Orientation

Residency programs help prepare competent nurses

by Vicky Goeddeke, RN, MS, CEN, CPEN

Editor’s note: This article is part one of a two-part series about nurse residency programs. Keep an eye out for part two on how to implement a program in an upcoming issue of Strategies for Nurse Managers.

Offering a nurse residency program is an important strategy for planning for the future in nursing, but many hospitals are finding these programs costly, considering the current economic conditions affecting many healthcare organizations. Despite the financial and personnel resources it takes to support a nurse residency program, there are sound reasons to continue or begin such a program in your organization.

Nurse orientations cost an estimated $20,000–$50,000 per nurse (Blanzola et al., 2004). In addition to orientation costs, turnover costs include marketing and recruitment expenses, salaries for overtime and/or external staffing resources to cover clinical staffing needs, and the potential effect on customer satisfaction scores. Nursing turnover has been estimated to cost 75%–125% of the average annual salary of an organization’s nurses (Pine et al., 2007).

Organizations must weigh the cost of a nurse residency program against the cost avoidance of nurse turnover. A successful nurse residency program can lead to positive outcomes for organizations, such as lower turnover and the development of competent clinical practitioners. Anticipated future returns include improvements in staff satisfaction, clinical productivity, outcomes of care, patient safety, and, as a result, customer satisfaction (Keller et al., 2006). A successful nurse residency program helps nurses develop advanced nursing skills that contribute to these outcomes.

Challenges for new graduate nurses

Although 90% of academic nurse leaders feel new nurse graduates are fully prepared to practice, only 10% of hospital nurse leaders share this opinion (Berkow, 2009). The challenges of transitioning from nursing school to clinical practice for new nurse graduates leads to first-year turnover rates of 35%–60% (Blanzola).
Residency programs

New nurse graduates face a huge challenge as they transition from student to competent practitioner. New nurses must adjust to the clinical demands and environment of a new work arena, which have increasingly complex patients and specialties that are becoming more technology-focused.

In addition, new nurse graduates often work demanding alternate or rotating shifts that they were unaccustomed to as students.

For these reasons, new nurse graduates are attracted to organizations offering nurse residency programs that facilitate their transition to professional practice. Many have identified an interest in and desire to begin work in specialty areas that require strong clinical knowledge.

Cultural considerations that may lead to a new nurse graduate selecting an organization’s nurse residency program include professional growth opportunities, coworker and physician relationships, nursing autonomy, scheduling, and recognition of nurses.

Orientation structure

Orientation programs are generally structured to introduce new hires to the new work environment and their new unit’s scope of services. Programs typically provide information regarding the organization and the unit. Programs also assess new hires’ knowledge and skill base and connect them to peer resources who can role-model expectations for nurses on that unit, as well as facilitate a sense of belonging to the team. The orientation period gives nurse leaders time to evaluate clinical competency, efficiency, communication skills, productivity, and customer service focus. Orientation programs are usually designed to guide nurses’ transition to a different work arena, not a different role.

New nurse graduates have a different transition challenge—one from student to the role of a nurse—and a nurse residency program needs to be more than an extended orientation. There are a wide range of goals, program lengths, and outcomes reported for nurse resident programs (Keller et al., 2006). New nurse graduates can become competent practitioners more quickly with the guidance of a nurse residency program. Programs should offer didactic and leadership components in addition to the standard clinical components offered in an orientation program. Incorporating didactic and leadership components supports the nurse resident’s development beyond clinical skills, enhancing clinical judgment and critical thinking skills (see “Components of a nurse residency program” on p. 3).

Residency design

Nurse residency is not a new concept—programs were first documented in 1980s literature (Altier & Krske, 2006), and most are based on Benner’s theory of novice to expert. Benner felt competence was typified by nurses who had been on the job in the same or similar situations...
and were consciously aware of connecting their actions to a long-range plan (Benner, 1984). Benner noted that competence was generally reached only after years of gaining experience as a practicing nurse. A nurse residency can facilitate new nurse graduates to advance more quickly from novices to competent nurses, lessening time as advanced beginners. A nurse residency, focused on developmental concepts, attracts new nurse graduates, and the organization enjoys the benefits of competent nurses and the bonus of low turnover.

