

Nursing 2015 Initiative
 Team Name: **Blue Team**
 Meeting Date: March 9, 2007

Strategic Direction: Practice culture, conditions, and benefits provide a win-win for nurses, consumers, and the organizations

Meeting facilitator(s): Rena Phillips, Jean Scholz & Jan Lanier **Secretary:** Pam Baker and Jan Lanier

Team Leaders: Grace Wakulchik & Michele Valentino

Agenda Item	Discussion	Decisions Made & Follow-Up Needed
Introductions	<p>Grace Wakulchik MSN, MBA, RN, Akron Children’s Hospital reviewed the Race to the Future Vision Statement and relevant strategic directions to use in the development of the best nursing environment in 2015.</p> <ul style="list-style-type: none"> • Practice Environment Components of the Nurse Work Index • AACN Healthy Work Environment • Magnet Nurse Work Environment 	
<p>Elements of Work Environment: Current environment</p>	<p>Grace led the group in a discussion of the what the current environment of nursing in Ohio in the following areas is today:</p> <ol style="list-style-type: none"> 1. Adequate Staffing for Quality Care: <ol style="list-style-type: none"> a. Appropriate staffing level b. Skill mix, staffing levels, scheduling, physical layout 2. Effective Nursing Leadership: <ol style="list-style-type: none"> a. Authentic leadership, b. Supportive nurse manager c. Meaningful recognition 3. Effective Nurse and Licensed Independent Practitioner (LIP) Relations 4. Staff Participations: <ol style="list-style-type: none"> a. Effective decision Making b. Skilled communications 5. Support for Nursing Model of Care: <ol style="list-style-type: none"> a. Delivery Systems b. Cultural values 6. Clinically Competent nurses and Support for education 	

Literature Review of topics for evidence-based practice recommendations

See attachment for participants' remarks on each topic to define the current state of Ohio nurse's experience of the work place environment

- Grace Wakulchik, , reviewed the OHA/OONE Nurse Staffing Position paper.
- John Baker, BSN, RN, student for MSN graduate program at Kent State University and Diane Sprankle, BSN, RN, student for MSN graduate program at Regis University reviewed current available literature on nurses floating. Highlights from their literature review are:
 - Research was done primarily in early 80's
 - Research was primarily done on satisfaction related to floating but not "solutions"
 - Issues of floating identified include: unfamiliarity of unit, staff, culture of unit and competency of staff floating into another unit
 - There is a gap in literature related to research of change in satisfaction results after changes in floating
 - Cost difference is not noted in cluster versus non-cluster staffing patterns
 - Idea that nurses are not interchangeable in skill and knowledge levels predominate in literature ("Is a plumber asked to paint for the day?")
- Pam Baker, MSN, RN, CNS, BC, Akron Children's Hospital reviewed current nursing leadership literature. Highlights from that literature review include:
 - Transformational nurse manager and staff research: transformational leadership is good strategy for developing staff
 - When hiring staff look for key "motivators" in nursing and other life experiences
 - Managers have pressure from administration and staff nurses and position is not viewed as attractive
- Pam Baker reviewed current nursing leadership literature on collegial relations of nurse-physicians (LIP)
 - Levels of relationships vary from unit to unit and nurse to LIP
 - 5 types of relationship: collegial, collaborative, student-teacher, friendly stranger, and adversarial or abusive.

References for literature reviews presented attached for participants.

- Nurse trust LIPs until that trust is taken away but LIPs tend to not trust until trust is “earned”
- Communication is a huge component to relationships and must be professional and consistent
- Two topics were not covered and other participants were asked to prepare information for the next meeting including:
 - Nursing foundations for quality of care
 - Nurse participation in hospital affairs

Plans for next meeting

Next meeting the group will complete literature review and detail out what the ideal nurse environment should be in the future and discuss how to get there by 2015.

Participants also decided that next meeting will be two hours only, not four.

