Bringing the Power Back to Staff with Unit Based Councils
Session #C809

2015 ANCC National Magnet Conference
October 8th 8-9am
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Aurora, Colorado

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Discussion Plan

- History/renewed focus on shared leadership
- Haven's Decisional Survey
- Setting the Framework for UBC's
- SBAR process
- Insights into Barriers and Success's
- Data Analysis

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Demographics*

- Academic medical center
- Not-for-profit
- Quaternary referral center
- Level II trauma center
- 611 Licensed Beds
- 5,761 Employees
- 2,000 RNs
- 28,621 Admissions
- 90,983 ED Visits
- 836,259 Clinic Visits

- 88% BSN or higher rate
- 53% Certification rate
- 111 articles in peer reviewed journals
- 272 local /national presentations
- 966 members of professional organizations
- 769 RNs on committees
- >300 projects

*FY14

University of Colorado Hospital

- Located in Aurora, Colorado
- Level II trauma center
- Has 551 licensed beds
  - 5,761 Employees
  - 2,000 RNs
  - 28,621 Admissions
  - 90,983 ED Visits
  - 836,259 Clinic Visits
- 12 Medical Surgical Units
- 8 ICU Units/2 Progressive Care. Units
- 769 RNs on committees
- Recently achieved our 4th designation as a Magnet hospital
- #1 ranked hospital in Colorado by the US News & World report for the past 3 years

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Nurse Stephanie

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Shared Leadership

Why Shared Leadership?

- *Empowers* frontline staff to be involved in decisions affecting their work environment
- *Enriches* interdisciplinary relationships on unit level.
- *Identifies* unit & staff level barriers to quality, patient experience, outcomes, efficiency; work together on improvements
- *Enhances* communication between the unit and executive levels, streamlining the dissemination of information to the individual.
- *Strengthens* best practices, information sharing across organization and system.

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UBC's Support the Magnet Components

- Transformational Leadership: Clinical nurse involvement with meeting mission, vision, and strategic plan, organization decision making, guiding nurses through change, change in the nurse practice environment, patient experience and nursing practice.
- Professional Development: Clinical nurses involved with interprofessional decision making, encourages professional development, improve the nurses expertise, and address strategic priorities.
- Exemplary Professional Practice: Clinical nurses are involved and interact with the professional practice model, care delivery system, standards of practice, interprofessional care, culture of safety, and especially the staffing, scheduling and budget process.
  - Specifically Autonomy is supported through the organizations shared-decision making structure.
- New Knowledge, Innovations and Improvements: Clinical nurses are engaged in nursing research, evaluating evidence based practice, improvements in workflow and efficiencies, and potentially create new initiatives that utilize innovation and technology.

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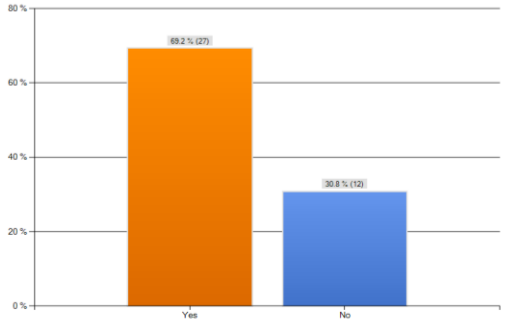
Unit Council Survey 2013:

Does your unit/clinic have committees or councils?



Distributed to PSAC and AS Nursing Clinical Leadership Distribution Lists July 2013
n=39/150 for 26% Response Rate

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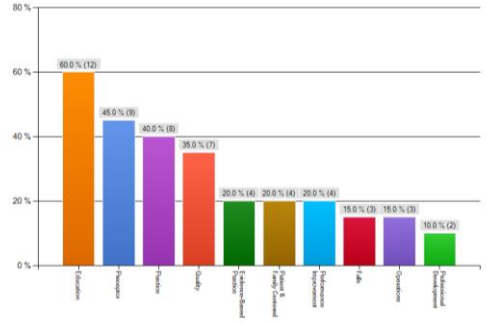
Unit Council Survey 2013:
Types of active unit/clinic committee(s) and council(s)



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Haven's Decisional Involvement Scale

- Two part 21 item scale-Evaluates staff nurse involvement in decisions and activities of the unit.
  - Perceived actual level of staff nurse decisional involvement
  - Preferred levels of staff nurse decisional involvement
- Valid and reliable
- The subscales:
  - Unit staffing
  - Quality of professional practice
  - Professional recruitment
  - Unit governance and leadership
  - Quality of support staff practice
  - Cooperation/liaison activities.

