Preceptor training success begins with your criteria and incentives

Who on your staff is preceptor material? Use these criteria and incentives to find out.

The success of your preceptorship program is highly dependent on the selection and training of qualified preceptors.

It is important, therefore, to clearly establish the selection criteria for potential preceptors on your unit.

The candidates for your preceptorship should meet the following criteria:

- Express desire to serve in the role of the preceptor
- Have education commensurate with the preceptor role (i.e., bachelor’s degree, critical care certificate, and so on)
- Be employed on the nursing unit; assigned for at least two years
- Have no negative evaluative performance criteria in the past year
- Have all unit competencies/annual education requirements up to date
- Serve on a professional practice committee
- Have no planned extended vacation periods during the preceptorship period
- Possess a clear understanding of their duties and act as a role model for professional nursing practices
- Be able to apply nursing theory in the workplace

Preceptor training success begins with your criteria and incentives

Having a great attitude helps, but it’s not the only way to help a new hire succeed. Follow this list of ideas to bring a new hire up to speed quickly and wisely:

- **Encourage questions.** The pleasantness and responsiveness of coworkers can be most helpful to a new hire in the first few months. New nurses should be encouraged to ask as many “how” and “why” questions as possible.

- **Provide as much reading material as possible**—New employees can use it all: standard operating procedures, checklists, facility policies. Copies of blank forms and templates that they will encounter regularly in their jobs can serve as references and study tools as well, as new hires become familiar with your facility and procedures.

- **Assign a buddy**—It is helpful for new hires (even experienced nurses) to have a point of contact for questions about the ways things are done at your facility. These can be questions from the location of the coffee to security issues, where to find supplies, and best methods for working with the physicians on the unit. Be sure the experienced nurses you assign as buddies are doing well themselves and are able to take on the task.

Source: HCPProfessor.com.
Preceptor training

An application process involving a checklist approach to the criteria noted above will ensure that only the most qualified preceptors are selected for your program.

In addition to the unit preceptors, you may need to identify some assistant preceptors who may be utilized within the preceptorship program when the preceptor has other obligations, such as committee meetings, or if there is an unexpected illness or absence of the preceptor.

Incentives
To attract qualified individuals to take on the additional responsibilities associated with a preceptorship may require some incentives.

The nursing administration must plan to reward preceptors, since some researchers have hypothesized that the amount of recognition/reward given to a preceptor directly reflects the value that the health care institution places on nursing clinical excellence and new nurse retention.

The following are some suggestions for incentives:

- Hourly wage differential during the preceptorship period
- Fixed bonus paid at the end of the preceptor period
- Reimbursement for attendance at a regional continuing education program
- Reimbursement of tuition costs for courses taken toward a degree
- Preceptor/preceptee recognition meals
- Articles in the institution newsletter
- Cross appointment (e.g., adjunct professor position) with the academic institution providing nursing students to the program

Several of these suggestions may be implemented as part of the overall program policy. Positive reinforcement is critical if the preceptor is to continue in this expanded and demanding role.

Decision time
To make a decision from among the preceptorship program applicants, a quick review of the characteristics that make up an ideal preceptor may be of assistance.

The preceptor must have the following attributes to make all interactions with preceptees beneficial:

- **Knowledge** of the policies, procedures, rules, regulations, and care practices of the institution.
  Although knowledge of the patient care area is a valuable asset for the preceptor, some preceptees have reported that their preceptorship experience was a disaster, despite the fact that their nurse “really knew her stuff.”

- **Skill** at performing the technical aspects of the position. The ability to model excellence in nursing practice—not taking shortcuts—ensures that the preceptor is respected by the preceptee, who may have only minimal opportunity to start IVs or complete a complex dressing change.

- **Ability** to integrate knowledge and skill into daily interactions in the health care environment. Many orientees have not yet had to care for more than two or three patients. The ability to multitask safely in the complex patient care environment of six or seven patients can be very effective education for the novice.

