Welcome to the CNL Study Guide!

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Contact Kirsten.spinelli@gmail.com for edits and editions

I. FIVE Organization Theories

1 **Classical**: focused on structure of the formal organization; premise is efficiency through design. Specialization of Labor (Ford), Chain of Command (hierarchy, authority).

2 **Neoclassical**: aka Humanistic Theory, acknowledges need for rational organizations like the Classical, but neoclassicals believe in cooperation and participation, tapping into motivation of the individual. (***Hawthorne Effect:** people act as expected when being watched, the act of research effects the outcome.) Must have willing participants.

3 **Systems theory**: view productivity as a function of the interplay among structure, people, technology, and environment; everything is interrelated.

- Closed systems: self-contained, like the physical sciences, rare!
- Open systems: interacts both internally and with its environment.
- Input: resources such as employees, patients, materials, money, and equipment.
- Throughput: The work process to produce a product.
- Output: The product of a work process.

4 **Contingency theory:** believe organizational performance can be enhanced by matching an organization structure to its environment. One work-site skill mix might not plug in at another location. Each MICRO-system with have their own set of challenged. EBR done in Japan might not work in Kaiser IN, SF. Optimal form of the organization is CONTIGENT upon the challenges and circumstances of the environment.

5 Chaos theory: The universe is not an orderly place with linear cause-and-effect relationships. The life cycle of an organization is dependent on its adaptability and response to changes in its environment. Grow, stabilize, develop formal standards, but to continue to be viable- org's must not lose their ability to adapt and change. Must avoid centralization, be flexible, and redesign structure when needed. Chaos theory expects cycles. Just because you are stable today, does not mean you will have a sellable product tomorrow. Think High Tech companies.

II. Three Relationship Oriented Structures

1. **Shared Governance**

An organizational paradigm based on the values of interdependence and accountability that allows nurses to make decisions in a decentralized environment

This innovative organizational model gives staff nurses control over their practice and can extend their influence into administrative areas previously controlled only by managers.

2. **Heterarch Structure**

A relational design based on the concept of connections. A formal structure, usually represented by a diagram of connected nodes, without any single permanent uppermost node

3. **Self-Organizing Structures**

Self-organizing is the process by which people mutually adjust their behaviors in ways needed to cope with changing internal and external environmental demand

III. RN Care Delivery Systems

1. Functional Nursing

Functional Nursing – the charge nurse makes assignments and gives directions to all nursing personnel assigned to the nursing unit; the primary purpose is to accomplish tasks with the greatest efficiency making personal attention to client needs difficult.

Advantages

- Client care is provided in an economic and efficient manner
- Minimum number of RNs are required for client care
- Tasks are completed quickly and there is little confusion about job responsibilities
- Cost effective and less staffing

Disadvantages

- Care may be fragmented, possibly overlooking priority client needs
- Clients may feel confused because of the many different care providers
- Caregivers may feel unchallenged and understimulated in performing repetitive functions.

2. Team Nursing

Team Leading- an RN leads a group of health care personnel in providing care for a group of clients during the shift.

Advantages

- Emphasizes holistic care, high quality comprehensive care can be provided with a relatively high proportion of ancillary staff
- Each team is able to participate in decision making an d problem solving
- Each team member is able to contribute their own special expertise or skills caring for the client

Disadvantages

- Time consuming, may cause undue workload and stress for team leader
- Continuity of care may suffer if daily assignment of team varies and client is exposed to many different caregivers.

3. Total Patient Care

Total Care – One nurse is responsible for planning, organizing and delivery of care to a particular client or group of clients during the assigned shift.

Advantages

- The nurse maintains a high degree of practice autonomy
- Lines of responsibility and accountability are clear
- Clients should receive holistic, unfragmanted care
- Clients assignment process is simple and direct.

Disadvantages

- Continuity of care may suffer because each nurse has the right to modify the care plan and client may get different approaches to care
- costly

4. **Primary Nursing**

Primary Nursing – an RN assumes 24 hour responsibility for planning, directing, and evaluating client care from the time of admission through discharge

Advantages

- Care provided by a few nurses allows for high quality, holistic client care, increased client satisfaction, increased rapport with RN, increased accountability, high job satisfaction (nurses have a high degree of autonomy and feel rewarded & challenged)

Disadvantages

- Expensive, needs large number of RNs
- May be difficulty to recruit and train large number of RNs
- Inadequately prepared nursed may not make necessary clinical decisions or communicate effectively with the health care team
- The RN may no be willing to accept 24 hour responsibility – RN "emotional burn out"

5. Practice Partnerships

A nursing care delivery system in which senior and junior staff members share patient care responsibilities.

6. Case Management

Case Management – a model of care delivery, the nurse case manager assesses, plans, implements, coordinates, monitors and evaluates client care options and services to meet health care needs

Advantages

- Maintains quality care while streamlining costs
- Client outcomes should be achieved within a specific time frame
- Clients are linked to appropriate recourses and coordinating service providers

Disadvantages

- The nurse may have a large case load
- Monitoring of health expenses may be more important than quality of care

7. Critical Pathways

Critical Pathways- also known as critical paths, clinical pathways, or care paths, are management plans that display goals for patients and provide the sequence and timing of actions necessary to achieve these goals with optimal efficiency. As competition in the healthcare industry has increased, managers have embraced critical pathways as a method to reduce variation in care, decrease resource utilization, and potentially improve healthcare quality.

8. Differentiated Practice Differentiated practice models are models of clinical nursing practice that are defined or differentiated by level of education, expected clinical skills or competencies, job descriptions, pay scales, and participation in decision making. Differentiated practice models have been implemented in acute care inpatient settings, rural community nursing centers, and acute care operating rooms.

Evidence indicates that differentiated practice models foster positive outcomes for job satisfaction, staffing costs, nurse turnover rates, adverse events (i.e., patient falls and medication errors), nursing roles, and patient interventions and outcomes.

