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Message From the President  The Economic Value of Nursing

As nurses, we recognize the essential contribution our profession makes to the health of our nation. And I am proud to report that in June 2008, the Center for American Nurses adopted a position declaring that professional nursing is essential to the delivery of quality patient care.

The economic value of nursing as well as our contribution to healthcare quality is demonstrated every day through professional practice that is safe, appropriate, and cost-effective. Research study after research study supports this claim. For example, Aiken’s work informs us that the quality of care declines when hospital units are short-staffed. Needleman and Buerhaus’ studies demonstrate that increasing the number of hours of skilled nursing care results in fewer patients developing pressure ulcers, infections from urinary catheters and ventilator-associated pneumonia. Further, the Institute of Medicine found that nurses are the providers most likely to prevent hospital-acquired pneumonia, which can add as much as 84% to the cost of a patient’s care. Studies by the University of Minnesota School of Public Health found that adding one more full-time RN to staff would produce a 9% decrease in the number of hospital-related deaths in intensive care units. And a 2009 report produced by the Lewin Group states that adding 133,000 RNs nationally would decrease hospital days by 3.6 million. Need I say more?

Clearly I must say more because policy makers, administrators, and consumers do not understand the value of services provided by professional nurses. The public finds nurses trustworthy but they do not understand the work of nursing.

At the Center for American Nurses, we believe helping nurses understand, demonstrate, and communicate their contributions is the first step in recognizing and valuing our profession in a way that impacts the nursing work environment. Here are four easy steps you can take to help others understand the value of professional nursing.

1) Articulate to your patients and to your employer your value to patient care and the financial and quality care bottom line of the facility for which you work. Value yourself as a nurse and the contributions you are making to the care of patients. Identify yourself to other providers and patients as a Registered Nurse or other relevant designation.

2) Maintain current knowledge of research trends demonstrating the value of nursing and the contribution of nursing interventions to improving patient outcomes and safe patient care.

3) Pursue ongoing professional development through continuing education and review professional literature in order to apply evidence-based practices.

Support nursing colleagues in efforts to improve patient care delivery and your workplace through evidence-based practice.

In the meantime, the Center will continue to provide support for initiatives that contribute to positive patient outcomes. We will support nurse-directed programs, services, and research focused on demonstrating the value of nursing to quality and safety in healthcare. And we will continue to serve as a catalyst in articulating the value of nursing, as it relates to patient safety, in terms understood by consumers.

Dennis Sherrod, EdD, RN
President
Center for American Nurses
Center for American Nurses  Mission, Vision, Purpose, and Values

Mission
To create healthy work environments through advocacy, education, and research

Vision
The leader in workforce advocacy for professional nurses

Purpose
To articulate, advocate, and provide workforce advocacy solutions to equip nurses in shaping their work environment

Values
Leadership: Resolve professional workforce issues; act as professional resource; provide role models for the balance between personal and professional life

Personal and Professional Development: Encourage individual nurse initiative in creating a healthy work environment and advocating for change in a positive persistent manner

Partnership: Build collaborative organizational and individual relationships beneficial to The Center and its professional work

Stewardship: Manage and develop The Center’s human and financial resources

Call for Manuscripts

NURSES FIRST invites authors to send your query letter or manuscript for publication to NURSESFIRST@CenterforAmericanNurses.org. For further information and to review the guidelines go to www.CenterforAmericanNurses.org

Congratulations!

Marla J. Weston, PhD, RN
Recipient of the Center for American Nurses 2009 Workforce Advocacy Champion Award
Respect: Beginning to Define the Concept in Nursing

BETH ULRICH, EdD, RN, FACHE, FAAN, RICK BREUGGER, M.A., CINDY LEFTON, PhD, RN

Respect — Do a Google search on the term ‘respect’ and you’ll find over 349 million hits. Amazon.com lists over 683,000 books on the same topic. In nursing, ‘respect’ is often mentioned in both general conversations and in research concerning issues such as a nursing job satisfaction and turnover. But what is respect? What specifically do people mean when they talk about respect? How do you know if someone respects you? How do other people know that you respect them?

Amazingly, there is little definitive research in nursing that addresses what nurses mean when they use the term respect. People talk about respect in the way we used to talk about quality — seeming to believe that you know it when you see it, but having a difficult time articulating what it really means conceptually and behaviorally. In recent years, however, we have identified ways to measure quality and, in doing so, have found ways to improve it. The challenge is to do the same thing with respect.

Background

Theoretical and philosophical discussions often trace the concept of respect to the philosopher Immanuel Kant in the late 1700s and discuss a myriad of variables involved in defining and displaying respect. Recent research has shown the construct to be very complicated and based on the perceptions of the beholder. While everyone may be able to provide their own definition of respect, the definitions will vary greatly from person to person. This is because the construct is multidimensional and it is affected by both environmental cues and culture.

Respect is important in the nursing profession. Beginning in the 1980s both the American Nurses Association and the American Association of Colleges of Nursing included respect in their conduct codes for nurses. The first provision of the ANA Code of Ethics (2001, p. 7) says that “The nurse, in all profes-
management would cause them to reconsider leaving (NurseWeek Publishing & AONE, 2002). Given those 
results, the investigators delved further into the respect 
issue in the follow-up survey in 2004 (Ulrich et al., 2005) 
and the results stimulated even more discussion. Results 
from the 2004 National Survey of Registered Nurses indi-
cated that more respect from front line management and 
from administration continued to be influential in whether 
RNs stayed in or left their current jobs. In addition, 71% of 
the RNs responding said that increased respect for nurses 
would help solve the nursing shortage. 

A question was also added to the 2004 survey with 
seven items that had been suggested by various authors 
as indicative of respect (i.e., involving nurses in decision-
making and listening to nurses’ concerns) and asked the 
participants if these items indicated respect to them. No 
item was selected by more than 43% of the respondents. 
Expanded literature reviews yielded very few studies in 
which respect was defined or conceptualized. In follow-up 
surveys, more respect from front-line managers and 
administrators continued to be two of the top four things 
that RNs say would cause them to reconsider leaving their 
current positions (Buerhaus, Donelan, Ulrich, DesRoches, & 
Dittus, 2007). Similar results were also found in two 
national surveys of critical care nurse work environments 
(Ulrich et al., 2006; Ulrich et al, 2009).

In presentations on the results of these studies, Dr. 
Ulrich often asked the audience members about their 
thoughts on respect. While nurses often cited respect as a 
key component of retention, job satisfaction, and a critical 
element in the delivery of safe patient care, few could pro-
vide a definition of respect or describe — without prompt-
ing — the behaviors that communicate or demonstrate 
respect. As the lack of clarity continued, the need for more 
in-depth study on respect in nursing became increasingly 
apparent. In 2008, Dr. Cindy Lefton and Psychological 
Associates joined what we now call The Respect Project to 
determine what RNs mean when they use the term ‘respect’ and what behaviors demonstrate respect. The 
plan for this long term research project includes directed 
interviews with a convenience sample of registered nurses 
and the development of an online instrument, leading to a 
large-scale survey of RNs to define respect in nursing and 
behaviors that indicate respect. This article reports the 
results of the initial interviews.

Methodology

Using a convenience sample, RNs were interviewed at 
hospitals and nursing conferences across the United 
States in 2008. Interview data included basic demo-
graphic information and open-ended questions concern-
ing the definition of respect and the behaviors that 
indicate respect. Questions were developed through a lit-
erature review and discussions with experienced RNs. 
Sixty-three (63) RNs from 27 different states participated 
in first round of interviews. Based on the first round 
results, several questions were modified. Forty-three 
RNs were interviewed in the second round.

Participants’ responses to questions were recorded 
verbatim. Results were analyzed using content analysis 
which allows for the discovery of general themes or pat-
terns to emerge.

