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Strategies for Nurse Managers

Orientation

Developing an effective nurse residency program

Continuing Education | Learning Objectives

After reading this article, you will be able to:

- Discuss how to implement a nursing residency program

by Vicky Goeddeke, RN, MS, CEN, CPEN

Editor's note: This is the second article in a two-part series about nurse residency programs. Part one, which discussed the benefits provided by residency programs, appeared in the August **Strategies for Nurse Managers.**

Benner (1984) told us that upon becoming a nurse, individuals develop in stages based on gaining experience. It is important to note that Benner describes experience not as longevity with the passage of time, but rather as the refinement of knowledge through encounters with many practical situations. Nurses are typically exposed to a variety of patients and care situations along the path to becoming competent. A well-structured nurse residency program can guide the new graduate nurse through exposure to many circumstances, thereby increasing experience, which in turn supports quicker development of competence.

Structuring a program

A nurse residency must be more than an extended orientation. New graduate nurses are not just transitioning to a new job environment, they are transitioning to a new role. This role development includes not only developing clinical skills, but learning to apply critical thinking and becoming acquainted with leadership skills. Residents are no longer nursing students; the focus of a nurse residency should be guidance for application of their knowledge.

The shared experience of entering the nursing profession together makes the residents true peers who can support each others' development as nurses.

Most organizations accept nurse resident applicants as a cohort, which helps manage the program efficiently. Participants also gain an informal support system in their resident peers.

Many programs struggle with how to integrate a didactic component into a nurse residency. Keeping didactics within the cohort can be beneficial, but as residents are working in various clinical specialties, topics must have a general focus. Although clinical exposure is the foundation of a nurse residency, didactics that enhance the experience of the specialty need to be incorporated. In addition, leadership skills should be touched upon during a nurse residency.

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Residency program

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The desired outcome of a nurse residency is new graduate nurses who quickly develop into competent, efficient, and confident staff members. Offering flexibility within the clinical structure to consider the nuances of various nursing specialties is crucial to the success of a program.

A successful program also requires preceptors and mentors who are committed to facilitating the growth of nurse residents.

Strong preceptors support the clinical component and guide residents gradually from shadowing to independent practice while ensuring exposure to different situations that lead to competence. Strong mentors support the didactic component by posing various challenges to residents that facilitate their assimilation of knowledge and clinical exposure into competent nursing practice.

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Sometimes, the roles of preceptor and mentor may be fulfilled by the same individual. Other times, depending on the scheduling needs for residents or the unit, multiple preceptors may be used. Communication among all those involved with residents is crucial to monitor progress and must extend to the unit's nursing leadership and the nurse residency program coordinator. This can be a formal or informal process but should be defined as part of the program.

Benefits of a nurse residency group

In developing or updating a nurse residency program, the initial considerations should look at activities to support the cohort. A nursing core orientation usually offers an in-depth overview to organizational nursing practice for newly hired nurses. Offering a separate core orientation for the resident cohort may better meet the new nurse graduates' needs.

Bringing the cohort together at defined intervals for education provides the opportunity not only to review various topics relevant across the practice spectrum, but also allows the individuals to build stronger relationships with other nurse residents.

Socialization is an important consideration in job satisfaction, and each nurse resident will integrate with his or her unit's team. But the shared experience of entering the nursing profession together makes the residents true peers who can support each others' development as nurses. And as the cohort successfully completes its journey through the residency, a recognition celebration for the group is in order.

Curriculum and activities

Developing unit-based activities for the nurse residency requires flexibility in guiding the structure of the program. Flexibility allows for program adaptation at the unit level, ensuring that it meets the needs of residents and the unit. Nurse residents typically should not "count in the staffing numbers" for an extended period, so a variety of learning

opportunities can fit into scheduled shifts. By having residents and preceptors teamed for patient assignments, there is flexibility for residents to be guided for clinical opportunities or be relieved for didactic components.

