Voice of the President

Happy New Year! I am both honored and excited to be serving as your 2020 AONL board president. Nursing will be in the limelight this year, as the World Health Organization has proclaimed 2020 as the Year of the Nurse and Midwife, honoring the 200th anniversary of Florence Nightingale’s birth. AONL will be involved in initiatives to raise the profile of nursing and further understanding of this important role in advancing health.

I look forward to partnering with Robyn Begley, the CEO of AONL and senior vice president/chief nursing officer, AHA, AONL’s board, and our membership to advance the mission of shaping health care through innovative and expert nursing leadership. I also would like to recognize Mary Beth Kingston for her significant contributions in 2019. As AONL president, she led the organization through a name change to better reflect our membership and extend the reach of AONL. I look forward to continued collaboration with Mary Beth as our immediate past-president.

I have had the honor of serving as AONL Region 3 director and during this time assisted with the annual conference, served on the System CNE Committee and participated in the academic/practice partnership between AONL and the American Association of Colleges of Nursing.

We have found when we can create [growth and development] experiences for staff . . . we help increase retention and support staff satisfaction.

I am trained as an oncology clinical nurse specialist but like many of you, my career path led me to serve in many progressive leadership roles including frontline clinical manager, service line director, clinical associate professor, associate operating officer, and CNO. Since 2011, I’ve had the privilege to serve as vice president of patient care services and system chief nurse executive for Duke University Health System as well as the associate dean of clinical affairs for the Duke University School of Nursing, Durham, N.C.

Continued on page 22
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January 2020

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Richmond, Va.
Work environments should be continuously evolving into contemporary, engaging, collaborative atmospheres that value diversity, creativity and innovation. This evolution necessitates creating environments that attract, engage and develop the next generation of nursing professionals and challenging long-held assumptions. Several years ago, leaders from Indiana University Health, Indianapolis, came to the realization that the professional image policy conveyed assumptions that nurses needed strict, detailed rules dictating how they presented at work. A few examples of rules include: no unnatural hair color, no visible tattoos and requirements for the type of shoes and socks that could be worn. The policy reflected a value of conformity instead of celebrating each nurse as a unique individual. In direct contrast with our expectation that each patient should be treated with respect and care, we did not provide the same respect for the individuality of our nurses and team members.

One chief nurse at an IU Health hospital shared reflections on managing expectations of the professional image policy:

As I began my role as a chief nursing officer, our senior leader team developed strategies to strengthen relationships with our team members. One component of the strategy included spending time on weekends and nights rounding and intentionally connecting with our teams providing patient care.

While rounding through departments and engaging team members in conversations, I realized that many were not as deliberate about covering their tattoos on nights and weekends as they were during weekday hours. During these connections, they shared stories behind their tattoos. Many tattoos were in memory of someone who had passed away, while others represented something meaningful to them—but all had a story.

My peer senior leaders had similar observations, so I asked them if they were offended by any of the tattoos that they had seen. The answer was always no. We questioned if enforcing the professional image policy was really how we wanted our frontline leaders to spend their time. Could their time be spent in more meaningful ways? Could time dedicated to enforcing details of the professional image policy be spent in conversations about what was important to each team member and what type of support he or she needed? More time might be available to coach team members in getting specialty certifications or pursuing an advanced degree. What if leaders had more time to focus on interdisciplinary collaboration and building high-performing teams that provide excellent care and engage in continuous quality improvement? The potential return on the investment of changing the culture was too great to ignore.

**Call to action**

Challenging established mental models required thoughtful, comprehensive ways to hear the voice of our team members and customers/patients. We partnered with the chief human resources officer to thoroughly assess our work environments and understand various assumptions.

Community partner and patient feedback surveys and online groups told us that visible tattoos and piercings were mainstream and did not negatively influence perceptions of nursing professionals. Surveys included the patient’s response to pictures of nurses with and without tattoos and various hair colors. Patients cared much more about how a nurse related to them and a nurse’s professional demeanor than a nurse’s body adornment or hair color. Team member surveys on professional image included feedback on the desire to be seen, bring their whole self to work, connect in genuine ways and be authentic. They valued leading with humility, having the courage to take risks, speaking up and asking for help. System shared governance members also were engaged in discussions about professional image and healthy work environments.

The feedback was a call to action to ditch the extensive, rules-driven professional image policy. This policy even prevented clinical managers in departments such as surgery and the neonatal intensive care unit from hiring nurses with visible tattoos that could not be covered when scrubbing in. The voice of our customers was used to transform mental models and challenge assumptions to develop a contemporary, values-based professional image policy, which was only a few pages in length. Importantly, we maintained infection prevention and safety standards; for example, a ban on artificial nails in certain environments...
clinical areas and dangling earrings were in the final policy, which was implemented on April 1, 2018.

Leader development was an essential part of rolling out the contemporary professional image policy. Some leaders were very comfortable with a rules-driven culture and found leading from a values-based mindset to be different and challenging. The transition from rules-driven to values-based leadership became the “crucible of leadership” that George (2015) describes in the book Discover Your True North. Leadership skills are tested and refined in this crucible. Our nursing leaders read this book to develop the authentic leadership characteristics necessary to lead in the new paradigm. The organization vision, mission and values were also a key component of policy implementation. The new organizational values of purpose, excellence, team and compassion were rolled out in tandem with the policy, helping leaders view changes through a new lens of values-based leadership.

