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Walden University
2018

Abstract

Nursing Self-Efficacy in the Acute Care Setting with the Neighborhood Staffing Model

by

Laurie Berghoff

MSN, Ball State University, 2009

BS, Indiana –Purdue University- Fort Wayne, 1993

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

August 2018

Due to changes in health care, along with increasing technological demands, nurse's experiences increased stress. Nurses who are asked to staff another area other than their own have increased stress that can lead to increased nurse turnover, absences, and nursing dissatisfaction scores. The purpose of this quality improvement project was to assess whether limiting what units a nurse works on can reduce nurse stress, improve self-efficacy, and improve nurse job satisfaction. The design of this pilot placed like nursing units within a neighborhood staffing model for floating. The plan-do-check-act model was used as a framework to implement a change in the nurse floating practices. An electronic survey was sent to the nursing team pre and post implementation of the model. Nursing hours will also be tracked during this period of time. Data related to floating after the implementation of the neighborhood staffing model showed a significant increase in floating hours inside (13.1 vs 20.9; $t=3.98$, $p<.001$), and there was a significant decrease in hours floated outside the neighborhood (26.3 vs 18.0; $t=5.15$, $p<.000$). Self-efficacy results showed an initial decline in the nurses' self-efficacy 4 weeks after the launch and a statistically significant increase over preimplementation levels at 8 weeks (pre 28.46; post 33.51; U=5003, $p<.001$); on the 3rd administration of the self-efficacy survey, a statistically significant increase was seen (28.5 vs. 33.5; $t=12.1$, $p<.001$). Allowing nurses to float to similar nursing areas will result in improved self-efficacy, a precursor to reduced job stress and increased job satisfaction, which represents a positive contribution to social change for the nurses who work in the hospital system.

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Dedication

This project is dedicated to my family (Luke, Gabi, Erika, and Sarah) for their support and unconditional love. My two moms- for their encouragement, voice of reason, and ability to make me laugh. Finally, to my Dad-for his encouragement to achieve all my dreams, and for being my guardian angel.

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I want to thank the facility of Walden for the encouragement and assistance in completing this terminal degree. I wish to thank Dr. Niedz for her guidance and positive attitude during this project. Dr. Whitehead and Dr. Long, thank you for believing in me and the project. Lastly, I want to thank my work family who has encouraged me to grow, stretch, and develop lifelong learning skills,

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Section 1: Nature of the Project

Introduction

Nurses face challenges related to a fast-paced, rapidly changing nursing world. Nurses are expected to balance patient perceptions, and employer expectations. There is a diminishing financial returns for each patient's length of stay, which presents challenges related to staffing and staffing mix. Nursing teams are asked to produce more quality models. The development of these quality care representations is seen in two areas: staffing model and patient-centered models. As nursing leadership accepts the challenges of health care, the staffing models will allow us to improve and change.

Nursing staffing models are defined based on the time of day for the patient census. These model do not include account patient acuity, activity within the units, or the individualized nursing skill needed to care for those patients (Kobs, 1997). To changing the staffing model of how the hospital assigns staff, nursing administrators must implement an innovative approach to develop strategies and address variables. Variables may include rapidly fluctuating numbers in the daily unit census, increased patient flow in and out of those same units, patients with higher acuity, and patients with higher technological needs (Wing, 2001). Nursing skills are not identified when staffing decisions are addressed, and often the factors are limited to the current number of staff. Nurses do not all have the same skills, depth of knowledge, and technological training (Trossman, 2015). Nurses hired into a specialized unit develop advanced skills and expertise to care for the patient population within that unit. When nurses are staffed based on numbers, the nurse has to provide care without the needed advanced education

or experience (Ruby & Sions, 2003). When nurses are assigned to units outside of their permanent clinical unit or base (floating), nurses are exposed to different levels of care and unfamiliar environments (White, 2003). This project was designed to determine if nurses experience a decrease in nursing stress when their work is limited to permanent and/or similar units. The reduction in nursing stress was posited to be the result of increased self-efficacy as evidenced by perceived competency and guided by past experiences in providing care for patients with needs similar to those on their permanent unit. In this project, I measured this decrease through a pre/post survey after implementation of the neighborhood staffing model.