Consideration should be given to developing tools or strategies that will help assess and monitor progress. A tracking tool that notes residents' exposure to skills and processes can offer insight. Creating a unit-specific tool can outline various assessment skills, equipment, procedures, specific medications, or documentation standards needed within the unit's specialty. It could be formatted for daily or ongoing use and it can note opportunities to observe or perform. Whatever tools are developed should be simple to use and have the purpose of guiding the resident-preceptor teams in structuring the clinical experience for variety and challenge.

The didactic component of a nurse residency should guide and support residents as adult learners and be addressed at the unit level and for the cohort. Mentors can facilitate residents' incorporation of clinical experiences and knowledge. It is this incorporation that leads to competency and efficiency and gives new nurses confidence in their practice.

Routine meeting time between residents and mentors away from the clinical setting can be used for discussion and review. This time may include going over new clinical experiences, knowledge that is important to the specialty area, or case studies, all avenues to reinforce learning.

Additional education can be accomplished through granting self-study or guided time. Residents can complete assignments that will benefit integrating specifics into their practice. This might include review of unit-based competencies or unit-based policies and procedures or specific classes such as ACLS. Residents may be assigned to visit alternative sites that give insight into the continuum of care for the patient. For example, a resident on a cardiac care unit might visit the cath lab, or a resident on a postsurgical unit might visit the operating room.

Residents should also have exposure to understanding nursing leadership. Mentors should take responsibility for introducing residents to issues such as resource utilization, peer review, and quality improvement. Shadowing a nurse leader at the organizational or unit level can give residents perspective on the demanding challenges of a nurse leader.

Length

Organizations offer various timelines for their programs, but be flexible with the prescribed program length to accommodate the needs of each specialty practice. Whatever the required length of time, participant evaluation is needed to monitor progress. Input for the evaluation should come from the preceptors, mentors, and unit nurse leaders and be shared with the resident program coordinator. Self-evaluation should be offered to residents, and peer evaluations from other nurses could be considered. In addition, nurse residents should have the opportunity to evaluate their preceptors and mentors.

When developing or updating a nurse resident program, start by setting objectives for participants to accomplish. There may be objectives for the cohort, with additional objectives for the resident's unit. The program's main goal is always competent nurses, regardless of the outlined objectives. By combining the structure of a nurse resident cohort with flexibility at the unit level, this goal will be accomplished. ■

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

Reference

Benner, P. (1984) *From Novice to Expert: Excellence and Power in Clinical Nursing Practice.* Menlo Park, CA: Addison-Wesley.

Professional development

Ease nurses' public speaking jitters

Continuing Education | Learning Objectives

After reading this article, you will be able to:

- Discuss how **NurseSPEAK℠** helps nurses become comfortable speaking in public
- Explain how public speaking benefits nurses' professional development

Many staff nurses at The Methodist Hospital System in Houston have experienced the racing heart, the sweaty palms, and the shaky voice that often accompany speaking in public. But those moments of apprehension and fear are coming to an end thanks to one program: **NurseSPEAK.**

"Overcoming fear of public speaking is a great challenge for many people," says **LaDia Sumlin, RN, BSN,** staff nurse at Methodist. "But **NurseSPEAK** provides a comfortable, warm, and friendly atmosphere to accommodate all."

> **"NurseSPEAK has helped strengthen my self-confidence in communication skills within my profession as an RN. The program has given me the opportunity to share my thoughts and feelings on many topics."**
>
> *—LaDia Sumlin, RN, BSN*

The **NurseSpeak** program was developed by **Terry Leydon, RN, MSHCM, CPHQ,** an ANCC Magnet Recognition Program® coordinator at Methodist, and colleague **Debra Belgard, MS, RN,** CNOR.

Leydon and Belgard became involved in an outside organization that helps people become comfortable and competent when speaking in public and discovered the benefits a similar program could have with Methodist nurses.

"We developed **NurseSPEAK** to help nurses improve speaking skills, build confidence, and grow professionally," says Belgard.

Start speaking

NurseSPEAK, a monthly hour-long class, is open to nursing and nonnursing staff members. Belgard and Leydon mentor the attendees, which have ranged in number from five to 18, and provide light refreshments and door prizes.

