Strategies
FOR NURSE MANAGERS

Patient safety

Cost-effective ways to strengthen your facility's infection control program

Continuing Education | Learning Objectives

After reading this article, you will be able to:

➤ Identify cost-effective strategies to bolster your facility's infection control (IC) program

➤ List free resources that provide updated information on IC practices

If you work in the healthcare industry today, you are likely feeling the pressure of doing more with less. It is probable that the act of asking for additional resources or more money will be followed with someone shaking his or her head no. But that falloff doesn't mean quality of care should decrease.

Despite tough economic times, there are several ways you can improve your facility's IC practices at little or no cost. The following seven steps can help reduce infection, regardless of your budget:

1. Reminder posters and e-mails. Following proper IC procedures is often second nature to seasoned nurses and physicians. They walk into patient rooms and wash their hands without thinking twice. But sometimes staff members develop bad habits, such as improperly removing gloves or neglecting hand hygiene. Place posters or signs above sinks, in patient rooms, or high-traffic areas as constant reminders to staff members about prevention measures. Also, don't neglect technology. Group e-mails with IC tips that are fast and easy to digest can serve as a daily or weekly reminder.

> **Stay connected to other colleagues to learn tips on how they implement evidence-based recommendations,** says **Libby Chinnes, RN, BSN, CIC.**

2. Recruit someone on the inside. Many IC programs make use of IC liaisons or appoint staff members to champion IC efforts. Often, a nurse who is on the floor and has developed relationships with other staff members can influence them.

"They can be your eyes and ears on the floor," says **Terri Rebmann, PhD, RN, CIC,** associate director of curricular affairs and assistant professor at the Institute for Biosecurity at Saint Louis University School of Public Health. "[Appoint] someone who already has infection control experience that the staff trusts," says Rebmann.

3. Pay attention to IC literature. "[The Centers for Disease Control and Prevention (CDC)] guidelines are some of the backbone of what we teach," says **Libby Chinnes, RN, BSN, CIC,** IC consultant at IC Solutions, LLC, in Mount Pleasant, SC. The CDC Web site *(www.cdc.gov)* is constantly updated and offers the most recent

HCPro

Infection control   *< continued from p. 1*

information for IC practices. Free downloadable features include the Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America's *Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals* and printable FAQ sheets for healthcare-associated infections (HAI).

Also, stay connected to other colleagues to learn tips on how they implement evidence-based recommendations, says Chinnes. Recycling these ideas can save time and money, while bringing a new approach to your facility.

4. Concentrate on UTIs. In the past, Lehigh Valley Hospital in Allentown, PA, focused primarily on the big, expensive infections such as surgical site infections, ventilator infections, and central line infections, says **Terry Burger, BSN, RN, CIC, CNA, BC,** director of IC at Lehigh Valley. But beginning in 2007, the hospital made a greater effort to focus on urinary tract infections (UTI).

"Although [UTIs] probably cost less than the other infections, they have the largest volume," Burger says.

Lehigh Valley's IC department created a UTI bundle, including a checklist for frontline staff members, and rolled out facilitywide education in an effort to reduce infections.

5. Inform your visitors. Wetzel County Hospital in New Martinsville, WV, recently implemented the Protect Our Patients (POP) program, launched by the Association for Professionals in Infection Control and Epidemiology and funded by Clorox. Part of the initiative involves educating visitors on the role they play in infection prevention.

The hospital has begun giving visitors "POP" quizzes and has placed disinfectant wipes at the hospital's entrance for visitors to use.

6. Give positive feedback. HAIs are a serious problem and detrimental to patients' health, so a lot of negativity is associated with them. But too much negativity is sure to kill employee morale. If a department of your hospital is reducing infection rates, spread the word. Everyone likes recognition for their efforts, and it may light a fire under other departments to improve their infection rates.

7. Provide incentives. Even the smallest incentives can motivate employees during the economic slump.

Lori Jensen, RN, a clinical consultant at Ansell Healthcare in Red Bank, NJ, says she has seen infection preventionists (IP) track employee hand hygiene and glove compliance. The IPs post compliance percentages on a board, replacing employee names with numbers to protect confidentially, so employees can see how they compare with other staff members.