**Stories**

What does transforming a culture really looked like in practice? A few stories exemplify the challenges of shifting from leading with rules to a culture of values-based leaders and how these changes personally impacted one of our nurses.

A new nurse was experiencing personal issues and needed to resign. To leave the organization in good standing and also leave the door open to potential rehiring in the future, this new nurse gave a two-week notice and committed to fulfilling this expectation. However, a personal issue came up unexpectedly and the nurse needed to miss a day of work. The new nurse called a colleague to cover the shift, but this put the colleague into two hours of overtime. All overtime needed pre-approval from the clinical manager, which did not happen in this circumstance. Therefore the clinical manager disciplined the colleague. The new nurse said that this is not an organization she wanted to be a part of and immediately resigned. The CNO and director had a coaching conversation with the clinical manager and reviewed the organizational values. The manager reflected and responded that she knew how to lead in a rules-driven culture but did not feel she could lead with the new expectations. The clinical manager found a different role and the director hired a new clinical manager committed to values-based leadership.

Sarah is a formal nurse leader in the emergency department. She was featured in a local publication about how changes to the professional image policy and the organization culture impacted her personally and professionally (Rudavsky, 2018). Sarah wore long sleeves under her scrub shirt for many years to cover her tattoos because she knew this was one of the rules. She now attributes her authentic connections with patients to the freedom to show her tattoos. When asked, she shares how her art is in memory of family members and a reflection of her dreams. Many patients, including some seniors, show her their tattoos and share their stories. Sarah noted that she still receives comments from nursing professionals who are surprised that our organization trusts our nurses enough to show their tattoos. Interestingly, she is in school to become a nurse practitioner and must cover her tattoos during clinical rotations.

How do we remain relevant as leaders to boldly lead a dynamic, complex and contemporary nursing workforce? Seize opportunities for reflection, ask those difficult questions and challenge traditional assumptions. This cultural transformation can be synthesized into one courageous statement: Use good judgment, we trust you.

**References**


**ABOUT THE AUTHORS**

Melora Ferren, MSN, RN-BC, is vice president, associate chief nurse executive, Indiana University Health, Indianapolis.

Lisa Sparks, MHA, RN, NE-BC, is chief nursing officer, Indiana University Health, Indianapolis suburban region.
“Coming together is a beginning; keeping together is progress; working together is success.” – Henry Ford

Grady Health System of Atlanta is an 800-bed nationally acclaimed Level I trauma center, a Baby Friendly designation, and has a comprehensive burn center and an advanced comprehensive stroke center. Grady is a pillar in Georgia, renowned for healing the patients with formidable health conditions and caring for the indigent and underserved. The health system is responsible for training most of the practicing physicians in Atlanta. Grady has a solid culture of serving others, providing the new millennial nurses an opportunity to fulfill their need to do meaningful work. Hundreds of applications for the nurse residency program are submitted annually. Typically, a potential nurse resident is euphoric if scheduled for an interview. They enter the organization victorious, grateful, joyous, eager, engaged and proud to be “Grady nurse.” However, early in 2016 a trend was identified: a substantial number of nurse residents were leaving the health system between six to 12 months of employment. Why the exodus? The organization failed to identify millennials as primary stakeholders and meet their needs. This article will focus on the collaborative leadership and cooperation that resulted in the restructuring and rejuvenation of the nurse residency program which in turn, improved first-year retention.

Stakeholders and silos

The 2010 Institute of Medicine report The Future of Nursing: Leading Change, Advancing Health highly recommended the use of a transitional program for new nurses entering the workforce. Grady Health System received a grant to implement a nurse residency program. The program’s evidence-based curriculum and tools were used to improve first-year retention. Unfortunately, it was not the primary focus of any stakeholder who interacted with the nurse residents (Figure 1).

The chief nursing officer discovered alarming data regarding first-year new nurse retention: An approximate retention rate of 55–65% between 2013 and early 2016. Deeper analysis revealed only one department and one nurse residency program coordinator were charged with improving nurse resident retention. Upon further investigation, it was discovered that communication and collaboration was poor between the stakeholders who directly impact first-year nurse resident retention and initial experiences. Clearly, the stakeholders were working in silos with separate goals.

The following provides a glimpse of the primary stakeholders, their goals and the processes in place producing gaps:

- **Human Resources**
  The talent acquisition team was primarily responsible for the recruitment and onboarding of the nurse resident. Its primary goal was to hire as many new graduates as possible to meet staffing demands. However, this was done without regard to organizational or clinical fit or alignment to nurse residency program start dates. The team had minimal knowledge of the nurse residency program processes and execution. Communication with the program coordinator was at a minimum and the team often had a poor response time to applicants’ emails and calls regarding changing start dates or their preferences to work in certain clinical areas.

- **Department of Nursing Education, Practice and Research**
  The department was assigned accountability and responsibility for the success of the program. It assigned personnel to implement the program as one of many job duties.

- **Program Coordinator**
  The primary goal of the program coordinator was to deliver the nurse residency program’s evidence-based curriculum. This was one job duty among many others. Additionally, the nurse residents were provided with a schedule of classes. Other duties were to promote discussions and act as sounding board, sharing successes, challenges and strategies to survive. The nurse residents were required to produce an evidence-based practice project, but received scant leadership support. The coordinator kept attendance records, but had minimal conversations with unit directors, human resources and advanced clinical nurse educators. Advocating for the nurse resident was not a priority.

