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Strategies for Nurse Managers

Teaching styles

Bridging the generation gap with diverse, creative education

Continuing Education | Learning Objectives

After reading this article, you will be able to:

- Describe the characteristics of the four generations in the workplace
- Identify teaching strategies appropriate to each generation in the workplace

Background

For the first time in history, there are four distinct generations in the American workplace. Although no one learning style or preference is common to all members of a specific generation, there are some general characteristics that serve as guidelines for teaching strategies. Be careful, however, not to stereotype learners. These characteristics and strategies are general suggestions that should be adapted to the needs of individual learners.

Research findings indicate that each generation has particular attitudes, expectations, values, work ethics, communication styles, and motivators (Hammill 2005). Let's look at each generation, its characteristics, and teaching strategies that might be most helpful for its members.

The Veterans

Also known as Traditionalists, Veterans were born between 1922 and 1945 and personally dealt with two of the most significant events of the 20th century: the Great Depression and World War II (Avillion 2008; Filipczak et al. 1999; and Hammill).

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The Veteran's view of family is that of a "traditional" nuclear family, consisting of two parents and their children within one household. They look upon education as a privilege (Avillion, Hammill) and view authority figures with respect. They are not likely to question authority or express concerns directly, so ask for feedback throughout the program; otherwise, you may not realize they have concerns until you read their evaluations. Veterans prefer formal, businesslike learning environments (Avillion).

Teaching strategies for Veterans include:

- Making sure learners are able to use equipment needed for the learning activity, especially for distance activities (such as computers, simulation tools,

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etc.), but don't assume they don't know how to use new technology.
- Providing organized handouts that summarize the key points of the learning activity.
- Explaining how new skills relate to job performance.
- Encouraging discussion.
- Not putting Veterans on the spot by asking them to demonstrate unfamiliar techniques in front of others. Allow practice time in private.

Baby boomers

Baby boomers, the product of the post–World War II baby boom, were born between 1946 and 1964. Baby boomers saw the beginnings of change in the family structure, from the traditional viewpoint of the Veterans to increased numbers of divorces and single-parent families (Avillion; Filipczak et al.; Hammill).

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Boomers were usually doted on by their parents and grew up believing that they were entitled to the best the world has to offer. They believe that they are entitled to education, including higher education, and that they have a responsibility to change the world for the better (Avillion; Filipczak et al.).

Boomers have a passionate work ethic and desire for financial success. They value both teamwork and personal gratification in the workplace. Boomers are dedicated learners and initiated the self-help craze (Avillion; Hammill).

Boomers may come across as know-it-alls and do not respond well to authority figures. They respond best to educators who treat them as equals and share examples of their own experiences with learners. They value teamwork activities during training sessions (Avillion). Baby boomers are best motivated to learn if new knowledge and skills are designed to help them excel on the job and gain recognition (Avillion; Filipczak et al.; Hammill).

Consider these tips when planning education for baby boomers:
- Incorporate team-building activities, discussion, and icebreakers as part of learning activities.
- Avoid extensive role-playing activities. Boomers do not usually like them.
- Allow time for private practice of new skills since boomers, like Veterans, don't like to display a lack of knowledge in public.
- Make information easily accessible. Remember that boomers are the first generation to access the Internet and are fascinated with its use.

Generation X

Members of Generation X were born between 1965 and 1980. Referred to as the latchkey generation, Xers are accustomed to having both parents work outside the home and letting themselves in after school with their own keys (Avillion; Hammill).

Xers view education as a means to success. They are cautious about money, having seen their parents downsized, perhaps more than once. Accustomed to change in family and work status, members of this generation are comfortable with change. They like a balance between work and leisure, value flexibility, dislike close supervision, and prefer self-directed learning. Xers are born distance learners (Avillion; Filipczak et al.; Hammill).

Because they witnessed the downsizing of their parents (and perhaps grandparents), members of Generation X are not loyal to an organization. They do not automatically respect authority figures; you need to earn their respect. Instead, they are loyal to themselves and their own career paths (Avillion; Filipczak et al.; Hammill).