"Sometimes, on top of that, they would give little goodie bags to the highest-percentage person and say this person got the highest numbers, just to recognize them in front of everybody," Jensen says. "That kind of stuff, it really goes a long way." ∎

Source

Adapted from **Briefings on Infection Control,** April 2009, HCPro, Inc.

Technology

Virtual world sets scene for real-life safety

3-D Web site plays up staff disaster readiness

Imagine someone showing up with a suspicious package on one of your hospital floors. Would your staff react quickly, calmly, and correctly, according to your hospital's policy?

Traditionally, finding the answer to such a question would include conducting a tabletop exercise or full-fledged disaster drill. However, now you can try this scenario in an innovative online application.

Children's Memorial Hospital in Chicago ran the suspicious-package scenario in a Second Life virtual world, set up like its real-life facility. Second Life is a 3-D Web site that its users help create.

Children's Memorial employees used characters, known as avatars, in the virtual hospital and evacuated virtual patients as the event unfolded. By critiquing staff member actions online, hospital leaders determined adjustments to their evacuation plan, unearthing some complications they hadn't anticipated. But best of all, the virtual scenario allowed employees to practice responding to an escalating incident, says **Mary Margaret Crulcich, BSN, MHA, CHS,** corporate manager of environmental safety and emergency preparedness at Children's Memorial. "In this virtual world, we practice and play out scenarios that help leaders and staff determine details such as the number of wheelchairs needed to evacuate safely," Crulcich says.

The hospital is interfacing with other local emergency responders that also have a Second Life presence, including Chicago's Department of Public Health and neighboring medical centers. Children's Memorial officials hope The Joint Commission (formerly JCAHO) will accept these virtual drills as a way to meet the community exercise requirement under EM.03.01.03.

Children's Memorial used grant money from the U.S. Department of Health and Human Services' (HHS) Assistant Secretary for Preparedness and Response to fund the simulation.

Second Life serves as a social and marketing network where users go to escape from real life and meet like-minded players. According to its developer, Linden Lab in San Francisco, millions of people around the world belong to the site *(www.secondlife.com)*, which offers free registration and charges for upgrades to one's world.

The site, which has been open to the public since 2003, is gaining a reputation for being a useful tool for public health and disaster readiness activities, including by the following entities:

➤ The Idaho Bioterrorism Awareness and Preparedness Program set up Play2Train.org, which documents how hospitals and other responders are enacting virtual disasters and using the information in their real-life plans. Watch the site's videos for examples of how virtual drills might work at your hospital.

➤ The Centers for Disease Control and Prevention not only spreads the flu virus around its virtual island for epidemiological research, but also conducts virtual health fairs in Second Life and Whyville *(www.whyville.com)* to promote good advice.

➤ HHS unveiled a Second Life island where HIV patients can find information and make decisions about their next move in care and treatment.

➤ Neurologists at Massachusetts General Hospital in Boston are using Second Life to administer therapy to volunteers to determine the effectiveness of stress-reduction techniques.

"It's an exciting, innovative way to learn," Crulcich says. "We don't look at this as a game, but as a learning tool. What we've found by playing out these scenarios is that we get a much higher participation rate among our employees." ∎

Source

Adapted from **Hospital Safety Center,** March 2009, HCPro, Inc.

Infection control

Prevent catheter-associated urinary tract infections

Recognizing risk factors on admission

> **Continuing Education | Learning Objectives**
>
> After reading this article, you will be able to:
> ➤ Explain the rationale for inserting, continuing, and remov-ing indwelling urinary catheters in hospitalized patients
> ➤ Identify populations at risk of catheter-associated urinary tract infections (CAUTI)

Editor's note: The following is adapted from HCPro's new book Preventing Catheter-Associated Urinary Tract Infections: Build an Evidence-Based Program to Improve Patient Outcomes. *For more information on this book or any other in our library, visit* www.hcmarketplace.com.

