Transformational Leadership

**Visibility, Accessibility and Communication**

**TL 10:** Describe and demonstrate structure and processes of how nurse leaders use input from direct-care nurses to improve the work environment and patient care.

Nurses are on the frontline and deal with patient care and clinical issues each day. The issues may affect a number of areas, including, but not limited to, patient satisfaction, direct patient care, and satisfaction of the many stakeholders. Clinical nursing staff has the opportunity to communicate with nurse leaders to provide feedback in a variety of venues to make changes that impact patient care, nursing practice, and/or the work environment. Suggestions for improved patient care, allocation of equipment and supplies, and work environment enhancements are among the areas in which feedback has been provided. Staff nurses participate in all six of the hospital-wide shared decision making councils and their input and their opinions are solicited, respected, and valued. Combined with the hospital-wide councils, the unit based SDM model as well as unit staff meetings, provide an infrastructure that is hardwired for nurse managers to get input from direct care nurses.

Through the strong SDM structure and philosophy, nurses at all levels participate in the identification of direct patient care issues and initiatives that would affect patient outcomes. Evidence based practice initiatives, journal clubs, unit, department, and hospital-wide councils and committees are an example of the various ways nurses can address patient care issues. Many of the patient care initiatives involve a collaborative interdisciplinary/multidisciplinary approach for resolution. Key stakeholders from other disciplines who are active participants in collaboration include social workers, case managers, physician/medical staff, pharmacy, respiratory, imaging, physical therapy, OT, and clinical laboratory staff.

All levels of York Hospital (YH) nurse leaders are visible and accessible to the bedside clinical nursing staff in multiple ways such as CNO Forum, CNO Walk a Mile in My Shoes Program, Patient Safety Rounds, walking rounds, SDM councils, unit based SDM meetings, Town Meetings, e-mails, staff meetings, performance evaluations, posted hours of availability, and 1:1 meetings. For example, a Clinical Director (CD) participates on each of the hospital-wide SDM councils and can assist in mentoring and developing chairpersons, supporting the direct care nursing staff, and acting as a real-time resource available for any issues that may be brought forth by direct care nurses. In addition, all CDs participate on the hospital-wide Leadership Council which has direct care nurse representation from all 7 service lines. The CDs and VPPCS/CNO hear real time issues, concerns, ideas from all levels of direct care providers firsthand, while participating in the SDM councils. At the nurse manager level, availability at each SDM meeting and presence on the unit to listen and respond to direct care nursing inquiries regarding practice, patient care, or the work environment is a consistent leadership practice.

The following are examples of how direct care nurses’ feedback is used to effect changes to enhance patient care, nursing practice, and/or the work environment in the various levels of Nursing Leadership.

**Medication Administration- Work Environment**

In November of 2009, the Oncology Nursing Unit (5 Main) was relocating to another unit (7 South) in the hospital. The new 7 South unit had only one ‘medication room’ which was different than the two medication rooms on 5 Main that the staff was accustomed to. The nursing staff felt this would prove problematic for a variety of reasons: 1) PA DOH has regulatory guidelines about equipment in the
hallways; 2) staff felt that one medication room would not be large enough to do their work around medication preparation and administration. Additionally, with the advent of electronic documentation of medication administration, the process would be cumbersome. The RN would need to go the medication cart in the medication room to retrieve one individual medication, push a regular computer on wheels to the bedside, scan the patient, administer the medication(s) for that patient, document on the computer, and then go back to the medication room and repeat this process for every subsequent patient. The nursing staff believed that this process would prove very “task intensive” for the RN.

The NM and the RNs on the Oncology unit already knew that the unit score on the NDNQI Nurse Satisfaction Survey for “TASK” was an area of low satisfaction. The process for electronic documentation of medication administration and the actual process related to the administration of medications would actually increase the tasks of the RN due to the changes in work flow.

The nurses on 7 South decided that the Computer on Wheels with medication cassettes (known as Med - COWs), trialed at Gettysburg Hospital (GH), would meet the need of decreasing tasks, increase efficiency, and ultimately increase the safety of medication administration.

