Editor’s note: This article is an excerpt from the book Charge Nurse Program Builder: Tools for Developing Unit Leaders, written by Tammy L. Berbarie, BA, RN, RN-BC.

Before you can start your new charge nurses on the leadership journey, you will need to assign them a charge nurse preceptor. This is not a common or consistent practice, and I plead with those who are revamping or starting a new charge nurse program to invest the time in adequate training. A charge nurse role is a new role, and nurses require time to develop this skill. It makes it a lot easier to transition charge nurses into this role if they have preceptors solely dedicated to ensuring that the necessary education is provided.

Many times in my nursing career, I have witnessed situations in which charge nurses are promoted to the role, attend a short charge nurse workshop, and then arrive on the unit to work with no one there to mentor them. Entering a job blindly, without someone to help orient you, is very difficult. How would you feel in such a situation? Could you comfortably perform your role? What do you think the challenges would be?

I have also seen situations in which charge nurses are precepted by the manager of the unit, but the manager doesn’t spend quality time with the new charge nurses. Leaders in your organization are ultimately responsible for mentoring others, and nurse managers should be actively engaged in supporting and growing this role.

Have a dedicated person to orient the charge nurse. The precepted program for the charge nurses on the unit should involve both an experienced charge nurse and the nurse manager/supervisor.

Preceptor selection criteria
Choosing the charge nurse preceptor is crucial to the success of new charge nurses’ skill development. As a unit nurse manager or educator, you should never choose a preceptor based solely on his or her level of experience. Instead, you should consider a combination of elements such as the following:
➤ Experience
➤ Competency
Charge nurse training (continued from p. 1)

- Ability to act as a role model
- Professional behavior
- Mentorship and coaching capabilities
- Problem-solving and conflict resolution skills
- Resourcefulness
- Time management skills
- Communication skills
- Leadership skills
- Overall management skills

Note: This list was adapted from Preceptor Handbook: A Guide for Effective Clinical Teaching, Collaborative Rural Nurse Practitioner Project, Minneapolis.

As you think about these elements, I also challenge you to review past charge nurse preceptor evaluations. Take a look at how other charge nurses perceived their experience with their preceptor. Was it a positive experience or a horrible one? Do you really want to use that preceptor to mentor another new charge nurse?

If you work in an organization without hardwired preceptor evaluations, consider implementing them as part of your charge nurse orientation program (see p. 4 for an example of a charge nurse preceptor evaluation form).

Time invested in training is not just a succession planning opportunity but also a financial investment.

Training charge nurse preceptors

You must ensure that your charge nurse preceptors have attended your facility preceptorship program before they begin precepting others, especially if they are new to the role. Preceptor classes teach methods for facilitating learning. Not all team members have the same learning style, so these classes teach preceptors how to adjust their teaching methods accordingly.

Preceptors also learn about regulatory issues involved with precepting. It is crucial that they understand the regulatory issues for which they will be held accountable. In addition, most preceptor classes should...
review the documentation requirements of orientation. Your charge nurse preceptors should understand the significance of documenting a charge nurse orientee’s progress. Documentation is a critical communication tool used to demonstrate that an orientee was adequately trained to the position. The progress notes and competency assessments will be reviewed by the educator and nurse manager to assess whether the charge nurse is ready to complete orientation and be independent, and if not, what skills he or she still needs to develop.

**Charge nurse precepted time**

Depending on your facility and how much time you want to invest, a two- to three-week precepted orientation may be sufficient. But be creative with your scheduling and think about how to get the biggest bang for your buck. Imagine that you orient charge nurses to a 12-hour shift and they work only three shifts per week. When they return the next week, which may be their last week of orientation, it is possible that they could forget what they learned the week before. Information overload is also possible. Try to schedule eight-hour shifts five days per week for the first two weeks of orientation. The more experience you give the charge nurses, the better off they will be when they are working independently.

Also, consider cross-training charge nurses so they know what to do on various shifts. In my experience, day, night, and weekend charge nurses typically encounter different situations. If you want to have a robust charge nurse training program and also have the flexibility to be able to ask charge nurses to work different shifts, it would be to your advantage to provide training opportunities that allow charge nurses to experience different shifts. Doing so will familiarize charge nurses with the duties and responsibilities of each shift; it will also serve as a team-building strategy.

