Retention

Five tips to reduce employee turnover at your facility

Learning objectives: After reading this article, you will be able to
1. list five ways to reduce employee turnover and increase employee satisfaction

It’s no secret that high turnover—defined as 50% or more of your staff being replaced within three years—is one of the most expensive problems nurse managers face, says Terri Levine, a master-certified business coach in North Wales, PA. The cost to find, train, and employ someone is significant, especially if you repeatedly incur these expenses. The following are five recommended methods to keep your staff happy and your vacancy rates low:

1. Offer competitive salary and benefits. Although compensation isn’t necessarily the most significant factor in keeping employees around, it’s the most obvious. Referring to the adage “cash counts,” Levine recommends offering salaries competitive with neighboring organizations.

And don’t overlook benefits. Some employees will even take a job with a lower salary in exchange for better benefits, Levine says. Health benefits are of particular concern. Try your best to keep employees’ health plans consistent from year to year and their contributions stable.

Also research other perks that staff will appreciate such as tuition reimbursement for career development or computer classes, she adds.

2. Set clear expectations. Clarify employees’ job responsibilities and your expectations, says consultant John-Henry Pfiifferling, PhD, an applied medical anthropologist and director of the Center for Professional Well-Being in Durham, NC.

“The easiest way to get people to leave earlier than expected is to create unnecessary ambiguity,” he says. Confusion often leads to conflict over whether employees perform well. Without knowing how to satisfy their employers, employees become frustrated and eventually throw in the towel.

In addition to providing precise job descriptions, share your organization’s vision, goals, and objectives. Staff must understand each objective (i.e., the steps the facility plans to take to reach its goals) to perform in a mutually satisfying way, Pfiifferling says. Regular unit meetings with staff that address these goals can ensure consistency and help them feel that they contribute to your success, he adds.

3. Deal with conflict. Longstanding, unresolved grievances will eventually cause nurses...
Retention

Turnover

and other staff to seek employment elsewhere.

Instead of denying that conflict exists on your unit, deal with matters promptly, Pfifferling says. Plan how you will handle disputes with a written conflict-resolution policy.

“Much unnecessary turnover is due to a toxic or intimidating work environment,” Pfifferling adds. Don’t allow disruptive behavior to poison your staff. In a written professionalism policy, address behaviors you will not tolerate (e.g., gossip or favoritism) and define the consequences. To ensure fairness, appoint an objective source (internal or external) as an informal judge or mediator, he says.

4. Demonstrate trustworthiness and support. The number-one complaint among employees with whom Levine conducts exit interviews is that they don’t trust their employers. Former staff may say their employers didn’t really care about them or even made fun of them behind their backs, she says. Even if you address unacceptable behavior in a written policy as mentioned above, you can’t “unhurt” a person’s feelings, she says.

With trust comes support at the workplace, which employees must be able to sense, Levine says. When people come to work, they may reach out to coworkers who they view as extended family and discuss their family, relationship, or financial problems.

5. Foster professional growth. Happy employees have a sense of autonomy and empowerment, Levine says. “They want to be able to give suggestions [that are] listened to and taken seriously.”

Even though you won’t carry out all ideas, consider them and encourage employees to continue to provide feedback.

Employees also need the right level of challenge, Levine says. Bored or overwhelmed employees are more likely to leave. If you witness either extreme—employees chatting too much or complaining they don’t have time to go to the restroom—make an adjustment. Is your unit clerk ready to take on more responsibility? Do you need an extra volunteer to help nurses handle their patient loads?

To entice employees to excel, design a clinical ladder for each position. Even in a small facility, you can increase a person’s responsibility (not necessarily workload) and create a new job title (e.g., charge nurse). This incentive gives employees something to aspire to, Levine says.