The Nurse Manager attended the (Information Technology) IT Nursing/Pharmacy meeting and questioned the process to obtain the COWs. Pharmacy was not agreeable to the change in nursing practice, citing that medications would be ‘moved around’ too much. Additionally, the Pharmacy identified that at Gettysburg Hospital, nurses had used the medication COWs and chose to no longer use them because they were too heavy to push around. Because of this “pilot,” pharmacy was reluctant to invest more money in medication COWs.

The NM challenged the decision on behalf of the RNs and thus a series of meetings ensued to include: Clinical Director Oncology Service Line (OSL), Nurse Manager 7S, Director of Pharmacy, Director of Quality for the Pharmacy, VPPCS/CNO, COO, and an RN from IT attended the initial meetings. Karen, NM of 7 South, spoke to the issues that concerned each party, and was able to show in a quantitative way (survey, time studies, safety—technician work, and statistics) that clinical staff found these medication COWs useful. The VPPCS/CNO assisted the Nurse Manager in advocating for the clinical staff to obtain computers on wheels with medication cassettes to afford a more defined method of medication delivery. Advocating at the CNO level after hearing input from the clinical staff and Nurse Manager shows staff that their requests are heard and acted upon. This will be followed by a translation/rollout of medication carts to other nursing units throughout York Hospital.

A medication work process flow was established, safety audits of nursing process flow compliance were done, and infection control processes were put into place. The COWs were delivered. As meetings progressed, the medication COW was determined to be best practice. Medications were administered without delay, documentation was done in real time, and this nursing task time was
decreased. The nurses were surveyed and admitted to never wanting to change back to the traditional medication cart. The Behavioral Health Unit was the next unit to make this change. In early 2011, the remaining medical surgical units in the South, North, and Main Buildings received the Med-COWs. More detailed information about this will be discussed in TL10EO.

**Moderate Sedation Practice Change in Vascular Lab – Patient Care**

Monthly Administrative Customer Service and Patient Safety rounds are scheduled on various units every month in which a member of the OOP and the Patient Safety Department attends. These rounds are attended by various members including the Office of the President (OOP), Patient Safety, Customer Service, Service Line Administration, and Nurse Managers. During these rounds, frontline staff is asked for input regarding patient safety concerns/issues. During the months after the Patient Safety Survey results are available, leaders bring the unit specific results to the rounds in order to generate conversation related to the rationale for their responses. They look for specific information or examples for why staff responded in the manner they did. If there is a negative perception, what can be done to improve? If a positive response, is there something that we can share with other areas of the hospital? They also like to provide staff with examples as to what has been done in the past with the results and what plans are in the works related to the survey results. This provides staff an opportunity to express any concerns related to patient safety.

Crew Resource Management techniques are used by vascular lab staff resulting in recommendations for anesthesia if the patient had significant co-morbid conditions or the patients were not true candidates for sedation. During rounds in the Vascular Lab, some concerns were discussed with regard to performing moderate sedation in the unit. While the area is trained in moderate sedation, it was identified that their patient population was changing and presenting with more co-morbidities. This was creating new challenges for the staff to provide adequate levels of sedation to a patient population with increased co-morbidities and higher risk when using sedation or anesthesia. The conversation was very candid and the staff questioned appropriateness of the patients who were being scheduled for procedures in the vascular lab. With the service line administrator, CNO and the vice president of operations in attendance, the concerns were taken seriously. Medical and Clinical Directors of the Surgical Service Line met with the Vascular Lab nursing staff to discuss the concerns that had been identified. The Surgical Service Line Medical and Clinical Directors, Vascular Lab nursing staff, Anesthesia and Vascular surgeons then met to discuss their concern and resolve identified issues.

Anesthesia cases are now scheduled one day a week with a plan to coordinate with anesthesia for vascular lab procedures on other days. Vascular Lab staff worked with the Perioperative CNS to increase their knowledge and skill level in moderate sedation. With the SSL emphasis on “crew resource management” staff were encouraged to speak up and address any safety concern to the nursing leadership within the surgical arena.