Think hard about how you can provide new charge nurses with as many precepted experiences as possible before they are on their own. Of course, even after orientation, they will not be completely on their own for a while. Nurse managers should be readily available and should round frequently with their charge nurses to ensure their needs are being met. Leaders and educators should also round frequently to assess needs. Visibility is crucial to the success of your new charge nurses.

As the new charge nurses approach the end of their precepted time, as a department leader or educator, you should meet with them to summarize their experience. This is a great chance for the charge nurses to evaluate the overall orientation program, ask for clarification on processes, and complete a preceptor evaluation. Use this feedback to make changes to the program as needed.

**Summary**

Charge nurses should be treated as though they are brand-new nurses orienting to your facility and department. They may not need as much detail as new employees, but they do need precepted time in their new roles.

You have a professional accountability to work with your charge nurses and ensure that they are competent and knowledgeable enough to perform their new skills. You cannot accomplish this if you do not assign them a preceptor to monitor their progress. If you hardwire preceptorship into your program, your new charge nurses will be able to provide effective leadership and maintain safe delivery of patient care.

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## CHARGE NURSE PRECEPTOR EVALUATION FORM

### COMPANY NAME (LOGO)

<table>
<thead>
<tr>
<th>INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preceptor name: ____________________________</td>
</tr>
<tr>
<td>Date of evaluation: _________________________</td>
</tr>
<tr>
<td>Name of charge nurse: ______________________</td>
</tr>
</tbody>
</table>

All preceptor evaluation ratings and comments will be confidential and only reviewed by the department manager.

### RATING SCALE AND INSTRUCTIONS

Using a scale of 1–4, assign the appropriate score in the rating box. If you score a 4 in any of the sections, please include a comment in the ‘Opportunities for Improvement’ section.

1 = Always met expectations
2 = Frequently met expectations
3 = Sometimes met expectations
4 = Never met expectations

<table>
<thead>
<tr>
<th>PERFORMANCE ELEMENT</th>
<th>RATING (1–4)</th>
<th>OPPORTUNITIES FOR IMPROVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>The preceptor was knowledgeable and competent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The preceptor gave me feedback on a regular basis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The preceptor behaved professionally at all times</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The preceptor was always readily available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The preceptor provided feedback and learning opportunities to improve my performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The preceptor communicated professionally and gave clear explanations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The preceptor was enthusiastic about my learning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The preceptor managed time effectively</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The preceptor contributed to a teamwork environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The preceptor communicated information in a timely and effective manner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The preceptor oriented me to the rotation and expectations of my role</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The preceptor provided problem-solving activities to enhance my learning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall, my learning needs were met during my orientation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ADDITIONAL COMMENTS

______________________________

______________________________

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Source: Charge Nurse Program Builder: Tools for Developing Unit Leaders, published by HCPro, Inc.
**Patient safety**

**Success in a fall reduction strategy**

**Continuing Education | Learning Objectives**

After reading this article, you will be able to:

➤ Describe the fall reduction strategy used by Mary Greeley Medical Center

by **Neal T. Loes, RN, BSN, MS**, CNO at Mary Greeley Medical Center in Ames, IA

Systemic change requires visionary leadership. The board of trustees for our facility established a new three-year strategic plan based on our six indicators of success. One such indicator is Quality & Patient Safety, and the board determined that this indicator should include a vision “to eliminate all preventable harm.”

Given this direction, we chose to focus on patient falls and began to ask ourselves whether we could eliminate all falls. The prior year baseline for our organization was 3.8 falls per 1,000 patient days. When compared to the National Database of Nursing Quality Indicators, we were within the benchmark for our medical-surgical units.

However, we still believed there was opportunity for improvement. To ensure organizational involvement, we added the organizational fall rate as part of the leadership merit-based performance management system. This includes all supervisors, directors, and the administrative team. This step was crucial to remove barriers and to demonstrate support for this common goal.

Our strategy was simple: First, we organized a multidisciplinary team to meet monthly and began to look at the data. We found that although our falls had reduced over the past five years, there was still great variability from month to month and from unit to unit. We had evaluated our fall reduction policy/program and felt it was relevant and remained current to the evidence-based literature we researched, with one exception: We implemented a national strategy promoted by the Iowa Healthcare Collaborative, which was to place a yellow wristband on all patients identified as a fall risk. We then reeducated our staff members on their roles and the importance of the program.