Differentiated practice outcomes include the opportunity for healthcare delivery organizations to capitalize on the education and experience provided by varied educational programs leading to RN licensure. The registered nurse has the opportunity to practice to his or her potential, taking full advantage of educational preparation.

Often, differentiated models of practice are supported by a clinical "ladder" or defined steps for advancement within the organization based on experience in nursing, additional education, specialty certification, or other indicators of professional excellence

9. Patient-centered care

Client-Focused Care – services and staff are organized around clients' needs rather than hospital or a department orientation

Advantages

- Client comes into contacts with fewer workers
- The workers are unit-based and able to spend more time in direct care than in transit between client care areas
- RNs functions at a high level because of being accountable for a wider range of services to the client – expertise care
- Cost productive
- Increase in client, staff, and physician satisfaction

Disadvantages

- Major change is required in the health organization and health team members
- Departments and nursing may have difficulty accepting shared tasks
- An increase in training, staff stress.

IV. Contemporary Leadership Theories:

Quantum leadership A leadership style based on the concepts of chaos theory. This model involves getting employees involved in decision making, is outcomes based, and appreciates that the world is fluid and constantly changing.

Charismatic leadership Leadership based on valued personal characteristics and beliefs.

Transactional leadership A leadership style based on principles of social exchange theory in which social interaction between leaders and followers is essentially economic and success is achieved when needs are met, loyalty is enhanced, and work performance is enhanced. *Skills oriented, training, send someone to an EKG class so they can function better within their role. This relies upon the maintaining the status quo, performing work according to policy and procedures.*

Transformational leadership A leadership style focused on effecting revolutionary change in organizations through a commitment to the organization's vision. *Help your staff realize their potential. Like helping a care partner get into nursing school.*

Relational (connective) leadership A leadership style that values collaboration and teamwork; interpersonal skills are used to promote collegiality in achieving organizational goals.

Servant leadership The premise that leadership originates from a desire to serve; a leader emerges when others' needs take priority. . Answers the question of whether the least advantaged in society benefit from the leader's service. Leadership as a noble calling, not a vain-glorious exercise.

Shared leadership An organizational structure in which several individuals share the responsibility for achieving the organization's goals. Based on empowerment principle, assumes a dedicated and caring work-force. "Wise heroic nurse."

Other Leadership Styles:

Autocratic leadership
A leadership style that assumes individuals are motivated by external forces; therefore, the leader makes all the decisions and directs the followers' behavior.

Bureaucratic leadership
A leadership style that assumes individuals are motivated by external forces; leader trusts neither followers nor self to make decisions and therefore relies on organizational policies and rules.

Directive leadership
A leadership style that involves telling employees expectations, giving guidance, ensuring adherence to rules, and scheduling work efforts.

Supportive leadership A leadership style that focuses on the needs of employees

V. Leadership Theories

Trait theory

- The trait theory of leadership is the idea that people are born with inherited character traits that are particularly suited to leadership.
- Since these attributes are considered to be part of a person's personality from birth, this theory tends to assume that people are born as leaders, or not as leaders.

The following traits and skills are critical to leaders:

Traits	Skills
• Adaptable to situations • Alert to social environment • Ambitious and achievement-orientated • Assertive • Cooperative • Decisive • Dependable • Dominant (desire to influence others) • Energetic (high activity level) • Persistent • Self-confident • Tolerant of stress • Willing to assume responsibility	• Clever • Conceptually skilled • Creative • Diplomatic and tactful • Fluent in speaking • Knowledgeable about group task • Organized (administrative ability) • Persuasive • Socially skilled

Behavioral Theory

- Behavioral theory is based upon the belief that:
    1. Leaders can be made, rather than are born
    2. People can learn to become successful leaders through teaching and observation
- This leadership theory focuses on the actions of leaders, not on their qualities.
- If success can be defined in terms of desirable actions, then it should be easy for other people to act in the same way.

Contingency Theory

- Contingency theory claims that there is no best way to organize a corporation, to lead a company, or to make decisions.
- The leader's ability to lead is contingent upon various internal and external situational factors, including the leader's preferred style, and the capabilities and behaviors of followers.
- It contends that there is no one best way of leading, and that a leadership style that is effective in some situations may not be successful in others.

VI. Ethical Decision Making

Ethics

Note: following info summarized from pg.s 518-533 in P. Kelly's "Nursing Leadership and management" 2nd ed., also from N614 notes, and from Van Leuven's health care policy and ethics lecture notes.

Distributive justice concerns what some consider to be socially just with respect to the allocation of goods in a society. Thus, a community in which incidental inequalities in outcome do not arise would be considered a society guided by the principles of distributive justice. Allocation of goods takes into thought the total amount of goods to be handed out, the process on how they in the civilization are going to dispense, and the pattern of division. Civilizations have a narrow amount of resources and capital; the problem arises on how the goods should be divided.

The common answer to this question is that every individual receives a fair share. Often contrasted with just process, which is concerned with just processes such as in the administration of law, distributive justice concentrates on just outcomes and consequences.
Proponents of **distributive justice** link it to the concepts of human rights, human dignity, and the common good. The concept of distributive justice entails what civilization is said to owe its individual members in a proportion:Resources that are available to the society. This includes financial and market considerations.

Everyone in society will receive equitable access to basic health care needs.

Distributive justice theory argues that societies have a duty to individuals in need and that all individuals have duties to help others in need. Many governments are known for dealing with issues of Distributive justice, especially countries with ethnic tensions and geographically distinctive minorities. Post-apartheid South Africa is an example of a country that deals with issues of re-allocating resources with respect to the distributive justice framework.

Ethics Defined

- the branch of philosophy that concerns the distinction of right from wrong on the basis of a body of knowledge, not just on the basis of opinions
- Governs professional groups and provides a framework for determining the right course of action in a particular situation.

Morality Defined

- behavior in accordance with custom or tradition and usually reflects personal or religious beliefs

Values Defined

- Personal beliefs about the truth of ideals, standards, principles, objects, and behaviors that give meaning and direction to life.