There are some distinct differences between how boomers and Xers view work and education. Boomers invented the 60-hour workweek, whereas Xers insist on a balance between work and leisure. Boomers value the team concept at work and in learning; Xers are perfectly content to pursue distance learning at a time and place convenient for them (Avillion; Filipczak et al.; Hammill).

The following are some tips for designing teaching/learning strategies for Xers:

- Make learning activities fun. Xers value fun as part of work and learning.
- Incorporate role-playing when possible. Xers enjoy role-playing scenarios and are not generally worried about making mistakes in front of others as they learn.
- Allow time for discussion. If the learning activity is conducted at a distance, set up time for group meetings or online chats. Make use of e-mail as a means to answer questions and share information.
- Earn Xers' respect by demonstrating expertise and sharing your experiences with them. Be enthusiastic.
- Xers like visual stimulation. They don't generally read as much as baby boomers and prefer visual illustrations over printed materials.

Generation Y

Members of Generation Y were born between 1981 and 2002 and are also referred to as members of the Echo-Boom Generation or Generation Net (Avillion; Filipczak et al.; Hammill).

Generation Ys have grown up with technology and are completely comfortable with its frequent advances and changes. They equate education with the ability to find good jobs (Avillion).

They view downsizing as normal and have even less loyalty to organizations than Xers. They focus on what they do, not where they work (Avillion; Filipczak et al.; Hammill).

The following are some education tips for Ys:

- Incorporate opportunities to interact with colleagues and educators.
- Incorporate fun as well as structure in education. Provide information about objectives, goals, and schedules.
- Establish a mentor program.
- Provide written resources and ways to access journals, books, and other materials. Unlike Xers, Ys enjoy and value the time that they spend reading.
- Provide convenient distance learning opportunities, but make sure that you offer opportunities to collaborate and have discussions with each other and with educators.

Because you will be dealing with members of all four generations, plan varied activities that incorporate a variety of teaching/learning strategies. Be flexible and enthusiastic. All learners value educators who are sincerely interested in facilitating continuing education and professional growth and development. ■

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Source

Adapted from ***The* Staff Educator,** October 2009, HCPro, Inc.

Quality improvement

Medication error prevention: Defeating work-arounds

Continuing Education | Learning Objectives

After reading this article, you will be able to:

- Identify common medication errors
- Explain examples of potential medication errors
- Discuss the role of vaccinations and work-arounds in logging medication errors

In an effort to eliminate medication errors, Central Vermont Medical Center (CVMC) in Barre has reexamined its process of charting medication errors and identifying work-arounds and other potential areas where the process can be derailed.

"We have a documentation system, which includes an adverse event report," says **Barb Sharp, RN, MS, CPHQ, CPHRM,** quality manager at CVMC. "The electronic form is completed by the medical area that discovered the error."

This report is structured to show how and when the physician was notified of an error and tracks the stage in the process where the error first occurred.

A description of the event is submitted electronically and goes to the chair of the medication use committee as well as to the pharmacy director and quality manager.

"I, as quality manager, look at all of these and conduct follow-up," says Sharp.

For example, a patient might receive 20 mg of methadone when he or she was supposed to receive 10 mg. Sharp tracks down the original occurrence of such an error and asks, "Do we have a problem here with diversion, a problem with not being able to read the dosage … it may be a case in which the nurse simply read the dose wrong."

Once per month, the medication management committee meets, during which time the group has an opportunity to review the logs for the automated medication dispensing system (the facility uses Pyxis MedStations). "We've found it useful to look at the Pyxis override logs," says Sharp. "We started reviewing those at every meeting, and it's interesting."

In a business or medical culture, you have to look at process problems, she says.

"You have to acknowledge that sometimes people deliberately ignore policies with work-arounds," says Sharp. "But if you see someone who is consistently overriding the system, it gives you an opportunity to go to that nurse or pharmacist and ask, 'What's the problem here?' "

This can be a learning situation for the organization and staff members. Are they using the work-around because the process itself is not working, or do staff members assume they know better and ignore the system's checks?

