Does your organization have a process for clinical advancement? Do many nurses pursue advancement, or do they feel there are barriers?

At Yale-New Haven (CT) Hospital, Pina Violano, MSPH, RN-BC, CCRN, PhD(c), was concerned that too few nurses took advantage of the clinical advancement program offered by her organization. Violano is now the injury prevention coordinator for the trauma department, but at the time she was a clinical nurse educator in the Center for Professional Practice. She says only 50% of nurses participated in the program and less than 0.2% achieved Clinical Nurse IV, the highest level of practice (Pellico & Violano, 2010). As a result, she felt there was a serious problem.

“As an educator, I was concerned that so few nurses were completing the application process to advance clinically,” says Violano. “I believed that nurses needed a voice to prepare themselves to attempt clinical advancement.”

She realized that nurses needed help preparing their application portfolios for advancement, which consist of a letter of intent, clinical narrative or exemplars, curriculum vitae (CV), a self-evaluation, and clinical practice goals. A completed portfolio is submitted to a formal committee that meets four times per year to review applications.

For nurses to begin the advancement process, the first step is to inform their manager of their plan to apply by submitting a letter of intent. After the manager gives the okay, nurses prepare the portfolio.

“I found that many nurses were intimidated by the process,” says Violano. So she developed a formal, day-long class where nurses could gather and work on the application process.

Class content

The class size was limited to 12, allowing for individualized attention and small group discussions. It was also the maximum number of people who could be accommodated in the computer lab.

“It is important that all participants have computer access since they actually work on writing letters, CVs,
etc., in the classroom setting," says Violano. “The goal is to have as much of the application portfolio completed by the end of the class as possible. In fact, about one-third of the class is generally able to complete their entire portfolios by the end of the day.”

Before the nurses could work on writing their portfolios, though, they needed help with computer and writing skills. “I found that even though we are extremely electronic in our organization, nurses still lacked typing and writing skills,” says Violano.

The class also had long, in-depth discussions on written communication skills and verbal communication skills. They reviewed tips for communicating with managers as well as how to compose a letter of intent.

Several templates were presented to help participants formulate their letters. (See p. 3 for two examples of letters of intent.)

**CV development**

During the class, Violano likened writing a CV to writing a storybook of participants’ professional careers. A template was developed so that nurses simply had to fill in critical information, individualizing the template to their own careers.

Nurses needed a lot of help with identifying activities and accomplishments to include in their CVs. “They tend to underestimate the skills and knowledge they possess,” Violano says.

**Clinical narratives and self-evaluations**

Although templates were useful for some aspects of portfolio development, they were not suitable for clinical narratives (exemplars) or self-evaluations. Exemplars require nurses to tell a story about their clinical decision-making and collaboration and how they positively affected a patient.

Nurses, in general, are not accustomed to praising themselves. Violano used the book _Women’s Ways of Knowing: The Development of Self, Voice, and Mind_ to help participants find their professional voices and express themselves in writing. The concept of finding one’s voice includes learning to express oneself, taking credit for successes, exploring areas for improvement, and identifying future goals and ambitions. The classroom setting provided a safe, supportive environment in which nurses could create their exemplars and reflect on their nursing practice.

In the next segment of the application, the self-evaluation segment, nurses must reflect on the current state of their practice and areas where they can grow and improve. The candor and thoughtfulness of these reflections allows the clinical advancement committee members to gain insight into applicants’ attributes and self-awareness.
Identifying professional goals

An important step in assembling a portfolio, is to identify measurable professional goals. Violano did not simply help write these goals; she also provided resources to assist nurses in meeting them.

“If someone says she wants to go back to school, I make it a point to have college catalogs available for them to look at,” she says. “Some may say they want to become more involved in professional associations, so I make sure that I have information about associations available.”

About 87% of the nurses who attended the classes have advanced on the clinical ladder. They report that having a nurturing environment to work on their portfolios was a great benefit.

Clinical advancement is an important retention tool. But, Violano points out, the real impetus of this program is the professional development of staff.

References


Source

Briefings on Evidence-Based Staff Development (formerly The Staff Educator), September 2010, HCPro, Inc.
Using the principles of just culture, the executive council decides the next steps to be taken. This often involves performing a root cause analysis, dealing with the issue on an individual basis, or both.

Making ‘believers’ out of staff

At MCDH, there’s an emphasis on balancing a non-punitive culture with one that’s completely blame free. Nevertheless, staff still need to be held accountable for their actions if high-risk behavior is discovered or policies are knowingly ignored.