Ethical Theories	
Deontology	Actions are based on moral rules and unchanging principles such as "do unto others as you would have them do unto you". The motives of the actor determine the goodness or value of the act. Thus a bad outcome is acceptable as long as the intent was good.
Teology	A person must take those actions that lead to good outcomes. The outcome of the act determines whether the act is good or of value and that achievement of a good outcome justifies using a less desirable means to attain the end.
Justice and Equity	An ethical person chooses the action that is fair to all, including those persons who are most disadvantaged.
Relativism	There are no universal ethical standards, ethical standards are relative to person, place time, and culture. Whatever a person thinks is right is right.
Virtue Ethics	Virtues such as trustworthiness are developed over time, a persons character must be developed so that by nature and habit the person will be disposed to behave virtuously.
Virtues	Four virtues that are illustrative of a virtuous person: • **Compassion**- desire to alleviate suffering • **Discernment**- possession of acuteness of judgement. • **Trustworthiness**- trust is well founded or deserved • **Integrity**- firm adherence to a code of conduct or an ethical value.

Ethical Principles	
Benficience	The duty to do good to others and to maintain a balance between benefits and harms
Non-maleficence	The principle of doing no harm
Justice	The principle of fairness that is served when an individual is given that which he or she is due, owed, deserves, or can legitimately claim
Autonomy	Respect for an individuals right to self determination; respect for individual liberty
Fidelity	The principle of keeping one's promise or word
Respect for others	The right of people to make their own decision
Veracity	The obligation to tell the truth

Ethics Committees

- Interdisciplinary in their membership and include representatives from clinical nursing and administration, medicine, clergy, clinical social services, and nutritional service, pharmacy, and the legal profession, with additional participants on an as need basis.
- Any one on the health care team has the opportunity to refer a situation that has an ethical dilemma associated with it to the ethics committee.

Ethics Test: to help in the decision making process when faced with doubt

- Is it right?
- Is it fair?
- Who gets hurt?
- Would you be comfortable if the details of your decision were reported on the front page of your local newspaper or through your hospitals e-mail system?
- Would you tell your child or young relative to do it?
- How does it smell? (intuition and common sense)

Guide for Decision Making

1. Gather data and identify conflicting moral claims
2. Identify key participants
3. Determine moral perspectives and phase of moral development of key participants
4. Determine desired outcomes
5. Identify options
6. Act on the choice
7. Evaluate outcomes of action

Creating an Ethical Workplace

- Formal mechanisms for monitoring ethics; ethics program or ethics hotline
- Written organizational codes of conduct
- Widespread communication in the hospital to reinforce ethical and socially responsible behavior
- Leadership by example
- Encouraging confrontation about ethical deviation
- Training program in ethics and social responsibility

Nursing Code of Ethics

- An international code of ethics for nurses was first adopted by the International Council of Nurses (ICN) and can be found on the American Nursing Association website.
- Addresses nurses and people, nurses and practice, nurses and the profession, nurses and co-workers.

VII. Legal Issues

RN Licensure
A credential provided by the state under a specific statute (nurse practice acts) that authorizes qualified individuals to perform designated skills and services.
Licensure protects the use of the titles Registered or Practical/ Vocational Nurse.
Nurse practice acts establish boards of nursing, which set and enforce rules and regulations pertaining to nursing practice. Since licensure is controlled by each state separately, nurses must apply for a reciprocal license to practice in a state different from the one in which he/she was licensed.

Patient's Rights
Protected under the Patient's Bill of Rights (American Hospital Association, 1992), which reiterates basic fundamental rights ascribed to individuals by the Constitution and courts of law such as privacy, confidentiality, informed consent, and refusal of treatment.

Implementation of HIPAA in 2003 has required far more stringent measures to ensure patient privacy and confidentiality.

Informed consent requires **capacity** (determined by age and competence), **voluntariness** (without duress, fraud or any form of coercion), and **information** (explanation of treatment, expected results, anticipated risks/benefits, possible alternatives, opportunity to have questions answered, and ability to withdraw consent at any time)
Legal responsibility for informed consent rests with individual performing treatment. RNs may attest/protest belief that patient has given informed consent and may witness patient signature.

Management Issues
Delegation and Supervision
RNs have a legal duty to ensure that staff under their supervision perform with the necessary knowledge, skills and competency to comply with standard of practice.
RNs can be held personally liable for negligent acts of commission or omission.

Employment Issues
In this section Sullivan and Decker refer to the large body of antidiscrimination laws that affect hiring, advancement, and termination of employees (age discrimination, ADA Act, Family and Medical Leave Act, OSHA, etc). Not super relevant to CNL scope of practice.

VIII. Decision Making

Group Think
A negative phenomenon occurring in highly cohesive, isolated groups in which members come to think alike, which interferes with critical thinking

Rational/normative decision-making model
A decision making process that is based on logical, well grounded rational choices that maximizes achievement of goals/outcomes.

Descriptive/bounded rationality model
A decision making process that emphasizes the limitations of rationality of the decision-maker. (ie. a manager is constrained by time/budget/politics and cannot control the decision.) Choices are 'good enough.'

Delphi technique
A decision-making technique when judgments on a particular topic are systemically gathered from participants who do not meet face to face (ie. the survey monkey for the pinning speakers.)

Normative group technique
A decision-making technique that elicits written questions, ideas, and reactions from group participants

IX. Conflict Process Model and Conflict Management

Conflict Process Model

By Filley, framework to explain how and why conflict occurs, and how to minimize and resolve conflict with least negative aftermath.

1. Antecedent Conditions: associated with increase in conflict, like your roommate never buying milk and you getting super angry- eventually. Incompatible goals, role conflict, structural conflict, competition for resources, differences in values and beliefs.

2. Perceived or Felt Conflict: characterized by mistrust, hostility, and fear; misunderstanding each other or jumping to conclusions based on limited information.