- **A good attitude** about using knowledge, skill, and ability all the time. It involves a sense of morality, or knowing right and wrong, that helps a person to consistently choose to do the right thing despite obstacles within the workplace. Effective patient-centered decision making thus involves modeling the attitude of a caregiver.

Despite having a good knowledge base, exemplary technical skills and abilities, and the right attitude,
there is another set of requirements that an effective preceptor needs to meet in order to communicate and model the best professional behaviors to others.

Preceptors must also have the following qualities:

- **Organized** while carrying out all daily activities. This is the ability to think logically when planning activities to ensure that goals are accomplished with minimal effort, conserving precious professional time.

- **Resourceful** when planning daily activities. This is the ability to adjust plans quickly and effectively, while still working within the framework of unit, as conditions change.

- **Creative** when providing learning opportunities. This is the ability to search for creative ways to provide new learning opportunities for the novice.

- **Objective** in all communications. This is the ability to communicate clearly and fairly in all interactions. It includes listening effectively, making/receiving constructive comments, and directing clearly.

**Editor’s note:** This article was excerpted from a new book by Brian R. Rogers, RN, BSc, CCRN, DHA, EMT-HP, a nursing educator who has taught a successful nurse preceptor training workshop for more than two years. The book, Nurse Preceptor Program Builder: Tools for a Successful Preceptor Program, is published by HCPro, Inc. Go to www.hcmarketplace.com for more information.

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**Legislation**

**CNA pins retention hopes on new mentor program**

The California Nurse Mentors Project is one example of how hospitals in the state are trying to prepare for the controversial new, state-wide nurse-staffing laws that take effect January 1, 2004.

A $904,000 grant from The California Endowment, a private statewide health foundation, will help the California Nurses Association (CNA) implement the three-year pilot program in four hospitals in the Catholic Healthcare West system beginning February 2004. The CNA is hoping to curb the attrition rate of nurses at acute hospitals in the state by matching novice nurses with more experienced nurses for training and support.

Overall, 160 registered nurses (RNs)—either new RN graduates, reentry RNs, or RNs who are learning to work in other areas, especially specialty care departments—will be paired with experienced RNs for three months, according to the CNA. A special multicultural and multilingual effort will be made in the mentor pairings, along with support for male nurses, to encourage broader diversity in the nurse work force.

“[It’s] an important step forward to guarantee that RNs more closely reflect the population we serve, and enhance the quality of care,” notes Kay McVay, president of the CNA.


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Managing competencies can be an overwhelming job

A recent HCPro survey of nurse managers in hospitals nationwide shows that competencies management continues to be a complex and difficult job.

Among the difficulties facing managers is the need to effectively tie competencies assessments to annual performance reviews.

With the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) checking to see that 100% of evaluations are completed on time and reviewing selected competencies documents via the new tracer methodology, the pressure is on to be sure that records are up to date.

Scheduling, documenting still most challenging
Most managers conduct annual competencies assessments, but scheduling and organizing their annual competencies assessment activities is viewed as a major challenge to 54% of the nursing directors and nurse managers who responded to the survey.

Fifty-one percent of managers indicated that creating useful competencies documentation forms is a difficult task. The practical aspects of competencies assessment are clearly a headache for nursing management.

There is consensus among nurse managers responding to the survey that competencies are most effectively assessed via observation of the staff at work, when possible. But this can be tough to schedule, and many use simulated skills days or other tools to validate competencies at a designated time and place.

To help with this effort, about 38% of managers are trying programs that involve peers in evaluation of their colleagues—but find it difficult to recruit and involve staff in these initiatives.

Choosing your focus
The problem is also connected to the sheer number of clinical competencies managers need to track, and the job of mapping all the competencies against the job descriptions for which they have responsibility is a challenge for 46% of nurse managers. It can also be hard to decide which competencies need to be assessed annually and which do not.