Floating, which refers to the process of nurses being assigned to a nursing unit other than their permanent unit to care for patients is used by nurse administrators to level workload throughout nursing units in a hospital (Frankhanel, 2016). Although this is fiscally sound in the short run, in the long-term, it may result in increased costs if nurses are leaving their employment position because of this practice (Bae, Yall, Mark, & Fried, 2010). The anticipated cost savings related to floating needs to be balanced with providing safe and competent care. Historically, non acuity staffing has been the driving force behind the nursing budget. Health care systems have also used floating to compensate for the nursing-shortages (Ferlise & Baggot, 2011) rather than developing solutions to remedy the problem. Non acuity based staffing models that incorporate floating have been shown to be detrimental to nursing satisfaction and quality patient care (Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002). Floating may be the

short-term response to staffing needs that could result in long-term adverse effects on nursing stress and satisfaction.

In exit interviews, nurses who voluntarily terminate their employment frequently identified floating as a cause for leaving the hospital (Nei, Snyder, & Litwiller, 2015). This project, the neighborhood staffing model, was introduced to the nursing team within the acute care setting. Linking nursing areas to neighborhood teams allowed for reduction in the stress that the nurses experience do to an increase familiarity with the patient population.

Problem Statement

In a hospital setting, staff nurses may work in many different areas, which is called floating. Floating can cause increased stress for the nurse related to the unfamiliarity of the unit environment and the patient population (Well, Manuel, & Cunning, 2011). Floating in the nursing work environment is a concern within nursing practice related to unfamiliar standards of care for the patient population (Garrett, 2008; Good & Bishop, 2011; Strayer & Diagnault-Cerullo, 2008). Nurse administrators who employ floating assume that all nurses have the same skill set (Strayer & Diagnault-Cerullo 2008). This skill mix is based on the nurses' educational background, which can be limited depending on the type of nursing program they have attended. If the nurses' skill mix does not match the job, the resultant job stress can be a predictor of increased nurse dissatisfaction-(Nicholls, Duplaga, & Meyer, 1996).

Floating has been attributed to high rates of turnover in acute care hospitals and medical centers, according to Garrett (2008). The practice of nursing within different

environments leads to nursing turnover. Floating to unfamiliar nursing units can increase nursing stress that could result in decreased nurse satisfaction (Bates, 2013). Strayer and Diagnault-Cerullo (2008) shared that the practice of floating is a basic staffing model that does not address the specialized knowledge and skill development needed for providing the highest quality of care for the patient population. Higher rates of floating within a hospital will increase the nurses' stress and may also impact self-efficacy and nurses' job satisfaction

Nurses become comfortable within their environment as they learn to care for their patient population. Klaus, Ekerdt, and Gajewski (2012) defined nurses as being more satisfied when there is a decrease in environmental stress, increased professional development opportunities, and improved autonomy. When floating takes place, nurses are out of their comfort zone, into an unfamiliar environment. This different environment can result in disorganization, loss of competency, and an increased risk in patient safety (Baernholdt & Mark, 2009). When nurses are repeatedly floated to the same unit, they develop comfort within that environment. This increase in support allows their skills to expand and knowledge to be absorbed. Nurses' stress decreases and their self-efficacy can increase with this type of floating. The stress of floating to multiple units can have a negative effect related to nursing skill and interest in the job and can, ultimately, influence patient care (Bates, 2013). Floating has many different consequences for nursing in many different ways, from effects on patient care to teamwork or overall job satisfaction.

The practice setting for this quality improvement project was within a not-for-profit hospital. The practice for staffing was completed by balancing the numbers on the staffing grid. Staffing grids are defined within the budgetary process using hours per patient days (HPPD) and a set number of patients. These guidelines allowed for a specified number of nurses and patient care technicians for a prescribed number of patients. The nurse leader addresses acuity within the units when completing the assignments for that shift. This process has been in place for over 10 years and has been viewed as a fair and equitable way of assigning staff based on the number of nurses budgeted and the number of patients needing care. However, the leadership team currently uses this model without considering the skill mix of the nursing staff.

In the neighborhood staffing model, nurses are allowed to float between a set group of units. Placing the nurses within a neighborhood can reduce the stress of floating by aligning the skill set of the nurse to the needs of the patients (McHugh, 1997). This neighborhood model allowed for familiarity within each unit, which decreases nurse stress, increases the nurses' self-efficacy, and improves nurse job satisfaction. In theory, nurses who are satisfied with their work will provide a better quality of care to the patients (Ruby & Sions, 2003). I implemented a neighborhood staffing model to improve nurse satisfaction as it relates to increase in comfort levels when assigned to units within the neighborhood.