Talking to staff members about their use of work-arounds can be invaluable.

Missed doses

CVMC primarily uses an electronic medical record (EMR), but still has certain units using manual administration records (MAR).

"We don't see a missed dose very often on the units using the EMR," says Sharp. "The majority of errors occur with the MAR—patients get so many medications these days it's easy to miss. With the EMR, it won't let you move on until you've satisfied [the dose requirements]."

Still, there are possibilities for errors even with the EMR. Sharp offers another hypothetical situation: An order is written after the pharmacy is closed involving a medication that is not available for night manager access.

What are the most common medication errors?

- Wrong drug
- Wrong dose
- Wrong route
- Wrong frequency

In this case, the dose could be missed until the pharmacy opens the next morning.

"The EMR couldn't help that," says Sharp.

Vaccinations

Missed doses also come into play when dealing with flu and pneumonia vaccinations. In certain cases, a nurse work-around may be required.

"If the patient has refused the vaccine or they aren't eligible for it, there would have to be a nurse override or nurse hold to make that happen," says Sharp.

In some ways, the process is more challenging than it should be, she says. The facility has a flu vaccine team, and the vaccinations are on the standing orders.

"For whatever reason, if the patient didn't need the medication, it comes up on the EMR as part of the standing orders," says Sharp.

The team brought in the hospital's information systems (IS) department to avoid work-arounds and allow users to identify when the patient has refused the vaccine or determine other reasons why the dose is not given.

"You've got to be sure [the process] makes sense," says Sharp. "One of the easiest things for a clinician to do, if a process is cumbersome, is find a work-around."

Upon finding an issue with the EMR or dispensing machines, a quality improvement person must involve the end users to identify the cause of the problem.

One big problem CVMC discovered is the use of work-arounds surrounding core measures and influenza and pneumococcal vaccinations.

"We've found by looking at the Pyxis logs that there are ways that are legitimate in finding that these vaccinations don't need to be given," says Sharp. "We're trying to standardize the process, make sure everyone is educated."

CVMC is examining Pyxis logs, has a nurse vaccination team, and includes pharmacy and IS in addressing this ongoing issue.

"We've identified these work-arounds as part of the vaccination issue, but it's bigger than that, and it has helped us," says Sharp. "The abstractors have identified the problem and sat down with a multidisciplinary team to address the issue."

The process has also helped resolve other issues, including vaccinations and scheduling on the MAR, which sets vaccinations for 2 p.m.

"If you've got a patient going home in the morning, those doses can be missed," says Sharp.

To fix this, an alert has been implemented as part of the discharge checklist that requires nurses to verify the status of patients' vaccinations.

"What I'm excited about is the fact we've got a medication systems team and a performance improvement team with two very different purposes who have found the same issues and are working together to improve the whole system," says Sharp.

Medication reconciliation is the next step in process improvement at CVMC.

"Our process is essentially paper-based currently," says Sharp. "I'd like to see that go completely electronic."

The facility has a hospitalist program, and the majority of inpatients go through the program. Hospitalists handwrite the medication reconciliation document, and the nurse completes the sheet and goes over it with the patient.

"This would be so much easier to read and faster as an electronic process," says Sharp. ■

Source

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

Infection control

Big Brother is on your side

New eICU technology provides additional support for bedside staff members

Continuing Education | Learning Objectives

After reading this article, you will be able to:

- Explain how the eICU works
- Indicate ways the eICU can help with infection control compliance
- Define Alegent's rules regarding the communication between the eICU and bedside staff members

Imagine you could interact with multiple patients, diagnose and treat their illnesses, administer drugs, and even ensure that staff members are following infection control best practices 24 hours per day, seven days per week, all without getting out of your chair.