Source: Adapted from Private Practice Success, March 2005, HCPro, Inc.
Interdisciplinary care corner

Falls prevention is not just for nurses

Learning objectives: After reading this article, you will be able to
1. describe four preventive tactics that all healthcare staff can use to reduce patient falls
2. explain a key factor in the success of an organization-wide approach to falls prevention
3. conduct a thorough risk assessment to qualify patients for standard or strict falls precautions

Assessing patients’ risks for falls and addressing these risks is a 2005 National Patient Safety Goal, and compliance requires an organizational effort.

Northwestern Memorial Hospital (NMH) developed a comprehensive falls prevention program based on the principles that all patients are at risk for falls and that everyone within the hospital has a role to play in falls prevention.

The 725-bed Chicago-based hospital began its “Take a second glance” program in 2003. The hospital developed the program based on a review of current practice, patient interviews, and literature.

NMH benchmarked its falls data against other hospitals’ through the National Database of Nursing Quality Indicators. The facility found that its rates were well below the average for both falls and injuries resulting from falls—which leadership attributes to NMH’s interdisciplinary method of preventing patient falls.

“Traditional approaches to fall prevention charge nursing with overall responsibility for fall prevention,” says Stephanie Kitt, RN, MSN, director of quality. “But we can only improve if everyone is aware that all patients are at risk for falls and that a collaborative effort is needed to help.”

Hospital educators should train anyone who has contact with patients, including housekeepers, food service staff, transporters, physicians, physical therapists, and family members, says Carol Payson, RN, MSN, interim director of surgical patient care.

To convey its message, the multidisciplinary team produced an educational video for staff. The video focused on strategies to prevent falls by showing incorrect approaches followed by correct approaches as demonstrated by staff in every area. For example,

- housekeepers let patients know when the floor is wet
- transporters make sure to lock wheelchair brakes
- physicians put up siderails after they leave a patient and ensure the tray table is in place
- caregivers stay in close proximity to patients escorted to the bathroom

The program also emphasizes that “all patients are at risk for falls, regardless of age,” says Payson. Staff at NMH use a fall risk assessment tool (see p. 4) that categorizes patients as either on standard or strict precaution levels for falls. All patients start on standard precautions, which include interventions such as making sure trays are within patients’ reach.

Track fall rate at the unit level

A key to the program’s success is tracking the fall rate at the unit level.

“Typically, data is reported as falls per 1,000 patient days,” says Kitt. “Our multidisciplinary committee’s view was that that number isn’t very meaningful to a staff nurse.”

The team selected parameters to be reported monthly at the unit level. Each unit works to reduce its number of falls and increase the number of days between falls. Some managers use a calendar to check off the number of days without falls on their units.

The hospital tracks fall data on the hospital dashboard as a sign of commitment to patient safety.

Source: Briefings on Patient Safety, March 2005, HCPro, Inc.
## Sample falls risk assessment

Complete for all conscious patients.

### Section I

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicators</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation/skilled care</td>
<td>Rehabilitation Institute of Chicago, nursing home, or ICU transfer</td>
<td></td>
</tr>
<tr>
<td>Falls</td>
<td>History of falls within the past six months</td>
<td></td>
</tr>
<tr>
<td>Mental status</td>
<td>Confusion/Delirium</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Altered level of consciousness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disorganized thinking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Memory or cognitive impairments</td>
<td></td>
</tr>
<tr>
<td>Mobility</td>
<td>Ataxic/Unsteady/Shuffling gait</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ambulates with assist of a person</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Balance impairment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unable to transfer/ambulate</td>
<td></td>
</tr>
</tbody>
</table>

Answering yes to any one category in section I qualifies a patient for strict falls precautions.