This doctoral project provides nurse leaders with the opportunity to change the way they are assisting other nursing units. When the Affordable Care Act was implemented, nurses were challenged with implementing different ways to care for the

increasing patient volume. The neighborhood staffing model allowed for a different type of nursing practice but continued to support the specialized care of patient in all areas. This new model limited floating to units within the neighborhood, which have similar patient populations and acuity. The neighborhood staffing model made the care more patient-specific and allows nurses to improve their workflow, reducing stress resulting in an improved job satisfaction.

Purpose

The purpose of this project was to assess whether an evidenced-based model of nursing staffing (the neighborhood model) reduced job stress in nurses and increased nursing (job) satisfaction through improved self-efficacy. The present staffing model was not acuity based and presented a gap in nursing administration's leadership, as the present model caused job stress for the nurses, which resulted in poor nurse satisfaction. By implementing this staffing model, I addressed this gap in practice while closing the loop related to evidence-based staffing,

The hospital leadership teams throughout the health care environment have historically embraced the practice of floating, believing that the method resulted in reduced costs (Kobs, 1997). This practice has been adopted due to nursing vacancies, unplanned time off, and increased patient capacity on selected units in response to expanding patient volume (Bae, Yall, Andrews, Mark, & Fried, 2010). In floating, nurses care for patients in many different settings. However, hidden costs are related to floating, including those unmeasured that are coupled to nurse dissatisfaction (Ferlise & Baggott, 2009). The need for this quality improvement initiative was identified by the

organization's Quality of Life Council through a strength, weakness, opportunities, and threats (SWOT) analysis of the nursing practice. The Quality of Life Council identified floating as a concern that is impacting nurses' quality of life related to the stress and anxiety they experienced when floating.

The practice-focused question that guided this project asks: Does implementation of a neighborhood staffing model increase nurse job satisfaction? In this project, I identified float hours outside the neighborhood before and after the application of the model. This DNP project had potential to reduce nurse stress and to improve nurse satisfaction at the site by limiting the float practice to a circumscribed neighborhood of units that have similar patient types. Also, nurses in the neighborhood units will build self-efficacy and confidence among the nursing staff within each neighborhood teams (Wing, 2001). Leadership support for this type of model allowing a decrease in the practice gap related to non-acuity-based staffing. Job stress within the nursing staff was affected by the change and positively affected nursing satisfaction. Implementation of the neighborhood staffing model allowed nurses to float to defined areas, resulting in reduced stress levels among the nurses and improved self-efficacy.

Nature of the Doctoral Project

The implementation of a neighborhood staffing model was designed to connect like nursing units to share staff while improving nurse job satisfaction. The goal of this DNP project was to develop and implement a neighborhood staffing model within the acute and critical care units of the hospitals. These units were placed within five defined neighborhoods. A pre/post survey was given to the nursing staff to identify perceptions

of the current staffing model and neighborhood model as part of an organizational quality improvement (QI) initiative. In the surveys, I measured perceived nurse stress related to the job satisfaction, confidence to care for patients, and self-efficacy. In addition to the pre and post survey, within the project, I also evaluated the number of hours floated in and out of the neighborhood before and after the implementation of the model.

In the results of this project, I measured the effects of the implementation of the neighborhood staffing model on stress and nurse satisfaction through self-efficacy. Nurses verbalize feeling of stress and anxiety when needing to float (Good & Bishop, 2011). These feelings can start before they enter the hospital, as nurses verbalized feeling of stress and anxiety before coming to work when their units have periods of low census (Good & Bishop,2011). In the current floating model, nurses look for different job opportunities (Bates, 2013; Ferlise & Baggott, 2009; Garrot, 2008; Lugo & Peck, 2008). This QI project, with the support of the Quality of Life Council, implemented the neighborhood model and evaluated the nurses' stress and satisfaction levels before and after the change, through a self-efficacy survey.

Implementation of the neighborhood staffing model will allow for nurses to float within a set number of nursing units. The two-county hospitals that participated in this QI project divided the 19 nursing units into five neighborhoods. Each neighborhood included between three and five nursing units (See Figure 1).