This is the basic premise of the eICU, an electronic subdivision of the ICU at Alegent Health in Omaha, NE. **Mark Kestner, MD,** senior vice president and chief medical officer at Alegent Health, likens it to an air traffic control tower. Nurses and physicians man an off-site location filled with two-way cameras linked to ICUs in three metropolitan hospitals and one rural hospital in the system.

Six nurses in the eICU routinely manage 15–20 patients each, in conjunction with on-site ICU staff members. A physician handles high-risk patients, and Alegent recently added a pharmacist to monitor antimicrobial activity.

The software built into the eICU not only feeds real-time data for roughly 100 patients, including vital signs, laboratory tests, cultures, and pharmacy data; it also sorts the information and sets off alerts if there are concerns with a patient. Nurses and physicians in the eICU can also alert bedside staff members if a patient needs emergency care.

"What it does is it frees up the bedside staff because they know that certain elements of information are being sorted and addressed and that they can then be more available for the immediate needs of the patients or the routine bedside needs of the patient," Kestner says.

Involving infection control

In its first two years, the eICU at Alegent has focused primarily on patient care, but **Emily Hawkins, RN, BSN,** director of IC at Alegent Health, says the centralized location of the eICU makes it a great opportunity to integrate infection prevention compliance, as well.

A pharmacist has already been incorporated into the eICU to monitor drug interaction, but Hawkins says there are also plans to use the eICU to build antimicrobial reviews, which will forward information to the lab and pharmacy. Going forward, an infectious disease physician will be present to intervene with antimicrobial counsel.

The eICU team is already incorporating ventilator and central line bundles into its everyday care.

"I think what this allows us to do is to standardize our compliance with ventilator bundles and with standards of care," Kestner says. "We already had a very low infection rate, but this allows us to have another set of eyes on the team asking very specific questions every day. The eICU team does have the checklists and they make sure the central line is taken out if it's not needed, the ventilator bundles are adhered to, the patient's head of the bed is up, and the patient is being extubated quickly if they don't need to be on the ventilator."

It also helps that the eICU suite is in the same office as the infection prevention program.

You're on candid camera

If this sounds a bit too Big Brother for you, you're not alone. ICU staff members were initially resistant to the idea of someone watching over their shoulder from a well-placed camera, Kestner says.

"If you think of these people doing their work and all of a sudden they have a two-way video camera in the

room and they know at any point in time someone could turn the camera on and be looking over their shoulders, they found that to be very intrusive," Kestner says.

The clinical practice committee that oversees the eICU created a set of rules to alleviate the Big Brother feeling, including:

- A bell rings to alert the on-site employee when the camera has been turned on
- Twice per day, the on-site nurse and the eICU nurse conduct interdisciplinary care rounds with patients and their families, fostering a working relationship between the bedside and eICU staff members

These team rounds were particularly helpful to establish a working relationship between the eICU and bedside nurses and the patients.

"And so not only now do the nurses have a relationship with the eICU, but families and the patients know who is on the other end of the camera and establish a relationship with those care providers," Kestner says. "It took us sort of actively intervening and teaching people how to act as a team in order to establish that relationship and not feel like the presence of eICU is intrusive, the presence of eICU is really being a part of their team."

U.S. Department of Health and Human Services Secretary Kathleen Sebelius praised the system when she visited Alegent's Lakeside Hospital July 12 to experience this interaction first hand.

Ultimately, patients and families also feel more secure when they interact with the person on the other side of the camera and they don't feel like it's just a machine, Kestner says.

"We have patients that are transferred from some of our smaller facilities to our bigger facilities, and the eICU will talk to the family before the patient leaves the smaller facility and then talk to them when they arrive at the new facility, so it makes them feel like their care has been seamless," Kestner says. "Families like having that extra set of eyes and have a sense of comfort knowing that they are there."

Absorbing the cost

Of course, as with any elaborate technology, the eICU comes with a hefty price tag. Alegent was able to integrate its rural hospital because of a United States Department of Agriculture Rural Development grant, Kestner says.