Results — Respect To and From Colleagues

Participants were asked how they define respect, what 
behaviors show respect for them, and what actions/behav-
iors they use to convey respect towards people with whom 
they work. Five themes emerged (see Table 1). They are 
listed below along with samples of the direct quotations 
from the participants.

Listen, be fully attentive, and truly hear.

• “When you are talking and the person listening is 
  actually hearing you.”
• “By listening and not talking at the same time I’m 
  talking.”
• “When people listen to you and your opinions and 
  then take into consideration what you have to say 
  and where you are coming from.”
• “I wish they wouldn’t walk away when I am talking 
  to them.”
• “Valuing what they are saying even if it doesn’t mean 
  anything to me and valuing what it means to them.
• “When you are talking, they don’t talk over you.”
• “Being engaged.”
• “Be present in mind, spirit, and body.”
• “Eye contact.”

Acknowledge and express appreciation.

• “When you walk into a room, say hi.”
• “Acknowledge them, always make sure you say 
  something personal, tell them they are doing a good 
  job and let them know they are appreciated.”
• “If I tell them good things it comes from my heart, I 
  don’t fake it, if I tell good things then it’s really good.”
• “Acknowledge they are doing a good job, congratu-
late them, and speak highly about good people to
others because we must look out for each other.”
• “Don’t treat me like I am stupid. I may not have the knowledge base senior nurses have, but I’m not a stupid person, because if I was, I wouldn’t be here.”

Exhibit empathy and understanding.
• “Try to be considerate of people’s feelings and try to understand the thoughts and feelings behind their actions.”
• “Courtesy, mutual tolerance of others, and valuing what they are saying even if it doesn’t mean anything to me, valuing what it means to them.”
• “Be inclusive, include everyone, including the quiet folks, and ask opinions of everyone.”

Display courtesy and consideration.
• “With eye contact and by looking at them.”
• “Address people by their names and say please and thank you.”
• “M.D.s during rounds ask me do you have any questions, they acknowledge me.”
• “By overly trying to please people by saying thank you to convey my respect and willingness to be part of the team.”
• “Be available to help.”

Be accountable and professional.
• “Come to work on time.”
• “Follow through on what I say I will do.”
• “Not talking behind your back; if there is an issue, coming to you to discuss it.”
• “They tell me the truth.”

Results – Respect From Managers
In addition to the previously mentioned ways of conveying respect, nurses were also asked what other behaviors by their managers indicate respect. Four themes emerged and are listed below with examples of participant responses (see Table 1).

<table>
<thead>
<tr>
<th>Acknowledge staff.</th>
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<tbody>
<tr>
<td>“Asking my opinion on things and listening.”</td>
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<tr>
<td>“Acknowledging you and your accomplishments.”</td>
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<tr>
<td>“When they come in every morning and go to every room and say good morning to each nurse.”</td>
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<tr>
<td>“Some managers are too busy to say ‘hi,’ but they should go around and check in with people and acknowledge that they are all there.”</td>
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<tr>
<td>“Acknowledgement — when managers made it a point to come by and say ‘good morning’ and touch base with you.”</td>
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<table>
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<tr>
<th>Communicate and provide for information exchange.</th>
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<tr>
<td>“Following through on what we talk about, doing what they say they will do and having closure on the issue whether it went the way I wanted or not is not important, just that it was dealt with.”</td>
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<td>“I want them to be up front, if I do something I want to know.”</td>
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<tr>
<td>“Greet me with a positive attitude, listen, be approachable, and easy for you to open up to.”</td>
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<tr>
<td>“GETS back to you in a timely manner and being generally helpful in needs requests and if they don’t have an answer, they will get back to you.”</td>
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<tr>
<td>“Returning e-mails in a timely fashion, keeping you in the know, acknowledging you, and sending out global information so we know what’s going on.”</td>
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<tr>
<td>“Not being so overextended that you don’t have time to participate in your unit, by saying my door is always open but really there is no time for that.”</td>
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<tr>
<td>“Having an open-door policy and meaning it.”</td>
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<th>Table 1: Indicating Respect – Themes</th>
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<tr>
<td>Respect To and From Colleagues</td>
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<td>• Listen, be fully attentive, and truly hear.</td>
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<td>• Treat others as you want to be treated.</td>
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<tr>
<td>• Acknowledge and express appreciation.</td>
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<tr>
<td>• Exhibit empathy and understanding.</td>
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<td>• Display courtesy and consideration.</td>
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<td>• Be accountable and professional.</td>
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<td>• Acknowledge staff.</td>
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<tr>
<td>• Communicate and provide for information exchange.</td>
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<tr>
<td>• Ask staff for their opinions and for what they need.</td>
</tr>
<tr>
<td>• Be supportive, fair, consistent, and empathetic.</td>
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</table>
Ask staff for their opinions and for what they need.

- “When they listen and ask my opinion it means they respect my ideals.”
- “Understand people have different needs, some have more experience or less experience, just be a second resource.”
- “Always ask questions about my concerns.”
- “Asking our opinions on things.”
- “Being open for criticism and honest input.”
- “Listening to problems and suggestions.”

Be supportive, fair, consistent, and empathetic.

- “Manager allows me to function independently and is always there to support me.”
- “Supporting the team as a whole, not just the day shift or the night shift, or senior nurses or less senior nurses, but keeping a good balance.”
- “When they consider my situation sometimes.”
- “Implement and practice what you preach; don’t be fake or plastic.”
- “When there is an issue they do try to listen to the whole issue, they get both sides and try to stay diplomatic.”
- “Do what they say they are going to do.”

Conclusions

Based on these interviews, five themes were identified in describing respect to and from colleagues and four themes were identified in describing respect from managers. These themes offer us further insight into an operational definition of the term ‘respect’ as used by nurses.

The question of what individuals mean when they talk about respect is an important one. This research, though in a preliminary stage, supports the need for nurses to initiate a dialog with each other and with other healthcare colleagues about what respect means and what behaviors best convey respect.

References


The Respect Project

We need your help in the next phase of The Respect Project. Beginning July 1, 2009, we will begin using an online version of The Respect Project tool. We would like your input on what respect means to you, what behaviors indicate to you that you are respected by others, and what behaviors you exhibit when you respect others. The survey tool will be available online on the Center for American Nurses website at www.centerforamericanurses.org. Please take a few minutes of your time and fill it out.

About the Authors

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Disruptive Behavior and Conflict in the Workplace: Enhancing Skills for Managers

By Diane E. Scott, RN, MSN

One of the most challenging aspects of being a manager is dealing with occurrences of disruptive behavior in the workplace. While overt types of disruption such as physical aggression or verbal threats may be resolved with immediate discipline or termination, less obvious behaviors such as gossip, teasing, and withholding information present more complex situations for managers and undermine patient safety. Enhancing conflict engagement skills can not only improve your ability to connect with colleagues but enhance your work satisfaction as well.

The Costs of Covert Disruptive Behaviors

Most employees can describe in detail their experiences with disruptive behaviors. And covert disruptive behaviors can be so deeply entrenched within the culture of a work environment that it is considered “normal” behavior. It is not unusual to see employees creating elaborate “work-arounds” to compensate for a colleague who exhibits disruptive behavior if their demands are not met. In other cases, newly hired employees or students may be expected to “pay their dues” by accepting less than fair assignments or schedules, thus creating an uneven distribution of power between peers.

Other examples of more passive forms of disruptive behavior include intimidation, failure to assist when needed, intentional damage to reputation or exclusion from social interactions (McKenna, Poole, & Coverdale, 2003). The cost of such behaviors is significant and range from physical and emotional illness to increased errors, task avoidance and lower staff morale. The table below lists documented effects of unresolved conflict (Gerardi, 2004).