Our experience at Northwest Community Hospital reflects these ideals. The initial nurse residency program was founded in 1995 and, based on Benner’s theory, was originally a 24-month program. We discovered in the early nurse resident groups that through the mentorship of the residency program, nurses reached competence more quickly, and the program was reset first to 18 months and then to 12 months. These nurses come out of the program as competent practitioners. There remains some turnover among our nurse residents, but there is also longevity: 30% of the first nurse residents were still employed at our organization after 10 years. We have a culture of longevity at Northwest Community Hospital, but our nursing workforce, like nursing in general, is aging. We are fortunate that our turnover rate is currently below the national and Greater Chicago-area averages. Because of our low nursing turnover, we enjoy a low nursing vacancy rate. But ours is a forward-thinking organization, so we continue to offer and support our nurse residency program. It’s the smart thing to do.

Editor’s note: Goeddeke is the ANCC Magnet Recognition Program® and nursing excellence manager at Northwest Community Hospital in Arlington Heights, IL.

References
U.S. Department of Health and Human Services, Health Resources and Services Administration (2004). “What is behind HRSA’s projected supply, demand, and shortage of registered nurses?”

Components of a nurse residency program
Include developmental plans with components specific to the practice area in a nurse residency program.
Clinical components:
➤ Organization-specific orientation considerations
➤ Nursing role considerations and management of care delivery
➤ Interdisciplinary interactions
➤ Emergency recognition
➤ Conflict resolution
➤ Assessment and procedural skill development
➤ Patient teaching
➤ Delegation
➤ Cultural diversity awareness
➤ End-of-life care considerations
Didactic components:
➤ Knowledge of specialty practice area
➤ Development of clinical judgment and decision-making skills
➤ Cultivation of critical thinking skills
➤ Integration of evidence-based knowledge
Leadership components:
➤ Commitment to the nursing profession
➤ Development of leadership skills
➤ Resource management
➤ Being a unit leader/charge nurse
➤ Nursing research
➤ Considerations for becoming a nurse leader
➤ Nurse manager role
➤ Nurse educator role
**Patient care**

**Keeping the hospital’s smallest patients safe**

*An Indiana hospital reduces noise levels to help premature babies’ development*

For babies born prematurely, even the noise generated from a normal conversation can be too loud for proper development. But mothers who give birth to premature babies at The Women’s Hospital in Newburgh, IN, need not worry about the noise level in the hospital’s neonatal ICU (NICU).

The Women’s Hospital installed sound meters and visual feedback cues to ensure that babies receive the safest possible care.

“We think that the developing brain, especially of the premature baby, is influenced by its environment,” says Kenneth Herrmann, MD, medical director of newborn services for the Deaconess-Riley NICU at The Women’s Hospital. “The environment is either promoting healthy development of the brain or it’s not. There is a school of thought that says any noxious stimulus—too bright a light, too loud a sound—is distracting to the task of growing and developing.”

**Average NICU noise level**

The American Academy of Pediatrics recommends that NICU noise levels remain at or softer than 45 decibels. Noise at this level is slightly quieter than the sound of rainfall, which is estimated at 50 decibels.

Keeping the NICU this quiet is almost impossible, says Herrmann. Necessary equipment such as ventilators, incubators, and monitors; infection-preventing but echo-inducing design; and nurses and visitors in the NICU all add to the sound level.

“Nurses are people too, and in the course of their care, they tend to talk to each other across the room and they have to talk over the ambient sound,” says Herrmann.

Many NICUs operate at sound levels closer to 80 or 90 decibels, he says. For the most part, the noise levels generated from equipment and hospital design cannot be altered without significant hospital renovations.

The Women’s Hospital seized its chance to change the behaviors of staff members and visitors in the NICU. Posting a sign and asking visitors to keep their voices down was not effective, says Herrmann. Instead, the hospital installed sound meters and light “trees,” which resemble overhead traffic lights, to give staff members a sense of the decibel level.

Using a computer system called SONICU, the sound level is measured every five seconds, and the data are transmitted to the light trees, which show a green, yellow, or red light, depending on the noise level. Green means the noise is at a good level, and yellow means staff members should be cautious about the noise level. If the noise level reaches the red zone, the overhead lights in the NICU begin to flicker, alerting people that they must be more quiet.