Participants to review information and bring ideas for the ideal nursing environment for next meeting.

Information of the current state of the nursing environment from participants on elements of the environment that influence nursing

ADEQUATE STAFFING FOR QUALITY CARE

POSITIVE	APPROPRIATE STAFFING	NEGATIVE
80% RNs in Skill mix	Vacancies directly impact staffing	Staff Nurses do not understand how budget and staffing decisions are made.
3 % Vacancy	Absences – unplanned Absences – related to FMLA “can’t replace or fire that position”	Staffing is tied to JCAHO core outcome measures but it does not seem to be sensitive to changes in staffing.
8% Turn over	We use work load management system for nursing (WMSN) to assess Acuity vs Staffing at 0200 and 1400	Float pool – Floating from units to staff others
New scheduling systems will allow staff to schedule / request from home	Facility standard 1.8 Cannot bust it.	Un-clustered floating to staff units Clustered floating to staff units Closed speciality units – self staffing
Need to communicate to staff how labor budget determined and how adjustments are made.	Shift Bidding	Staff unaware of how FTE are calculated (staffing formulas)
Moving away from Traditional 7-3; 3-11; 11-7 scheduling makes it easier to work with staff personal needs.	Self Scheduling	Staff understanding of staffing is usually limited to their own unit or shift.
Utilize a matrix to guide nurse / patient ratio.	Decentralized Staffing Good or Bad?	Short staffing effects willingness of units to accept patients.
Nursing decision is ultimate determining factor for staffing need.		Admission nurses in the ED help with throughput and staff satisfaction.
AWHONN Staffing Standards – GOOD!		Do you have a float pool?
For Adjusting Staff		Shift bidding too quickly out of float pool – not yet oriented to all units.
Unit Manager		Incentives to support staffing that create an environment of entitlement
Staffing person who looks at staffing throughout hospital.		We only use agency personnel when we are desperate. Regular staff has opportunity for over-time prior to scheduling agency.
Will adjust staff to cover all areas.		Negatives of agency: do not know hospital or policies.
Send people home if needed.		Do not always care about the patient, just there to do a job.
Mandatory Overtime		
Maintain Safe Staffing Level		
PRN Nursing		
Older experienced nurses flexible scheduling		
Well paid		
Nursing internship program improves competency		

POSITIVE

Staffing is being done strictly based on numbers and staff input from previous shift. Though we have the quadramed acuity system it is not utilized to determine staffing needs or assignment, thus some nurses end up with section assignments that are too heavy.

Current

- All scheduling policies under revision

- Automated system is cumbersome

- Only USC's do bidding for open shifts and they like it

- Self scheduling units consistently short on "premium shifts" M-F and weekends

- Floating between units dissatisfier

Not a union environment

No mandatory OT

Unit with high vacancies can have nurses sign contracts in advance to fill in empty shifts

Acuity tools and finance are not always related

- Assess how sick patient is

- Budget limits for responding

- Inter rater reliability issues

- Reimbursement doesn't change

- DRG even if acuity goes up

APPROPRIATE STAFFING

NEGATIVE

Mandatory OT

Flexible scheduling (shifts / hours) are not as readily available in all areas (had to staff 24/7)

Skill mix do units have right mix of RN/UAP?
Expectations of floating to desperate units to cover increase in census / acuity.

Budget constraints for increasing licensed staff for higher acuity patients in hospital.

The current formula for budgeting staffing and scheduling is inadequate for dealing with the flexibility needed to meet patient staff needs.

Unsure if current acuity tool really drives staffing decisions

Floating

Appropriate mix of RN/ LPN / MA in relationship to acuity

Home grown doesn't communicate between hospitals

FTE based on director productivity – not always accurate.