Avoidance

One of the most frequent strategies used by managers to confront disruptive behaviors is avoidance. The reasons why many leaders avoid confronting the more covert forms of disruptive behavior can vary. For some, the perception

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<th>Direct Costs</th>
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<tr>
<td>• Litigation costs</td>
<td>• Poor morale</td>
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<tr>
<td>• Loss in productivity</td>
<td>• Loss of opportunities</td>
</tr>
<tr>
<td>• Turnover</td>
<td>• Increase in overall costs</td>
</tr>
<tr>
<td>• Workman’s compensation and disability/</td>
<td>• Tarnished reputation</td>
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<tr>
<td>stress claims</td>
<td>• Negative impact on market position</td>
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<tr>
<td>• Fines or loss of contracts or both</td>
<td>• Changes in morale and behavior of staff</td>
</tr>
<tr>
<td>• Increased cost for adverse patient outcomes</td>
<td>• Increase in disruptive behavior</td>
</tr>
<tr>
<td>• Sabotage and criminal acts</td>
<td>• Emotional suffering</td>
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exists that the amount of time it takes to address such behaviors is prohibitive, while others lack the skills or knowledge to facilitate critical conversations with the involved employees.

Regardless of the reason, using avoidance as a means to deal with conflict allows decisions to be determined by default rather than a deliberate process to address the issues at hand (Cavanagh, 2004, Valentine, 2001). Moreover, it only delays the inevitable recurrence of the behavior while disruptions may continue to infiltrate and infect the entire culture of the work environment.

While it is a common belief that some people are not “naturally good” at managing conflict, engaging in conflict is a skill that can be learned and practiced. Transforming a leader’s natural reaction from avoidance to one of engagement requires that a leader gain the skills and integrate processes and accountabilities for workplace communication regardless of the work setting.

**Assessing the Workplace Environment**

The first step in positively managing conflict is to assess the current work environment. While multiple tools are available to help with the assessment process, it is important that the process be succinct, confidential, and allows every employee to participate.

As part of a United States Department of Health Resources and Services Administration grant application, the Center for American Nurses (2008) developed a tool to assess nurse’s opinion of conflict within the workplace. This web-based tool addresses the prevalence of conflict within the workplace, confidence in addressing conflict, and solicits individual’s preferred training format.

An assessment survey also provides the grounding for beginning the dialogue to address conflict and disruptive behaviors and provides insight into specific areas of concerns noted by staff.

**Developing the Skills for Managers**

Frequently managers demonstrate great proficiency within their practice area but may not be comfortable addressing disruptive behavior. In particular, new managers are rarely prepared to deal with conflict nor are they given the proper mentoring or education needed to deal with disruptive behaviors.

Our work environments are melting pots of cultures, philosophies, and values. We bring our personal experiences and perceptions to every situation so conflict naturally arises. Looking at conflict with a fixed mindset can limit the options available to resolve conflict. However, employing simple strategies such as examining your contribution to the conflict can lead to greater personal flexibility and more options for successful engagement.

Even leaders who have had previous education and training with conflict may identify the need to become more proficient in navigating today’s complex work environment. As nurses become confident in dealing with conflict, cultural transformations occur more rapidly thus moving teams of individuals to a higher level of functioning.

**Addressing the Workforce**

Just as with any new skill set, becoming competent requires more than one step. First, the knowledge behind the theory should be given. Then, the opportunity to “practice” the conversations and dialogues should be provided to integrate specific and descriptive codes of conduct.

When offering educational opportunities to employees, it is important that every team member utilize the same terminology as their co-workers. Web-based programs work well for settings that are unable to free-up entire teams for training or where there is multiple settings thus making class time prohibitive. A program should also be selected for its applicability to the work setting. In particular, utilizing case-based scenarios that participants are familiar with can be very effective.

In addition, face-to-face training reinforces the educational component and allows participants to practice their new skills. On-site training with small groups is desirable so that the instructor can facilitate feedback and dialogue. Specific templates for discussion should be given to participants to increase their comfort levels with conflict discussions as well as opportunities for feedback within their small group sessions.

An on-site training component also provides an opportunity for organizations to clarify expectations regarding professional conduct. Discussing behaviors that will not be tolerated as well as expectations of staff when they encounter disruptive behaviors is critical. Obtaining employees’ agreement to adhere to these behaviors and conveying the consequences for the behaviors must be clearly delineated.

**The New Expectations**

Managers who are conflict competent will understand conflict dynamics and demonstrate skills for engaging in conflict, an open mindset and reflective practices. By serving as role models and resolving issues you can restore trust within your team and incorporate healthier communications in your workplace.
References


About the Author
Diane E. Scott, RN, MSN, is the Program Director for the Center for American Nurses, Conflict Engagement Program which offers an unprecedented approach at helping organizations and individuals learn the skills of successful conflict engagement. She can be reached at dianescott@CenterforAmericanNurses.org.
Career Coach,

I am currently a Charge Nurse at the hospital where I have worked for 10 years. I supervise 9 nurses, serve on various committees and am responsible for administrative duties, education and employee management. I will be graduating with my Master’s degree in a couple of months, and I need to make a decision about my next steps. If I stay, I would very much like to have my title changed to Nurse Manager with a corresponding increase in pay, since my current responsibilities are in line with that title and compensation. I have broached the subject informally to my supervisor, and the response has been lackluster. My reputation with my colleagues at the hospital is very good. I have put together a proposal listing my accomplishments and the results of my market research, but I am not sure where to go from here. Who should I talk to and what approach should I take?

Needing Clarity

Dear Needing Clarity,

First of all, your idea of a proposal makes sense. It’s important to make a solid case about your contributions and the value you bring to the organization when asking for a raise of promotion.

Before approaching your boss about your request, here are some things to consider:

1. Even if you intend to stay with your current organization, look at external opportunities so that you know your own value.
2. Take a look at the individuals with whom you interact and who may have input in any decisions about your career trajectory. Using positive, neutral and negative, rank each person in terms of your relationship with them, your communication with them and your ability to exchange information with them. To maximize your relationships and increase your visibility, you want to give positives a reason to stay positive, move neutrals to positive and neutralize the negatives.
3. Approach your HR department with your hypothetical situation for some friendly advice about the best way to proceed.
4. Without veering outside the chain of command, approach the most senior person you can to improve the likelihood that any decisions made about your title and compensation will stand.
5. Tailor your conversation to the perspective of the person listening.

Some possible conversation starters:

- I need your help with something…
- I have something I want to accomplish and I need your help to get it done…

Briefly cover 2 or 3 points in each area: your accomplishments, your ideas and the results of your market analysis, then stop. To end the conversation, ask “is it possible for me to get this name change and increase in compensation?” If the answer is no, ask if it the change you desire can happen at a future date.

Be positive, prepared, confident and polite. Remember to let the person know how much you love working there and appreciate the fact that you have a job.

Good luck!

Marlanda English, Ph.D.

Dr. English, a valuable member of the Center’s coaching team, recently passed away. She will be missed by her family, colleagues and friends. To learn more about the Center’s coaching program, please visit www.centerforamericannursescoaching.org.
The path to career satisfaction is personal.

The Center for American Nurses is proud to bring you a coaching program designed to connect registered nurses with professional coaches specializing in the diverse aspects of a nursing career.

A professional coach can help you:

• **Evaluate your career choices** through the lens of your strengths, values, and long-term personal and professional goals.

• Look at the way your current choices impact your **work-life balance** and identify the changes that will have the biggest impact on your personal and professional satisfaction.

• **Develop more confidence**, create strategies to improve your visibility and promote-ability and give you a safe place to practice critical conversations.

• **Objectively assess your leadership, communication, or conflict skills** and provide you with tools you can use immediately to increase your emotional intelligence and become more effective both personally and professionally.

• Identify strategies to deal with a **difficult situation at work**.