- **Advanced Clinical Nurse Educators**
  The advanced clinical nurse educator/clinical nurse specialists’ (ACNE/CNEs) primary goal was to meet

Deborah R. Davis, MSN, RN

It Takes a Village: Collaborating to Improve First-Year Nurse Retention

American Organization for Nursing Leadership
with the nurse residents to discuss and to distribute an orientation plan and expectations. They sporadically monitored progress and had some or no interaction with preceptors. Nurse residents were assessed the same as experienced nurses during orientation. The ACNE/CNEs rarely communicated issues to program manager.

- **Unit Director**
  The primary goal of unit directors was to fill their vacancies. At that time, the directors encouraged an expedited orientation of the nurse resident. Preceptors were assigned who had minimal training and interest. Directors minimally met with nurse residents to identify their needs and were not knowledgeable of the nurse residency program guidelines/expectations. They provided inconsistent support for the nurse residency program and had poor attendance at nurse residency program events.

  There was little evidence from any of the listed stakeholders to show they had retention in their lists of priorities. The stakeholders and others were brought together to address one collaborative goal: retention of the nurse resident in the first year.

  Sharing this goal would require a mutual restructuring on how the stakeholders conducted business. They had to become connected and fluid to meet the needs of the nurses. While the stakeholders were developing strategies to symbiotically retain the nurse resident, other collaborations were in process. The chief nursing officer solidified the cooperation and collaboration among the organization’s executives for the necessary resources needed to support first-year nurse retention and the nurse residency program. It was through this administrative influence that the nurse resident and the nurse residency program gained increased visibility and became a central organization focus.

  The nurse resident at first was not recognized as a stakeholder. However, nurse residents’ feedback and input was needed to assure that what was important to them was incorporated into the health system’s strategies and goals.

**Nurse resident experiences**

Nurse residents of today want to be valued, heard and feel recognized for their input. The following experiences were derived from nurse statements in residency sessions.

Nurses were dissatisfied with the interview and hiring process, with poor communication at every step in the process. Some said they had inaccurate communication about where they would be working, with some changing nursing units immediately after arrival at the health system. Others said they didn’t have the opportunity to sign a contract until after hire.

They expressed coming into non-welcoming clinical environments, with disorganized unit orientation, lack of management support and visibility and working months before beginning the nurse residency program. By that time, they were unsure of program’s value.

Some said they were paired with unengaged/harsh preceptors. New nurses also feared being pushed out of orientation too soon, putting their newly acquired licenses in jeopardy. They verbalized feelings of helplessness, isolation and the lack of supportive and nurturing relationships with management team and coworkers. In addition, some expressed dissatisfaction with lower starting salaries than
other local hospitals. Grady nurse leaders used this information to direct their efforts of retention.

Collaborative teamwork
Once the retention became the common goal, Grady was able to move forward to improve outcomes. Changes made by the stakeholders incorporated the concepts and actions deemed important to millennials: technologically based communication, minimal response time, timely information, clear direction, safe and social work environments, relationships with peers and mutual respect. This included efforts to recognize them for their accomplishments.

• Human Resources
This department hired a senior talent acquisition specialist primarily assigned to recruiting graduate nurses. This person is responsible for the oversight of the nurse resident candidate including timely and efficient communication, processing applications, selecting interviewees, the interview process, hiring and initial onboarding. Open and continuous communication with the nurse residency program manager allows for alignment of all nurse resident start dates. The contract/agreement is discussed and presented prior to hire. The department developed qualification criteria for residents seeking specialty units. Residents have the option to choose up to three areas of interest for interview. The team now requires mandatory attendance of the program manager/unit management team during interview events. The shared governance council members interact with nurse residents and share experiences while the residents are awaiting interview appointments.

• Unit Management
Unit managers assure nurse residents are welcomed and positively supported throughout orientation and the first year. They adhere to and support the nurse residency program curriculum and activities. They assure preceptors have received education and/or attend workshops and assign committed preceptors. Unit managers are now highly encouraged by the nursing executive team to attend nurse resident presentations/graduations, communicate and collaborate with program manager concerns and challenges.

• Department of Nursing Education, Practice and Research
The director of this department eliminated the program coordinator assignment and replaced that position with a program manager. A facilitator was assigned to assist with the program. This department now has overall responsibility for maintaining retention data and supporting the needs of the nurse residents. The department creates strategies and communicates with leadership about the needs of the program. It provides consultative services and guidance to the program manager. In addition, the department provides guidance, escalates concerns, evaluates the program and assures that the ACNE/CNE prioritize the nurse resident.

<table>
<thead>
<tr>
<th>TABLE 1: Grady Nurse Residency Program</th>
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<tbody>
<tr>
<td>Cohort A: 42 Residents – Starting August, 2016</td>
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<td>Cohort B: 29 Residents – Starting January, 2017</td>
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<td>Cohort C: 35 Residents – Starting April, 2017</td>
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<td>Cohort D: 67 Residents – Starting August, 2017</td>
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<td>Cohort E: 42 Residents – Starting February, 2018</td>
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<td>Cohort F: 67 Residents – Starting August, 2018</td>
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<th>Cohort</th>
<th>Year 1</th>
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<tr>
<td>Cohort A</td>
<td>92%</td>
<td>83%</td>
<td>71%</td>
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<tr>
<td>Cohort B</td>
<td>93%</td>
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<td>Cohort C</td>
<td>95%</td>
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<td>Cohort D</td>
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<td>Cohort E</td>
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<td>Cohort F</td>
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• **Program Coordinator**
  The program coordinator manages all aspects of the nurse resident for first 14 weeks of orientation or when the nurse resident meets baseline competencies to provide safe patient care, fully supporting the nurse resident journey. She or he advocates, counsels, supports and communicates the residents’ individual or group needs/concerns, has strong collaboration with human resources, the unit management team, and ACNE/CNS. He or she also holds educational in-services for the leadership team on the residency program and created “Guidelines for Leadership” providing detailed information about the program and stakeholder expectations and responsibilities.