EFFECTIVE NURSING LEADERSHIP

POSITIVE	Authentic Leadership Meaningful Recognition	NEGATIVE
Rounding by Management / Administration	Manager support of shared governance with staff.	Limited Tools / Training
Daily / Weekly – increased contact with staff / environment / concerns	Supportive Nurse Manager	Limited orientation
I have always felt that my nurse manager has supported me.	Nurse Manager – open to suggestions from staff	Nurse Manager – Knee jerk reactions – doesn't always think issue through. Makes decisions that affect all staff instead of dealing with individual causing problem.
Mentorship for new nurse managers	Need for nurse manager tool box	Promotion by longevity or clinical expertise not management ability.
I work with a dynamic Nurse Manager. Well respected by staff. Great leader and develops staff. We have a new CNO (6 months) who has made significant changes to improve development and education of Nurse Manager / Directors.	Nurse Manager is most effective when includes staff in decision making regarding unit operations.	Need leadership tools / education for managers
Manager provides opportunity for clinical and administrative growth.	My chain of command supports me. They allow me to make decisions and help me learn from my own and their mistakes	Need for nurse leadership academy
Nurse Manager / Leaders Shaves vision and need of area with staff.		Need access to resources to help with finance, performance metrics and process improvement.
A positive relationship with nurse manager is critical to a satisfied staff.		The job of a nurse manager is often viewed as undesirable.
We recognize an RN and UAP each month as peer of the month Peer nominated Peer selected Small rewards Certificate / picture / time off		Inconsistent educational / development of Nurse Manager
Nursing Leadership Participates Support group decision Provide tools for competence Staff aware of negotiable non-negotiable points		Lack of support for some Nurse Managers
Recognition and appreciation are important to everyone. Improves satisfaction.		Very dependent of their director's leadership.

POSITIVE	Authentic Leadership Meaningful Recognition	NEGATIVE
		Effective Nurse Manager Role is unattractive (Hard to recruit and retain good, effective Nurse Managers)
		It's hard to not be invited to the "Tupperware party". Sometimes Management is a thankless job.
		Need for additional training in leadership, management, human resources for nurse manager.
		Nursing and Hospital Leadership must be willing to implement problem resolution recommended by staff. Participation when the staff followed the facilities problem solving method.
		An even bigger shortage in nurse management is coming.
		Administration does not know what nurse management involves.

EFFECTIVE NURSE / PHYSICIAN RELATIONS

POSITIVE	True Collaboration	NEGATIVE
Nurses are equal in power for clinical judgment with doctors.	Yes, good working relationship with physicians, but, still is air of superiority.	Even though it is written on the board, which nurse has patient, they still ask which nurse has their patient.
Non teaching facility MD must really count on nurse judgment and assessment.	Nurses respond positively to physicians who are willing to teach rather than criticize their mistakes.	Non teaching facility with nurses not being treated as collaborative team member.
Some good teamwork between nursing and MDs on shared processes: Hyperbili process – decrease infant heel-sticks.	Rounding with physician to discuss and collaborate on care.	RN staff lack understanding of MD needs.
Nurse Physician Relationship is variable depending on players, but policy to address bad behavior on both sides is helpful.		Continue to have issues with MDs “acting out” with staff.
Be professional to be treated as a professional.		No formal reporting system for disruptive behavior.
Nurses have to earn MD respect, but once they’ve earned it, the physicians are very open to nursing input and usually ask their opinion.		Nurses don’t realize that they can contribute to problem.
There seems to be teamwork between physicians and nurses. Most of them ask who has their patient.		Rude Physicians
Nursing Physician relationships are good.		Perceived “slap on the wrist” discipline does not change behavior.
Very good working relationship		RNs need to promote own level of professionalism and education to gain MD respect.
No joint practice		Administration says “call me” but in essence, the environment is fairly dictatorial. Need for increased communication.
MDs recognize staff competence		
We have a physician and a nurse on our Board of Trustees.		