Then, we went back and manually stratified the data into day of week, time of day, level of fall prevention in place at time of fall, staffing adequacy, etc. We found through our data review that 42% of falls occurred with bathroom activities, and there was a pattern of falls occurring at the change of shift.

To address these two issues, we educated our nursing staff on the data and modified our hourly rounding program so nursing staff were required to assist fall risk patients to the bathroom hourly. The other strategy was adjustment of the change of shift activities to free up the patient care technicians so they could make bathroom rounds prior to performing their vital signs and other duties. We use shift huddles to reinforce the fall prevention strategies and report successes, as well as issues, with falls that occur.

When a fall occurs—and yes, they do occur—we conduct an immediate root cause analysis. We evaluate whether the patient was assessed correctly and whether interventions were implemented, then determine the cause variable that led to the patient’s fall. Each fall is reported at the monthly meeting for further evaluation and education.

Other fall reduction strategies that we continued to use are as follows:

➤ **Bed alarms.** We purchased more units and increased use of the bed alarms through our call light to the two-way communication device.

➤ **Volunteer sitter program.** We are fortunate to live in a university community and have tapped into the university to establish a sitter pool for students to volunteer once provided the competency development.

> continued on p. 6
Patient safety  < continued from p. 5

➤ Companion program. We have hired staff to work in our float pool to function as companions for patients needing one-to-one care. The companions function as patient care technicians for the one patient assignment, thus freeing time for nursing staff to care for other patients.

➤ Daily fall risk assessment and falling star program. We evaluate patients for fall risk at least once per day to see what variables have changed. In addition, if a patient has suffered a fall, we attach a falling star symbol to the outside of the patient room to alert all staff to the greater potential of a repeat fall.

➤ Monthly celebration. We track the unit fall rates daily. The unit that goes the most days without a patient fall within the month receives a celebration.

➤ Polypharmacy review. We are just implementing a polypharmacy review of all fall risk patients on 10 or more medications to identify opportunities to reduce the impact of medications on the patient’s outcome.

The results through the first six months of this fiscal year demonstrate our fall rate as 2.8/1000. This is a 26% reduction in falls from the previous year baseline rate of 3.8/1000, and the monthly variation in fall rate has diminished. We have not eliminated falls, nor do I know if that is possible; however, we feel we are well on our way to reducing the potential of this harm for our patients.

Source
Briefings on The Joint Commission, August 2010, HCPro, Inc.

Shared decision-making
Strengthen shared governance hospitalwide

When Athens (GA) Regional Medical Center (ARMC) implemented shared governance five years ago, the initial drive of the program was met with different levels of success. Unit councils excelled in some areas and struggled in others, leading to inconsistent results.

The organization decided it was time to change that—and it pursued clear data to back up its decision-making process.

“We saw varying success, especially in our unit councils,” says Nancy Arata, RN, BSN, MBA, from the ARMC Office of Professional Excellence. “We wanted to be able to determine if there were particular factors that influenced our success.”

Based solely on gut reaction to existing success rates, ARMC’s nursing leadership could see that some unit councils were outperforming others, with great results and projects coming out of the units. One of those great results: higher nursing satisfaction scores.

“Our question was, ‘Could having a productive unit-based council correlate with high nurse satisfaction? Are you going to have happier nurses in units where nurses are making decisions?’ ” says Arata. The leadership team decided to look for evidence proving or disproving the theory—and that meant conducting a research study.

Looking for evidence

The team developed a survey and distributed it to the unit-based council members and chairs. The 11-question anonymous survey included an area where respondents were asked to list specific decisions made from the previous year.
Focus groups

The next step upon correlating the data was to reach out to council members and leaders to get feedback and input in real time. This meant organizing focus groups. These sessions were mandatory for every unit chair and leader. The organizers, however, were gracious in scheduling the meetings to make sure they would work well for attendees by using multiple dates, including in the evening.

“It’s hard to get away from the bedside, but if you take that time to have a conversation and gain a deeper understanding of the shared governance process and outcomes, you will see it is worth it for the patient,” says Arata.

“There were about 10 people in each group, and we gave lunch passes to those who attended,” she says. “We had conversations: ‘What is working on your unit? What isn’t? What is frustrating? Where are your barriers to improvement?’ ”

They also asked these groups about how management and leadership helped encourage decision-making and change.