• **Advanced Clinical Nurse Educators**
  ACNEs meet with nurse residents initially and weekly during orientation, supporting their needs during the first year. They are responsible for all phases of orientation and monitor preceptor and nurse resident relationships, providing education and guidance to preceptors. They develop professional relationships and trust with the nurse resident and act as a liaison for the nurse resident in various situations. ACNEs guide nurse residents’ evidence-based projects and also communicate and work closely with the program manager.

  The changes made by the stakeholders in the past two and a half years have directly impacted the retention of the nurse resident at Grady Health System (Table 1). The nurse resident is a priority of the organization at all levels. The experience of horizontal hostility is significantly reduced; preceptors are taking an interest in the nurse residents’ success. Nurse residents are developing relationships with their preceptors, staff and management team and say directors are more visible and engaged in their well-being. Executive leadership personally addresses the nurse resident concerns by attending sessions, encouraging and accepting open honest dialogue. Nurse residents now receive a significant monetary boost to their salary upon completion of the program, a true concern of millennials. Opportunities are provided to build collaborative relationships with health care members in various departments who impact their ability to do their jobs effectively through hospital rotations. Grady supports their need to explore career opportunities by arranging shadowing experiences for those looking to transfer to other clinical units after their first year. Preceptors are required to be trained and receptive to the nurse resident. The program manager remains their primary advocate so that they are heard and positive outcomes are realized.

  Grady leaders have learned retaining the nurse resident during the first year is a collaborative effort requiring executive leadership support. A common goal enabled the system to drive necessary processes forward to maintain a culture supportive of new nurses. Overall, nurse resident feedback has positively improved and the first-year nurse resident average retention rate has been 93–95% since 2017.

  “It takes a village” is an old African proverb meaning that a child’s upbringing is a communal effort. We have modified the proverb: It takes an organization to retain a nurse resident!

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Creating a Bright Future: Identifying Supports for Millennial Nurse Leaders

As a millennial leader, I am constantly questioning my ability to make decisions, set direction and mentor other leaders in my role. The question “Who am I to coach a leader 25 years my senior?” happens on a frequent basis, especially now that I am leading leaders. It is this daily case of imposter syndrome and my desire to support others that prompted me to understand better “What is it about millennials?”

The generational workforce

A generation can be defined from a sociological perspective; people born in a range of years that share common beliefs, behaviors, and societal experiences (Gardner, 2016). Recent studies have shortened the years of the millennial generation from 1981-2001 to 1981-1996. Researchers felt it was imperative to delineate the importance of September 11th in the millennial generation. The political, economic and social factors that defined millennials through their formative years offer a clear distinction between them and their Generation Z successors (Dimock, 2019). Most notably, millennials entered the workforce during a recession, many with mass amounts of student debt. While this may not directly impact leadership, it may play a part in their motivation to succeed and desire to achieve high-level leadership positions.

Three generations are in the nursing leadership workforce currently: baby boomers, Generation X, and millennials. Baby boomers hold the most leadership positions nationwide. With the impending retirement of this generation, we can anticipate the nursing leadership gaps replaced with millennials. The good news is that 36% of millennial nurses are interested in moving to positions of leadership (Faller, 2018). While we have a motivated group of millennial nurse leaders to fill the gap, an experience gap will be present.

For previous generations, positions of leadership were often obtained hierarchically and after years of tenure. With that came a pool of wisdom and experience that will soon be retiring. With the motivation for learning and knowledge acquisition, millennials will enter leadership with excitement and some foundational knowledge, but may lack the expertise to aid in decision-making, leadership and coaching. Understanding the characteristics of millennials in nursing leadership and developing strategies to support can help with this transition.

Millennial leader characteristics

An abundance of literature defines and outlines aspects of millennials in leadership (Figure 1).

**FIGURE 1: Millennial Leader Characteristics**

- **Relational**
- **Innovative**
- **Learners**
- **Motivated**
- **High Expectations**

**Relational**

Millennials enjoy developing relationships. They are people-oriented, collaborative and value working with teams (Gardner, 2016). These qualities are encouraged in leaders; they are often vital in identifying and including stakeholders, eliminating silos and the development of conceptual thought. But these qualities also can be a barrier to moving projects and initiatives forward. At times collaboration and teamwork can lead to cycles of continuous feedback collection and approval that subsequently stymies a project. Offering support with deadlines, check-ins and frequent feedback can keep a project moving forward.
Innovative
This is where many millennial nurse leaders shine. Their vision and risk-taking idea generation (Harrison, 2017) can drive rapid and progressive change in the health care sector. Whether it be exploring ways to use technology to improve daily tasks or leaning in to the “what could be,” millennials’ strengths in innovation are a huge asset.

This strength does require some development and finesse. The literature suggests intentionally developing competencies to support innovation. Organizations can create thoughtful leadership orientations that promote the acquisition of these abilities. By doing this, they can support and develop innovation in nursing leaders.