Some argue that having that extra set of eyes will decrease infections and lengths of stay and shorten patient days throughout the unit, ultimately benefiting hospitals' financials. But Kestner says it's also worth it from a patient satisfaction and efficiency perspective.

"I think the way we are looking at it is length of stay for the whole hospitalization, shortening length of stay in the whole ICU, shortening length of stay on the ventilator," Kestner says. "We just have our baseline data, so I'm not sure we can say we have absolutely saved enough money to offset the initial expense, but it allows us going forward to remain efficient."

As to whether this is sustainable technology for the future, Kestner recognizes that the startup costs are too high for most hospitals. He suggests this kind of movement in the future would require government involvement.

"You can almost suggest that it's something similar to meaningful use," Kestner says. "Is there a meaningful justification for this type of technology, and does it improve outcomes and improve care and start to rationalize our workforce issues?" ■

Source

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

Patient safety

Hospital focuses on improving patient ID processes

Continuing Education | Learning Objectives

After reading this article, you will be able to:

- Examine how Self Regional Healthcare identified patient ID errors
- Discuss strategies used to prevent patient ID errors

In 2007, as part of an annual performance improvement review, **Leisa Butler, RHIA, CPHQ,** performance manager in the quality management services department at Self Regional Healthcare (SRH) in Greenwood, SC, began tracking safety events occurring within the facility with an identification (ID) events team consisting of staff members from the operating room (OR), emergency care center (ECC), laboratory, and risk management department.

From this performance improvement review, Butler and her team discovered that patient ID events comprised the majority of safety events occurring at SRH. In targeting patient ID processes, SRH managed to reduce ID events by 65% after one month of implementing a new plan. These ID events included misidentification of a patient, specimen, medication, test results, and/or medical record.

"We conducted a common-cause analysis, and after looking at why the events occurred and the circumstances under which they occurred, we found that the vast majority of patient identification errors were in specimen IDs," says Butler. "The specimens were either mislabeled or not labeled at all." The specimen ID errors occurred on everything from blood to urine to tissue samples.

In addition to mislabeled or unlabeled specimens, the team found that incorrect patient ID numbers were being entered into the EKG machine. As a result, many hard copies of EKGs were mislabeled, which created confusion.

"Hard copies of the EKGs were stamped with the patient ID number and caused confusion at times because the hard copy sometimes would not get stamped or the ID numbers were illegible," says **Joie Rogers,** performance improvement analyst at SRH. (See "EKG process" on p. 9 for a process map showing how SRH addressed this problem.)

Bar codes give edge and help with efficiency

Once the aforementioned problems were addressed, Butler and her team focused on preventing patient ID errors. Part of the solution came to Butler via ADMIN RX, an electronic device that scans the bar code on patient ID bands, then scans the medication and confirms the appropriateness of that medication based on pharmacy profiling.

This system essentially helps the nurse confirm that the correct patient is receiving the correct medication.

"We thought to ourselves, 'Why can't we use the scanners on ADMIN RX and give every patient an ID band with a bar code that confirms all the information and is usable for other scanner programs?' " says Butler.

Butler and her team developed a plan that would allow SRH to distribute bar codes to all patients, as well as provide a label for specimens being sent to different areas of the hospital. The team reviewed the cost of supplying the entire facility with bedside scanners and the kind of printer needed to print a scannable armband.

"Printers that would print labels for the ID armband were found. Scanners were purchased that would scan a patient's ID band and generate a label with unique patient identifiers that could be placed on the specimen at the point of collection," says Butler.

In the first month after implementation, SRH managed to reduce ID events by 65% just by implementing the new technology and using the scannable armbands and labels.

Clarifying delivery and ID

The team then analyzed the areas in the hospital from which specimens were coming and found that a

vast majority of the specimen ID errors were occurring in the ED and the lab.

Butler and her team decided to map out the actual process of specimen collection in several areas in the hospital and examine how the specimens were sent and received in the lab. Primary areas of focus included the ECC, the OR, and preop testing.