“In the intensive care nursery where there are no complainers, sound levels can get out of control,” says Herrmann of a premature baby’s inability to verbally alert a caregiver to discomfort. “You can have an automated system that is nonjudgmental, that signals to everybody when it’s getting too loud.”

When The Women’s Hospital started using visual cues in 2007 to alert staff members and visitors to noise levels, the red light was triggered to go off at 75 decibels and the yellow light was triggered at 60 decibels. Since then, staff members have learned to keep their voices down enough so that the red light is now triggered at 60 decibels and the yellow at 48. Although the light trees help spread awareness about the NICU’s noise level, they
are directly overhead and can blend in with the environment. The flickering overhead fluorescent lights, a special system that The Women’s Hospital NICU had installed, act as a visual cue that is more difficult for staff members to ignore. The lighting system has also allowed the NICU to simulate the effects of sunrise and sunset to prepare premature babies for the real world.

“People have to be willing to cooperate. SONICU enables us to get rid of the policeman, the person who has to walk around and say, ‘You’re being too loud,’ ” says Herrmann. “It means the staff has to embrace the idea that sound levels are important to the babies and that they are part of the reason why the care is better or worse.”

The SONICU system also allows the Deaconess-Riley NICU to track the number of yellow and red alerts that occur during a given time. That way, Hermann can show staff members that they are too loud or are speaking at appropriate levels.

**Beyond the NICU**

Although this technology is currently being used in the NICU at The Women’s Hospital, Herrmann sees potential for the SONICU system in a more general hospital setting, especially for those hospitals looking to improve their patient satisfaction scores.

“From my perspective, this piece of technology would be used to greatest advantage in those noisy hallways where most of the hospital patients are adults,” he says.

Adult patients often express dissatisfaction with noise levels during a hospital stay because they are uncomfortable in some other way because of their sickness or treatment. One question on the Hospital Consumer Assessment of Healthcare Provider and Systems (HCAHPS) survey specifically asks patients whether the area around their rooms was quiet at night. The noise level is usually a stressor that can be reduced during a patient’s stay and is often a consideration with current evidence-based design initiatives. Any hospital being built today would be wise to include this type of technology, says Herrmann. A hospital doing renovations could easily implement an automated system, such as SONICU, to create a quieter, less stressful environment for patients.

Herrmann advises hospitals that want to attract more business to examine their quality ratings (often HCAHPS scores) and decide whether a system such as SONICU would help improve these ratings.

“The noise, commonly enough, is people’s voices out in the hall, which, if it’s during a no-visiting time, it’s nursing staff in the middle of the night talking too loud outside of the patient’s room,” says Herrmann. “It’s a big deal in the adult world, and yet not much is done about it.”

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**Source**

Adapted from *Briefings on Patient Safety*, July 2009, HCPro, Inc.

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Use peer review to boost nursing autonomy and competence

by Gina Boring, MSN, RN, NE-BC

Peer evaluations and self appraisals can be useful tools to measure competence and professional development and promote professionalism and accountability.

Managers may want to consider instituting an annual peer review process, which can include various elements, such as feedback from six peers, feedback from the unit director (see Pella [IA] Regional Health Center’s peer review tool on p. 7), and a self-evaluation completed by the nurse being reviewed.

“The peer review tool has proven to be very worthwhile in offering objective input for peer evaluation for both the staff level and the leadership level,” says Yvonne O’Brien, MS, RN, CNO at Pella Regional Health Center.

Set goals

Help nurses improve professionally by having them set specific, measurable, action-oriented, realistic, and timely (SMART) goals during the peer review process. Then incorporate the goals into the nurse’s plan for the upcoming year. Once SMART goals are set by the employee, the manager’s role becomes that of a facilitator.

Follow-up on the goals set during a peer review/performance appraisal evaluation should occur two to six months after the initial plan is set. The measurable, realistic, and timely qualities of the goals, along with the level of employee engagement, will determine the follow-up interval.

If no progress is made, use the peer review feedback and goals to hold the nurse accountable. But if progress has been made, celebrate the accomplishments.