Neighborhood Model

Campus 1

Critical care	Acute Core	Heart Specific
Unit A	Unit AA	Unit KK
Unit B	Unit BB	Unit JJ
Unit C		
Unit D	Unit CC	Unit LL
	Unit DD	
	Unit EE	

Campus 2

Acute	Post-Acute
Unit mm	Unit RR
Unit NN	Unit SS
Unit OO	Unit TT
Unit PP	
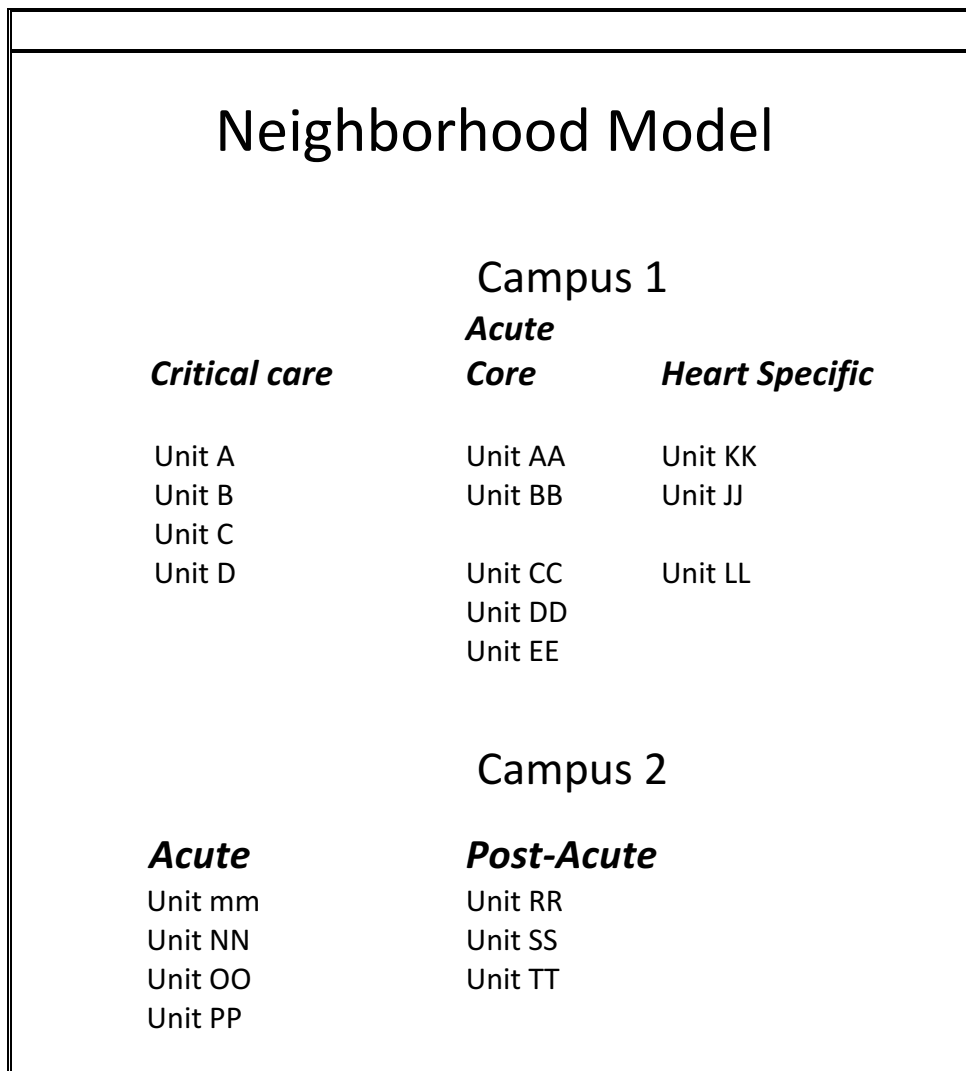
Figure 1. Neighborhood staffing model.

Implementing neighborhoods was the focus of this QI project to reduce job stress and improve nurse satisfaction through improved self-efficacy. A short electronic survey was completed before and after the 4th week of the implementation phase. In addition, the hours floating inside/outside the neighborhood in 2-week intervals were tracked prior to the implementation and after the 4-week period.

The development of a neighborhood staffing model may support nursing satisfaction by allowing nursing to float to a set number of similar units. This model is

similar to McHugh's (1997) cluster vs. nonclustered staffing model (McHugh, 1997). The neighborhood staffing model allowed nurses to improve their perception of their work environment, while reducing stress and resolving the nursing administration's gap in practice by changing the floating model used within this health system.

