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INSIDE

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Competency testing gains in priority, but struggles with lack of standards

ICUs search for criteria in designing suitable performance exams

How effective is your competency assessment tool? Frazzled by a lack of both time and materials, busy managers are using home-grown creativity to assess their ICU staffs' abilities by fashioning assessment tools pulled together from inside and outside their organizations.

In the absence of national guidelines or standards covering competency assessment, many departments are resorting to internally devised interviewing tools and exams when evaluating their staff's technical know-how.

"You usually end up developing your own because each unit as a whole operates in different ways," says **Georgiann Homuth**, RN, MS, CCRN, a clinical nurse specialist and competency assessment expert at Swedish American Health System in Rockville, IL.

Homuth emphasizes that exams should test nurses on the less obvious, less-often practiced and high-risk areas of patient care. "It's the

SPECIAL REPORT: NURSING COMPETENCIES

This is the first of a three-part series that will inform you how to achieve optimum ICU nurse competencies. In this issue, we tell you how to achieve high standards of nursing care through proven competency programs that have worked for others and where to get detailed information to formulate your own internal unit guidelines.

In parts two and three, learn how to design and implement an assessment tool and find out how to conduct focused group interviews, qualitative research studies, and in-depth discussions that will accurately assess your nursing staff clinical competence. Our series will help you develop the skills to test your nurses on professional and cognitive competencies, interpersonal skills, and effective patterns of patient interactions.

things that nurses don't do often that you want to test them on."

However, not all hospitals are in agreement with that approach.

At the Department of Veterans Affairs Medical Center (VA) in West Palm Beach, FL, for example, nurses developed an interviewing tool that emphasizes detailed problem-solving situations designed to test a broad range of nurses' clinical knowledge.

The tool assigns one of four grades ranging from a negative and a neutral to a positive and a double positive based on how well, relatively speaking, a nurse can evaluate patients' problems and prescribe appropriate, effective interventions, according to the VA.

Nurses at the VA had outside help chiefly from nurse certification exams and similar sources in developing the tool. The tool was comparable to the exam offered for certification in critical care nursing by the American Critical Care Nurses Association (AACN) in Aliso Viejo, CA.

Competency tool based on hospital need

But a large part of it was based on the contents of the nursing literature and what the hospital needed to accomplish in recruiting and retaining good nurses, says **Sara Moore**, RN, MSN, CCRN, a critical care nurse who helped develop the VA hospital's testing tool.

In 1997, Moore won a National Teaching Institute Creative Solutions Abstract Award offered by AACN for her work in devising the competency-interviewing tool at the VA.

Whether efforts such as those are reliable is open to question considering the lack of national competency testing standards. What is known is that ICUs are assessing nurse competencies in a variety of ways and using various testing criteria.

But no one is certain how well those tools actually gauge nurse competencies, according to nurses contacted by *Critical Care Management*.

For this reason, many RNs say that managers need to begin the process by developing relevant standards and objectives to guide them in assessing competency.

According to Moore, departments vary widely in the criteria they bring to the process. One hospital may differ markedly from another. And in many cases, some nurses speculate, the quality of competency testing may range from good to nonexistent.

Yet, there are abundant resources available including such places as the Internet and through private consultants and nursing organizations for managers who want to create accurate, intelligent skills-assessment tools.

Short of fixed national standards, these resources do a good job, Homuth says. "But they involve some research and foot-work," she adds. The difficulty helps to explain the variety of assessment approaches, Homuth says.

For many nursing departments, competency assessment is the least-liked, most onerous responsibility that managers are required to perform, according to veteran managers. **(For a few reasons and factors that may make competency testing more difficult, see the article on p. 135.)**

The chief complaint is that the process is slow, labor-intensive, and often doesn't accurately reflect the day-to-day clinical realities of nurses' responsibilities.

Testing tools should target objectives

But that can occur when nurses put too little time or effort in constructing relevant, effective testing tools, says Homuth. The first place to begin is by creating guidelines that target desired objectives.

Testing new nurses or recent college graduates differs markedly from assessing veteran nurses or those with fewer than five years in critical care, she observes.

The contents of the test is important. But "whatever your objectives, the guidelines you develop should incorporate more than the actual test design," Homuth adds.

The guidelines should include:

- **creation of pretesting materials;**
- **preparation protocols, including necessary inservice coursework;**
- **actual testing schedules and intervals between tests;**
- **criteria for selection of nurses to be tested;**
- **how often the test should be scheduled during the year;**
- **an equitable grading system;**
- **provisions for training and retesting nurses who don't pass the first time.**

Here are some additional ideas on guideline development suggested by Homuth and Moore:

- **Emphasize actual nurse practice.**

Incorporate questions and testing scenarios into the assessment tool that concentrate on what nurses do every day, and what is done most often.

