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Educating to the Collaborative Care Model

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
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Abstract

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MSN, Walden University, 2014

BSN, East Central University, 2011

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

The problem addressed in this project was the lack of experienced RNs needed in the acute care setting to deliver safe, quality patient care, while effectively managing resources and providing job satisfaction. The purpose of this project was to determine if an education module designed to educate charge and rover nurses on the Collaborative Care Model (CCM) would enhance staff nurses' abilities to provide safe, high quality care to patients, and improve staff nurse retention on one unit in an acute care setting. The theoretical frameworks utilized to guide the education module included: Lewin's theory of planned change, Benner's novice to expert model, and AACN's synergy model for patient care. The project question asked if an educative process designed around the CCM for charge nurses and rovers would result in improvement and sustainment of nursing quality indicators on the unit and improve staff nurse retention. The educational modules included two, four-hour education sessions with power point presentations and interactive assignments presented on two separate dates. Analysis of effectiveness was determined by comparing initial and post education nursing quality indicators (Hospital Consumer Assessment of Healthcare Providers & Systems Dashboard and the Human Resources Score Card) for the unit. Results showed that staff turnover was reduced from 41% to 35.9% and patients' perceptions of teamwork increased from 47.4% to 60.9% following the education modules. This project contributes to positive social change by providing education to promote quality care and staff nurse retention.

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Dedication

This project is dedicated to my family. Without their selfless support and never ending patience (and understanding of my endless stubborn streak), I would not be here. We have walked this road together, the three of us, with many sacrifices made along the way. I promise there is a kitchen table underneath all the books. I love you both, with all that I am. To the crew at Medical-Pediatrics, you have taught me the true meaning of what it takes to be a part of a team. Each and every one of you is truly a blessing. But most of all, in fulfillment of a promise made long ago, Dad, this is for you.

Acknowledgments

I would like to acknowledge the tireless efforts of my chairperson, Dr. Joanne Minnick. Dr. Minnick has been such a constant presence during this time, bringing such a unique sense of energy, one that I cannot begin to explain, and surely one I will never forget. Thank you, for more than you know. I would also like to acknowledge the roles of my committee member, Dr. Anna Valdez, and my University Research Reviewer, Dr. Janice Long. Thank you for your guidance in helping me achieve this goal. I would like to acknowledge my preceptor, Tammy Franklin, and Chief Nursing Officer/Vice President of Nursing, Debbie Pender. Tammy, your calmness has been a source of peace. Debbie, your faith in me has brought me strength. I will always remember to be empowered and stand with a presence.

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Section 1: Introduction

Introduction

Research has shown that nurse staffing can play an important role in the number of adverse patient outcomes that occur in acute care settings (West, Patrician, & Loan, 2012). These adverse outcomes are related not only to the number of nursing staff but also to their skill mix (Frith et al., 2010; West et al., 2012). Barriers to providing adequate nurse-patient ratios and skill mix include the rising costs of healthcare, decreasing reimbursement rates, nursing shortages, and the inability to meet the increased demand for RNs

In 2004, the Health Resource and Services Administration (HRSA) forecasted a 12% shortage of RNs by 2010 (Snyder, Medina, Bell, & Wavara, 2004). The HRSA (2014) pointed out, what is obvious to those in nursing, that healthcare workers are constantly being affected by factors such as a growing yet aging population, patient and workforce; economics; and new and evolving disease processes. While projections for supply and demand of both RNs and LPNs/Licensed Vocational Nurses (LVNs) is favorable under the HRSA Simulation Model (2014), distributional configurations indicate an existing shortage that may continue and even worsen in some locations in the presence of scenarios such as earlier-than-anticipated retirement, a drop in graduates, or a lack of educators.

In 2015, the National Nursing Workforce Survey was performed for the second time by the National Council of State Boards of Nursing (NCSBN) and the National Forum of State Nursing Workforce Centers (Budden et al., 2016). This survey assists in

providing current data on the nursing workforce, to include analysis by location/state, licensure level, age, and education level. These data are critical to the forecast of potential shortages, recruitment and education efforts, and the allocation of assets (Budden et al., 2016). The Workforce Survey indicated that in June of 2015, there were 4,378,273 active RN licenses held and 1,030,080 active LPN/LVN licenses held throughout the United States and its territories (Budden et al., 2016). Out of the 260,000 nurses surveyed, 78,738 responses were received, noting that the average age of RNs was 48.8 years and average age of LPNs was 47.8 years (Budden et al., 2016).

In the 2016 Healthcare Staffing Survey Report, the American Nurses Association (ANA) estimated that 269,100 RNs are planning retirement or a reduction in work hours within the next 3 years and that the draw to Advanced Practice Nursing will take another 198,000 RNs from the bedside (Nursing Solutions, Inc., 2016). ANA (2016) projected a shortage of 327,000 RNs for 2016–2017, after accounting for the 140,000 new graduates expected to pass boards, and a projected national RN shortage of 949,035 by the year 2030 (Nursing Solutions, Inc., 2016). Staffing shortages, along with the increasing demands of more acutely ill patients remaining in the acute care setting, are leading nurses to look for and design new practice models of care to help better manage the process and workload (Kalisch & Lee, 2013). The potential for positive social change comes from the projects format for educating nurses on the scope of practice and resources available in a newly designed care model. This education also has the potential for streamlining and standardizing workflows, developing job planning practices, and

encouraging investment in job education and enrichment practices, which can help improve not only the staff satisfaction, but their feeling of value (Colosi, n.d.).

Problem Statement

The problem addressed in the proposed project was the lack of experienced RNs in the acute care setting, such as medical-surgical/pediatrics, to deliver quality patient care, ensure patient safety, contain costs, manage resources, and provide job satisfaction. The current lack of available staff, financial strains of overtime; and push for adequate work-life balance were part of the impetus for a ministry-wide LPN/LVN pilot project. This pilot project called for one unit in each of four hospitals, in two different states, to adjust the skill mix, increasing the number of LPN/LVNs. On the medical-surgical/pediatrics, 32 bed acute care unit at the community hospital under study, in lieu of simply increasing the number of LPN/LVNs in the staffing mix, the new Collaborative Care nursing model (CCM) was developed. The practice model was developed by the staff with support from leadership and focused on increased collaboration, communication, knowledge, and the use of each level of licensure to their fullest scope. It is known that the use of teamwork and collaboration in nursing has the potential to improve patient safety, outcomes, and quality of care, as well as decrease the rate of missed nursing care (Kalisch & Lee, 2010). The combination of the additional licensed nurses allotted for with the pilot project and the teamwork, collaboration, and increased knowledge and support provided by the educative process of the CCM had the potential to redesign the workflow ensuring the optimal use of every level of staff. The potential for a significant financial impact through a system-wide implementation was noted as

well. Estimated annual savings for the first year of the pilot and CCM in tandem was $199,284.00. This project challenged that in a collaborative and supportive environment with an educative process in place, a staffing mix containing additional LPN/LVNs used to the highest level of licensure could provide safe, high quality care to patients, while allowing for a better work-life balance, as evidenced by increased retention rates.

Purpose

The purpose of the proposed project was to develop an education module and accompanying toolkit designed around the CCM to present to the unit charge nurses and unit rovers. The rover, a position designed and implemented with the CCM, is an RN used to support the LPN/LVNs with tasks that are not within their scope of practice, as well as the rest of the unit in times of high acuity, high throughput, and heavy need patients. The rover is also used to support the patients who are receiving inpatient dialysis. The majority of these patients are admitted to the medical-surgical/pediatric unit, but some go to intermediate care, other units for overflow, or to rehabilitation when discharged. While the dialysis itself is contracted out, all other nursing care, to include medications, turning, and hygiene care, is to be seen to by a hospital staff member. This makes the rover a valuable resource to the hospital overall, as they provide care for the patients and allow staff to remain on their units. The intended outcomes of this education would be for all charge nurses and rovers to fully understand each aspect of the model, allowing for the collaborative and supportive environment needed to sustain it successfully. Tools in this guide included, but were not limited to; a delegation guide, communication tools, scope of practice grids, unit staffing matrix, and standard work for

each level of staff. Allocating resources per staff acuity and providing support for both patients and staff are both tasks for an RN (Snyder et al., 2004). Ensuring the charge nurses, who are responsible for making staffing arrangements, were educated to the delegation processes and scope of practice, as well as a standard workflow for each licensure level were ways to help ensure the success of all staff and of the model, and most importantly, improve patient outcomes.

Practice-Focused Question

The purpose of this project was to develop an education module and accompanying toolkit, specifically on the CCM, for the unit charge nurses and rovers. Constant formative evaluation was done on the unit by myself and other facility leaders to ensure safe, high quality patient care from bedside staff. There was also a consistent effort to ensure that the layer between bedside staff and management had the knowledge and education needed to help provide support and leadership. The charge nurses and rovers were part of that important layer, the informal leaders. Downey, Parslow, and Smart (2011) described an informal leader as one who brings out the best in others through their actions, advocacy, knowledge, and skills. The practice-focused question was as follows:

P (Population) – Charge nurses and rovers (informal leadership)

I (Intervention) – Specific educative process on the CCM

C (Comparison) – No educational intervention

O (Outcome) – Sustainment of and/or improvement upon nursing quality

indicators

Would an educative process, specifically designed around the CCM and delivered to unit charge nurses and rovers, result in sustainment of and/or improvement upon nursing quality indicators on that unit when compared with no educational intervention?

Implications for Change in Practice

Prior to this project, there was no formal or standard education process for the informal leaders in regards to the implementation of the LPN pilot or the CCM. Communication in regards to change was dependent upon staff reading their company e-mail and the communication board; attending daily huddles, which were often missed due to the pace of the unit; and word of mouth, which was often be unreliable when at the end of a long shift and the nurses were reporting on 32 patients. An education module allowed for a standardized orientation process to be put into place, with clear expectations outlined. This, in turn, gave a solid foundation for the education of this model and consistency in its application. An additional relation to social change was the opportunity given to the charge nurse and rovers to have "buy-in," a sense of ownership, as well as pride in their current practice by improving the outcomes of patients during their hospitalizations as well as upon their discharge.

Nature of the Doctoral Project

A formative evaluation process was put in place by myself, my mentor, and facility education department to assure that the implementation of any changes made in the pilot and model met with coinciding education as well as to ensure the tools provided fulfilled their purpose. I used facility records to determine the decreased vacancy rate secondary to increased nursing satisfaction occurring since the implementation of (a) the

CCM and (b) the education process. Tracking of vacancies, turnover, and other desired

data were accessed for a total to 13 months, 4 of that being pre education implementation.

As the CCM was already in place without the educative process, I started go-live at the

beginning of a month for stability of data tracking. Comparison data were included in

this time frame as they were tracked in a rolling calendar method, accessible in both

dashboard and scorecard format. Dashboards of the nursing quality indicators, created

for the pilot units across the system, allowed for comparison from the time period prior to

the implementation as well. The scores of Professional Research Consultants, Inc. (PRC;

2016), a third party company whose scores included, but were not limited to, quality of

care, transition of care, and patient satisfaction, were all used for the same time period. I

also included a literature review on the education of nurses in the project.

Significance

The significance of this project can be looked at two-fold. First, educated

informal leaders will lead to a unit that runs more efficiently and effectively, has more

open communication, and sustains change (Downey et al., 2011). Second, with increased

collaboration and support roles and the use of each nursing level at the top of their

licensure, the safety and quality of patient care and outcomes will not be compromised,

regardless of the skill mix.

There were four units throughout the system, two located in Oklahoma and two in

Missouri, designated to change the skill mix under the LPN/LVN pilot program. With

the make-up of the identified 32-bed medical-surgical/pediatric acute care unit being

quite different from the others, the decision was made by myself and the staff members

on that unit to try something different. This unit was unique from the others in the diverse patient population being served, and equally distinctive with the staffing of LPN/LVNs in daily practice not being a new concept. However, the number of LPN/LVNs in the staffing mix that the unit could expect to increase to was new. The CCM allowed for an increase in the overall staffing on this unit and for RNs to hire onto other units where they were greatly needed. An educative process could help ensure a smooth transition for both new LPN/LVNs and staff already assigned to the unit. This educational process could also be expanded upon to include each level of staff as well as interdisciplinary team members outside of the unit to promote a better understanding of both how the pilot and model work. This process would also be easily adaptable to other units and facilities and to how their pilot units are run.