“We took that information, along with the research study, and totally revamped our nursing governance structure,” says Arata. At the organization and unit level, this meant reeducating leaders. The organization provided what amounted to a shared governance 101 program, with the thought that since the program had been in existence for half a decade, it was time to revisit its core.

“What is its purpose? What can it impact?” says Arata. “It’s ultimately about patient outcomes, and that is impacted by nursing satisfaction, and higher nurse satisfaction leads to higher patient satisfaction.”

Interestingly, the actual lifespan of the council—how long it had been in existence and functioning—didn’t correlate with nurse satisfaction. What came into play was the council’s own sense of its maturity—for example, councils that felt they were just starting out tended to have beginning-level scores, regardless of how long they had been in existence. Another determining factor: If the unit director coached the council—“coached” being the operative word, rather than “directed”—the unit tended to have higher satisfaction scores.

“There was a definite correlation between the number of decisions the councils had made and RN satisfaction scores,” says Arata. “If you feel like you have the authority to make decisions to impact patient care and your work environment, our study showed a correlation between that and nurse satisfaction.”

> continued on p. 8
Shared governance

nursing administration. One of our nursing councils is the leadership council, made up of formal and informal leaders. They look at these reports.”

This is not a “gotcha” process—the leadership council takes note and praises good work, and the reports are published internally so various units can learn from each other and their individual successes.

“If, for example, surgery is doing great work on preventing central line infections, other units can look at what they’ve been doing and learn from them,” says Arata.

On the other hand, if leadership finds that a unit is not making decisions, it has an opportunity to contact that unit’s chair and ask how it can help and what barriers the unit is struggling to circumvent. Leadership provides tools and education to help prepare the unit council to take the next step in decision-making.

“We want our units to be innovative,” says Arata.

The new structure

Specific changes to the shared governance program took effect in January. ARMC plans to resurvey in October to collect data on the results of these changes. “We’re hoping to have strong data from that,” says Arata.

In the meantime, however, there are signs of great successes throughout the organization.

“One of our units started this process on their own a year ago,” says Arata. “They revamped all of their unit-based councils so that they got everyone in the unit involved in a council.”

Apparently, involvement leads to satisfaction—this unit was surveyed recently and was found to be in the top 10th percentile for the nation in nurse satisfaction. “They have some of the highest nurse satisfaction scores in the country,” Arata says.

This confirmed the results of ARMC’s research. “We’d done our research study, and this particular unit had already started making changes,” she says.

There were lessons learned along the way as well. “We definitely would have had the accountability part in place five years ago,” says Arata. “It’s a big part of the work we’re doing.”

Also, don’t be afraid to reeducate your staff. “It’s never too early to go back and reeducate everybody,” she says. “Everyone had been educated at some point in time. We had a workshop in November but decided it was still important and necessary to get people into small groups.”

The workshop was attended by more than a hundred nurses, but breaking them into smaller groups—where people were more likely to open up, make suggestions, and speak their minds—was an even more effective educational tool.

“Looking back, we would have done those sharing sessions sooner,” says Arata.

There was a learning curve. Initially, nurses were nervous about updating or changing the processes.

“Once they start making decisions that impact the care they give, it’s like a lightbulb comes on,” says Arata. “Especially when they see improvements that they were a part of creating. That’s when the nursing staff really can embrace the whole philosophy of shared decision-making.”

Source
HCPro’s Advisor to the ANCC Magnet Recognition Program®, July 2010, HCPro, Inc.

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November 4—Nursing Accountability: Promote Personal Commitments with Proven Cutting-Edge Strategies

December 8—Nurse Retention and Workforce Planning: Meaningful Recognition Strategies for Building a Healthy Work Environment

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Patient care

Simplifying documentation provides nurses more time at the bedside

Nursing documentation is an overcomplicated process. Although many Joint Commission standards require documentation, hospitals tend to write policies with which they cannot comply.

In HCPro’s April 30 audio conference, “Simplifying Nursing Documentation: Meet Regulatory Requirements and Reduce the Burden on Your Staff,” Bud Pate, REHS, vice president for content and development at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, and Lisa Eddy, RN, CPHQ, senior consultant at Greeley, discussed how hospitals over-burden themselves concerning documentation. “Folks across the country are struggling with how much time nurses are spending at the chart or computer, rather than at the bedside, and we think this is one approach to addressing that, while at the same time achieving compliance,” said Pate.