JCAHO standard HR.5 requires that hospitals establish the content and frequency of competence assessments according to the laws, regulations, and hospital-specific policy.

“I need help to decide exactly what kind of competencies JCAHO requires. Some are rather vague in description,” one manager wrote.

Generally, department managers and staff educators are responsible for the identification of annual competencies.

There is no doubt that a number of variables should be considered when managers design their annual competencies program.

The annual competency process is not meant to be comprehensive, unlike the competency validation that occurs at orientation.

Consider the following when conducting your assessments:

Questions? Comments? Ideas?

Contact Associate Editor Debbie Blumberg

Telephone: 781/639-1872, Ext. 3425
E-mail: dblumberg@hcpro.com
• Department functions
• Performance improvement activities
• Infection control reports
• New technology
• Low-volume, high-risk procedures
• Age-specific care

Whichever method is used to select the competencies to be assessed, the selection should be department-specific, but reflect key areas that are important to the organization’s mission and performance improvement goals as well.

The program should also help establish areas for initiatives that can lead to further learning and skills improvement among staff.

Source: HCPro, Inc., reader survey.

Communication

Learn how to use ‘I’ messages

It can be challenging to provide employee feedback, especially when it calls for improvement. But the way you provide feedback can be the key to successful communication between you and your employees.

For example, use “I” v. “you” when giving feedback. “You” messages imply blame and accusation—i.e., “you said,” “you did,” “you should have.” So practice turning “you” into “I.”

Instead of saying, “You never get to work on time,” you could say, “I’m concerned that you are frequently late.”

Here are some other examples:
• Replace, “You know you cannot go to lunch until all the patients are fed,” with “I want you to make sure all the patients are fed before you go to lunch.”

• Instead of saying to a doctor, “How do you expect anyone to read these orders? You’re going to cause a nurse to make a big medication error one of these days!” you could say, “Please write your orders more legibly. I’m concerned that a nurse may make a medication error.”

Remember, “I” messages take responsibility for one’s own actions, whereas “you” messages place the blame on others.

Learn the seven Ts of managerial feedback

Proper feedback allows you and your employees to work toward common goals. The following is a list of seven Ts that will guide you during this process:

1. Told—Inform your employees that they will receive feedback, both scheduled and spontaneous.
2. Timely—Feedback should closely follow the behavior, whether it is positive or negative.
3. Timed—Make sure the feedback is given at the right time. For example, if you know that the employee has just received bad news at home, don’t give him or her negative feedback at that moment.
4. Targeted—Feedback needs to be specific. Do not use general words such as “good” or “bad.” Also, do not bring up past problems that are not related and do not make critical remarks about an individual’s personality. Make sure the criticism is work-related.
5. Tactful—Make sure your feedback is not perceived as a threat by your employee. If an employee feels threatened or attacked, he or she will become defensive and will not be able to make use of the information.
6. Truthful—It’s important to be open, honest, and direct when giving feedback. This is the only way to help the employee.
7. Tuned—Make sure you and your employee have a clear line of communication. Make sure he or she understands the feedback. It’s a good idea to have your employee rephrase the feedback to make sure he or she heard the intended message.


Client hospitals applaud telepharmacy benefits

Telepharmacy is a new way for hospitals to safely dispense medication to patients when the pharmacy is closed. At facilities that use telepharmacy, nurses fax medication orders to off-site pharmacists after hours, who then review and approve orders.

At Sibley Memorial Hospital in Washington, both the pharmacy and nursing staff report satisfaction with their telepharmacy system, provided by MedNova-tions Inc., a health care solutions company in Greenbelt, MD. “[Nurses] don’t have a delay in treatment in terms of waiting for the on-call pharmacist to respond to any type of inquiry,” says Jamie Belcastro, RPh, Sibley’s pharmacy operations manager. “When [nurses] fax over a response to MedNovations, the response is relatively instant. So it’s almost like having their own in-house pharmacy.”