3. Outcomes: Overt behavior like aggression, competition, debate, or problem solving. Covert behavior like scapegoating, avoiding or apathy. Suppression occurs when one person defeats another. Resolution occurs when a mutually agreed upon goal is reached.

Conflict: an important part of any change process, conflict management skills are crucial to the CNL; conflict is not BAD, it encourages creativity and innovation.

3 Sources of Conflict

Intrapersonal: conflict within self (should I call in sick and attend my daughter's birthday party- I asked for the day off and didn't get it)

Interpersonal-person to person, or team to team. Personality conflict with a peer, or anger at the emergency department transferring a patient during report.

Organizational: aka as Intergroup conflict, competition for resources is an example. Quality of patient care (nurse patient ratio) competing with COST!

7 Conflict Management Techniques

Avoiding: ignoring the conflict

Pos(+): does not make a big deal out of nothing
Neg(-): conflict can become bigger than anticipated

Accommodating: smoothing out, cooperating; one side gives in to the other side.

Pos(+): One side is more concerned w/an issue than the other side, this works; stakes not high enough for other side to be concerned about, this works.
Neg(-): One side holds more power and can force the other side to give in; the importance of the stakes are not as apparent to one side as the other.

Competing: forcing, the 2 or 3 sides must compete for the goal.

Pos(+): Produces a winner, good when time is short and stakes are high.
Neg(-): Produces a LOSER! Leaves anger and resentment on losing sides (think Hilter after Germany was destroyed in WWI)

Compromising: each side gives something up and gains something.

Pos(+): No one should win or lose both should gain something; good for disagreements between individuals.

Neg(-): May cause a return to the conflict if what is given up becomes more important than the original goal.

Negotiating: high-level discussion that seeks agreement but no necessarily consensus.

Pos(+): Stakes are very high, and solution is rather permanent; often involves powerful groups (think legal issues).

Neg(-): Agreements are permanent, even though each side has gains and losses.

Collaborating: both sides work to develop optimal outcomes. Considered BEST!!

Pos(+): Best solution for the conflict and encompasses all important goals to each side *(this reminds me of organizing Take Back the Night Marches- lots and lots of talking and making sure everyone is included…)*

Neg(-): Takes a lot of time; requires commitment to success.

Confronting: immediate and obvious movement to stop conflict at the very start.

Pos(+): Does not allow conflict to take root; very powerful.

Neg(-): Make leave impression that conflict is not tolerated; may make something big out of nothing.

X. POWER!!

Referent power is based on admiration and respect for an individual.

Connection power is based on an individual's formal and informal links to influential or prestigious persons within and outside an area or organization.

Information power is based on access to valued data.

Reward power is based on the inducements the manager can offer group members in exchange for cooperation and contributions that advance the manager's objectives.

Punishment, or coercive, power is based on the penalties a manager might impose on an individual or a group.

Legitimate power stems from the manager's right to make a request because of the authority associated with job and rank in an organizational hierarchy.

Expert power is based on possession of unique skills, knowledge, and competence.

Information power is based on access to valued data.

XI. Delegation

- **Responsibility:** obligation to a accomplish a task
- **Accountability:** accepting ownership for the results or lack thereof.
- **Benefits to delegate:** can bring trust and support, building self-esteem and confidence. Increasing cooperation and enhancing teamwork.
- **Obstacles:** Fear of criticism, liability, loss of control and overburdening others
- **Liability and delegation:** Five rights of delegation: right task, right circumstances, right person, right direction and communication and right supervision
    - Nurse is responsible for exercising informed judgment and basing the decision tot delegate on the individual’s competencies and qualifications

XII. Budgeting

the process of planning and controlling future operations by comparing actual results with planned expectations

Key terms:

Incremental, or line-by-line budget

= a budget worksheet listing expense items

- Each expense item or category is listed on a separate expense line
- The expense line is usually divided into salary and non-salary items
- Its advantage: its simplicity of preparation
- Its disadvantage: it discourages cost efficiency

Zero-based budgeting (ZBB)

- A method of budgeting in which all expenses must be justified for each new period
- Assumes the base for projecting next year's budget is zero
- It examines activities that might be considered costly or ineffective that continue to be funded because they were never examined
- This budgeting approach aims to improve accuracy, efficiency and control
- Requires preparation of the next year's budget as if it were a new, not continuing budget; that is, the budget begins at zero and requires justification of every line item and dollar amount. Simply put, every proposed expenditure (all activities, all programs) for the new year must be justified under the current environment and its fit with the organizations objectives.
- Benefits of using zero-base budgeting include: increased efficiency, cost savings, better allocation of resources
- It's a more time-consuming approach that takes much longer that traditional, cost-based budgeting. Because of this, organizations may not use this process every year.

Fixed or Variable budgets

- Fixed = a budget in which budgeted amounts are set regardless of changes that occur during the year. Examples: patient volume or program activities.
- Variable = a budget developed with the understanding that adjustments to the budget may need to be made during the year, based on changes in revenues, patient census, utilization of supplies, and other expenses.

Revenue budget:

- A projection of expected income for a budget period based on volume and mix of patients, rates, and discounts.
- Healthcare providers are reimbursed based on the following: reimbursement of a pre-determined amount, such as fixed costs per case (Medicare recipients); negotiated rates, such as per diems (a specified reimbursement amount per patient, per day); negotiated discounts; and capitation (one rate per member, per month, regardless of the service provided)
- Medicare payments for inpatient services are made at a predetermined specific rate for each Medicare recipient based on the patient's diagnosis. Care is classified into diagnosis-related groups (DRGs).

- DRGs are based on primary and secondary diagnoses, age, and treatment received.

- The healthcare organization has a financial incentive to provide care at a cost below the fixed DRG price because it can keep the difference between the cost of treating the patient and the amount the organization is paid; h/c organization may reduce patient's LOS due to this incentive.