CAUTIs are the most common of all hospital-acquired conditions (HAC). Eighty percent of UTIs result from indwelling urinary catheters, and 12%–16% of patients admitted to acute care hospitals may have indwelling urinary catheters at some point during their stay.

Significant changes in assessment, care, and documentation are needed in most facilities to prevent CAUTIs in inpatient populations. And to effectively reduce CAUTIs in hospital settings, nurses' attitudes regarding catheter use must change.

The knowledge that as many as 15%–25% of patients will have a urinary catheter inserted during the course of their hospitalization should provide sufficient cause for clinicians to recognize the risk for patients to acquire CAUTIs (see "Identifying CAUTI risk factors" on p. 5) as a result of catheter use in hospital settings[1].

With this proportion of patients having indwelling urinary catheters, coupled with the fact that CAUTI is the most common type of HAC, the decision to place indwelling urinary catheters should not be taken lightly. Catheter insertion, continuation, and care are in the hands of clinicians who have an opportunity to prevent patients from

being exposed to this significant HAC. It is important to assess patients who already have catheters in place on arrival, as well as to monitor those who have catheters placed once they are admitted to hospital settings.

It is also essential to review documentation tools and ensure that assessment items related to catheter insertion and care are in place to allow staff members to document specifics with ease. In organizations with electronic documentation, reports can be provided by mining data that allow clinicians to monitor the number and types of catheters used, specific aspects of the care provided, and the number of catheter days.

As patients enter your facility, assessments and appropriate actions should be taken with patients who are symptomatic for UTIs. In cases in which the patient presents with a catheter in place or requires catheter placement shortly after admission, having the proper tests completed to be able to document that the patient's UTI was present on admission (POA) saves the organization from being held accountable for CAUTIs.

Decisions regarding the process for initial and ongoing assessment and management of patients with asymptomatic UTIs documented with positive urine cultures will need to be led by your physician champions with the guidance of infectious disease specialists. Recommended courses of action for assessment, monitoring, and management of symptomatic and asymptomatic bacteriuria also need to be established and communicated to physicians and to the clinical staff.

Detailed assessments of patients by their nurses during the admission process must be carefully partnered with and supported by physician documentation to determine whether a patient's UTI preceded placement of the urinary catheter and was POA, or whether the infection was acquired as a result of the hospital admission and is then considered a HAC according to the Centers

for Medicare & Medicaid Services' (CMS) definitions[2]. POA conditions are determined by using the following criteria:

➤ There must be clear differentiation in the presence of diagnosis/condition at time of admission or development of the problem after admission.

➤ Physician documentation of the condition must exist in the patient's medical record. If POA, it must be documented concurrently with the physician's admission orders.

➤ Primary responsibility for complete and accurate documentation lies with the physician/licensed independent practitioner.

➤ Any incomplete documentation requires provider clarification.

Physicians and nurses must work closely as a team to identify patients at high risk for CAUTI and carefully and accurately document findings in patients' medical records. These intraprofessional team members must also share the opinion that the best means of preventing CAUTI is to reduce catheter use whenever possible.

Nurses must remember that not all patients with a UTI develop signs and symptoms and learn how to distinguish between symptomatic and asymptomatic bacteriuria in these hospitalized patients[3]. Starting with comprehensive patient histories on arrival is essential to identify patients' risk factors for developing a CAUTI or to determine whether they already have a UTI on admission. ■

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2. **CMS** (2008). "Hospital-Acquired Conditions." Available from *www.cms.hhs.gov/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp#TopOfPage.*

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Identifying CAUTI risk factors

Current literature findings and a record review of patients with catheter-associated urinary tract infections (CAUTI) suggest the following as risk factors[1]:

➤ Gender (e.g., women are more likely to have UTIs than men)

➤ Advanced age

➤ History of urinary tract problems (e.g., enlarged prostate or urologic surgery)

➤ Neurologic conditions (e.g., spinal cord injury) causing neurogenic bladder problems

➤ Previous UTIs

➤ Previous and/or current abnormal voiding patterns

➤ Current catheter history

➤ Incontinence

➤ Comorbid conditions such as diabetes

➤ Immunosuppression

Patient assessments must also include documentation of any signs and symptoms of UTIs, including:

➤ A frequent urge to urinate

➤ A painful, burning feeling in the area of the bladder or urethra while urinating

➤ A fullness in the rectum (in men)

➤ Suprapubic tenderness

➤ Passing only a small amount of urine

➤ Cloudy or reddish-colored urine

➤ Fever greater than 100.3°F (38°C), with or without chills

➤ Incontinence

➤ Pain in the back or side

Reference

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Source

Adapted from *Preventing Catheter-Associated Urinary Tract Infections: Build an Evidence-Based Program to Improve Patient Outcomes.*

Patient care

Find your facility's fit

Piece together an effective patient satisfaction program

> **Continuing Education | Learning Objectives**
>
> After reading this article, you will be able to:
> ➤ Identify strategies to boost patient satisfaction

Achieving complete patient satisfaction is every facility's goal when implementing a patient satisfaction program. But it takes innovative nurse leaders to find the right pieces for the program and an engaged staff to make them fit.

This was the situation at Norton Suburban Hospital, located in Louisville, KY, whose postoperative unit's collaborative program pushed its overall Press Ganey patient satisfaction score from the 1st percentile in 2006 to the 97th percentile in 2007. Two years later, the score lingers in the 92nd percentile.

"We tried a lot of different approaches during the [previous two years] and nothing was successful," says **Shelia Goold, RN, CBN,** nurse manager of the unit. "We had to make some major changes."

Identifying weak spots

Goold and **Carol Goss, MSN, RN-BC,** medical-surgical clinical educator at the facility, set out to make changes by first reviewing nursing literature and other facilities' best practices. They sought to pinpoint areas in which their unit could improve and developed the following measures:

➤ **Customer satisfaction team.** Goold, frontline staff members, and a representative from the facility's service excellence department formed a unit team to garner staff feedback about patient satisfaction practices that were ineffective and how they could be improved. The team also met with patients to ask what was most important to them.

➤ **Patient satisfaction surveys.** The unit monitored Press Ganey surveys to compare its results to those of other hospitals across the country.

Goold and Goss then built initiatives around four questions on the survey in which the unit scored poorly. The initiatives focused on how staff members:

➤ Controlled patients' pain
➤ Included patients in treatment decisions
➤ Paid attention to patients' personal and special needs
➤ Responded to patients' calls

Hosting a convention

Goss organized a patient satisfaction convention and invited all hospital units to educate everyone about the new patient satisfaction initiatives and ensure that all staff members understood them. The convention included the following discussion and training exercises:

➤ **Norton Healthcare service basics:** Covered the importance of safe work habits, communication, teamwork, and professional behavior
➤ **Press Ganey 101 session:** Explained how to interpret patient satisfaction survey data
➤ **Torchbearer training:** Taught key individuals tactics for creating a customer service team that they later initiated on their units

"We set [the convention] up like a Republican and Democratic convention," says Goss. "We had a big hall decorated and [formed] delegates from each of the units."

Further education about patient satisfaction initiatives were provided to staff members via group and one-on-one meetings, role-playing sessions, and postings on the unit.

Improving staff communication and behavior

Goold and Goss realized that a culture change was also needed to enhance patient satisfaction on the unit, so they developed programs to build a harmonious work environment. They held training sessions on improving multigenerational communication, as well as classes

defining horizontal violence that gave staff members tools to address inappropriate behavior. They also implemented a zero tolerance policy for the unit and required all staff members to sign a "Commitment to coworkers" form (see p. 8).

Centering on patients' needs

Goold and Goss knew patient satisfaction scores couldn't increase without enhancing staff communication with patients.

Thus, they implemented bedside shift reporting so staff members could perform handoffs in patient rooms, instead of at the nursing station. As a result of their involvement in the development of the program, "staff felt like they owned the program, and we felt they would be more likely to use it," says Goss.

They also focused on other efforts to encourage patient involvement in care and to ensure that staff members honed in on patient needs, including:

➤ **Hourly rounding.** Nurses and ancillary staff members in the unit began performing hourly rounds, which Goold says decreased call-light use immensely.