Career and Work-Life Balance Tele-Seminars

Tele-seminars, led by members of the Center’s coaching team, are available. Topics range from How to Deal with Layoffs to Strategies for Managing Fatigue. Program materials are provided for each tele-seminar. To register go to www.CenterforAmericanNursesCoaching.org
The Nurse Licensure Compact — Ten Years Later

LaTonia Denise Wright, RN, BSN, JD

Multi-state licensure, interstate practice, and mutual recognition are synonyms for the practice of allowing a nurse to obtain a license in the state of residence, the home state, and granting a privilege to practice in the home state and across state lines in remote states (NCSBN, 2008). The purpose of the Nursing Licensure Compact (NLC) is to eliminate the need for a nurse to obtain an individual license in each state of practice via the traditional licensure by endorsement process, which varies from state to state and can be cumbersome (Schaffer & Sheets, 2001). States first joined the compact in 1999 and ten years later the implications of the NLC are still being examined.

Laura Poe, MS, RN, Executive Administrator, Utah State Board of Nursing (2008) noted the single-state licensure model for nursing regulation began in 1903 and a more current model, the compact, is needed to reflect today’s times of telenursing and multistate practice because nursing practice is no longer confined to a patient room, healthcare facility, or state boundary. The compact eliminates the need for nurses to obtain multiple state licenses as they provide physical, telephonic, or electronic nursing care or follow-up care to patients in different states. Roy Simpson, RNC, FNAP, FAAN (2008) stated that e-health and telehealth offer an avenue to provide quality care to underserved populations and the evolution of nursing regulation from state-based to national and international licensure has already begun with the compact because state-based licensure and regulation of nursing practice impedes caring on a national and a global scale.

How it Works

A national law governing nursing practice does not exist since regulation is viewed as a state issue in accordance with the Tenth Amendment to the United States Constitution (NCSBN, 2008). Therefore, in order to participate in the Nurse Licensure Compact, a state must enact legislation or regulation authorizing the compact. The legislation provides additional regulatory authority specific to granting privileges and sharing information. States entering the compact also adopt administrative rules and regulations to further facilitate implementation of the NCL.

For example, the Commonwealth of Kentucky became a Nurse Licensure Compact state on March 28, 2006 when Governor Fletcher signed the Kentucky Nurse Licensure Compact Bill (HB 102). The NLC was implemented in Kentucky June 1, 2007. Compact provisions were incorporated into the Kentucky Nurse Practice Act and the Kentucky Board of Nursing regulations.

How does this work practically? A registered nurse or a licensed practical nurse whose primary state of residence (home state) is Kentucky, which is now a compact state, is issued a license by the Kentucky Board of Nursing and no longer needs individual licenses to practice in other compact (remote) states. However a nurse who lives and resides in Indiana (a non-compact state) or Ohio (a non-compact state) and applies for a Kentucky nursing license is issued a nursing license valid only in the Commonwealth of Kentucky (single state license) because neither the State of Indiana nor the State of Ohio participate in the NLC.

A separate body composed of NLC administrators representing each compact state was established to manage the process and develop compact rules (NCSBN, 2008). In addition, an online license verification system — Nursys.com — has been made available for employers and the general public to rapidly verify a nurse’s NLC status as well as any disciplinary action that has been noted (NCSBN, 2009).

What about APRNs?

The NLC addresses licensure for registered nurses and licensed practical nurses only (Schaffer & Sheets, 2001). In 2002, the National Council of State Boards of Nursing (NCSBN) Delegate Assembly approved model language for a compact specific to advanced practice registered nurses (APRNs). The APRN compact offers states the mechanism for mutually recognizing APRN licenses/authority to practice. States must adopt a NLC for RNs/LPNs prior to adopting a compact for APRNs; however, a state can simultaneously adopt a NLC for RNs, LPNs, and APRNs (Schaffer & Sheets, 2001). Although Utah, Iowa, and Texas have all passed APRN compact legislation, there are no nurses practicing pursuant to the APRN compact (Schaffer & Sheets, 2001).
Is my state a member of the compact?
Of the 50 states, 23 joined the compact. Below is a list of participating states.

<table>
<thead>
<tr>
<th>State</th>
<th>Date Joining</th>
<th>State</th>
<th>Date Joining</th>
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<tbody>
<tr>
<td>Arizona</td>
<td>7/1/2002</td>
<td>New Mexico</td>
<td>1/1/2004</td>
</tr>
<tr>
<td>Colorado</td>
<td>10/1/2007</td>
<td>North Dakota</td>
<td>1/1/2004</td>
</tr>
<tr>
<td>Delaware</td>
<td>7/1/2000</td>
<td>Rhode Island</td>
<td>7/1/2008</td>
</tr>
<tr>
<td>Idaho</td>
<td>7/1/2001</td>
<td>South Carolina</td>
<td>2/1/2006</td>
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<tr>
<td>Iowa</td>
<td>7/1/2000</td>
<td>South Dakota</td>
<td>1/1/2001</td>
</tr>
<tr>
<td>Kentucky</td>
<td>6/1/2007</td>
<td>Tennessee</td>
<td>7/1/2003</td>
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<tr>
<td>Maine</td>
<td>7/1/2001</td>
<td>Texas</td>
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<td>Maryland</td>
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<td>Mississippi</td>
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<td>Virginia</td>
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<td>Nebraska</td>
<td>1/1/2001</td>
<td>Wisconsin</td>
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<td>New Hampshire</td>
<td>1/1/2006</td>
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Implications for the Future

Nursing licensure by endorsement is still the prevailing manner of obtaining a nursing license and practicing as a nurse in another state (Schaffer & Sheets, 2001). Licensure by endorsement is the process of obtaining a nursing license in a state or jurisdiction other than the state of original nursing licensure. A wide gap still exists between states utilizing the nursing licensure via endorsement process and states utilizing the NLC. However, it is important to note this gap is slowly closing as more states join the compact.

The multi-state licensure approach was intended to expedite access to qualified nurses by simplifying licensure processes and removing regulatory barriers. The ability to expedite the licensure process appeals to both nurses and employers and facilitates mobilization of nurses during times of national disasters. While the NLC facilitates license portability some states have adopted the Uniform Emergency Volunteer Health Practitioners Act which provides license reciprocity and offers legal protections that address specific concerns related to emergency deployments (National Conference of Commissions on Uniform State Laws, 2006). The act has been introduced in 19 state legislatures however, only six states have adopted it.

With the growing use of telenursing, telehealth, and looming pandemics, the need for nurses to work across states lines is evident. The NLC is the model most states have adopted to reduce regulatory barriers; however, pros and cons remain a topic of debate by nurses regardless of education, role, specialty, or title.

The Center for American Nurses is pleased to present a legal webinar discussing the pros and cons of the professional, legal, and regulatory aspects of the Nursing Licensure Compact for nurses in today's workforce. The webinar, Nursing Licensure Compact: Pros and Cons is scheduled for September 16, 2009 from 7 p.m. to 8:15 p.m. ET.

References

About the Author
LaTonia Denise Wright, R.N., B.S.N., J.D. is a licensed RN (Ohio) and an attorney in private practice. Her law practice is limited to representing, counseling, and advising nurses in licensure and professional practice matters in Ohio, Kentucky, and Indiana. She is also a consultant for the Center for American Nurses. Ms. Wright is a former Center Board Member (2004-2006) and served as editor of the Center’s legal monograph, Legal Basics for Professional Nursing Practice (2006). She is a member of the Center for American Nurses, Ohio Nurses Association and the American Association of Nurse Attorneys. Ms. Wright can be reached via email at ldw@nursing-jurisprudence.com.
Networking for Nursing Introverts

Diane E. Scott, RN, MSN

As a nurse, I rarely have problems talking to patients or families, but I really have difficulty making small talk with other professionals. To begin with, I rarely see other nurses outside my department. When I am at a meeting or a social function with people I don’t know, I am exhausted when I get home. As an introvert, how can I learn to network?