To publicize the program, Belgard and Leydon initially promoted **NurseSPEAK** in the hospital's nursing newsletter, in flyers that were handed out during nursing meetings, and in the CEO's weekly e-mails that are sent to staff members organizationwide.

"Now, the program has its own standing corner in the nursing newsletter that details when the next meeting is and other updates, which helps us draw nurses and nonnurses to the meetings," says Leydon.

As part of **NurseSPEAK,** nurses are expected to present six speeches. The first speech, called "Get to know you," has nurses tell a story from their life. The speech must have a beginning, middle, body, and conclusion, says Leydon. Attendees are also called on randomly throughout the program to answer impromptu questions as a way of encouraging them to speak up.

"We have some nurses who come into a meeting and they literally don't want to talk at first—they just want to listen," says Leydon. "With speaking, you have to practice, practice, practice, and relax, relax, relax! Once you've practiced, you're going to have confidence and deliver the material in a positive way."

The second speech is a prepared speech on a research topic (e.g., prescription drug abuse), which must be three minutes long. The remaining speeches continue to focus on the research topic, increasing in length and developing into PowerPoint presentations. Attendees are given a Flash drive on which to upload their PowerPoint presentations.

"This way, they are completely prepared to take their presentation to a conference or wherever they may be presenting," says Belgard.

After each speech, feedback from all attendees is presented verbally to the nurse by using the commonly known "sandwich technique."

"We always open with positive feedback, provide something that requires improvement, and then close with positive feedback," says Leydon.

Tie into professional development

NurseSPEAK is tied into Methodist's clinical ladder program. When a nurse climbs the clinical ladder, he or she is encouraged and expected to give presentations in and outside of the organization. This can be traumatic for a nurse who is not comfortable with public speaking, says Leydon. "We want to make sure our nurses are [professionally] developed enough to represent the hospital in a positive way," she says.

NurseSPEAK is also tied into the clinical ladder program by allowing nurses who attend the program to take on the facilitator role. Belgard and Leydon are happy to occasionally hand over the reins of the meeting to staff nurses.

"As a staff nurse climbing the clinical ladder program, you are going to be in meetings and be in a position where you need to know how to run a meeting," explains Belgard. "Giving nurses the opportunity to become a facilitator is another positive aspect to growing them professionally."

Polish your speaking skills

Another benefit of the **NurseSPEAK** program is how it ties into nursing research. Often, the successful outcomes of the research project lead to staff nurses submitting an abstract to a conference. If the abstract is accepted, the nurse will speak on his or her research topic in front of a large audience—a frightful experience for many.

But Belgard and Leydon also educate nurses during **NurseSPEAK** on how to develop certain skills that will enable them to ease those speaking jitters and interact with the audience. These skills include how to use stage space, maintain eye contact, show excitement, and make efficient use of body movement.

"I really try to help nurses form that relationship with the audience by interacting with them," says Leydon. "[We work on many skills], such as don't stand with your arms crossed, don't stay focused in one direction, and make sure eye contact is spread throughout the room."

Attendees are also taught how to become aware of their sentence structure. Belgard and Leydon focus on making sure nurses string their sentences together and do not use filler words during presentations such as "you know," "um," or "though."

"**NurseSPEAK** has helped strengthen my self-confidence in communication skills within my profession as an RN," says Sumlin**.** "The program has given me the opportunity to share my thoughts and feelings on many topics from healthcare issues to common day-to-day concerns people may have." ■

Source

Adapted from **HCPro's Advisor** to the ANCC Magnet Recognition Program®, June 2009, HCPro, Inc.

Infection control

Swine flu scare provides real-time preparedness training

Continuing Education | Learning Objectives

After reading this article, you will be able to:

- Explain why pandemic preparedness deserves national collaboration
- Identify reasons healthcare workers would stay home during a pandemic

For years, the Centers for Disease Control and Prevention has proclaimed that the potential of a pandemic is not a question of if, but when. Hospitals around the country and the world may be heeding that advice more urgently after the recent outbreaks of novel influenza A H1N1, commonly known as swine flu.

The scare may have served as a wake-up call for many facilities and a pandemic planning practice round for others.

