1. If you are not getting the response that you need from the resident who would you call?
   a. Attending physician
   b. Nurse Manager/Nursing Administrative Office (NAO)
   c. Number 1 and 2
   d. Administrator on Call
2. Negligence is failure to exercise the level of care that a reasonable person, possessed of the same knowledge, would have exercised under the same circumstances.
   a. True
   b. False
3. When a piece of equipment being used on a patient fails, the following steps should be taken:
   a. Remove it from service, tag it, and document the error on the tag
   b. Enter the equipment failure into IDinc
   c. Notify bio-med and risk management as soon as possible
   d. All of the above
4. The 5 Rights of Delegation include all of the following except:
   a. Right task
   b. Right circumstances
   c. Right person
   d. Right medication
5. Which of the following is NOT a factor to weigh when selecting the task to delegate:
   a. The potential for patient harm
   b. The level of supervision required
   c. The expected or desired outcome
   d. The patient’s past medical history
6. An activity that may NOT be delegated by a Registered Nurse is:
   a. Assessment
   b. Vital Signs
   c. Ambulation
   d. Blood Glucose Monitoring
7. What are the elements in the model for team effectiveness?
   a. Goals, roles, process, interpersonal relationships
   b. Goals, responding, interaction, priorities
   c. Avoiding, accommodating, persuasion
8. Conflict is:
   a. Harmful to teamwork
   b. When one party perceives that the other has frustrated, or is about to frustrate, some concern of his.
   c. Not inherently harmful, depending on how it is handled.
   d. Both b and c
9. Which mode for handling conflict is sometimes necessary when you need to find a middle ground that partially satisfies both parties?
   a. Accommodation
   b. Compromise
   c. Collaboration
   d. Competition
10. If you are promoting teamwork, which method is usually preferred?
    a. Accommodation
    b. Compromise
    c. Collaboration
    d. Competition
# Lead the Charge: Charge Nurse Development Program

**March 26 or March 27, 2008**

Dave & Buster’s Restaurant

## Agenda

<table>
<thead>
<tr>
<th>TIME</th>
<th>TOPIC</th>
<th>SPEAKER</th>
</tr>
</thead>
<tbody>
<tr>
<td>0700-0800</td>
<td>Registration, Pre-Test &amp; Opening Comments</td>
<td>Tracee Holzendorf, MSN, RN – Director, Pavilion Services</td>
</tr>
<tr>
<td>0800-0815</td>
<td>CNO Welcome</td>
<td>Kelly S. Miles, MSN, RN, CNAA-BC – Vice President &amp; Chief Nursing Officer</td>
</tr>
<tr>
<td>0815-0830</td>
<td>Charge Nurse Focus Group feedback and new Charge Nurse Manual</td>
<td>Stephanie Monico, MSN, RN, RNC – Director, Women’s Services</td>
</tr>
<tr>
<td>0830-0930</td>
<td><strong>KEYNOTE ADDRESS:</strong> “Don’t Forget Our Charge Nurses”</td>
<td>Rose Sherman, EdD, RN, CNAA-BC – Assistant Professor and Program Director, Nursing Leadership Institute, Florida Atlantic University</td>
</tr>
<tr>
<td>0930-0945</td>
<td>Break</td>
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<td>TIME</td>
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<td>SPEAKER</td>
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<tr>
<td>0945-1100</td>
<td><strong>Legal Rodeo: The Regulatory Environment</strong></td>
<td>Joan Sacerio, MHSA, RN-BC, CHPN – Director, Professional Practice and Research</td>
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<tr>
<td></td>
<td></td>
<td>Joni Lourcey, BSN, RN, LHCRM – Director, Regulatory Compliance, Licensure, Accreditation, and Risk</td>
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<td>Sandra McDonald, MSN, RN – Patient Safety Officer</td>
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<td>Cherry Schneider, RN – Lead Regulatory Specialist</td>
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<tr>
<td>1100-1215</td>
<td><strong>Round ‘em Up, Lead ‘em Out: The Art of Delegation and Other Scenarios</strong></td>
<td>Mary Parry, MS, RN, CNA-BC – Director of Nursing, Clinical Practice</td>
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<td>Gloria Dunham, MA, BSN, RN – Clinical Education Specialist</td>
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<tr>
<td>1215-1345</td>
<td>Lunch and “Team-Building” at Dave &amp; Buster’s</td>
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<tr>
<td>1345-1515</td>
<td><strong>Home on the Range: Teamwork, Communication and Conflict Management</strong></td>
<td>Pamela McCaleb, MA, SPHR – Director, Success Academy</td>
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<tr>
<td></td>
<td></td>
<td>Monica Wells, BSN, RN, CCRN – Nurse Educator</td>
</tr>
<tr>
<td>1515-1530</td>
<td>Summary, Post-Test and Evaluations</td>
<td>Roberta Vallish, MSN, ARNP – Coordinator Clinical Research</td>
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<tr>
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<td>Professional Practice and Research</td>
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<tr>
<td>Tracee Holzendorf, MSN, RN</td>
<td>Director, Clinical Services, Shands Jacksonville FCN Grant and Program Administrator Primary Investigator Charge Nurse Leadership Development Program as a Retention Strategy</td>
<td><a href="mailto:tracee.holzendorf@jax.ufl.edu">tracee.holzendorf@jax.ufl.edu</a></td>
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<tr>
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<td><a href="mailto:roberta.vallish@jax.ufl.edu">roberta.vallish@jax.ufl.edu</a></td>
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<tr>
<td>Kelly S. Miles, MSN, RN, CNAA-BC</td>
<td>Vice President and Chief Nursing Officer, Shands Jacksonville Program Facilitator</td>
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<tr>
<td>Stephanie Monico, MSN, RN, RNC</td>
<td>Director, Women’s Services, Shands Jacksonville</td>
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<td>Rose Sherman, EdD, RN, CNAA-BC</td>
<td>Assistant Professor and Program Director, Nursing Leadership Institute, Florida Atlantic University</td>
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<td>Sandra McDonald, MSN, RN</td>
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<td><a href="mailto:sandra.mcdonald@jax.ufl.edu">sandra.mcdonald@jax.ufl.edu</a></td>
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<tr>
<td>Name</td>
<td>Title and Affiliation</td>
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<tr>
<td>Cherry Schneider, RN</td>
<td>Lead Regulatory Specialist, Shands Jacksonville</td>
<td><a href="mailto:cherry.schneider@jax.ufl.edu">cherry.schneider@jax.ufl.edu</a></td>
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<td>Mary Parry, MS, RN, CNA-BC</td>
<td>Director, Clinical Practice, Shands Jacksonville</td>
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<td>Gloria Dunham, MA, BSN, RN</td>
<td>Clinical Education Specialist, Shands Jacksonville</td>
<td><a href="mailto:gloria.dunham@jax.ufl.edu">gloria.dunham@jax.ufl.edu</a></td>
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<tr>
<td>Pamela McCaleb, MA, SPHR</td>
<td>Director, Success Academy, Shands Jacksonville</td>
<td><a href="mailto:pamela.mccaleb@jax.ufl.edu">pamela.mccaleb@jax.ufl.edu</a></td>
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<tr>
<td>Monica Wells, BSN, RN, CCRN</td>
<td>Nurse Educator, Shands Jacksonville</td>
<td><a href="mailto:monica.wells@jax.ufl.edu">monica.wells@jax.ufl.edu</a></td>
</tr>
</tbody>
</table>
Dear Charge Nurses:

Welcome to our first charge nurse leadership development program--*Lead the Charge*. This program is designed to provide you with some helpful tools to serve effectively in the role of charge nurse. In addition, the program is intended to recognize and reward you for all of the work that you do each day to ensure our patients receive excellent care.

As you are aware, many charge nurses enter into this role by default (because you are the most experienced or tenured on your shift) and without formal training. Recent research conducted by our keynote speaker indicates that without well-prepared charge nurses, frontline staff may become dissatisfied, nursing turnover may increase, patient satisfaction may decrease, and the potential for errors may increase.

Therefore, I am pleased that you are joining us today for this charge nurse development program, and we are delighted to have been awarded a grant from the State of Florida Department of Health through the University of Central Florida to fund this initial program. Just so you know, we plan to continue an annual recognition program for you going forward.

As our organization continues on the Magnet Journey, we hope this program will prepare you to lead in your role as charge nurses in a way that supports a Magnet environment and perform in a way that is reflective of a Magnet nurse.

I am very proud of you and the work that you do to serve our patients, families, and coworkers. I hope you will continue to embrace and be committed to nursing here at Shands Jacksonville. Thank you for supporting the organization’s tradition of being the BEST (Building Excellent Services Together).

Sincerely,

Kelly S. Miles, MSN, RN, CNAA-BC
Vice President and Chief Nursing Officer
Shands Jacksonville
## Charge Nurse Development Day
### Teamwork: Communication and Conflict Resolution
#### Leader’s Guide
**Time:** 1.5 hours

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Resources</th>
</tr>
</thead>
</table>
| 15”  | Review Learning Objectives  
Connection  
Activity 1:  
Draw a picture of your “team” at work.  
Share with your table mates.  
Debrief: List on chart various team members.  
Activity 2:  
Discuss two questions with your table mates:  
• What conditions promote good teamwork?  
• What barriers exist that prevent good teamwork?  
Debrief | Powerpoint slides  
Participant Guide  
Blank paper (in handout)  
Crayons  
Flip chart with paper, markers |
| 15”  | Content  
Presentation on teamwork, communication, and conflict resolution. |  |
| 5”   | Activity: Puppy, Lion, Turtle |  |
| 15”  | Assessment: Complete the Conflict-Management Style Survey | Conflict-Management Style Survey |
| 10”  | Present descriptions and uses of styles |  |
| 20”  | Practice  
Activity:  
Group in pairs.  
Each person in the pair describes a situation at work involving conflict or problem solving.  
Use the 5 styles to discuss possible approaches in dealing with the situation. Consider the pros and cons of each style. (10” per person) |  |
| 10”  | Application  
Complete the commitment form.  
Activity:  
Discuss with your table how you can apply what you have just learned when you return to work.  
Debrief by asking the group what they are going to apply. | Commitment Form |
Don’t Forget Our Charge Nurses

Executive Summary

► In a shift with high patient turnover, staffing pressure, and patient, family, and physician demands, a strong charge nurse can lead the unit staff through these typical days if he or she has the right skills.

