

LEADERSHIP & PROFESSIONAL DEVELOPMENT

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A Day in the Life of a Manager: Incorporating Leadership, Mentoring, and Role Modeling

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The demands on the manager of a nursing unit or department are multiple, complex, and growing. One of the difficult challenges of managers is to ensure that leadership, mentoring, and role modeling are included in our practices (Counsell, Gilbert, & McCain, 2001; Sullivan, Bretschneider, & McCausland, 2003). Daily operations, the crisis du jour, and the unique demands of special projects often drain away time that well-intentioned managers would like to commit to the development of their staffs. Although some managers may believe that they just do not have enough time for leadership, mentoring, and role modeling while still managing the other responsibilities and expectations of our roles, one way we can weave these crucial traits and roles into our busy schedules is to intertwine them in our planning and project development, thereby embedding them as a part of our daily activities. If we wait until we have time, we will share only a portion of what we have to offer our staff and we may not enjoy the excitement of watching our staff grow and become. Also important are reflecting and recognizing when we have unconsciously embedded leadership, mentoring, or role modeling in day-to-day practice in the past and learning from those experiences. Understanding and recognizing when this has occurred can be very helpful in enabling us to become more intentional as we proceed with day-to-day functions. Using one of my institution's major projects as an example, I would like to offer some suggestions on how we can look at these principles a little differently and instill them into our daily routines.

Almost four years ago, our organization embarked on the journey of designing our electronic medical record (EMR). As we initiated the process of planning and determining how we would design nursing documentation in the EMR, we also took the first steps on the road of mentoring staff, role modeling,

and building staff development into the complex and long-term project. Those key management functions were woven into

- Creation of our vision
- Identification of staff perceptions and incorporation of this information into the plan design
- Development of a plan to ensure that staff members had a central role in the design of their documentation
- Embedding of research into our plan
- Incorporation of system evaluation
- Publication.

The purpose of this article is to briefly describe each of these activities and how they incorporated leadership, mentoring, and role modeling.

Baseline Assessment

Before the EMR project began, we asked a pilot group of staff members to share their attitudes and opinions related to the use of computers and EMRs in health care. The information shared via the anonymous survey guided the design of the nursing documentation project plan. At the same time, the survey supported and demonstrated to staff members that nursing leadership valued their perceptions and participation. It modeled the values of commitment and inclusion of staff members and their input into the design of the project plan. The gathered data were shared with the Core Team and often guided system development.

Vision

The journey began with creation of a vision that would set the stage for what was to come. This vision—to design efficient and effective nursing documentation that supports care of the individual patient and also supports nursing research, quality improvement, and enhanced professional practice—was communicated early and often, continued to evolve, and truly became a guiding principle

as the work unfolded. As we repeatedly returned to our vision to refocus our direction, staff members were able to see that a thoughtful articulation of what the future would look like could serve as a core guiding principle as the project moved forward.

Assembly of the Core Team

A cornerstone of the project was creation of a multidisciplinary group of nursing staff from various subspecialties and individuals with various job titles. This Core Team would play the principle role in crafting nursing documentation in the EMR. Throughout the design work with the Core Team, leadership, mentoring, and role modeling were integrally entwined. For example, many staff members approached the design process with the assumption that the Core Team's primary focus would be translating paper forms into an electronic format. Division of Nursing leadership assisted staff members in exploring and recognizing that the EMR development process was an opportunity to step back and examine what we had been doing and why. In many cases, the staff discovered that practices were the result of work-arounds created in response to broken systems, information was gathered because of tradition and provided no value-added meaning to care delivery or care planning, recorded information was duplicated in multiple places, or the data collected did not reflect evolving nursing care standards or evidence-based practice. The process of evaluating current documentation practices created new insights and understandings, and we often were able to

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mentor and nurture creative ideas. The Core Team originally was developed to ensure staff input into the design of nursing documentation. As the project unfolded, the Core Team members were recognized broadly in the organization as key participants in and architects of the design process. Working with the Core Team and facilitating the weekly meetings offered regular opportunities to guide the development of staff members, and they became increasingly knowledgeable about the design of documentation tools in an electronic medium.

As the Core Team gained understanding and insight, the team members also began to embrace the vision and wonderful potentials for practice, patient care, and research embodied by an EMR. With that knowledge came enthusiasm and commitment. Members of the Core Team began to participate in other facets of design and development, such as the laboratory order-entry design process. Several members of the team collaborated with systems analysts and laboratory staff for almost nine months, advising them regarding the issues and complexity of laboratory orders from the vantage of nursing staff. As these individuals worked on the laboratory order-entry design project, they increasingly realized that their knowledge, experience, and expertise were valuable contributions to the design process.

Incorporation of Research

Research was integral to the project plan from its inception. Upon completion of the process-improvement pilot survey of staff regarding their opinions and attitudes about the use of computers and the value of EMRs in health care, we submitted a protocol to the institutional review board and received approval to conduct an anonymous pre- and postimplementation survey of all inpatient nursing staff members. The preimplementation data were instrumental in refining the initial project plan. The purpose of the postimplementation survey was to measure the changes in perceptions held by staff after using an EMR. The postimplementation data, which have been collected and are in the analysis process, present a new opportunity to demonstrate leadership and role modeling. Once the preliminary analysis has been completed, we will be able to collaborate with clinical staff members in defining how the outcomes of the survey should influence the evolution of the EMR design and implementation strategy.