Evaluation process

Two powerful questions asked on many of our units are, “How well do you like following this nurse’s assignment?” and “How well do you like being assigned on the same team as this nurse?”

The first question allows the participants to discuss how well tasks and needs are addressed from the previous shift, charting completeness, handoff communication, patient satisfaction, or environmental issues. The second question addresses teamwork, witnessed quality of care, interaction with patients and family, and professionalism.

Each of the questions is answered using one of the following ratings:

- 0 = Needs improvement
- 1 = Consistently meets standards
- 2 = Consistently exceeds standards

We ask that any rating of “0” include an explanatory comment, and space is provided for narrative feedback. Many organizations choose to have the feedback from peer review in a purely narrative format, which negates the need for a scoring or rating. The evaluation simply needs to fit the process.

Practicing a formal written peer review process provides nursing staff members with an opportunity to meet the highest performance expectations. Thus, it’s important to work with staff nurses at all levels and across all settings to design a peer review process that meets the patient population served, the unit culture, and the mission and values of the organization.

Editor’s note: Boring is the ANCC Magnet Recognition Program® project director at Aultman Hospital in Canton, OH.

Source

Adapted from HCPro’s Advisor to the ANCC Magnet Recognition Program®, June 2009, HCPro, Inc.
Peer review worksheet

Employee: ____________________________ Position: ____________________________
Department/unit: ______________________ Manager: __________________________
Evaluator: ____________________________ Return by: __________________________
Performance period: ______________________ Start date: ________________________

Please rate each factor/competency using the rating scale below.

<table>
<thead>
<tr>
<th>Rating factor for performance</th>
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<tr>
<td>Below standard 1 2 3 4 5 Exceptional</td>
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<table>
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<tr>
<th>Factor / competency</th>
<th>Description of ideal performance</th>
<th>90-day appraisal</th>
<th>Annual appraisal</th>
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<tbody>
<tr>
<td>Quality of work</td>
<td>How does this person demonstrate the ability to perform the various duties and special projects required of his or her position? Consider thoroughness, the ability to apply knowledge to the task at hand, the timeliness and accuracy of the completed project, ongoing communication, and the ability to explain the result to those involved.</td>
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<tr>
<td>Interpersonal relationships</td>
<td>How does this person demonstrate the ability to communicate effectively with coworkers or managers? How does he or she promote positive relationships with customers or coworkers and demonstrate excellent customer service? Describe this person’s ability to work cooperatively with coworkers. Is he or she a team player? Does he or she treat others with respect? Does he or she communicate in a positive and tactful way? Does this person handle constructive criticism well? Does he or she respect others’ time by arriving for meetings on time and being prepared?</td>
<td></td>
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</tr>
<tr>
<td>Quantity of work</td>
<td>How does this person demonstrate the ability to handle the assigned workload or project efficiently? Were you kept informed throughout the project? Consider his or her productivity, ability to complete assignments on time, to multitask, and to stay on task.</td>
<td></td>
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</tr>
<tr>
<td>Professional requirements</td>
<td>Describe how this person demonstrates an understanding of and adherence to the facility’s policies and procedures. Consider the facility’s policies pertaining to attendance, dress code, confidentiality, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mission effectiveness</td>
<td>Describe how this person demonstrates and supports the mission of [insert organization] to provide quality services to its internal and external customers. Is he or she kind, courteous, and respectful of all people, including patients, families, coworkers, and management? Is he or she responsive to customers’ needs?</td>
<td></td>
<td></td>
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Source: Pella (IA) Regional Health Center. Adapted with permission.
Infection control

Putting a stop to ventilator-associated pneumonia

After reading this article, you will be able to:

- Identify the risks VAP poses to patients on mechanical ventilation
- Discuss tips to prevent VAP in patients

For a long time, ventilator-associated pneumonia (VAP) had been viewed as an unavoidable evil, particularly in ICUs.

The healthcare-associated infection (HAI) was a common occurrence among patients who had been on mechanical ventilation on an endotracheal or tracheostomy tube for more than 48 hours. However, as with many HAIs, the healthcare world’s view on prevention has changed. Lee Memorial Health System, a Ft. Myers, FL–based health system, targeted VAP as an HAI the organization would completely eradicate.