"Things like where the patient received their bar-coded armband, who collected the specimen versus how and when it was labeled, and how the specimen was then sent on to the lab all varied depending on the area," says Butler. "So as a team, we decided to come up with a core common process." (See p. 10.)

In developing a common core process, the team decided that there could be no exceptions to key components. This decision was made to decrease the variability found during the initial assessment. However, the team also decided to allow specialty areas to add a step in the process if necessary. For example, in the OR, there are additional steps for processing and transferring specimens.

Along with that process, Butler and her team noted that steps could be added, but no steps could be left out during the processing or transferring of specimens.

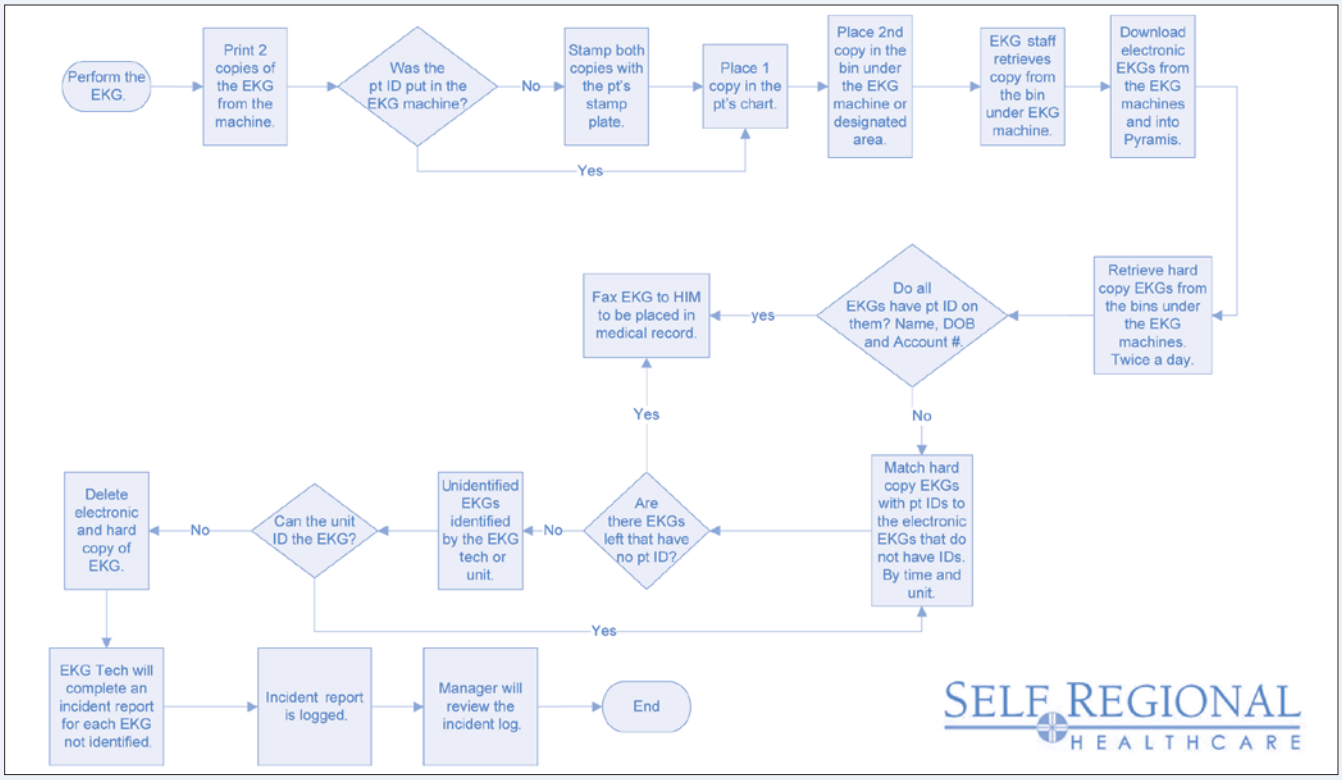
"If an event occurs that deals with specimen labeling or ID labeling, then the standard flow chart must be reviewed, and it has to be noted where in the process things failed," says Butler.