But also focus on situations that seldom

Why is competency testing so difficult and elusive?

External forces pushing for better tools

Part of the problem with competency testing is a lack of uniform standards and universally accepted measurement tools, says **Georgiann Homuth**, RN, MS, CCRN, a clinical nurse specialist and competency assessment expert at Swedish American Health System in Rockville, IL.

Although there are helpful resources available to hospitals, such as nursing certification exams and published research, there are no widely used or accepted guidelines in critical care, she says.

Technology is another factor. Critical care is extremely technology-driven, and many nurses can't stay abreast of new protocols or developments in the field. As a result, many competency tests don't necessarily reflect the best evidence-based practice, nurses say.

However, the field is changing. "Accreditation bodies such as the Joint Commission on Accreditation of Health Care Organizations are demanding stronger proof of staff competencies," says **Sara Moore**, RN, MSN, CCRN, a critical care nurse for the Department of Veterans Affairs Medical Center (VA) in West Palm Beach, FL, who developed the hospital's competency assessment tool.

State laws are also requiring that providers demonstrate nurse competencies. Local regulatory agencies are using demonstrated clinical competence as a benchmark for patient safety and quality assurance.

In fact, the certification program for clinical nurse specialist sponsored by the American Association of Critical Care Nurses Certification Corp. (AACNCC) in Aliso Viejo, CA, reflects the trend among states demanding more evidence of skills-based performance from ICU nurses. ■

occur, Homuth says. This can be done by reviewing the hospital's database, the patient records, and surveying the staff on its most common bedside procedures.

Testing nurses on less-traveled areas may not reflect what you do 90% of the times, but it sharpens nurses' skills so they can perform as expected in the remaining 10%, she observes.

Make exams challenging

- **Avoid written tests.**

Design tests that involve oral questions and answers. This format allows the tester and test-taker the opportunity to fully cover each assessment area. The test may be offered in written form, but should be taken orally in the presence of a nurse assigned to do the competency interviewing, says Moore.

At the VA, nurses are tested in two key areas: 1) knowledge, skills, and ability (KAS) that cover technical and procedural areas of expertise; and 2) work orientation factors (WOF) that involve problem-solving, interpersonal skills, and family visitation scenarios.

- **Challenge the test-taker.**

Create realistic and complex scenarios that require the test-taker to explain in detail the problem-solving steps involved in answering the questions, says Moore.

One option, suggested by Homuth, is to observe a nurse during the shift or give the test orally during the course of bedside care. Of course, this alternative depends on the size, staffing, and amount of activity during the day.

But the actual, hands-on situation can yield a better assessment than a simulation-based test, Homuth notes.

- **Be comprehensive.**

The assessment tool may focus on what nurses actually do in the unit. But it should also cover the entire gamut of nursing skills. "Make a detailed list of things nurses should know," says Homuth.

The list should cover basic knowledge, such as a Foley catheter insertion to higher-order skills performing textbook nursing care in a pericardiocentesis.

Also, design your tool equitably so nurses without sufficient experience aren't held accountable for higher-order skills, Homuth says.

- **Use external resources.**

Homuth strongly advocates borrowing from outside sources, especially the AACN's core curriculum for critical care nurses, in developing assessment tools.

Carol Hartigan, RN, a certification specialist with AACN Certification Corp. (AACNCC) says the core curriculum can furnish a basis for developing assessment questions.

Blueprint for CCRN Certification

Clinical judgment (80%)* (Partial list)
— assess, plan, intervene/implement, and evaluate a plan of care for a patient with:

• **Cardiovascular (2%)**
— acute myocardial infarction/ischemia
— unstable angina
— myocardial conduction system defect
— cardiomyopathies

• **Pulmonary (17%)**
— acute respiratory failure
— respiratory distress syndrome
— acute respiratory infection
— status asthmaticus

• **Endocrine (3%)**
— diabetes insipidus
— syndrome of inappropriate secretion of anti-diuretic hormone
— diabetic ketoacidosis
— hyperglycemic hyperosmolar nonketotic coma

• **Hematology/Immunology (3%)**
— organ transplantation
— life-threatening coagulopathies
— immunosuppression

Professional caring and ethical practice (20%)
• Advocacy/moral agency (4%)
• Caring practices (4%)
• Collaboration (4%)
• Systems thinking (2%)
• Response to diversity (2%)
• Clinical inquiry (2%)
• Facilitator of learning (2%)

* Percentages denote relative weight given to test content.

Source: American Association of Critical Care Nurses Certification Corp., Aliso Viejo, CA.

But it won't provide much more than that. However, as a reference, it does reflect what ICU nurses actually do in the field and can be valuable in helping nurses with test designs.

Another useful source, according to Homuth, is the certification exam for critical care nurse. The test itself is not available for the purpose of competency testing.