➤ **Whiteboards.** Patient rooms on the unit now feature dry erase boards, which contain information pertinent to each patient's care. The information is updated as needed. In addition, all interacting staff members must list their names and contact information on the whiteboards.

Goold says nurses focus on four main areas that are important to patients:

– **Pain.** This includes the acceptable pain level determined by the patient, as well as pain medication ordered and the last time it was administered.

– **Information.** Patients tell nurses who they want to keep informed of their care, such as a spouse or child, and nurses serve as their messenger.

– **Activities of daily living.** Nurses identify the level of activity assistance needed.

– **Special needs.** Nurses incorporate anything that is important to the patient in their care (e.g., the patient wants dentures in before seeing visitors).

"Keeping pain under control is of utmost importance," says Goold. "We talk to patients about their appropriate pain threshold, what pain they are currently experiencing, and what is an acceptable pain level—and we work with them to maintain that pain level."

Elevating patient satisfaction scores

All these initiatives combined to increase patient satisfaction scores. Goss and Goold attribute the unit's success to ongoing education and engagement that can be achieved by involving staff members in the building of the program from the beginning. ∎

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Commitment to coworkers

As your coworker, with a shared goal of making our patients feel like VIPs (very important patients) by providing high-quality care to patients and families, I commit to the following:

1. I will make a great first impression by always following the Golden Rule: Do unto others as you would have others do unto you.

2. I will accept responsibility for establishing and maintaining healthy interpersonal relationships with every member of this staff. I will talk to you promptly if I am having a problem with you. The only time I will discuss it with another person is when I need help in deciding how to communicate with you appropriately, demonstrating courtesy, clarity, and respect.

3. I will establish and maintain a relationship of functional trust with you and every member of this staff. My relationships with each of you will demonstrate teamwork by being equally respectful, regardless of job titles or levels of educational preparation.

4. I will maintain a secure and trusting environment by not complaining about another team member and ask you not to as well. If I hear you doing so, I will ask you to talk to that person.

5. I will do the right thing by not criticizing, infighting, sabotaging, gossiping, nit-picking, intimidating, threatening, excluding, devaluing, scapegoating, bullying, discouraging, ignoring, or belittling. If I hear you doing so, I will ask you not to as well.

6. I will demonstrate compassion by accepting you as you are today, forgiving past problems, and ask you to do the same with me.

7. I will be committed to ensuring a safe environment by finding solutions to problems rather than complaining about them or blaming someone, and ask you to do the same.

8. I will show appreciation by affirming your contribution to quality service when you keep patients and families informed and participate in the unit process improvement.

9. I will acknowledge your worth by looking at you as I walk down the hall and speaking to you within 5 ft., and ask you to do the same.

10. I will demonstrate compassion by remembering that neither of us is perfect, and that human errors are opportunities not for shame or guilt, but for forgiveness and growth.

11. I will demonstrate pride in my unit, my hospital, and my system by holding myself and my coworkers accountable to stopping horizontal violence in the workplace.

I understand that there is a zero tolerance culture related to horizontal violence in my unit.

_____   _____

Signature   Date

Source: Norton Suburban Hospital, Louisville, KY. Adapted with permission.

The Joint Commission

Mock surveys make a difference in staff education

> **Continuing Education | Learning Objectives**
>
> After reading this article, you will be able to:
> ➤ Describe methods for setting up a tracer program in a large hospital
> ➤ Discuss the benefits of staff education on the tracer process
> ➤ Identify ideas for ensuring tracers are performed regularly

Constructing a tracer process from scratch for a 645-bed hospital is no simple matter, but that was precisely the task before Medical City Dallas Hospital's survey readiness committee, says **Carol Carach, RN, BSN, MPH,** regulatory and accreditation survey supervisor at the facility.

"When I arrived in November of 2006, we didn't have any sort of formal readiness process, and we were up for our Joint Commission survey in 2007," says Carach.

However, the facility had a survey readiness committee that decided it would institute mock drills and tracers.

"That's where we got started," says Carach. "We [looked at] maybe three units as part of our initial drill and then instituted a more formal tracer."