Since then, the health system has gone 24 months without a case.

There were several reasons Lee Memorial chose VAP as a target for zero—part of the Association for Professionals in Infection Control and Epidemiology’s (APIC) Targeting Zero campaign. First, VAP occurring in the ICU has the highest rate of fatality of any HAI, says Stephen Streed, MS, CIC, system director of epidemiology and infection prevention at Lee Memorial and an APIC board member.

“[Studies show that] 14% of patients who have VAP also have a fatal outcome,” Streed says. “That is too much.”

In the past, there was a 30% chance the patient would contract VAP, says Marilyn Kole, MD, medical director of system intensive care services at Gulf Coast Medical Center in Panama City, FL, part of the Lee Memorial Health System. Medical professionals “talked about [VAP] being expected,” says Kole.

The historical statistics on VAP are particularly frightening, as there was a 5% cumulative chance a patient would contract VAP, meaning after 10 days in the ICU, there was a 50% chance the patient would come down with the infection.

“That was the norm. We just accepted it,” says Streed. And then an epiphany occurred.

“We saw a small rural hospital—not a teaching institution—give a talk on how they went a year without a VAP,” says Kole. “We thought, ‘If they can do it, so can we.’”

And so, in a competitive spirit, Lee Memorial moved forward with plans to put a stop to VAP at the institution.

A matter of perspective

One reason for the hospital’s success has been a dual-level approach to looking at VAPs. On one side, it has the intensivist perspective, examining the individual patient and the individual case. But it now also incorporates an epidemiology perspective, looking at groupings, recurrences, and trends.

“The difference is looking at patients one at a time versus groups, the way an epidemiologist would look,” says Kole. “An intensivist will look at the patients one at a time.”

The facility now reviews each case but also looks at long-term trends to evaluate whether it’s headed in the right direction.

Ownership

This improvement process has increased awareness among staff members and built a sense of pride—particularly following the organization’s extended success in combating VAP.

“They take it very personally now,” says Streed. “They have ownership. If a VAP case were to occur, everyone would be distressed. Were one to happen now, we’d do an almost root cause analysis–level exploration of the individual and the case.”

This ownership has taken root in everyone, not just clinical staff members. And everyone is paying attention.
“That was an evolution,” says Kole. “Now you get an infection and everyone wants to know what’s going on. They want to know which patient it is.”

**A change of culture**

“We realized we had a lot of work to do to change our culture,” says Kole. “Just because we were magically transformed [because of the rural hospital’s talk] didn’t automatically mean everyone at the hospital would accept this. It took a lot of work and organization to make everyone understand why we wanted them to change what they were doing.”

One concept that took time to take hold was making sure an intervention was not overlooked after implementing a bundle (i.e., a set of interventions).

The effect of the whole bundle is lessened if steps are skipped, says Streed. “We needed to make sure we had consistent implementation and documentation of the bundles,” he says.

**Education and awareness**

Kole and Streed advocate not only staff involvement, but patient and family involvement as well.

“We do multidisciplinary rounds with a big team every day,” says Kole. “We’ve been promoting educating families on rounds. [We need to] explain to them why things are happening.”

Some Lee Memorial hospitals have crafted promise statements to patients and their families, such as “We promise we will not give you an infection,” and “We promise we will keep you elevated.”

“We spend a good bit of time on education on simple things like hand hygiene,” says Streed. “If you’re coming down with a cold, don’t go visit your relative in the hospital, for example. If we can control what’s being brought in to those patients through the families, we can prevent the related adverse effects.”

Aiming for zero can be a daunting task, so prioritize, track results, and start small. “There are so many things that can be overwhelming when you start a project like this,” says Kole. “There are plenty of rocks, and you can’t pick up all the rocks every day.” Don’t try to institute a zero policy in a unit with 22 patients on Monday, says Kole. Start small with one patient and one nurse on one day.

“Do baby steps—small successes along the way—and test what you’re doing along the way. Measure what you do,” Kole says.

Targeting Zero falls in line with The Joint Commission’s National Patient Safety Goals and new governmental regulations (e.g., CMS regulations reducing reimbursement if an HAI infection occurs).