High expectations
Millenials or those who work closely with them will find this characteristic familiar. One area where this plays out: the expectation of instant feedback and decision-making (Gardner, 2016). Because of this, it is not surprising to hear that e-mail culture at many institutions feels like a text-message culture. From a sociological standpoint, we can make many assumptions as to why this is happening, with social media being the biggest driver. The more important piece is to determine how to set and meet expectations with not only the millennial nurse leader, but all leaders. Providing clear expectations and boundaries about communication on weekends and after shift is essential. It also will support millennials’ desire to have work-life balance.

Millenials thrive on constructive criticism from which they can learn and develop (Kosterlitz & Lewis, 2017). Yearly formal performance feedback likely will not meet this need (Gardner, 2016). Identifying ways to provide informal feedback by using mentors, project managers and peers can fill this gap.

Millenial nurse leaders also will have expectations from the employer organizations. Millennials expect their jobs to provide them with meaning, challenge and flexibility (Defrank-Cole & Tan, 2017). Connecting the millennial with the mission and values of the organization, both professionally and personally, can help meet this expectation. Also, challenging them to create their vision for the specialty with which they work will help fulfill the expectations while encouraging engagement with the role.

Motivated
The external societal norms that many millennial nurses grew up with have impacted desire and motivation in the working environment. These norms include achievement through participation and an enhanced focus on competition. Millennial leaders feel pressure to succeed at everything they do (Gardner, 2016). In addition to the drive for success, millennial leaders are highly optimistic (Kosterlitz & Lewis, 2017), competitive (Defrank-Cole & Tan, 2017) and confident. A simple strategy to support motivated millennial nurse leaders is frequent and specific praise (Gardner, 2016). In addition to praise, identifying stretch projects for the millennial leader to engage in (with adequate coaching and support) will support the need for a challenge and success.

Life-Long Learner
Millenials are actively engaged in their learning and professional growth. According to Becker’s Review, 39% of millennials plan to pursue a master’s degree in nursing in the next three years (Faller, 2018). As a result, supporting advancing education for all leaders is pivotal in developing a highly educated nursing leadership pool. The knowledge is essential, as many millennial leaders will lean on knowledge, not extensive experience.

In addition to millennials’ motivation to learn, they learn differently as a generation. Traditional classroom-based pedagogy may not meet the need of millennial learners (Harrison, 2017). Millennial learners can benefit from the use of social media-like learning management systems, games, practical application activities and reflective practices. Investing in tools that support just-in-time learning for millennial nurse leaders will foster resourcefulness and the ability to learn and grow from experiences.

Mentorship models
Mentorship seems to be a common theme not only for millennials, but for new leaders. In the traditional mentor model, an experienced and tenured nursing leader provides wisdom, knowledge and feedback. While this model has much research and literature to support it, soon the millennial leaders will outnumber those with the expertise and wisdom to mentor. With that knowledge, other mentor models have been emerging (Figure 2).
The reverse mentor model, highlighted in publications such as the Voice of Nursing Leadership and in conference presentations, has been used successfully in the technology and financial industries. Reverse mentoring occurs when a newer/younger leader mentors a senior leader. This mentoring is typically used for the mentor to share skills and knowledge with social media and technology advances. This model leverages skillsets and characteristics of one generation, pairing it with the knowledge, wisdom and expertise of another to drive faster innovation and better outcomes.

The Hartford, an insurance company, implemented a reverse mentor model and experienced impressive results. Of 12 younger mentors who participated, 11 were promoted within the year. In addition to the promotion, two patents were filed, a policy change on personal electronic use was made and financial savings on a marketing campaign occurred—all successful outcomes of the model (Sloan Center on Aging and Work, 2013). The reverse mentor model created bidirectional knowledge sharing between the mentor and mentee to promote positive change within the organization. Also, the millennial leader was able to better network, gain exposure to stretch projects and feel more connected to the organization.

Another approach is the intergenerational mentor model, which operates on the premise that “everyone leads, everyone learns.” It focuses on targeted skill and knowledge acquisition between generations. This approach assesses the generational strengths of all ages within a workplace and matches the strengths with leader needs or gaps. The benefit of this approach is that it focuses less on seniority and more on the skills and needs of all leaders equally (Satterly, Cullen, & Dyson, 2018).

No matter the mentor model used, mentorship is integral in the development and support of not only millennial nurse leaders, but all nurse leaders. Mentorship offers bidirectional learning, increased networking, improves decision-making, creates a space for regular feedback and encourages knowledge sharing.

Support and development of millennial nurse leaders doesn’t have to evolve from research and theories. In March, I gave a presentation for the Seattle chapter of the Northwest Organization of Nursing Executives on millennials in nursing leadership. The group was a mix of tenured nursing leaders and new-to-leadership millennials. Together, we created ideas that nurse leaders of any generation could use to support one another (Figure 3).

Much research, theory and evidence describes practice transition. When any generation of nurses, including millennials, enters new leadership roles, they will experience transition shock. Nursing professional development departments can create and support evidence-based nurse leader transition-to-practice programs. These programs can offer foundational knowledge, leadership support and mentorship for new nurse leaders. These departments’ expertise in practice transition is arguably essential for leadership transition.

Millennials will soon outnumber any other generation in nursing leadership. They have specific strengths and characteristics which make them unique. Although health care organizations can and will find ways to address these characteristics, support for the millennial nurse leader is truly no different than for any other generation. Creating a safe support network allowing for bidirectional knowledge sharing, providing regular feedback for both motivation and growth and being open to ideas will help the millennial nurse transition to a leadership role.