The primary concern regarding an influenza pandemic is that the nation's resources will be exhausted, leaving hospitals on their own to deal with any problems concerning staff members or supplies.

"A pandemic is such a potentially overwhelming situation in terms of the resources needed to respond that it's not the same as a regular disaster because regular disasters tend to be more local," says **Terri Rebmann, PhD, RN, CIC,** associate director of curricular affairs and assistant professor at the Saint Louis University School of Public Health.

Another chief concern during any disaster involves the "worried well." This group consists of patients who flood hospitals and healthcare centers thinking they are sick or injured. This is particularly apparent during a pandemic, when fears of sickness escalate and even the smallest sniffle can send people running to the emergency room.

This creates numerous complications as it floods the system and forces hospitals to do triage quickly to determine who is and is not sick, says Rebmann.

Healthcare workers must step back from the constant barrage of news accounts, sift through the facts, and deal strictly with the epidemiological evidence at hand, says **Jim Kendig, MS, CHSP, CHCM, HEM, LHRM,** vice president of safety, security, and clinical/courier transportation at Health First in Melbourne, FL.

A legitimate concern for healthcare workers is their own safety during an influenza pandemic. Although numbers and percentages vary, some studies have reported that as many as 50% of healthcare workers would not show up to work during a pandemic for a variety of reasons, including concern for their own or their family's health.

This was the reason Kendig pushed forward a historically based pandemic flu plan, the first in the state of Florida. The plan details specific hospital procedures regarding personal protective equipment (PPE) and isolation precautions that align with the pandemic phases announced by the World Health Organization.

"That's why we did so much work on it initially, because what the surveys were telling us was, 'If you take care of me, I'm much more apt to come to work,' " says Kendig. " 'If you don't have a plan, if you haven't articulated that plan, or if you haven't done anything, the likelihood of me not coming to work and putting myself at risk, and therefore my family at risk, is greater.' "

But there are more factors than just the fear of infection. School closures or public transportation limitations can affect whether employees come to work. A nurse who is a single parent will probably not come to work if he or she needs to care for a child.

Therefore, in addition to providing proper PPE for workers, hospitals need to advise them to make a personal pandemic plan to assess any conflicts ahead of time, Rebmann says. ■

Source

Adapted from **Briefings on Infection Control,** July 1, 2009, HCPro, Inc.

Staff development

Matching teaching strategies with adult learning styles maximizes education effectiveness

Continuing Education | Learning Objectives

After reading this section, you will be able to:

- Describe the characteristics of various adult learning styles
- Identify teaching strategies that correspond to various adult learning styles

The ways adults learn have a great effect on their ability to acquire and apply knowledge, seek learning experiences, and enjoy participating in the education process. All adults have learning styles that best suit them. Adults often have a preference for one style over another, but these preferences may vary depending on the situation and how learning objectives are to be achieved.

Right- vs. left-brain learning preferences

The right and left hemispheres of the brain process information differently, and learners tend to absorb and manage information using the dominant hemisphere. Although one hemisphere dominates, both hemispheres are used to some extent in all thinking processes.

The right hemisphere of the brain is devoted to the creative aspects of learning and depends on music, visual stimulation, color, and pictures to process information. The left brain enables learners to deal with language, math, and problems requiring analysis.

Staff development specialists must recognize the right- and left-brain characteristics in their learners and plan programs that stimulate the use of both hemispheres to achieve successful educational outcomes.

Note: Find a tool about the characteristics of left- and right-brain learners and suggestions to facilitate learning in the Tools Library at *www.StrategiesForNurseManagers.com*. Subscribers to this newsletter have free access to all the tools and resources on the Web site.

The right-brain learner processes information holistically, seeing the big picture or the answer first, not the details. When analyzing a problem, right-brain learners start with the major concept and work backward to find the details and formulate a conclusion. These learners may become impatient with the details of a problem unless they can "see" the conclusion or solution quickly.

For example, when attending a class on cardiac events, a right-brain learner may leap to the answer (e.g., the patient is having a myocardial infarction) and then work backward to gather details to support the conclusion. When teaching right-brain learners, acknowledge that clinical experience may allow a leap to identify the final outcome or problem. But also emphasize the importance of having detailed evidence to support conclusions because overlooking details can sometimes lead to an incorrect interpretation of a problem. This can be effectively taught through case study strategy or role-playing activities.