► In addition to clinical skills, the charge nurse role requires communication, supervision and delegation, conflict management, and team building skills.

► The author describes a successful charge nurse development workshop entitled, “How to Be a Great Nursing Leader When You Are Not the Boss.”

► The workshop highlighted areas that routinely challenge charge nurses such as the scope of practice for an RN and LPN, working with unlicensed assistive personal, adaptable communication styles, preferred conflict management styles, and strategies to foster a sense of community.

► A sample ROI for a 350-bed community hospital demonstrates a yield of nearly $9.00 per dollar invested.

Please don’t forget our charge nurses. That was a clear message communicated during recent research conducted by the author with nurse managers (Sherman, Bishop, Eggenberger, & Karden 2003). During the Fall of 2002, 120 nurse managers in 24 health care agencies throughout south Florida and the Treasure Coast were interviewed. The goal of the study was to identify critical competencies for today’s nurse managers for use in curriculum development. During the interviews, nursing managers expressed concern that their charge nurses were key leadership staff on their units yet most had received no leadership training.

These conversations led to the development of highly successful charge nurse development workshop titled How to Be a Great Nursing Leader When You Are Not the Boss. The one-day workshop is designed to address four critical skills needed by charge nurses today (see Figure 1). These skills include communication, supervision and delegation, conflict management, and team building. During the past 2 years, this workshop has been attended by hundreds of charge nurses and unit facilitators from a wide variety of health care settings. The insights gained from workshop participants into the challenges of the charge nurse role in today’s health care environment point to a need for organizations to take a much closer look at how they are educating and coaching nurses who assume these positions. A strong business case can be established for investing resources to educate nurses who assume these roles that are so integral to the effective and safe operational management of patient care units.

Nursing Literature on the Charge Nurse Role

The charge nurse role has received little recent attention in the nursing literature when compared with other nursing leadership positions. Bostrom and Suter (1992) examined how charge nurses make decisions about patient assignments and concluded that experienced charge nurses were more likely to consider factors beyond patient acuity. Connelly, Yoder, and Miner-Williams (2003) conducted a qualitative study on

Rose O. Sherman

Acknowledgment: The author wishes to acknowledge Yvette Hill, MHM, RN, and Ruth Karden, MSN, RN, who help teach the charge nurse workshop. The charge nurse development program is made possible through the generous grant support of the Palm Healthcare Foundation.
charge nurse competencies involving interviews with 42 nurses representing all levels of nursing leaders. Fifty-four specific competencies were identified and grouped into the four categories of clinical/technical, critical thinking, organizational, and human relations skills. The study led to the development of a successful charge nurse workshop that was tailored to the needs of the organization. Krugman and Smith (2003) described the development of a permanent charge nurse role at the University of Colorado hospital. Their program used the Kouzes and Posner’s Leadership Model as a theoretical framework. Their research indicated that a structured orientation to the role improved the functioning of charge nurses.

Yee and Swillum (2003) identified the importance of charge nurse reference manuals when their discussions with new charge nurses revealed that they lacked the database of leadership information necessary to address the problems and situations experienced while in the role. The literature points to a need for more discussion on strategies that organizations can use to prepare registered nurses to assume charge responsibilities as their role continues to expand.

Changes in Nursing Care Delivery
In response to a growing nursing shortage and financial constraints, health care organizations are redesigning their models of nursing care delivery to a team approach that includes the use of licensed practical nurses and unlicensed assistive personnel. Balentine (2003), in a survey conducted for the American Organization of Nurse Executives, found that team nursing was the most common nursing care delivery model reported by 32% of chief nursing officers who responded to the survey. Of the 45% of respondents who had changed their models of care in the past 6 months, the majority had transitioned to team nursing. Many of today’s RNs have had little experience with team nursing and even less with the demands of team leadership that are required. One workshop attendee summarized the frustrations of many others when she said, “I am trying to practice primary nursing and our model has shifted.”

Porter-O’Grady (2003) discusses the environment of care today as one where nurses are managing patient turnover as lengths of stay decrease. The admission, discharge, and transfer process is a focal point in the charge nurse role and accountability for many aspects of these processes are within the RN’s scope of practice. It is common for today’s charge nurse to also have responsibility for staffing plans for their tour of duty and performance evaluations of the staff who work with them. Frustrations expressed during our workshops have included the professional disengagement of team members, managing conflict, communication issues, and confusion about the nursing scope of practice and assignment of care.

Program Content
The program was designed as a 1-day workshop to cover basic content in the areas of supervision and delegation, communication, conflict resolution, and team building. Although the content is

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**Figure 1. Workshop Agenda**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 9:00 AM</td>
<td>Icebreaker and Review of the Agenda</td>
</tr>
<tr>
<td>9:00 – 10:00 AM</td>
<td>Communication</td>
</tr>
<tr>
<td></td>
<td>What’s Your Communication Style</td>
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<td></td>
<td>Assessment Tool</td>
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<td></td>
<td>How Style impacts your Effectiveness as a Leader</td>
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<tr>
<td></td>
<td>The Do’s and Don’ts of Communication in Delegation</td>
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<tr>
<td>10:00 AM</td>
<td>Break</td>
</tr>
<tr>
<td>10:15 AM</td>
<td>What Is Team Nursing?</td>
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<tr>
<td>10:45 AM – 12 PM</td>
<td>Delegation and Supervision</td>
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<tr>
<td></td>
<td>The Do’s and Don’ts of Delegation</td>
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<td></td>
<td>The Florida Nurse Practice Act – Your Role in</td>
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<td></td>
<td>Supervising Team Members</td>
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<td></td>
<td>Delegation and Supervision Role Plays</td>
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<tr>
<td>12 – 1:00 PM</td>
<td>Lunch</td>
</tr>
<tr>
<td>1:00 – 2:00 PM</td>
<td>Managing Conflict on Your Team</td>
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<tr>
<td></td>
<td>Thomas-Kilmann Conflict Mode Instrument</td>
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<td></td>
<td>Your Style of Managing Conflict</td>
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<td></td>
<td>Dealing with Generational Conflict</td>
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<tr>
<td>2:00 – 2:15 PM</td>
<td>Break</td>
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<tr>
<td>2:15 – 3:45 PM</td>
<td>Building a Great Nursing Team</td>
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<tr>
<td></td>
<td>Team Building Exercises</td>
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<tr>
<td>3:45 – 4:00 PM</td>
<td>Summary and Evaluation</td>
</tr>
</tbody>
</table>
ambitious for a 1-day workshop, staffing constraints in the health care agencies in our community made this the most feasible design. The workshop includes the use of assessment tools, case scenarios, and group activities. An important part of our training involves education about the nursing scope of practice. Initially, this was not a major focus of the workshop but the charge nurses expressed confusion about the differentiation in scope of practice between the RN and LPN role and this content was added.

Scope of nursing practice. Johnson (1996) suggested that the hardest aspect of teaching delegation is to educate RNs about their own scope of practice. This has been our experience. Some workshop participants believe that there is essentially no differentiation in practice and that licensed practical or vocational nurses can assume the role of primary caregiver for a group of acute patients with no supervision from a RN. Distribution and review of the nurse practice act for our state is now an integral part of the workshop. Differences in the role of the licensed practical nurses in long-term care versus acute care are clarified. This is important as licensed practical nurses are transitioning into acute care from long-term care where their scope of practice may be different under their state nurse practice act.

Assessment, reassessment, and development of the plan of care in the acute care setting are scope of practice issues that generate the most confusion. Charge nurses often don’t realize their accountability for these aspects of care when licensed practical nurses are working on their teams. The significant legal and patient safety issues that arise when team member notes are co-signed by charge nurses without assessing the patient have also become a major point of emphasis. We recommend to charge nurses that they review the functional statements or position descriptions of their team members. Although it may seem basic to include this in a leadership workshop, it cannot be assumed that staff have read and understood these documents. Additional health care agency policies that are integral to the work of charge nurses and should be reviewed include the assignment of patient care, the assessment of patients, and the health care agency’s documentation policy. These documents usually delineate scope of practice issues and outline the accountability of RNs when supervising and delegating to other team members.

Supervision and delegation. The principles of delegation and expectations regarding followup supervision are key areas to include in the educational training of charge nurses. Haase-Herrick (2004) advises RNs that the most significant changes in their practice today involves the delivery of care through others using the process of delegation and that this is likely to increase. The National Council of State Boards of Nursing (1997) developed a Critical Components of Delegation Curriculum Outline that provides an excellent framework to educate charge nurses about their role and responsibilities when working with unlicensed assistive personnel and licensed practical or vocational nurses.

When nursing care delivery models shifted to primary care nursing in the 1970s and 1980s, many nursing programs dropped this content from their leadership curriculum. Most of our participants have had little or no theoretical content on the principles of supervision. The National State Board of Nursing Council has recently expanded the number of NCLEX questions in this area on the exam and most nursing programs now have this content included in their curriculum. Case examples and discussion work well with charge nurses and allow for active discussion of ideas and strategies particularly in situations where staffing may be short and priorities need to be established.

Discussion about competency assessment in delegating care is another key area of emphasis. Competencies in the clinical management of the patient and in the use of equipment on the patient care unit are critical considerations in delegating care. This discussion is not only important in reflecting on the assignments which should or could be given to unlicensed assistive personnel and licensed practical or vocational nurses but also to other professional nurses especially those who work agency or per diem.

Communication. The Institute of Medicine (2004) identified communication failures as a significant causation component of medical errors. The impact of one’s own style of communication on team interactions is an important consideration for charge nurses. We have used the What’s My Communication Style Tool (Russo, 1995) to assist charge nurses to identify their dominant and less used styles of communication. The strengths and weaknesses of different communication styles can effectively be woven into discussion on all aspects of the charge nurse role. If one has a direct style of communication, this may be very positive in interacting with physicians but can be perceived as inconsiderate and uncaring by other staff, patients, and family members. Learning to flex a dominant communication style to the needs of the situation through case scenario examples and group feedback can be a valuable learning experience for charge nurses.

Generational and cultural dimensions of communication are issues that charge nurses readily admit struggling with. Identifying one’s own attitudes and beliefs is an important initial step to appreciating diversity on the health care
team. Case scenarios with real life communication issues drawn from the work environment provide a good basis for group discussion. The significance of taking professional responsibility for communication and followup on patient care issues is a key point of emphasis.