**Development and Implementation of an Obstetrical Rapid Response Team (Code Neon)-Patient Care**

The Institute of Healthcare Improvement and the Agency for Healthcare Research and Quality have recommended the development and implementation of an obstetric rapid response team to decrease errors and maternal mortality rates. Nurses in the Maternity and L&D areas gave input and feedback within the SDM unit councils and staff meetings regarding the development of a rapid response team at YH to enhance patient safety.
In L&D, the previous system of notifying appropriate personnel for an obstetrical emergency was a sequential activation, involving multiple phone calls; an emergency response would be more efficient utilizing a simultaneous notification and activation. Knowing that obstetrical errors such as; failures to adequately control blood pressure in hypertensive women and diagnose and treat pulmonary edema in women with pre-eclampsia, failure to recognize changes in vital signs following cesarean delivery, and hemorrhage following cesarean delivery may be prevented with the use of a rapid response team, the clinical educators and clinical staff in labor and delivery made a decision to act on developing a rapid response system. This is one of the patient safety initiatives currently being promoted by the Institute for Healthcare Improvement and the Agency for Healthcare Research and Quality.

Beginning in June of 2010, a plan for developing and implementing an obstetrical rapid response team was introduced to the Women and Children's Service Line administration, management, and leadership along with representatives from the departments of anesthesia and respiratory therapy.

For the next ten months, T4 and L&D staff members, nursing management, nurse educators, and a perinatologist collaborated to develop policies and procedures, establish criteria for activation, and determine the mix of team members and roles. Meetings were held with hospital telephone operators and biomedical personnel to discuss telecommunication and pager requirements. Documentation and debriefing tools were also developed.

Input from the debriefing following the October simulation revealed that there was a need for a backup method of notifying personnel in the event of an emergency. An action plan was once again developed based on input provided at the debriefing following this training and simulation which resulted in obtaining iPhones for Code Neon team members.
In April 2011, the ACOG Committee on Patient Safety and Quality Improvement issued a statement regarding early warning system and appropriate response. Actions that were implemented as a result: Grand Rounds informational presentation regarding the obstetrical rapid response team, Code Neon, was offered to the OB/Gyn physicians (October 2011); educational sessions were conducted for T4, L&D, and NICU personnel (October 2011); and surveys were distributed to gather data regarding emergency preparedness and response.

A Code Neon Team resulted from the actions taken from feedback from the RNs in Maternity and L&D. The team is available 24/7 and includes one RN from L&D and one RN from Maternity (T4). The simulations and actual Code Neon calls revealed areas for improvement. Quick access to medications for postpartum hemorrhage was urgently needed and continued to be a concern. Staff conducted collaborative meetings between nursing and pharmacy resulting in hemorrhage medication trays being placed on each Code Neon cart and a postpartum hemorrhage medication kit became available in Pyxis.

In July of 2011, a multidisciplinary education and simulation on obstetrical hemorrhage was held. The training included crew resource concepts, communication, a skills station regarding visual estimation of blood loss, and massive transfusion protocol. Following the simulation training, an action plan was developed based on input provided at the debriefing which included the following: competencies for quick visual estimation of blood loss and completed by early Fall (9/2011); and quick access to supplies and medications was resolved by the use of Code Neon carts that were placed on T4 and L&D (identical and contained all of the necessary supplies for an obstetrical emergency) and; pagers were tested and distributed. More details surrounding the Code NEON team will be described in TL 10EO.

**ED Workplace Safety- Work Environment**

The Emergency Department staff had expressed concerns about safety and security issues in the various geographic areas in the ED. A multi-disciplinary team was formed with the purpose of making recommendations which would create a work environment where ED staff members can feel safe when working, and patients and visitors will feel safe during their own or family’s ED visit.

To ensure success in this pursuit, strong collaboration between the Emergency Medicine and Safety & Security departments occurred to address threatening events and decrease the number of these events in the ED through the application of the Lean/Six Sigma methodology. The team was designed to be multi-disciplinary and included staff from the ED and Safety/Security, ED RNs, an ED Physician, nursing assistant, patient representative, PSS, Security Officers, Security leadership and ED leadership representatives. Team meetings occurred every two weeks for 2 hours.
Performance Improvement tools were applied to this project and included:

1. Exploring phases of team development to foster buy-in and promote a high performing team:

   TL10.4 Tuckman Model diagram used with ED Staff

   Tuckman Model
   Tuckman, Bruce (1965)
   "Developmental sequence in small groups"
   Psychological Bulletin, 63, 384-399

2. Mapping of the current process:

   TL10.4 Flow Diagram of ED Admission Process
3. Cause/effect diagrams/brainstorming:

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--- TL10.5 Fishbone Diagram of ED Process ---
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4. Current staff, patient, and visitor flow

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--- TL10.6 ED Workspace Diagram with employee walk flow ---
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The ED environment can quickly become overcrowded due in part to uncontrolled visitor volumes. This can contribute to threatening events. Quantifying the problem in the ED from 7/2011 – 4/2012 indicates visitors contribute to greater than 20% of all threatening events in the YH ED. This is well above the 3-4% national average for visitor events in the ED. ED Safety/Security events, defined as verbal or physical threats or actions toward ED and/or Security Officers increased over the past 2.5 years, with both ED staff and Security Officers injured at times. Quantifying the number and severity of events and resources needed is difficult due to under-reporting and a lack of time-stamping for each event. ED Staff security surveys indicate that 67% of those responding agree that an increased number of violent patients came to the ED in the past year.

ED staff considers themselves “First Responders” to most events with Security Officers waiting to be instructed as to what to do in many cases. Less than 25% of ED staff has been formally trained in de-escalation techniques and 100% of Security Officers have been trained in restraint techniques. ED staff report that their behavior during a verbal threat from a patient or visitor can antagonize the situation more than 50% of the time. In addition, Security Officers are given conflicting direction (help vs. stand back and wait) from ED nursing based upon the individual staff involved in a particular event. The result is a strained ED-Security Officer relationship and a disorganized response.

A revised ED Visitor Policy, using the Emergency Nurses Association tool kit, has been completed and initiated to align with the opening of the renovated ED waiting room. Announcements will be made to Wellspan Health and the public which is being coordinated by Wellspan PR. The de-escalation LMS module is in final phases of development and will be rolled out to ED and Safety/Security staff as mandatory training to support a standardized approach to threatening events in the ED.

Additional FTEs for security staff have been approved, recruited and hired to enhance the safety and security in the large YH Emergency Department as well. The issues identified by the direct care ED staff are heard and being addressed to improve the ED work environment.
**Wellspan Preoperative Navigation-Patient Care**

RN working in Pre-Hospital Assessment Services (PHAS) call all patients prior to surgery to collect medical history and information important to best surgical outcomes, providing education to patients about their surgical experience, referencing the Preoperative Preparation of Patients (PPP) Guidelines to guide coordination of preoperative testing with lab and imaging services, and collaborate with Anesthesia physicians to evaluate any abnormal results and optimize the patient for surgery.

Multi-disciplinary teams consisting of PHAS staff, physicians from anesthesia and surgery, hospitalists, pharmacists, operating room schedulers, perioperative staff, laboratory and imaging personnel, surgeon’s office staff, and Care Management were participants in this endeavor. Research, Quality Management, and Information Technology were also instrumental in the effort.

In July 2010, the PPP Guidelines, which were approved by all medical and surgical staff, are in use throughout Wellspan Health (WSH). Standardization in locating and communicating changes in the patient’s preoperative needs was the fundamental focus of this group; electronic documentation makes information available to all caregivers and the patients now have one RN contact in PHAS.

As the safety initiative rolled out across the system, YH PHAS nurses found themselves learning many new aspects of medical management. They sought out the expertise of a clinical pharmacist to help them organize and understand medications. This pharmacist developed a user friendly format for the PPP recommendations to live on the WSH INET. Many office visits and group updates providing education to surgical office staff beginning in 2010 and continue. Operating Room schedulers, Care Management and PHAS nurses could convey vital messages to ensure that every office could access the PHAS portal on the Wellspan INET. As WSH headed toward EHR, PHAS from YH & GH moved to the use of a common communication tool. The PCPF (PHAS Chart Processing Form) (TL10.7) is located in the patient’s EHR and is now visible to all. Contained in this document are the components to determine readiness of patients for their procedure. Once again, anyone who has access to WSH electronic documentation can gather this information.
Striving for continued standardization, an YH PHAS Fax Cover Form was developed in collaboration with Anesthesia and the physician offices. This way all could use the same form to communicate their needs and relay requirements. A pilot was organized to interpret the best flow for preoperative testing and abnormal value evaluation in the fall of 2011. Collaboration between surgeons’ office staff, anesthesia and the perioperative team will be crucial. This initiative will provide the most seamless surgical experience for our patients. A rollout to including education and implementation of the navigation process with all surgical offices in Wellspan Health will begin during this next year.

