**Professional development**

Clinical ladders offer staff nurses the opportunity to be rewarded for their exceptional skills and care while remaining at the bedside. See how one facility designed its program on p. 4.

**Retention**

Offering a wide range of benefits can help staff members balance their work and home lives. Read about the various policies you can implement and how they work to decrease staff turnover on p. 6.

**Nurse-to-nurse hostility**

Building and maintaining a healthy work environment can change the culture at any healthcare facility. Learn how you can create this type of environment at your facility on p. 10.

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**Patient safety**

**Hourly rounding improves patient safety, reduces call-light use**

**Learning objectives:** After reading this article, you will be able to

1. describe the call-light reduction and patient safety benefits of hourly roundings
2. explain two points nurses should address during their rounding

Call lights are both frustrating and essential in most hospital units. Although the lights are invaluable for alerting staff members to patient needs, those needs often are not emergencies, and constantly answering the calls can tie up a workday. A recent study shows that using hourly rounding reduced call-light use by 38%, and the nature of those calls were more important to the patient’s well-being.

The change freed up time for staff members to complete their tasks without constant interruptions and improved patient safety.

**Proactive care saves time**

Lyn Ketelsen, RN, MBA, is a coach for the Studer Group, which conducted the study. She says the idea came after the group would go to hospitals for consulting work.

They would notice that most nursing units are constantly reacting to events after they happen, which kept staff members harried and under stress. It led to call lights that weren’t answered, which would anger patients.

“You could see which units functioned proactively and which ones did not,” says Ketelsen. “There’s a disparate difference, and patients feel that difference.”

In response, the group devised the hourly rounding program, along with required key language and points to cover during rounds for clients to try.

The group noticed a positive change and decided to study the concept.

The results of the national study show that nursing units that use hourly rounding increase patient and staff satisfaction and reduce many patient safety risks.

It may seem counterintuitive, but asking nurses to commit to rounding every one or two hours actually saves them time overall.

That is because patients use their call lights less frequently, which leads to less running back and forth for nurses, says Ketelsen.

“[Nurses] felt they had control of the day,” she says. “Now the standard of care is consistent.”

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Patient safety benefits
Units that adopted hourly rounding cut their patient fall rates in half and reduced the number of decubitus ulcers developed by patients.

“Many times we can intervene before a fall occurs,” says Ketelsen.

Once the nurses understand how to function in the system, they can see the ways it helps keep patients safe, she says. The rounds lead to better care because they build trust between patients and caregivers.

“The communication is better, so there’s freer information flow from the patient,” says Ketelsen.

Points to address in the round
Ketelsen says staffers in medical-surgical units address the “three Ps” during their rounds—pain, position, and potty. These are the most common reasons why patients in medical-surgical units use a call light, she says. Once patients understand that nurses will round consistently to address these issues, they stop using the call light.

Next, nurses should check for environmental concerns that could lead to a patient using the call light. They should check for tissues, a pitcher of water, and other comforts for the patient. Before a nurse leaves, he or she should ask whether the patient needs anything else and then tell the patient when to expect another round.

Ketelsen says the system is customizable for different units and facilities, so nurses can design the rounds to address their most common or urgent needs.

“These behaviors are tweaked for the different kinds of units. [Although] the three Ps may work for a med-surg unit, you may need other behaviors for an [intensive care unit] or mother-child unit,” she says.

Retrain patients as you retrain staff
Ketelsen says nurses themselves are largely to blame for the overuse of call lights.

Generations of nurses have told patients to use the light “if they need anything,” so it shouldn’t be a surprise when patients do just that.

“We created this slippery slope for ourselves,” she says. “We have to get back to what used to be a ‘drop and run’ mentality for call lights. Now, the nonurgent needs are met in the context of the hourly rounds.”

Once the rounds take hold and the smaller needs are addressed regularly, the call light regains its traditional importance, says Ketelsen. Units that rounded and reduced call-light use found that when the lights did go off, it was for an urgent reason.

“Patients begin to know what to expect, as [do] staff,” she says. The study included 64 nursing units in 22 hospitals nationwide. The units were a mix of different services, says Ketelsen.