Conflict management. The icebreaker for the workshop includes a question about challenges in the charge nurse role today. Inevitably at each session, the challenge of managing conflict in today's health care environment rises to the top of the priority list. Charge nurses report that this may be their single biggest stressor and evaluate this content as the most helpful in their workshop summaries. There is recognition that failure to effectively manage conflict contributes to absenteeism, turnover, and the potential for medical errors in the work environment.

The Thomas-Kilmann Conflict Mode Instrument (1974) is used to assist charge nurses to identify their preferred mode of managing conflict. It is helpful for charge nurses to examine if their natural conflict management behavior is avoidance. Conflict negotiation steps are reviewed. The use of one or two current conflict situations that charge nurse attendees are struggling with as case examples has proven extremely valuable in demonstrating strategies to manage conflict. The ability of the charge nurse to effectively manage conflict on the work team has a significant impact on team cohesion and working relations.

Twelve-hour shifts in acute care settings in many communities are now the norm. While these tours provide enormous flexibility in work-life management for the nurses who work them, we have learned that it does present challenges for charge nurses in building effective and cohesive working teams in today's work environment. Teams are not static and the membership rotates throughout the workweek. The addition of nurses to the team who work per diem, for nursing agencies, or on traveling contracts further increases the challenge of building a strong nursing team.

Teaching charge nurses strategies to foster a sense of community on their teams that will enhance communication, reduce conflict, and promote team motivation is an essential part of charge nurse education. Examples of how to do this are given by an experienced nursing leader but the most memorable discussion happens when we ask participants to share their own best practices. A recent workshop participant shared with us what he does when a team member is floated to another unit. “No matter how hectic my intensive care unit is, I visit the nurse that I asked to float at least twice during the shift and I make sure that they get a chance to have a break. I can’t tell you how happy my staff is to see me when I come to visit. They know I care.”

The value of charge nurse training has become clear over the past 2 years and feedback has been consistently positive. Health care agencies often have a large cadre of nurses who either routinely assume charge responsibilities or rotate into charge positions. The prospect of providing leadership education to this group of nurses may seem daunting and expensive.

Return on Investment for Charge Nurse Education

Many health care organizations today are demanding that a return on investment assessment outlining the monetary benefits to the organization should be performed prior to initiating any large scale training program. Phillips (1997) proposed a return on investment model that incorporates a five-stage evaluation process (see Table 1). Most current training programs are evaluated at the first or second stage. A projected return on investment is done by identifying the costs of the program and the benefits (see Tables 2, 3, & 4). The return on investment is calculated by subtracting the projected monetary benefits of the program.

<table>
<thead>
<tr>
<th>Levels of Evaluation</th>
<th>Type of Evaluation</th>
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<tbody>
<tr>
<td>Level One</td>
<td>Measures the reactions of participants to the training often using a Likert scale. Asks how training will be used.</td>
</tr>
<tr>
<td>Level Two</td>
<td>Measures the learning gained from the training often by using pre and post tests.</td>
</tr>
<tr>
<td>Level Three</td>
<td>Assesses the application of the training to the job using followup interviews and surveys with participants and their supervisors.</td>
</tr>
<tr>
<td>Level Four</td>
<td>Evaluates the business results received from the training such as improvement in Press-Ganey scores after customer service training.</td>
</tr>
<tr>
<td>Level Five</td>
<td>Evaluates the monetary return on investment to the organization as a result of the training.</td>
</tr>
</tbody>
</table>

Source: Phillips (1997)
### Table 2. Sample Program Costs and Potential Benefits of Charge Nurse Training

<table>
<thead>
<tr>
<th>Sample Program Costs</th>
<th>Potential Program Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of the program design (can be prorated against the number of times the program will be given)</td>
<td>Reduced absenteeism on the work team</td>
</tr>
<tr>
<td>Cost of program materials (videos, participant handouts, assessment instruments)</td>
<td>Increased job satisfaction</td>
</tr>
<tr>
<td>Instructor costs (includes guest speakers, preparatory time, delivery time, followup with participants)</td>
<td>Reduced complaints and grievances</td>
</tr>
<tr>
<td>Cost of facility rental, utilities, audiovisual equipment, meals, and travel</td>
<td>Reduced medical errors</td>
</tr>
<tr>
<td>Participant hourly cost including salary and benefits and replacement costs to the unit</td>
<td>Improved admission, discharge, and transfer process</td>
</tr>
<tr>
<td>Cost of professional contact hours if given</td>
<td>Reduced employee turnover</td>
</tr>
<tr>
<td>Administrative and support overhead costs for the program</td>
<td>Improved internal and external customer satisfaction</td>
</tr>
</tbody>
</table>

### Table 3. Sample Program Costs for a 350-Bed Community Hospital

<table>
<thead>
<tr>
<th>Program Costs</th>
<th>Factors Included in the Calculation</th>
<th>Total Cost of Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of the program design</td>
<td>40 nurse educator hours to design the program at $39 per hour (includes salary of $31 hour and $8.00 in benefits)</td>
<td>$1,560</td>
</tr>
<tr>
<td>Cost of program materials (videos, participant handouts, assessment instruments)</td>
<td>Video on conflict – $750 (prorated against three uses = $250) Assessments Tools – $250 Handouts – $250</td>
<td>$750</td>
</tr>
<tr>
<td>Instructor costs (includes guest speakers, preparatory time, delivery time, followup with participants)</td>
<td>16 nurse educator hours – $624 10 guest presenter hours – $390 One honorarium – $250</td>
<td>$1,264</td>
</tr>
<tr>
<td>Cost of facility rental, utilities, audiovisual equipment, meals, and travel</td>
<td>Given onsite – depreciation on equipment and utilities = $200 Meals for participants (continental breakfast, lunch) = $400</td>
<td>$600</td>
</tr>
<tr>
<td>Participant hourly cost including salary and benefits and replacement costs to the unit</td>
<td>25 charge nurses – 8.5 hours at $31.25 per hour ($25 salary and $6.25 in benefits) Replacement costs 25 x $32 per diem x 8.5 hours</td>
<td>$6,640</td>
</tr>
<tr>
<td>Cost of professional contact hours if given</td>
<td>Average CE cost $10 per participant – paperwork, certificates, cost of provider number</td>
<td>$250</td>
</tr>
<tr>
<td>Administrative and support overhead costs for the program</td>
<td>8 secretarial support hours at $15 per hour (includes salary of $12 and $3 in benefits)</td>
<td>$120</td>
</tr>
<tr>
<td><strong>Total Program Costs</strong></td>
<td></td>
<td><strong>$17,984</strong></td>
</tr>
</tbody>
</table>
minus the program costs divided by the program costs x 100.

As seen in Figure 2, a sample return on investment ROI (%) for a 350-bed community hospital with 25 charge nurses attending the workshop each year using a conservative approach with modest outcome goals indicates the return on investment would be $8.98 for each dollar invested in the training.

Most organizations have historical data on the current costs of the potential monetary benefits suggested previously. Phillips (1997) recommends a conservative but realistic approach in estimating potential program benefits when calculating a return on investment. Taking the time to estimate the potential return on investment will strengthen the arguments for providing leadership training to charge nurses within the organization. Intangible benefits also need to be considered. Experience has taught us that charge nurses, even within the same organization, often have never met although they may have had telephone conversations involving the transfer of patients or floating of staff members. The rapport that can be built through education is an additional benefit of providing this type of training on an ongoing basis to nurses in these roles within the health care agency.

**Implications for Nursing Leaders**

Recent research conducted by Sherman (2004) indicates that it is becoming more difficult to convince nurses to step up to the plate to assume leadership responsibilities even at the charge nurse level. The American Association of Colleges of Nursing (2004) has proposed a new role in nursing, the clinical nurse leader. While it is unclear at this point how this role would fit into the current structure of nursing care environments, the need for stronger leadership at the point of care has been identified. The Institute of Medicine (2004) makes a strong case in support of the crucial role of nursing leadership in promoting a safe patient care environment. In the quest to improve the quality of nursing leadership, it is important that we not forget the contributions and needs of charge nurses in our health care organizations.

**REFERENCES**


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Table 4.
Sample Program Benefits for a 350-Bed Community Hospital

<table>
<thead>
<tr>
<th>Three Program Benefits Projected</th>
<th>Potential Organizational Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced absenteeism on the work</td>
<td>Replacement costs when absent = $32 per hour per</td>
</tr>
<tr>
<td>team of charge nurses – Two RN</td>
<td>diem x 12-hour shift</td>
</tr>
<tr>
<td>absences reduced each month on</td>
<td>24 hours per month x 12 units x $32 = $9,216</td>
</tr>
<tr>
<td>12 units is goal through better</td>
<td></td>
</tr>
<tr>
<td>conflict management</td>
<td></td>
</tr>
<tr>
<td>Reduced complaints and grievances</td>
<td>Organization estimates $100 spent</td>
</tr>
<tr>
<td>of patients, physicians and staff</td>
<td>resolving each formal complaint</td>
</tr>
<tr>
<td></td>
<td>and projects a reduction of 15 per</td>
</tr>
<tr>
<td></td>
<td>year = $1,500 cost savings to</td>
</tr>
<tr>
<td>Reduced employee turnover</td>
<td>organization</td>
</tr>
<tr>
<td></td>
<td>Hospital projects that five fewer</td>
</tr>
<tr>
<td></td>
<td>RN employees will leave each year</td>
</tr>
<tr>
<td></td>
<td>within first 3 months of employment</td>
</tr>
<tr>
<td></td>
<td>due to better unit-based orientation</td>
</tr>
<tr>
<td></td>
<td>from charge nurses. Replacement</td>
</tr>
<tr>
<td></td>
<td>cost is 75% of $45,000 starting</td>
</tr>
<tr>
<td></td>
<td>salary. 5 x 33,750 = $168,750 per</td>
</tr>
<tr>
<td></td>
<td>year</td>
</tr>
<tr>
<td><strong>Total Projected Benefits</strong></td>
<td><strong>$179,466</strong></td>
</tr>
</tbody>
</table>

Figure 2.
Program Return on Investment

```
Net Program Benefits $161,482 = (Program Benefits – Costs) x 100 = 898%
Program Costs $17,984

$179,466 - $17,984 = $161,482
```

continued on page 143
and goals can be sustained over time.