### Section II

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicators</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms/diagnoses</td>
<td>Shortness of breath</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unstable glucose levels</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Immunocompromised</td>
<td></td>
</tr>
<tr>
<td></td>
<td>New cerebrovascular accident/amputee</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bleeding disorders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Osteoporosis</td>
<td></td>
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<tr>
<td></td>
<td>Withdrawal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vertigo</td>
<td></td>
</tr>
<tr>
<td>Elimination</td>
<td>Incontinent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgency</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frequency</td>
<td></td>
</tr>
<tr>
<td>Four or more of the following medications</td>
<td>Anesthesia within the past 48 hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anticoagulants</td>
<td></td>
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<tr>
<td></td>
<td>Antidepressants</td>
<td></td>
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<tr>
<td></td>
<td>Benzodiazepines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Laxatives/Diuretics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Opioids (narcotics)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sedatives/Hypnotics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vasodilators</td>
<td></td>
</tr>
<tr>
<td>Environment</td>
<td>PCA, chest tube, drains, bedside commode, ambulates with assistive device, auditory/visual impairments</td>
<td></td>
</tr>
</tbody>
</table>

Answering yes to any two categories in section II qualifies a patient for strict falls precautions.

*Source: Northwestern Memorial Hospital in Chicago. Reprinted with permission.*
Communication

Stop ‘bad scenes’ at your facility once and for all

**Learning objectives:** After reading this article, you will be able to
1. explain why “bad scenes” occur between nurses and physicians and discuss the unfavorable results caused by this behavior
2. describe at least five techniques to prevent poor communication among caregivers

**Faye,** a pediatric RN, tried to hold on to the squirming baby. The physician’s first two attempts at a lumbar puncture had already failed. Then he missed again.

Faye put the baby back in its crib and took off her gloves. “What do you think you’re doing?” yelled the doctor.

This scene between Faye and the physician can be classified as a “bad scene.” Bad scenes are caused by poor communication between nurses and physicians. They may include verbal abuse, intimidation, or any behavior that demeans or belittles the nurse or physician involved in the conflict. Bad scenes leave doctors and nurses at odds, which puts their patients at risk. Therefore, it is important to understand why bad scenes occur and how to handle them.

According to **Kathleen Bartholomew, RN, BS,** nurse manager at Swedish Medical Center in Seattle, bad scenes always have one thing in common: a tremendous amount of emotional charge.

What should you do? Disengage—physically remove yourself and others from the verbal abuse—and then return to the issue at a later date. After the physician yelled at Faye, she disengaged from the situation for her benefit and the benefit of the patient.

“Get back here!” the doctor screamed.

“No,” she replied. “That’s enough.”

Two days later, Faye and the doctor sat in front of the CEO. The doctor ranted loudly, stating his case for several minutes. Then it was Faye’s turn. She said only one sentence: “If that was your son, would you have wanted the nurse to hold him for yet a fourth try at a lumbar puncture?”

The doctor was caught off-guard. “No,” he said hesitantly. “If that were my son, I would have wanted you to do exactly what you did.”

Like Faye, refuse to allow yourself to be affected by different types of abuse. Instead, do the following:

- Page the manager or medical director
- Follow your hospital’s code for disruptive behavior
- Take the conversation off the floor
- Refuse to participate if the physician yells

**Telephone trouble**

Another forum for dysfunctional physician-nurse communication is the telephone call. Physicians often act as though a nurse’s phone call is a huge interruption, without considering that the call interrupts the nurse’s day as well. Try these tips the next time you need to contact a physician by phone:

- Don’t begin with an apology. Begin by identifying yourself and the patient.
- Always have the chart, labs, and latest vital signs in hand.
- Put yourself in the physician’s shoes; use critical thinking skills and have an idea of what you think is needed before you call.
- Don’t beat around the bush; say what you need.
- Repeat back to the physician a summary of the order or the conversation.
- If a physician is verbally abusive, say, “I am hanging up now. Please call back when you are calmer.” Then hang up.

**Editor’s note:** This article is adapted from the HCPro book *Speak Your Truth: Proven Strategies for Effective Nurse-Physician Communication,* by Kathleen Bartholomew, RN, BS. Call 800/650-6787 to find out more.
Staff engagement

Spread the Magnet message to staff nurses

Getting staff nurses to buy into the effort to achieve Magnet designation requires innovation and commitment from senior leadership, Magnet coordinators, and steering committees. In addition to compiling onerous paperwork and implementing cultural changes, these groups must encourage staff nurses to participate in the process.