Both Studer Group client and nonclient hospitals were included. The final results took information from hospitals that met a high confidence interval in their results, she adds.

A year after the study concluded, the group contacted the units involved to see whether they were still using the rounds.

Nearly 90% were, and many had decided to expand the system to other units in the hospital.

Source: Briefings on Patient Safety, April 2007, HCPro, Inc.
Discipline

Recognizing the positive aspects of discipline
*Teach employees to correct their behavior before it goes too far*

**Learning objectives:** After reading this article, you will be able to
1. explain what constitutes appropriate employee discipline
2. describe the positive results of employee discipline

Employee discipline has received something of a black eye lately. Because of the abuses that more than a few overzealous supervisors and managers have committed, for many employees, the word discipline conjures up visions of crazed management tirades, embarrassing public scolding, and much worse.

The reality is that employee discipline can be a positive experience. Through discipline, you can bring issues to your employees’ attention so that they can take actions to correct them before they become major problems.

Remember, however, that it is important to build a strong foundation of trust that can be drawn upon when dealing with the negatives. The primary goal of discipline isn’t to punish your employees; you want to help guide them back toward satisfactory job performance.

Of course, sometimes this step isn’t possible, and you have no choice but to terminate employees who can’t perform satisfactorily.

The following are the two main reasons to discipline your employees:
- **Performance problems:** All employees must meet goals as a part of their jobs. When employees fail to meet their performance goals, administering some form of discipline is required.
- **Misconduct:** Sometimes employees behave in ways that are unacceptable to you as a manager and to the organization. For example, if an employee abuses the company sick leave policy, you have a valid reason to discipline that employee.

Discipline ranges from simple verbal counseling to termination. A wide variety of options lie between these two extremes, the use of which depends on the nature of the problem, its severity, and the work history of the employee involved. For example, if the problem is an isolated incident and the employee normally performs well, the discipline will be less severe than if the problem is repeated and persistent.

Always carry out discipline as soon after the incident as possible—it’s easier to deal with problems before they escalate. And, as with rewarding employees, your message is much stronger and relevant when it has the immediacy of a recent event. If too much time lapses between an incident and the discipline that you conduct afterward, your employee may forget the specifics of the incident. Not only that, but you also send the message that the problem isn’t that serious because you don’t bother doing anything about it for so long.


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Professional development

Up, up, and away! Clinical ladders offer opportunities

It was not too long ago that bedside nurses were rewarded for their exceptional skills and the high-quality care they provided to their patients by progressing in their careers to management positions—which then took their skills away from the bedside.

To rectify this, many facilities designed career development opportunities for nurses who wanted to stay at the bedside. One popular avenue for such advancement is the clinical ladder. These programs reward and honor nurses for their work while keeping them at the bedside, where their skills are so greatly needed.

At Presbyterian Hospital of Dallas, the clinical ladder program—known to the Presbyterian staff as the Career Advancement System (CAS)—has been in place since the late 1980s, says Rosa Belgard, MS, RN, Magnet coordinator and manager of nursing and patient education at Presbyterian Hospital. CAS has gone through several revisions since its inception.

The policy

According to Presbyterian Hospital’s CAS generic policy, the system permits and encourages individual nurses to:

- Assume responsibility for the work to be done
- Set goals and propose ways to achieve them
- Be accountable for professional goal achievement
- Receive recognition and compensation for achievement and expertise

The CAS involves the following four progressive levels of clinical nursing practice, which range from novice to expert, reflecting Benner’s Model of Skill Acquisition in Nursing:

- **Level I**—At this level, nurses have minimal experience and are usually graduate nurses or interns. Upon completing the state board exams, obtaining the initial RN license, and successfully completing the RN internship program, these nurses advance to the next level.
- **Level II**—This level is the base for RNs. “That’s sort of the standard level of practice that’s expected of all nurses,” Belgard says.
- **Level III**—For advancement to this level, nurses must consistently perform at a strong level on all clinical nurse performance standards.
- **Level IV**—To reach this level, nurses must have been at Level III for a minimum of two years and have at least five years of experience in nursing. At this level, nurses have shown that they are leaders and role models in the clinical setting and have outstanding job performance. The criteria for nurses to advance to Levels III or IV involve receiving a minimum number of points (see p. 5 for a grid of the criteria for career advancement).