**References**


**FIGURE 3: Millennial Nurse Leader Support Strategies**

- Give specific praise: What they did, what strength they demonstrated and why it matters. More than just a “good job.”
- Embrace continuous improvement and failing: allow them to try projects without having all of the answers.
- Support the desire for learning offer educational group workshops, webinars, and tuition reimbursement.
- Assess/explore top values and expectations. Determine what leader activities will help achieve their values.
- Say “yes, let’s try it” more often.


The Sloan Center on Aging and Work and the Center for Family and Work at Boston College. (2013). Reverse mentoring at The Hartford: Cross-generational transfer of knowledge about social media. Boston: DeAngelis, K.L.

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This program is co-taught by the American Organization for Nursing Leadership (AONL) and the Healthcare Financial Management Association (HFMA).
Team Scheduling: Creating Flexibility and Accountability for an ICU

Autonomy is a broad term used to describe self-governance. Nursing autonomy and control over nursing practice are key elements of a healthy work environment (Weston, 2010). While autonomy in nursing practice is critical, autonomy over the work environment, including staffing and scheduling practices, also contributes to a flexible, supportive team structure. Autonomy is associated with increased job satisfaction and nurse retention (Kramer & Schmalenberg, 2004). An environment that supports autonomy promotes nurse engagement with both the profession and the health care organization. While self-scheduling has been promoted as an effective method to promote work-life balance, it needs to balance the needs of team members with the needs of the organization (Bell, Collins, & Song, 2007).

WellSpan Health York (Pa.) Hospital has a long tradition of supporting autonomy for clinical nurses. The 10-bed medical intensive care unit at WellSpan York adopted a team scheduling process during a transition of unit leadership. Team scheduling, and the flexibility that it provides, has proven to be a key satisfier for this multigenerational team. While each generation of nurses share core values like teamwork and professionalism, they also have unique values and preferences (Bell, 2013).

All unit staff, clinical nurses and cross-trained unit secretary/nursing assistants, are scheduled for 12-hour shifts with a combination of full-time, part-time and weekend option staff. During my team interview, I recall being startled by the question: “Will you be taking over our schedule?” As I inquired further, it became clear the nurses valued their autonomy and were concerned about relinquishing control of the unit schedule. Individual preferences, when balanced with unit staffing needs, are key satisfiers for nurses who strive to achieve work-life balance (Mullen, 2015).

The scheduling committee consists of two tenured RNs, who are members of the unit’s shared decision-making structure, called the unit practice council. The committee, using the hospital’s human resources policies, developed unit specific guidelines with their peers and leadership. The guidelines have been reviewed and revised at least annually to reflect changes in hospital policy, needs of team members, and changes in the unit census and acuity. As younger nurses join the team, their perspectives continue to inform and refine unit policies. One recent change included the adoption of a 12-hour holiday matrix allowing nurses to spend additional time with their families while meeting hospital requirements. Prior to that revision, unit nurses were working either the eve or day of every holiday.

Benefits

While some leaders may identify risks to team scheduling, there are also many benefits. It supports professional growth and leadership development, but it does require a time commitment and excellent communication skills. The committee balances individual requests with unit needs and in accordance with human resources policies. The nurses have become skilled negotiators with their peers and they promptly escalate any concerns to the unit’s nurse manager—but this is rarely needed. To promote fairness and support transparency, the committee maintains a log book displaying nights for those RNs who are day/night rotators, work holidays, call and floating shifts. This log, readily available to their peers, is consulted when schedule conflicts arise. Conflicts are discussed and negotiated openly and respectfully among the peers; this promotes a culture of peer accountability. With this model, the unit nurse manager role is limited to mentoring, coaching, consultation and oversight.

This model promotes autonomy and accountability while offering flexibility. The schedule committee owns the process and the committee members have earned the respect and trust of their peers as unit leaders.

References


Continued on page 18
“Certification has validated that I have the essential, specific knowledge to carry out complex leadership responsibilities, which directly affects the quality of care to patients and families. Passing the exam has led to a sense of personal growth, accomplishment and confidence—it has truly heightened my job satisfaction!”

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Like many hospitals, Harborview Medical Center (HMC) in Seattle has increasingly faced a high census and longer hospital length of stay (LOS). LOS had increased from an average of 5.95 days in 2012 to 7.65 in 2018 (Figure 1). In light of the problems hospitals face accommodating an influx of flu patients in the winter, as well as Harborview’s unique influx of trauma patients in the sunny summer months, this article details the actions HMC took to manage a higher census and provide high-quality, appropriate care to each patient.

HMC is a 413-bed safety net, academic referral center—one of four hospitals in the UW Medicine Health System, and the only level 1 trauma/burn referral center for the states of Washington, Wyoming, Alaska, Montana and Idaho. HMC serves as one of three major teaching sites for the University of Washington Schools of Nursing, Medicine, Pharmacy and Social Work. HMC is the designated care site for our mission population, the citizens of King County, Washington.

With almost 20,000 admissions annually, about 80% of patients are admitted through the emergency department and about 30% are transferred from outside health systems. The payer mix is 35% Medicaid, 34% Medicare and about 5% self-pay. Approximately 25% of patients admitted to HMC have substance use or mental health disorders and 13% report being homeless or marginally housed. This complex patient mix is very challenging to place into lower level care, such as skilled nursing facilities or adult family homes.