This statement echoes the thoughts and feelings of many nurses across the nation. According to businesspundit.com, 70% of the world’s population are extroverts. For the remaining 30%, making important professional connections through networking is a difficult but vital step to career enhancement and growth. Talented and gifted nursing professionals who do not learn the skills for successful networking may never have the opportunities to showcase their knowledge or help others with their experiences.

Whether you are an introvert or an extrovert, networking is important. Successful networking involves meeting new people and dialoguing with them. You need to be able to develop professional relationships with others that are mutually beneficial, and networking allows you to open the doors to form those relationships.

To an extrovert, this type of interaction may seem natural. Conversely, introverts may be horrified at the thought of talking to a stranger or uncomfortable promoting themselves. Fortunately, introverts can develop skills for networking. Here are some tips that may help:

Making Networking a Habit

Meghan Wier is the author of “Confessions of an Introvert: The Shy Girl’s Guide to Career, Networking and Getting the Most Out of Life.” She suggests that people need to think of networking as part of your job. Regardless of how busy your life is, set goals to network on a routine basis. She states that sending emails to past coworkers, fellow students or past bosses can reestablish great contacts — even if the email is just to say “hello.”

The Art of Small Talk

Nancy Fenn, of introvertzcoach.com, coaches introverts to start by learning how to initiate small talk. By using basic opening lines, such as “What’s new?” or asking a person a question about themselves, you are using a mechanism that allows the larger populations of extroverts to talk about themselves. Extroverts, she concurs, enjoy being asked questions about themselves and more introverted people are their perfect audience. She states, “In some cases, people will wind up thinking you’re a fascinating person because in your presence they hear themselves say fascinating things.” Fenn suggests compiling a list of opening statements and questions that are “small enough” that no one is antagonized and is geared to include as many people as possible. She recommends avoiding topics such as religion and politics so that others can join the conversation.
Networking at Conferences

For nurses who are extroverts, conferences or meetings are a prime opportunity to get to meet and reestablish connections with others. However, if you are an introverted nurse, groups of unfamiliar people can be very uncomfortable. To make the most of a conference, choose the venues you are most comfortable with when selecting break-out sessions. To some introverts, large groups may be more comfortable because they offer anonymity, but, to others, small break out sessions are much less intimidating.

Regardless of the room size, use the conference to practice small talk. Find a person who is alone and sit next to them during a session. Try asking where they are from or what their specialty is. Every opportunity you get to meet someone at the conference is a chance to establish a new relationship.

Use Email

Penelope Trunk’s article, Networking for introverts: A 5-step plan, published on BankRate.com, suggests that introverts use email as a way of making connections. She stated the advantages of being able to “write and rewrite your message until it’s right” and not having to worry about saying something silly and inappropriate to a person. While the closeness of a personal meeting may be lost by using the Internet, she suggests compensating by sending an extra email to the person to establish a connection.

Helping Others

Trunk also suggests that helping others is an excellent way of collecting a team of contacts. For instance, sending leads to others for jobs or projects is an excellent way of reaching out to others. People are grateful for leads that help them and will often reciprocate in some manner in the future.

While there are a myriad of resources that teach various networking techniques for both introverts and extroverts, the consensus is that the biggest mistake is to avoid networking altogether. Whether you are an introvert or an extrovert, making networking part of your career journey is vital to your career, and your experience and expertise benefits others. Regardless of where you are in your nursing career, we hope that you will benefit from this series as well as the other products and services offered at the Center for American Nurses. For more information, please contact the Center at www.centerforamericannurses.org.

References


**WISERWoman**

**Less Stress in a Stressed Economy**

I magine this: Enough money to pay all of your bills each month, a savings account to get you through a rough time, and money set aside for your retirement. Sound impossible? You’re not alone.

Right now, experts agree that too many families are on the edge financially—living paycheck to paycheck, without any savings. Even worse, the family paycheck often doesn’t cover the monthly bills, so routine expenses like gas, food and medicine are going on the credit cards.

The stress that comes with being on shaky ground with your finances is significant. Gas prices, a credit crunch and rising unemployment are causing Americans to take a closer look at their household finances. Fortunately, we can all take steps to put ourselves on sounder footing. It is important to our well-being that we are prepared for tough times.

Getting started is often the hardest part. If you are worried about your financial future, don’t ignore the warning signs any longer. Begin to take steps to move in the right direction.

**Getting a Grip**

If you sense that you are already in trouble, get professional help. For one-on-one credit counseling, contact the National Foundation for Consumer Credit at 800-388-2227 or www.nfcc.org. This non-profit group will help you work out a plan to get your finances in order.

Start organizing your finances. Begin by asking yourself how you will pay your bills if you, your spouse or partner loses a job. This is an intimidating question, but facing it and making a plan is one key to financial security. Unexpected things happen to all of us at some time. Losing a job, an illness and similar problems can be better managed if you have a solid back-up plan.

Resolve to save at least three to six months of living expenses for emergencies. Sign up for a monthly, automatic deposit into your savings account. If you have little in savings right now, aim for putting up to 10 percent of your salary away every month for emergencies—or start with less if you can’t manage that much. Don’t touch your emergency fund except for true emergencies.

Review your household budget, or create one if you don’t have one, and then stick to it. If you go to the store for lunch meat, don’t buy anything else. American families spend about 1 percent each year more than their household income and have more debt than ever before.

If your monthly expenses exceed your income, you need to make immediate changes in your spending habits. Reduce expenses so that you are spending less than you bring in each month. Take a close look at your spending habits for a month and find areas to economize. WISER's website has suggestions for reducing expenses and saving more money.

If it makes sense to carpool with a few of your co-workers, take the initiative and organize one. Simple steps are often enough to put your budget on track. Studies show that families that live with a budget save more and are on sounder financial footing.

Make a plan to pay off your debts, particularly high interest credit cards. Using credit can quickly become a vicious cycle as interest payments eat up a bigger and bigger share of the household budget, and families charge living expenses to fill the gap. The average family has about $10,000 in debt, not including their mortgage! If you pay only the monthly minimum, you will not pay off your debt for decades.

If some of your debts are too large to pay off in the short-term, consider trying to reduce your interest rate. Refinance a car loan, or ask a credit card lender to reduce your interest rate. Postpone purchases until your debt is paid down. Don’t be late on credit card payments. Many lenders raise interest rates sharply when payments are late or missed.

**WISER's website has tools for creating a household budget, managing credit, saving and investing. Use these tools to face facts—your financial facts—and take control of your financial future. www.wiserwomen.org**
Past and present! Keeping track of old pensions and 401(k)s

Shortly before retiring at age 71, Carmen D., of Maryland, realized she still had some important work left to do. So, instead of planning a retirement party, Carmen spent her last few months in the workforce searching for retirement money she had earned from pensions and 401(k)s at previous jobs. “I worked for several employers—the federal government, a couple of nonprofits,” Carmen says. “When I got ready to retire it was very hard for me to track down what I had with whom.”

Complicating matters further, one company had changed its name since Carmen left. “Women need to be their own advocates and reach out and find the correct information,” Carmen says. She suggests staying in touch with past employers and knowing who the pension plan administrators are from year to year, “so you know where to go for answers. It can get pretty complicated.”

Do you know where your retirement plans are? The Pension Action Center has a publication that may help you in your search. Go to www.pensionaction.org and click on Publications, Finding a Lost Pension.

Another valuable resource is the Pension Benefit Guaranty Corporation (PBGC). For over a decade, its Pension Search Directory has helped individuals locate their lost pensions. The online service is free and available 24 hours a day. Go to www.pbgc.gov and click on Pension Search Directory. PBGC does not recommend that individuals pay for a firm’s help when free services exist, such as their own. In 2007, PBGC reported $133 million in unclaimed pension benefits.