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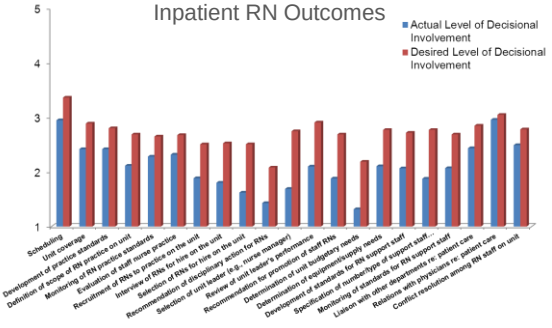
Havens Decisional Involvement Survey
Inpatient RN Outcomes



Decisional Involvement Survey Administered September 2013; n=424 35% Response Rate
Scale: 1-Admin/mgmt only; 2-Primarily admin/mgmt w/ some staff RN input;
3-Equally shared by admin/mgmt & staff RNs; 4-Primarily staff RNs w/ some admin/mgmt input; 5-Staff RNs only

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Our Unit's experience

Pulmonary Unit:

- 36 bed medical surgical unit
- Treat a variety of patients including Respiratory disease and complications, Pulmonary Hypertension, Thoracic Surgery, ENT patients, and Medical patients
- Ranked #2 in the U.S. News and World Report for Pulmonary.
  - 90 staff (60RN's)
- Designated Comprehensive Care Center for Pulmonary Hypertension

Pulmonary Unit Based committee (PUB)

- Elections March-May 2014,
- June 2014-first meeting
- Utilized a toolkit:
  - Job descriptions for the Chair/Secretary/Members
  - Charter
  - Manager toolkit-how to get started
  - Unit Based Committee Literature

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Unit/Clinic/Department Council Structure

- Title: Unit/Clinic/Department Practice Council
- Members: apply to serve, voted on by staff
  - 10% of staff is target representation
  - Focus on multiple disciplines
  - Ad Hoc members used for expertise (pharmacist, Skin Champion, etc)
- Manager/Assoc Manager: required to attend in consultant role.

Focus on unit activities:

- Schedules, patient outcomes, hiring, standards, quality outcome benchmarks

Chair: Elected by finalized committee

- attends division council meetings quarterly to share best practices across the division.

Meetings: Monthly, one hour

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Manager Toolkit-Start up

- Utilize the Structured Toolkit for managers
  - Staff meeting powerpoint to introduce what UBC is and is not.
  - Create a buzz (next slide)
  - Application process: to serve/make a difference
  - Election ballot- Staff instructed to recommend informal leaders who share your perspective

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Identify the right players

Think of peers who have the following qualities:

Natural leaders

Motivators

Safety sticklers

Resource and reference go-to

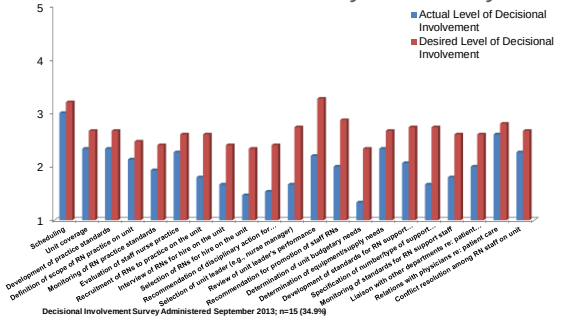
Tech geek

Service excellent Star

The First Meeting

- ❑ Expectations/bylaws
- ❑ Training-Skillful Discussion
- ❑ Accountability to Peers
- ❑ Havens Decisional Model
- ❑ Review mission, vision and values of the hospital
- ❑ Generate their ideas for priorities for this group to address
- ❑ Elect chairs/secretary

Decisional Involvement Survey: Pulmonary RNs



Decisional Involvement Survey Administered September 2013; n=15 (34.9%)

Scale: 1 – Admin/mgmt only; 2 – Primarily admin/mgmt w/ some staff RN input; 3 – Equally shared by admin/mgmt & staff RNs; 4 – Primarily staff RNs w/ some admin/mgmt input; 5 – Staff RNs only

Create a tool to submit ideas/issues with recommendations

- Name of Person Submitting:
- Who needs to be involved:

- **S**ituation: What is the issue, problem, or idea?
- **B**ackground: What is the clinical context, hospital policy, or standard of practice surrounding the issue?
- **A**ssessment: What do YOU think the problem is? What is really happening?
- **R**ecommendation: What would you do to correct or improve this?