Nursing documentation has become increasingly complicated. There are numerous Joint Commission standards that require nursing documentation and can pose challenges to an organization (see p. 10). The following problematic areas were discussed during the audio conference.

The initial assessment

Nurses are required to complete an initial assessment within 24 hours of patient admission. However, hospitals define what information is collected in various settings and for various patients. When indicated, the initial assessment should include a physical assessment, psychosocial assessment, nutrition and hydration status, and functional status.

Hospitals often fail by requiring the nursing staff to collect too much information in the initial assessment, much of which has little bearing on the patient’s care, said Eddy. “We’re encouraging you to consider that less really is more and that you require staff only to collect information that makes a real difference in how they plan and provide care,” she said.

Nutritional and functional screening

Nutritional and functional assessments also must be performed within 24 hours of admission. Nursing staff often fall out of compliance because screening and accompanying documentation do not always work to identify patients with a need for dietary and rehabilitation services, said Eddy.

She suggests following the natural process of what often occurs in the dietary department with a diagnosis, procedure, diet order, and diet tech review, because nursing referrals are not technically required.

“Nutritional services has nutritional screening,” Eddy said. “They identify the patients on their own, and the same concept holds true for functional screening. Evaluate the processes and disciplines that already have these processes in place and ask yourself, ‘Does nursing really have to perform this function, or would it be better performed by the services that provide that type of care to the patient?’ ”

Pain requirements

Pain documentation often falls out of compliance because hospitals require documented reassessments of pain at intervals that are not realistic and not required by regulation, said Eddy. Hospitals are often cited for not upholding their own stringent requirements. Additionally, nurses frequently do not have time to document patients’ pain levels as often as required and forget to do it later, regardless of whether they are assessing patients’ pain—and they usually are.

Eddy suggests revising your policy to reflect actual practice and educating physicians and nurses about pain management. Requiring real-time documentation may invite failure. “Why not write a policy that says, ‘The patient’s pain level will be reassessed in accordance with the”

> continued on p. 10
Simplifying documentation < continued from p. 9

intervention provided but not documented until the end of the nurses’ shift, and then you map your shift assessment and care planning evaluation piece to reflect that,” she said.

Challenging nursing standards

1. Assessments
   a. PC.01.02.01, element of performance (EP) 4 (hospital defines required information gathered in initial assessments: nutritional status, functional status, psychological/social)
   b. PC.01.02.03, EP 6 (initial nursing assessment within 24 hours)
   c. PC.01.02.03, EPs 7 and 8 (nutritional/functional screening)

2. Reassessments
   a. PC.01.02.03, EP 3 (reassessments based on plan of care)

3. Care planning
   a. PC.01.02.05, EP 5 (nursing care based on initial assessment)
   b. PC.01.03.01, EP 1 (plan of care based on the assessed needs of the patient)
   c. PC.01.03.01, EP 5 (plan of care based on the goals, time frames, settings, and services required to meet goals)
   d. PC.01.03.01, EPs 22 and 23 (progress toward goals is evaluated/plan of care revised accordingly)

4. Pain
   a. PC.01.02.07, EPs 1 and 3 (initial pain assessment and reassessments)

5. Restraint
   a. PC.03.05.01, EPs 3–5 (less restrictive measures, discontinuation)
   b. PC.03.05.05, EPs 1 and 6 (initial and renewal orders for restraint)
   c. PC.03.05.07, EP 1 (patient monitoring)
   d. PC.03.05.15, EP 1 (documentation)
   e. PC.03.05.03, EP 2 (restraint included in plan of care)

6. Education
   a. PC.02.03.01, EP 1 (learning needs assessment)
      i. EP 4 (education based on assessed needs)
      ii. EP 5 (coordination with other disciplines)
      iii. EP 10 (based on assessed needs, education as appropriate)
   b. PC.02.03.01, EP 27 (communication of safety concerns)
   c. NPSG.07.03.01, EP 3 (multidrug-resistant organisms patient/family education)
   d. NPSG.07.04.01, EP 2 (central line infection prevention patient/family education)
   e. NPSG.07.05.01, EP 2 (surgical site infection prevention patient/family education)

7. Medication reconciliation (existing standards 08.01.01–08.04.01)
   a. NPSG.03.07.01, EPs 1–5 (Joint Commission investigating alternatives; not scored until July 2011 at the earliest)

8. Coordination of care
   a. PC.02.02.01, EPs 2 and 3 (handoff communication and care coordination)

Source: “Simplifying Nursing Documentation: Meet Regulatory Requirements and Reduce the Burden on Your Staff.”
Orientation

Seeing the big picture: Facilitating critical thinking in new nurses

Nurses beginning their first job after graduation need help developing critical thinking skills. Pamela Schubert Bob, MHA, RN, CPN, NE-BC, nurse manager at Children’s Hospital Boston, wanted to facilitate critical thinking in new, or as she refers to them, “novice” nurses.