Implications for this project include the development of a culture of accountability amongst not only the formal and informal leadership, but the bedside staff. With everyone educated on the standard work of each level and the 'why behind the what,' the peer-to-peer accountability will be an expectation. The financial savings would have an impact on all stakeholders, including the unit staff, the facility and system, and the community itself.

While I designed this education module and toolkit for charge nurses and rovers, what I learned through this project has helped provide the framework for building a detailed, educative process for the scope of practice for LPN/LVNs in the acute care setting. The LPN/LVN care model is being expanded system-wide across the ministry. This educative process and toolkit, which can be easily as well as quickly adaptable to

both facility policies and state board of nursing guidelines, will address a large gap in practice with little lapse in time.

Summary

Providing an education and orientation process on the CCM to charge nurse and rovers will further their ability to provide a collaborative and supportive environment, benefiting the team on the unit, interdisciplinary team members, patients, and families. Development of this process could contribute to the knowledge base and decrease the stress level of the unit's informal leaders. Creation of a curriculum that keeps the stages of skill acquisition at the center and a formative evaluation process will help to ensure sustainment of quality patient outcomes.

Section 2 will include the theoretical framework supporting the CCM education and orientation guide. In the section, I will revisit the practice problem and the purpose for this doctoral project. I will provide research summarizing the current state of this practice on both the practicum unit and overall charge nurse education and orientation practices as well as the local relevance of the issue to the hospital and the system.

Section 2: Background and Content

Introduction

This problem addressed in the proposed project was the lack of experienced RNs in the acute care setting to deliver quality patient care, ensure patient safety, contain costs, manage resources, and provide job satisfaction. The practice-focused question was as follows:

Would an educative process, specifically designed around the CCM and delivered to unit charge nurses and rovers, result in sustainment of and/or improvement upon nursing quality indicators on the pilot unit when compared with no educational intervention?

The purpose of the project was to develop an educative process and guide on the CCM for the pilot unit charge nurses and rovers. These tools would provide knowledge of items such as delegation responsibility, each licensure level's scope of practice, standard workflow, and the unit matrix. In gaining this knowledge, the informal leaders would be better prepared to support the RNs and LPN/LVNs and assist in providing collaboration and fostering teamwork, while ensuring the sustainment of and improvement upon nursing quality indicators remained a priority. Supporting tasks, such as freeing staff for lunch and breaks; service recovery assistance; rounding for problems, knowledge availability, and staff needs; and LPN scope of practice support, play a huge role in the work-life balance for staff, and hence, retention.

In this section, I will provide the rationale for the models and theories used in this doctoral project. I will identify the relevance of the literature reviewed to nursing

practice, to include the more comprehensive problem along with the local context which initially drew attention. I will also describe my professional role as the doctoral nursing student (DNP) in this project at length.

Theoretical Framework

As a profession, nursing is obligated to contribute to humanity with knowledge-based practice (McCurry, Hunter-Revell, & Roy, 2009). Knowledge originates from theory, and theory, together with their philosophical base and disciplinary goals, becomes the framework for nursing practice (McCurry et al., 2009). A theoretical framework provides a guiding process for a project, providing contextual understanding (McEwen & Willis, 2014). Theories and concepts not only help to guide nursing practice and produce additional knowledge, they enable nurses to better understand the "why behind the what". The theories I used for this project in conjunction, included Lewin's theory of planned change (TPC; 1951), Benner's novice to expert model (1984), and the American Association of Critical Care Nurses' (AACN) synergy model for patient care (n.d.).

Theory: Lewin's TPC

Kurt Lewin, an early 20th century social psychologist, is known for the development of the force field analysis framework for recognizing and observing the factors influencing a situation, to include defining the forces that were either helping or hindering progress (Shirley, 2013). Lewin's belief was that if the defining forces were identified, a better understanding could be had of why groups behaved as they do and what actions would be needed to implement and sustain change (Shirley, 2013). This framework is the foundation for Lewin's TPC (see Figure 1), and referred to as the

phases of (a) unfreezing, (b) movement, and (c) refreezing (Manchester et al., 2014;

Shirley, 2013). I chose this theory as framework for my project because of the nursing

staffs' ability to relate to the phases, as the model lends itself to stages of the nursing

process: plan, implement, and evaluate (Bowers, 2011). The theory allows for change to

be planned for and structured and for the defining forces to be identified and planned for

accordingly prior to implementation (unfreezing; Bowers, 2011). Resistance can be

decreased as stakeholders will have the opportunity to voice concerns, interject ideas, and

feel a part of the process (Bowers, 2011). During the movement or transition stage,

continued clear communication and shared visions for a desired goal will help keep

everyone moving forward (Shirley, 2013). The third stage, refreezing, calls for

stabilization of the driving forces to ensure sustainment, or hardwiring, or the change

(Shirley, 2013).

Figure 1. Pictorial representation of Lewin's Theory of Planned Change, which allows for the development of a plan for change, and leading to the creation of a new shared vision. From "Organizational Change Management in Practice," by A. Barnstable, 2013, DePaul University. Retrieved from the DePaul University website: https://depaul.digication.com/andreabarnstable/Advanced_Project_-_More_Change_Management

Theory: Benner's From Novice to Expert Model

Dr. Patricia Benner's from novice to expert model (see Figure 2), which applies the Dreyfus model of skill acquisition to nursing, was first published in 1984 (McEwen & Willis, 2014). This model summarizes five stages of skill acquirement: novice, advanced beginner, competent, proficient, and expert, with respect to the areas of application in administration, education, practice, and research (Current Nursing, 2011; McEwen & Willis, 2014, p. 230). Listed below are descriptions of these five stages, and how one can be expected to act upon achieving each.

1. Novice: A beginner with no life experience, taught rules to help with performance.

2. Advanced beginner: An individual who has gained experience in actual situations and can demonstrate acceptable performance.

3. Competent: This stage is typically reached after 2 to 3 years in the same or similar situations, with perspectives gained from planning own actions.

4. Proficient: The individual perceives situations as a whole and learns from experience what usually events can be expected in a given situation and can modify in response to these events

5. Expert: Highly fluid performer, no longer has to rely on principles, rules, or guidelines to determine actions (Current Nursing, 2011; McEwen & Willis, 2014, p. 230).

Benner presented the concept that nurses develop their skills and understanding over time through practical knowledge and education (Current Nursing, 2011). A great

significance of this theory is that each step builds upon the previous one, expanding on skills and experiences. The nurse gains knowledge with every new experience, even with failure, because they have learned something. Expertise becomes a reality when visions of 'what is possible' become a characteristic of the nurse (Benner, 2001). In the paper, "Using the Dreyfus Model of Skill Acquisition to Describe and Interpret Skill Acquisition and Clinical Judgment in Nursing Practice and Education," Benner (2004) pointed out that for one to improve in their clinical practice requires sincerity and receptiveness. Both the Dreyfus and Benner models call for the nurse to be at different levels of the continuum at different times, based on their experience and knowledge level (Benner, 2004).

My decision to use this model in this project was an easy one. The unit has such a variable of staff, to include the high number of LPN/LVNs, many of whom are newly licensed, newly licensed RNs, and charge nurses who, while seasoned RNs, are new to the informal leader role. This model will help guide not only the on-boarding and orientation process of those newly licensed but provide an understanding of how a nurse may move from one level to the next and the learning needs and styles at different levels of skill acquisition.

For the acquisition of knowledge, the adult learner brings with them previous knowledge and learning experiences, anticipations, and attitudes (Peisachovich, 2015). It is important to remember that every nurse will not be at the same skill level on the continuum at the same time. Pairing the Benner model with the synergy model, which I

will discuss next, allows for additional guidance as many of the models' facets are intertwined.
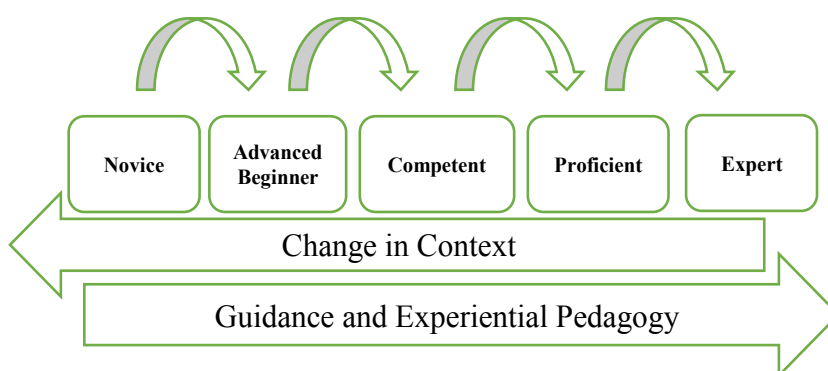
Figure 2. Pictorial representation of the components of Benner's From Novice to Expert model, which applies the Dreyfus model of skill acquisition to nursing. From "The Importance of Intercultural Fluency in Developing Clinical Judgment" by E.H. Peisachovich, 2015, *Journal of Nursing and Health Care, 2*(2), p. 54.

Theory: AACN's Synergy Model for Patient Care

The AACN synergy model for patient care (see Figure 3), a broad, conceptual model and middle range theory, is based on the concept that when the patient and family needs are matched to the nurse's level of expertise or competencies, that this match directly contributes to optimal patient outcomes (Kaplow & Reed, 2008). In simple terms, the patient is matched with a nurse who is strong in the particular area the patient needs helps with and that will help the nurse reach the best outcome for the patient. Synergy is said to occur when the needs or characteristics of a patient, clinical unit, or system are matched with the expertise or competencies of a nurse (AACN, n.d.).

The rationale behind my use of this model was the ability to incorporate it into basically every aspect of the unit, to include leadership, clinical practice, education, and nursing rounds (AACN, n.d.). The synergy model concludes there are three levels of outcomes, those resulting from (a) the patient, (b) the nurse, and (c) the health care system (Kerfoot, 2002). Leadership in all stages must be at least part onboard for the team to be successful in providing the optimal outcomes and excellent patient care (Kerfoot, 2002). The framework for nursing rounds provides nurses with the ability to articulate their patients' needs as well as how they are able to impact the outcomes based upon their own unique skills and abilities (Mullen, 2002). The goal and focus for nurse and staff education is to ensure that the care delivered is high quality and patient/family-centered (Kaplow, 2002). These are all things that the team at the community hospital under study made clear were important to them and that they wanted to improve on.

The capability to integrate this model into the decision-making process of patient placement was probably the deciding factor for its use in this project. The synergy model provides eight personal needs and characteristics that each patient and family bring to a healthcare situation (CITE). These characteristics span a continuum, as the patient can exist at different points at any given time, with changing needs calling for different levels of competencies (Kaplow & Reed, 2008; Mullen, 2002). The model also provides eight dimensions of nursing practice, also spanning a continuum ranging from competent to expert (CITE). With the increased number of LPN/LVNs on the unit and patient characteristics driving the nurse competencies, I used the synergy model to create a tool to help the charge nurses with their decision process in patient placement.
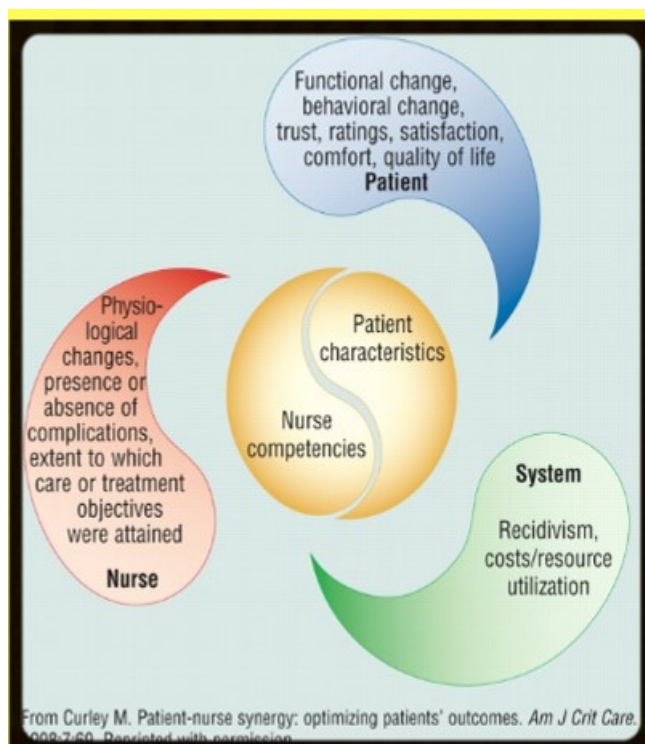
Figure 3. Pictorial representation of the AACN synergy model for patient care, which links optimal patient outcomes to the synergy created with the matching of patient and family needs with nurse competencies. Reproduced from "Patient-Nurse Synergy: Optimizing Patients' Outcomes," by M. Curley, 1998, *American Journal of Critical Care, 7,* p. 69.