Butler concludes that the rollout of the new patient ID processes has been such a success because information was communicated and understood clearly by all staff members. "The staff was very receptive of the new processes," she says. ■

Source

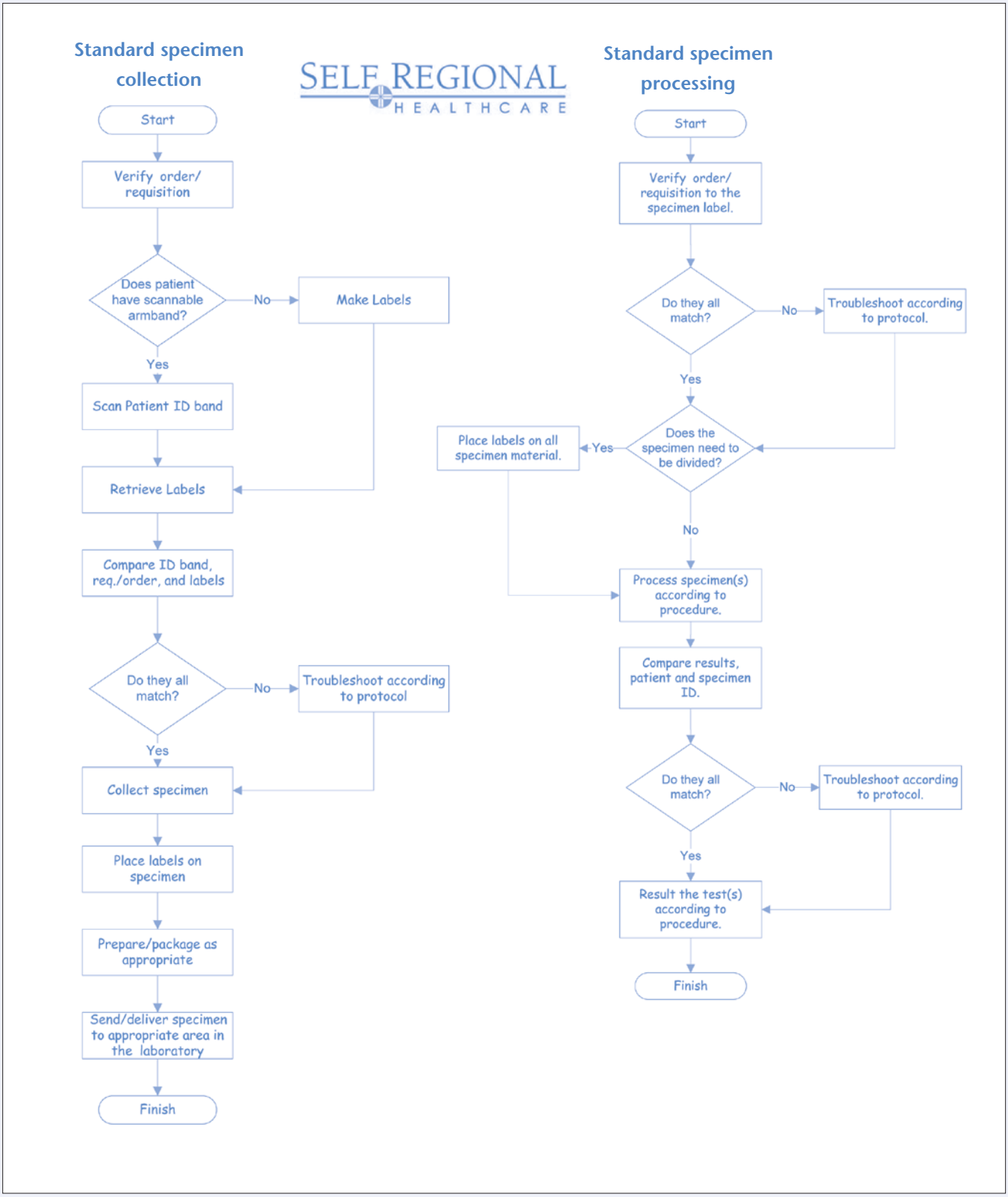
Adapted from **Briefings on Patient Safety,** July 2009, HCPro, Inc.