Recognizing that human error will happen is essential to understanding why a just culture is imperative, Weber says. When reevaluating the hospital’s just culture program, MCDH focused on three behaviors:

➤ Human error (e.g., mistakes)
➤ At-risk behavior (e.g., shortcuts, not following policies exactly in low-risk settings)
➤ Reckless behavior (e.g., conscious disregard for following policies and procedures in high-risk areas)

These definitions help the executive council frame its decisions on next steps, says Weber. If a safety event was the result of human error as opposed to reckless behavior, the course of action will reflect that.

Although meeting with the executive council can be a daunting experience after an error or near miss has occurred, Weber says it’s at that point that staff members truly understand what it means to work in a just culture.

“Once they’ve been involved in that process, and certainly if they’ve been involved in a root cause analysis, that’s when you make believers out of people,” she says. “Because then they see that this was not punitive at all—it was really trying to figure out what went wrong and how we can prevent something from happening in the future.”
Additionally, attending a meeting with the executive council shows staff members that the hospital cares about who it employs by going through the process of determining whether reckless behavior was exhibited—which is usually not the case, says Weber.

**Seeing results from hard work**

MCDH has found that a broad focus on reducing errors and supporting a just culture has helped the facility maintain a low fall rate and a low medication error rate.

Weber says that since the hospital took a second look at its culture two and a half years ago, staff have rated the two questions on the annual employee engagement survey—concerning the reduction of medical errors and support for the reporting of patient safety issues—as two of the most favorably scored areas.

**Advice for hospitals building a just culture**

Continuous communication is a must if your hospital is serious about building and maintaining a culture of safety, says Weber. One of the areas in which MCDH has had to focus is making staff aware that they work in a nonpunitive environment.

Presenting real-life examples to the staff to show how easily adverse events can occur helps them understand the culture. It also shows that the organization wants those events to be reported so a proper analysis can be done; however, this takes time and effort.

Involving staff members in the analysis of an event when something goes wrong has bolstered MCDH’s efforts in sustaining a just culture. Through the executive council’s guidance and process, the hospital has incorporated staff in this important process. But prior to the improvement project, Weber’s team found that it wasn’t involving frontline caregivers as much as it should have. It took a recommitment from senior leadership to communicate the expectation that staff involved in the event should participate in the analysis of that event.

“That occurred on two levels. One, it was making the managers accountable for getting their staff to the team meetings and working with them on whatever they needed to do,” says Weber. The second included working around night staff’s schedules.

---

**Clearly defined just culture terms**

The following definitions are reviewed in a meeting between Medical City Dallas Hospital’s executive council and staff involved in a near miss or adverse event:

- **Close call:** An unplanned occurrence that does not cause injury or harm to people or property but, under different circumstances, could have.
- **Just culture:** Marx’s four concepts of behavior create the link between discipline process and patient safety:
  - **Human error:** Inadvertent action that caused or could have caused an undesirable outcome.
  - **Negligent conduct:** System failure or failure to act as a reasonably prudent person (e.g., nurse, respiratory therapist) would in the same or similar circumstance. It is directly related to harm.
  - **Reckless conduct:** Conscious disregard for a substantial risk
  - **Intentional rule violation:** Intentional, knowing violation of a rule, procedure, or duty in the course of performing a task
- **Sentinel event:** An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Major permanent loss of function means sensory, motor, physiologic, or intellectual impairment not present on admission requiring continued treatment or lifestyle change.
- **Serious preventable adverse event:** Any event (including CMS reportable events, CMS hospital-acquired conditions including those specified as serious preventable events, and National Quality Forum and Leapfrog serious reportable events) within the control of a provider that results in harm and requires a new or modified physician order for management of the patient’s medical care.

**Source**

Patient Safety Monitor (Briefings on Patient Safety), October 2010, HCPro, Inc.
Patient care

Specialist nurses trained to obtain informed consent

After reading this article, you will be able to:

➤ Discuss The Joint Commission’s response to nurses obtaining informed consent for PICC lines
➤ Describe specialized training for PICC line nurses
➤ Identify recommendations for acquiring informed consent

“We had a process in place and were in the middle of bringing the program back into place,” says Lisa Randazzo, director of performance management and clinical outcomes at St. Mary’s Health Center. “The question of informed consent came back up. We were getting a lot of different feedback from people doing it different ways.”

Because it had been some time since the PICC line program had been in place, the team reexamined the whole program from top to bottom. The issue of informed consent arose early on.