The points system

Points are earned by completing specific activities, such as the following:

- Becoming nationally certified
- Participating in shared governance
- Coordinating or participating in a research project
- Precepting
- Achieving continuing education
- Presenting an inservice
- Getting published
- Participating in committees
- Cross-training to another clinical area
- Receiving certification

Each activity has been assigned specific requirements that must be met before the points are earned, and each has a specific point value.

“We look at what are the things we want to develop overall in our nursing population, and what are the things that take more time and more ‘stretch’ for a staff nurse or direct care nurse to learn and do, and that is how we decide which things get the highest points,” Belgard says.

To move to Level III, 100 points are needed; to move to Level IV, 155 points are needed. The points are divided into categories, and nurses need a certain ratio of each category to progress: 40% must be clinical, 35% must be educational, and 25% can be in any category.

All activity points must be documented, and in order
Professional development

to advance to the next level, a discipline-free record from the previous year is required.

**Climbing the ladder rung by rung**

Kathy Coleman, RN, BSN, CRRN, a Level III nurse, has earned some of her points through research. “The CAS has empowered me to be a leader in my field and to present my findings to further enrich those around me, both professionally as a caregiver, as well as professionally as a colleague,” she says.

Nurses participating in the CAS must submit a packet of information annually to show what activities they have completed. “They get to choose those activities in conjunction with their nurse manager and the clinical specialist on those units so that they are activities that are helpful to the unit or helpful to the hospital,” Belgard says. She reports that CAS has been a well-received program at Presbyterian Hospital.

“The CAS has been an avenue for me to grow professionally on an annual basis,” says Tanya Schlemmer, MS, MSN, RN-BC, CCRN-CMC, FNP-C, a Level III nurse. “The CAS has allowed me to be recognized within my profession and amongst my peers for all my ongoing efforts to provide quality healthcare services in the communities I serve.”

Nurses are given a monetary incentive for reaching Levels III and IV. At Level III, a nurse receives a bonus of $2,080, and at Level IV, $4,160.

In addition, unit celebrations are held for pinning ceremonies.

**References**


**Source:** *Magnet Status Advisor, April 2007, HCPro, Inc.*

### Career advancement criteria

<table>
<thead>
<tr>
<th>GN</th>
<th>Required clinical experience*</th>
<th>Minimum time in level**</th>
<th>Full- or part-time</th>
<th>Annual eval score</th>
<th>Education</th>
<th>Disciplinary action</th>
<th>Review board</th>
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<td>Entry</td>
<td>FT or PT</td>
<td>2 avg.</td>
<td>ADN diploma</td>
<td>N/A</td>
<td>Nurse manager</td>
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<td>RN</td>
<td>Varies</td>
<td>One year</td>
<td>FT or PT</td>
<td>2.2 avg.</td>
<td>ADN diploma</td>
<td>N/A</td>
<td>Nurse manager</td>
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<tr>
<td>Career advance Level III</td>
<td>* Three years RN</td>
<td>Two years</td>
<td>FT or PT 48 hrs/pp min.</td>
<td>3.5 avg.</td>
<td>ADN diploma</td>
<td>No written</td>
<td>Service</td>
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<tr>
<td>Career advance Level IV</td>
<td>Five years</td>
<td></td>
<td></td>
<td>4.0 avg.</td>
<td>ADN diploma</td>
<td>No written</td>
<td>Division</td>
</tr>
</tbody>
</table>

* Required clinical experience is paid employment as a GN or licensed RN.

** It may take more time for individual nurses to progress. Minimum time in level is simply a requirement—not a statement of norm. Any progression in levels is based on performance evaluation of the applicant, not time in a level. A CAS III must be a CAS III for two years before progressing to CAS IV.

**Source:** Presbyterian Hospital of Dallas. Adapted with permission.
Retention

Family-friendly policies decrease staff turnover
Help your staff to balance work and home life

From flexible work schedules to childcare programs to family leave policies, many organizations now offer a wide range of company benefits intended to help employees successfully balance their home and work lives.