But AACNCC provides a blueprint on the Internet that managers may use in developing guidelines, Hartigan says. The blueprint can be accessed by logging on to the Web site: www.certcorp.org. **(The chart, left, has an excerpt of the CCRN certification blueprint.)**

Of course, most ICUs have a procedure manual or "black bible" that outlines in detail the unit's clinical policies and procedures. The value of the black bible is that it documents only steps and procedures used within the unit, which focuses directly on what nurses most need to know, says Homuth.

Competency assessment has come a long way, says Moore. "From self-study programs and low accountability, the process is becoming much more disciplined and formal," Moore adds. "But hospitals are still largely doing things their own way." ■

Pneumonia therapy helps reduce new cases by 43%

Rotation regimen raises hopes of lowering rates

A small but growing legion of critical care professionals believe that a relatively new therapeutic protocol for preventing hospital-acquired pneumonia can significantly reduce the number of new cases in the ICU.

Until now, the orthodox treatment for hospital-acquired, or nosocomial, pneumonia (HAP) largely has been based on the use of antibiotics and monitored respiratory therapy.

But nurses at Western Medical Center in Santa Ana, CA, and other hospitals have been achieving notable results through carefully executed procedures involving physically rotating patients laterally at regular intervals.

When used in conjunction with established protocols, including nutritional therapy and respiratory support, the regimen cut the rate of new diagnosed cases.

Therapy helped cut cases

In the Western Medical study, the hospital cut the rate almost in half (43%) in a year's time, according to a study released earlier this year in the journal *RN* and presented at a nursing conference in Chicago. It also shortened length-of-stay for those patients by one day and reduced the average number of days the patient needed

(Continued on page 138)

PIRT Scoring System Guidelines
(PIRT Tool)

PIRT Score

	+4	+3	+2	+1	0	+1	+2	+3	+4
Temp.	≤ 105.7	102.2 - 105.6	101.3 - 102	99.7 - 101.2	97.0 - 99.6	93.2 - 96.9	90 - 93.1		< 90
MAP	≥ 160	130 - 159	110 - 129		70 - 109		50 - 69		≥ 49
HR	≥180	140 - 179	111 - 139	101 - 110	65 - 100	55-64		40 - 54	≤ 39
RR	≥ 50	35 - 49		25 - 34	15 - 24	10 - 15		6 - 9	≤ 5
a/A Ratio	paO_2/pAO_2 $pAO_2 = (713 \times FiO_2) - (PaCO_2/.8)$				≥ .6		.41 - .6	.25 - .4	< .25
Vent.	PEEP > 5 &/or AC	70 -100% nonreber. Mask, IMV, PEEP ≤ 5	O_2 ≤ 6L	O_2 N/C ≤ 2L	Room Air				
Art. PH		7.6 - 7.69		7.46 - 7.59	7.35 - 7.45	7.25 - 7.34	7.15 - 7.24	< 7.15	
Creat.	≥ 3.5	2 - 3.4	1.3 - 1.9		.6 - 1.2		< .6		
Hgh.	≥ 19.1		18.1 - 19	16.1 - 18	12.1 - 16	10.1 - 12	8 - 10	6.1 - 7.9	≤ 6
WBC	≥ 40	20 - 39.9		15 - 19.9	3 - 14.9		1 - 2.9		<1
Alb	< 2	2 - 2.5	2.6 - 3	3.1 - 3.5	> 3.5				
GCS	**15 minus actual Glasgow Coma Score**								
Age	≥ 65	55 - 64	45 - 54		≤ 44				
Chronic Health	**One of the following = 3 points, 2 or more = 5 points** AIDS, hx of lung/laryngeal CA, chemo or radiation within 60 mos., recent surgery lasting > 6 hours, COPD with home O_2, acute neuromuscular paralyzing disorder, recurrent or persistent fluid imbal. (from liver fail, renal fail, DI, SIADH, CHF).								