Left-brain learners, on the other hand, process information in a linear manner, processing from the parts and then to the whole. These learners gather information and problem solve in a step-by-step manner, using logic and reason to form conclusions. Left-brain learners need learning activities to be organized. They maintain daily schedules and create lists, checking off tasks as they are accomplished.

In a clinical situation, these learners will gather data (e.g., physical assessment findings and diagnostic study results) and come to conclusions about patient problems in a logical, step-by-step manner using plenty of data to support their decisions.

In addition to specific characteristics of right- and left-brain learners, most experts recognize three main learning styles: visual, auditory, and tactile/kinesthetic.

> *continued on p. 8*

Staff development

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Visual learners

Among adults, visual learning predominates. In regard to education implications, visual learners:

- Focus on using the sense of sight to learn and to enhance learning
- Sit in the front of a classroom because they need to see the instructor to effectively process information
- Take detailed notes and benefit from the use of color, illustrations, and graphics as part of handouts, PowerPoint presentations, or computer programs
- Prefer quiet or a minimum of auditory or tactile stimulation when concentrating
- Seek written information using professional journals, books, and the Internet to acquire knowledge when confronted by a new task or procedure

Auditory learners

Auditory learners prefer leisure activities that focus on auditory stimuli. Using the sense of hearing is critical. They prefer activities such as listening to audiobooks or attending concerts. In regard to educational implications, auditory learners:

- Benefit more from hearing information than seeing it in written form
- Sometimes appear not to be paying attention, but are actively listening
- Assimilate new knowledge and skills by describing the behaviors or facts to be learned aloud (auditory learners also absorb new information by reading aloud)
- Often study or read while music is playing in the background
- Talk through problems, procedures, or tasks
- Correlate new behaviors or knowledge with auditory stimuli
- Get distracted by too many visual stimuli
- Ask for verbal explanations from colleagues already familiar with a topic when there's a need to acquire new knowledge

Tactile (kinesthetic) learners

Tactile or kinesthetic learners depend on physical participation in a learning activity to absorb knowledge. In regard to educational implications, tactile learners:

- Need to take frequent breaks.
- Prefer hands-on learning activities such as return demonstration and simulation.
- Can facilitate learning by handling equipment and manipulating objects (e.g., flash cards).
- Acquire new knowledge best when accompanied by physical movement. Listening to audiotapes while exercising is an example of a technique useful in knowledge acquisition.
- Will jump right in and attempt to practice a new behavior or psychomotor skill when confronted with the need to perform a new task. The need to take a hands-on approach supercedes the need to read about or hear about the task.

The figure on p. 9 provides greater detail about the behavioral characteristics of visual, auditory, and tactile learners, as well as educational implications for each.

Many learners may not be aware of their preferred learning style, yet it is incredibly helpful to have this understanding. Consider incorporating a learning style self-assessment tool into your education programs. (***Note:*** You can find one in the Tools Library at *www.StrategiesforNurseManagers.com*.) ■

Source

Adapted from HCPro's book *Learning Styles In Nursing Education: Integrating Teaching Strategies Into Staff Development.* For more information on this book or any other in our library, visit *www.hcmarketplace.com.*

Overview of visual, auditory, and tactile learning styles

Visual

Behaviors:

- Leisure activities rely on sight, such as reading or watching television.
- Appearance is important. Clothing and accessories are color coordinated.
- Facial expressions reveal thoughts and emotions.
- Phrases and words incorporate vision, such as "I see what you mean."
- Prefer to interact professionally on a face-to-face basis. Eye contact is important.