An initial sign-up sheet garnered teams for two patient care units immediately, and the facility was able to begin tracers in all units roughly six months later.

"We leave it up to the teams to schedule the tracers with their partners. They are encouraged to invite the unit manager or a designee," says Carach.

"While managing 70 people for tracer teams may prove to be challenging, we have found so much value in the ability to spread knowledge about Joint Commission standards throughout the entire organization," says **Laura Weber, RN, MBA/HCM,** director of quality management at Medical City.

Building teams

Medical City has 35 two-person tracer teams roving the halls to cover the facility's 645 beds. Maintaining those teams can be somewhat difficult. After the first round of recruiting, Medical City had 25 teams and ran tracers for all units that had teams assigned to them while it tried to fill in the blanks.

There were certain areas that required more active recruiting, and, in more challenging cases, unit managers selected or assigned their team members. Team members were educated on the tracer process and took this knowledge to their units. They were then assigned to trace another department. "Part of the setup is that you do not trace your own unit. You'll pass over things that are not in compliance" simply because of familiarity, says Carach.

Providing education

"Because it first started in the survey readiness committee, that is where the formal education began," says Carach. "As the teams evolved, I had a formal education plan set up and continue to do formal education for new team members on an annual basis, at a minimum."

The teams are also encouraged to communicate with one another. Twice per year, the 35 teams meet to share experiences and tips on running tracers.

And education isn't only for the survey teams. "It is important to increase awareness of survey accreditation requirements, not only among the teams, but the staff and people they talk to while they are surveying the units," says Carach. "The tracer teams become educators there. The staff feel more comfortable being interviewed, and they are better able to communicate the standards."

Reporting efficiently

Team reports can prove lengthy. "We used to have the teams verbally report the findings at the survey readiness meeting, but that became too time-consuming," Carach says.

Mock surveys   *< continued from p. 9*

Medical City transitioned the reporting process into a database on a shared drive in the hospital. "Each team puts their findings into the database, and they leave a copy of their report with the manager of the unit," says Carach.

Team members also send the names of staff members and physicians they interviewed to HR and medical staff departments so their files can be checked.

Scheduling tracers

One challenge for the teams was making sure they blocked off sufficient time to conduct their tracers.

"People have very good intentions; they want to help out, and they're very willing to do so. But at the end of the month, they find they've run out of time," says Carach.

To prevent this, she sends messages reminding team members to schedule their monthly tracer.

How the teams handle their scheduling is up to them. Some have a standing appointment established. Others keep a more informal schedule to complete the tracer.

Utilizing tools

"We have a form intended to guide the team through the tracer," says Carach. The form includes a chart review, so team members randomly choose a chart from the unit and look it over for specific items, including the:

➤ History and physical
➤ Time, date, and signature on medical record entries
➤ Home medication list
➤ Interdisciplinary patient education

The tool also includes a staff review section. Mock surveyors try to choose the nurse who is taking care of the patient for the reviewed chart, when possible. "We also ask National Patient Safety Goal–related questions to give staff the chance to practice answering the sort of questions they should expect when actual surveyors come," says Carach.

The tracer tool lives on the shared drive, along with the reports from the teams to keep all teams working off the same version of the tool.

Acknowledging improvement

The semiannual team meeting serves the purpose of not only sharing information and lessons learned, but also identifying excellence and improvement.

"We recognize the most improved team and unit, as well as the most consistent team and unit," says Carach.

Honorees are rewarded with a small party and recognition in the hospital's newsletter. The tracer team and unit share the reward as a method of building a sense of partnership. For the first two quarters, Medical City recognized consistent excellence on the orthopedic surgery floor and saw improvements on the pediatric unit. ■

Source

Adapted from **Briefings on The Joint Commission,** January 2009, HCPro, Inc.

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Motivation

Balance work and life on a staycation

How staying close to home can help you get away

Although flying to a tropical island or a snowy ski resort are great ways to spend a vacation, a similarly relaxing destination may be right in your backyard. It's called a staycation, and it's a trend that is quickly becoming popular among healthcare professionals.