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SBAR for Seniority

- Name of Person Submitting: Mijoo
- Who needs to be involved: Scheduler, Staff RN, Manager

- **S**ituation: Some staff members are wondering why some staff are scheduled only on day shifts while other staff members are on rotating shifts.
- **B**ackground: There is no guarantee of shift preference, although this may be considered based on unit/department needs.
- **A**ssessment: It appears that some staff members are scheduled on day shifts based on experience as a nurse, not by seniority of the staff member on the unit.
- **R**ecommendation: A waiting list to determine those who prefer to be on day shift and seniority of the staff member on the unit considered

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Pulmonary Seniority Point System

Engagement and Seniority System

Credentialing:
- Level II RN= 1 point
- Level III RN= 4 points
- Level IV RN= 6 points

Nursing experience
- 2-4 years= 2 points
- 5-6 years= 3 points
- 7+ years= 4 points

Certifications:
- ACLS = 1 point
- Nursing- related (CMSRN, PCCN, Pain, etc)= 2 points

Other:
- Relief charge in the past year= 1 point
- Preceptor in the past year = 1 point
- Working on a unit project= 2 points
- Host a journal club= 1 point
- Committee involvement (>75% participation)= 1 point
- Unit specific conference= 1 point

Experienced new hires will rotate days and nights for 6 months then they can be assigned seniority as above.
If two nurses has the same seniority score, priority will be given to the nurse who was hired to Pulmonary as a nurse first.

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Example of SBAR's Items

- Bath's and Walking not consistent (Kelsi G): CNA's are just too busy with primary care to get to consistent bath's and walks as needed by our patients
- *Acuities : Created routine services and average acuity scores for better assessment of workload acuity.*
- *Nourishment room PAR levels (Nights/Weekends):*
- Phone calls: Need for triaging calls prior to going to the nurse. Working with other departments to ensure they are calling the right person first-MRI, Dialysis, Radiology, Operator, Pharmacy, Tele. Evaluation/Audit of a typical day of calls: Phone log via the phone and ID inappropriate nursing calls. Evaluate PSC time
- Lunch Breaks : Previous survey stated 60% of staff do not want to give up phone. Potential for rerouting calls during lunches. Discover other strategies that would work to decrease patient needs and phone calls *during specified 30 min break for lunch.*
- Input/Output consistent charting: Steph H created a new process and is doing one on one teaching
- *Leadership Hiring: Hired Associate Manager and Educator, soon to come charge nurse?*
- *Flu Shot Shortages:*
- *Cancel Calendar*
- Shortage of Wall Suction and canister holders:

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Magnet Examples

- Transformational Leadership:
  - Change in the nurse practice environment
  - Change in the patient experience and nursing practice
    - Example: Changing the CNA structure on the unit-Baths and Walks, Blanket Warmers, Admission Bundle
- Professional Development:
  - Clinical nurses involved with inter-professional decision making
  - Encourages professional development
    - Example: Changing nourishment room PAR levels, Flu shot shortages, UBC shared decision making training and Chairperson Facilitation Training.

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Magnet Examples

- Exemplary Professional Practice:
  - Clinical nurses are involved and interact with the professional practice model and care delivery system,
  - Staffing, scheduling and budget process.
    - Example: Seniority scale, Pulmonary Hypertension clinic sharing, Cancel Calendar
- New Knowledge, Innovations and Improvements:
  - Clinical nurses are engaged in nursing research, evaluating evidence based practice.
  - Improvements in workflow and efficiencies, and potentially create new initiatives that utilize innovation and technology.
    - Unit Example: Glucose management research study, Input and output documentation/roles

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Closing the Loop

Resolved	In Progress	Can't complete right now, and why
Scheduling-Seniority scale now implemented	Shortage of Wall Suction-In the process of ordering	
Nourishment room not stocked-Par levels changed and much better	Lunch Breaks: waiting for survey results	
Flu Shot shortages: increased amount per pharmacist	Diabetes Sliding Scale Research project: Waiting for IRB approval	
Dietary Tray Removals: instituted door magnet project with much success	Phone calls: Evaluation of inappropriate RN calls until August 10th.	