“We were told that informed consent is a doctor’s responsibility, but we still had our nurses who had been a part of the program previously who thought [obtaining informed consent] had worked before,” says Randazzo.

So the facility began the research process.

Legal counsel

The first place it looked, of course, was the hospital’s legal representation.

“The initial response was that if it’s a physician ordering the procedure, they need to provide informed consent,” says Randazzo.

This was relayed back to the team, and the PICC line–credentialed nurses raised their own concerns. “They said, ‘Here’s why it worked before—I’m concerned, were we doing the wrong thing?’” says Randazzo.

There was a legitimate worry that they had been following inappropriate practices in the past. “I shared the nurses’ opinion—we had made a conscious decision in the past,” says Randazzo.

They addressed these concerns with legal counsel.

“For the majority of procedures out there, whoever is ordering the procedure is going to talk about it to the patient—they may not be the performing physician,” or in this case, the performing nurse, says Randazzo.

St. Mary’s legal counsel kept saying that although the nurse might be performing the procedure and be trained
“Usually you can expect a yes-or-no answer or an explanation of the standards,” says Randazzo. “A personal call was very surprising. I asked if I startled them with my question!”

What she was told, though, was that the language of the standards lagged a bit behind current technological trends and practices.

“He advised me to look at some of the national bodies covering PICC lines, like the state board of nursing,” says Randazzo. “We’re in Missouri, so I also looked at the nurse practice act.”

Missouri’s nurse practice act has a decision tree that is used by the state board to walk through the steps of a process and determine what a nurse can or cannot do.

“From looking at it, I found that if I entered the decision tree thinking the nurse could obtain informed consent, I would come to that conclusion at the end of the tree, or vice versa,” says Randazzo.

So she went back to the standards again to look for anything stating that a nurse could not obtain informed consent. She came up empty.

Randazzo also consulted national societies governing infusion clinics and organizations focusing on chemotherapy and blood transfusions.

“I found a little bit about PICC lines but not a lot about informed consent,” she says.

Randazzo then set up a conference call with legal counsel to walk them through the research thus far, including the response from The Joint Commission.

“I talked with them about how passionately we felt about this—that someone who has gone through this intense training who will be performing the procedure should be able to be the one to talk about it with the patient,” she says.

Randazzo explained to the counsel that the language she had encountered in the field pointed to the person with the most knowledge about the procedure as the one who should obtain informed consent.

“We felt we had made something of a case for that,” she says.

> continued on p. 8
Specialist nurses

The end result was something of a compromise. St. Mary’s informed consent form was amended to say that the patient gave his or her consent to the nurse to insert a PICC line as ordered by the ordering physician. This allowed the nurse to handle the face-to-face communication.

“Before getting the go-ahead, I phoned the state board of nursing,” says Randazzo. “I laid it all out: ‘Here’s what we’re trying to do, here is our research’ … I told them we think this is the right thing to do, but felt a little weird about it still. But at the same time we were still seeing a lot of chatter in the field about it. To me there wasn’t a clear division” on how to handle informed consent.

The hospital asked the state nursing association straight out whether there was anything in the nurse practice act that would prohibit a nurse from getting informed consent if he or she had the knowledge and expertise to perform the procedure.

Nurse reaction

The specialized nurses had two distinct reactions to the discussion about informed consent. The first was concern—if they were not allowed to obtain informed consent now, had they erred in the past when they were actively doing so?

The other, however, was just the opposite—some nurses were vocal about their professional pride and were frustrated that, despite their additional training, they might have this responsibility taken from them. “They didn’t want to be disrespectful to their physician colleagues, but these nurses were the ones actually doing the PICC lines,” says Randazzo. “I was a little frustrated myself because I’d been a part of the program before and had my own concerns.”

Next steps

Since the decision on PICC lines, St. Mary’s has added one more procedure for which nurses are allowed to obtain informed consent.

Small-bore feeding tubes are now inserted by nurses without the use of thoroscopy (in the past, this procedure was traditionally done by a radiologist). “If we were going to allow nurses to do this for PICC lines, it made sense they could also do this for small-bore feeding tubes,” says Randazzo. “We applied the same logic to the decision.”

Overall, it has been an eye-opening experience, says Randazzo. “I really appreciated the opportunity to further explore,” she says. “It would have been very easy to say, ‘Legal says we can’t, so we’re done.’ I also really appreciated the chance to talk further with someone directly from SIG. We had a really nice conversation. It was great to really be able to talk to someone in real time and bounce ideas off him. His advice was really sound.”

Source

Briefings on The Joint Commission, September 2010, HCPro, Inc.