Other benefits include the following, according to Christopher Keeyes, PharmD, BCPS, RPh, MedNo-vations chief executive officer:

- Nurses report high satisfaction with the fact that MedNovations pharmacists contact physicians directly if there is a problem with their order.
- Nursing administrators say they are pleased with the level of review, which exceeds what their nurses could do (Keeyes and his staff have the pharmacy profile to screen against for drug interactions, allergies, and dosing). Nurse administrators say that in the past they were uncomfortable being the ones that had to do that review.
- Medication errors have decreased.
- Administrators no longer have to fight for staff to work extra hours with the current pharmacist shortage.
- Pharmacists enjoy the system because they don’t have to staff nights, but they’re can stay in the loop professionally and economically—as part of the program, each facility much staff an on-call pharmacist.

Success and revelation come with a first-time infant security fair

The prevention of infant abductions is a hospital-wide concern. However, much of the training and education that administrators at Brigham and Women’s Hospital in Boston provided to that end took place only with staff members in the maternity and pediatric units.

“We just sort of forgot about the rest of the hospital,” recalls Robert Chicarello, assistant director of security and parking.

Time for a debut
The solution was simple and turned out to be a hit: The hospital held its first-ever infant security fair. The fair was inexpensive, entertaining, and perhaps most importantly, it rooted out some training concerns.

Organizers set up the fair outside the hospital’s main cafeteria from 11:30 a.m. to 1:30 p.m. on two consecutive days to take advantage of the lunchtime crowd. People enjoyed taking photographs with McGruff the Crime Dog, and an infant CPR doll caught some folks by surprise.

Free stuff? All right!
Volunteers who staffed the tables handed out custom pens and one-page fliers. On one side of the sheets were facts about infant security, and on the other side were quiz questions. Employees took the quizzes and turned them in for raffle drawings, which included 10 prizes of free lunch at Au Bon Pain restaurant, and a grand prize of a $300 DVD player. All the prizes were donations.

Keeping up with demand
Organizers printed 500 quizzes for the first day and ran out. The next day, they brought another 1,000 copies and gave away 750, so the quizzes made it into the hands of about 12.5% of the hospital’s 10,000 employees. In the end, 775 staff members turned in their quizzes for the raffles, which Chicarello considers a success.

Efforts such as an infant security fair look good to surveyors, particularly in light of the restructured environment of care (EC) standards from the Joint Commission on Accreditation of Healthcare Organizations. The renumbered EC.2.10 (security risks)—effective January 1, 2004—includes a new, specific reference to carrying out responses for infant abductions.

The infant security fair and abductions also highlighted some important basic security and patient safety policies and precautions, and the fair was a great refresher to all employees about the risks of forgetting security measures.

Consider polling your departments on areas they consider to be department specific patient safety issues—many may be candidates for organization-wide awareness programs that will contribute to patient safety improvements across the board.

Retention

Phrase your praise to retain good employees

Think about how you felt when you were praised for a job well done. Now think about having the power to make your employees feel that way.

All employees want to hear what a great job they are doing and it works wonders for retention.

Take your employees’ individual preferences into account and then praise them in the following ways:

- **Spontaneously.** Catch people doing something right and thank them on the spot. Or leave voice mail recognition messages.
- **Specifically.** Praise people for specific efforts.
- **Purposefully.** Take an employee to lunch or dinner at a great restaurant to show your appreciation for a job well done.
- **Privately.** Go to your employee’s work area to give a personal, verbal thank you and praise.
- **Publicly.** Praise your employee in the presence of others.

- **In writing.** Send a letter, memo, or e-mail. Send a copy to upper management as well.