DEMOGRAPHIC & OUTCOME / PIRT SCORE

Room # _____ ICU Admit Date _____ ICU DC Date _____

DX & HX _____

Admit CXR Results ☐ PNEUM ☐ ATELEC ☐ INFILT ☐ Other

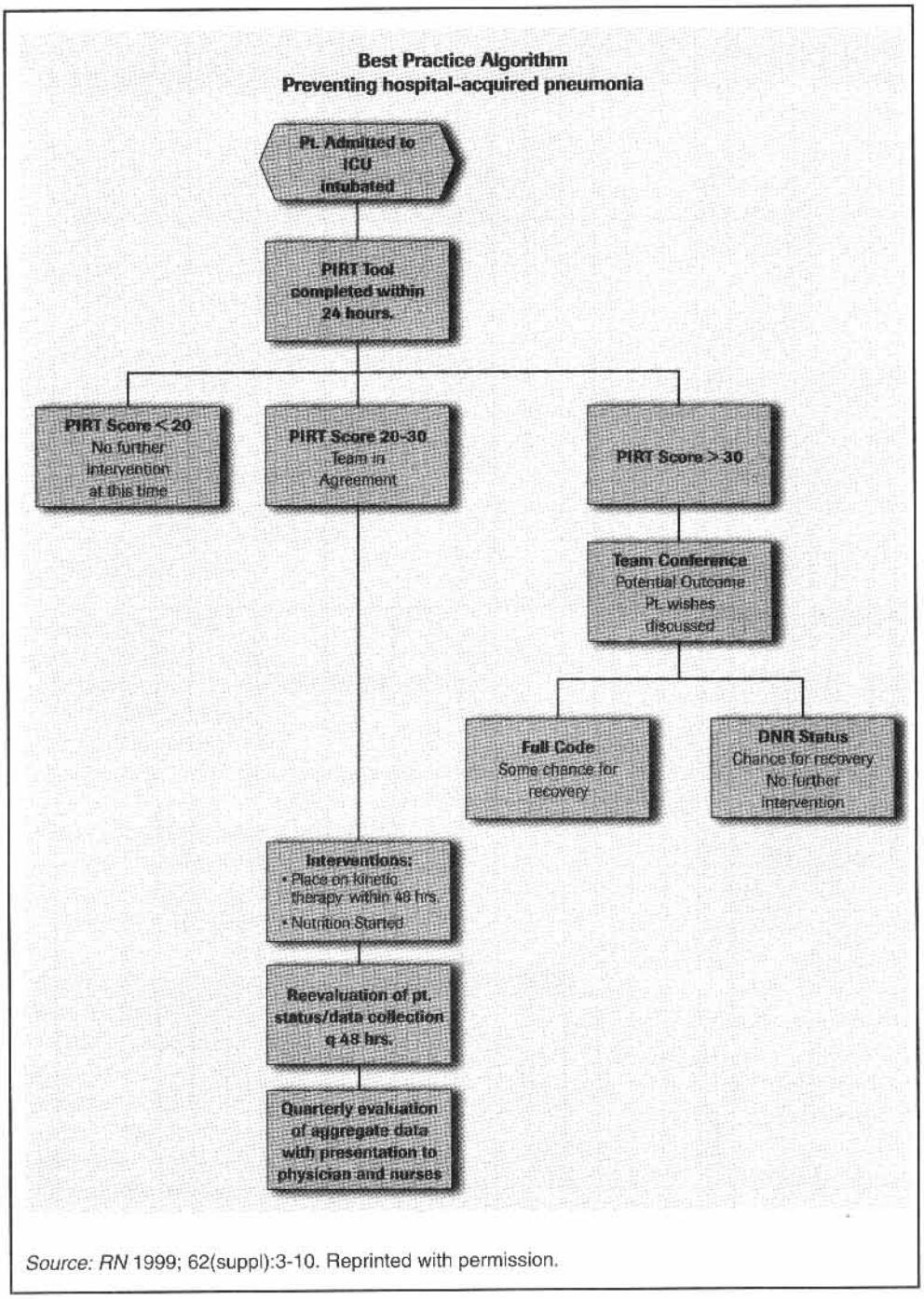
Date On TriaDyne _____ Intub Date _____ Extub Date _____

Date Off TriaDyne _____ Intub Date _____ Extub Date _____

Patient Expired / DNR _____

	Date _____	Date _____	Date _____	Date _____	Date _____	Date _____	Date _____	Date _____
Temp.								
MAP								
HR								
RR								
a/A Ratio								
Vent.								
Art. pH								
Creat.								
Hgb.								
WBC								
Alb.								
GCS								
Age								
Chronic Health								
Total								
PaO_2								
CO_2								
FiO_2								

Source: RN 1999; 62(suppl):3-10. Reprinted with permission.



Source: RN 1999; 62(suppl):3-10. Reprinted with permission.

ventilator support by 20%.[1]

"The therapy is beneficial. It's low risk, noninvasive and fits into most traditional therapeutic regimens," says **Cheryl McKay**, RN, MSN, an ICU clinical nurse specialist who participated in the Western Medical Center research.

But McKay, who now works at a 43-bed long-term acute care facility operated by Select Medical Corp. in Oklahoma City, OK, says the combination therapy is far from trouble-free, especially for clinicians.

For years, HAP has posed enormous challenges for clinicians in the ICU. Although its prevalence rate in ICUs isn't exactly known, researchers estimate that the rate may be as high as 10 cases per 1,000 hospital admissions.

Comparisons with other ICU admissions weren't cited, but the rate is believed to be among the highest in new critically ill patients, according to sources.