6 Ways to Succeed with Money

1. **Don’t Wait! Pay Yourself First:** You know this, but it doesn’t hurt to hear it again. Close your eyes, hold your nose and try to put 10 percent of your gross income into a forced savings plan. If your employer offers a 401(k) plan, take advantage. Invest in an IRA. Once you start, you won’t miss it.

2. **Short-Term Investments:** Are you saving up to buy a house in a year or two? Then don’t put your money into long-term investments such as stocks or bonds—their value will most likely fluctuate over the short-term. Instead, consider when you will need the cash. Try investing in money market mutual funds, bank savings accounts, or bank CDs. The chance of earning big returns is not as high, but your risk of losing some or all of your principle is significantly lower. You can select short-term investments where your return on principle is a guaranteed 100 percent. This means that when you’re ready to buy your house, your money will be there. The same idea applies to debt. Your credit cards are not intended to be used for long-term purchases. Credit cards have a very high rate of interest. If you don’t have the cash to pay for your purchase of something big — for example a washer and dryer — plan ahead and take out a personal loan at a rate that is lower than what your credit card would charge you. Try not to use your credit card when you know you will not be able to pay the entire balance when you receive the monthly statement.

3. **Long-Term—Investing for Your Future:** Saving for your children’s education or your retirement? These are longer term investments. Do some research. Consider index funds. These provide cost savings and risk diversification.

4. **Understand Asset Allocation:** You can lessen your risk if you divide your resources among different categories such as stocks, bonds, mutual funds, real estate, insured bank deposits, and life insurance. The idea is that each asset group has a different correlation to the others; so, when stocks rise, bonds often fall, or when stocks fall, the real estate market may begin generating above average returns. The amount

**Using credit can quickly become a vicious cycle as interest payments eat up a bigger and bigger share of the household budget.**

**Contact the National Foundation for Consumer Credit at 800-388-2227 or www.nfcc.org.**
that you allocate to the various classes depends on your financial goals and timeline. You will want to readjust your allocations periodically, as your life circumstances change, or invest in a “target retirement fund” that does this automatically.

5. Recognize Depreciating Assets: When you take a brand new car or HD-TV or any other asset off the lot or out of the store, its value depreciates—immediately. Instead of buying new, look for a good used vehicle that will be more affordable.

6. Don’t Spend Your Retirement Money Before You Retire!

Figured Out How Much Money You Will Have?

Let Retirement Calculators Do the Math

- The Social Security Administration (SSA) currently has four online Benefit Calculators—Quick, Online, Windfall Elimination, and Detailed—available to help individuals understand and predict their future Social Security benefits. A new calculator, the Retirement Estimator, will allow users to factor in “what if” scenarios regarding future earnings and various retirement dates. Access SSA’s Benefit Calculators by going to http://www.ssa.gov/planners/calculators.htm.

- Fidelity Investments offers a free calculator called myPlan Snapshot, which predicts future retirement income following a few questions regarding current savings and investments. The tool is quick and easy to use. Access it online at www.fidelity.com/myplan.

- T. Rowe Price’s Retirement Income Calculator is a useful tool in predicting how much — and how fast — you will be able to draw down on your retirement savings once you actually retire. Using what is known as the “Monte Carlo Simulation” method, T. Rowe provides a more realistic assessment by accounting for 500 various, fluctuating market returns, instead of one average rate of return over a period of time. Access this calculator online at http://www3.troweprice.com/ric/RIC/.

About the Nurses’ Investor Education Project

Opportunities, Challenges, and Moving Forward

The Center for American Nurses and the Women’s Institute for a Secure Retirement (WISER) have formed a retirement project partnership called the Nurses’ Investor Education Project. It is a three-year project funded by a grant from the FINRA Investor Education Foundation.

The Nurses’ Investor Education Project Goals:

1) Understanding nurses’ financial knowledge with a special focus on their understanding of and preferences for investment education;

2) Changing nurses’ investment behavior and planning; and

3) Creating investor education materials, activities, and a training program that will provide benefits beyond the conclusion of the project.

The Women’s Institute for a Secure Retirement (WISER), launched in 1996, is the only non-profit organization dedicated exclusively to providing education to improve the long-term financial quality of life for women. WISER is funded by both public and private grants, including eight years of grant funding from the U.S. Administration on Aging to develop financial education for minority and low-income women.
Handoffs: Implications for Nurses

Mary Ann Friesen, Susan V. White, Jacqueline F. Byers

The Agency for Healthcare Research and Quality (AHRQ) recently published a new book, *Patient Safety and Quality: An Evidence-Based Handbook for Nurses.* (AHRQ Publication No. 08-0043). This comprehensive 1400 page handbook for nurses provides valuable information for nurses on patient safety and quality, evidence-based practice, patient centered care, working conditions, and work environment for nurses. The following article is an excerpt from Chapter 34 of this handbook. The complete book is available online at www.ahrq.gov/qual/nurseshdbk.

The term “handoff” will be used and defined as, “The transfer of information (along with authority and responsibility) during transitions in care across the continuum; to include an opportunity to ask questions, clarify and confirm”23 (p. 31). The concept of a handoff is complex and “includes communication between the change of shift, communication between care providers about patient care, handoff, records, and information tools to assist in communication between care providers about patient care”1 (p. 1). The handoff is also “a mechanism for transferring information, primary responsibility, and authority from one or a set of caregivers, to oncoming staff”17 (p. 1). So, conceptually, the handoff must provide critical information about the patient, include communication methods between sender and receiver, transfer responsibility for care, and be performed within complex organizational systems and cultures that impact patient safety. The complexity and nuance of the type of information, communication methods, and various caregivers for each of these factors impact the effectiveness and efficiency of the handoff as well as patient safety.

Background

The transfer of essential information and the responsibility for care of the patient from one health care provider to another is an integral component of communication in health care. This critical transfer point is known as a handoff.1–3 An effective handoff supports the transition of critical information and continuity of care and treatment. However, the literature continues to highlight the effects of ineffective handoffs: adverse events and patient safety risks.4–11 The Institute of Medicine (IOM) reported that “it is in inadequate handoffs that safety often fails first”15 (p. 45). This chapter presents an overview of handoffs, a summary of selected literature, gaps in the knowledge, and suggestions for quality improvement initiatives and recommendations for future research.

What Is a Handoff?

First one needs to recognize the term “handoff” and synonymous terms that are used in a wide variety of contexts and clinical settings. There are a number of terms used to describe the handoff process, such as handover,1 13, 14 sign-out,15, 16 signover,17 cross-coverage,18, 19 and shift report20–22 For the purpose of this discussion, the term
Table 2. Strategies to Improve Handoff Communication