Expense budget:

- A comprehensive budget that reflect patient care objectives and activity parameters for the nursing unit
- Consists of salary and non-salary items
- *Direct costs* = expenses that directly affect patient care such as salaries for nursing personnel
- *Indirect costs* = necessary expenditures that do not affect patient care directly such as salaries for dietary or housekeeping personnel
- *Cost centers* = the smallest area of activity within an organization for which costs are accumulated
    - May be revenue producing, such as laboratory or radiology, or non-revenue producing, such as environmental services and administration.
- *Fixed costs* = costs that will remain the same for the budget period regardless of the activity level of the organization i.e. rental payments and insurance premiums.
- *Variable costs* = costs that change in direct proportion to patient volume and patient acuity, such as patient care supply expenses. For instance, if more patients are admitted to a nursing unit, more supplies are used, causing higher supply expenses.

XIII. Time Management:

- Watch for "time wasters" like interruptions (phone calls), meetings, lack of clear goals, plans, personal organization/self discipline, lack of knowledge and ineffective communication

Goal setting:

- long and short range goals
- Goals provide direction and vision for action (and follow the mission of the organization), plus use a timeline
- Helps reduce stress
- Helps relate current behavior, activities, or operations to the organizations or individual's long-range goals to achieve outcomes
- Goals should be measurable, realistic, and achievable
- Helpful to categorize goals (i.e. department, unit, professional, financial, etc.)
- Five major questions to answer: Objectives? Activities necessary to achieve them? How much time for each activity? Order of activities – concurrently or sequentially? Which activities can be delegated to staff?

Delegation (in terms of time management) see Rachael's section for more on delegation:

- Efficient time management tool
- Most difficult leadership skill for nurses to acquire!!

Time Analysis:

- How is time being used?
- Is the time use appropriate to the manager's or leader's role?
- Is it just busywork?
- Time logs (journals of activities) are useful (30 to 60 minute intervals)
- Different time management and organizational skills are needed to be a manager or leader (as opposed to a staff nurse)
- Focus on priorities and evaluate time use in the leadership role

Setting priorities:

- Identify activities as urgent and important, important but not urgent, urgent but not important, busy work, or wasted time; this determines what needs completion the soonest

Daily planning and scheduling:

- Create a to-do list each day with a time-frame for each task

Grouping Activities/minimizing routine work:

- Group similar tasks together
- Set aside blocks of uninterrupted time for very important tasks
- Use "wait" time as well – an opportunity to get other things done

Implementation:

- Implement daily plan and do a time analysis now and then to make sure you are managing your time well

Personal organization and self-discipline:

- Lack of personal organization or self-discipline can be a time waster
- Also, inability to say “no”, waiting for others, and excessive /ineffective paperwork
- Priorities and objectives are often related to other professionals or patients/families as well
- Being well organized and having self-discipline is necessary to be a good manager/leader
- Keep a neat desk and set aside blocks of time for tasks to not become overwhelmed,
- stressed and overloaded

Controlling interruption:

- Some interruptions are necessary and important
- Be careful not to allow interruptions that are more within the scope of accountability within the nursing practice
- Keep an interruption log now and then to identify patterns

Minimize interruptions such as telephone calls and drop-in visitors by utilizing voice mail, email, and appointment setting

Paperwork:

- Plan and schedule paperwork time
- Sort paperwork effectively with file systems
- Use the computer for all letters, memos, reports, and messages
- Analyze paperwork frequently including reviews of paperwork policies and purges of unnecessary stuff
- Do not become a paper shuffler: handle a piece of paper only once

Respecting time:

- respect your own time as well as others
- Ask “What is the best use of my time right now? For myself and my goals, for my staff and their goals, or for the organization and its goals?

XIV. CHANGE Process

Change Process: Assess, Plan, Implement, Evaluation
3 basic reasons to introduce change:
1) To solve a problem
2) To improve efficiency
3) To reduce unnecessary workload for some group

Assessment
- Identify the problem or the opportunity for improvement through change by collecting and analyzing data
- Assessment must be aimed at the perceived problem or opportunity
- Data collection and analysis should be from several sources:
    - Structural – problem is one of physical space of the configuration of physical space
    - Technological – problems may include a lack of wall outlets for necessary equipment, poorly situated computer locations, lack of computer system capability, etc.
    - People – problems may include personnel with inadequate training, willingness, commitment, or understanding to change and meet any new goals

Plan
- In this step, the who, how, and when of the change is determined
- Driving and resisting forces are examined
- Strategies determined for implementing change
- Target date for implementation and outcomes or goals are clearly determined and stated in measurable terms
- The most successful plan for change is one in which the affected people are involved, satisfied, and committed → change cannot be thrust upon people without expecting resistance

Implementation
- In this step, the plan goes LIVE
- The most common method to encourage change by individuals is to provide information
- Another methods used to change individuals is competency-based education → the educator provides information and practice

Group Change Strategies
- **Power-coercive strategy** – "do it or get out" → based on power, control, authority
    - Reserved for situations in which resistance is expected but not important to power group

- **Normative-reeducative strategy** – based on assumption that group norms are used to socialize individuals
    - Assumes that because people are social beings, social relationships are important, and they will go along with a change if the social group sanctions it
    - Information and knowledge ARE NOT used to gain compliance but rather the individual's need for satisfying social relationships in the workplace is used

- **Rational-empirical strategy** – assumes that humans are rational people and will use knowledge to embrace change