**Minimizing Mother-Baby-Patient Care**

A committee comprised of clinical RNs, clinical educators and nurse managers from L&D, Maternity, and NICU meet monthly to increase breastfeeding exclusivity and minimize mother-baby separation. Through the strong shared decision-making structure and philosophy, nurses at all levels participate in the identification of direct patient care issues and the development, implementation and evaluation of policies, procedures, protocols and initiatives that would affect patient outcomes.

Following birth, practice norm dictated that newborns have been separated from their mothers for many years to weigh, measure, assess, and observe for approximately two hours. Newborns were also taken to the newborn nursery for daily nursing assessments, blood draws, and at mom’s request. Most Pediatricians, Pediatric Residents, and Family Practice physicians request that babies be returned from the mother’s room to the newborn nursery for the physician’s daily assessments. Minimizing Mother-baby separation is a recommendation from the research literature and having the newborn in

![TL10.8 PHAS Log of Patient Assessment](image-url)
the room can assist the mother in becoming involved and more confident in caring for the newborn; research shows that these mothers have fewer problems at home.

Knowing the many benefits of mother and baby spending time together in the first couple of days post birth, non-separation has been a goal of our nurses and physicians for several years however; the barriers to reach that goal seemed insurmountable. The CNS approached the Maternity leadership team regarding the use of Lean methodology and A3 thinking. A Quality Improvement staff member was invited to join our meetings to guide us in reducing barriers using the A3 thinking method. As a first step, an Ishikawa diagram was used to gather cause-and-effect factors. The higher scoring items on the respondent survey were the most difficult barriers to break down however; the group discovered that these were the ones on which we needed to focus in making the work environment staff and patient-friendly.

Initial data showed that 40% to 57% of all newborns were in the newborn nursery instead of in their mother’s room from 2300 to 0300. An action plan was developed and one intervention was to weigh and assess the newborns in mother’s room during early evening to assist in changing patient culture of the idea of bedtime for mother. The newborn was returned to the NBN at 11:00 pm for shift assessment. In addition a welcome video was developed for all mothers to view upon transfer post delivery that discusses the benefits of rooming-in and breastfeeding.

The Minimizing Mother-Baby Separation Task Force further advocated for the newborns by initiating several additional actions; development of scripting for the nursing staff stating expectations to mothers regarding rooming-in, education for the nursing staff which was reinforced by a conference titled, “From Birthing Suite to Discharge: Improving Outcomes through Skin-to-Skin Care” given by an international expert. Another action was an outreach to the Obstetrical groups in the area in hopes of moving important education to the prenatal period; a booklet to be given to the mothers during their pregnancy outlines the expectations of non-separation and the many benefits of skin-to-skin care. This education is broken down into trimesters appropriate for that particular subject to be given to the mother. More regarding Mother Baby Separation Can be seen in TL10EO.

Data collected in June of 2012 showed a 54% increase in the rate of newborns who are rooming-in, thus achieving significant results in minimizing mother-baby separation.

Gift of Life-Patient Care

Gift of Life is a non-profit organ donation organization in Southeast Pennsylvania, Southern NJ and Delaware that provides support for families of organ donors as well as transplant recipients and their families. After notification by the hospital, a Gift of Life representative is sent to the hospital to determine whether organ donation will be considered and permitted by the family of a patient who is a candidate. A successful collaboration between nursing units and the Gift of Life representative to support the family through a devastating event by honoring their wishes that was not of a clinical nature.

