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Don't Forget Our Charge Nurses

Executive Summary

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

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

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

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

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

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

These conversations led to the development of highly successful charge nurse development workshop titled *How to Be a Great Nursing Leader When You Are Not the Boss.* The one-day workshop is designed to address four critical skills needed by charge nurses today (see Figure 1). These skills include communication, supervision and delegation, conflict management, and team building. During the past 2 years, this workshop has been attended by hundreds of charge nurses and unit facilitators from a wide variety of health care settings. The insights gained from workshop participants into the challenges of the charge nurse role in today's health care environment point to a need

for organizations to take a much closer look at how they are educating and coaching nurses who assume these positions. A strong business case can be established for investing resources to educate nurses who assume these roles that are so integral to the effective and safe operational management of patient care units.

Nursing Literature on the Charge Nurse Role

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

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"How to Be a Great Nursing Leader When You Are Not the Boss": A Program for Charge Nurses	
8:30 – 9:00 AM	Icebreaker and Review of the Agenda
9:00 – 10:00 AM	Communication *What's Your Communication Style* *Assessment Tool* How Style impacts your Effectiveness as a Leader The Do's and Don'ts of Communication in Delegation
10:00 AM	Break
10:15 AM	What Is Team Nursing?
10:45 AM – 12 PM	Delegation and Supervision The Do's and Don'ts of Delegation The Florida Nurse Practice Act – Your Role in Supervising Team Members Delegation and Supervision Role Plays
12 – 1:00 PM	Lunch
1:00 – 2:00 PM	Managing Conflict on Your Team Thomas-Kilmann Conflict Mode Instrument *Your Style of Managing Conflict* *Dealing with Generational Conflict*
2:00 – 2:15 PM	Break
2:15 – 3:45 PM	Building a Great Nursing Team Team Building Exercises
3:45 – 4:00 PM	Summary and Evaluation

charge nurse competencies involving interviews with 42 nurses representing all levels of nursing leaders. Fifty-four specific competencies were identified and grouped into the four categories of clinical/technical, critical thinking, organizational, and human relations skills. The study led to the development of a successful charge nurse workshop that was tailored to the needs of the organization. Krugman and Smith (2003) described the development of a permanent charge nurse role at the University of Colorado hospital. Their program used the Kouzes and Posner's Leadership Model as a theoretical framework. Their research indicated that a structured orientation to the role improved the functioning of charge nurses.

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

Changes in Nursing Care Delivery

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

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

Program Content

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

ambitious for a 1-day workshop, staffing constraints in the health care agencies in our community made this the most feasible design. The workshop includes the use of assessment tools, case scenarios, and group activities. An important part of our training involves education about the nursing scope of practice. Initially, this was not a major focus of the workshop but the charge nurses expressed confusion about the differentiation in scope of practice between the RN and LPN role and this content was added.

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

Assessment, reassessment, and development of the plan of care in the acute care setting are scope of practice issues that generate the most confusion. Charge nurses often don't realize their accountability for these aspects of care when licensed practical nurses are working on their teams. The significant legal and patient safety issues that arise when team member notes are co-signed by charge nurses without assessing the patient have also become a major point of emphasis. We recommend to charge nurses that they review the functional statements or posi-

tion descriptions of their team members. Although it may seem basic to include this in a leadership workshop, it cannot be assumed that staff have read and understood these documents. Additional health care agency policies that are integral to the work of charge nurses and should be reviewed include the assignment of patient care, the assessment of patients, and the health care agency's documentation policy. These documents usually delineate scope of practice issues and outline the accountability of RNs when supervising and delegating to other team members.

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

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

allow for active discussion of ideas and strategies particularly in situations where staffing may be short and priorities need to be established.

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

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

Generational and cultural dimensions of communication are issues that charge nurses readily admit struggling with. Identifying one's own attitudes and beliefs is an important initial step to appreciating diversity on the health care

Table 1.
Levels of Training Evaluation

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

Source: Phillips (1997)

team. Case scenarios with real life communication issues drawn from the work environment provide a good basis for group discussion. The significance of taking professional responsibility for communication and followup on patient care issues is a key point of emphasis.

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

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

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

building a strong nursing team.

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

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

Return on Investment for Charge Nurse Education

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

Table 2.
Sample Program Costs and Potential Benefits of Charge Nurse Training

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

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

Program Costs	Factors Included in the Calculation	Total Cost of Item
Cost of the program design	40 nurse educator hours to design the program at $39 per hour (includes salary of $31 hour and $8.00 in benefits)	$1,560
Cost of program materials (videos, participant handouts, assessment instruments)	Video on conflict – $750 (prorated against three uses = $250) Assessment Tools – $250 Handouts – $250	$750
Instructor costs (includes guest speakers, preparatory time, delivery time, followup with participants)	16 nurse educator hours – $624 10 guest presenter hours – $390 One honorarium – $250	$1,264
Cost of facility rental, utilities, audiovisual equipment, meals, and travel	Given onsite – depreciation on equipment and utilities = $200 Meals for participants (continental breakfast, lunch) = $400	$600
Participant hourly cost including salary and benefits and replacement costs to the unit	25 charge nurses – 8.5 hours at $31.25 per hour ($25 salary and $6.25 in benefits)	$6,640
	Replacement costs 25 x $32 per diem x 8.5 hours	$6,800
Cost of professional contact hours if given	Average CE cost $10 per participant – paperwork, certificates, cost of provider number	$250
Administrative and support overhead costs for the program	8 secretarial support hours at $15 per hour (includes salary of $12 and $3 in benefits)	$120
Total Program Costs		**$17,984**

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

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

Figure 2.
Program Return on Investment

$$\frac{\text{Net Program Benefits } \$161,482}{\text{Program Costs} \qquad \$17,984} = \frac{(\text{Program Benefits} - \text{Costs}) \times 100 = 898\%}{\$179,466 - \$17,984}$$

minus the program costs divided by the program costs x 100.

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

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

Implications for Nursing Leaders

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

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and goals can be sustained over time.

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

Summary

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

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

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