Evaluation

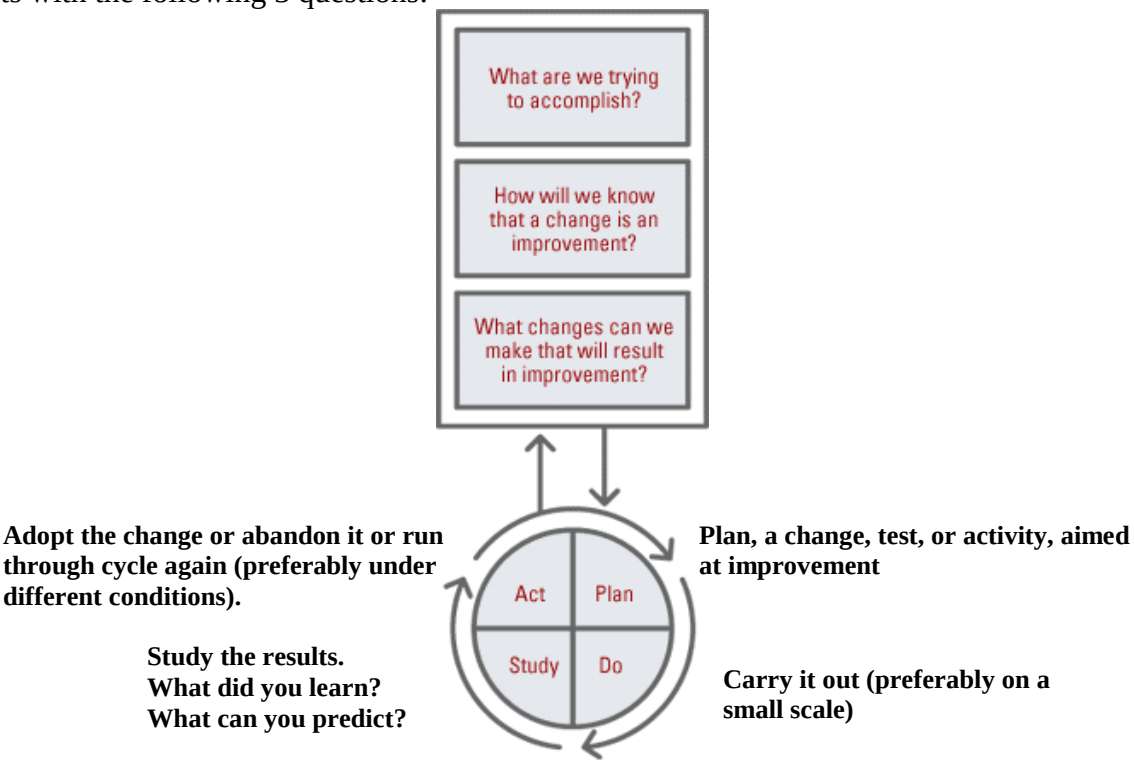
- In this step the effectiveness of the change is evaluated according to the outcomes identified during the planning and implementation steps.
- Time intervals for evaluation should be identified and allowed to elapse before modifications and declarations of failure are asserted
- If outcomes are achieved, then the change was a success
- If not, some revision or modification may be necessary to achieve the anticipated outcomes

Stabilization of Change

- Change agent bows out, and the affected employees own the change
- Often, reevaluation is planned after the first six months or year of implementation to assure that stabilization has occured

Plan-Do-Study-Act (PDSA)

Starts with the following 3 questions:



- As these questions are being answered, testing needs to be done to evaluate any proposed changes.
- Testing is done to evaluate the effect of a proposed change and to learn abotut different alternatives
- The goal is to increase the ability to predict the effect that one or more change would have if they were implemented
- PDSA cycle encourages ongoing quality improvements

Standardize-Do-Study-Act (SDSA)

- Once we have determined the PDSA result to be the current “best practice”, we should take action to Standardize-Do-Study-Act (SDSA).
- We will create the conditions to ensure this “best practice”is embedded in daily activities until a NEW change is identified and then the SDSA moves back to the PDSA cycle to test the idea to then standardize again.

The SDSA cycle aims to:

- **Standardize** - clearly identify how we think the system operates
- **Do** - Run the system consistently
- **Study** - Collect data, information and knowledge about how the system works
- **Act** - Develop feedback systems to maintain consistency and make continual improvement

XV. Change Theories

Lewin's Force Field Model

Unfreeze

- The current or old way of doing is flawed
- People begin to be aware of the needs for doing things differently

