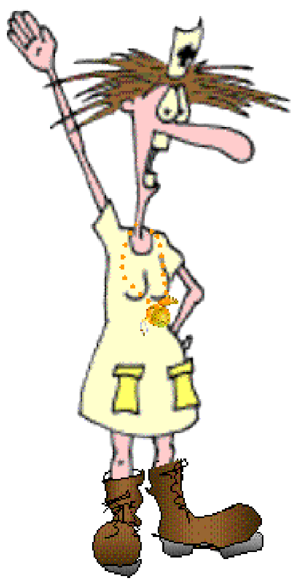
The Nurse Manager Boot Camp E-zine...



Changing Organizational Culture

There is in each institution an implicit, invisible, intrinsic, informal yet instantly recognizable *welenschaung, which is best,* described as its "corporate culture." Like most really important things, it is terribly difficult to define or even describe. In fact, it's much easier to say what it is *not* than to say what is. For example, "corporate culture" is *not* the same thing as "organizational climate" nor is it "corporate identity" nor is it merely a subset of the "national culture." Many hospitals today are suffering from disruptions of the corporate culture as a result of the imposition of business values on a human services culture. Almost all organizational analysts warn against attempting to change a corporate culture, especially a strong and stable one. They urge corporate leaders to design strategies that "fit" the culture and capitalize on its strong points. However, if there is no choice, a culture can be changed – incrementally.

To begin, you analyze the existing culture: 1) identify and develop an appropriate list of organizational values; 2) measure the degree to which employees and managers share those values; and 3) measure the degree to which they perceive the institution as demonstrating those values. When changes and strategies are introduced, use words and phrases that appeal to those traditional values. As employees begin experiencing the changes, introduce "symbols" and "heroes" of the new culture -always noting their roots in the old culture while emphasizing their growth toward the new. As you begin to modify the existing culture, plans must be made to sustain the desired culture. *Leah Curtin.*

CHAT SCHEDULE

How to Retain Staff (this ain't rocket science!)
Monday, January 11, 2006 - 3:00 PM *EST*
Leah Curtin, RN, ScD(h), FAAN

Handling Difficult People
Monday, January 18, 2006 - 3:00 PM *EST*
Jeanne Clement, RN, EdD, FAAN

What the Books Don't Tell You!

"Don't let your assets become your liabilities"

Each of us attained our current positions because of our perceived assets. That might include our understanding of professional practice, ability to manage a budget, our reputation, history within an organization, our relationship with key individuals, or any number of other reasons. But organizations change, new personalities arrive, priorities shift, and circumstances change. The assets that originally brought you to your position may no longer be important, and in fact, can even evolve to become perceived weaknesses. Even if your title and scope of responsibility remains exactly the same, you better not!

Constantly evaluate the needs of the organization, and your contribution to meeting them. Adjust your approach to match new personalities and management. Be sure you contribute more than you cost. Develop new competencies demanded by emerging organizational requirements. Rethink. Retool. Refocus. Look at your job and determine the key "make or break" outcomes – not as you perceive them, but as others do. Make sure you produce them. *Gail Wolf, EdD, RN, FAAN*

5 Easy and Cheap Ways to Reduce ADEs

In March, 2001, the USP released "Use Caution, Avoid Confusion," an updated list highlighting hundreds of confusing drug name sets and identifying more than 750 unique drug names that have been reported to the Medication Errors Reporting program. A poster and a laminated, quick-reference card are available for health care professionals free of charge from the USP by contacting USP's Practitioner and Product Experience department at (800) 487-7776, or the list may be accessed from USP's Web site at http://www.usp.org/reporting/review/rev_076.htm.

At present, the Institute for Safe Medication Practices, USP and the FDA collect and track medication errors and make information available to health care providers and the public. Information and alerts about confusing drug names and current initiatives to have confusing names changed may be obtained from the organizations' Web sites: www.ismp.org, www.usp.org, and www.fda.gov

Other suggestions for minimizing the risk of errors include:

1. Do not store problem medications alphabetically by name. Store such identified medications out of order, or in an alternate location.

2. Provide or ask for both the generic and brand names of drugs for medication orders in order to provide patients and staff with information to avoid unintentional duplication.