Educational implications:

- Need to see the instructor in a classroom setting
- Take copious notes regardless of the method of educational delivery
- Find that the most useful handouts and computer presentations (e.g., computer-based learning or PowerPoint) include visual illustrations, color, and graphics
- May be distracted by auditory or tactile stimuli when attempting to concentrate

Auditory

Behaviors:

- Leisure activities focus on hearing, such as attending a concert
- Emotions are revealed by the sound of the voice
- Remember people by the sounds of their voices
- Phrases and words related to hearing are common, such as "I hear what you mean," or "That sounds okay"

Educational implications:

- Don't care where they sit in the classroom as long as they can hear. They're listening, but may look as though they are not paying attention.
- May verbally describe new knowledge or behaviors that need to be learned; absorb knowledge by "listening" to it.
- Read aloud to absorb information.
- Auditory stimulation, such as background music, helps them absorb knowledge.
- New knowledge is associated with auditory stimuli.
- Distracted by too much visual stimuli.

Tactile

Behaviors:

- Leisure activities focus on movement, such as sports, dancing, or exercising
- Associate meeting new people with the circumstances or events taking place during the meeting
- Emotions are revealed and interpreted by body language
- Phrases and words have a tactile focus, such as "That doesn't feel right to me," or "I am having trouble getting a handle on the problem"

Education implications:

- Frequent breaks are needed
- Preferred learning activities include return demonstration and simulation
- Manipulating objects (e.g., flash cards and procedural equipment) facilitates learning
- Learn most easily when education is accompanied by physical movement

Source: Learning Styles In Nursing Education: Integrating Teaching Styles Into Staff Development, *published by HCPro, Inc.*

Patient safety

Facility lowers rate of pressure ulcers, specifically on heel

Use of boot proves to be a step in right direction

NCH Healthcare System in Naples, FL, has seen a considerable decrease in the prevalence of ulcers, along with a significant savings associated with its prevention plan.

"Assuming that each time a pressure ulcer case was prevented the cost would be $3,000, we calculated that NCH saved $11.5 million annually," says **Joan A. McInerney, MSN, RN-BC, CWOCN,** wound ostomy continence (WOC) nurse coordinator at NCH**.**

Over the five-year period from January 2002 to January 2007, NCH's rate of pressure ulcers dropped from 12.8% to 1.9%. During that time, the number of heel pressure ulcers alone dropped from 6.7% to 1.1%.

In January 2002, staff members at NCH realized the facility's prevalence of hospital-acquired pressure ulcers (HAPU) was 12.8%, high above the national average of 8.5%. Heel ulcers made up more than half of this number.

After hearing these statistics, McInerney and her partner, a newly hired WOC nurse, met with physicians, risk managers, and members of the leadership team to find a solution to help lower future heel ulcer outbreaks.

However, before McInerney and her fellow staff members had a chance to implement a new product, a patient in the critical care unit suffered a serious injury due to a heel ulcer.

This sentinel event, along with the recently discovered statistics, accelerated NCH's implementation of a new boot product to help lower the incidence of HAPUs, specifically on patients' heels.

At the time of the sentinel event, NCH was using the Braden Scale for Predicting Pressure Sore Risk and had implemented an electronic medical records system, says McInerney.

In 2002, NCH decided that when a new patient came into the facility, a nurse would assess the patient's skin integrity and ask him or her to answer a series of questions. Based on the assessment and the patient's answers, the computer would score the answers according to the Braden scale and all six subscales.

NCH staff members continue to use this practice to assess a patient's risk for HAPU upon admission to the facility.

"The electronic record allows us to capture every patient that is at risk for developing any sort or pressure ulcer," says McInerney. "We set up several alerts on the program in the event a patient qualifies for a boot, and automatic orders are placed, as well as needed consults with myself or the other wound ostomy continence nurse."

Trend analysis and boot protocol implemented

In addition to using the electronic record to determine whether a patient needs a boot, NCH also began a trend analysis of the prevalence of pressure ulcers every six months for the five years between January 2002 and January 2007.

The results of more frequently recorded pressure ulcers were seen almost immediately, and within the first six months, pressure ulcer prevalence dropped from

Questions? Comments? Ideas?

Contact Senior Managing Editor Rebecca Hendren

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12.8% to 7.5%, McInerney says. Heel ulcers dropped from 6.7% to 3.5%.

"I was so excited and thrilled by the initial results with heel ulcers," says McInerney. "Everyone was very happy and maybe a little relieved that we seemed to be on the right track."