Some studies have estimated the number to be 20 times higher for patients on mechanical ventilation. Reported cases have extended inpatient hospital stays by an estimated seven to nine days for each patient. The mortality rate for that population ranges around 30%, the highest of all nosocomial infections.[2]

HAP is defined as a pneumonia occurring within 48 hours of admission. At Western Medical, nearly half of all cases involved neurosurgical cases. But a third of trauma patients also were likely to develop HAP in the ICU, according to McKay.

To attack the problem, clinicians created a multidisciplinary approach that involved early nutrition, aggressive ventilation, and regular kinetic therapy.

The therapy specifically involved rotating the patient laterally at a 40-degree angle or greater to each side, creating an 80-degree arc.

To accomplish this, the ICU needed to acquire specially engineered beds with the ability to automatically rotate the patient at regular time intervals using a computerized system.

McKay says the protocol was three-pronged:

- **nutritional therapy within 48 hours of admission;**
- **tracheostomy and peg tube insertion by day seven if long-term ventilation is required;**
- **early use of lateral rotation.**

In the rotation segment, the angle and length of time of the rotation was determined by the

patient's condition and tolerance to the therapy, says **Gayla Smith**, RN, CCRN, a clinical nurse specialist in adult critical care at Western Medical.

"The intervals in which the rotation stopped typically averaged between five and 10 minutes, and were intended chiefly to allow the patient to rest on his back and permit routine nursing care," she says.

Some researchers believe that the rotation's beneficial effects come mainly from increased oxygenation of the lungs. The rotations stimulate the lungs into receiving increased levels of oxygen.

In the worst cases, McKay says, the patient should be in rotation a total of 18 hours per day with a total of six hours for nursing care.

The procedure also helps to reduce build-up of fluids and mucous, thereby strengthening the ventilator support and preventing potential infection and damage to the lungs, according to **Suhail Raoof**, MD, who has tested the therapy at Nassau County Medical Center in Long Island, NY.[3]

"It is likely that the if [kinetic therapy] were used more frequently and aggressively, many more lives could be saved," Raoof asserts in his study.

Troubled by the lack of any formal system for evaluating neurosurgical and trauma cases of HAP, the Western Medical team reviewed conventional nosocomial infection prevention procedures and the pathogenesis of the most common bacteria related to HAP, McKay says.

During rounds, the team also assessed the existing nutritional therapy and tracheostomy and gastrostomy protocols and found in need of changes, McKay adds.

The team soon developed a scoring system to evaluate leading indicators for HAP, including arterial pressure, vital signs, a/A ratio (paO_2/pAO_2) and 11 other physiological variables.

McKay says the scoring system, known as a PIRT (Patient Identification for Rotational Therapy) scoring tool was developed using the APACHE II patient classification scoring system, a system widely used in assessing critical care patients. **(A sample of a PIRT scoring system is on p. 137.)**

The PIRT tool is used within 24 hours of admission. If a patient achieves a PIRT score of less than 20, no intervention is rendered at the time.

If the score ranges between 20 and 30, rotation therapy is implemented within 48 hours, controlled nutrition is started, and the patient reevaluated every 48 hours.

If the score is higher than 30, the multidisciplinary team (made up of physicians, nurses, dietician, and respiratory therapist) discusses other clinical options. **(A copy of the PIRT algorithm is on p. 138.)**

The PIRT scores were previously developed by pneumonia researchers based on the Acute Physiology and Chronic Health Evaluation (APACHE) classifications, and are themselves arbitrary numbers that imperfectly signify the level of perceived gravity in pneumonia cases.

Therapy has its downside

However, the protocol isn't without its inherent problems, says Smith. Many times, needed nursing care has to interrupt the rotation cycle, or the therapy forces nurses into competing with the rotation regimen.

There also are contraindications in the patient's condition — such as an unstable pelvis fracture, skeletal traction, or a spinal cord injury — that make physical rotation ill-advised.

A third problem, Smith says, is the risk that rotating the patient may accidentally pull ventilator tubing and other life-sustaining lines out of the patient when nurses aren't watching. "Forty degrees is a very steep turn," Smith says.

The rotation also can interfere with patients who require their head to be elevated by more than 30 degrees. McKay says these problems excluded the majority of patients from qualifying for kinetic therapy.

However, of those who did receive the therapy, the protocol was used to both prevent the occurrence of HAP and treat the condition after it was manifested.

Rotation for those patients began after 48 hours of intubation if the PIRT score was between 20 and 30.

Finally, the cost of the specially designed rotation beds can be prohibitive, says Smith. Many hospitals have leased the beds. At Western Medical, the lease rates have been around $125 per day, Smith says.

Meanwhile, results will likely vary between providers, says Smith. "You may not get the same results; that's why it's important that you collect the data and determine the effectiveness before you go out and buy a bed," Smith adds.

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1990s. *Am J Med* 1991; 91(suppl):44-53.