And who says measurement can’t be fun? Measurement in the form of an open self-correcting system of feedback that provides knowledge to enable growth and learning and enhances significance is a beautiful thing. All living organisms grow and learn by trial and error. A tree puts out a root and receives the feedback that the chosen path is blocked by a rock. But the root is not diverted from its mission of finding food and water for the tree, and diverts itself around the rock.

**Summary**

We measure to determine where we stand financially or in our quality outcomes. As people see the connection of measures and the success of the company, everything makes more sense. Izzo (2005) writes that profits/net margins are important to an organization and are like oxygen to a person. If we have oxygen, we can focus on the important things in life; if we don’t we are preoccupied with gasping for air. Organizations are the same way. With the oxygen of profits, organizations can focus on those things that matter most to the staff and the customer. But when the search for profits becomes obsessive because of greed for excess profits or impending financial doom, everybody loses. Izzo (2005) reminds us that organizations shouldn’t exist for only profit, just as people don’t exist for only oxygen. Oxygen is merely an enabler for us to do the work of living.

Measurement and numbers are the oxygen needed to achieve excellence. As people in organizations use numbers as their servants rather than being slaves to numbers, everyone will succeed. If the use of measurement is seen as punitive, and not a system of serving people to attain that zest for business and a higher mission, we will not achieve the level of excellence our people, patients, and communities deserve.

**REFERENCES**


**ADDITIONAL READING**


**Charge Nurses**

*continued from page 130*


Sherman, R. (2004). *Building our nursing leadership bench strength: What will it take to interest our younger nurses in leadership positions?* Research presentation at the American Organization of Nurse Executives Annual Convention, New Orleans, LA.

Sherman, R. (2004). *Building our nursing leadership bench strength: What will it take to interest our younger nurses in leadership positions?* Research presentation at the American Organization of Nurse Executives Annual Convention, Phoenix, AZ.


**Nurses’ Perceptions**

*continued from page 118*


Don’t Forget our Charge Nurses

Lead the Charge
Charge Nurse Development Program
Shands Jacksonville
March 26th and 27th, 2008
Please Don’t Forget our Charge Nurses

“I know today that we have been discussing the nurse manager role but when you are designing leadership training for us, the nurse managers and leaders…..please don’t forget our charge nurses. They are the unsung heroes in our work. Our units would not function without our charge nurses but they are too often forgotten”.

Nurse Manager, South Florida 2002
Our Topics for Today

- What we have learned from research about the Charge Nurse role.
- Key challenges for today’s Charge Nurses
- Your impact as a Charge Nurse on Nursing’s future
Our Initial Nursing Leadership Research

- Conducted in 2002 with Grant Funding from the Palm Healthcare Foundation
- Qualitative Study – Structured Interviews
- Face to face interviews with 120 Nurse Managers.
- 23 South Florida Healthcare Agencies participated.
- Findings from the Research were used to develop a Nursing Leadership Competency Model

Realities of the Current Nurse Manager Role

- Enlarged span of control – many manage multiple units
- Supervision of significant numbers of FTE
- Financial manager of multimillion dollar budgets
- Compliance officer at the unit level with multiple layers of regulatory compliance
- Organizational customer service representative
- Educator and coach
Impact on Charge Nurses

- Charge Nurses act as the “Air Traffic Controllers” for the Unit.
- Charge Nurses assume more accountability for the clinical management of the unit.
- Charge Nurses are very involved with the assessment of staff competency.
- Charge Nurses are more involved with interpersonal relationship issues with staff, physicians and patients.
- Charge Nurses assume more accountability for patient throughput and patient outcomes.
Workshop – *How to be a Great Nursing Leader when You are not the Boss* – attended by over 400 Charge Nurses throughout South Florida.

**Challenges and Needs**

1. Scope of Practice Issues exist between the RN and LPN Role.
2. Supervision and Delegation is challenging for informal leaders.
3. Communication is key but not everyone has the same style.
4. Conflict management and generational diversity issues are the biggest challenges in the role.
5. Team Building is complex with 12 hour shifts.

Research on the Charge Nurse Role

- Charge Nurse Competency Study

- Investigators: Linda Yoder, Ph.D., RN; Denise Miner-Williams, MSN, RN 2002

- Funded by TriService Nursing Research Program (TSNRP # 96045)

- Qualitative, descriptive design

- Data from 42 semi-structured interviews with Charge Nurses, Nurse Managers and Staff Nurses

- Published in Medical-Surgical Nursing - October 2003
Themes in this Study

- Immense amount of responsibility although leadership is informal
- Importance of human relations skills/caring
- Need for ongoing training
- Relationship of head nurse & charge nurse is critical
  - Feedback from supportive people
  - Developmental relationship
- Importance of staying focused on the patients in the role
  - “The prime focus is the patient care. Everything else comes second. So long as the patient needs are satisfied, then you’re fine.”
Four Major Categories

- Clinical/technical
- Critical thinking
- Organizational
- Human relations
Characteristics of Effective Charge Nurses

- Accountability
- Assertiveness
- Attitude (positive)
- Authority
- Confidence
- Need to control
- Fairness
More Characteristics needed for Charge Nurses

- Flexibility
- Humor
- Image
- Initiative
- Maturity
- Learn from mistakes
- Command respect
- Responsibility
Key Challenges for Charge Nurses Today
Healthcare’s Crisis

A Perfect Storm

An Aging Population
+  
Reimbursement Challenges
+  
Workforce Shortages
Dramatic Changes in Health Care

- Aging population
- Increased Acuity in hospitals
- Focus on the need to improve Patient Safety
- Growing cultural diversity in the patient population
- New areas of knowledge and treatment i.e. genetics, environmental health, biomedical
- Pay for Performance and Reimbursement Challenges
- An informed consumer – public reporting of performance
The Nursing Shortage

Ever notice how we take certain things for granted until they're gone?
New Workforce Data

- Revised projections are based on significant increases of those born in the 1970s entering nursing at a later point in life.
- Age of an RN has decreased to 43.5 years.
- Foreign Nurse Recruitment has increased and Foreign Nurses are now 14% of the Labor Market – up from 9% in 2000.
- New Projected Shortage by 2020 is 340,000

Aurebach, Buerhaus and Staiger
Health Affairs Jan/ Feb 2007
Florida Center for Nursing Data
January 2007

- Average Age = 47.5 Years
- 25% Ethnic Minorities and 9% Male
- If most nurses in Florida retire by Age 60 – Florida will lose 40% of currently licensed RNs in the next 10 years.
- 13,837 RNs in Duval, Clay, Flagler, Nassau, Baker and Putnam counties
- 36.5% of the current workforce are 51 years of age or older.
- Only 12.4% of RNs in the workforces of these counties are under 30.

Florida Center for Nursing
www.flcenterfornursing.org
No Time to Lose

Nursing Management Aging Workforce Study

- 978 Nursing Leaders Participated
- 55% of Respondents plan to retire between 2011 and 2020
- 52% of Respondents were over age 50
- Only 28% of healthcare agencies are actively succession planning.

Nursing Management July 2006
Implications for Charge Nurses

• The demand for nursing will continue to increase.

• We will see large cadres of our most experienced nurses and nurse leaders retire taking with them “intellectual capital about care of patients and their organizations”.

• We will have more new graduates than ever before in critical care.

• We will have greater percentages of foreign nurse graduates.

• We will depend more on our Charge Nurses to provide clinical leadership at the point of care.
Looking toward our Future

Charge Nurse Impact on our Nursing Workforce
Employees don’t leave organizations – they leave the people who lead them.
What We are Learning about our Novices

Novice Nurse Leadership Initiative

• Ten Community Partners are sending their novices
• $250,000 in Grant Funding over 2 years (2006-2008).
• 19 Graduates in 2007 – 29 Novices in Program 2008
National Studies indicate that between 30 and 50% of novice nurses leave their employers before the end of their first year.

Satisfaction for novices is highest in the first three months of practice. They are most vulnerable at the 6-12 month point.

Novices often grieve for the loss of school.

Horizontal Violence remains a significant issue for novice nurses.
The Novice Nurse Journey
What is Different about Being a Novice Today?

- Chaotic, unpredictable and fast paced healthcare world
- Higher patient acuity and rapid patient turnover
- Expanding nursing and medical knowledge base
- Disconnections between role expectations and initial role preparation
How Charge Nurses can Help......

- Recognize that different generational cohorts may have values, attitudes and beliefs that differ from your own.

- Maintain a culture on your team that discourages horizontal violence.

- Nurture our novices by helping them with their critical thinking skills.
“You just never know whose life you might touch. You just never know what change you might initiate and what impact you might have. You just never know when that critical moment might come. What you do know is that you can make a difference. You can leave this world better than you found it”.
Questions and Discussion
Contact Information

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Home Office – (561) 624-7066
Fax – (561) 297-2765
E-Mail – rsherman@fau.edu
Home E-Mail – rjshermangroup@aol.com

EDUCATION
B.A. Political Science - University of Florida, 1974
B.S.N. Nursing - University of Florida, 1976
M.S.N. Nursing - Catholic University, 1981

FELLOWSHIPS
Robert Wood Johnson Executive Nurse Fellowship Program 2006-2009

CERTIFICATIONS
Advanced Nursing Administration – June 2003/Current
American Nurses Credentialing Center
Clinical Nurse Leader – 2007-2012
American Association of Colleges of Nursing
Myers-Briggs Personality Indicator
Certified Facilitator – September 2001/Current
Center for Application of Psychological Type

PROFESSIONAL EXPERIENCE
2004 – Present Assistant Professor
Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, Florida. Graduate faculty member, Program Coordinator- Nursing Administration and Clinical Nurse Leader Tracks

6/2002 - present Director, Nursing Leadership Institute
Christine E. Lynn College of Nursing
Director of an Institute initially grant funded by the Palm Healthcare Foundation to conduct research on nursing
leadership issues and provide continuing leadership education for nurse executives, nurse managers and other RN staff being groomed for leadership positions throughout South Florida.