Clarification of Terms

The following terms were used in guiding this project:

Clinical imagination: "…a related way of thinking about patients…to conjure up possibilities, resources, and constraints in the patient and families situations" (Benner, Sutphen, Leonard, & Day, 2010, p. 85).

Clinical leader: "…a registered nurse who influences and coordinates patients, families and health care team colleagues for the purpose of integrating the care they

provide to achieve positive patient outcomes" (Patrick, Spence-Laschinger, Wong, & Finegan, 2011, p. 450).

Clinical reasoning: "…often defined in practice-based disciplines, such as nursing and medicine as the application of critical thinking to the clinical situation" (Victor-Chmil, 2013, p. 35). "…the ability to reason as a clinical situation changes, taking into account the context and concerns of the patient and family" (Benner et al., 2010, p. 85).

Collaboration: "…people working together in a prescribed role with a shared end goal mind" (ANA & American Organization of Nurse Executives [AONE], n.d., para. 1).

Culture: "…a social energy built over time, which can move people to act or impede them from acting" (Hall, 2016, p. 14). "Culture is formed by invitation, not mandate, by commitment, not coercion…it is built through everyday actions" (Hall, 2016, p. 17).*IV LPN*: An LPN in this community hospital, who in accordance with the Oklahoma Nurse Practice Act, specifically 59 O.S. § 567.3a.2., (Oklahoma Nurse Practice Act, 2002/2015) as having received appropriate training, has documented education and competencies, and has a job description allowing for specific IV therapy and medication administration skills.

Relevance to Nursing Practice

Professional development with an obligation to lifelong learning is an expectation of every nurse according to Standard 8 of *Nursing: Scope and Standards of Practice* (ANA, 2015) as well as the *Nursing Professional Development Scope and Standards of Practice* (National Nursing Staff Development Organization ANA, 2010). The continuous expansion of responsibilities, technical skills, and an increasing number of

both acute and chronically ill patients, is calling for nurses of all levels of expertise to continue their education in some form or another (Benner et al., 2010). To help ensure optimal outcomes, there is a great need for the patient, their nurse, and in short, anyone on the patient's interprofessional healthcare team, to collaborate. In doing so, each can apply their specific knowledge and skill set, integrating clinical reasoning to the patient's particular conditions and situations (Benner et al., 2010). When knowledge recall and immediate interventions are needed, the development and sustainment of a nurses' ability to use clinical imagination and reasoning become essential (Benner et al., 2010).

Strategies and Standards

The Principles of Collaborative Relationships (ANA & AONE, n.d.) were developed by clinical nurses and nurse managers to help guide in the creation of synergistic, collaborative, and relationship principles. In doing so, they found when working relationships are solid and collaborative, nurses at all levels are able to function as a team, providing high quality, effective, care in a supportive environment (ANA & AONE, n.d.). Unassuming and sustained changes to the way staff communicate with, relate to, and support each other can make large impacts towards having a synergistic and collaborative environment in their workplace

The implementation of one shared accountability model was very similar to the care model in this project. The pilot was completed on three medical-surgical units in three separate states, with perspective being to use all levels of nursing to the fullest scope of practice. Prior to implementation, revisions were completed on all policies, competencies, and job descriptions, an acuity tool was designed, and education was

completed by all RNs, LPN/LVNs and unlicensed assistive personal (UAPs; Rudisill, Callis, Hardin, Dienemann, & Samuelson, 2014). Preliminary results support the sustainment of clinical quality, both nurse and patient satisfaction, and a decrease in costs, with a shared accountability model containing an intended skill mix of educated nurses, permitted to practice to the fullest scope of their licensure, supported by delegation, collaboration, and teamwork (Rudisill et al., 2014).

Patrick, Spence-Laschinger, Wong, and Finegan (2011) identified five defining attributes of a clinical leader:

1. Clinical expertise: one with this attribute has clinical knowledge, clinical competence, and is familiar with how the team works.

2. Effective communication: demonstrates these abilities by articulating and clarifying information, as well as motivating and empowering others.

3. Collaborating and coordinating: able to influence others to see and understand positions from various perceptions, coordinate processes, and serve as a liaison.

4. Interpersonal understanding: ability to emphasize with others, while managing one's self and others, to safeguard patient-centered and appropriate care.

The use of these attributes in practice led to a feeling of autonomy and empowerment, with nurses feeling supported in making decisions based on their knowledge and clinical judgment, resulting in positive outcomes (Patrick et al., 2011). This model has the potential for implementation coinciding with the LPN/LVN pilot in a system-wide

capacity, filling the knowledge gap, and helping each unit individualize their program to meet the needs of their staff and their patient population.

Local Background and Context

There was recognition from the system that despite recruitment efforts, hundreds of RN positions remained unfilled in many of its hospitals. With the desire to provide adequate staff to support safe, high-quality, patient care, decrease stress on current staff, and address recruitment and retention challenges, the LPN pilot programs were initiated. Experience within the system validates LPN turnover was marginal, and increasing their use would allow RNs to focus more on actions appropriate to their licensure level. In June 2015, it was determined that the 32-bed medical-surgical/pediatrics unit would be the home of the LPN pilot. Instead of simply choosing a model, myself and the staff, or team, on the unit was invited to come together and take part in helping choose from the models provided by senior nursing leadership (SNL), or to help design their own. The CCM was designed and taken back to SNL. This change in nursing model was approved at both the local and system level, supported by both chief nursing officers (CNOs).

In August 2015, education was provided by the facility education department to the manager/director level staff, and in September/October 2015, I assisted the education department in providing classes for unit staff on delegation, the pilot, and the model roll-out itself. The team and I went live with the pilot and model in November 2015, with a total of six LPN/LVNs on staff. As of August, 2016, there were 17 LPN/LVNs. When designing the model, the team and I established two rules: (a) each time there was a change made, it was to be left in place for a full 90 days so the true results can be seen,

and (b) if someone brought forward a problem or a suggestion for a change, they were to also bring with them two possible solutions. This was to encourage accountability and ownership in the process, and in the unit. Once the model went live, a formative evaluation process was put into place, again by the team on the unit and myself, to make changes only at 90 day intervals.

Overall, the educative process provided to the staff focused on delegation, the unit matrix, and the role of the rover. While all of these things were, and still are, a very important part of both the pilot and the model of care, there was a piece of the puzzle that appeared to be missing. With the increase of LPN/LVNs on the unit came the increased need of support from the RNs, and an increased need for teamwork and collaboration. With that also came a change of culture for everyone on the unit, especially for the informal leaders who often are responsible for the overall tone of the staff.

The team was involved in the care model and pilot from the beginning. They were included in the news of the upcoming change, designing of the care model itself, and every change in between. The development of a formal educative process and guide for the informal leaders helped to ensure a more cemented collaborative process (ANA & AONE, n.d.). While it is important to further educate the staff, the focus on the development and empowerment of this initial group impacted the performance of the unit in a positive manner. Educating them on the scope of practice for each level of licensure, to include RN, LPN/LVN, and UAP, as determined by the National Council of State Boards of Nursing (NCSN), the Oklahoma Board of Nurses (OK BON), and both local and system-wide policy was a priority. Education included a competency on delegation,

as the responsibility grows when they are determining assignments. An additional

priority was ensuring they had access to this information, and could teach others.

Role of the DNP Student

At the time of the study, I was serving as the clinical staff coordinator and clinical

educator of the medical-surgical/pediatric unit responsible for the LPN/LVN pilot and

newly designed CCM. I have worked for this community hospital and system for 17

years, having spent the last 11 with this unit in some capacity. When advised by SNL

that we would be undergoing the LPN/LVN pilot project on this unit, I was told we could

leave our model as it was, or come up with something different. As someone who has

spent time at the bedside, as a charge nurse, and as a manager on this unit, I felt this was

not my decision alone to make. I knew with the increase of LPN/LVNs, the workflow for

everyone would need to change. How it would change needed to be a discussion I held

with my team. The LPN/LVNs currently on staff were proud of the skills they could

perform and the contributions they brought to the team. I also knew we would have a

difficult time with recruitment of additional LPN/LVNs if we restricted their practice.

This knowledge was first hand, as we had three LPN/LVN nurse technicians on our unit

that would be graduating in a matter of months and were excited about continuing to

work there as a licensed nurse. I spent time talking with them about what this scope of

practice could look like, and gathering some insight. My team wanted everyone to have

the opportunity to work together, to learn and grow, and collaborate. The product of this

was our model of care.

The motivation behind this project came after putting both the pilot and the model of care into place. The initial education to the team was provided in tandem with the education department, and was put out system-wide, regardless of the type of care model being used. While I did provide them with the staffing matrix and information on the model itself, it was difficult to personalize it to our unit. The continuous formative evaluation process, to include the 90 day ruling and staff feedback, has remained in place since the beginning of the pilot. The one noted area of lacking was a true educative process of the charge nurse and rover role.

Perspectives that affected this project were the perceptions of the others, and what they believed the informal leader role, especially the rover, should look like. It was often viewed as an 'extra nurse' that should be available to help on other units, pulled away whenever anyone else felt it was necessary. Scope of practice had another profound effect on this project. While the OK BON (Oklahoma Nurse Practice Act, 2015) allowed for a rather broad scope of practice, because we were in a system that spans several states and often fell under system-wide policies, the scope of practice for our LPN/LVNs was affected, such as the care planning activities. Electronic health record charting in a system-wide process spanning several states, influenced the scope of practice and the direction of this education. One thing I determined was that this project needed to consist of living documents and tools, as they need to be adaptable with the changes to the unit, to policies, to healthcare, and to the learning methods of any new informal leaders that join the team.

Summary

The perspective for this project was not just about developing new strategies to increase collaboration, communication, and teamwork, or the development of an educative process, though those are important. It was about changing and sustaining a culture. It was about involving the team that has been there from the start, who believed in and remained as passionate about the success of this project, creating a shared vision. Seeking to involve the team in the designing of the educative process helped ensure that all the needs were being met, that the different methods of learning were being accounted for, and that new challenges or possible barriers could be noted and addressed early on. This would also continue to support a culture of ownership and accountability within the team.

> The only visions that take hold are shared visions – and you will create them only when you listen very, very closely to others, appreciate their hopes, and attend to their needs. The best leaders are able to bring their people into the future because they engage in the oldest form of research: They observe the human condition" (Kouzes & Posner, 2009).

Section 3 will detail the plan for the project design, as well as collection and analysis of data. Included will be the sources of evidence and their relationship to the projects purpose. The intended evaluation points, scores, and comparison and monitoring periods will also be defined in this section.

Section 3: Collection and Analysis of Evidence

Introduction

Approval from the Walden Institutional Review Board (IBR) was received

February 3, 2017. The Walden IBR approval number is 02-03-17-0376017.

With this project, I addressed the need for an educative process to the CCM,

initially developed and implemented in tandem with an LPN pilot project, to support the

charge nurses and rovers, also referred to as the informal leaders of the acute care

medical-surgical/pediatric unit of a community hospital. The education included a toolkit

to help provide these informal leaders with a thorough understanding of delegation

responsibility, scope of practice, adult learning, implementing change, standard

workflow, and the unit matrix. In gaining this knowledge, they were better prepared to

provide support to the staff using the CCM, while also prioritizing the sustainment of and

improvement on quality indicators.

In this section, I will restate the practice-focused question, while clarifying and

aligning it with the purpose of the project. I will also provide a discussion surrounding

the collection, analysis, and synthesis of evidence collected to reassure appropriate

safeguards were in place to address the practice-focused question.