<div align="center">**Significance**</div>

Hospitals use floating to move nurses from their permanent units to care for patients throughout the health system (Frankhanel, 2016). Different stakeholders are involved in this floating process from leadership down to the clinical bedside nurse. The leadership team, which consisted of managers and directors, was not aware of the potential of using a different staffing model. With the implementation of this staffing model, the team moved to an evidence-based model. The leadership team will be the change agents within the practice of floating and embrace this new culture shift (Muls et al., 2015). The change will affect the nursing staff within the day-to-day staffing assignments. The adoption of the neighborhood staffing model allowed autonomy within the role of the nurse lead or charge nurse by empowering local control over where nurses will work. Nurses were the primary stakeholders and beneficiaries of this practice because it directly affects the environment in which they practice and the care they can provide.

Non-acuity-based staffing has been the practice for nursing's staffing model for many years despite the evidence outlining the negative impact to nurses (Trossman, 2015). When nurses hear the word floating, they become anxious (Bates, 2013; Ferlise & Baggott, 2009; Garrett, 2008). Developing a nursing staffing model that limits where

nurses will float to will allow for the practice of floating to continue while reducing or removing nursing stressors. This neighborhood staffing model resulted in an improved nurse self-efficacy that resulted in improved job satisfaction.

The neighborhood staffing model had the prospective to maintain the flexibility that floating offers to staff a given unit, while at the same time, minimizing nurses' stress and maximizing nurses' satisfaction. Sharing this type of staffing model with other health care institutions will result in a positive impact for the nurses who are required to float within their health care environment. This type of practice model can also be used outside of nursing; this kind of model could be used in the laboratory or respiratory setting to improve the comfort level of health care professionals as they care for more complex patients. This type neighborhood staffing model allows all health care providers to have some comfort and confidence regarding the possibility of floating. The neighborhood staffing model changed the way nurses expect to float, allowing them to develop self-efficacy, resulting in a decrease in nursing stress and improved nurse job satisfaction.

The neighborhood staffing model removed those negative feelings related to floating many nurses experience similar to the cluster model that McHugh shared(McHugh,1997). With the development of the neighborhood staff model, all stakeholders had a positive experience regarding the sharing of staff. In this staffing model, nurses could gain familiarity with the assigned neighborhood units. The model addressed the hospital's Quality of Life Committee concerns for the nurses' quality of work life. When changing the staffing model to the neighborhood staffing model, nurses

were able to improve self-efficacy while building relationship with another unit within their neighborhood allowing for improved comfort while decreasing stress and improving nurse job satisfaction.

Summary

The practice of floating is a common practice among nursing leadership, resulting in a perceived cost-effective and efficient use of staff (Needleman et al., 2002). This method allows for the health care system to ensure that all patients have a nurse to care for them, but it does not allow the identification of skill mix of the nursing staff that could affect the quality of care (Bates, 2013). When participating in this type of practice, nurses are experiencing an increase in stress that can lead to job dissatisfaction, along with a decrease in self-efficacy.

The neighborhood model is a nursing staffing model allowed for the practice of floating while providing limitations of where nurses will float. This type of model was designed to improve self-efficacy while decreasing stress and improving job satisfaction within the nursing staff. Predetermining or defining where nurses floated to lets nurses have a sense of comfort when reporting for work. Moving away from hospital-wide floating to floating within neighborhoods will allow for the continued practice of floating while developing a positive experience for the nurse. This method resulted in improved nurse self-efficacy, decreased stress, and improved job satisfaction.

In Section 2, I present evidence in on the concepts in this staffing model and the association between floating, nurse stress, and nurse job satisfaction.

Section 2: Background and Context

Introduction

Floating is a process that is used in health care systems that can cause stress in nurses, resulting in decreased job satisfaction. The practice-focused question that guided this project was as follows: Does implementation of a neighborhood staffing model increase nurse job satisfaction? In this project, I developed and implemented a neighborhood staffing model to limit the units where nurses float. This model allowed me to attach units defined by the patient population to identify neighborhoods. Limiting where nurses float allowed them to develop a comfort and knowledge of each unit. The development of this familiarity and comfort within set units resulted in the nurses' decreased job stress and increased in self-efficacy. When nurses have improved self-efficacy, they have less stress, allowing for the process of floating to continue. In the social cognitive theory of self-efficacy, Bandura's (1999) claimed that three factors that affect self-efficacy include environment, behavior, and personal factors. Self-efficacy is confidence in the ability to exert control over an individual's motivation, behavior, and social environment (Bandura, 2004). Nurses with high self-efficacy are more likely to be successful when floating within the health care environment. Floating is necessary for the health care environment; however, limiting where nurses float can have a positive effect on nurse job satisfaction, improving self-efficacy.