HMC has a long history of caring for medically and socially complex patients. Although about 40 experienced continuity of care nurses (CCNs) serve as discharge planners in the 30 clinical teams throughout acute care services, we were still met with challenges regarding patient flow. Social workers, acute care nurses, pharmacists, and physical, occupational and speech therapists were unit based. Significant communication and activity surrounding patient throughput and discharge occurred, but communication was not standardized. It did not involve all members of the team and the team did not have a shared mental model of patients’ clinical milestones and anticipated discharge dates. Additionally, the discharge process lacked patient and family involvement; patients often were surprised to learn they would be discharged soon.

**Bringing the team together**

To improve the program and transform our care processes, we created a department of care management reporting to a director-level administrator. The director was responsible for leading the department and creating collaborative partnerships with the rest of the interprofessional team. In addition to the restructuring of care management, a capacity management physician role was created to serve as a dyad partner to the director of care management. The five-physician team was essential in building the multidisciplinary team for the implementation of new throughput initiatives.

A multidisciplinary production, preparation and process (3P) event led by our process improvement department gathered the stakeholders in August 2018. This group...
included nurse managers, acute care nurses, CCNs, faculty and resident physicians, nurse practitioners, physician assistants, social workers, pharmacists and rehabilitation therapists. There were three areas of focus: bed management (right bed/first placement), discharge planning (discharge tasks completed at the right time, e.g., begin patient education regarding anticoagulation at first dose) and discharge huddles.

Daily discharge huddles for each clinical service were redesigned to a new format. The new huddles were multidisciplinary including all members of the care team, brief (taking 15 minutes or less) and patient-centered. The CCNs now lead these huddles. The huddles are scripted and standardized with specific attention to expected LOS, barriers to discharge with mitigation strategies and action items assigned to specific individuals/roles, and include a plan and timeline for completion. The CCNs also are responsible for direct communication and engagement with the patient/family about the discharge plan. To help implement the new format, CCNs received coaching to ensure consistent huddles across teams. The reporting process at the bedside also was modified to ensure more consistent frontline nurse engagement; huddle times were changed to accommodate charge nurse participation. In addition, bedside clinical nurses received specific training regarding the discharge process. Data collection/tracking and transparent display of barriers by discipline also were implemented. Data are displayed in each clinical team room including process and outcome measures such as discharge before noon and LOS by unit and service can be viewed by anyone anywhere.

Enhanced discharge huddles and integration of our nurse-led huddles with all LOS/throughput initiatives have been central to our initiatives. With all of the nurse-led changes, our discharge process is now more standardized, focused, multidisciplinary and patient-centered. Our culture is transforming and our LOS improved, as shown in Figure 2, which begin in August 2018.

**Key learnings**

Active frontline engagement of the entire multidisciplinary care team in discharge is key to creating a shared mental model. Collaboration, shared accountability, transparency, standardized best practices, data-driven continuous evaluation and improvements, in addition to the integration and coordination of care LOS/throughput initiatives, have been crucial to be able to care for a high number of patients. The support of our chief executive officer, chief nursing officer and chief medical officer also has been essential in moving the needle.

Cultural transformation around safe and effective throughput and discharge planning is an ongoing effort across our institution. Led by nurses—in collaboration with all members of our multidisciplinary care team—our journey continues. We hope our story inspires other clinicians to bring their teams together, driving improvements and cultural transformation.

### ABOUT THE AUTHORS

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**ABOUT THE AUTHOR**

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**Addendum**

The article “Leveraging Staffing Technology to Improve Nurse Staffing Outcomes” appeared in the November issue of Voice of Nursing Leadership and discussed work to improve nurse staffing at Legacy Health, Portland, Ore. Voice is offering these additional references to learn more about this nurse staffing work.

**References**


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**LeaderRead**

**Bonnie Sakallaris read**

**Appreciative Leadership: Focus on What Works to Drive Winning Performance and Build a Thriving Organization**

*By Diana Whitney, Amanda Trosten-Bloom and Kae Rader*

**What I liked:** The authors’ research into appreciative inquiry is used to develop a map of leadership strategies and practices that inspires high levels of contribution, engagement and performance. They use straightforward language and compelling stories to demonstrate how to get results with “positive power.”

**What I learned:** Leaders can bring out the best in each other and make a positive difference by creating the conditions people need to be high performers: to know they belong; to feel valued for what they have to contribute; to know where the organization is headed; to know that excellence is expected and can be depended on; and to know that they are contributing to the greater good. The authors outline and illustrate five core strategies to mobilize creative potential and turn it into positive power: inquiry, illumination, inclusion, inspiration and integrity.

**Leadership insight:** As a leader, being and feeling powerful are essential to optimal performance. Being powerful means bringing your best forward, giving voice to what matters to you and engaging with others to create a world that matters for all. It is about helping others to be powerful by meeting their needs for optimal contribution. Practicing appreciative leadership makes good things happen for yourself and those you serve.