Practice-Focused Question

The problem I addressed in the proposed project was the lack of experienced RNs

in the acute care setting to deliver quality care, ensure patient safety, contain costs,

manage resources and provide job satisfaction. With the pilot project increasing the use

of LPN/LVNs and development of the new model of care leading to significant changes,

the gap-in-practice was found to be an educative process for the unit's charge nurses and rovers, also known as the informal leadership. The practice-focused question was as follows:

Would an educative process, specifically designed around the CCM and delivered to unit charge nurses and rovers, result in sustainment of and/or improvement upon nursing quality indicators on the pilot unit when compared with no educational intervention?

The purpose of the project was to create an education module and toolkit, based on the principles and characteristics of adult learning, to increase the knowledge level of the unit charge nurses and rovers of processes changed and/or implemented with the CCM. The module included enhanced education on adult learning principles and styles, implementation and sustainment of change, scope of practice and delegation responsibility amongst each licensure level, standard workflow, unit expectations, and unit matrix and productivity. I developed PowerPoint presentations covering each piece of the toolkit and interactive assignments to help each member of the class build confidence in their leadership and communication skills as part of the educative process as well. Role-playing was used for those areas where nurse participants struggled with the concepts as a way of helping work through the ideas and find ways to improve upon those areas. I invited guest speakers to provide insight on different perspectives, situations, and possibilities. This time allowed for the class to see that it would take time to gain all the knowledge and insight, but that if they were willing to put the effort in, the knowledge and insight would come. Gaining or enhancement of this knowledge better

prepared these charge nurses and rovers to provide a more collaborative and supportive environment, as they could identify not only their learning style, but those of the members of their team. In doing so, the charge nurses and rovers were able to recognize ways to help others improve in areas of opportunity. Ensuring delegation was done appropriately, acting as agents of change while identifying both barriers and influences (Swihart & Hess, 2014), and learning how the matrix and productivity are intertwined were all an important part of the educative process. Perhaps the most important lesson of all that I developed was how the process all tied back to how the supportive environment helps to ensure sustainment of and/or improvement upon optimal patient outcomes.

Sources of Evidence

I used evidence gathered from various sources to address the practice-focused question. These sources included a literature review, facility scorecard, and nursing dashboard. Descriptions of what each of these consists of is included below.

I used the literature review to locate relevant evidence-based adult learning principle and theory from which to design an education module and toolkit. It is imperative that the nurses in these positions have a clear understanding of not only their role and its relationship to the quality patient outcomes, collaboration, and teamwork on the unit, they must also have a thorough understanding of the role of each person they work alongside (Wojciechowski, Ritze-Cullen, & Tyrrell, 2011). This review was relevant in identifying learning needs, common barriers, and available resources. I used the evidence I gathered to help determine the best educative methods or approaches to

use in the module, and these were helpful when designing the toolkit to compliment the formal training.

A balanced scorecard is a method used for measuring and tracking organizational quality indicators and summarizing the quality of care (Santiago, 1999). This form of trended information can be used to pinpoint areas in need of improvement, measure noted improvement, recognize best practice, and function as performance bench markers (Jeffs, Merkley, Richardson, Eli, & McAllister, 2011). In this project, I used the scorecard from the hospital's human resources (HR) department to track retention, turnover, and vacancy rates, while the facility and system-wide scorecard was used to track and compare items such as overall quality of care, readmissions, and pathway utilization.

Nursing dashboards are another form of visual communication, used to track processes, outcomes, and safety, often using nursing quality indicators as the focus (Frith, Anderson, & Sewell, 2010). The focus of the nursing dashboard is on sustainment of, or improvement on these quality indicators, outcomes, and processes (Jeffs et al., 2014). Much like a scorecard, the results on the nursing dashboard for this project were a visual representation of the relationship of the education module and toolkit to the expectations and demands of the unit. The increased frequency of updates to the dashboard, in comparison to that of the balanced scorecard, allowed for quicker identification and analysis of barriers and issues as well as resolutions. I used unit and tower nursing dashboards, created from data collected during leader, manager, and charge nurse rounding, to track nursing quality indicators, such as fall precautions, pain assessments, bedside handoff and hourly rounding, core measures, and other required documentation.

Published Outcomes and Research

The purpose of this project was to create an education module and a toolkit to increase the knowledge level of the unit charge nurses and rovers in regards to those expectations and processes changed and/or implemented with the CCM. I used a literature review to examine relevant evidence-based adult learning principles, theories, and models and identify learning needs assessment and evaluation formats and possible barriers. This evidence was used to help create the education class and toolkit necessary to fill the gap-in-practice. I initially conducted the literature search using the CINAHL, ProQuest, and PubMed databases. A secondary search was performed on the webpages of the Association for Nursing Professional Development and www.nurseeducatoronline.com. These two additional websites allowed for easily accessible, professional, evidence-based articles. The keyword search terms I used included *adult learning principles, adult learning models, adult learning theory, adult learning assessment, pedagogy, andragogy, charge nurse, inpatient, healthcare environment, education, orientation,* and a combination of these terms. My selection criteria included the article being a primary source, being from a peer-reviewed scholarly journal published between 2011 and 2016, and the level of evidence. My comprehensive focus was on articles with evidence of (a) use of a pertinent learning model/approach or adult learning principles or theory in a health care environment; (b) identification of a learning needs assessment format; and (c) a thorough evaluation process with barrier identification.

Archival and Operational Data: Balanced Scorecard and Dashboards

At the community hospital study site, the practicum facility balanced scorecard is a living document known as "True North." This document is owned by a nurse leader, who updates and compiles the data monthly after collecting it from the individual departments. This document shows data for the overall facility, which can be displayed by unit for certain categories. Included in the True North data are (a) readmissions, (b) overall quality of care, (c) teamwork, (d) financial performance, (e) turnover rate (rolling 12 months), (f) vacancy rate (rolling 12 months), and as this is a faith-based facility, (g) pausing for prayer. The significance in each unit's performance is great. For example, if one unit is high in turnover, or a larger unit has a low individual score in teamwork, these numbers drive the overall facility percentage down very quickly, which can be significant. The monitoring of this data, with the availability of baseline data (pre education and pre-CCM), allowed me to see a true visual of what worked and what did not. When a form of education was tried, through both the formative evaluation process and the visual of the True North graphs, I received an accurate picture of whether the education module and toolkits were meeting their intended purpose. The data portrayed on these scorecards and graphics were displayed in a rollover format. For instances, the turnover and vacancy data, which were received from the HR department, showed in both facility total and individual unit in a rolling 12-month period. Teamwork was another scorecard reflected as a facility-wide score and available as an individual unit score. These data were collected via PRC (2016) and are reflective of the patient's perspective.

In addition to collecting the core Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data, PRC (2016) customized supplementary survey

questions in an attempt to learn more about what patients' value and their feelings on the care delivered by hospitals. With the correct education module and toolkit in place, educated informal nurse leaders had the ability to inspire and encourage staff to perform to their greatest potential and engage a high sense of teamwork on the unit (Wojciechowski et al., 2011). The relevance of this data to the gap-in-practice was the expectation that the scorecards would improve and sustain once the education of the informal leaders was successfully implemented. Monitoring of these scorecards would allow for areas in need of improvement to be recognized and focused on and celebrations held for those areas where noted improvement had been made and best practice is occurring (Jeffs et al., 2011). Each of the scorecards was available on the facility intranet, with access being granted by the CNO, or if the person is a coworker, their direct supervisor. This access was granted only after a requisition was placed, stating the specific reason it was needed and added by information technology support. The True North scorecard data were filtered through one individual for entry, who verified validity prior to entering. Individual scorecard data, such as HR and quality, was also entered by one designated individual in each of those departments.

I used several nursing dashboards for data collection for this project. As stated earlier, the dashboards allowed for visual communication of the tracking and trending of processes, quality outcomes, patient safety, and nursing quality indicators. Much like the scorecards, the data on the dashboards were helpful in determining the effectiveness of the educative module and toolkit as well as the performance of unit leaders, charge nurses, rovers, bedside staff, the LPN/LVN pilot project, and the CCM itself. The Pilot

Dashboard was one of the main sources of data I used. This dashboard was initiated at the system level, at the time of the pilot's beginning, to include all four pilot units in the system. It included baseline data and allowed for a view of the home unit alone, or an inclusive comparison view. This dashboard was updated monthly and access was granted by the CNO or the direct supervisor in the same manner as the scorecards.

Other dashboards I used for data collection were the HCAHPS dashboards. Again, the data in these dashboards were collected for the system by PRC (2016), a contracted company. The data were collected via a phone call to a random sample of adult inpatients, 48 hours to 6 weeks after discharge (Centers for Medicare & Medicaid Services, 2015). The data were disseminated out by the patient satisfaction manager at each facility electronically via e-mail, at staff meetings, placed on huddle boards, in unit newsletters, and various other forms of verbal and written communication. There were eight categories, each with subcategories, reported out on the dashboard: (a) communication with nurses, (b) communication with doctors, (c) responsiveness of staff, (d) pain management, (e) communication about medications, (f) hospital environment, (g) discharge information, and (8) care transition. The overall rating was also reported on the dashboard. These categories were important to monitor as some of the processes changed with the pilot and CCM implementation, changing the standard work and expectations of the staff on the unit. These dashboards were updated weekly with monthly and quarterly roll-ups also being provided. When evaluating the results, it was imperative for me to note the number of surveys currently considered in the percentage, as that influenced the standings showing at that time. Final monthly results were

analyzed for assurance of accuracy and areas of opportunity. Access to this information

in the format needed for this project was granted by the CNO.

Finally, I used the nursing tower dashboard as a data collection tool. This

dashboard was a collection of data from the surgical unit, medical-surgical/pediatric unit,

medical-surgical overflow, intermediate care unit, intensive care unit, and the secondary

overflow unit, also known as the patient tower. This was a living document, with the

addition and subtraction of areas in need of focus in the patient tower. For example,

restraint documentation with correct order procedure was an area of struggle, so this was

monitored on the dashboard. Bedside handoff and hourly rounding documentation in the

electronic health record was another area being monitored. The misuse of locked

medication drawers; and new bed/chair alarm equipment accounted for their addition to

the dashboard. The relevance to the project was their addition to the charge nurse

rounding and chart audits, equaling a change in their standard workflow. Without proper

education on what is expected of them, most importantly, quality outcomes for the patient

would not be obtained. Secondly, as the charge nurses were main attributers in the

collection of data for this dashboard, having a thorough understanding and clear

expectations of what data they needed to collect was imperative. At the time of this

project, this data was collected by the charge nurses and rovers; a part time nurse auditor;

and the unit clinical staff coordinators. As none of the listed parties were available on a

consistent basis to collect the data, the accuracy was questionable. A standard work with

expectations, and an education process allowing them to do just-in-time coaching on

areas they see in need of improvement, gave the units charge nurses and rovers the skills

they needed to impact organizational outcomes, inspire teamwork, promote nursing excellence, and be a mentor for others (Wojciechowski et al., 2011). Access to this dashboard was granted by permission from the CNO and the director of nurses.

Analysis and Synthesis

The literature on staffing, to include the shortage of experienced RNs, the use of LPN/LVNs, changing a model of care, and the development of an educative process were reviewed for best practice. System and facility policies, as well as state BON scope of practice and guidelines were reviewed to ensure any standard work, educative process, and toolkits were within legal limits; such as scope of practice. This research provided an extensive amount of evidence and data in regards to the development of the educative module and tools, and into what format it was placed, but it was the nursing dashboards and balanced scorecards that were the true indicators of the projects successful area, as well as those that required additional focus. The projects purpose was to create an education module and toolkit to increase the knowledge level of the unit charge nurses and rovers in regards to those expectations and processes changed and/or implemented with the CCM. Sustainment of and/or improvement upon quality indicators and optimal patient outcomes were the factual measurements of a successful education process. I began data collection began in November 2015, which marked the CCM implementation partnered with no formal education, other than a small roll out to all staff. I presented the educative process was presented to the unit charge nurses and rovers in February 2016, to include a toolkit containing items to assist with areas such as communication, budget, change implementation, leadership, and delegation. I continued the monitoring and

evaluation of areas falling into nursing quality indicators, teamwork scores, and nursing retention through December 2016. These areas were monitored closely through nursing dashboards, balanced scorecards, and feedback from rounding on patients and staff via a continuous formative evaluation process, to help ensure barriers were promptly identified and addressed.