3. Write the purpose of the medication on the prescription.

4. Develop a policy for taking verbal or telephone orders. For example, when taking verbal drug orders, clearly repeat the name of the drug, the dosage ordered, and request or provide correct spelling. The National Coordinating Council for Medication Error Reporting and Prevention recently released comprehensive recommendations. They can be found at www.nccmerp.org

5. Provide patients with written information about their drugs including the brand and generic names. Inquire if the prescribed drug is a routine medication and withhold medications that the patient questions or does not

Evaluating the Effectiveness of Your Recruitment Plan

The following is a "check up" tool to evaluate the effectiveness of your past and future Recruitment Plans bassed on 2 criteria:

1. Do you know where your best source of new hires came from during the past year? (They should be tracked according to source code.)

2. Did you measure the effectiveness of your advertising and media plans? Do you know what venues brought you the most qualified applicants. Don't plan to spend more money out of next year's budget in areas yielding little or no return.

How many hires resulted from conference and job fair attendance. (These statistics should also be captured by source codes. What percentage of your new hires was attracted through an Employee Referral Award Program? If the percentage is below 40%, analyze the barriers, give the plan a "face lift", and re-market the program in a highly visible manner to your employees. Be sure to include program information during orientation.

Review your application processing time for effectiveness. Are nurse's resumes being responded to within 24 hours?

Review your "walk in" applicant process. Do applicants get escorted to the nurse recruiter from any point of contact within the hospital? Are managers willing to interview "on the spot"?

Once the job offer has been accepted, what is the timeline for getting the new hire working? If the timeframe is not acceptable, what are the barriers?

Do you have a college relations "strategy"?

Does Nursing Education meet with Recruitment to understand the candidate pool not meeting minimum qualifications? You can discover local "hidden" pools of talent willing to work if the right educational program is developed so they qualify for vacant positions.

Do you reconcile the posted vacant positions against position control at least twice a month?

When was the last assessment of your current RN market conducted?

When was the last assessment of your local competition conducted?

Do you interview each new hire after 90 days?

Do you conduct exit interviews with each nurse who voluntarily leaves your organization?

Quantifiable information gets you started on formulating a "first time" recruitment plan, or serve as a means for evaluating what you did in the last year.

TICK:Involving Staff in Staffing!

Back in the late 1970s, when healthcare was in the midst of one of its cyclical nursing shortages, John R. Howard, MBA of Santa Monica, California developed a unique system for enabling staff to use their clinical judgment in tight staffing situations. "How" he asked, " does a hospital permit nurses on the unit to decide their own staffing, yet remain within budget?" The answer may be found in Howard's system, which he called 'TICK': a simple technique of using a (+ or -) check mark for staffing. 'TICK' is not a replacement for an acuity system. It is merely a system of granting a credit (tick) each time a unit receives less staffing than is called for according to census. Each tick received can be cashed in at any time to receive higher staffing whenever the unit decides it is needed. No tick - no extra staff, although "credit" can be given when necessary for short periods.

'TICK' allows each unit to be self-reliant in determining its own staffing needs and still staying within its budget. In a centralized staffing arrangement, acuities may be reported up to four hours before the start of the shift. At this time, the 'TICK' determination of High, Normal or Low is reported. If "Normal" is reported along with 20 patients, then the unit is to be staffed for 20. If "Low" is reported, then the unit is staffed for 19. If this results in one less person, then a tick is received. If "High" is reported, then the unit is staffed for 21. If this results in one more person, then a tick is used.

Variations are possible, such as reporting "Very High, High, Normal, Low and Very Low ,"and adjusting one patient census for each determination, but the theory and bookkeeping are all very simple. Some units may find it difficult to request less staff for whatever reason. In this case, 'TICK' can be used differently. If a unit with an average census of 20 is budgeted for 5.6 HPPD, then a guideline could be established which would give them 5.4 HPPD plus 3-1 h. ticks per week, which when used, would add up to .2 HPPD. Ticks can also be accumulated or used on the basis of cost: RN = 4 ticks, LVN= 3, NA= 2. If staffing resulted in one less RN, then the unit would receive 4 ticks, which could be cashed in for one RN or two NAs. To establish the correct distribution of agreed upon HPPD for each unit, a one-time or ongoing assessment can be made. Please note, 'TICK' does not determine what the average HPPD should be; detailed analysis is necessary to make such a determination.

'TICK' is simple to implement, yet allows for complex judgments made on the part of the staff nurse to be taken into consideration each time a floor is staffed. Many of these judgments such as quality and types of personnel, orientees, students, etc., are not addressed when using an acuity system alone. With TICK, the nurse's perception of his or her needs can be met fairly and within limits. No small accomplishment that!

John R. Howard, MBA