2/1997 – 12/2001  Chief, Employee Education Service  
Department of Veterans Affairs Medical Center 
West Palm Beach, Florida

4/1993 – 2/1997  Associate Chief Nurse and Medical Program Co-Leader  
Department of Veterans Affairs Medical Center 
West Palm Beach, Florida

01/1992 – 4/1993  Visiting Assistant Professor  
Funded by the Department of Veterans Affairs 
Seattle University and Seattle Community College

09/1990 – 01/1992  Evening Nursing Care Director  
Department of Veterans Affairs Medical Center  
Seattle, Washington

09/1988 – 08/1990  Weekend Nursing Care Director  
Department of Veterans Affairs Medical Center  
New York City, New York

05/1987 – 09/1988  Director, Nursing Recruitment and Staffing  
Department of Veterans Affairs Medical Center  
New York City, New York

10/1986 – 05/1987  Nursing Director, Medical Services  
Department of Veterans Affairs Medical Center  
Miami, Florida

12/1984 – 10/1986  Nurse Manager  
Department of Veterans Affairs Medical Center  
Miami, Florida

06/1982 – 12/1984  Director of Nursing Recruitment & Retention  
Department of Veterans Affairs Medical Center  
Miami, Florida

05/1981 – 06/1982  Clinical Nurse Specialist  
Department of Veterans Affairs  
Washington DC
12/1976 – 05/1981  Staff Nurse Positions
Washington DC VA Medical Center
Miami VA Medical Center

RESEARCH AND PROJECT GRANTS

Role Transition Experiences of Clinical Nurse Leaders SM
Qualitative Study involving interviews with 75 Clinical Nurse Leaders Nationwide in partnership with the American Association of Colleges of Nursing.

Principal Investigator – Novice Nurse Leadership Institute – Co-Investigator and Project Director, Susan Dyess.
$250,489 - Palm Healthcare Foundation Grant Funded September 2006 – August 2008. A one year transition program for nurses in their first year of practice. Goals include: 1) retention in the clinical setting 2) development of a leadership mindset 3) articulation into next level of nursing education.

Principal Investigator – The Clinical Nurse Leader Project
$815,981 HRSA Grant funded July 1st, 2005 – June 2008. Program grant to implement CNL curriculum and conduct research.

Principal Investigator – Nursing Faculty Development Initiative – Grant funded for $190,505 August 2004-2006 by the Palm Healthcare Foundation - this project is a part of the Nursing Education Initiative of Palm Beach County. An introductory program to the roles and responsibilities of nursing faculty positions will be offered each seminar to new faculty, experienced faculty who need updates and aspiring nursing faculty. Evaluation research completed June 2006.

Principal Investigator – Use of a ConCensus Process to Identify the factors that influence the decision of younger nurses to accept or reject Nursing Leadership Positions. A Proposal submitted to the American Organization of Nurse Executives, Chicago, Illinois $3000.00 Grant (funded Spring 2003). Study involved focus groups with 48 Nurses under the age of 40. Research completed September 2003.

Principal Investigator - Identification of Critical Leadership Competencies for Today’s Nurse Manager – A proposal submitted as part of the Palm Healthcare Foundation Grant, Palm Beach County, Florida $282,000 Grant (funded Summer 2002).
The research study was completed in October 2002 and involved interviews with 120 nurse managers from 24 facilities in South Florida. Study completed in 4 months with 4 investigators. Research findings were presented onsite to the Nursing Leadership Teams at 14 of the 24 participating healthcare agencies.

**JOURNALS – *Peer Reviewed***


**BOOK CHAPTERS - *Peer Reviewed***


**UNDER REVIEW *Peer Reviewed Journals***


Sherman, R. & Eggenberger, T. Transitioning internationally recruited nurses into clinical settings. Under review by the Journal of Continuing Education in Nursing Data Based
Accepted for Publication
Sherman, R., Clark, J.S. & Maloney, J. Developing the Clinical Nurse Leader℠ Role in the Twelve Bed Hospital Model ® Accepted for publication in Nurse Leader.

*Sherman, R. & Murphy, N. Finding a mentor. Accepted for publication in the American Nurse Today.

*Sherman, R. Factors influencing organizational participation in the Clinical Nurse Leader Project. Accepted for Publication by Nursing Economics Data Based

EDITORIAL BOARD
June 2007 – Present Nurse Leader
Official Journal of the American Organization of Nurse Executives

JOURNAL REVIEWER
November 2004 – Present Nursing Leadership Article Reviewer for Nursing Outlook
August 2006 – Present Journal of Nursing Education
August 2006 – Present American Nurse Today

SCHOLARLY PRESENTATIONS  *REFERRED  #DATA BASED
National Presentations and Poster Presentations
Facilitating Evidenced-Based Practice through the Role of the Clinical Nurse Leader℠ Health Resources Services Administration (HRSA) Grantee Conference Washington DC February 25th, 2008

Lessons Learned in Innovation: Role Transition Experiences of Clinical Nurse Leaders℠
Pioneering the CNL® role in School Health

Facilitating Evidenced-Based Practice through the Role of the Clinical Nurse Leader. Chief Nursing Officer Summit – Invited – Palm Springs, California, October 29th, 2007.

Bridging Intergenerational Differences in Today’s Nursing Workforce


*The Clinical Nurse Leader Project – Panel Presentation
American Organization of Nurse Executives Annual Conference April 2006 – Orlando, Florida

The Nuts and Bolts of Developing Nursing Faculty – Invited Presentation
AHEC Clinical Nurse Educators Conference March 7th, 2006 – Greenville, North Carolina

*#Growing our Future Nursing Leaders – Concurrent Session
Sigma Theta Tau Biennial Conference, Indianapolis Indiana – November 15th, 2005

*A Community Faculty Development Program – Concurrent Session
Sigma Theta Tau Biennial Conference, Indianapolis Indiana – November 13th, 2005

The Clinical Nurse Leader Project – Invited Presentation

*#Growing our Future Nursing Leaders – Concurrent Session
American Organization of Nurse Executives 37th Annual Meeting Phoenix, Arizona April 21, 2004 (Podium Presentation)
*A Community Solution to the Nursing Shortage - Mayo Clinic Quest for Quality Conference, Rochester, Minnesota – November 4th, 2003 (Podium Presentation)


**Selecting the Right Data from the Right Source to do an Education Return on Investment. American Society of Training & Development International Convention, Orlando Florida June 2001.


State/Regional Presentations
**Factors driving Organizational Involvement in the CNL Project, Florida Organization of Nurse Executives, St. Augustine, Florida. June 28th, 2007.

*Factors driving Organizational Involvement in the CNL Project, University Community Hospital, Tampa, Florida. June 26th, 2007.


Developing and Using a Leadership Competency Model (Invited), Phoenix Area Indian Health Service Nursing Leadership Council, Webinar Presentation, June 4th, 2007.


The Clinical Nurse Leader Project in the State of Florida (Invited)
Florida Organization of Nurse Executives Spring Meeting, St Augustine Florida, June 23rd, 2005.

*Nursing Leaders as Academic Educators: A Faculty Development Initiative* Invited Speaker – Florida Organization of Nurse Executives, Fall Meeting October 22nd, 2004.


*#Growing our Future Nursing Leaders – Plenary Session Invited Speaker* Florida Organization of Nurse Executives Orlando, Florida June 25th, 2004 (Podium Presentation)


*The Nursing Leadership Institute:* South Florida Organization of Nurse Executive Annual Conference, Fort Lauderdale September 2002.

*The Nursing Shortage:* Radio Interview with Joe Irwin – Channel 1034 AM August 2002.

*The Nursing Shortage: TV Interview.* Did live TV Interview on News Channel 5 NBC Affiliate with Roxanne Stein, the Healthcare Reporter. May 9th, 2002.

*Situational Leadership* V-tel Presentation to all VA Medical Centers in Florida and Puerto Rico, April 2002.

*The Nuts and Bolts of Supervision* 40 hour Leadership Development Program. West Palm Beach VA Medical Center, April 2001.

*Situational Leadership* V-tel Presentation to all VA Medical Centers in Florida and Puerto Rico, May 2001.

Local Presentations - 2004/2007

The Future of Nursing Leadership: Implications for Critical Care Nurses
Palm Beach County of Critical Care Nurses, May 11th, 2007.

The US Healthcare Delivery System. Florida Atlantic University
University of Tokushima Students and Faculty, March 14th, 2007.

Creating Healthy Work Environments. Fort Lauderdale

Present and Future Nursing Workforce Shortages. Deerfield Beach March of
Dimes 9th Annual Perinatal Conference, November 3rd, 2006

The Nuts and Bolts of Being a Clinical Instructor. Florida Atlantic
University. Palm Healthcare Nursing Faculty Development Initiative,
October 27th, 2006.

Grooming our Future Nursing Leaders: A Leadership Imperative. Florida
Atlantic University. Iota Xi Fall Meeting, October 19th, 2006.

Leading Different Generations in the Workplace. Fort Lauderdale
HCA South Florida Emerging Leaders Program, September 13th, 2006

What are Nursing Leaders Telling Us about their Roles. Aventura Hospital
Miami Nursing Leadership Retreat, August 24th, 2006.

The AONE Proposal for the BSN as Entry into Practice. South Florida

Healthcare Professional Shortages in Florida: Issues, Challenges and
Community Responses. Helping Hands – the Palm Beach Coalition
Children’s Conference, April 22nd, 2005.

The Clinical Nurse Leader Project
Jackson Memorial Hospital, Miami Florida, April 7th, 2005.