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INSIGHTS INTO BARRIERS AND SUCCESSES WITH UBC'S

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We have a committee, now what do we do?

Generating ideas/issues

First go to Haven's, find the largest discrepancy, or an area that staff desired decision making ability Inquire to staff

- Process that doesn't work
- Survey/Opinion/Feedback
- Idea board
- SBAR
- Complaints-but need to have a recommendation
- Magnet criteria
- Manager's can bring issues

Diving into the problem

- Identify owners (either a UBC member or the submitter)
- Chairs need to evenly distribute/delegate tasks
- All staff may need to go back and ask their coworkers/get feedback.
- With finalizing the recommendation: Every member is required to support and communicate the final decision (even if they didn't agree, but was not the majority)

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Other Strategies For Success

- Training staff to lead/participate in skillful discussion
- Guide the manager on Dimensions of Decision making-what and how much delegation and authority should occur
- Peer to Peer teaching: Creating an accountability framework, similar to charge nurse org chart?
  - Responsible for teaching/sharing/presenting the recommendations
  - Responsible for promoting SBAR if they are having a complaint/process problem?
- Partnering with other UBC: ex RT's UBC with PUB
- Invite patient and family to help us understand one of the most important perspectives
- Journal club on UBC literature
- Partner with Unit Champions to discuss action plans that need to be implemented

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UBC Training: Skillful Discussion

- Create self awareness:
  - What you are trying to accomplish
  - How that affects your thinking and speaking
- Balance advocacy and inquiry:
  - Ask questions to gain understanding of all sides
- Build shared meaning
  - Explore what others mean by their words
  - Ask what all agree on and what they disagree on
  - Pinpoint sources of disagreement, which are often:
    - Facts
    - Methods
    - Goals
    - Values
- Listen, Be open to new ideas, be willing to see others perspectives
- Ask: what is needed to move forward

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Skillful Discussion

What it is and is not

Raw Debate	Polite Discussion	Skillful Discussion	Dialogue
Argue it out	Talk about it, nicely	Come to closure on an issue	Explore, discover, gain insight

A CONTINUUM

South Central Libraries

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Dimensions of Decision Making

Factors leaders/chairs must consider before involving others in a decision

- Who owns the expertise?
- Are the goals of the group aligned with the objectives of the organization
- Does the group have the ability to synergistically problem solve?
  - Can they engage in skillful discussion?
- Do we have time in this situation, or is this issue worth the time? (Shared decision making does take more time)
- Would involvement in this decision be a good development opportunity?
- Would involvement in the decision help to achieve better staff buy in? (People do support what they help build)

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Manager/Leadership Considerations

- It is important to be present, so you can be an:
  - Advocate
  - Information resource
  - Mentor
  - Barrier remover
  - Empower
  - Governor/Financial Owner
  - Listener

It is important for

- Flexibility is key
- Make your UBC fit in with your culture
- All decisions must support your organizations mission, vision, values, and strategic plan.
- Don't duplicate another committee's efforts
- Decisions should be made on the basis of consensus whenever possible

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Forms of Shared Decision Making

Level of Influence

How to avoid –

"You asked us and then did the opposite of what we decided!"

Opinion	Opinion	Veto	Responsible
Employees able to offer an opinion	Employee opinions are considered	Employees can veto a decision	Decision made solely by employees

Cotton, Vollrath, Froggatt, Lengnick-Hall, and Jennings, 1988

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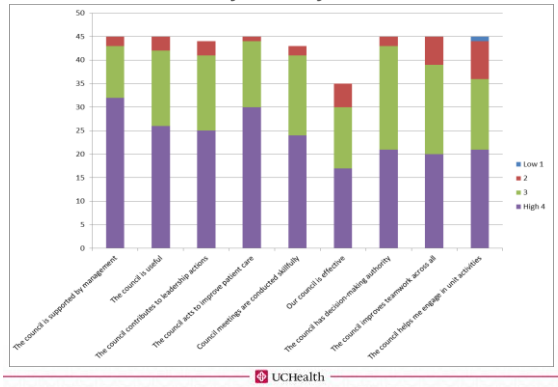
Pulmonary Survey-6 months