“I overheard one of my nurses tell a doctor, ‘I don’t know anything about that because I wasn’t here yesterday,’” says Schubert Bob. “I cringed because this was an unacceptable response. I felt that younger, newer staff weren’t seeing the big picture. They were looking at taking care of patients for a shift instead of taking care of a patient as a whole.

“I wanted to create an environment in which it was okay for the staff to ask and answer critical thinking questions.”

Creating a critical thinking program

Schubert Bob began by approaching a newly hired nurse whose patient had a history of seizures. “I asked her what she would do if her patient had a seizure. She wasn’t sure how to respond. We worked through things like what equipment should be at the bedside, what actions to take during a seizure, etc. At the end of those five minutes she felt much more confident.”

Schubert Bob continued these informal critical thinking exercises. After each report, she would interact with new nurses, asking critical thinking questions and sometimes using worst-case scenarios as a starting point.

The impact on nurses’ critical thinking skills was almost immediate. To help with mentoring, she developed a critical thinking program that relied on the expertise of available senior nursing staff. These experienced nurses were trained to interact on a one-to-one basis with new nurses in five-minute sessions.

Training nurses to stimulate others’ critical thinking skills

Schubert Bob points out that “not every experienced nurse can mentor and teach others. You really have to want to do it.” Most staff nurses “jumped at the chance,” she says.

Schubert Bob provided the initial training, which included an explanation of critical thinking and its importance to nursing practice, the kinds of questions to ask new nurses for the purpose of improving critical thinking, and how to formulate and ask open-ended questions such as the following:

➤ What is the worst-case scenario for your patient?
➤ What are your plans for patient education?
➤ How will your documentation help your peers to maintain continuity of care?

These critical thinking sessions were designed to take about five minutes. After training, each senior nurse listened to a critical thinking session between a new nurse and Schubert Bob or another trained facilitator.

“Regular sessions for questions, direction, and support were offered until the senior nurses were comfortable facilitating critical thinking sessions,” says Schubert Bob.

Once the program started, either senior or new nurses could initiate sessions. A list of trained critical thinking mentors was posted so new nurses could easily approach trained facilitators. Both new and experienced nurses felt that this program improved critical thinking skills.

Source

Briefings on Evidence-Based Staff Development (formerly The Staff Educator), August 2010, HCPro, Inc.
If any of the excuses below sound familiar to you—if they’re excuses you’ve used before—please note this makes you normal. When a person becomes comfortable and has an excuse not to do something—in this case, delegate—he or she will have little motivation to change.

As a nurse manager, you may be afraid to delegate for any of several reasons:

➤ You’re afraid staff will feel even more overworked than they already do
➤ You worry that staff cannot complete the task as well as you
➤ You don’t trust anyone else on staff to handle the task
➤ You believe you can complete the task more effectively and efficiently yourself
➤ You don’t think your boss would want you to delegate any of your job functions or tasks

Each day you continue this pattern of not delegating, realize that you are:

➤ Disempowering your staff
➤ Discouraging professional accountability
➤ Giving the impression that you don’t respect or trust your staff
➤ Sending the message that you believe your staff lack the knowledge or skill to do the job

Tip of the month
There’s no excuse for not delegating

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

Website spotlight

You’re more likely to get burned out if you don’t spend some time outside the hospital walls. Burnout is a leading ailment of many busy nurse managers, but here’s one way to prevent it: Take a vacation! Even if you only have a couple days, it’s vital to maximize your R&R. Plan your vacation months ahead of time. It can be almost as gratifying just thinking about an upcoming trip as it will be to actually take it. Also, knowing that you have something fun coming up will help get you through stressful times. Put up vacation reminders that you’ll see every day. Mark the trip on your calendar, put a picture of your destination in your purse or wallet, or make the background of your computer something you’re excited to see on your trip.

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