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Example</th>
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<tbody>
<tr>
<td><strong>1</strong> Use clear language and avoid use of abbreviations or terms that can be misinterpreted.</td>
<td>During the reconciliation process, the nurse noted a medication that is usually administered once daily being given every other day. The handwritten order for daily was written QD but read as QOD. QD and QOD are on the Joint Commission official “Do Not Use” list. According to the list, “daily” should be written instead of QD and QOD should be written as “every other day.”</td>
</tr>
<tr>
<td><strong>2</strong> Use effective communication techniques. Limit interruptions. Implement and utilize read-backs or check-back techniques.</td>
<td>In the middle of a shift handoff, the unit clerk interrupts the nurse to inform her that a patient needs assistance to go to the bathroom. The nurse must leave report to assist the patient or find a nurse’s aide to help the patient. During this interruption, the off-going nurse is in a rush to leave and get her son from child care. Due to the need to leave quickly, the offgoing nurse forgets to document and report to the oncoming nurse that a patient fell right before the shift change. Efforts need to be made to ensure adequate staffing during shift report to minimize interruptions.</td>
</tr>
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<td><strong>3</strong> Standardize reporting shift-to-shift and unit-to-unit.</td>
<td>The surgical unit standardized shift-to-shift handoff report with a one-page tool that is used for each patient, thereby providing a comprehensive, structured approach to providing the critical information on new and recovering postoperative patients.</td>
</tr>
<tr>
<td><strong>4</strong> Assure smooth handoffs between settings.</td>
<td>One of the busiest units in the hospital is the emergency department (ED). Patients must be discharged or moved quickly out of the ED to an inpatient unit. To ensure rapid patient flow, a new handoff process is established that includes a phone call to the receiving unit, the assignment of an admission nurse so that there are no delays on the receiving unit, telephone report so the receiving unit can prepare any special equipment, and then a final verbal handoff between the two nurses while viewing the patient to verify the condition of the patient and ensure no changes from one setting to another.</td>
</tr>
<tr>
<td><strong>5</strong> Use technology to enhance communication. Electronic records can support the timely and efficient transmission of patient information.</td>
<td>The hospital has an electronic record and utilizes portable computers. Walking rounds are made by the offgoing and oncoming nurse using the portable computer and visiting each patient for introductions and quick visual assessment. The use of this technology allows the nurse to view the patient’s plan of care, medications, and IVs at a glance to prepare for care during the next shift.</td>
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Why Is There a Problem With Handoffs Today?

As health care has evolved and become more specialized, with greater numbers of clinicians involved in patient care, patients are likely to encounter more handoffs than in the simpler and less complex health care delivery system of a few generations ago.11 Ineffective handoffs can contribute to gaps in patient care and breaches (i.e., failures) in patient safety, including medication errors,15, 24 wrong-site surgery,3 and patient deaths.4, 7 Clinical environments are dynamic and complex, presenting many challenges for effective communication among health care providers, patients, and families.25–27 Some nursing units may “transfer or discharge 40 percent to 70 percent of their patients every day”28, thereby illustrating the frequency of handoffs encountered daily and the number of possible breaches at each transition point.

What contributes to fumbled handoffs? An examination of how communication breakdown occurs among other disciplines may have implications for nurses. A study of incidents reported by surgeons found communication breakdowns were a contributing factor in 43 percent of incidents, and two-thirds of these communication issues were related to handoff issues.29 The use of sign-out sheets for communication between physicians is a common practice, yet one study found errors in 67 percent of the sheets.30 The errors included missing allergy and weight, and incorrect medication information.15 In another study, focused on near misses and adverse events involving novice nurses, the nurses identified handoffs as a concern, particularly related to incomplete or missing information.37

Where Do Handoffs Occur?

Handoffs occur across the entire health care continuum in all types of settings. There are different types of handoffs from one health care provider to another, such as in the transfer of a patient from one location to another within the hospital31 or the transition of information and responsibility during the handoff between shifts on the same unit.1, 14, 43 Interdisciplinary handoffs occur between nurses and physicians, and nurses and diagnostic personnel, while intradisciplinary handoffs occur between physicians3, 15, 31 or between nurses.13, 14, 41, 42, 43 Interfacility handoffs occur between hospitals and among multiple organizations,68 including home health agencies,69, 70 hospices,71 and extended-care facilities72, 73

Handoffs may involve use of specialized technology (e.g., audio recorders, pagers, hand-held devices, and computerized records), fax,73, 74 written documents,44 and oral communication.71, 75, 77

Each type and location of handoff presents similar as well as unique challenges. Given the variety of handoffs, the following discussion will focus on:

- Shift-to-shift handoff
- Nursing unit-to-nursing unit handoff
- Nursing unit to diagnostic area.
- Special settings (operating room, emergency department).
- Discharge and interfacility transfer handoff
- Handoffs and medications
- Physician-to-physician handoffs

**Shift-to-Shift Handoff**

There are paradoxes in communication and handoffs, especially at shift changes.29 Many human factors play a role. Human factors (ergonomics) focus on behavior and interaction between human beings and their environment. Human factors engineering focuses on “how humans interact with the world around them and the application of that knowledge to the design of systems that are safe, efficient, and comfortable”76. The handoff poses numerous human factors engineering implications. From the perspective of patient safety, the primary purpose of the shift report or shift handoff is to convey essential patient care information,14, 43, 55, 78, 79 promote continuity of care5, 41, 77, 78, 80 to meet therapeutic goals, and assure the safe transfer of care of the patient to a qualified and competent nurse. However, other reported purposes of shift report include education,41, 78, 81 debriefing,14, 41 socialization,78, 82 planning and organization,78 enhancement of teamwork,81 and supportive functions.83

The intershift handoff is influenced by various factors, including the organizational culture. An organization that promotes open communication and allows all levels of personnel to ask questions and express concerns in a non-
Hierarchical fashion is congruent with an environment that promotes a culture of safety.34 Interestingly, one study reported novice nurses seeking information approached those seen as “less authoritarian.”34 The importance of facilitating communication is critical in promoting patient safety. The shift-to-shift handoff is a multifaceted activity.78, 85, 86 A poor shift report may contribute to an adverse outcome for a patient.55

Handoff intricacies. A phenomenon well known to nurses is the use of nurse-developed notations, “cheat sheets” or “scrap sheets” of information, while receiving or giving intershift reports. A study of such note taking found scrap sheets are used for a variety of purposes, including creating to-do lists and recording specific information and perceptions about the patient and family.87 This approach presents some challenges, as no one else has easy access to the information; therefore, continuity of care may be compromised during a meal break, for example, or if the scrap or cheat sheet is misplaced.

Method of shift-to-shift handoff. Handoffs are given using various methods:15, 41, 88, 89 verbally,75, 77 with handwritten notes,28, 80, 87 at the bedside,1, 41, 52, 94 by telephone,91 by audiotape,31, 53 nonverbally,54 using electronic reports,92 computers printouts,14 and memory.14 The strength of the bedside report method is its effort to focus on and include the patient in the report. There have been concerns regarding patient confidentiality.45, 52, 96 which could be compromised if not carefully addressed. A qualitative study focused on describing the perceptions of patients who were present during a bedside report found some patients are in favor of bedside handoff, while others are not.52 Patients also expressed concern regarding the jargon used by nurses.22 One patient noted that including the patient in the handoff added another level of safety as erroneous data could be addressed and corrected.52 Case studies indicate the bedside handoff may be implemented for a number of reasons, including addressing specific issues and improving care delivery.57, 92 A summary of the strengths and weaknesses of verbal, bedside, written, and taped shift-to-shift reports is included in Table 3.

The challenge during handoffs across settings and times is to identify methods and implement strategies that protect against information decay and funneling,66 contributing to the loss of important clinical information. It is a challenge to develop a handoff process that is efficient and comprehensive, as case studies illustrate.57, 88, 92, 93 Observation of shift handoffs reveals that 84.6 percent of information presented in handoffs could be documented in the medical record.42 A concern that emerged in this study was some handoff reports actually “promote confusion,” and therefore the authors advocated improving the handoff process.42

Another concern with handoffs is the degree to which the report is actually congruent with the patient’s condition. One study found 70 percent congruence between the shift report and the patient’s actual condition, with an omission rate of 12 percent.52 A synthesized case example of a psychiatric patient presents the adverse consequences for the patient if essential information is not communicated.44 The importance of communicating objective descriptions of the patient condition is highlighted.