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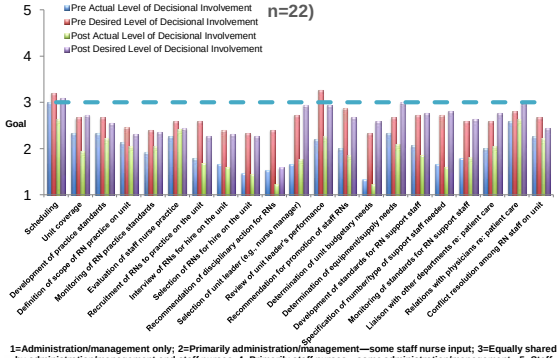
Decisional Involvement Survey: Pulmonary Unit (Pre, n=15; Post, n=22)



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Decisional Involvement Survey:
Did we close the gap between actual and desired staff decision making?

Inpatient RN Outcomes: Pulmonary Unit

	N	Mean	SD	Range	P Value
PRE	**15**				
Actual		2.02	0.40	1.33 – 3.00	
Desired		2.65	0.25	2.33 – 3.27	$p < .001$
POST	**22**				
Actual		1.94	0.40	1.23 – 2.64	
Desired		2.60	0.35	1.59 – 3.09	$p < .001$

- Goal: close the gap between the actual and desired staff decision making. There should be no significant difference.
- T-tests were conducted between the Pre actual and desired decision-making mean scores and Post actual and desired decision-making mean scores.
- The gap did not improve (i.e., close) between 2013 and 2015 as shown by significant p < .001 values. Pulmonary Unit RNs perceived *Actual* decision-making declined in 14 of 21 items between pre and post time periods.

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What improved

- Monitoring of RN Practice Standards and Evaluation of Staff Nurse Practice
- Selection of Unit Leaders (Review of leaders performance)
- Monitoring of Standards for RN support staff
- Liaison with other departments re: pt care
- Relations with physicians re: patient care

What didn't

- Scheduling-
- Unit Coverage/specification of number/type of support staff needed
- Recruitment/Interview/Selection of RN's for hire on the unit.
- Determination of budgetary/equipment/supply needs
- Conflict resolution among RN staff on the unit/recommendation of disciplinary action/promotion of staff.

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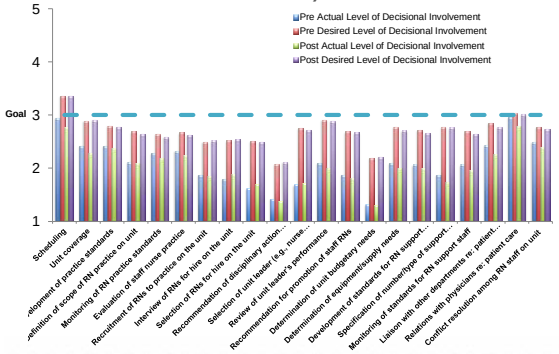
Decisional Involvement Survey: Inpatient RNs (Pre, n=424; Post, n=665)



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Decisional Involvement Survey:
Did we close the gap between actual and desired staff decision making?

Inpatient RN Outcomes

	N	Mean	SD	Range	P Value
PRE	**424**				
Actual		2.11	0.43	1.32 – 2.96	
Desired		2.71	0.27	2.08 – 3.36	$p < .001$
POST	**665**				
Actual		2.04	0.38	1.31 – 2.79	
Desired		2.68	0.26	2.11 – 3.36	$p < .001$

- Goal: close the gap between the actual and desired staff decision making. There should be no significant difference.
- T-tests were conducted between the Pre actual and desired decision-making mean scores and Post actual and desired decision-making mean scores.
- The gap did not improve (i.e., close) between 2013 and 2015 as shown by significant p < .001 values. Inpatient RN perceived *Actual* decision-making declined in 18 of 21 items between pre and post time periods.

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Thoughts on Results

- Hospital wide changes reflect some loss of control, as reflected in the hospital survey
  - Pay practice changes
  - Scheduling software changes
- Unit wide changes
  - Loss of a full patient population to another hospital, replaced with new medicine population
  - 50% change in members, with two co-chairs taking other positions
  - New staff not involved in the pre-survey
  - Accountability of the UBC's
  - Staff don't want any more projects/change

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Questions???

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Thank you for taking the time to listen

For any other questions today or next month:

Contact Information:
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Thanks to my Fabulous Pub Members

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