3. Raoof S, Chowdhrey N, Raoof, et al. Effect of combined kinetic therapy and percussion therapy on the resolution of atelectasis in critically ill patients. *Chest* 1999; 115:1,658-1,666. ■

Mentoring comes back as nurse retention effort

Relationships boost job satisfaction

If you haven't heard, an old buzzword gaining currency again in nursing circles is mentoring. True, the idea has been around for ages, but the cycle seems to be turning once again in favor of nurse mentoring as one of the best forms of staff development.

The Illinois Organization of Nurse Leaders (IONL) in Carbondale and the American Organization of Nurse Executives (AONE) are two organizations that support mentoring in an effort to address nursing work force problems.

"Nurse mentoring is now as much a sophisticated science as it is an art," says **Catherine Neuman**, RN, MSN, a member of the IONL committee in Carbondale, IL.

"The discipline has gone in and out of fashion, but has never gone away," adds Neuman, who is also administrative director of patient care services at Memorial Hospital of Carbondale.

Managers lack mentoring skills

The Chicago-based AONE is pushing the idea of mentoring as an effective means of generating nurse retention and job satisfaction. And with staff shortages and retention problems in ICUs running high, nowhere is the need for mentoring more acute than in critical care, advocates say.

Yet despite considerable research and years of practice, nursing departments know little about the fundamentals of this form of staff development, and many even confuse mentoring with other workplace learning relationships, Neuman asserts. For example:

• **Nursing supervisors, especially many in critical care, generally look at mentoring as something of a sideline activity to be scraped together if there's time, and in loose fashion.**

• **As a result of the relegated low priority given to the activity, nursing "administrators often select the wrong nurses for the job, or they don't give the process sufficient time and management support," Neuman says.**

• **Mentoring programs also get shortchanged by a low investment in time spent by a mentor with a nurse, or mentee, and a lack of additional resources, such as sponsored seminars or tuition reimbursements.**

Research shows that nurses, especially inexperienced ones, usually benefit from someone who is designated to be available over a long period of time and isn't a nurse preceptor or a mother hen, but an adviser and pundit for nurses.[1]

"A mentor can impart a broad scope of wisdom and knowledge about working with critically ill patients," says Neuman.

But the mentoring process is complex and beset by so-called "human variables," such as compatibility factors between mentor and mentee, the availability of time for mentoring, and management's commitment to the activity, she observes.

The human variables are what often undermine a mentoring program, Neuman adds.

For managers, the fundamental issue at the outset is selecting the appropriate nurse to function as a mentor, says **Marilyn Oermann**, RN, PhD, a nursing professor and an expert on mentoring at Wayne State University in Detroit. The right individual can achieve great things in the unit, she says.

Therefore, the mentor's role must be clearly defined and distinguished from other individuals in the staff development process. "Mentors are not preceptors or sponsors. They aren't friends, allies, and especially not mother hens to nurses, but more like advisers and role models," Oermann explains.

Tips for Successful Mentoring

- Be creative in giving and receiving feedback.
- Be respectful of time, but meet regularly.
- Listen closely and purposely to the mentee's concerns.
- Be a role model, but don't be dogmatic or a teacher.
- Use multiple resources to advance learning.
- Be prepared for separation as advancement occurs.
- Recognize and reward each other with encouragement frequently.

Source: The Mentoring Committee of the Illinois Organization of Nurse Leaders, Carbondale, IL.

Three Types of Support Relationships

I. **Precepting.** Used to acquaint new nurses to their environment, it is a formal teaching assignment usually given to an experienced bedside nurse and lasts for a limited time period as determined by managers. Preceptors assist new nurses in learning specific procedures involving patient care.

II. **Sponsoring.** A form of support and coaching aimed at "facilitating the growth of a protégé [inexperienced nurse] within the organization," it is a less formal or instructional function than precepting or mentoring, and therefore more guidance and advocacy-oriented.

III. **Mentoring.** A higher-functioning relationship than sponsoring, but less formal and educational than precepting, it is mainly a long-term relationship between an experienced nurse and another nurse that is characterized by sustained interaction, communication, and compatibility.

The interaction may not be constant, regular, or nursing-specific; and the communication can be conducted over long distances. The mentor serves as a role model and guide.

In all three, there are varying degrees of role modeling and coaching.

Source: The Mentoring Committee of the Illinois Organization of Nurse Leaders, Carbondale, IL.

(The box, above, outlines the differences.)

Veteran mentors have identified several stages in a mentoring relationship. The first, called "the initiation," focuses on determining a suitable match and is likely to be the most important, advocates argue. "It's is probably the cornerstone of a successful program. There's got to be good chemistry there between the mentor and nurse," Neuman says.

The initiation stage establishes a suitable match between a mentor and a mentee. Neuman and Oermann both emphasize that the mentor nurse has to be someone with wisdom, experience, maturity, and people skills.