How do you phrase your praise to retain good employees? The following are some opening lines that can be effective:

- “You really made a difference by . . .”
- “I’m impressed with . . .”
- “You got my attention with . . .”
- “You’re doing top quality work on . . .”
- “You’re right on the mark with . . .”
- “One of the things I enjoy most about you is . . .”
- “You can be proud of yourself for . . .”
- “We couldn’t have done it without your . . .”
- “What an effective way to . . .”
- “You’ve made my day because . . .”


Save the date!

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Continuing Competence: Where Education and Practice Meet

30th Annual National Conference on Professional Nursing Educational Development

Featuring more than 100 sessions, poster exhibits, and roundtable discussions, organizers say every concurrent session will have topics of interest for each major specialty group—academic education, staff development, and continuing education.

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- Teaching Evidence-Based Practice: Practical Considerations
- Planting the SEEDS of Technology: Bridging the Gap Between Education and Practice
- Teach, Advice, Guide: A Collaborative Approach to Precepting
- Are You Sure They Are Competent? A Measurement Tool Box for Educators

For more information, go to www.kuce.org/kumc/nec/.
Interdisciplinary care

Poorly stated patient problems can derail your interdisciplinary plan of care

Your interdisciplinary approach to patient care can’t happen without there being a way for all of the clinical disciplines that assessed the patient to collectively prioritize the patients’ problems.

But, before that can happen, consideration must be given to the way in which your care team communicates patient problems.

“Every discipline believes it knows how to state the patient problem[s], but often they don’t. It is a necessary first step, and it is essential that problems be written in a common language that is mutually understood by all disciplines,” explains Brenda Summers, MBA, MHA, MSN, RN, CNAA, a senior consultant for The Greeley Company in Marblehead, MA.

Summers suggests that every clinical discipline in on the assessment of a patient consider the following:

- **Is the problem patient-focused?** Clinical team members often incorrectly make reference to things such as “the rehab plan of care” and “the respiratory plan of care”, or “the nursing problems” and “the social worker problems.” They need to remember that these are the patient’s problems. They are the disciplines that bring expertise to help address that problem.

  For example, patient-focused problems might be: “no money to buy medications,” “doesn’t understand how to change dressing,” and “unable to get out of bed without two people assisting.”

- **Is the problem written in a common language?** If your problem statements aren’t patient-centered and written in an agreed-upon common language, then those problem statements begin to resemble the particular discipline that identified them, she says.

  “Suddenly, it has become that discipline’s problem and, perhaps, other disciplines can’t even understand what is being communicat- ed,” she says.

  Be aware of discipline-centered problem statements such as “alteration in fluid volume deficit,” “alteration in respiratory status,” or “ineffective coping.”

  Editor’s note: If you have a question about how to initiate or support interdisciplinary care at your facility, submit your question to Strategies for Nurse Managers via e-mail to dblumberg@hcpro.com.

  **It is essential that problems be written in a common language that is mutually understood by all disciplines.”**

  —Brenda Summers, MBA, MHA, MSN, RN, CNAA

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Share your management tip and win!

Has your facility started a notable new program? Do you have a special tip to tell your fellow nurse managers? Let Strategies for Nurse Managers know how you handled a sticky situation, or tell us what administrators have done to improve your facility.

If your tip is published, you will be entered into a drawing this Fall for a **$50** prize. E-mail Associate Editor Debbie Blumberg at dblumberg@hcpro.com or call 781/639-1872, ext. 3425. Mention the fall drawing when you submit your strategy.
Nine steps for a better patient-handling program

Back injuries, chronic back pain, and other musculoskeletal disorders are painful reminders of what your body goes through every day.

The American Nursing Association (ANA) claims back injuries force as much as 12% of your nursing colleagues out of the profession each year, making its new “Handle with Care” educational campaign a retention initiative as much as it is a safety issue.

The Handle with Care campaign is designed to support the ANA’s push for a nationwide “no-lifting” policy when it comes to patient-handling tasks.

It suggests the following nine steps for instituting a safe patient handling and movement program in your facility:

1. **Create an ergonomics committee** to be in charge of establishing, implementing, and monitoring your program.