In keeping with APIC’s mission and vision for 2012, Targeting Zero promotes the philosophy that every healthcare institution should be working toward a goal of zero HAIs. Although not all HAIs are preventable, APIC believes that all organizations should set the inspirational goal of elimination and strive for zero infections.

*Editor’s note: Visit www.apic.org/AM/Template.cfm?Section=Targeting_Zero for more information on this program.*

**Source**

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

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### Five strategies for VAP prevention

- Keep patients at a 30°–35° angle. “Keep them that way at all cost,” says **Stephen Streed, MS, CIC**, system director of epidemiology and infection prevention at Lee Memorial Health System in Ft. Myers, FL. “It helps in terms of aspiration past the tube.”
- Perform proper mouth care. “We do judicious mouth care using an antimicrobial substance,” says Streed. “Imagine not brushing your teeth for days. We work to keep the number of organisms in the mouth down.”
- Take care to watch for any leakage around the tube. Keep the area clear to avoid infection.
- Work toward a sedation vacation. “The sooner you get them off the ventilator, the less likely it is they’ll have an infection,” says Streed.
- Watch out for peptic ulcer disease prophylaxis and deep vein thrombosis prophylaxis. Pay attention to acid levels in the stomach of the patient and the risk of pulmonary embolism.
Nursing TV dramas controversial but get people talking

Two new fictional nurses, Jackie Peyton (portrayed in Showtime’s Nurse Jackie) and Christina Hawthorne (TNT’s HawthoRNe), lit up the TV screens this summer and brought an intriguing focus on nursing to the media. A third show is set to debut in the fall, when NBC introduces Veronica Callahan in the nursing drama Mercy. But how the shows portray and will affect real-world nurses has come into question.

“Television shows largely depict physician characters doing the work that nurses do in real life,” says Sandy Summers, RN, MSN, MPH, founder and executive director of The Truth About Nursing and coauthor of Saving Lives: Why the Media’s Portrayal of Nurses Puts Us All at Risk. “Hollywood media shows physicians performing triage, defibrillation, providing 24/7 surveillance, and handling complex ICU machinery—this is all exciting, dramatic work of nursing that nurses deserve credit for.”

The debut of Nurse Jackie on June 8 and HawthoRNe on June 16 brought nurses back in the limelight as the shows’ main characters. Although Summers is happy nurses are getting more TV exposure, she stresses the damage current dramas have on the profession.

“Career seekers who want to pursue careers with autonomy look elsewhere,” Summers says. “Who would want the job of nursing as it is portrayed on House or Grey’s Anatomy? Nurses barely exist on those shows, but to the extent they do appear, they are fawning or bitter lackeys—the lowly cleanup crew of healthcare.” Such depictions, she says, will not lead to funding for nursing practice, education, or research.

Do the shows accurately illustrate the lives of real nurses or do they support some of Hollywood’s long-standing stereotypes?

Much controversy surrounded the premiere of the dark comedy Nurse Jackie, which captures Peyton’s life as an ED nurse working at a New York City hospital. Peyton’s depicted drug addiction to Oxycontin pills, for one, has ignited some heated debates among nurses.

“I think many nurses are having a reflexive negative reaction to Nurse Jackie,” says Summers. “But it provides us with so many opportunities to change how the public thinks about nursing and to change how nurses think about the media. [The Truth About Nursing’s] main goal is to get nurses and the public—like it or not—to watch the show and talk about what nursing is, what it is not, and what it should and could be.”

Adrianne E. Avillion, DEd, RN, who has more than 30 years of nursing experience and is owner of Avillion’s Curriculum Design in York, PA, doesn’t hold out much hope for Mercy.

The show will follow the happenings of a hospital through Callahan, who just returned from a tour in Iraq, and two other nurses. According to the NBC Web site, the show will also include interactive digital features, such as a “Test Your Nursing Skills” quiz with first aid questions and answers. The concept comes across as demeaning to Avillion.

“Just get right on there,” she says. “Anybody can do it. Anybody can be a nurse ... There’s nothing about ‘Test Your Doctor Skills.’ ”

HawthoRNe, which stars Jada Pinkett Smith, appears to hold more promise.