The successful end result of this project was the development of the education module and accompanying toolkit. This formalized process not only allowed the unit charge nurses and rovers to evaluate, learn about, and build upon their own knowledge levels, learning styles, and abilities; it allowed for them to learn how teach, support, and collaborate better. While there were barriers and setbacks, the rating of 'excellent' for overall teamwork scores, rose from 27.8% in July 2015, 47.4% in November 2015, to 70.6% in August 2016. In December 2016, with a change in management, the scores were still at 60.9%.

Summary

While the literature review provided an extensive amount of evidence and information on which to base how the education was developed and in what format it was delivered, the balanced scorecard and nursing dashboards were true indicators of measurement to its success. The purpose of the project was to create an education module and toolkit to increase the knowledge level of the unit charge nurses and rovers of process changes and/or implementations with the CCM. Improvement and/or sustainment of quality indicators and optimal patient outcomes were an indicator of a

successful education process. In Section 4, I will present the project findings and the

strengths and limitations of the project.

Section 4: Findings and Recommendations

Introduction

The problem I addressed in the project was the lack of experience of RNs in the acute care setting, such as the pilot unit of medical-surgical/medical-pediatrics. While the increased hiring and use of LPN/LVNs and development of the CCM did improve the nurse-to-patient ratio, the lack of a formalized educative process remained a gap-in-practice. The purpose of this project was to determine if education designed to promote a collaborative and supportive environment, provided with a staffing mix or matrix containing additional LPN/LVNs used to the highest level of licensure, can provide safe, high quality care to patients, allowing for retention of staff. The project objectives were to create an educative process that (a) was specifically designed around the CCM, (b) would prepare charge nurses and rovers to provide a more collaborative and supportive environment, and (c) increases the charge nurses' and rovers' knowledge and ability on guiding each skill level to practice at the top of their licensure. The practice-focused question that guided the project was as follows:

Would an educative process, specifically designed around the CCM and delivered to unit charge nurses and rovers, result in sustainment of and/or improvement upon nursing quality indicators on the pilot unit when compared with no educational intervention?

The project resulted in me gathering evidence from the facility and system balanced scorecards, facility and system nursing dashboards, and a contracted third party. Data collection began in November 2015, with the educative process and toolkit being

given to the unit charge nurses and rovers in February 2016. I obtained post education

comparison data beginning March 2016 and continued collecting the data through

November and December 2016, dependent upon availability. Some third-party collected

data I used in the project did have a lag in reporting time. These deidentified data were

generated and collected through organizational components connected to quality

improvement, education, and reporting measures.

Findings and Implications

There has been much research focused on the specific education and competency

needs for nurse leaders at the recognized levels but little tailored specifically to the

education necessary to become a successful charge nurse, or informal nurse leader

(Wojciechowski et al., 2011). Charge nurses and/or rovers, need to have a thorough

understanding of the important part they play in not only achieving optimal patient

outcomes but in setting the tone with the staff on the unit and motivating and inspiring

them to increase teamwork (Wojciechowski et al., 2011).

I found the importance of taking into consideration how an adult learns best and

incorporating these approaches into the process in the literature to be one of the strategies

to help ensure motivation and avoid barriers to learning. Knowles' theory was the most

prevalent theory found in my search, outlining six assumptions related to the motivation

of adult learning: (a) need to know, (b) foundation, (c) self-concept, (d) readiness, (e)

orientation, and (f) motivation (Noor, Harun, & Aris, 2012). In simple terms, they need

to know the 'why behind the what,' or why something is important, or relevant, for them

to learn prior to them learning it. Kertis (2007) explained the importance of the inclusion

of this theory in a preceptor teaching tool by focusing on points with immediate relevance to the learner (readiness) and then providing feedback (self-concept). The collaboration, or interaction, between learner and teacher, leads to a more thorough understanding (ANA & AONE, n.d.).

Reed and Snell (2014) employed Knowles' theory in their use of standardized patients to teach and assess interpersonal communication skills. Their use of this theory outside of a skills lab opened the door for the assessment of performance (foundation) and feedback (self-concept; Reed & Shell, 2014). The motivation in these scenarios in their study was simple, the delivery of bad news to a pediatric patient and their family, a situation which these medical students one day must face in the real world. The outcome of their study led them to believe that they could expand it to other areas where interpersonal communication skills needed to be assessed and possibly refined.

Laughlin (2012) performed a study examining the literature regarding midlife adult learners, those defined as 45 years of age or older, to determine the best learning methods to meet their needs. In the study, Laughlin found Knowles' theory and the constructivism theory, which can used together, to be appropriate teaching methods. Constructivism can be used in conjunction with Knowles' by helping learners expand their previous knowledge base, allowing them to build on what they already know and modify that structure as they encounter new experiences and situations (Laughlin, 2012). Laughlin also pointed out the importance of mentoring; physiological factors, such as lighting, font size, layout of materials, and learning speed; and retention through education. Nurses want the opportunity to learn, be it a skill, a change in technology, or a

chance to cross-train to benefit their unit or facility. Linking the opportunities to the

relevance, or readiness and need to know assumptions of Knowles' theory, can help sway

nurses to become intrigued and motivated (Palumbo, McIntosh, Rambur, & Naud, 2009).

Quality indicators, which are also referred to as nursing-sensitive indicators, are

what identify the structure and processes which may influence the patient care outcomes

(Assi, 2015). These data are used to show the impact that nurses have on the quality of

patient care and optimal patient outcomes (Chasey et al., 2011). These quality indicators

include restraint use, patient falls with and without injury, hospital-acquired pressure

ulcers, and hospital-acquired infections to include central line- associated bloodstream

infections and catheter-associated urinary tract infections (Assi, 2015; Chasey et al.,

2011; Montalvo, 2007). Measures inclusive to the nursing structure alone include

turnover rates, skill mix, and paid hours per patient day, which is used to measure the

intensity of nursing care as defined by the ANA (Assi, 2015; Chasey et al., 2011).

All of the research I found in the literature emphasizes the importance of

increasing the knowledge of the charge nurses and rovers on the unit to help ensure a

thorough understanding of structure, processes, and expected outcomes (Agnew & Flin,

2013). The goal of increasing this knowledge level is to improve performance of staff

overall as well as achieve optimal patient outcomes (Wojciechowski et al., 2011). Often,

this simply starts with identifying overall barriers, determining an effective approach, and

making it acceptable to say 'I don't know what I don't know' (Rosler, 2016).

In my monitoring and review of the HR facility scorecard, which reports out the

data for nursing vacancy and turnover rates, I noted improvement after the

implementation of the LPN/LVN pilot alone, with further progress following the addition

of education. Table 1 reflects HR scorecard data for 2 months pre-CCM implementation

(informational purposes only) and 3 months preformal education and the inclusion of the

education go-live month, February 2016. It must be taken into consideration when

looking at this data that all staff for this unit was included, licensed and unlicensed. The

CCM and the formal educative process were designed to be all-inclusive, and therefore, I

would hope have a positive influence on the unlicensed staff as well.

Table 1

Pre-CCM, Pre education Implementation HR Scorecard

Month:	Sept '15	Oct '15	Nov '15	Dec '15	Jan '16	Feb '16
Retention Rate:	100.00%	98.39%	96.77%	96.77%	93.55%	93.55%
Vacancy Rate:	9.68%	16.13%	17.74%	14.52%	14.52%	12.90%
Turnover/Month	0.00%	1.61%	3.23%	3.23%	6.45%	6.45%
Turnover Rolling Year	48.3%	47.1%	38.9%	40.2%	43.2%	43.1%
Open Position	6	10	11	9	9	8
Avg Headcount for Rolling Year	62	62	62	62	62	62

Table 2 includes the post education data collected from the HR scorecard. I

collected these data from March 2016 through December 2016, again, including all levels

of staff from the unit. Considerations for December 2016 were a change in management

at the beginning of the month, which by default equals a small degree of turnover. There

were also two licensed positions that were posted to be filled for nurses that would be

leaving in the future, one to retire and one that had given notice March 2016 for

relocation. Early posting gave the chance for filling and orientation to the position prior

to nurse vacating the position. July 2016 showed a rise in open positions and vacancy

rate, which actually was the start of the new fiscal year and an increase in the matrix,

allowing for additional postings to be placed and the hiring of new graduate nurses. As

evidenced by the scorecard, these positions were filled rather quickly and remained so.

Table 2

Post education HR Scorecard

Month:	Mar '16	Apr '16	May '16	Jun '16	Jul '16	Aug '16	Sept '16	Oct '16	Nov '16	Dec '16
Retention Rate:	100.00%	97.06%	95.38%	96.97%	97.01%	97.10%	97.14%	98.61%	98.61%	97.30%
Vacancy Rate:	11.04%	5.88%	7.69%	4.55%	10.45%	8.70%	4.29%	1.39%	1.39%	5.41%
Turnover/Month	0.00%	2.94%	4.62%	3.03%	2.99%	2.90%	2.86%	1.39%	1.39%	2.70%
Turnover Rolling Year	41.0%	42.1%	43.2%	39.5%	34.2%	36.3%	37.0%	37.7%	35.9%	37.0%
Open Position	7	4	5	3	7	6	3	1	1	4*
Avg Headcount for Rolling Year	63	68	65	66	67	69	70	72	72	74

HCAHPS measures were reported out by PRC, a third-party company, and

delivered via a dashboard that showed scores, both unit and facility, broken down into six

composite topics: (a) nurse communication, (b) doctor communication, (c)

responsiveness of staff, (d) pain management, (e) communication about medication, and

(e) discharge information; two individual topics: (a) cleanliness of hospital environment

and (b) quietness of hospital environment; and two global items: (a) overall rating of

hospital and (b) willingness to recommend hospital (HCAHPS, n.d.). In November 2015,

the overall rating of stay was 85% and willingness to recommend was 90% with 20

surveys completed. One year later in November 2016, the overall rating of stay was at

80.56%, with willingness to recommend at 69.44% with 36 surveys completed.

HCAHPS scores can be monitored routinely and are often reported out in a rolling

quarterly fashion. Table 3 reflects a comparison of the percentage of patients responding

"always" to the facilities' HCAHPS composite and individual topics questions for the

October–December 2015 and October–December 2016 quarters. These scores reflect

sustainment in many areas but also make those areas with opportunity easily identifiable.

Table 3

Comparison of 2015 and 2016 HCAHPS Survey Scores at Practicum Facility

Question	Oct-Dec 2015	Oct-Dec 2016
Response to call button	75% w/ 68 surveys	68.6% w/ 86 surveys
Cleanliness	84.6% w/ 78 surveys	83.7% w/ 98 surveys
Quiet	74.4% w/ 78 surveys	75.8% w/ 99 surveys
Bathroom help	76.1% w/ 46 surveys	81.7% w/ 71 surveys
Pain controlled	58% w/ 50 surveys	62.5% w/ 56 surveys
Help with pain	80% w/ 50 surveys	73.2% w/ 56 surveys
Explanation of new medicine	81.8% w/ 29 surveys	81.1% w/ 37 surveys
New medicine side effects	51.6% w/ 33 surveys	52.6% w/ 38 surveys
Symptoms	92.6% w/ 68 surveys	89.2% w/ 83 surveys
Overall quality of care	50.0% w/ 78 surveys	49.5% w/ 99 surveys

Overall teamwork between doctors, nurses, and staff is another component I

monitored for this project. Data were again received in dashboard format from PRC,

specific for the facility. A review of this measure going back to July 2015 showed 27.8%

of patients rated the staff excellent. November 2015 showed an excellent rating

percentage of 47.4% upon the implementation of the LPN pilot. In August 2016, the

score was 70.6%, with a score in December 2016 of 60.9%. The monitoring of additional

nursing quality indicators, such as hospital-acquired pressure ulcers, catheter-associated

urinary tract infections, and central line-associated bloodstream infections, was done via

the nursing dashboard and LPN pilot dashboard. The data indicated that the quality of

care has been, at minimum, sustained, with increasing potential.