Convincing staff of the benefits of Magnet can be challenging. A recent thread on a national nursing listserv evoked negative comments about Magnet. Nurses who posted criticism of the designation claimed that Magnet is a costly undertaking and an “overhyped” marketing ploy with little benefit to individual staff nurses. Such criticism underscores the need to ensure nursing buy-in at every level of the organization.

It’s training time

At Fox Chase Cancer Center in Philadelphia, the Magnet steering committee wasted little time generating enthusiasm among staff about the Magnet process. Several clinical nurse specialists, managers, a nurse researcher, and about 20 staff nurses from all patient-care areas met quarterly for educational sessions a year prior to the application preparation and then gathered monthly for all-day meetings during the year they wrote the application.

In the meetings, staff reviewed the American Nurses Credentialing Center’s (ANCC) standards—now the 14 Forces of Magnetism—and discussed current Magnet literature, says Anne Jadwin, RN, MSN, AOCN, CNA, director of nursing. During the meetings, Jadwin also assigned various work groups to examine the standards and suggest examples of compliance (i.e., sources of evidence). She then filed the evidence of compliance under each standard and used it to write the narratives in the application.

To prepare for the ANCC’s site visit, Jadwin conducted mock surveys on all nursing units, “and the members of the executive nurse council held five sessions of Magnet-preparation inservices, in which the 14 Forces of Magnetism were highlighted using PowerPoint posters,” says Jadwin.

Fox Chase also pioneered another creative way to include staff nurses in the Magnet process. They invited all staff to participate in a contest to design the cover for the Magnet application materials.

A team effort

An active multidisciplinary steering committee is vital in making Magnet an organizational initiative, says Janet Cahill, RN, BSN, MBA, director of professional practice and development and Magnet project coordinator at Northwestern Memorial Hospital in Chicago, which is currently applying for the designation.

At her facility, both nursing and nonnursing members of the executive team actively participate on the steering committee. Representatives from both areas disseminate information about Magnet throughout their respective departments.

Cahill communicates the Magnet message through another method, her facility’s monthly newsletter, Connections. Nonnursing committees help craft content, quizzes, and messages to engage all staff at Northwestern memorial hospital in the Magnet process.

Upcoming audioconferences

May 17 Incident-based Peer Review in Nursing
June 21 What Nurse Managers Need to Know Before Implementing EHR
June 28 Observation Status for Case Managers

To register, call customer service at 800/650-6787 or visit www.hcmarketplace.com.
Stop setting up new managers to fail

Learning objectives: After reading this article, you will be able to
1. identify two methods to respond to high leadership turnover rates
2. list and describe four training focuses that contribute to an effective leadership orientation program

Getting new managers to stay in their positions is challenging. Many leave because they feel overwhelmed by the demands and stress of their new jobs.

“The turnover rate can be just as high [for management staff] as it is at the bedside,” says Teresa Eberhart, RN, BC, MS, nurse educator at North Shore University Hospital in Manhasset, NY.

Troubled by intensifying turnover rates, Eberhart developed a leadership training series to encourage new managers to stay and to help them maintain essential leadership competencies.

The leadership series is a training program strictly for managers that allows them to learn about topics relevant to their jobs. Keeping managers’ lessons separate from those of their staff is important. “There were times, for instance, when a manager didn’t want staff to know that he or she didn’t know how to run a budget,” Eberhart says.

The training series occurs monthly, with sessions running twice daily so managers from all shifts can participate.

However, despite these training efforts, nurse managers still struggled to grasp new leadership concepts.

She realized the training element wasn’t enough for the new managers, so she decided to add the missing piece that would help retain managers: leadership orientation.

Orienting new nursing leaders
To get a feel for managers’ needs, Eberhart performed a needs assessment. She discovered that many new managers took their positions because they felt it was the next step in their careers, but they were unsure of their ability to perform these new roles, she says. To help new managers feel more confident, Eberhart created a three-day leadership orientation.