"There's the myth that you have to go somewhere to be on vacation," says **Terri Levine,** life coach at Comprehensive U, Inc., in North Wales, PA, who frequently works with healthcare professionals. "That's just not true."

A staycation—said to be coined by a Canadian comedian—has become a widely used term, as the United States saw a decline in summer and holiday travel in 2008.

Described as the time an individual or family spends at home relaxing or making day trips to area attractions rather than taking a traditional vacation, staycations are becoming increasingly popular in today's tough economy of rising unemployment rates and cost of living. People are looking for ways to balance their work and personal life without spending a lot of money.

Sometimes, the only way to save money and still enjoy time off is to stay home and just enjoy the downtime, says **Marlene Gonzalez,** life coach at Life Coaching Group, LLC, in Plainfield, IL. A staycation can offer more benefits than most people realize, Levine adds.

Staycation time can be used to do some gardening, lounge by the pool, or visit local parks, festivals, and museums. Or you can use it to concentrate on yourself and your well-being. "You can go on a mental vacation," Levine says. In doing so, you'll find that you can replenish and renourish yourself physically, emotionally, mentally, and spiritually.

Gonzalez advises her clients to take at least one week per year to focus on that replenishment. "It's about taking ownership for yourself and your needs. When you go away on vacation, you're often escaping yourself and your needs," she says.

Traveling can often cause more stress than relaxation when dealing with long lines and wait times at the airport. The ever-increasing costs of a vacation and other activities add to that stress.

Gonzalez has several clients who skip the hassles of traveling to simply focus on their personal needs. For example, one opted for music therapy and another signed up for a weeklong intensive yoga class. Others have taken courses offered at local colleges.

Taking a staycation can be a great time to simply rest and get the proper sleep many lack, Levine says. Change your routine slightly during your time off. Focus on mind, body, and spirit, she says. Go for a walk, take a long bath, or have lunch with a friend.

Levine makes an agreement with clients prohibiting them from doing anything work-related, such as checking e-mail, which can hinder a real vacation.

Plan four staycations per year, whether that means a week off from work or just a day or two, says Levine.

Develop a list of things you want to accomplish while you're at home, such as completing projects around the house you haven't had time for, picking up a book you've been wanting to read, or spending time with family or friends.

"You have to make sure these things are just as important as anything else on your to-do list," Levine says, adding that the list should align with goals for self-improvement to help you learn more about yourself.

Planning a true staycation should involve:

➤ Scheduling official start and end dates so your staycation won't become regular downtime that can include too much time in front of the television

➤ Scheduling fun daily activities that are close to home to get you out of the house ∎

Source

Adapted from **The Doctor's Office,** April 2009, HCPro, Inc.

Tip of the month

When error occurs: Create a culture free of blame

How do you handle a staff member who has made a medical error? Does your intervention vary depending on whether the error led to a critical outcome? Now, imagine knowing your action or lack of action was responsible for a patient's demise.

The culture surrounding the nursing profession leads us to believe we are to practice as clinical perfectionists. However, although we strive to deliver safe patient care free of error, it may be unrealistic to hold such an opinion of ourselves. Instead, we should learn from medical staff colleagues who are making strides with disclosures and apologies.

The book *Why Hospitals Should Fly: The Ultimate Flight Plan to Patient Safety and Quality Care* can assist you in your decision-making when errors occur and also in your ability to effectively lead staff members through processes following an error.

Consider stimulating a discussion with staff members at a meeting by asking them the following questions:

➤ Do you think nurses should lose their license if a patient dies as a result of their error?

➤ How do you think our organization should manage nurses who make an error?

➤ What can we do to encourage nurses to be comfortable acknowledging errors? ■

References

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Source

Shelley Cohen, RN, BS, CEN, Health Resources Unlimited, *www.hru.net*. Adapted with permission.

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"The fundamental belief behind shared governance is that nurses at every level should govern their practice and be included in all decisions that affect their practice. This belief requires a redistribution of influence among managers and staff from one in which all decisions are made by administrators from the top down to one in which decisions are agreed upon collaboratively from the bottom up."

—*Barbara Hannon, RN, MSN, CPHQ*

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