Project evaluation, a second important facet, was a critical element that needed early attention to determine how the staff was responding to the EMR design after implementation. Our literature review had disclosed that staff acceptance is fundamental to successful system implementation (Ammenwerth, Mansmann, Iller, & Eichstadter, 2003; Davis, 1989, 1993; Dillon, McDowell, Salimian, & Conklin, 1998; Gardner & Lundsgaarde, 1994).

We wanted to know very soon after implementation if the system had undiscovered design flaws or other issues that were creating frustration or hardship for the staff, as well as understand what was going well. Therefore, about four weeks after implementing nursing documentation in the EMR on two units, we conducted a brief postimplementation survey of the staff. The Likert-type survey asked specific questions about the various applications of the EMR and also enabled staff members to communicate additional comments, concerns, and suggestions. Feedback generally was positive and included a number of recommendations regarding revisions that would enable the EMR to fit more smoothly into workflow of the staff. After the data were analyzed, the Core Team initiated a collaborative process with staff members from the pilot units to communicate the outcomes of the evaluation and define the changes in the EMR documentation design that were needed. The process encompassed about three weeks, and the changes were made in the database and placed in the production system in about eight weeks.

Once again, the evaluation process described earlier demonstrated leadership, mentoring, and role modeling on two planes. First, a clear message was sent to the staff on the pilot units that sincere concern and interest existed in their opinions, that we wanted to know what those opinions were, and, finally, that we would respond to those opinions and suggestions by working with them to clarify the issues and reaching consensus regarding appropriate changes. Second, the Core Team gained an understanding of the importance of identifying end-user reactions and responses to the system, listening to them, partnering with them to define and prioritize the desired changes, and implementing the appropriate corrective actions.

The experience gained with evaluation of the system shortly after implementation prepared the Core Team and staff members on the pilot-test units for our first data-mining endeavor. About two months after implementation, we queried the system for all of the pain scale scores (the fifth vital sign) documented in a 30-day period, performed descriptive statistical analyses, and presented the data in a graphic format. The project revealed new horizons and information to the staff.

- The laborious process of random data collection from medical records could become a thing of the past.
- They could collect a much more complete set of data from the EMR than was feasible from paper records.
- The time previously spent collecting data could be redirected to discerning the meaning of the data and identifying appropriate responses.
- They were doing an excellent job collecting and documenting pain data as the fifth vital sign.

- They knew much more than ever before about the kind of pain (frequency of each pain score) and how much pain (pain score distribution) their patient population experienced.

The data-mining process also enabled the staff to identify additional information not currently available in the EMR that would enhance further their understanding of their practice and how that information could influence their practice to enhance patient care or improve patient outcomes related to pain. Although a very small dataset in the context of overall patient care and documentation, the more than 13,000 pain scores kindled a spark of understanding and excitement regarding the potential of the EMR to influence care delivery and support clinical research.

As the project progressed and the EMR was extended to the remaining inpatient units, the Core Team members assumed new leadership roles and responsibilities. Once the pilot phase was completed, we had three additional implementations, introducing EMR documentation to four or five patient care units at each stage. Our commitment to successful implementation was evidenced through the support that individuals presented around the clock for 7–10 days on each unit. Support was defined as individuals whose sole responsibility was to be present to answer questions, assist staff who were having difficulty, and guide staff through some of the more advanced features of the system once they had achieved confidence with documentation in the EMR. Several of the clinical staff members expressed interest in serving in the support function. After ensuring that these staff members could be released from their clinical responsibilities for a shift, they were able to mentor staff on other units during rollout of the system. Furthermore, these same individuals became role models, coaches, and expert resources on their home units.

The support that the clinical staff members of the project team provided expanded after implementation. System monitoring, coaching staff members who were struggling to use the features of the system effectively, and assessment for lapses in correct use of the EMR needed to be conducted on a regular basis. Two or three volunteers on each inpatient unit received instruction on the monitoring processes, supported by the Core Team facilitator. Many of these team members embraced the process, identifying process-improvement opportunities to reduce ineffective or incomplete use of the system, and one unit created a competency-evaluation program to support more robust system usage.

Publications

Publication became another means of mentoring the staff. Several peer-reviewed journal articles and posters have resulted from our experiences over the past four years. Mentoring staff by encouraging their participation in the authorship of these articles and posters has been a growth opportunity

for all of us. Staff members have witnessed the process of identifying and developing an idea, sharing thoughts and the work of writing, negotiating content and style, and the thrill of approval of their submissions for publication. From these experiences, we now have staff members authoring projects with coaching from leadership staff who will not receive author credit.

Although we are far from the completion of the development of our EMR, we already have reaped many benefits from this experience, in both the data and information we have and will continue to gain from the EMR, as well as the learning and growth we have experienced as the project has evolved. These experiences will enable the future process to be richer and more robust, influencing the EMR and the processes we create.

One of the major lessons to be shared from our experience is that leadership, mentoring, and role modeling are not set-aside activities but are best woven into the fabric of daily operations. Beginning with a plan that

thoughtfully includes these concepts allows the implementation process to actually create new opportunities, with each opportunity spawning new and sometimes unanticipated opportunities. Additionally, as staff members assume expanded roles and gain expertise and competence, managers are empowered to turn their attention to new avenues, confident that their staff members are able to continue to use their new skills.

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