Concepts, Theories, and Models

Staffing Models

Staffing is a concept that has been studied over the years. Staffing models are created to decrease nurse stress and improve job satisfaction. Limiting where nurses float has been studied in different practices. Ferlise and Baggot (2002) completed a QI project allowing no floats and only using their staff to care for the units staffing needs. This pilot took place over a 6-month period that included all staff within this intensive care unit ICU. Data were collected based on current productivity, nonproductive nursing hours, and percentage of overtime (Ferlise & Baggot, 2002). Ferlise and Baggot showed a decrease in voluntary turnover from 9% to 1.1% after the 6-month pilot. The annualized turnover for this ICU from 1 year to the next went from 9% to 1.9% with the implementation of this staffing model (Ferlise & Baggot, 2002). This decrease represented an estimated cost saving of $595,000 in orientation cost (Ferlise & Baggot, 2002). Limited data collected along with the small sample size were the limitations of this pilot.

A different option for staffing is related to grouping units into groups with common patient populations. McHugh (1997) addressed the cost-effectiveness of grouping (clustered) nurses to areas or nongrouping (unclustered) of nurses to units related to floating. Working on nongroup unit was defined as the temporary reassignment for a one shift to any other patient care unit throughout the hospital (McHugh,1997). The grouped units were limited to where the nurse were reassigned, limiting reassignment to two or three units with similar patient populations

(McHugh,1997). McHugh did not find that there was a difference in cost between

restricting or nonrestricting floating (t [9] =.05, p=NS; McHugh, 1997). McHugh first

addressed understaffing of units in both unclustered and cluster units. McHugh found

that the unclustered staffing model resulted in fewer understaffed shits due to nurses

floating to unfamiliar areas versus taking unpaid days (t [9] =29, p,.01). McHugh also

identified that there was not a significant difference in cost related to overstaffing in

either the clustered or unclustered units (t [9] =3, p=NS). Limitations of this study

included not addressing staff morale or turnover rate and only addressing inpatient units

within a government veteran's administration (VA) system. McHugh did not support one

staffing pattern as being significant. Cost was the key variable with this study,

identifying options for different staffing models related to their overall cost to an

organization.

Nursing leadership is concerned with the cost of floating. Nursing stress and job

satisfaction are also variables that affect leadership decisions related to floating. Leaders

consider stress when looking at staffing. Good and Bishop (2011) developed a clinical

project to address the stress related to floating with the development of a "no-pull rule"

and the Willing to Walk Program. This program was implemented throughout the

hospital for all nursing areas. This QI process was tracked by turnover rates and nurse

satisfaction (Good & Bishop, 2011). The turnover rates went from 7.3% to 4.3% within

the health care system (Good & Bishop 2011). The staff satisfaction increased from

65.47% to 69.01% per their National Database of Nursing Quality Indicators (Good &

Bishop, 2011). According to Good and Bishop, this type of floating allows for the

establishment of comfort within an area. Good and Bishop also identified that there can be many variables that related to nurse turnover, including nurse satisfaction. With this type of autonomy and empowerment, nursing satisfaction was improved (Good & Bishop, 2011). Good and Bishop shared that there can be a way to limit stress for nursing related to floating.

The third model is defined as a closed staffing model: nurses only staff one unit. Strayer and Diagnault-Cerullo (2008) examined only staffing the unit with their own staff. This pilot was developed for a critical care unit to allow for a different model while remaining budget neutral. The data collected for this pilot were contract hour expenses and mandatory hours (Strayer & Diagnault-Cerullo, 2008). Strayer and Diagnault-Cerullo showed that each unit had a decrease in contract labor expenses: cardiovascular intensive care unit decreased by 50%, intensive care unit decreased by 28.8%, and coronary care unit showed a 44.7% decrease. Opportunities for improvement with this pilot related to communication between units, mentoring of new charge nurses, and developing trust within the team. A nurse survey was given to the team after the pilot was completed. Three questions addressed floating outside the unit, staff morale, and improved communication. All three questions resulted in a positive response in the survey between 99-100% (Strayer & Diagnault-Cerullo, 2008)