The leadership orientation program occurs three times per year. Although it was created for new nurse managers, experienced staff can also attend. “Incumbent staff who feel they would benefit from one or all of the topics covered are always welcome to come,” says Eberhart.

Presenters at the leadership orientation include facility directors, nursing directors, and other nursing management with expertise in a given area, says Eberhart.

The CEO also presents at the beginning of each session. She discusses the history of, current status of, and future plans for the nursing department with the small group of managers, highlighting their importance to the organization, says Eberhart.

The number of attendees for each session is limited to 20 because the sessions are interactive, Eberhart says. “They do a lot of networking, role playing, games, and discussion.”

Topics of choice
During orientation, managers are trained on a number of topics—so many that Eberhart has considered adding a fourth day.

“We pack a lot of information into those three days,” she says. Currently, orientation consists of these four topics:

1. The essence of leadership. In this session, participants discuss leadership theories and various types of leaders, why they became nurses and leaders, and the characteristics of effective leaders.
Training

**New managers**

**2. Work force development.** Managers learn about nursing education at the facility, says Eberhart. For example, they learn how a nurse goes through orientation, competencies, and mandatory programs.

“We wanted to let the managers know what their staff will be going through from beginning to end so they can then fully support them,” says Eberhart.

**3. Resource management.** This session shows managers how to manage staffing and scheduling, budgets, and material operations. It also covers performance improvement, Eberhart says.

**4. Leadership skills.** Managers learn important leadership techniques, such as communication, conflict resolution, interviewing, and providing effective feedback, says Eberhart. A representative from human resources also speaks to the group about personnel policies and disciplinary actions.

*Source: Competency Management Advisor, March 2005, HCPro, Inc.*

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**Creating assessment opportunities**

Training and assessing management staff can be tricky. Not only do you have to find topics on which to train managers, but you also need to find meaningful ways to measure their improvement or decline.

This is not a problem for **Teresa Eberhart, RN, BC, MS**, nurse educator at North Shore University Hospital in Manhasset, NY. The hospital’s leadership orientation and training series allows managers to learn about topics important to their jobs, such as resource management and work force development, and creates perfect opportunities for staff educators to validate the leadership competencies learned.

In the future, Eberhart plans to use a tool to assess and record managers’ competencies. The tool would be similar to one used for staff organizationwide. Then, as each session in the leadership series is completed, managers’ competency tools will be updated accordingly.

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Case study

Use current drug references to prevent meds mishaps

If your drug reference isn’t the most current version, it’s not reliable and could pose a serious patient safety risk. Since the reference’s publication, there could have been new medications added, drug incompatibilities, adverse event information, and changes in practice. Errors such as the one below are possible, and you must know how to prevent them.

Case study

A nursing supervisor needed a 600 mg dose of the anticonvulsant Carbatrol (carbamazepine, extended-release) from the pharmacy night cabinet, but she inadvertently chose the immediate-release formulation, tegretol (carbamazepine).

She looked up the drug by its generic name, carbamazepine, but the outdated reference did not list the newer product. She assumed the products were equivalent. Luckily, the patient was unharmed.

What you can do

To avoid medication mix-ups from outdated references, use the following tips:

- Work with your pharmacy to standardize the nursing text references used in your organization
- Your budget should provide a sufficient number of medication references annually
- Discard any outdated texts
- Do not bring your personal drug references to work
- Provide nurses with electronic references that are frequently updated (e.g., Micromedex, Lexi-Comp)
- If your reference does not give you complete information, current version or not, talk to your pharmacist before giving a medication.


Rewards and recognition

Reward yourself for a fresh start

The idea that anyone can get by each year on a week or two of vacation is flawed. That’s why you need to become skilled at rewarding yourself daily to stay sharp.

Just as you recognize employees on an ongoing basis and not just at the time of their performance reviews, you need to “catch” yourself doing something right each day.

But how often do you take time to reward your efforts? Most people in today’s work force are extremely busy, and it’s easy to feel overworked and underappreciated. In the process, you could become a victim at work, being quick to blame others about the lack of recognition you receive.