EKG process



Source: Self Regional Healthcare, Greenwood, SC. Reprinted with permission.

Specimen labeling: Standard specimen collection



Source: Self Regional Healthcare, Greenwood, SC. Reprinted with permission.

Recruitment

More than a warm body: Hiring the perfect nurse for your unit starts with attracting the right candidates

Find the right nurses for your unit by focusing on attitude and aptitude

Imagine the situation: You have just finished interviewing a nurse for an open position. Her résumé looks fine, she said all the right things, and you are desperate to bring in another staff member to relieve the pressure. But a current employee comes up to you and says she worked with the interviewee at a past job and the candidate was not the type of nurse you should hire. Do you take her advice?

It may be tempting to overlook the advice, but experts say seeking input from existing staff members can help you hire a candidate who not only possesses the necessary clinical skills, but also has the character to fit in on your unit.

Hiring nurses is not an exact science, but there are steps managers can take to recruit the best candidates. It's important to get the right people through the door by writing an appealing, informative recruitment ad; screening résumés; and calling references.

Decide who you want to recruit

Before placing an ad, it's important to decide what type of person you want to recruit for your unit, says **Tom Ealey,** a professor at Alma (MI) College and an experienced practice administrator and practice management consultant.

Angela W. Gordon, practice administrator at Dunwoody (GA) Pediatrics, says she also decides on specific requirements before beginning the recruiting process. "You need to assess exactly what this person's job description and job requirements will be, as well as experience and educational background," says Gordon.

Ealey says the quality of a new hire really comes down to two things: aptitude and attitude. "Somebody with a good aptitude and attitude I can train," he says. "For someone with a bad attitude, it doesn't matter how much you train them."

Write an attractive, accurate ad

Once you've determined the type of person you'd like to hire, write a detailed recruitment ad. It's important to "be very specific in your recruiting ad, otherwise you will receive a lot of unqualified résumés," says Gordon.

"You need a concise ad with clear information. If you want certain experience, you have to put that in the ad," Ealey says.

After you've written the ad, it's time to decide where to place it. "Contact any of your listservs or associations you are affiliated with and let them know what you are looking for," Gordon says. "Many times, they have résumés on file or they may know of a good candidate."

Screen résumés and interview candidates

Hopefully, after carefully writing a detailed recruitment ad and placing it with the right publications and organizations, you will have several résumés of well-qualified applicants to weed through.

After choosing the applicants you want to interview, think about what questions you want to ask them to get a better idea about their experience and behavior.

It is also important to call references for every serious candidate because hearing about someone from a past employer is often helpful, Ealey says.

"I try to get a picture of a person because they're going to have to be part of the team and they're going to have to deal with people," he says. "There's a cliché we throw around—we can improve skills, but we can't change personality." ■

Source

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

Tip of the month

Economic challenges and bringing new initiatives to life

Managers everywhere are hearing the same song played repeatedly, and the name of the tune is "do more with less."

Now is the time to start exploring other options for support to assist you and your staff with process change, improvement, and other projects. Connecting with a school of nursing that has a graduate program can prove to be a great support and resource. Grad students are typically motivated, have deadlines, and stay connected to their faculty oversight.

Consider the following if you elect to explore this path:

- Identify a specific project and include goals and objectives
- Ensure that the project is realistic
- Be willing to play the role of a mentor/preceptor
- Be willing to allot time to grad students and understand that their success will be partly related to your input and guidance
- Explore liability/insurance issues with your HR department
- Prepare for the organization to sign a contract with the school providing the student

This can be an engaging process for you as a leader, the staff, the patients you serve, and the organization overall. You never know when that right person will click and eventually become part of your permanent staff. In addition, your nurses see what is possible within the profession and as individual nurses. ■

Source

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