Danielle Godfrey RN, a nurse from Maternity (Tower 4) was in charge and got a call from a representative from Gift of Life asking if they had ink to do handprints. She told her that they did and offered to send her some to use. The gift of life coordinator told her that there was a sixteen year old who was in the ICU, who had been in an accident and was on life support and also was the father of a one year old child. She asked if I could help this grieving family and bring the supplies to the unit for a handprint to be made.
When she arrived to the ICU she was surprised to see this young man with his facial piercings and bracelets on, looking like he was asleep. Aside from the multiple IV sites and a breathing tube there was no indication of injury. She was surprised to find out that they intended her to do the handprints of this young man for a keepsake for the child. She had misunderstood and thought she was coming to do the child’s prints. Suddenly, she understood why this family wanted the handprints; this son, boyfriend, and father was not going to survive, and they were attempting to obtain the patients handprints as a memento for the child who would never know his father. Still wanting to help, she cut apart the ink sheets and connected several together. With the girlfriend’s help, they made multiple copies of his fingers, hands and feet on colored mats that she had gotten from the NICU. Overall, she spent about an hour off the floor away from her charge nurse duties, helping this family make a keepsake for this child from their loved one. When finished, she was thanked by her fellow colleague ICU nurse, the family, and Gift of Life Coordinator. That day made a great impression on her. Not only to appreciate life but as a nurse, she was able to do something that may have made a difference to this family. Their son wasn’t going to come back but maybe the memento of having his prints made their burden of grief a little lighter.

Transforming Care at the Bedside- Patient Care

Adequate nurse staffing, both skill mix and number of staff, is critical to the delivery of quality patient care. The specific needs of a patient population on an inpatient unit are reflected in the patient assignment through the use of American Nurses Association (ANA) staffing principles. Tower 3, a member of Cohort 2 of the national TCAB initiative, uses a framework for change built around improvements in safe and reliable care using an “Adapt-Adopt-Abandon” principle which uses small tests of change. Gains in staff satisfaction and fair assignments can be made if trialing with small tests of change occur and use is consistent and supported after adoption of the tool.

Clinical staff had voiced concerns regarding difficult and demanding patient assignments that were made without a tool to identify or classify acuity. This concern was the driver of the development of an acuity tool that assists the charge nurse to make appropriate patient assignments focused on quality and safety for best outcomes.

A team of T3 staff nurses collaborated in developing an Acuity Tool to assist the charge nurses in making appropriate and safe patient assignments according to the level of care needed for each patient.

### Additional Acuity Factors for Consideration

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<tr>
<td>Contact precautions</td>
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**TL10.9 Tower 3 Acuity Tool TCAB Project**
Input from clinical staff was imperative as they assisted in refining the tool, and making changes before implementation. An acuity tool was developed, trialed and is now used to identify those patients who require higher intensity of nursing care and resulting in higher quality and safer patient outcomes along with increased staff satisfaction. Geography, census, and expertise of the nurse along with functional ability, culture and language, severity of condition, and availability of social support are also considered.

T3 has encouraged the dissemination of this work to other units by encouraging them to review the literature surrounding their patient population, seek input from their staff, and develop a tool, utilizing a “bucket” system, that is easy to use and understand. This will help in refining the tool, and making changes before implementation. It also will help at attaining reliability, by keeping the numbers small, and utilizing a category system.

| T3 ACUITY TOOL | 1 Independent w/Mobility Few/Minimal PO Meds | 2 Contact guard/1 assist Few min PO meds IV PCA being DC’d Continent Eating Independently No Telemetry | 3 1 Assist Moderate PO Meds Continuous IV PCA 1 IV push med/PRN Continent or incont @ times Urgency Foley Telemetry (TNNFT) 1 Scheduled test Being D/C’d that shift Foley | 4 2 Assist Mod-Lg amt PO meds Continuous PCA or 2+ IV push meds pain/BP Telemetry (TNFT) Incontinent/Foley Partial feed/cont tube feed PICC Line/Central Line TPN/PPN New Colostomy Cmplx Q day dsg change VAC dsg | 5 3+ Assist/Lift Many PO meds Meds crushed/given by PEG Many IV meds PICC Line/Central Line Telemetry (TNFT) Critical VS/Lyte Imbalances Complete feed/new PEG tube New NG tube > than nasal cannula O2 Cmplx dsg changes > QD VAC dsg Frequent VS |