As a CNO, Hawthorne is depicted as a hero who “prides herself on standing up for her patients and preventing them from falling through the cracks of hospital bureaucracy,” states TNT’s Web site.

Regardless of how the shows unfold, Summers will view them as mediums to reshape nursing’s image.

“Each show looks promising in its own way, but we won’t know more until we see the full episodes,” she says. “And even after they air, I’m sure there will be things we think work well to educate the world about nursing and things that reinforce long-standing stereotypes. But there seems to be basic understanding on each of the shows that stereotypes need to be broken.”
Staff education

Turn to educational liaisons to help meet staff nurses’ educational needs

by Deana Kearns, RN-BC, MSN, director of clinical practice at FirstHealth Moore Regional Hospital in Pinehurst, NC

Providing unit-based educational resources without adding nursing professional development personnel is an ongoing challenge at FirstHealth Moore Regional Hospital. But education is kept at the forefront despite the small size of the education department by focusing on the bedside nurse. Our professional development nurses work closely with education liaisons to train bedside staff members.

Nurses spend the majority of their time at patients’ bedside and working with peers. They see how processes are working, determine what needs to be changed, and discover components that necessitate further education. These observations led to the creation of the education liaison role, which is filled by bedside nurses who assist peers with educational development on their units.

Select nurses for the role

We have 18 unit-based education liaisons who were selected by their managers through an interview process after showing interest in the position. They receive a pay differential and serve as members of the education council. The liaisons spend eight to 12 hours every two weeks on education and assisting peers with development on the unit.

The education council meets monthly to discuss unit-based and hospitalwide educational initiatives. This communication allows for sharing of information and resources outside of the usual unit/service line boundaries.

Train liaisons

The professional development nurses mentor the liaisons by providing guidance in professional development and educational methodologies. Initial training for the education liaisons consists of:

- Teaching and learning styles
- Education planning and competency validation
- Public speaking
- Adult learning theory

Although each liaison’s duties differ from unit to unit, all are responsible for:

- Matching new hires with preceptors
- Coordinating preceptor and orientee schedules and evaluations
- Conducting unit-based skills fairs to assess annual competencies
- Determining education needs of the unit and assisting with the development of an annual education plan

Educate staff nurses

Many of the liaisons educate their peers through presentations, posters, and inservices. The liaisons are one of the first lines of communication and one of the best ways to provide new information to staff nurses.

Communicate the benefits

Overall, the results of the education liaison role have been positive. Communication and sharing of resources between nursing units has improved, and we have also seen the enrollment of several liaisons in advanced degree programs. Our investment in developing and mentoring this group of bedside nurses will ultimately result in a new generation of nurse leaders.

Source

Adapted from HCPpro’s Advisor to the ANCC Magnet Recognition Program®, May 2009, HCPPro, Inc.
Tip of the month

Test the mettle of interview candidates

Our reliance as managers on the interview process has served us well in the past—or has it? Many argue that evidence of work product is a better indicator of ability to perform a job (Heath and Heath, 2009). Many executive positions now require candidates to produce a sample work product, such as a staffing plan, to demonstrate they are prepared for the job.

Consider preparing a brief written test for your next potential hire. Include items based on the nurse’s years of experience and specialty worked. For example:

- Present a scenario requiring critical thinking, such as a list of three patients with distinct problems, and ask the candidate to select which patient requires attention first
- List two common medications with questions related to the expected side effects
- Provide examples of two nurses’ notes and ask the candidate to circle what is inappropriate in each note

We have all been part of an interview in which a nurse talked a good story, but it becomes clear on the first day of orientation that the person was not suited for the job.

A good work ethic is important, but it is of no use when skills are lacking. Do not be afraid to get innovative and add testing to your interview process. You will be surprised at what you might discover.

Reference


Source

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

Web site spotlight

Can Twitter improve healthcare communication? The social network based around the phrase, “What are you doing right now?” continues to gain popularity in healthcare. But can it improve communication with patients’ families? Children’s Medical Center in Dallas thinks so. The latest facility to “tweet” during surgery, Children’s sees the technology as a way to help communication between physicians and families.

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