Limitations

Implementation of an educative process, even to a small population, can be a difficult task. Adapting to the learning styles and needs of even a small number of adult learners, to include taking into consideration the shift work was a limitation in itself. An additional barrier in this project was the resignation of one night charge nurse. While this began as a barrier, it became a blessing as this nurse remained as a relief charge on the same shift and was able to aide in the training of the new charge nurse and carry over what they had learned on the unit. It also helped drive home the fact that this would always be a continuous process.

There were several limitations regarding the programs evaluation. The time needed for each charge nurse and rover to learn and hardwire the culture change and processes differed, which influenced the data. The data were collected retrospectively, making it challenging to control the variables or dependability (Portney & Watkins, 2009). When monitoring the scorecards and dashboards, there were unique factors to each that had to be considered. For example, on the HR facility scorecard for vacancy and turnover rates, I had to keep in mind that these figures included all staff on the unit, licensed and unlicensed. It also was inclusive of those vacating their positions within the first 90 days of employment, whether it be voluntary or involuntary. It was beneficial to have the LPN/LVN Pilot dashboard to refer to for specifics on licensed positions per pilot units. Upon review of this dashboard, it was found that from May 2016 to November 2016, at no time was there ever a licensed opening without a replacement already hired. The facility dashboard for overall teamwork between doctors, nurses, and staff presented

limitations as well. It was noted on the unit that while nurses made an effort to round with physicians, with a patient load of five to six acute patients and no set rounding hours for physicians, this was just not always feasible. Additional limitations to this, as well as other questions on the HCAHPS survey was the presentation of the question as to the patients' perception. When compared to leader rounding with patients and asking the same question, the results were quite different, with November 2016 being 95%. This could be attributed to the additional explanation, if asked, or perhaps the in-person conversation, but without a doubt, the results were higher. In regards to overall rating and willingness to recommend, I had to take into consideration the fact that the patient was being asked to rate their stay overall, which could have been influenced by an admit that was done through the emergency room, or started on a different unit, such as the Intensive Care Unit or the surgical floor.

Limitations arose when the system-wide policy overrode the state scope of practice for the LPNs/LVNs for the facility. Due to the electronic health record crossing over four states, the inability of the technology to be individualized; and with three of those states having more confined scopes, limitations applied to all employed LPNs/LVNs. In regards to documentation, this became an education issue, as well as a culture change, for both licensure levels. It also became a process change for the charge nurses and rovers to adapt to when making assignments, as well as auditing and in some cases an extra duty to pick up depending on the workload of the other staff.

Potential Implications to Social Change

Due to the success of the decreased turnover and vacancies, the potential for a model of care similar to the CCM, but customized for a unit's needs, to be implemented throughout the system became a distinct possibility. With the projected national nursing shortage of over 949,000 by the year 2030 (Nursing Solutions Inc., 2016), recruitment and retention are a priority. Decreased turnover and vacancy rates equate to a better work-life balance, and for several reasons, increased nursing satisfaction. This type of shared accountability model containing an intended skill mix of nurses; practicing to the fullest extent of their licensure and supported by delegation, collaboration and teamwork (Rudisill et al., 2014); can provide the solid foundation needed to build synergistic relationships. Under this type of collaborative, supportive, environment, nurses at all levels were found to be able to provide high quality, effective care (ANA & AONE, n.d.).

Recommendations

In an effort to learn and adapt to the learning styles and needs of each adult learner, it was found helpful for each of them to first fully understand their own learning style. There are a variety of tools available that were used to help not only the educator, but the student, to assess and understand what type of learner they may be and how they may best comprehend, communicate, implement and sustain change, and delegate. The tools provided to the unit charge nurses and rovers were included in their education module, easy to use, and played an important part in their roles on the unit. *Overview of right-versus left-brain learners* (Appendix A; Avillion, 2009), outlines characteristics of both left and right brain dominants, as well as suggestions to facilitate learning for both. This tool can help them determine the approach when they are educating a staff member.

The *Learning style assessment tool* (Appendix B; Avillion, 2009), which can assist

learners in recognizing if they are a predominately a visual, auditory, or tactical learner,

as well as being able to identifying others learning styles (Avillion, 2009). This tool can

also assist the educator in identifying the types of learners in the group and better plan the

educative route.

Hardwiring the education of process changes is important, but it is every bit as

important for the charge nurses and rovers to have the skills to guide, support, and

encourage those that they are expected to lead. Ensuring they have the communication

skills to convey these process changes to staff and to guide accordingly, is a

recommendation for future work. The *Leadership learning cycle* (Appendix C; Avillion

& Buchwach, 2010) was built into the original formal educative process and will be

followed up with additional leadership classes, as it is an imperative part of the program's

success. Additional communication skills provided for in the educative process include

feedback with, *Simple strategy to provide feedback to all generations* (Appendix G;

Lower, 2006), speaking and listening with, *Tips for being a clear speaker and active*

listener (Appendix H; Dohmann, 2009), and difficult conversations with *Scripts for*

difficult conversations (Appendix I; Bryne, Garrison, & Moore, 2009). Peer to peer

exercises are recommended with these tools in a controlled environment to ensure

comfort in their use and to provide constructive feedback.

The *Plan, Do, Study, Act (PDSA)*, while one of the simplest, is also one of the

most successful ways to implement change. Sharing this tool with the team on the front

side, educating them to 'why behind the what,' and encouraging them to have a more

thorough understanding of the change process overall will help to ensure more quick wins, as well as a quicker indication when there may be a barrier, or the change is not one that is going to be appropriate (Appendix D; Hunt & Laughon, 2011).

The *ARCTIC assessment tool* (Appendix E; Swihart & Hess, 2014), is used to help identify those things that staff value, which can be different for everyone. Swihart and Hess describe the reason for failure in organizational change as what occurs "when smart people resist going from doing the wrong thing well to doing the right new thing poorly" (Black & Gregersen, 2003, p. 84). This tool helps to ensure that by identifying what is important to all staff on an individual level, barriers are removed, and change is successfully implemented, in the form of shared governance (Swihart & Hess, 2014). The use of this tool with any change process helps to bring it more tightly together in shared governance format, securing buy-in and understanding from not only the staff on the unit, but from affected units and personnel.

Productivity, staffing, and being 'on matrix' are all terms that seemed to be beyond the unit charge nurses and rovers grasp at the beginning of the education module. With the help of *3 Basic Budgeting Formulas* (Appendix F; Waxman, 2008), while reviewing the unit matrix and staffing in detail, they began to realize how being even one staff member over can affect productivity. This tool serves a great purpose for them out on the unit on a daily basis.

Delegation can quickly become one of the biggest questions on a unit, especially when there are various levels of licensure. The *Summary of decision making model* (Appendix J; OK BON, 2013) is designed to present a process to define acts appropriate

to nursing at various levels. The *Pilot unit LPN delegation grid* (Appendix K; McCord et al., 2004) is an LPN/LVN delegation grid specific to the project pilot unit, adapted from the *AACN Delegation Handbook*, 2nd ed. (2004). This grid was designed to help guide the unit LPN/LVNs in knowing what skills and documentation they could and could not perform per the board of nursing, facility and system policy. These tools were not reserved for charge nurses and rovers alone, there were posted throughout the unit and given to each nurse; and are given to each new nurse that is hired on. These tools were extremely useful for ensuring accuracy for delegating, as well as scope of practice.

Strength and Limitations of the Project

The strength of this project was the strength of the team on the study unit, and their willingness to come together and face an unknown pilot project, as well as design a new model of care. They faced so many changes in such a short amount of time, and though there was struggle and disconnect at times, there was never a time that optimal patient outcomes and teamwork was not the end goal; the shared vision. An additional strength was the small number of charge nurses and rovers, and the flexibility of schedules to work with. This made the structured educative process easier to accomplish.

Limitations to the project were the lack of communication and unwillingness to learn and to adapt or change from other departments. Miscommunication led to errors in staffing, misunderstanding of the role of the rover, and difficulty in ensuring all the necessary duties were completed, per the education and structured tools, on the floor. An additional limitation was the resignation of one charge nurse, who decided to go back to the bedside in the middle of the process. However, this allowed me to see how well the

educative process worked on a staff member coming new to both the unit and to the charge role. This occurred again, this time with a rover, who left the unit and facility entirely and was replaced with another staff member.

Because of the involvement from the system on the LPN/LVN pilot, there was some strength in numbers. Support was found on group calls, where there was discussion on how to better or broaden communication. I also found that others were experiencing some of the same issues, unrelated to the educative side, which gave me some relief that I was not alone.

Section 5: Dissemination Plan

Introduction

I plan on disseminating this project for the practicum site through presentation opportunities both locally and system-wide, allowing for communication of the results of the project and any resources developed. Presenting to stake holders such as other unit leaders from the practicum facility, board members, and nurse residency will allow for them to see and become involved with the local side of the implementation. Disseminating the results on a system-wide level, or perhaps outside the system, may encourage positive change on a much broader level. Included in my plan is also a poster presentation. I would like to present this at the practicum site's system-wide innovation conference as well as the Sigma Theta Tau International Phi Nu Chapter virtual poster presentation, which is granting continuing education units and can be attended worldwide. Finally, I would also like to present the poster at a national conference, such as Sigma Theta Tau International or the Association for Nursing Professional Development, both of which I am a member. Presenting there would allow for the feedback of an audience of educative nature as well as active bedside staff.

Analysis of Self

There have been many challenges throughout this project, all of which have given me the opportunity to learn, grow, and become not only a better nurse and educator, but a better person. There were times when the LPN/LVN pilot project linked to the CCM was unpopular, not only on the unit, but in the practicum facility, which made for difficult conversations. Persistence and taking the time to reeducate to again, the 'why behind the

what' helped to reinforce the shared vision. Cohen (2015) described a shared vision as what a group can accomplish when they are dedicated to achieving a common goal, with a sense of purpose and direction. This project has helped me to learn about creating a culture of ownership, commitment; and accountability, while learning to listen more to the needs of others when they talk about what barriers are being faced.

I have learned that I am passionate about nursing, evidence-based practice, education, about all of it. I truly love this career. I challenge my staff every day to ask themselves, "is there a better way to do this" and then to go look for one. I feel that combining it all into a future of nursing education will allow me the outlet to share that passion in the most productive way possible. While my professional goal is to achieve my DNP, it will by no means be my last goal. I will continue to strive to learn something new every day and to pass what I have learned on to someone else. I will lead by example as I have learned to do throughout this time.

I have also learned that although I would always like to be successful, I have to accept this will not always be the case. Throughout this journey, I have become better accepting of the limitations of others and at understanding what I can do to help them perform at their highest level. I have also become better accepting at my own limitations and taking one step at a time. Knowing that I helped someone learn something new, reached a goal they wished to achieve, or helped the unit achieve a small win will be enough each day, I cannot always win the big fight. Minor Myers Jr. once said "Go into the world and do well. But more importantly, go into the world and do good" (Miner, 2014). I have learned through this project that in my future, I want to pass this type of

thinking onto the nurses that I teach. I want to teach them to go out and do good by their patients, the families, and by each other and to celebrate the small wins that are so very important in the sustainment of success.

Summary

The LPN/LVN pilot project, in conjunction with the CCM, allowed for an initial significant decrease in vacancy rates, decreased turnover, and a better work-life balance for the staff on the practicum unit, as identified by the retention rate. A formalized education process for the charge nurses and rovers, with tools put in place to standardize the workflow, helped to increase the efficiency and effectiveness of the unit, increase communication, and help sustain change (Downey et al., 2011). With increased communication, collaboration, and educated support roles, the limitations regarding scope of practice for LPN/LVNs in each state could be addressed, as each level is used at the top of their licensure and all staff is educated to delegation. While the project did not produce vigorous results, there is potential for additional improvements over time with continued education, a consistent evaluation process, and team involvement.