Leadership/management

Six steps to ensure new nurse manager success

How are vacant nurse manager positions filled at your hospital? Too often, nurses are promoted to managers because they are excellent clinicians and communicators. Once in their new role, they suddenly have to deal with finance and budgeting, patient safety concerns, quality improvement projects, recalcitrant staff, and many other tough topics. And they are expected to achieve a blend of clinical and business management with little to no training.
“It’s not unusual for a person to be promoted into a management role because of their effective leadership in a clinical arena,” says Mary Ann Holt, partner, operations improvement at IMA Consulting. “But not everyone with clinical expertise can transition to being an effective leader.”

Holt says organizations must set expectations for new nurse managers so they understand their role. Investing in training, coaching, and mentoring is vital.

Holt’s advice is echoed by Shelley Cohen, RN, MSN, CEN, president of Health Resources Unlimited, an educator who often leads new nurse manager boot camps. Cohen recommends organizations follow six principles to help new managers adjust to their role:

1. Have realistic expectations. One of the biggest hurdles new nurse managers face are unrealistic expectations from the person they report to.
   “They expect them to have no transition period,” says Cohen. “They haven’t even been oriented to the department and we expect them to go in there and start battling.”

2. Allow time for orientation. For the first two weeks, new managers should spend time as a staff nurse observing and learning the unit, not in management tasks.
   “This will help them get a grip on how the department functions from a staff nurse’s eyes,” says Cohen. “It gives them a chance to get to know the staff, the demographics of the patients, and gets them to see in real time what the issues are and better understand them.”

3. Plan the first 30 days. “Give them a piece of paper with ‘here’s what I expect in the first 30 days of you on the job,’ ” says Cohen. Include the formal time for orientation on the unit and the most important issues nurse managers need to become familiar with and devote their time to.

4. Manager support. New managers need support from their director in the form of uninterrupted time.
   Directors should schedule three-minute meetings twice a week with new managers. “That means no texting and no e-mail while they are talking,” says Cohen.
   Transition to once-a-week, hour-long meetings. After the first month, work out a schedule for how often and how long to meet. Cohen says these meetings are important. “Even if the new manager says ‘I don’t need to meet anymore,’ that’s not true,” she says. “This is a clue there’s a bigger problem. They need to force the meeting.”

5. Learning leadership principles. New managers who are promoted from within the organization must make a difficult transition from being “one of us” to “one of them.” All new nurse managers want to be liked by the staff, and one of the biggest challenges for the people they report to is to teach them that it’s not being liked by the staff that counts, but how effective they are in their role.
   “It takes time to teach this,” says Cohen, “but it is one of the biggest jobs of the person they report to.”
   Both internal and external managers find the volume of work overwhelming when they do not receive training on how to deal with problems.
   “They just put Band-Aids on everything so they can get through the day,” says Cohen. “They need to be taught how to solve the problems so they permanently go away.”
   Organizations should invest in sending them to fundamental leadership classes or find someone in-house who can teach the ABCs of leadership.

6. Find a mentor. Being fresh to the role, coupled with a lack of trust from staff due to being new, can leave managers feeling like they are on their own. Find a mentor who can offer support and encouragement.
   The mentor may be another nurse manager in the organization or from a sister organization.
   Just because new managers have mentors doesn’t mean directors can relinquish this area of responsibility; mentoring nurse managers should be a vital part of their job. “My greatest mentor was the person I reported to,” says Cohen. “He felt that was part of his job and he took ownership of it. And that was the key to my success in leadership.”
   The key to success and retention of new nurse managers is the time and support put in at the beginning. Investing in these crucial managers will pay dividends in staff satisfaction and the competent management of units.

Source
HealthLeaders Media, June 2010, HCPro, Inc.
Evidence-based practice

New York hospital’s PICU celebrates one year without central line infections

On July 7, staff members in the pediatric ICU (PICU) at Steven and Alexandra Cohen Children’s Medical Center of New York (CCMC) celebrated one full year free of central line infections.

The milestone, something that only a small number of ICUs across the country have achieved, was accomplished through adherence to standard infection control practices and a reengineering of the culture of safety within the environment.

“In the traditional environment, the nurses do their thing, the doctors do their thing,” says Peter Silver, MD, chief of critical care medicine at CCMC. “Here we have one team, and everybody’s responsible for everything.”

Silver credits a team mentality as the driving force behind the PICU’s success. All staff members on the unit are empowered to speak up and voice concerns because patient care is seen as everyone’s responsibility.