The Clinical Nurse Leader Project
St Lucie Medical Center, January 5th, 2005

Clinical Nurse Leader Project
Boca Raton Community Hospital, November 17th, 2004

The Nuts and Bolts of Teaching in an Academic Nursing Program
Faculty Development Workshop, November 13th and 14th, 2004
**Critical Thinking in the Charge Nurse Role**  
Charge Nurse Workshop – Boca Raton Community Hospital  
November 4th, 2004

**Clinical Nurse Leader Project**  
Martin Memorial Health System, October 12th, 2004

**Systems Thinking in Nursing Today**  
Nursing Leadership Institute Presentation, May 27th, 2004

**Growing our Future Nursing Leaders – A Research Presentation**  
West Palm Beach VA Medical Center, May 12th, 2004

**Nursing Leadership Today**  
Treasure Coast Chapter of the American Association of Critical Care Nurses  
May 8th, 2004

**How to be a Great Nursing Preceptor**  
Martin Memorial Medical Center, April 28th, 2004

**How to be a Great Nursing Leader when You are Not the Boss**  
Nursing Leadership Institute Charge Nurse Workshop, April 13th, 2004

**Hot Topics in Nursing Today**  
Wellington Regional Medical Center, March 17th, 2004

**Growing our Future Nursing Leaders – A Research Presentation**  
Good Samaritan Hospital, March 10th, 2004

**Growing our Future Nursing Leaders – A Research Presentation**  
Holy Cross Hospital, March 10th, 2004

**Growing our Future Nursing Leaders – A Research Presentation**  
Palm Beach County Health Department, March 9th, 2004

**They Just Don’t Get It – Generational Diversity in the Workforce**  
Nursing Leadership Institute Workshop  
February 19th, 2004

**The Future of Long Term Care Nursing Leadership**  
Presentation to the Long Term Care Administrators, Palm Beach County Chapter,  
Growing our Future Nursing Leaders – A Research Presentation
St. Lucie Medical Center, February 4th, 2004

Growing our Future Nursing Leaders – A Research Presentation
Jupiter Medical Center, February 3rd, 2004

The Nursing Faculty Shortage – Presentation to the Palm Beach Post Editorial Board, February 3rd, 2004

Growing our Future Nursing Leaders – A Research Presentation
Boca Raton Medical Center, January 28th, 2004

Growing our Future Nursing Leaders – A Research Presentation
West Boca Medical Center, January 22nd, 2004

Growing our Future Nursing Leaders – A Research Presentation
JFK Medical Center, January 21st, 2004

MEMBERSHIPS
American Association of Higher Education
American Organization of Nurse Executives
Council on Graduate Education in Nursing Administration - CGEAN
Florida Hospital Association
Florida Nurses Association
Florida Organization of Nurse Executives
Iron Overload Association – National Board Member
Leadership Palm Beach County
South Florida Organization of Nurse Executives
Sigma Theta Tau

HONORS
Phi Beta Kappa
Sigma Theta Tau
Leadership Palm Beach County Class of 2001
Palm Healthcare Foundation Volunteer of the Year 2003
PBC Giraffe Award for Leadership, 2004
Commitment to Community Award, December 2004
2005 Nurse Leader of the Year, Florida Organization of Nurse Executives
2006-2009 Robert Wood Johnson Nurse Executive Fellowship
**EXPERT WITNESS WORK**  
Completed Risk Management Institute Expert Witness Program  
**November 2001**  
Currently serves as an Expert Witness on Nursing Practice Issues for the Florida Department of Health  
**Areas of Expertise:** Scope of Practice of Registered Nurses and Licensed Practical Nurses, Supervision and Delegation by Professional Nurses, Staffing and Assignment of Nursing Care by Charge Nurses, Professional Conduct, Compliance of Nursing Policies and Procedures with Regulatory Standards.

**CONSULTATION**  
University of Alabama Clinical Nurse Leader  
HRSA Grant – July 2006 – 2009

**COMMUNITY SERVICE**  
November 2007-Present  
Leadership Palm Beach County  
Leadership Excellence Dinner and Awards Committee

January 2005 – Present  
Palm Healthcare Foundation Initiatives Committee

December 2004 – Present  
Palm Healthcare Foundation Nursing Regional Planning Team

June 2004 – Present  
Chair, Higher Education Workgroup  
Nursing Education Initiative  
Palm Healthcare Foundation

May 6th – 7th 2004  
Chair, Expo Education Committee  
Salute to Nursing in Palm Beach County  
Sponsored by the Palm Healthcare Foundation

June 12th, 2003  
Chair, Building & Sustaining a Workforce for our Community Conference  
Conference Sponsor – Palm Healthcare Foundation

May 9th 2003  
Chair, Salute to Nursing in Palm Beach County Dinner sponsored by the Palm Healthcare Foundation.

June 2002 – Present  
Palm Healthcare Foundation Workforce Initiative Executive Committee Member
May 2002 – 2004  Leadership Palm Beach County Focus Program
Curriculum Developer on a two-day program
offered to new corporate and non-profit leaders to
Palm Beach County

April 2002 – Present  United Way of Palm Beach County
Serves as a committee member for grant
distributions to agencies providing medical care.

**PROFESSIONAL SERVICE**
American Organization of Nurse Executives – International Committee
2006 - 2007

American Association of Colleges of Nursing – National Advisory Board
Member for the Clinical Nurse Leader Certification Program 2005 - Present

Florida Organization of Nurse Executives – Board Member 2006

Nursing Spectrum Magazine – Advisory Board for Southeast Region Issue
2005 - Present

National Program Planning Committee – American Organization of Nurse
Executives 2005 & 2006 National Conference – Abstract Reviewer

Florida Organization of Nurse Executives – Education Planning Committee

Florida Organization of Nurse Executives – Research Committee Member

South Florida Organization of Nurse Executives – Board Member and
Education Planning Committee

**College Service**
Committee on Faculty – Academic Year 2004 – Present

Nurse Executive Committee – Academic Year 2006/007

Graduate Programs Committee – Attended meetings and served as the Curriculum
Chairperson for the CNL and Nursing Administration Tracks.

College of Nursing Program Committee – Academic Year 2002-2003

College of Nursing Learning Resource Committee – Academic Year 2003-2004
University Service
Admission and Retention Committee – Academic Year 2006/2008
Strategic Planning Task Force on Goal 2 – Academic Year 2004/2005

Curriculum Development
Project Chair, Clinical Nurse Leader Curriculum – May 2004 – present

Updated March 2008
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<tr>
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<td>Allow program participants the opportunity to ask questions related to regulatory, legal and risk management issues.</td>
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Regulatory, Risk, and Patient Safety

Joni Lourcey BSN, RN, LHCRM
Cherry Schneider RN
Sandy McDonald MSN, RN
“There are some patients we cannot help... there are none we cannot harm.”

Arthur Bloomfield, M.D.
Objectives

• Distinguish between scope of practice and standard of care
• Be familiar with regulatory authorities (AHCA, CMS, The Joint Commission, DCF, Law Enforcement)
• Implement strategies that promote patient safety and minimize potential for litigation relative to scope of practice
What is Scope of Practice

Approved and recognized parameters of functioning based on:

- Training, education, and experience
- License and individual practice acts
- Facility credentialing and privileging
- Facility protocols, policies, and procedures
Going beyond your Scope … is “practicing medicine without a license”!

- Potential harm to patient
- Malpractice exposure for facility and practitioner
- Administrative and civil fines
- Disciplinary action by Regulatory Boards
Standard of Care

• That level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.
What is Negligence

• Failure to exercise the level of care that a reasonable person, possessed of the same knowledge, would have exercised under the same circumstances.
Scope of Practice Strategies

1. Stay within your scope of practice and realm of expertise!
   • If licensed, know and follow your practice act.
   • Assure unlicensed staff, know and follow your written protocols.
   • Understand scope of practice for PAs, ARNPs, vendors.
   • Know and follow the Shands Healthcare core, Shands Jacksonville, Nursing and Unit specific policies and procedures.
Strategies Cont’d

2. Delegate and Accept Responsibility Appropriately!

• When delegating tasks, have a clear understanding of staff competence and abilities and make sure it is consistent with their scope of practice or job function.

• Make sure appropriate supervision is available.

• Do not accept work assignments that you are not competent, trained or licensed to perform.

• Example: RN vs LPN responsibilities
Strategies Cont’d

3. To assure practice within the standard of care, maintain competency in your field.

- Current skills and competency assessments.
- Know job descriptions and practice protocols.
- Provide for staff education and training to keep up with technological and policy changes. (Get them to education sessions)
- Current licensure renewals; ACLS, BLS and CEU requirements.
Strategies Cont’d

4. Don’t offer medical opinions to patients but do maintain a good line of communication with them.

- Avoid telling a patient what you think their diagnosis is or giving advice about available treatments or procedures (practicing without a license).

- Don’t criticize other staff members or physicians in front of the patient.

- Provide timely follow-up to patient requests for care and complaints regarding care.
Strategies Cont’d

5. Document adequately, timely, accurately and objectively in the clinical record.

- Poor documentation can lose a case despite good care.
- Documentation of observations, decisions and actions is considered more reliable evidence than oral testimony.
- Document events as they occur and avoid late entries.
- Know the proper method to correct an error.
- Examples: Change in patient condition; skin assessment and legibility
<table>
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<tr>
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<td>80</td>
<td>18/0</td>
<td>120/LBS/KG</td>
<td>180</td>
<td>RA</td>
<td>4/6/5/15</td>
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</table>

**REASON FOR VISIT/CHIEF COMPLAINT:**

Motion sickness after eating. Lived in hospital for 3 weeks. History of allergic reactions.

**PAST MEDICAL HISTORY**

- CAD
- Asthma
- Kidney Disease
- CVA
- COPD
- Dialysis
- CABG
- IDDM
- Liver Disease
- Pacemaker
- NIDDM
- Sickle Cell Disease
- Head Injury
- Premature Birth
- HMR Sheet Complete
Fluconazole 400 mg PO TID

If the vancomycin level is ≤10,
give 15 mg/IV/1 dose
Stage III

Stage IV

[Images of medical conditions]
Strategies Cont’d

6. Notify your Supervisor and Risk Manager immediately regarding scope of practice issues.

• Activate the chain of command.

• Can’t fix a problem unless it is known.

• Notification delays create potential for patient harm and increased exposure to liability.
What is Patient Safety

• A patient’s “freedom from accidental injury” due to medical care or medical errors.

Institute of Medicine
Patient Awareness

- High Profile Claims
- Increased Patient Access to Information
- Newspaper
- Television
- Computer/Internet
- Cell Phones
Shands apologizes for death of boy

An undated photo of Sebastian Ferrero of Gainesville. He died earlier this month.

By DIANE CHUN
Sun staff writer
12:00 am, October 28, 2007

Three-year-old Sebastian Ferrero of Gainesville was a healthy, happy youngster who happened to be short for his age.
Third baby dies after error at Indiana hospital

By Theodore Kim and Tammy Webber, USA TODAY

INDIANAPOLIS — A third premature baby has died in a case of medical error here that has shaken one of Indiana’s largest hospitals.

Five-day-old Thursday Dawn Jeffers died late Tuesday, said Jon Mills, a spokesman for Methodist Hospital.

The Jeffers infant was one of six premature babies who received overdoses of the anti-clotting drug heparin Saturday in Methodist’s neonatal intensive care unit.

Thursday Dawn was being treated at Riley Hospital for Children, where she had been transferred after being born at Methodist.

“They killed my baby. Why, oh why?” the child’s mother, Heather Jeffers, asked her mother as they hugged outside the younger woman’s apartment.