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Wojciechowski, E., Ritze-Cullen, N., & Tyrrell, S. (2011). Understanding the learning needs of the charge nurse. *Journal for Nurses in Staff Development*, *27*(4), E10–E17. http://dx.doi.org/10.1097/NND.0b013e318224e0c5

Appendix A: Overview of Right- Versus Left-Brain Learners

Learning style	Characteristics	Teaching suggestions
Right-brain dominant	Processes information holistically. Works backward from the big picture to the details. Uses intuition instead of logic to come to conclusions. Starts with the answer to a problem and works backward. Dislikes schedules and adherence to fixed timetables. Has trouble meeting deadlines because they move from one task to another without completing the first one. Has trouble processing symbols and needs to be able to see, hear, or touch an object. Has difficulty with tasks that require symbols and sequencing such as spelling and math.	Have information about the class available prior to the start of the learning activity (e.g., class objectives, outline of material, how new knowledge will be applied in the job setting, how new knowledge will improve job performance). These learners need to see the big picture and the overall conclusion of a learning activity. They also need help to see the details. Help them to organize these tasks by using color and visuals. For example, color-coded stickers can facilitate note taking and establishing schedules. Whenever possible, offer education that can be accessed in a

	Needs visual stimulation and responds to color. Bases decisions on feelings instead of reason. Has trouble expressing ideas verbally. Emphasizes the visual.	flexible way, without requiring adherence to specific schedules. Provide concrete examples of conceptual ideas. Use visuals such as illustrations and recorded images to facilitate learning.
Left-brain dominant	Processes information linearly, from the parts to the whole in a step-by-step manner. Uses logic and reason to come to conclusions. Is comfortable using symbols and performing tasks that require sequencing including spelling, math, and grammar. Adheres to rules and schedules. Excels at verbal communication.	Provide information about timetables and schedules. Include information about the big picture as well as the details to help them use both hemispheres. Use verbal interaction as a learning technique. Offer plenty of opportunity for discussions and question-and-answer periods.

Avillion, A. E. (2009). *Learning styles in nursing education: Integrating strategies into staff development.* Marblehead, MA: HCPro, Inc. Retrieved from: http://www.strategiesfornursemanagers.com/tools_library.cfm

Appendix B: Learning Style Assessment Tool

Consider incorporating a learning style assessment tool into your education programs. This tool is merely a starting point. Although it is not the product of scientific research, a tool such as this will give learners and educators an idea of the different types of learning styles present in the population who participates in continuing education.

You can recognize learners' learning styles and your own learning style and use this recognition to enhance educational offerings and your own studying. However, remember that although one learning style may dominate, most adults learn in a variety of ways.

1. When participating in leisure activities, I prefer to:
a. Read
b. Listen to music
c. Take a walk

2. When I want to determine what someone else is thinking or feeling, I pay attention to:
a. Their facial expressions
b. The tone of their voice
c. Their body language

3. When I attend an education program in a classroom setting, it is most important to me to be able to:
a. See the instructor
b. Hear the instructor
c. Make sure that the instructor allows for frequent breaks

4. When I meet new people, I try to remember them by:
1. Their appearance
2. Their name or tone of voice
3. The circumstances during which we met

5. When studying, I best absorb new knowledge by:
a. Reading to myself
b. Reading aloud
c. Performing a physical task such as working with new equipment

6. My favorite way of acquiring continuing education is:
a. Participating in a face-to-face classroom setting
b. Listening to an audio conference
c. Participating in a skills demonstration

7. When I am learning a new clinical procedure that requires the use of complex equipment, the first thing I do is:
a. Seek professional journals that allow you to read about the procedure
b. Ask someone who is familiar with the procedure to tell you about it
c. Find the equipment and look it over

8. When I participate in computer-based learning, I:
a. Like every screen to have illustrations or graphics
b. Enjoy when there is an auditory component that accompanies the program
c. Prefer to have some kind of skills lab accompany the computer program

9. If I were stranded on a deserted island, the thing I would most like to have with me is:
a. A good book
b. An iPod
c. A treadmill

10. When preparing for an activity such as cardiopulmonary resuscitation (CPR) certification, I like to:
a. Read about any new or revised standards or requirements
b. Have someone explain any changes to the certification process
c. Immediately practice CPR

People who choose "a" as a response to the majority of questions are most likely a visual learner. A majority of "b" responses indicate an auditory learner, and a majority of "c" responses suggest a tactile learning preference. Again, no one is exclusively one type of learner, but a particular learning style will predominate. Consider adding your own questions to this tool. Use it and incorporate some fun into the learning process.

Avillion, A. E. (2009). *Learning styles in nursing education: Integrating strategies into staff development.* Marblehead, MA: HCPro, Inc. Retrieved from: http://www.strategiesfornursemanagers.com/tools_library.cfm

Appendix C: Leadership Learning Cycle

Many times new nurses are given authority based on policies and procedures, but are never given the proper interpersonal skills necessary to lead and manage. To help build future leaders, it is important to guide, direct, motivate, and teach them. Their ability to build relationships is every bit as important as their clinical competence.

It is important to create an environment when nurses can hone their leadership skills. One way to create this environment and help encourage and support their leadership role is by enrolling new nurses in leadership development classes.

Share this process to provide both education and interaction with others on the same journey. By following this cycle, new nurses can work together in assisting the growth and development of the new leadership team.
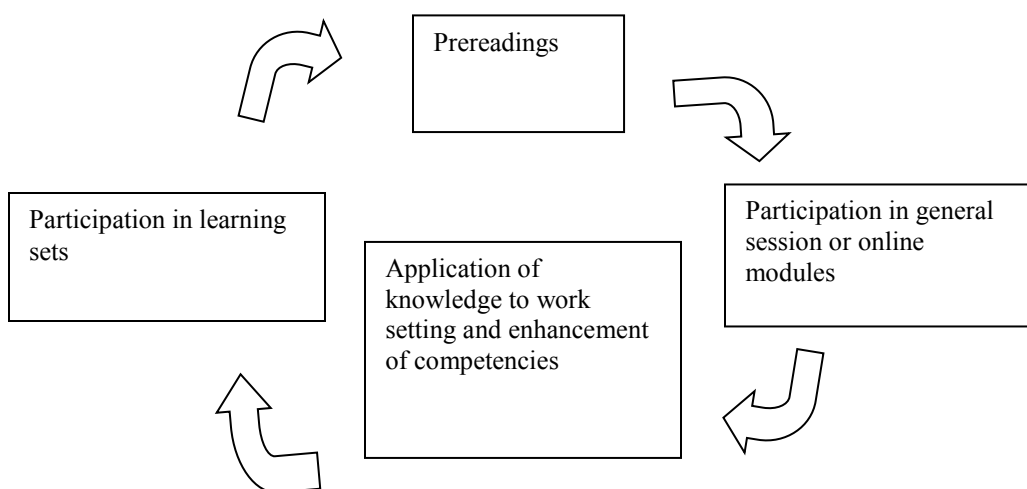
Prereadings

Participation in general session or online modules

Application of knowledge to work setting and enhancement of competencies

Participation in learning sets

Avillion, A. E., & Buchwach, D. (2010). *Nursing orientation program builder: Tools for a successful new hire program.* Marblehead, MA: HCPro, Inc. Retrieved from: http://www.strategiesfornursemanagers.com/tools_library.cfm

Appendix D: Plan, Do, Study, Act (PDSA) Plan

One of the simplest tools to implement successful change is Plan, Do, Study, Act (PDSA). You might suggest a pilot study in your discussions with the executive team, which will lead you to this tool. This process encourages rapid incremental improvements in cost and quality outcomes. Sometimes we spend so long planning formal changes that we miss the opportunity for, as well as the immediate value from, the change. This process facilitates movement and results in the opportunity to see quick wins or when a change might not be a good fit for your unit or organization and needs to be stopped. A simple overview of each step is noted in this table.

Plan	Do	Study	Act
- Clearly state the objective - Predict the impact of the change-what and why - Your literature support for the project - Use the five Whys to ensure you have included the key variables: who is involved, what will change, when, where, what data will reflect the change, and how it will be captured	- Conduct the test - Document problems and unexpected observations as well as the positive findings - Begin reviewing the data concurrently	- Complete the data analyses at designated times - Compare the results against plan - Summarize what was learned	- Determine any modifications required - Prepare for the next step, such as a longer timeframe, a different population, and different metrics. - PDSA is cyclic; it should trigger a next step

Hunt, P., & Laughon, D. (2011). *The nurse leader's guide to business skills: Strategies for optimizing financial performance.* Marblehead, MA: HCPro, Inc. Retrieved from: http://www.strategiesfornursemanagers.com/tools_library.cfm

Appendix E: ARCTIC Assessment Tool

Failure to move towards organizational change happens when smart people resist going from doing the wrong thing well to doing the right new thing poorly. Leaders must ensure that the destination is clear, resources are in place, and valued rewards are provided to break through this barrier. The ARCTIC assessment tool (adapted from Black & Gregersen [2003, p. 84]) can help identify rewards that would have greater meaning to people and more power to move change and successfully implement shared governance.

ARCTIC	Rewards
Achievement	Accomplishment: the need to meet or beat goals, to do better in the future than one has done in the past
	Competition: the need to compare one's performance with that of others and do better than others do
Relations	Approval: the need to be appreciated and recognized by others
	Belonging: the need to feel a part of and accepted by the group
Conceptual Thinking	Problem solving: the need to confront problems and create answers
	Coordination: the need to relate pieces and integrate them into a whole
Improvement	Growth: the need to feel continued improvement and growth as a person, not just improved results
	Exploration: the need to move into unknown territory for discovery
Control	Competence: the need to feel personally capable and competent
	Influence: the need to influence others' opinions and actions

Swihart, D., & Hess, R. G. (2014). *Shared governance: A practical approach to transforming interprofessional healthcare.* Marblehead, MA: HCPro, Inc. Retrieved from http://www.strategiesfornursemanagers.com/tools_library.cfm

Appendix F: Basic Budgeting Formulas

3 Basic Budgeting Formulas:

1. FTE = Number of hours worked in a year divided by the number of hours in a year (2080)

2. HPPD = Total hours of staff worked in a 24 hours period divided by midnight census

3. Salary CPUOS = Total staff hours worked X hourly rate X hours divided by midnight census

Waxman, K. (2008). *A practical guide to finance and budgeting: Skills for nurse managers* (2nd ed). Marblehead, MA: HCPro, Inc. Retrieved from http://www.strategiesfornursemanagers.com/tools_library.cfm

Appendix G: Feedback Strategy

Simple strategy to provide feedback to all generations

The practice of "closing" at the end of a shift is a great way to give immediate feedback to all generations.

The two or three people who worked together during a shift say what went well on the shift, what went poorly, what they wished had happened, and what they wished had not happened. This gives them an opportunity to recognize, acknowledge, and discuss the day's events and everyone's contribution.

Closing allows for timely, factual information to be exchanged by the people who were involved, and it facilitates corrections, clarifications, and learning.

Examples of what to say during closing

- I wish I had realized that you're saying "no" to my offer to help actually meant, "I am drowning and have no idea what to even ask for."

- It would have been more helpful if I had known that your patient's condition had worsened and rendered you unable to take the next admission as soon as it occurred, rather than as the patient was rolling in the door. Had I known earlier, I could have gotten you help, reassigned the admission, and given that nurse a longer "heads-up" period.

- I felt we worked well together, kept each other informed, and tackled that complex case as a team. I hope I can work with you again tomorrow.

Lower, J. (2006). *A practical guide to managing the multigenerational workforce: Skills for nurse managers.* Marblehead, MA: HCPro, Inc. Retrieved from http://www.strategiesfornursemanagers.com/tools_library.cfm

Appendix H: Tips for Clear Speaking and Active Listening

Tips for being a clear speaker and an active listener

When two people are involved in a conversation, one is sending information and the other is receiving it. For successful communication to occur, the sender must be a clear speaker and the receiver must be an active listener.

The sender should:

- State one idea at a time
- State ideas simply and clearly
- Monitor your tone of voice and tempo
- Explain when appropriate
- Repeat if necessary (if you see ANY doubt!)
- Encourage feedback—ask if the receiver is getting the message
- Read between the lines: Do your choice of words, tone, and body language all convey the same meaning?

The receiver should:

- Listen carefully, concentrate
- Evaluate—think and process the information
- Provide feedback
- Interpret the message
- Verify the message you heard was correct

Editor's note: This tool was featured in the book, Accountability in Nursing: Six Strategies to Build and Maintain a Culture of Commitment. *To find out more about the book and to order a copy visit* www.hcmarketplace.com/prod-7294.html.