2. **Analyze the data** that you obtain through incident reports, walk-throughs, and employee surveys to examine who is being injured and why.

3. **Assess patient dependency levels** and make equipment decisions based on patient needs and abilities.

4. **Assess risky patient-handling tasks** by performing an ergonomics hazard assessment.

5. **Develop and adopt a safe patient-handling policy**, such as a “no lift” policy, that discourages manual patient-handling and requires the use of appropriate equipment and devices as necessary.

6. **Research, evaluate, select, pilot, and institute patient-handling equipment and devices**, remembering to use frontline health care workers to ensure optimal use of new equipment.

7. **Provide comprehensive and interactive training for staff** on policies and devices before implementing them.

8. **Encourage reporting of back injuries** by creating a blame-free environment for reporting work-related injuries or illnesses.

9. **Track patient and worker injuries and evaluate the program by** analyzing data and updating the program with the latest policies, best practices, and new technology.

Compared to other occupations, nursing personnel are among the highest at risk for musculoskeletal disorders. The Bureau of Labor Statistics lists RNs sixth in a list of at-risk occupations for strains and sprains.

*Adapted from: ANA’s Handle with Care Web site, go to www.nursingworld.org/handlewithcare/*.

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Building morale is fairly easy to do, but it often gets overlooked because of time and budget constraints.

According to a survey by New York City–based consulting firm Towers Perrin, 75% of employees polled believe they have a direct impact on their company’s success and 72% say they feel a sense of accomplishment from their jobs.

Think about the little things you can do to make your staff feel appreciated.

Sometimes, it is as simple as thanking them for a job well done, or congratulating them on a successful day. Or maybe it is something bigger—something planned in advance to thank all of your staff.

At Miami’s Baptist Hospital, employees give themselves a break from the tension of the hospital environment by throwing a “Monotony Breaker Day,” on minor holidays, such as Oktoberfest or the birthday of a famous poet.

Snacks, drinks, and room decorations all celebrate the day’s theme, and employees are encouraged to drop by the party room when it is convenient to socialize or just relax and take a break.

The satisfaction your employees will feel by knowing they are appreciated will filter through to their patients.


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Patient safety

Six steps to building support for a new program

Heavy-duty staff involvement precipitated the rollout of Memorial Health System's new patient safety initiative called “It’s OK to Ask” in March 2003. The program's goal is to encourage patients and the public to question staff about things like infection control precautions to help ensure a safer environment of care.

This is a key point often missed by other hospitals attempting similar goals, says Jim Bente, RN, vice president of quality and organizational development at the Springfield, IL, hospital. “This was a very different approach than most organizations take,” Bente says. “It wasn’t just in [the hospital] newsletter. We went out and talked to people.

Let’s look at what the process involved:
1. The hospital convened focus groups totaling 100 employees in 2002 to talk about encouraging patients to question their care more.
2. The focus groups liked the proposal, so it moved to the facility's quality and safety committee. Liability concerns arose about whether the program’s existence would imply that there was subpar care at Memorial Health. However, hospital officials felt comfortable that “It’s OK to Ask” bolstered the quality of care, and didn’t expose any shortfalls.
3. The quality and safety committee eventually endorsed the idea, which led to training senior executives.
4. From there, department heads received an introduction to the program, with orders to talk directly with their employees.
5. Supervisors spoke with every worker individually. This part of the training took a month, Bente says.
6. Once hospital officials were satisfied that the program had enough of an internal foundation, a Web site went up and Memorial Health held a press conference to announce the start of the program during National Patient Safety Week this past March.

Adapted from Briefings on Hospital Safety.

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Contact Associate Editor Debbie Blumberg
Phone: 781/639-1872, Ext. 3425
Mail: 200 Hoods Lane, Marblehead, MA 01945
E-mail: dblumberg@hcpro.com
Fax: 781/639-2982

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