"Today people spend a lot of time at their job, and we know that probably the most important thing is [that it's] not just about salary and benefits, but it's about the work environments, being made to feel that you're valued, you're recognized for doing a good job, and that you make a difference," says Marilyn Potgiesser, RN, HR director at Bronson Healthcare Group in Kalamazoo, MI.

Flexible schedules
Telecommuting, flextime, part-time hours, job sharing, and compressed workweeks are some of the ways in which healthcare organizations can ease the schedules of working parents. However, your ability to offer these benefits depends on the individual structure of your setting.

For example, hospitals must balance the needs of their employees with the need for round-the-clock coverage. "We can't often do things like job shares easily. We can't do working from home as easily when we're caring for patients," Potgiesser says.

Communicate with your staff to see what their needs are. "Pay attention to your demographics and ask your employees what they need to have work and life success," says Linda Matzigkeit, senior vice president of HR at Children’s Healthcare of Atlanta. "You want to make sure any programs or benefits address a need and, ultimately, create a positive return for the organization.

Kathy Harris, vice president of HR for Mercy Health System in Janesville, WI, agrees. Often, employers worry about offering benefits such as job shares to every employee, because they fear that everyone will take advantage of the program, she says.

Matzigkeit adds that organizations shouldn’t offer family-friendly policies just because they feel like they have to. "You have to genuinely value people to get a return on the investments you make," she says.

Mentor programs
Mentor programs also have proven to be beneficial for both employees and employers. In July 2004, the HR
Retention

department at Children’s Healthcare began noticing an increase in the number of women who were not returning from maternity leave. Women make up more than 80% of the pediatric hospital’s work force.

“Children’s launched the Children’s Great Expectations Program, baby showers that are celebrations for expectant parents and a forum for them to learn about the resources and benefits Children’s offers,” Matzigkeit says.

“The Children’s Great Expectations Program has increased the return-to-work rate after maternity leave from 64% to 86%, with more and more employees choosing to return to work after having a child,” she adds. Mentor programs are not just limited to new moms. Bronson, for example, offers “new dad boot camps” to learn about baby care and ways to support mom, Potgiesser says.

Childcare programs

Several childcare programs are also starting to emerge as standard corporate offerings. For example, Bronson offers a summer camp for the children of its employees, Potgiesser says.

“Under our work force development initiative, we determined it would be helpful to focus on providing an activity in the summer for children in [grades four through six], where they could not only have some exciting and interesting camp things to do, which helps daycare issues in the summer for our employees, but also our initiative to encourage young people to be interested in healthcare careers, because we know there’s an impending shortage,” Potgiesser says. The summer camp teaches children about healthcare careers. “The focus of the camp is to have fun, to have a safe and interesting place to go for a week at a low cost for our parents and our families,” she says.

You don’t have to do anything extravagant to implement a great children’s program. Smaller facilities can implement a bring-your-child-to-work-day program similar to the one offered by Mercy.

Mercy structures its program in a way that provides a learning opportunity for the children, and not just an opportunity for parents to bring their children to work, Harris says. For example, the older children take a tour of the hospital and listen to presentations on healthcare careers. The younger children, too, “learn some really good things, like hand-washing, that can really be made fun,” Harris says, adding that, at the end of the day, “they get to color their impression of the doctor and the hospital less threatening to them.”

Healthcare facilities can join forces with other community organizations to offer these opportunities, says Potgiesser. “You don’t have to do it yourself, and that’s true with our daycare,” she says. “We found that sponsoring some women in our community to become licensed daycare providers in the neighborhood where our employees live is just as beneficial as trying to own our own daycare.”

There are other small ways to create a family-friendly workplace. For example, Matzigkeit says, “Children’s offers many unique programs, including backup care options to help employees find temporary care for infants through the elderly, child care credits, and even an online database that matches parents with more than 3,000 prescreened Atlanta-area sitters.”