A study focusing on assessing the effects of manipulating information in a shift handoff on the receiving nurse’s care planning found in the different types of taped reports that the information recalled ranged from 20 percent to 34 percent.95 Another study, by Pothier and colleagues,15 examined different methods for transferring information during 5 consecutive simulated handoffs of 12 fictional patients. Three methods of handoffs were analyzed; the method demonstrating the greatest amount of information retention involved utilization of a preprinted sheet containing patient information with verbal report, followed by note taking and verbal report method, and lastly, only verbal report. The retained total data points for each style of handoff varied considerably during the five handoffs. Over 96 percent to 100 percent of information was retained using the preprinted sheet containing patient information and verbal report. Only 31 percent to 58 percent of the data were retained using the note taking style and verbal report.52 The verbal-only style demonstrated the greatest amount of information loss, with retention ranging from 0 percent to 26 percent.52 None of the data was retained using the verbal-only method for two handoff cycles. The insertion of incorrect information was observed in the verbal-only method. The generation of incorrect data did not occur at all during the handoff with the written or preprinted form style of report. This study15 supports the use of a consistent preprinted form with relevant patient information during shift report, with less reliance on verbal-only reports, in order to optimize communication.

Nursing Unit-to-Nursing Unit Handoff

Patients may be transferred frequently during their hospital stays.28 Yet, the patient transfer is fraught with potential problems and can have an adverse impact on
Patients. Issues have been identified in the transfer handoff process, including incomplete medical records and omission of essential information during the handoff report. A number of factors that contribute to inefficiency during patient transfers from one nursing unit to another have been identified, including delay or wasted time caused by communication breakdowns, waiting for responses from other nurses or physicians or a response from patient placement management or bed control. Bed control involves personnel who manage the bed assignments of new and transferring patients. Decreasing the number of transfers is a possible strategy to decrease risks associated with handoffs.

Nursing Unit to Diagnostic Area

Patients are frequently sent from a nursing unit to diagnostic areas during the normal course of a hospitalization. Transfers have been cited as a contributor to medication errors between nursing units and diagnostic areas (e.g., radiology, cardiac catheterization, nuclear medicine). It is important when patients change nursing units, particularly to a different level of care, or go to a procedure in another department that there is clear, consistent communication and that the receiving area staff have the information they need to safely care for the patient. Complexity of the patient’s condition may require that the nurse caring for the patient actually accompanies the patient to the new setting.

Special Settings

Operating room and postanesthesia. Several special handoff situations occur in certain hospital settings. The operating room (OR) is considered “one of the most complex work environments in health care” (p. 159), with a reported mean of 4.8 handoffs per case. Nursing staff average 2.8 handoffs per case, with a range of one to seven handoffs.

There have been at least 615 wrong-site surgeries reported to the Joint Commission between 1995 and 2007. To help prevent wrong-site surgery, the Joint Commission developed the Universal Protocol for Preventing Wrong Site Surgery, Wrong Procedure, Wrong Person Surgery. It is based on the consensus of experts and endorsed by more than 50 professional organizations. Effective interdisciplinary communication is critical. For example, a health care organization using a perioperative briefing process reported that no wrong-site surgeries have occurred since the adoption of the interdisciplinary briefings.

Dierks suggests five categories for handoffs in the OR: (1) baseline metrics/benchmarks, (2) most recent phase of care, (3) current status, (4) expectations for the next phase of care, and (5) other issues such as “who is to be contacted for specific issues” (p. 10). The use of a team checklist in the OR was pilot tested in another study and found to show “promise as a method for improving the quality and safety of patient care in the OR” (p. 345).

A study focused on OR communication processes identified a number of patterns and found the most common reason for communication in 2,074 episodes was coordination of equipment, followed by “preparedness” for surgery. The authors recommend increasing the use of automated processes to enhance process flow, especially related to “equipment management,” thereby helping with transmission of information in a more efficient manner.

Communication in handoffs is critical in all phases of care. However, a survey of 276 handoffs conducted in a postanesthesia care unit (PACU) revealed 20 percent of postoperative instructions were either not documented or written illegibly. The nurses rated the handoffs from anesthesia staff as “good” in 48 percent of cases, “satisfactory” in 28 percent, and “bad” in 24 percent. A number of suggestions for improving the quality of the postanesthesia care unit handoff protocol were presented including the need to communicate information verbally to the nurse.

Emergency department. A study of five emergency departments (EDs) revealed that there were differences in the characteristics of handoffs among the EDs studied, but “nearly universal” attributes of handoffs were also noted. The researchers developed a conceptual framework for addressing handoffs in the emergency setting. The handoffs were not one way communication processes as both the outgoing and incoming providers were engaged in interactive handoffs.

According to Behara and colleagues, 8 of 21 handoff strategies used in other industries were observed “consistently” in the ED setting, while four were used less often and nine were not or rarely used. The handoff in the ED setting is viewed as a “rich source for adverse events” (p. 1). There are inherent risks in handoffs, but it was also noted that the handoff can provide the opportunity for two health care providers to assess the same situation and identify a “previously unrecognized problem” (p. 2).

Studies focused on emergency nursing handoffs highlight unique aspects of this process. Currie reported in a survey of 28 ED nurses that the top three concerns nurses had with handoffs were missing information, dis-
tractions, and lack of confidentiality. Recommendations included the development of guidelines to improve the handoff process in the ED.

**Discharge and Interfacility Transfer Handoff**

Handoffs from one facility to another occur frequently between many different settings. Handoffs take place between hospitals when patients require a different level of care. The usual interfacility handoffs are between hospitals and long-term care facilities, rehabilitation centers, home health agencies, and hospice organizations. The factor that tends to make these handoffs challenging is gaps and barriers to communication among these agencies. Handoffs between facilities are also impacted by the cultural differences between the types of facility. Agencies are often geographically separate, requiring physical relocation of the patient, belongings, and paper records. Once the transfer has taken place, seeking additional information becomes a challenge.

The continuity of patient care requires communication among various health care organizations. One problem noted is nurses in different settings have different perceptions about what is important to be conveyed, such as different perceptions between the hospital and home health care. Another area of concern noted in transfers from hospitals to other health care organizations is incomplete documentation. More information was transmitted when a standard form to communicate information was utilized between a hospital and home health agency (HHA). The usage of referral forms varies among health care institutions. Rates of transmission of information differ from hospitals to HHAs and to extended-care facilities. It was found that HHAs affiliated with hospitals received more referral data than free-standing HHAs.

Discharge planning forms address “the anticipation of a certain type of gap and also of an effort to create a bridge to permit care to flow smoothly over the gap” (p. 793). One example of the development of such a form using “a consensus process” resulted in the implementation of a Patient Transition Information Checklist to help improve communication between hospitals and nursing homes. Another type of form for communication of patient information among health care organizations was developed in Germany; however, followup revealed use of the form was not as widespread as anticipated because process barriers emerged, precluding users from easily completing and transmitting the forms. Development of any type of “patient accompanying form” requires numerous considerations and a balance between being comprehensive and not being cumbersome to use. There also needs to be adequate resources to allow health care providers to retrieve necessary data and transmit patient information between agencies.

Inadequate discharge planning has been implicated in adverse outcomes of patients. A study of 400 patients found 76 patients incurred an adverse outcome after discharge from the hospital. The researchers reported “ineffective communication contributed to many of the preventable and ameliorable adverse events” (p. 166). The most frequent type of adverse event was related to medications. The implications of this study indicate the need to enhance communication in the handoff between the hospital and posthospital care. Suggested potential strategies to improve the handoff include discharge planning and education of patients related to medications prior to discharge.

A number of contributors to a failed handoff in the discharge planning process have been identified, including, lack of knowledge about the discharge process, lack of time, lack of effective communication, patient and family issues, system issues, and staffing issues. Communication issues have emerged as a potential contributor to readmissions. An ineffective nursing handoff has been identified as a contributor to miscommunication within the discharge process. The improvement of discharge planning requires that emphasis be placed on collaboration and interdisciplinary communication. Well-orchestrated discharge planning is recommended to help improve patient safety by controlling the risk of gaps occurring in the discharge process and its inherent handoffs.

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