To further NCH's goal of improving pressure ulcer prevention, specifically heel ulcers, a team came together to search for a new boot and to develop specific protocols to determine which patients should wear the boot. The team consisted of McInerney, her partner, a critical care physician, a podiatrist, and a risk manager. The team solicited samples from boot companies, and from those options, staff members tried on the boots to see which ones elevated the heel. After some deliberation, the group chose the Heelift Suspension Boot by DM Systems in Evanston, IL.

The team—with the help of the chief medical officer, the chief nursing officer, an information technology staff member, and the heads of central distribution, the operating room, education, and critical care—determined protocols for which patients were to receive the boot.

Along with using the initial assessment during a patient's admittance, McInerney and her team determined that all patients with end-stage renal disease who were on hemodialysis and all patients using ventilators would automatically be required to wear the boots.

McInerney says it was important to empower staff members to use their discretion when judging whether the use of a boot is necessary with a particular patient.

"[Even though we were already using the] initial assessment—less than 13 on the Braden scale—and the boot protocol [as indicators], we also wanted to make it clear to staff that if they thought a patient was at risk, and they did not fall into predetermined categories, to give them a boot," says McInerney.

Visible success and results maintained

Since NCH first saw its pressure ulcer prevalence numbers drop between January and July 2002, the facility has continued to see success.

"The fact that the idea of lowering NCH's pressure ulcer prevalence has been drilled into the staff members' heads has really helped our numbers," says McInerney. "It's such a part of our life now, and I have no painful memories of this process."

McInerney created posters and flyers displaying a foot on a mattress with a red slash to illustrate that patients at risk for pressure ulcers should not have their feet on the bed, but rather elevated in a boot. In addition, NCH's CEO discussed the pressure ulcer rate in his weekly newsletter.

Another factor that helped NCH maintain a low pressure ulcer rate was the decision to upgrade the system's hospital beds. In 2004, nurses purchased pressure-relieving, continuous lateral rotation therapy air mattresses for critical care units, and other units in the hospital received pressure-reducing foam mattresses.

NCH continues to have great success keeping pressure ulcer numbers low. In the past two years, NCH's pressure ulcer rate has remained under 2%, reports McInerney.

"I attribute a lot of our success to the product itself," she says. "But you have to remember that it takes persistence. The idea of electronic records which force consults to make sure everyone is covered may cause some overlap. But compared to what you save on preventing pressure ulcers and that it is the right thing to do, one has to focus on the bigger picture." ■

Source

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

Tip of the month

What's your style of leadership?

When you ask nurse managers what their style of leadership is, you may hear responses such as:

- I have an open door policy
- I like to hold people accountable
- I am all for staff members dealing with their own issues before coming to me
- I make sure I do not micromanage

Although these statements may be attributes of some styles of leadership, it is important for nurse managers to create an identity for themselves. Over the years, the profession has heard many terms used to identify different leadership methods, such as quantum, mentoring, transformational, and collaborative leadership.

All of this boils down to one question: How is your leadership style working for you?

Should your style not result in effective leadership, you need to rethink what style you want to represent. As healthcare continues to change at a rapid pace, how we lead and manage may need to be fine-tuned or adjusted along the way. What worked five years ago may no longer be viable today.

As you consider your style of leadership, be open and flexible as you look to the future; be willing to accept what may no longer be appropriate for your leadership style. Break out the canvas and create a new and improved identity ready to face today and tomorrow as a leader. ■

Source

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

Web site spotlight

As a newsletter subscriber, you have **FREE** access!

Check out our blog, The Leaders' Lounge

"Quint Studer, a well-known healthcare leader who has led hospitals to breakthrough results, frequently makes the point that many leaders never grasp hold of how vital recognition really is to employee morale. This is Studer's list of common myths and excuses often cited for not giving staff compliments:

- *If I compliment them too much, they'll get a big head.*
- *If I tell them they've done a good job, they'll get complacent.*
- *I can give out only so many compliments in a week."*

—Bonnie Clair, MSN, RN

www.StrategiesforNurseManagers.com