Family leave policies

Leave policies limited to new moms are also becoming a thing of the past, replaced by policies extended to fathers and parents who adopt children. At Mercy, adoptive parents receive up to $8,000 toward adoption expenses, in addition to 12 weeks off—with up to six weeks off fully paid after one year of service. Bronson and Children’s offer similar policies.

Harris adds that Mercy is also exploring new ways to approach the “sandwich generation,” so called because they care for both their children and their aging parents. “Where some organizations are cutting back on their benefits, that’s not what our strategy has been,” Harris says. “Our strategy has been to make our benefits even better.”

Source: The Doctor’s Office, April 2007, HCPro, Inc.
Learning objective: After reading this article, you will be able to
1. list examples of patients whom surveyors expect you to assess for suicide risk

Although Joint Commission surveyors showed up unannounced at Broadlawns Medical Center in Des Moines, IA, months earlier than expected, the hospital was ready the moment the five surveyors walked through the door. The surveyors—a physician, administrator, nurse, psychologist, and *Life Safety Code* specialist—were each greeted by hospital staff members and then immediately taken to meet Broadlawns’ leadership team. There, the surveyors received a full rundown on hospital operations and all documentation they requested, according to Francie Jahn, RN, BSN, MSHSA, senior vice president for clinical services at Broadlawns. “They never had to wait at all for us,” says Jahn. “Everything they asked for we had at our fingertips ready to give them. That made them happy, and then they proceeded to give a fair, but rigorous survey, all while putting our staff at ease.”

Broadlawns—which is licensed for 200 beds and fewer than 100 inpatients, with a full psychology component and a large outpatient clinic—performed well on its survey, receiving seven requirements for improvement for the hospital and three for the behavioral health unit over the course of its three-day survey in January.

What a pain
One focus area for this survey was pain assessment. The surveyors wanted the staff to do more than just assess and reassess pain, Jahn says. “They wanted to make sure we were looking at all the key components of pain, such as location, duration, intensity, and treatment. It wasn’t just about the pain scale to them.”

Questions surveyors asked staff members about pain assessment included the following:
- What is the time frame for reassessment?
- How do you assess unresponsive patients?
- What do you do to address patients not obtaining relief after the same interventions have been repeated multiple times?

The surveyors provided this education through the vast number of tracers they performed. “They traced just about everything they could find, but especially point-of-care testing and pain assessment and reassessment,” Jahn says.

NPSGs spread throughout survey
Surveyors also paid close attention to the National Patient Safety Goals (NPSG), but not by picking one goal and focusing in on it. For example, the surveyors did not directly ask about reducing the risk of patient harm from falls (NPSG #9); rather, they made it a part of appropriate tracers, Jahn says. Surveyors were impressed with what Broadlawns was doing to meet NPSG #15A, identifying patients at risk for suicide.

A surveyor followed a tracer that took a patient in the intensive care unit with a medical problem who was being transferred to the inpatient mental health unit. The surveyor wanted to know who would perform the risk assessment and when it would be completed, because the patient had been admitted with an overdose, Jahn says.

Staff members had all of the answers because of a suicide-risk assessment plan the hospital had put in place to rate any patients at risk on a graduated scale. Patients with a history of depression, overdose, self-inflicted wounds, intent to hurt others, past suicide attempts, or substance abuse may qualify as patients at risk.

From there, patients are rated on a scale of zero to three for their risk factor (see p. 9 for a sample of Broadlawns’ suicide risk assessment form).

Source: Briefings on The Joint Commission, April 2007, HCPro, Inc.
## Suicide risk assessment