“You only get in trouble if you don’t talk around here,” Silver says.

A focus on central line infections

CCMC joined a collaborative in summer 2009 sponsored by the National Association of Children’s Hospitals and Related Institutions (NACHRI) that was focused on the reduction of central line infections. The PICU’s 80 full-time nurses and 11 attending physicians were all educated on how to prevent central line infections in pediatric patients, which is rather different than preventing them in adult patients, says Silver.

There are two main instances during which central line infections occur: during insertion and during day-to-day maintenance and care of the line. In pediatric patients, insertion infections account for only 10% of infections, but in adults that number jumps to 90%. This is likely due to the differences in immune responses in these populations, says Silver.

To prevent insertion infections, staff in the PICU, which has 20 beds and sees 1,600 patients each year, utilized a set of practices shared with them through the NACHRI collaborative. These included:

➤ Changing the scrub from Betadine® soap to chlorhexidine soap
➤ Scrubbing the site for two minutes
➤ Total draping of the patient
➤ Strict hand washing
➤ Use of gloves, gown, mask, and cap
➤ Dedicated observer to ensure adherence to practices

To prevent infections related to maintenance, staff members used a different set of practices, also shared via the NACHRI collaborative:

➤ Daily review of whether the line is necessary (CCMC does this three times per day)
➤ Prior to every entry into the catheter, 30-second scrub with chlorhexidine
➤ Standard dressing changes
➤ Tubing changes every 72 hours, or every 24 when blood is given

One way Silver involved the staff was by hosting a contest for the catchiest 30-second jingle to remind staff members how long to scrub the site. The winning jingle was sung to the tune of “America the Beautiful.”

“Every bedside has a laminated card of our 30-second jingle,” he says. “You need to do things like that to get people to buy in, make it fun, and give them a sense of ownership.”

Achieving a culture of safety

Although using proper infection control practices is important in the prevention of central line infections, building the appropriate culture of safety has also been
rounds is mandatory, and we round on our patients three times a day,” he says. “Part of that participation is the nursing assessment of the central line—appearance, how it’s functioning, and whether it’s still necessary—because a central line that isn’t in place can’t get infected.”

In fact, reducing the number of central line days is a big part of the unit’s efforts and factors in to its achievement of zero infections for one full year. Silver says the PICU has reduced the number of central line days by 25%.

Confronting the naysayers

Because going an entire year without a central line infection is such a rare achievement and because it’s so difficult, there were many who doubted CCMC’s PICU’s ability to attain this goal prior to its participation in the NACHRI collaborative.

“Some of my physician colleagues said, ‘Why are you working so hard on this? Central line infections happen,’ when we were having about one a month,” says Silver.

What helped set staff on the right track and get everyone in the right mind-set was thinking of central line infections as never events. Strive to eliminate them, even though they will sometimes occur, says Silver.

“Sometimes never events happen, meaning that you don’t expect it to happen, you engineer yourself to not have it happen, it’s not accepted that it happens—but it happens,” says Silver. But by simply acknowledging that when they do occur it’s not something the organization accepts, the organization will do everything in its power to prevent them from happening again, he says.

Silver credits collaboration as one of the key factors in the improvement project’s success.

After one year of fostering a team mentality, improving the culture of safety, and utilizing proper infection control techniques, CCMC’s PICU can proudly report that for 2,574 central line days, it had zero infections, compared with the national average of 2.9 infections per 1,000 days.

Source

Patient Safety Monitor (Briefings on Patient Safety), October 2010, HCPro, Inc.
Tip of the month
Navigating discussion and behavior at staff meetings

Most managers would rather deal with a patient complaint than conduct a staff meeting. But a little bit of preparation can help you hold productive staff meetings.

Preparation is always key, as is follow-up to discussion and action items raised at a meeting. However, underneath all of the process aspects of having staff meetings, many managers miss the point—meetings are for staff, not you!

Who is doing the majority of talking at your departmental meetings? Is it you or the staff? Your role should be one of a facilitator and a resource person only. In order to cultivate a more participatory climate, I find it helpful to remember the types of personalities and characters that attend.

Craig Harrison’s article on people who display what he describes as “bothersome behaviors” helps managers improve their preparation, approach, and options for the meeting agenda. One character he describes is “the attacker,” a person who intertwines his or her negativism with personal attacks and then uses significant energy to challenge what others bring to the table for discussion.

As you read the article, you will understand why it’s a good idea for managers to guide staff in developing ground rules for meetings: They benefit everyone attending.

Reference

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