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<td>AONL Annual Conference</td>
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<td>Certified in Executive Nursing Practice (CENP) Review Course</td>
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2019 Highlights

Reflecting our membership, rebranded as the American Organization for Nursing Leadership

Annual Conference
- 100+ presenters
- 4,000+ total attendees

Advocacy
- 130 nurse leaders from 29 states visited
- 200 congressional offices

Website
- 1,842,790 website pageviews
- 380,803 active visitors
- 105,204 Leader2Leader pageviews

Social Media
- 1,064+ new Twitter followers
- 800 new Facebook followers
- 1,824 new LinkedIn followers

Young Professional Voices
- Recognized and engaged 20 high-potential nurses under 40

Certifications
- 156 nurse leaders earned their CENP in 2019
- 870 CENP active certifications
- 397 nurse leaders earned their CNML in 2019
- 2,294 CNML active certifications

Inaugural Year
- 37 Nurse Managers
- 29 Nurse Directors
- 23 Nurse Executives embarked on a leadership journey in 2019
Mission: To shape health care through innovative and expert nursing leadership

Vision: Nursing leadership—one voice advancing health

9,800+ members

AONL Foundation

$17,000 awarded from the new Pamela Austin Thompson Fellowship Fund

150+ nurse leaders assisted the Foundation through volunteer groups and committees

$39,000 awarded in research funds

More than $130,000 raised to support Foundation initiatives

Inaugural Year

18 nurse leaders named AONL Fellows

Fellowships

37 Nurse Managers

29 Nurse Directors

23 Nurse Executives

embarked on a leadership journey in 2019

AONL Fellow Designation

Education

475 continuing education contact hours offered in sites from Keene, N.H., to San Diego

95% of participants likely to recommend the programs

Nurse Leader Competency Assessments

475 180 degree assessments completed

4,909 Individual assessments completed

Website
**Younger generations**

This issue of Voice focuses on generations X, Y and Z and how we can support and enhance the work of all nurses, regardless of their generation. As a core value of AONL, we know that a robust and diverse nursing workforce is essential to the health of all Americans. From rethinking social constructs about professional image policy to developing and retaining first- and second-year nurses to giving our millennial colleagues a leadership voice, this issue chronicles several innovative strategies to advance this work.

At Duke Health, I find that we are navigating many of the challenges that are addressed in this issue, including the multi-generational workforce, retention of early- mid- and late-career nurses, and preparing a new generation of nurses to lead in a dynamic industry.

Deborah Davis at Grady Health System shares an excellent case of collaborative leadership success, which was used to improve the complex problem of first-year nurse resident retention. Stakeholders working within silos were identified and brought together to address retention and developed strategies to meet nurse resident needs. The work at Grady made me further reflect on the high nurse retention rate we have enjoyed across Duke Health for the past several years. However, when meeting with nurses with one to three years of experience at a recent retention summit, it was clear that after the 12-month residency program, our staff felt unsupported during year two of employment. This led to turnover by year three and an idea from our second-year staff to create a nurse fellowship program. We partnered a core group of our recent nurse residency program graduates with our education experts to create this one-year program. The goal is to provide support during the second year of employment in areas identified by the residents, equip the nurses to advance on our career ladder and sit for their clinical specialty certification exam. We are just getting ready to implement the program and I hope to be able to share some successful results in the future.

As leaders, we strive to have a workforce representative of the community that we serve; this diversity helps to provide an environment facilitating comfort and safety for all. Managing across multiple generations can be a challenge. I believe, however, that if we understand the people we serve as individuals we will have an increased chance to achieve whatever the specific goals may be according to the situation. Lauren Kalember nicely describes some of the key characteristics of the generational workforces and how the time period of birth may foster some preferences, such as the adoption of technology, speed of expectation of response or preference for type of feedback. She speaks specifically to motivation, noting how people prefer to learn and how to provide support, especially through mentorship.

At Duke Health we strive for retention and I’ll share two related experiences from my health system. The first is a systematic “stay interview” process. Managers meet with their staff (not during a performance review) quarterly or every six months to discuss how they can help create experiences for staff to grow and develop, to better understand the staff members’ dream roles and help them achieve them. We have found when we can create these experiences for staff—which more often than not are lateral moves—we help increase retention and support staff satisfaction.

Second, in the past we had a challenge recruiting into nurse manager roles. We did not have systems in place to best identify or prepare a pipeline of staff interested in the roles. As a mentor to one of my CNOs who was completing her doctoral program, I encouraged her to establish a leadership development program for nurses at the advanced levels of our clinical ladder. The program used online leader learning modules, paired with select didactic sessions with nurse leaders. The program received overwhelming support from all generations from millennials to baby boomers and they loved sharing with each other. We had one missing element—a formal mentoring program—just like Kalember highlights! Mentoring is now incorporated. And guess what? We no longer have nurse manager vacancies!

Kalember also speaks to the importance of feedback and recognition. I believe that we should be open to both positive and not-so-positive feedback. Constructive feedback doesn’t always feel good but provides us a great opportunity to grow. We use a 360-degree process and I find this most helpful. As leaders, we also have the responsibility to develop the skill of delivering constructive feedback. We should be thoughtful so that our comments are specific and individualized, with recognition and opportunities for growth as appropriate. We cannot underestimate the importance this has on the success of our team and our organizations.

As we continue to focus on generations X, Y and Z we recognize every nurse is a leader and that is indeed the focus of AONL. We have changed our name to promote diversity and inclusion of our younger generation nurses, and appointed early careerists as board members. In addition, we have established specific leadership development content and recognition programming and awards for those earlier on their leadership journeys. These complement the already broad array of offerings for nurse leaders across the span of their careers.

Today’s health care environment is dynamic, holding an uncertain future. This requires that nurse leaders be prepared, available and engaged to innovate, transform and lead care wherever it occurs, and AONL is uniquely positioned to support you in these efforts. I hope that you enjoy this edition of Voice. Again, I am so honored to be serving you this year as your board president. ◆
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