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Lower Risk 0</th>
<th>Mild Risk 1</th>
<th>Moderate Risk 2</th>
<th>Serious Risk 3</th>
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<td>Male</td>
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<td></td>
</tr>
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<td>Age</td>
<td>1–15</td>
<td>15–24</td>
<td>25–49</td>
<td>50+</td>
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<tr>
<td>Marital/partner status</td>
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<td>Single</td>
<td>Divorced</td>
<td>Widowed</td>
</tr>
<tr>
<td>Lethality of attempt</td>
<td>Ideation only</td>
<td>Gesture</td>
<td>Nonlethal</td>
<td>Potentially lethal</td>
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<tr>
<td>Family history of suicide</td>
<td>None</td>
<td>10+ years ago</td>
<td>1–5 years ago</td>
<td>Past year</td>
</tr>
<tr>
<td>History of attempts</td>
<td>First attempt</td>
<td>Past 10 years</td>
<td>1–3 years ago</td>
<td>Past year</td>
</tr>
<tr>
<td>Intent/ambience</td>
<td>No intent to die</td>
<td>Minimal intent</td>
<td>Moderate intent</td>
<td>Clear intent</td>
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<td>Support system</td>
<td>Good support</td>
<td>Some support</td>
<td>Conflicted</td>
<td>None</td>
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<tr>
<td>Loss and trauma (past 6 months)</td>
<td>None</td>
<td>Moderate</td>
<td>Serious</td>
<td>Multiple</td>
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<tr>
<td>Impulsiveness/aggression</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
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<tr>
<td>Substance abuse</td>
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<td>Recreational</td>
<td>Abuse</td>
<td>Dependence</td>
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<tr>
<td>Hopelessness</td>
<td>Hopeful</td>
<td>Some hope</td>
<td>Ambivalent</td>
<td>Hopeless</td>
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</table>

Scores over 12 should be considered for increased acuity level or additional precautions. Assess for appropriate level of care. Further assessment of risk for self-harm is indicated.

**Total score:** _________

Additional precautions indicated;  □ No  □ Yes

**IF YES:**

Level of intervention  □ 1:1  □ Other (specify) _________________

Patient able/willing to contract for safety  □ Yes  □ No

Intervention added to treatment plan  □ Yes  □ No  □ N/A

Comments: ____________________________________________

____________________________________________________

____________________________________________________

Signature: __________________________________________ Date: _______________________

Source: Broadlawns Medical Center, Des Moines, IA. Reprinted with permission.
Nurse-to-nurse hostility

Take action: Create a healthy work environment

Strategies to get rid of horizontal hostility

Unless you've been hiding in the supply closet for the past couple of decades, you probably have heard about nurse-to-nurse hostility.

You've heard about peers cutting each other down. You've heard about gossip, sabotage, whining, and back-stabbing.

What you may still be waiting for is a way to make it all go away.

“We’re going to peel this onion,” said Melissa Fitzpatrick, RN, MSN, FAAN, kicking off the recent HCPro audioconference “Solutions to End Nurse-to-Nurse Hostility: Tips and tools to create a healthy work environment.”

Fitzpatrick and Kathleen Bartholomew, RN, MN, presented two action plans—one personal and the other managerial—to help nurses deal with this growing problem in their profession.

“There’s an awful lot that you can do as a staff nurse, a charge nurse, and a manager to eliminate hostility,” said Bartholomew, the manager of a 57-bed orthopedic and spine unit in a tertiary hospital in Seattle. “Horizontal hostility is like a drop of poison. Toxic is the right word.”

Let’s get personal

Fitzpatrick, the chief healthcare strategist for the SAS Institute in Cary, NC, has held positions ranging from critical care staff nurse to chief nurse executive throughout her nursing career.

She presented a 10-point action plan on how to effectively deal with hostile coworkers on a personal level. “We can empower ourselves to be part of the solution,” she said.

Fitzpatrick’s 10-point plan is as follows:

1. Be aware of the signs and symptoms of horizontal hostility.
2. Don’t hold a grudge.
3. Never speak about another nurse when he or she is not present, and never stand by and allow someone to talk negatively about a peer.
4. Adopt a zero-tolerance philosophy.
5. Compliment a coworker every day.
6. Evaluate your belief system.
7. Improve your confrontation skills. Take a class or read up on how to deal with conflict.
8. Take new employees, transfers, and new grads under your wing. Be a resource and support system.
9. Debrief after a particularly emotional day. “If you’ve had a really, really bad day and everyone’s at the end of their rope, let’s address that. Make sure you are patient with each other,” she said.
10. Take care of yourself.

“As every one of you partners up with a colleague and agrees to some of these solutions, you will see an absolute change,” Fitzpatrick added. “It doesn’t even take long.”

Are you in charge here?