“We are all saddened by this news and our hearts are with this family,
Patient’s “Journals”
The Spin-off Effect

• Public has expressed zero tolerance for error.

• The legislature has called for increased accountability and certain errors are a basis for disciplinary action by respective licensure Boards.
Intersection of Patient Safety

Quality

- Evidenced-Based Medicine/Nursing
- Policies, Processes, and Guidelines
- Training/Competency
- Forms
- Measurements / Benchmarking
Intersection of Patient Safety

- Environment
  - Hallways
  - Distractions/Noise
  - At Risk Patients
- Falls Prevention
  - Room Arrangement
- Equipment/Materials
  - Alarms
  - Faulty equipment
Intersection of Patient Safety

- Disclosure
- Costs
- Policies and Procedures
- Reporting - ID inc
- Discipline
- Participation (e.g. on rounds)
Intersection of Patient Safety

- Communication
  - Hand-off
  - Patient input
  - Health literacy

- Reporting

- Chain of command
  - Sharing or silence
  - Support or firing
  - Change welcomed or not

Culture
Intersection of Patient Safety

- Quality
- Safety
- Culture
- Management
Regulatory Agencies

• The Joint Commission (TJC)
• Agency for Healthcare Administration (AHCA)
• Center for Medicare and Medicaid Services (CMS)
• Department of Children and Families (DCF)
The Joint Commission Sentinel
Event Policy

• Purpose:
  • To have a positive impact in improving patient care.
  
• To focus attention of organization on understanding causes that underlie even and making system/process changes to prevent recurrence.

• To maintain confidence of public in the accreditation process.
Sentinel Event Defined

- Unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof ("near miss").
- Death from wrong blood transfusion
- Surgery on wrong person/body part
- Retained foreign body
• Medication Errors:
  - Potassium Chloride
  - Drugs that look and sound alike
  - Potentially dangerous abbreviations
• Infusion pumps
• Blood transfusion errors
• Patient controlled analgesia by proxy
• High Alert Medications
• Tubing Misconnections
• Using Med reconciliation to prevent errors
The Joint Commission
Expectations

• Root Cause Analysis
• Development of action plan
• Ongoing monitoring of actions
• “Tweaking” action plan as performance dictates to ensure continued improvement
Root Cause Analysis Reviews All Potential Contributory Factors:

- Equipment
- Staffing/Resources
- Documentation
- Environmental
- Leadership
- Communication
- Consideration of relevant literature
Data Analysis

- Collecting data alone does not improve safety.
- Root cause analysis for specific events is key.
- Appropriate analysis of systems data is vital.
Systems Analysis

• “Incompetent people are, at most, 1% of the problem. The other 99% are good people trying to do a good job who make very simple mistakes and it’s the processes that set them up to make these mistakes.”

Dr. Lucian Leape, Harvard School of Public Health
AHCA Definition of Adverse Event

- Occurrence over which health care providers could control AND

- Is associated in whole or in part with an intervention, rather than with the condition for which the intervention occurred (patient’s underlying medical problems)

- AND.....Results in the following:
15 Day Reportable Adverse Events

- Death
- Brain/spinal damage
- Wrong patient surgery
- Wrong site surgery
- Wrong procedure surgery
- Medically unnecessary surgery or unrelated to patient’s diagnosis/condition
- Surgeries to repair damage from planned procedures wherein damage was not included in preoperative informed consent
- Procedures to remove foreign object's remaining from planned procedure
Annual Reportable Incidents

- Any incidents previously reported as Code 15
- Permanent disfigurement
- Fracture/dislocation of bones/joints
- Limitation of neurological, physical or sensory function which continues after discharge
- Condition that requires transfer of patient, within or outside facility, to a more acute level of care
- Condition that requires specialized medical or surgical treatment (excludes emergencies to which the patient has not given his informed consent)
It’s the Law (CMS, AHCA, DCF, etc.)

- Rules and Regulations
  - Restraints
  - Consents
  - Disclosure Law
  - Baker Acts
  - Elopements vs. AMA
  - EMTALA
  - Abuse and Sexual Assault
  - Prisoners
  - Crime Scenes
Patient Autonomy/Consents

- Informed consent
- Disclosure of diagnosis and complications
- Advance directives
- Right to access medical record
- Availability of alternative care options
- Jehovah Witness
Disclosure Law

- 395.1051*- Duty to notify patients of adverse events. An appropriately trained person must inform each patient in person about adverse incidents that result in serious harm.

- CP1.43 - Shands Core Policy requires disclosure by a appropriately trained physician.

- * Disclosure does not constitute an acknowledgement or admission of liability, nor can it be introduced as evidence.
Involuntary Baker Acts

- A patient may not be held for an involuntary examination longer than **72 hours**, or one working day following a weekend.

- The **72 hour** time clock ceases when it is determined an individual has an emergency medical condition and starts again when the physician has documented that the patient’s emergency medical condition has stabilized or no longer exists.
Baker Act Cont’d

• Once the patient’s emergency medical condition is stabilized, the receiving facility must be notified within 2 hours and the patient transferred within 12 hours for an examination by a qualified professional.

• An ex parte Order for Involuntary Exam expires after 7 days if the patient is not taken to a receiving facility or taken into custody.
EMTALA
Emergency Medical Treatment and Active Labor Act

- Commonly referred to as the Patient Anti-Dumping Act passed in 1986 under COBRA (Consolidated Omnibus Budget Reconciliation Act).

- Legislative response to refusals by hospitals to provide emergency care to poor and uninsured.

- Law applies to any and all patients, not just Medicare/Medicaid or those with insufficient resources.
EMTALA - Transfers

• Determination of Capacity

• Whatever a hospital usually does to accommodate patients in excess of its occupancy, equipment and personnel limits.

• Personnel - The level of care that the personnel of the hospital can provide within the training and scope of their professional licenses.

• Facility - There is physical space, equipment, supplies and services.
Most Common EMTALA Violations

- Failure of on-call physicians to see patients as requested
- Failure to stabilize patient within capability before transfer
- Refusal to accept transfer of patient
- Delay in treatment due to financial issues
- Failure to complete transfer certification form
- Failure to explain risks and benefits to AMA patients
Prisoners

• The mission of Wackenhut Security Officers assigned to Shands Jacksonville is to first ensure prisoner patients are properly accounted for, monitored, escorted, and returned to custody of the Sheriff’s department without incident, harm, or endangerment to the Wackenhut officers, Shands staff, the general public, or the prisoners themselves.
Allegations of Abuse; Sexual Harassment and/or Assault of patient

- Patient abused prior to admission, notify case management
- Protect your patient and staff with careful assignments
- If an allegation occurs:
  - Notify your Nurse Manager or NAO
  - Call Regulatory/Risk Management
  - Notify Security for on campus
  - Notify the patient’s physician
  - Notify Regulatory /Risk Management
Potential Police Involvement
(Crime Scenes)

- Notify your Nurse Manager or NAO
- Call Security
- Call Regulatory/Risk
- Secure the area
- Calm the staff
- Leave the area untouched
- Do not clean the room or bathe the patient
Restraints

- CMS changed restraint regulations last year.
  - Violent, self-destructive;
  - Non-violent, Non-self destructive
- Requirement to notify CMS within 24 hours of ANY patient death while in restraints
- Call Regulatory, enter into IDinc.
Types of Errors

**System Errors**
- Communication
- Heavy workload/Fatigue
- Incomplete or unwritten policies
- Inadequate training or supervision
- Inadequate maintenance of equipment/buildings

**Human Mistakes**
- Action slips or failures (e.g. picking up the wrong syringe)
- Cognitive failures (e.g. memory lapses, mistakes through misreading a situation)
- Violations (i.e. deviation from standard procedures; e.g. work- arounds)
What to do if an Error Occurs?

• 1. Contact the patient’s physician.  
  Patient Safety First!
• 2. Complete a patient safety report IDinc
• 3. Notify risk management of all serious adverse events

“The only real mistake is the one from which we learn nothing.”

John Powell
All Staff Enter Events Here

Please select your action:

- Report an Event
- References

Only Management Enter Here
A Famous Case

• “Joan Morris” has the procedure (an electrophysiologic study with possible implantable cardiac defibrillator and pacemaker) scheduled for “Jane Morrison.”

• 17 separate errors identify by RCA.

• “Physicians failed to communicate with nurses, attendings failed to communicate with residents and fellows, staff from one unit failed to communicate with those from others, and no one listened carefully to the patient.”

• Chassin & Becker, Annals of Internal Medicine, 2002, pp 826-833
Failure to Speak Up

- Nurse #1, who transported the patient from the floor to the operating room, noticed the absence of an informed consent for the procedure. She assumed the studied was arranged, however.

- Nurse #2, upon receiving the patient, notices the lack of informed consent and pages the electrophysiology fellow (EF).

- The EF is “surprised” at the lack of pertinent information regarding this patient and her need for the procedure, but he gets her to sign the consent form.
More....

- The resident taking care of Joan Morris is “surprised” to find her missing; he assumes, however, that the attending ordered the study without telling him;

- The electrophysiology charge nurse notices no patients are scheduled that day named “Joan Morris.” But by the time she questions this, the procedure had already begun, and she does not pursue the conversation further.

- The electrophysiology attending finally discovers the error and aborts the procedure.
Questions
<table>
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<tr>
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<td>5. Describe how communication is the key to the delegation process</td>
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<td>6. Discuss the “5 Rights” of delegation and the role of the Charge Nurse in delegation</td>
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<td>Present Keynote Address</td>
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<tr>
<td>30&quot;</td>
<td>Activity</td>
<td>Paper Scenarios Unit map</td>
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<td>1. Assign different scenarios to each table based on table number.</td>
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<td>2. Provide map of unit to program participants</td>
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<td>3. Ask participants to make assignments for each nurse for their unit based on the nurse/patient scenario provided.</td>
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<td>4. Each table to assign a spokesperson to report out their team’s decision and rationale.</td>
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Round ‘em up, Lead ‘em out:
The ART of DELEGATION
and Other Scenarios

Mary K. Parry, MS, BSN, RN, CNA-BC
Gloria Dunham, MA, BSN, RN
Objectives

• Define delegation according to the Florida Board of Nursing
• Name activities that CAN and CANNOT be delegated
• Identify the responsibility of the nurse for supervision of delegated tasks
• List factors to consider in selecting a task or delegating to a specific individual
• Describe how communication is the key to the delegation process
• Discuss the “5 Rights” of delegation and the role of the Charge Nurse in delegation
The State NURSE PRACTICE ACT defines the legal parameters for nursing practice, which includes delegation.