But he or she also has to have the right character, values, and personal philosophy to offer the nurse mentee the correct advice, guidance, and feedback, Oermann says.

Compatibility often determines the success of the other three, Neuman observes. IONL officials recommend that administrators give nurse mentees the option of selecting their mentors through interviews.

The interview questions might be:

- **Why are you choosing to be a mentor?**
- **What special skills do you have to offer?**
- **Do you have the time to devote to mentoring?**
- **What amount of time do you expect this process to take?**
- **Do you have any preset conditions or rules for this relationship?**
- **What do you expect of a mentee?**

In turn, the prospective mentor should interview the nurse mentee with similar telling questions regarding the reasons, motivations, and willingness of a nurse to enter into a mentoring relationship, the IONL recommendations note.

The mentor's qualifications for the job can greatly enhance the other factors underlying a successful mentoring program, says Neuman. Two major components of a successful relationship include:

1. A needs assessment.

Determine areas of need and priorities, says Neuman. Although the mentoring process doesn't require strict adherence to instructional plans, it should involve some specific areas of nursing in which the mentor can positively influence the staff.

Some typical areas for mentors to focus on might be to address staff burnout, balancing work and personal life, adjusting to rotating schedules, and working with patients' families, Oermann notes.

2. Defined goals and expectations.

Although most mentor relationships aren't fixed in time, there should be a general expectation regarding what will be achieved within a certain period of time, Oermann says.

Determine at the outset what is expected of the mentoring relationship and roughly how long it will last. For example, following their preceptorship, inexperienced new nurses may be assigned a mentor for six months to adjust fully to the demands of the working environment, Neuman says.

Most mentoring advocates caution that the process requires additional time and energy from nurses. It could mean placing extra stress on already demanding work schedules.

Also, the process can backfire and result in nurses who get over-dependent on their mentors, which can interfere with workplace performance or independent thinking. The relationships also can

lead to mimicking rather than genuine internalizing of positive learned behaviors, IONL cautions.

However, in most cases the benefits outweigh the risks. If properly conducted, the mentoring relationship can help boost job satisfaction and therefore allow units to retain their nurses longer, Neuman says.

Reference

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Nurses see shaky future for CA fixed staffing law

Acute care nurses in California, the birthplace of managed care, are cheering over an unprecedented new law that imposes mandatory nurse-to-patient ratios on acute-care hospitals throughout the state.

But critical care nurses in the state who have been working under mandatory staffing levels for several years are questioning whether the law will have any direct benefit to nurses or their patients.

Under the statute, which will be implemented in 2002, acute-care hospitals will be barred from staffing inpatient units at levels below the legal requirement. It requires hospitals to meet set levels of nursing care by limiting the number of patients assigned to each bedside nurse.

"This is a good law because it finally comes close to providing the kind of patient protection that we as nurses have needed for several years," says **Jill Furillo**, RN, director of government relations with the California Nurses Association (CNA) in Sacramento.

The statute doesn't specify the nurse-to-patient ratio, but directs the California Department of Health Services to develop standards that will fix the number of nurses to patients in units.

The law originally was scheduled to take effect on Jan. 1, 2001, but backers of the legislation agreed to extend the date by one year to give the state ample time to work on a formula.

Affected will be all general, psychiatric, and specialty hospitals throughout the state.

Supporters of the act, including the 30,000-member CNA, the state's largest nursing group, asserted that the statute was needed to protect them and ensure patient safety. Drastic hospital cost-cutting and downsizing have sharply reduced nursing departments and, according to nurses, have compromised patient safety and quality medical care.

Hospital industry officials say the cost cuts have been a response to lowered reimbursements and increasing pressure from managed care organizations to restrict inpatient admissions and lengths of stay.

Industry officials say that a severe nursing shortage in many fields is likely to hamper the ability of individual administrators to comply with the law unless provisions are made for training thousands of new nurses over the next five years.

"If these ratios become costly, then the question becomes 'where are we going to get the money to hire additional new nurses, if they are available at all?'" says **Harry Osborne**, a legislative advocate for the California Healthcare Association, a hospital industry trade group.

"There is nothing in the law the that requires managed care organizations to pay for any part of this," Osborne says.

For California's critical care nurses who have been working under mandatory nurse-to-patient ratios for two decades, the statute may be a hollow victory.

"To talk about simply assigning bodies to patients without discussing nurse competence or patient acuity falls short of a real discussion," says **Justine L. Medina**, RN, MS, CCRN, a clinical practice specialist with the American Association of Critical Care Nurses in Aliso Viejo, CA.

But Furillo countered that state law requires

COMING IN FUTURE MONTHS

- Ten steps to creating effective nurse retention strategies
- Developing assessment protocols for alcoholic seniors in the ICU
- Creating effective guidelines for competency-based interviewing
- How to get nurses to accept new technology and research
- Ways to make automated drug dispensing a cost-effective option

hospitals to use a system of patient classification as the basis for determining optimum staffing levels. The new law for the first time sets ratios at the state level and makes them mandatory, she says.