Bartholomew, the bestselling author of HCPro’s Ending Nurse-to-Nurse Hostility: Why Nurses Eat Their Young and Each Other, focused on an action plan for managers. It began the same way as the personal action plan, putting an awareness of the signs and symptoms of horizontal hostility at the top. “Teach the nurses what horizontal hostility is,” said Bartholomew.

She created the following 10-point plan to help managers deal with the issue:

1. Verbalize awareness of the problem to staff. “As leaders, we can have an inservice and teach what horizontal hostility is,” Bartholomew said.
2. Establish a supportive and open communication network. “You can’t be everywhere at all times,” she added. (Get help from “Commitment to coworkers” on p. 11.)
3. Set clear expectations by holding a clear vision and adopting a zero-tolerance philosophy.
4. **Demonstrate the effect by holding crucial conversations.**

5. **Respond in a timely and consistent manner.** “I can’t tell you how important it is to respond right away,” Bartholomew said.

6. **Provide education and training.**

7. **Increase the communication and confrontation skills of leaders, especially charge nurses.**

8. **Provide opportunities for socialization.**

9. **Provide tools so staff members can constructively give feedback.**

10. **Role model the behaviors you want to see in your team members.**

“It’s not rocket science. Some of these are very simple things,” said Fitzpatrick, providing some final thoughts for the program.

“What they all have in common is you are opening up the environment to conversation, to feedback, to really being colleagues. That is the foundation for a healthy work environment,” she said.

*Editor’s note: To order a copy of the audioconference, visit www.hcmarketplace.com or call customer service at 877/727-1728.*

*Source: The Staff Educator, March 2007, HCPro, Inc.*

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### Commitment to coworkers

- We will maintain a supportive attitude with peers, creating a positive team environment by recognizing our colleagues for performance that exceeds expectations. We will hold each other accountable for our behavior and performance, recognizing that the actions of one speak for the entire team.
- We recognize that each of us plays a vital role in this facility’s operations and treat each other accordingly.
- Rudeness is never tolerated.
- There is no blaming, finger-pointing, or undermining our fellow employees or those in other departments.
- We are on time for our shifts, for our meetings, and when returning from breaks.
- We treat each other as professionals with courtesy, honesty, and respect.
- We welcome and nurture newcomers.
- We recognize that many hands make light work and offer to help each other.
- We show appreciation and support to staff members who come to our aid from other units and departments.
- We do not call in sick unless we are sick.
- We recognize that we all have strengths and weaknesses and that it takes many diverse personalities to make a team.
- We respect cultural differences in one another.
- We praise each other in public and criticize in private.
- We do not gossip. We protect the privacy and feelings of our fellow employees.
- We profess that “there is no ‘I’ in ‘team.’ ”
- Our actions and attitudes make our fellow employees feel appreciated, included, and valued.
- Staff members and leaders share ideas and openly communicate with each other.
- We respect each other’s time and avoid urgent requests.
- We have fun and keep a sense of humor at work.

*Source: Orange Regional Medical Center, Middletown, NY, and HCPro’s Ending Nurse-to-Nurse Hostility: Why Nurses Eat Their Young and Each Other, by Kathleen Bartholomew, RN, MN. Reprinted with permission.*
Tip of the month

Close ties: Developing a relationship with your manager

Regardless of whether you like your manager, developing a positive working relationship with this person will help you do your job effectively.

Ask yourself the following questions:
• Do you feel respected by the person to whom you report?
• Do you think the person to whom you report feels that you respect him or her?
• Are you willing to admit that respect and trust go hand in hand?
• Do the two of you use effective communication techniques?
• Have the two of you identified what each other needs professionally and emotionally so that feedback is perceived as well done?
• Have you both clarified what you can and do expect from one another?

As with any relationship, whether it is at work or home, it takes time to nurture the bond.

If you answered no to many of the questions above, you need to make the time to get the answers you need so that you can answer yes.

Bring a copy of this tip with you to your next meeting and let your manager know you want to build on the strength of your working relationship. These questions can be good topics for the chief nurse to discuss during nurse manager meetings.

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

Strategies for Nurse Managers

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