It doesn’t have to be that way. Take control of your own needs and do something to recognize and reward yourself when you finish a project, help a coworker, or meet a personal performance goal. To relax, acknowledge your success and give yourself a chance to appreciate it. Regeneration is essential to staying fresh and effective regardless of the challenges you face.

Relaxation and rejuvenation methods vary, so be aware of the activities that you find most satisfying and rewarding. For some people it’s reading, and for others, it may be exercise. Some people like to go shopping.

Whatever your personal rewards are, make time for them on an ongoing basis, and especially during a stressful situation, to acknowledge a milestone, or to lift your spirits when you feel down.

Quality improvement

Use dashboards to give quality data meaning

**Learning objectives:** After reading this article, you will be able to
1. define the purpose of a dashboard system
2. discuss the relationship between a dashboard system and an organization’s performance improvement (PI) efforts/strategies

Any manager can collect data. But what good is data collection if you don’t get the most value out of it? Below, Thomas J. Mulvaney, MD, CPE, vice president for medical affairs at Winchester (MA) Hospital explains how to present your data in a clear and meaningful way.

“Many organizations present as their primary indicators the charts and graphs they develop, but this [method of representation] adds layers, and many audience members don’t need or want all that data. They just want the meaning of the data,” Mulvaney says. To achieve this at Winchester, he developed a dashboard or scorecard system.

A dashboard is a collection of quality, performance, and other key information displayed in an easy-to-view format, typically on one page, using spreadsheet software such as Excel. It serves as the front page to all of the charts and graphs collected. The purpose of a dashboard is to disseminate information organizationwide, from leadership down to all appropriate managers, so everyone can see how the organization performs.

Winchester tracks clinical, financial, human resource, and competitive indicators on its dashboard (see p. 11). Ten department managers send their data to the dashboard manager, who populates the chart. Depending on the cycle of an indicator, organizations can collect data monthly (e.g., for patient falls), quarterly (e.g., for operating margin), or every six months (e.g., for market share).

Although the JCAHO does not require using dashboards, it requires leaders to prioritize performance improvement efforts and strategies, says Steven Bryant, practice director of accreditation and regulatory compliance at The Greeley Company, a division of HCPro, which publishes this newsletter.

Although Winchester has only begun using its dashboard, it impressed JCAHO surveyors during a recent visit and has already produced positive results. For example, the dashboard showed inpatient satisfaction scores declining from one quarter to another, from 87% to 86.6%. Although it didn’t seem to be a large slip, administrators hired a patient satisfaction coordinator.

“To that extent, Winchester did a magnificent job clearly articulating what the priorities of [the hospital] are,” Bryant says.

Useful data such as Winchester’s patient satisfaction score can be helpful to nurse leaders. Using a dashboard system to track nursing indicators at the unit level can contribute to the overall performance of an organization, emphasize nursing’s strengths, and target areas for improvement.

**Source:** Adapted from *Briefings on Patient Safety, March 2005, HCPro, Inc.*

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Sample dashboard: Hospital organizational performance measures

Manager tip of the month

Electronic human resources for managers

As a manager, you need to be prepared to handle various human resource (HR) issues, such as interviewing employees, hiring them, and performing their evaluations. Some responsibilities, such as motivating reluctant staff, may even be new to you.

Regardless of the HR training you’ve received, it’s helpful to have a reliable resource that answers your questions and concerns.

On about.com’s HR Web site (www.humanresources.about.com), you can find articles, tips, resources, and tools related to all of the HR issues that you handle.

For example, one article, “What do great managers do differently?” by Susan Heathfield, discusses how to develop staff’s professional skills—even for those staff who have resisted change in the past.

On the site, you can also subscribe to the free e-mail newsletter, About Human Resources, which addresses timely HR concerns shared by most managers.

Below are a few of the motivational items the newsletter recently addressed. Check them out the next time you’re online:

- Motivating your staff in a time of change
- Set them free: Two musts for motivation
- Foster success for people: Two more musts for motivation
- You can make their day: Motivational leaders

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