgerald, MS, RN, why might the CMS proposal listing nine hospital-acquired conditions that hospitals will no longer receive payment for be beneficial?
    a. It lowers infection rates
    b. It allows nurses to work as a team
    c. It improves retention
    d. It optimizes patient care

August 2008

1. In regard to protecting patient information, what is the first step to helping staff members deal with disclosure woes?
   a. Designating people with whom staff members can consult when they face a confusing situation
   b. Teaching staff members to stay subjective in complex situations
   c. Conducting annual training sessions and refresher classes
   d. Enforcing the need for proper documentation

2. Before its Joint Commission survey, Trover Health System in Madisonville, KY, used a whiteboard to ________________.
   a. communicate performance goals
   b. communicate performance goals and update staff members about what was happening hospitalwide
   c. list the names of staff members and what duties they would be responsible for
   d. compare past survey rates

3. Why might facilities trying to lower MRSA rates consider deploying a positive deviance technique?
   a. It promotes learning for MRSA patients
   b. It encourages patients to get involved in MRSA prevention practices
   c. It encourages staff members to come up with creative ideas to fight MRSA
   d. It eliminates the margin for error in MRSA prevention

4. How were “discovery and action” dialogues used in the Maryland Patient Safety Center MRSA Prevention Initiative?
   a. To teach participants about the benefits of MRSA prevention
   b. To teach participants how to find the unique solutions to everyday occurrences within their facilities
   c. To teach participants about evidence-based practices on MRSA
   d. To teach participants how to use positive deviance skills in their personal lives

5. Why did a Nevada endoscopy clinic report that as many as 40,000 patients might have been exposed to hepatitis C and other bloodborne pathogens at their facility?
   a. There was inappropriate reuse of single-use vials of anesthesia
   b. There was inappropriate use of multiple-use vials of anesthesia
   c. There was inappropriate blood-drawing from an indwelling IV catheter
   d. There was inappropriate blood-drawing from an indwelling IV catheter and reuse of the syringe to perform a saline flush
6. According to Joe Perz, DRPH, why do many unsafe injection practice cases go underreported?
   a. They are difficult to detect
   b. Patients are hesitant to come forward
   c. Staff members rarely admit they make mistakes
   d. Staff members fear they will lose their jobs

7. Which of the following is not a general category under which unsafe injection practices fall?
   a. Using the same syringe to administer medication to more than one patient, even if the needle was changed
   b. Using a common bag of saline or other IV fluid for more than one patient
   c. Using a bag of saline or other IV fluid for each patient
   d. Accessing a shared medication vial with a syringe that has already been used to administer medication to a patient

8. Facilities can reinforce the importance of safe injection practices with staff members by ____________.
   a. reviewing safe practices once every five years
   b. reviewing safe practices once every three years
   c. focusing on hand hygiene
   d. making exceptions when an error is made

9. According to Aviva Halpert, MA, RHIA, CHPS, __________ should be incorporated into HIPAA disclosure training sessions for staff members.
   a. real-life situations
   b. role-playing
   c. surveys
   d. research projects

10. Why has protecting patient information recently become more challenging for healthcare professionals?
    a. Poor HIPAA training policies
    b. An increase in divorced families
    c. A rise in blended families
    d. An increase in minors having children

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September 2008

1. Which of the following is a conflict resolution tactic Jo-Ann C. Byrne, RN, MHSA, emphasizes in project management?
   a. Exploring options of the individual
   b. Developing cohesion in a group through mutual respect
   c. Working on independent tasks
   d. Setting goals and achieving them regardless of conflict

2. Why does Jo-Ann C. Byrne, RN, MHSA, recommend prioritizing the tasks necessary to complete projects and mapping them out in a project schedule?
   a. It ensures that the most crucial steps are given an adequate time estimate
   b. It allows the nurse to retain more information
   c. It gives the nurse more time to juggle his or her other responsibilities
   d. It makes it more likely that the project will be successful

3. What was not one of the benefits an hourly rounding schedule brought to Sts. Mary & Elizabeth Hospital in Louisville, KY?
   a. Patient falls decreased
   b. Patient satisfaction increased
   c. Turnover rates dropped
   d. Call light usage dropped

4. Before implementing the rounding program at Sts. Mary & Elizabeth Hospital in Louisville, KY, some nurses feared ____________.
   a. it would create nurse-patient conflict
   b. it would add to their workload
   c. patients would be unhappy
   d. it would create nurse-nurse conflict

5. In regard to medication reconciliation, which of the following guiding principles should be considered when designing the process?
   a. Clearly defined roles and responsibilities for each discipline
   b. Competency of each person involved
   c. Making the wrong thing to do the easiest thing to do within the patterns of normal practice
   d. Developing effective prompts or reminders for unprofessional behavior

6. By using hospital incident command systems, hospitals can make improvements in areas of ____________.
   a. emergency management planning, response, and recovery capabilities
   b. recruitment and retention
   c. medication delivery and reconciliation
   d. nurse accountability
7. According to Kristine Sanger, hospital incident command systems can be helpful because they _____________.
   a. guarantee staff members will be able to respond to a large-scale disaster
   b. ensure that the system is working well and lets members hone their response skills
   c. help facilities combat all infections
   d. help staff members develop excellent critical-thinking skills

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8. Hospital incident command systems are typically designed for outbreaks and bioterrorism attacks, but can be useful to ________.
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9. How was The Western Pennsylvania Hospital in Pittsburgh able to improve the medication delivery process for neonatal patients?
   a. Boosting the wages for neonatal nurses
   b. Setting up surveillance systems to monitor medication administration
   c. Expanding its medication delivery process from seven steps to 25 steps
   d. Expanding its medication delivery process from seven steps to 18 steps

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10. How can hospitals minimize their facility’s chance of medical identity theft?
    a. Enforcing strict penalties, such as termination, if an employee does not follow protocol
    b. Conducting routine reviews of employee performance to discover potential wrongdoing
    c. Reiterating the importance of medical identity theft in the healthcare setting to patients
    d. Researching compliance rates at surrounding facilities

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Evaluation

1. Did this CE activity relate to its stated learning objectives? _______________________________________________________

2. Was the format of this CE activity easy to use? _________________________________________________________________

3. Did we avoid commercial bias in the presentation of our content? _________________________________________________

4. Will this activity enhance your professional development? _______________________________________________________

5. How long did it take you to complete this activity (including reading, exam, and evaluation)? __________________________
   _______________________________________________________________________________________________________