(Chapter 464 Florida Statutes)
Florida Board of Nursing

- Rules of the Board of Nursing
- Chapter 64B9-14 of Florida Administrative Code “Delegation to Unlicensed Assistive Personnel”
Definition of Delegation

“Transference to a competent individual the authority to perform a selected task or activity in a selected situation by a nurse qualified by licensure and experience to perform the task or activity”

(Rules of Florida Board of Nursing, Chapter 64B9-14.001 of Florida Administrative Code)
Who is the delegator?

• In Florida, it is the RN or LPN who delegates authority to the UAP (Unlicensed Assistive Personnel)

• UAP’s may be CNA’s, PCA’s, Techs, Student Nurses, etc.

• UAP’s do not hold licenses from the Division of Health Quality Assurance of the Department of Health
What are the roles of each?

**REGISTERED NURSE**

- Observation, Assessment, Nursing Diagnosis, Planning, Intervention, Evaluation of Care and Health Teaching
- Administration of Medications and Treatments as prescribed by a duly authorized licensed practitioner in the state
- Supervision and Teaching of other personnel in the performance of the above acts.
What are the roles of each?

**LICENSED PRACTICAL NURSE**

- Performance of selected acts including administration of treatments and medication in the care of the ill, injured, or infirm and the promotion of wellness, maintenance of health, and prevention of illness of others.

- Works under the direction of a Registered Nurse, a Licensed Physician, a Licensed Osteopath, a Licensed Podiatric Physician or a Dentist.
What are the roles of each?

UNLICENSED ASSISTIVE PERSONNEL

- Are assigned to function in an assistive role to RN’s or LPN’s in the provision of patient care services through regular assignments, or delegated tasks or activities, and under the supervision of a nurse.
- “Assignments” are the normal daily functions of the UAP based on institutional job duties which do not involve delegation of nursing duties or nursing judgment.
The RN may delegate **elements** of care but does not delegate the **nursing process** itself.

The RN transfers the **responsibility** for the performance of a task, but retains professional **accountability** for the overall care of the patient.
Activities that CAN be delegated

• Activities of daily living
• Data collection – I&O, Vital Signs, Accuchecks
• Activities/procedures authorized in the job description and for which the individual is competent
Activities that should NOT be delegated

• Activities outside of the scope of practice or job description
• Activities for which the individual has not demonstrated competence
• Activities that include the use of the nursing process or the judgment/skill of a nurse:
  – Nursing assessment, diagnosis, nursing goals and plan of care, evaluation of patient progress
You cannot delegate something for which you don’t have the knowledge and skills yourself.

Nurses are accountable for supervising those to whom they have delegated tasks!
What about Supervision?

“Supervision is the provision of guidance by a qualified nurse and inspection by the nurse for the accomplishment of a nursing task or activity, provided the nurse is qualified and legally entitled to perform such task or activity.”
The delegator must use **nursing judgment** to consider the suitability of the task or activity to be delegated.

- The needs and condition of the patient
- Potential for harm to the patient
- Complexity of the task
- Predictability of the outcomes
- Level of interaction/communication required
- Resources – equipment or personnel
Factors to consider in delegating to a specific individual

- Normal assignment
- Validation of education/training
- Job description
- Competency
Don’t Assume!

• That team members know what you want

• That all staff understand priorities of care

• That UAP’s or LPN’s understand the scope of their practice
Communication: The Key to the Delegation Process

1. Identification of the task or activity
2. The expected or desired outcome
3. The limits of authority
4. The time frame
5. The nature of supervision required
6. Verification of the delegate’s understanding of the assignment
7. Verification of monitoring and equipment
Communication:

• Based on a relationship - conveys dignity and mutual respect

• 4 C’s of Communication:
  Clear, Concise, Correct and Complete

• Two-way process – specify what you want reported back and allow opportunity for clarification or questions

• Promotes teamwork!
The 5 Rights of Delegation

The **Right Task**
Under the **Right Circumstance**
To the **Right Person**
With the **Right Direction**
Under the **Right Supervision**
Charge Nurse responsibilities in delegation

1. Assignment:
   - based on condition of the patients
   - the competence of members of the staff
   - degree of supervision required
2. Availability as a clinical resource person
3. Direct delegation of specific tasks
4. Supervision of delegated tasks
5. Evaluation and feedback
6. Chain of command
Any questions?

• AND NOW ON TO OTHER SCENARIOS…
Charge Nurse Development Day
Post Test

1. If you are not getting the response that you need from the resident who would you call?
   a. Attending physician
   b. Nurse Manager/Nursing Administrative Office (NAO)
   c. Number 1 and 2
   d. Administrator on Call

2. Negligence is failure to exercise the level of care that a reasonable person, possessed of the same knowledge, would have exercised under the same circumstances.
   a. True
   b. False

3. When a piece of equipment being used on a patient fails, the following steps should be taken:
   a. Remove it from service, tag it, and document the error on the tag
   b. Enter the equipment failure into IDinc
   c. Notify bio-med and risk management as soon as possible
   d. All of the above

4. The 5 Rights of Delegation include all of the following except:
   a. Right task
   b. Right circumstances
   c. Right person
   d. Right medication

5. Which of the following is NOT a factor to weigh when selecting the task to delegate:
   a. The potential for patient harm
   b. The level of supervision required
   c. The expected or desired outcome
   d. The patient’s past medical history

6. An activity that may NOT be delegated by a Registered Nurse is:
   a. Assessment
   b. Vital Signs
   c. Ambulation
   d. Blood Glucose Monitoring

7. What are the elements in the model for team effectiveness?
   a. Goals, roles, process, interpersonal relationships
   b. Goals, responding, interaction, priorities
   c. Avoiding, accommodating, persuasion

8. Conflict is:
   a. Harmful to teamwork
   b. When one party perceives that the other has frustrated, or is about to frustrate, some concern of his.
   c. Not inherently harmful, depending on how it is handled.
   d. Both b and c

9. Which mode for handling conflict is sometimes necessary when you need to find a middle ground that partially satisfies both parties?
   a. Accommodation
   b. Compromise
   c. Collaboration
   d. Competition

10. If you are promoting teamwork, which method is usually preferred?
    a. Accommodation
    b. Compromise
    c. Collaboration
    d. Competition
Instructions: Please circle the response that best expresses your reaction to each item listed.

<table>
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<th>Presenter(s):</th>
<th>Knowledge of Subject</th>
<th>Teaching Methods</th>
<th>Organization</th>
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<td>High</td>
<td>Low..............</td>
<td>High..........</td>
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<tr>
<td>Rose Sherman, EdD, RN, CNAA</td>
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<td>Joan Sacerio, MHSA, RN-BC, CHPN</td>
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<tr>
<td>Cherry Schneider, RN</td>
<td>1</td>
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<tr>
<td>Mary Parry, MS, RN</td>
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<tr>
<td>Gloria Dunham, MA, BSN, RN</td>
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<tr>
<td>Pamela McCaleb, MA, SPHR</td>
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<tr>
<td>Monica Wells, BSN, RN, CCRN</td>
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</tbody>
</table>

Content

<table>
<thead>
<tr>
<th>Below Average</th>
<th>Average</th>
<th>Above Average</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>The length of the program was appropriate for the material presented.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>The information presented was current and accurate.</td>
<td>1</td>
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</tr>
<tr>
<td>The learning objectives were clearly stated.</td>
<td>1</td>
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</tbody>
</table>

Program Objectives

<table>
<thead>
<tr>
<th>Objective</th>
<th>Description</th>
<th>Below Average</th>
<th>Average</th>
<th>Above Average</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 1:</td>
<td>Describe Evidenced-Based findings related to the Charge Nurse’s Role.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Objective 2:</td>
<td>Identify the key challenges for Charge Nurses in today’s healthcare environment.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
</tr>
<tr>
<td>Objective 3:</td>
<td>Describe strategies that can be used in practice by Charge Nurses to improve staff recruitment, retention and satisfaction</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Objective 4:</td>
<td>Distinguish between scope of practice &amp; standard of care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Objective 5:</td>
<td>Identify the regulatory authorities and their function</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>Objective 6:</td>
<td>Implement strategies that promote patient safety and minimize potential for litigation relative to scope of practice</td>
<td>1</td>
<td>2</td>
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<td>4</td>
</tr>
<tr>
<td>Objective 7:</td>
<td>Define delegation according to Florida Board of Nursing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>Objective 8:</td>
<td>Cite activities that CAN &amp; CANNOT be delegated</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Objective 9:</td>
<td>Identify the responsibility of the nurse for supervision of delegated tasks</td>
<td>1</td>
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<tr>
<td>Program Objectives (cont)</td>
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<tr>
<td><strong>Objective 10:</strong> List factors to consider in selecting a task or delegating to a specific individual</td>
<td>1</td>
<td>2</td>
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<tr>
<td><strong>Objective 11:</strong> Describe how communication is the key to the delegation process</td>
<td>1</td>
<td>2</td>
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<tr>
<td><strong>Objective 12:</strong> Discuss the “5 Rights” of delegation and the role of the Charge Nurse in delegation</td>
<td>1</td>
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<tr>
<td><strong>Objective 13:</strong> Identify the elements in the model for team effectiveness</td>
<td>1</td>
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<td><strong>Objective 14:</strong> Describe the impact of conflict on a team</td>
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<tr>
<td><strong>Objective 15:</strong> Explain the preferred mode for handling conflict</td>
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<tr>
<td><strong>Objective 16:</strong> Select appropriate use of various conflict modes, based on the situation</td>
<td>1</td>
<td>2</td>
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</tbody>
</table>

Overall, the program was:  Excellent  Above Average  No Opinion  Average  Below Average

OUTCOMES: Based on the content presented, I will:

- Do nothing further with the information because it reinforced what I already knew.  Yes  No
- Do nothing further with the information because it contradicts what I believe to be true.  Yes  No
- Change my practice to reflect updated skills and concepts presented today.  Yes  No
- Will this information be helpful to you professionally?  Yes  No

OTHER COMMENTS:

What training topics or activities would you like to see offered in the future?