STAFF PARTICIPATION		
POSITIVE	Effective Decision Making Skilled Communication	NEGATIVE
Nurses involved in Shared Governance		Staff lack communication skills.
Nurses have opportunity for clinical ladder.		It's easier for manager to design process / policy without staff participation.
CNO / Administrators are equal players.		Budget / time restraints may prevent nurses from leaving unit to participate.
Shared Governance and empowerment based on items within control of staff with established guidelines.		Don't let the bullies rule.
Unit staff action teams to make decisions for unit.		There is still "fear" about confronting bad behavior. Staff sometimes believe administration "knows" when they do not always know.
Steering team – representatives from each staff action team plus all nurse managers, 1 Nurse Supervisor and 1 Case Manager led by staff. Nurse internal coordinator who also serves on Nursing ad staff as staff representative.		Staff don't want to participate.
Unit Councils Peer evaluations Peer Reviews		Need for preceptor programs presently inadequate.
Shared governance is a continuum Input - - participation - - decision making		Staff feel lack of ownership and want it their way, but want someone else to solve the problem.
Unit practice Councils "Shared Governance"		Lack of involvement but high level of complaining.
The director of nursing does come up to the floors to see how things are going.		
The CEO conducts coffee breaks where staff can ask questions.		
The CEO comes to the floor and talks to patients.		
All staff is given opportunity to be member of various teams, committees, etc.		
We have a defined career ladder. We use annual career counseling with each RN to make sure they are provided opportunities and to check if they are taking them.		

POSITIVE	Effective Decision Making Skilled Communication	NEGATIVE
Daily Rounds by Hospital / MD / NSG Administration to talk with staff on unit and see how life is going.		
Nurses very universal. Nurse executive has health system seat.		
Strong clinical ladder program.		
Nurses who are flexible will support and / or deal with change more effectively especially when they believe they are not only participants but the decision makers for the change.		

SUPPORT FOR NURSING MODEL OF CARE

POSITIVE	Delivery Systems / Cultural Values	NEGATIVE
Increasing support for nursing philosophy.		We are not sure we have the best model of care at this time.
Nursing Process is deeply ingrained in what we do to the points that the nurses often do it sub-consciously.		CNO willingness to develop / explore / test new (EBP) Nursing Models of patient care.
Staff decide what the model should be.		Forcing nurses to float.
Professional Practice Model adopted and working well.		Lack of staff understanding of nursing model. Some facilities with no model. (Research based)
Shared vision for nursing. Goals / plan of care		
Function under the Professional Practice Care Delivery Model.		
Performance improvement is sometimes based on issues identified by staff. Staff collect data and then staff comes up with solutions if in fact data shows it is an issue.		
Fostering an Evidence Based Nursing Practice Model. Becoming consumers and creators of good science based nursing practice.		

CLINICALLY COMPETENT NURSES

POSITIVE	Support for Education	NEGATIVE
New clinical advancement programs		Support for education in budget can't meet all staff education needs.
Individually training / orientation no matter what the cost. You want to retain nurses instead of paying 20,000 to replace.		Not enough money for education.
Strong commitment from nursing leadership for clinical competence		The working retired nurse.
Excellence in nursing is now seeing support from philanthropy.		The bless her heart attitude / nurse.
Nursing Residency Program.		Need larger educational budget individualized to specific unit.
I work with some very competent nurses!		Need specific dates (scheduled) for individual training / development.
Extended orientation program Internship program Grand rounds Support for professional organizations.		I work with some very inept "scary" nurses.
There are educational forums at work to get CEUs, but not well attended. Why won't people come to them after a lot of time has been spent on setting them up?		Not all units provide same level of education / competency.
We have a precepted orientation program for all new staff regardless of past experience. Orientation is individualized Evaluated on a weekly basis We use a "Release Form Orientation" document when all requirements completed.		Lack of consistent resourceing.
Regional or State consortiums to promote good continuing education that crosses into all aspects of nursing at lower costs, resources sharing and promotes networking.		