Dohmann, E. L. (2009). *Accountability in nursing: Six strategies to build and maintain a culture of commitment.* Marblehead, MA: HCPro, Inc. Retrieved from http://www.strategiesfornursemanagers.com/tools_library.cfm

Appendix I: Scripting for Difficult Conversations

Scripts for difficult conversations

Situation	Script
Practice variation/being criticized	"Can you explain to me why you did [procedure] that way and not by protocol?"
	"Let me show you the method that the protocol/policy describes. I'm sure you'll see why it's important to do it this way."
	"Do you want to show/tell me how you would have done it differently/how you would have handled the situation?"
Being ignored	"I understand you're busy, what can I do to help?"
	"Excuse me, I'd like to help/participate."
	"I can come back in 10 minutes if that works better for you."
Feelings of resentment/personal conflicts	"I'm trying to do my best, but I need to …"
	"Please help me understand why you feel this way."
	"Can we discuss this in the breakroom? I would like to understand what I did to upset you."
	"We all need to work together. Can we find a compromise/common ground so we can move forward?"
Being teased or humiliated	"I don't understand why you did [action]. Can you explain it to me?"
	"Please help me understand why …"
	"I'm sorry you feel/think/believe that. What can I do to change your perception?"
	"I heard what you said to [person A] about [person B]. I think we should talk and figure things out. We all need to work together."
	"That hurt my feelings. Can we sit down and talk about this? We need to work this out."

Bryne, J. C., Garrison, K .L. & Moore, F. M. (2009). *Quick-E pro scripting: A guide for nurses.* Marblehead, MA: HCPro, Inc. Retrieved from http://www.strategiesfornursemanagers.com/tools_library.cfm
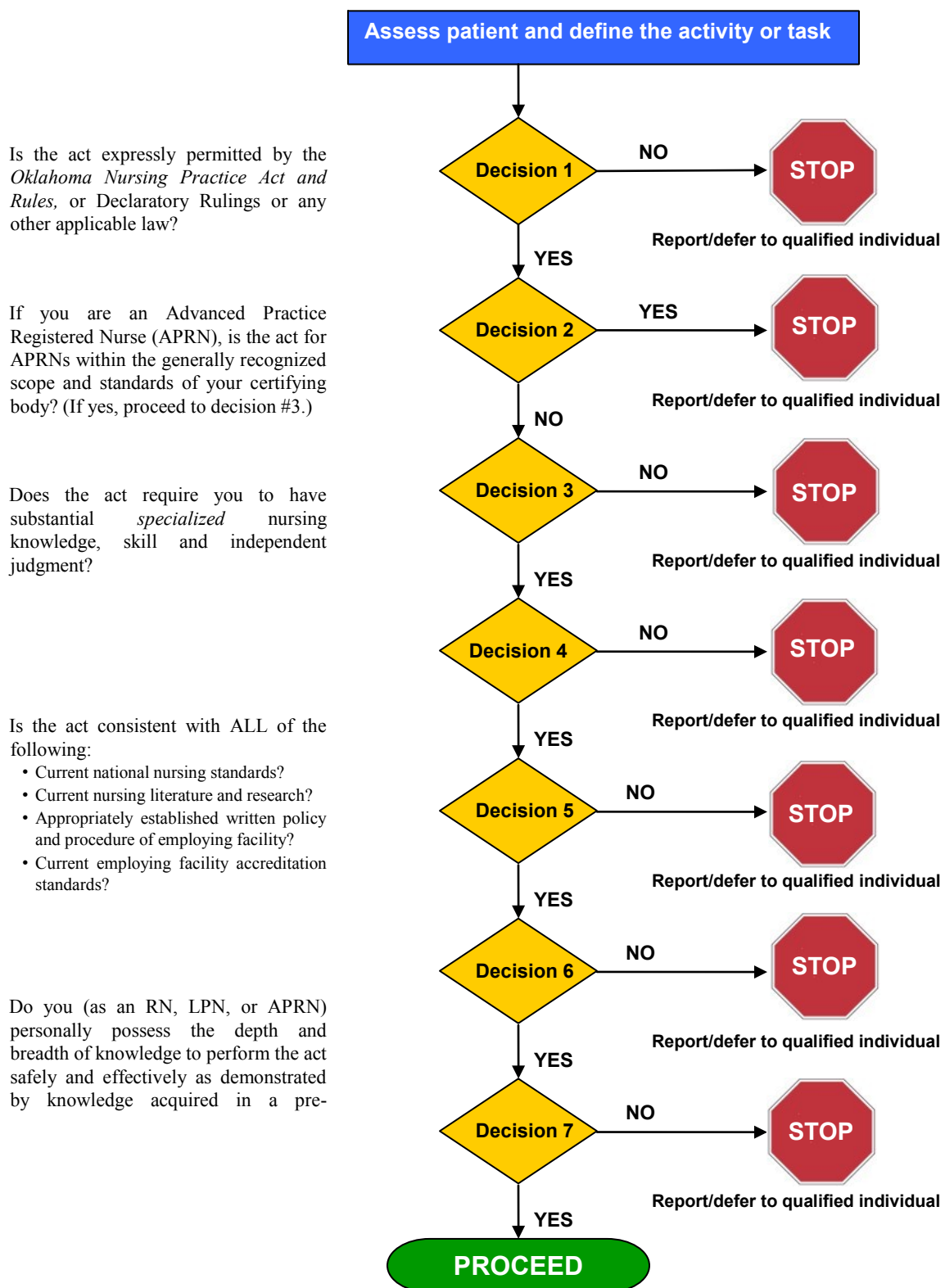
Appendix J: Oklahoma Board of Nursing Decision-Making Model

Summary of Decision Making Model

Assess patient and define the activity or task

Is the act expressly permitted by the *Oklahoma Nursing Practice Act and Rules,* or Declaratory Rulings or any other applicable law?

Decision 1 — NO → STOP
Report/defer to qualified individual

YES

If you are an Advanced Practice Registered Nurse (APRN), is the act for APRNs within the generally recognized scope and standards of your certifying body? (If yes, proceed to decision #3.)

Decision 2 — YES → STOP
Report/defer to qualified individual

NO

Does the act require you to have substantial *specialized* nursing knowledge, skill and independent judgment?

Decision 3 — NO → STOP
Report/defer to qualified individual

YES

Decision 4 — NO → STOP
Report/defer to qualified individual

YES

Is the act consistent with ALL of the following:
• Current national nursing standards?
• Current nursing literature and research?
• Appropriately established written policy and procedure of employing facility?
• Current employing facility accreditation standards?

Decision 5 — NO → STOP
Report/defer to qualified individual

YES

Decision 6 — NO → STOP
Report/defer to qualified individual

YES

Do you (as an RN, LPN, or APRN) personally possess the depth and breadth of knowledge to perform the act safely and effectively as demonstrated by knowledge acquired in a pre-

Decision 7 — NO → STOP
Report/defer to qualified individual

YES

PROCEED

licensure program, post-basic program, or continuing education program?

Do you personally possess current, documented clinical competence to perform this act safely?

Is the performance of this act within accepted "standard of care" which would be provided in similar circumstances by reasonable and prudent nurses who have similar training and experience?

As Declaratory Rulings, Board Guidelines and Position Statements are developed by the Board in response to a specific question(s) to guide what a reasonable and prudent nurse should do, such rulings should be considered when responding to this decision.

Are you prepared to accept the consequences of your actions?

Oklahoma Board of Nurses. (2013). Decision-making model for scope of nursing practice decisions: Determining advanced practice registered nurses, registered nurses, and licensed practical nurse scope of practice guidelines. Retrieved from https://nursing.ok.gov/prac1.html.

Appendix K: LPN Delegation Grid

Pilot Unit LPN Delegation Grid

ASPECT OF ROLE	Can perform	Can't perform	Limiting Body
Unit assignment Independent patient assignment	X		
Work in a team relationship, partnered with an RN	X		
Assessment Initial physical assessment on admission to hospital, unit, or area (Exception-expectation is that LPN will perform assessment in tandem with the RN, not in place of)	X		BON/System
Complete other data on admission form – Specific to policy	X*		
Shift physical assessment (RN assessment must occur once in every 24 hour period)	X*		
Focused assessment with change in patient condition – Must notify Charge RN/Physician	X		
Planning Initiate Plan of Care	X		System
Determine patient problems (nursing diagnoses)		X	BON
Complete referral section of the Initial Data Base	X		
Resolve problems on the Plan of Care after discussion with RN		X	BON
Document plan for unresolved problems at discharge		X	BON
Intervention – IV therapy (peripheral, CVC) Calculate and adjust flow rates on pumps			

	X		
Observe and report of site, reaction to drugs (Must report to Charge RN/Physician)	X		
Change dressing, administration set, injection cap	X		
Insert SQ needle for injection of medication that is routine for patient	X		
Insert a peripheral catheter to withdraw blood or initiate IV fluids	X		
Insert a midline/PICC catheter to withdraw blood or initiate IV fluids		X	BON
Remove a peripheral IV/catheter	X		
Flush a peripheral, midline IV, CVC, accessed port (includes heparin if IV certified)	X†		
Flush a PICC line	X†		BON
Convert a continuous to an intermittent and vice versa	X†		
Administer pharmacy-prepared IV medications—peripheral or central * refer to IV medication policy to determine meds that require RN administration and monitoring	X†		
Administer PPN peripherally with RN on site	X†		
Administer TPN centrally (with RN supervision and after comprehensive patient assessment)	X†		
Draw blood from central line catheters		X	Facility
Draw blood from PICC and ports		X	Facility
Initiate first dose of IV medication after RN assessment	X†		
Access and deaccess ports		X	System
Give medications IVP	X†		

Add medication to an existing IV		X	Facility
Administer vesicant chemotherapy		X	BON
Administer nonvesicant chemotherapy			Facility
Remove a midline or central catheter		X	System
Intervention – blood administration			
Administer blood and blood products	X		
Verify and sign blood product to be hung	X		
Monitor vital signs after 15-minute assessment by RN	X		
Intervention – pain management			
Review PCA/epidural pump history	X†		
Stop infusion pump—PCA or epidural	X†		
ASPECT OF CARE	**Can perform**	**Can't perform**	**Limiting Body**
Change program or doses including bolus on PCA or epidural w/ dual signature	X†		
Cosign dosing changes made by RN	X		
Perform dermatome assessment (initial must be done by RN, any change must be referred to RN for focused assessment)		X	
Change infusion rate on IV pump (not PCA)	X		
Intervention – tracheostomy tube change	X		
Intervention – peritoneal dialysis		X	Facility (Outsourced)
Intervention – emergency situations	X		
Assess situation and notify physician			
Assist in getting supplies from crash cart or on unit	X		
Assemble dosed medication syringes	X		

Draw up emergency medications from vials (under direct supervision of physician or code team)	X		
Record on code record	X		
Intervention – physician/provider order			
Transcribe and sign-off orders on own patient	X		
Accept verbal or telephone orders	X		
Perform 24-hour chart check	X		
Intervention – patient education			
Assess learning barriers		X	BON
Provide education within scope	X		
Evaluation			
Resolve problems on Plan of Care sheet after collaboration with RN	X		
Document plan for unresolved problems at discharge		X	BON
Supervision of staff			
Delegate specified actions to PCA and be responsible for completion of acts delegated (refers to OK BON decision tree)	X		

Abbreviations: CVC, central venous catheter; IV, intravenous; IVP, intravenous pyelogram; LPN, licensed practical nurse; IV LPN, LPN that has completed the certification for IV therapy LPN; PCA, patient-controlled analgesia; PICC, peripherally inserted central catheter ; PPN, peripheral parenteral nutrition; RN, registered nurse; SQ, subcutaneous; TPN, total parenteral nutrition.

 *LPN assessments do not need to be cosigned by the RN. Both signatures will appear on the Initial Data Base, because both are gathering information.

†After course completion for IV LPN, to perform infusion therapy, the LPN must complete an infusion therapy program including didactic and clinical practicum and competency validation.

Disclaimer: Based on the Nurse Practice Act in Oklahoma. Adapted from the AACN Delegation Handbook, 2nd ed.

McCord, M., Johnson, D., LaHart, L., Rossi, S., Dunne. L., & Mowery, P. (2004). Delegation sample grid: LPN – Aspects of the role. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.684.8460&rep=rep1&type=pdf