For critical care nurses, the mandatory level has been 2-to-1, or one nurse for every two patients. ICUs can exceed the coverage to, say 1-to-1, but they can't exceed the caseload for each nurse beyond the fixed two-patient number.

Hospitals have evaded regulation

But Medina says nurse staffing in most California ICUs has achieved mixed results under the fixed ratios, which were required by provisions of a federal funding regulation that affected California hospitals in the 1970s.

Administrators have in many cases circumvented the mandatory ratios without violating the law by using a loophole in the code. The loophole permits licensed practical nurses (LPNs) and other licensed but nonregistered nursing personnel to care for patients under the same ratio.

Although the RN is ultimately responsible for the patients, under the regulation, an LPN can administer the same level of care as the RN, but at a substantial cost savings to the hospital, Medina says.

So hospitals end up fulfilling the letter, if not the spirit, of the law's intent, Medina says.

The current statute bars unlicensed caregivers from attending to patients under the fixed ratio, but it doesn't restrict the use of licensed personnel.

Medina says the current statute is written in such a way that hospitals may try to evade the law.

Meanwhile, the CNA says nursing groups in other states are watching developments in California with an eye toward introducing similar staffing bills in their own legislatures.

"With the current groundswell of support for adequate patient care and coverage, it is likely that we'll see more states following our lead," says Furillo. ■

Hospitals criticize HCFA rule on patient restraint

Hospital administrators are opposing a regulation issued by the Health Care Financing Administration (HCFA) that spells out tough new policies regarding the restraint and seclusion of patients in acute-care facilities.

Earlier this year, HCFA, which administers the Medicare and Medicaid programs from Baltimore, promulgated an interim final rule that requires a physician to make a "face-to-face evaluation" before any patient is to be restrained or secluded.

It also imposes a time limit of no more than one hour for the evaluation to occur before a patient is actually restrained or moved to a secluded area of the facility.

Although the regulation is likely to have a greater effect on long-term care facilities, critical care nurses are subject to the same provisions. In literal terms, the rule requires that even unconscious patients who pose no physical threat to themselves or a nurse must be evaluated by a physician before restraints can be applied.

The regulation makes following the rule a condition of participation for providers that means hospitals risk loss of their Medicare and Medicaid

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contracts for violations.

The American Hospital Association (AHA) hotly contested the new rule, arguing that HCFA did not provide sufficient time for public comment. The AHA voiced concerns about employee safety.

According to the Justice Department, nearly half of all nonfatal hospital workplace assaults stem from patients, although most occur at mental health facilities.

In a letter to HCFA, AHA Adminstrator Nancy-Ann DeParle urged the agency to monitor the impact of the regulation. "Overuse may be a problem, but underuse is just as dangerous," she wrote.

HCFA officials say they were concerned about patient safety following reports of patient deaths resulting from restraint by hospital staff. Most of those incidents occurred in nursing homes and psychiatric hospitals.

However, all acute-care facilities are covered by the new rule. The regulation was issued as part of a package of patient protection regulations to the Medicare and Medicaid handbook and went into effect on an interim basis in September. Officials of the American Association of Critical Care Nurses in Aliso Viejo, CA, had no comment on the matter. ■

New on-line service targets hospital nurse shortage

Creators of a Web site designed by nurses and specifically for nurses hope the on-line service will ease the worsening nurse shortage and help link the right nurses and hospitals during job searches.

The service, www.NursesNetwork.com/Hospitals/Hospital.asp, also offers users information by state on local licensing requirements, nursing organizations, and major meetings and conventions.

The service also provides resume writing and printing capabilities, and has links to related clinical information such as current research on drugs, medications, diagnostic procedures, and treatment modalities.

But the centerpiece of the service will be the confidential, on-line job-search tool, which is expected to provide information on hundreds of hospitals by nurse specialty.

Nurses who may be interested in new employment can use the site regularly free of charge by signing on to the site, says **Kenneth W. Rickert Jr.**, president and CEO of NursesNetwork.com in West Palm Beach, FL.

"The most efficient way for hospitals to find qualified candidates, and the most cost-effective way for nurses to network in various markets is through the Internet," he says.

The job information will be free to nurses who register on the site. But hospitals will have to pay a fee to list their openings. The company was formerly called FIRSTAT and provided nurse recruitment services for hospitals and other providers. ■

CE objectives

After reading each issue of *Critical Care Management*, participants in the continuing education program should be able to:

- identify particular clinical, administrative, or management issues related to the critical care unit;
- describe how those issues affect nurse managers and administrators, hospitals, or the health care industry in general;
- cite practical solutions to problems that critical care/intensive care managers and administrators commonly encounter in their daily activities. ■

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