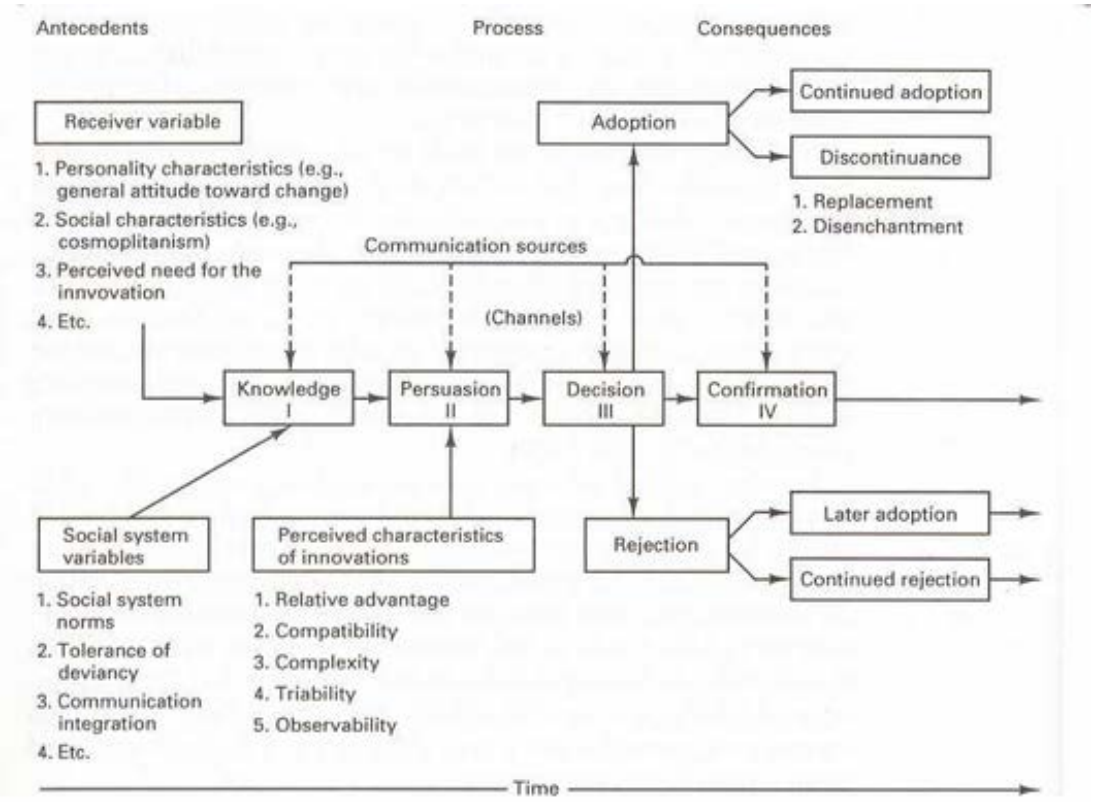
Change

- The intervention or change is introduced and explained
- The benefits and disadvantages are discussed, and the change is implemented

Refreeze

- The new way of doing is incorporated into the routines or habits of the affected people

Roger's Diffusion of Innovations



- Roger believed that the change can be rejected initially and then adopted at a later time
    - Change is a reversible process and that initial rejection does not necessarily mean the change will never be adopted

Roger's Diffusion of Innovations	
Knowledge	In this stage the individual is first exposed to an innovation but lacks information about the innovation. It should be noted that during this stage of the process the individual has not been inspired to find more information about the innovation.
Persuasion	In this stage the individual is interested in the innovation and actively seeks information/detail about the innovation.
Decision	In this stage the individual takes the concept of the innovation and weighs the advantages/disadvantages of using the innovation and decides whether to adopt or reject the innovation. Due to the individualistic nature of this stage Rogers notes that it is the most difficult stage to acquire empirical evidence
Implementation	In this stage the individual employs the innovation to a varying degree depending on the situation. During this stage the individual determines the usefulness of the innovation and may search for further information about it.
Confirmation	Although the name of this stage may be misleading, in this stage the individual finalizes their decision to continue using the innovation and may use the innovation to its fullest potential.

Adopter Catagories

Innovators
Innovators are the first individuals to adopt an innovation. Innovators are willing to take risks, youngest in age, have the highest social class, have great financial lucidity, very social and have closest contact to scientific sources and interaction with other innovators.

Early Adopters
This is second fastest category of individuals who adopt an innovation. These individuals have the highest degree of opinion leadership among the other adopter categories. Early adopters are typically younger in age, have a higher social status, have more financial lucidity, advanced education, and are more socially forward than late adopters

Early Majority
Individuals in this category adopt an innovation after a varying degree of time. This time of adoption is significantly longer than the innovators and early adopters. Early Majority tend to be slower in the adoption process, have above average social status, contact with early adopters, and

show some opinion leadership

Late Majority
Individuals in this category will adopt an innovation after the average member of the society. These individuals approach an innovation with a high degree of skepticism and after the majority of society has adopted the innovation. Late Majority are typically skeptical about an innovation, have below average social status, very little financial lucidity, in contact with others in late majority and early majority, very little opinion leadership.

Laggards
Individuals in this category are the last to adopt an innovation. Unlike some of the previous categories, individuals in this category show little to no opinion leadership. These individuals typically have an aversion to change-agents and tend to be advanced in age. Laggards typically tend to be focused on “traditions”, have lowest social status, lowest financial fluidity, oldest of all other adopters, in contact with only family and close friends, very little to no opinion leadership.

XVI. Three Change Agent Strategies

Power-coercive strategies
Change agent strategies based on the application of power by legitimate authority, economic sanctions, or political clout.

Empirical-rational model
A change agent strategy based on the assumption that people are rational and follow self-interest if that self-interest is made clear.

Normative-reeducative strategy
A change agent strategy based on the assumption that people act in accordance with social norms and values.

Helpful Terms:

Change - The process of making something different from what it was.

Change agent - One who works to bring about change.

Driving forces - Behaviors that facilitate change by pushing participants in the desired direction.

Restraining forces - Behaviors that impede change by discouraging participants from making specified changes.

XVII. Research

Internal Validity: The degree to which the results of a study are not due to bias or confounding.

Confounding: A distortion in the degree of association between a study exposure and outcome due to a mixing of effects between the exposure and an incidental factor known as a confounding factor or confounder.

External Validity: The degree to which the results of a study are relevant for poulations other than the target population. AKA Generalizability

Confidence Interval: The probable range in which a population parameter lies based on a random sample of the population. The most common interval is the 95% confidence interval. It represents the range that on can be 95% confident that the population parameter lies.

Odds Ratio: The ratio of two odds. In a case-control study, the odds ratio may be expressed as the odds of exposure among the cases to the odds of exposure among the controls.

Relative Risk: The ratio of the absolute risk of a disease among the exposed group to the absolute risk of the disease among the unexposed group in an epidemiologic study. The relative risk is the measure of association between an exposure and outcome. AKA risk ratio.

Causal Association: A statistical association in which a change in the exposure produces a corresponding change in the outcome. A causal association is an association that cannot be explained by bias, sampling error, or confounding.

Research: This one is tough- can you find a list of all the kinds of research? Cohort, RCT, stuff like that- include strongest to weakest evidence.

Scale of Research Grades and Levels

A: Strongly recommended, good evidence.
B: Recommended, fair evidence
C: No rec. +/- equal, benefit to harm too close.
D: Recommend against, fair evidence is ineffective or hard outweighs the benefits
F: insufficient evidence; poor quality evidence, harm/benefit cannot be determined.

Levels of Evidence

I Meta Analysis of multiple studies
II Experimental Studies
III Well designed, quasi experimental studies
IV Well designed, non-experimental studies
V Case reports and Clinical examples

Levels of Strength of Evidence

1 Supported by two or more clinical trials
2 Supported by 1 clinical trial and 2 or more methodological sound studies
3 Supported by 1 methodological study
4 Supported by rigorous quality improvements study
5 Step by research utilization or clinical adoption report using structural evaluation
6 Supported by expert opinion

I. Quantitative Research

Quantitative research is a formal, objective, rigorous, systematic process for generating information about the world. It is based upon logical positivism. There are four types listed below.

- **Descriptive**
  Descriptive research is the exploration and description of phenomena in real-life situations. This includes the description of concepts, identification of relationships, and development of hypotheses to provide a basis for future quantitative research.

- **Correlation**
  Correlation research involves the systematic investigation of relationships between or among variables. The primary intent of correlation studies is to explain the nature of relationships in the real world rather than the cause and effect.

- **Quasi Experimental**
  Examines the causal relationship or to determine the effect of one variable on another. This includes implementing a treatment and examining the effects of this treatment using selected methods of measurement. Usually these types of studies lack as much control over the participants and outcome.

- **Experimental**

This is an objective, systematic, highly controlled investigation for the purpose of predicting and controlling phenomena in nursing practice. Causality between the independent and the dependent variables is examined under highly controlled situations.

II. Qualitative Research

Systematic, subjective approach used to describe life experiences and give them meaning. Not currently included in the body of EBP. Similar to other studies; researcher must select a topic, state the problem or question, justify the significance, design the study, identify sources of data, gain access to the data sources, gather data, describe, analyze, and interpret the data, develop a written report of the results.

- **Phenomenological research**
  Phenomenologist's view persons as inseparable from their environment. The world shapes the self, and the self shapes the world. Phenomena occur only when a person experiences them. An experience is considered unique to the individual. To describe experiences as they are lived, to capture the "lived experience" of study participants.

- **Grounded theory research**
  Grounded theory research is an inductive technique that emerged from the discipline of sociology. The term grounded means that the theory that developed from the research has its roots in the data from which it was derived. This theory explores how people's beliefs are related to their actions. You must understand someone's culture to interpret the meaning associated with an action. This theory explores how people define reality and how their beliefs are related to their actions.

- **Ethnographic research**
  The word ethnography means, "portrait of people." Allows researcher to obtain perspectives beyond their own culture. In nursing, this research is used to promote culturally sensitive care. Culture is reflected in people's language, clothing, food, traditions, and customs. Research is to describe culture by examining various cultural characteristics.

- **Historical research**
  Examines past events. Historians believe the greatest contribution is self-understanding; for nurses, we gain a greater understanding of our profession. The researcher must develop a question/s to be examined during the research process, usually more general and analytical than those in quantitative studies.

Data Collection for Qualitative Data

- **Observation** with the aim of gathering firsthand information in a naturally occurring setting, maybe even videotaping and reviewing later so as not to miss any details.

- **Interview** formats are usually open-ended, researcher and participant share a common goal of making sense of a subject.

- **Text as a source** like written narratives, patient records, procedure manuals, newspaper articles, letters, notes taken during an interview.

XVIII. Technology Key Terms:

Clinical information systems Systems used to collect, integrate, and distribute information to the appropriate areas of responsibility.

Computerized physician order entry (CPOE) Automated systems for physicians to enter orders and access decision support.

Expert systems Computer programs that provide inference-generated solutions to aid decision makers.

Hospital information system An integrated system used in health care settings to manage patient information.

Management information system A defined set of techniques to capture and collect data, analytical tools, operating policies and procedures, and reporting and communicating protocols that support decision making.

Nursing information system A component of the integrated hospital system that standardizes nursing records across the system.

Online instruction A method of instruction that uses the Internet for teaching and learning. It is the fastest-growing method of distance education.

Personal data assistants (PDAs) Hand-held devices that can be used to access information, enter orders, monitor patients, and complete record keeping.

Telehealth The use of network technology to provide medical, nursing, and other health care through electronic linkages.

Root cause analysis (**RCA**) is a class of problem solving methods aimed at identifying the root causes of problems or events. The practice of RCA is predicated on the belief that problems are best solved by attempting to correct or eliminate root causes, as opposed to merely addressing the immediately obvious symptoms. By directing corrective measures at root causes, it is hoped that the likelihood of problem recurrence will be minimized. However, it is recognized that complete prevention of recurrence by a single intervention is not always possible. Thus, RCA is often considered to be an iterative process, and is frequently viewed as a tool of continuous improvement.

RCA, initially is a reactive method of problem detection and solving. This means that the analysis is done **after** an event has occurred. By gaining expertise in RCA it becomes a pro-active method. This means that RCA is able to **forecast** the possibility of an event even **before** it could occur.

A **failure modes and effects analysis (FMEA)**, is a procedure in product development and operations management for analysis of potential failure modes within a system for classification by the severity and likelihood of the failures. A successful FMEA activity helps a team to identify potential failure modes based on past experience with similar products or processes, enabling the team to design those failures out of the system with the minimum of effort and resource expenditure, thereby reducing development time and costs. It is widely used in manufacturing industries in various phases of the product life cycle and is now increasingly finding use in the service industry. *Failure modes* are any errors or defects in a process, design, or item, especially those that affect the customer, and can be potential or actual. *Effects analysis* refers to studying the consequences of those failures.

http://en.wikipedia.org/wiki/Failure_mode_and_effects_analysis
can someone grab this image??
☺

Failure mode: "The manner by which a failure is observed; it generally describes the way the failure occurs." *Failure effect*: Immediate consequences of a failure on operation, function or functionality, or status of some item *Indenture levels*: An identifier for item complexity. Complexity increases as levels are closer to one. *Local effect*: The Failure effect as it applies to the item under analysis. *Next higher level effect*: The Failure effect as it applies at the next higher indenture level. *End effect*: The failure effect at the highest indenture level or total system. *Failure cause*: Defects in design, process, quality, or part application, which are the underlying cause of the failure or which initiate a process which leads to failure. *Severity*: "The consequences of a failure mode. Severity considers the worst potential consequence of a failure, determined by

the degree of injury, property damage, or system damage that could ultimately occur."