Job Stress in Nurses and Floating

Limiting where nurses float to can reduce the stress of the nurses but may not be the only factor with improving nurses job satisfaction. Overall stress or perception of stress can result in a positive or negative response to any situation. Purcell, Kutash, and

Cobb (2011) examined the relationship between nursing stress and nurse staffing within

the hospital. This descriptive correlational study was completed using a password-

protected self-survey method. Two instruments were used to measure nurses' stress: the

Nurse Stress Scale (NSS) and the Perceived Stress Scale (PSS; Purcell et al., 2011). The

NSS is a 34-question survey designed to measure job-related stress. The PSS is a 14-item

survey measuring life situations that are deemed stressful. Both of these tool use the

Likert scale for measurement (Purcell et al., 2011). Testing of the NSS for internal

consistency showed a coefficient of 0.89 while the PSS had an instrument test-retest

correlation of 0.85 (Purcell et al., 2011). The range for the NSS was 0 to 102 and for the

PSS, it was 0 to 56. Higher scores correlated with increased stress. Other study variables

collected included shift, hours, patient load, and days of the week. Central tendency of

measurement was conducted, including mean, median, standard deviation (*SD*), and

variance. The average hours worked per week were identified as 38 hours; these nurses

had an average of 10.5 years of nursing service (Purcell et al., 2011). The 45.7% work

day shift was primarily Monday and Tuesday (Purcell et al., 2011). Purcell et al. showed

that the NSS (mean = 89.6, *SD* = 21.5) and the PSS (mean = 36.6, *SD* = 8.0). The older

nurses had higher mean (*m* = 48.0, *SD* = 7.1) compared to the younger nurses mean (*m*=

29.6, *SD* = 4.6) related to patient workload. The PSS for the older nursing participants

(mean=35.7, *SD*=8.3) was lower than the perceived stress score of the younger nurses

(mean=37.4, *SD*7.7; Purcell et al., 2011). The PSS were not statistically significant but

was noticeable per Purcell (Purcell et al,2011). Comparing the scores related to patient

assignment, there was a statistically significant positive correlation (*r* = 0.363, *P*< 0.05)

for both the NSS and the PSS related to the nurses' age and the highest number of patients assigned ($r = 0.218$, $P < 0.05$; Purcell et al., 2011). In analyzing the variances, the younger nurses had significantly more stress than the older nurses ($F_{1,195} = 4.283$, $P < 0.05$; Purcell et al, 2011). Nursing stress is a factor in nursing practice. Stress can affect nursing from patient care through retention. Developing strategies to lower stress should be the aim of the nursing leadership team.

Perception of stress and the relationship to nursing can be identified. Nursing stress can be from within or outside of the health care environment. Decreasing daily stress is a goal for all leadership, especially in the health care environment. Donnelly (2014) identified perceived stressors in critical care nurses and noncritical care areas, comparing finding within both areas. A two-stage cluster sampling was used, targeting nurses working in the critical care area and noncritical care cares (Donnelly, 2014). The two sections included information regarding different work areas and a convenience sample of qualified nurses. A target sample of 200 was identified, and data were collected using the Bianchi stress questionnaire tool (Donnelly, 2014). Participants answered the questionnaire regarding how stressful they perceived it to be using a Likert scale. Reliability was obtained with a test and retest method using eight randomly select particulates (Donnelly, 2014). Data were stratified to explore difference between critical care/non-critical care, age, years of experience, educational background, and role of the participates (Donnelly,2014). Critical care nurses represented 63.7% ($n = 86$) of the results while 36.3% ($n = 49$) results were from noncritical care nurses (Donnelly,2014). There was no statistical significant between age, education level, experience, or length of

service (Donnelly, 2014). Donnelly showed a higher *t*-value in three of the stressors, which included staffing, communication with the family/patient, and work/life balance. The highest perceive stress was redeployment to another area ($p = 0.996$) followed by communicating with other department ($p = 0.999$; Donnelly, 2014). Work conditions or changes in work conditions can impact a nurse's stress level, resulting a change in job satisfaction.

Nursing skills are developed as nurses practice; this comfort in practice can be defined as self-efficacy. When entering a patient's room, nurses with high self-efficacy know instinctively what to do. Floating to another unfamiliar unit can alter this self-efficacy due to being in an unfamiliar environment. Welsh (2014) evaluated the medical surgical nurses' belief related to self-efficacy. This tool was developed with the Nursing Care Self-Efficacy Scale (NCSES) and guidance from Bandura for scale construction (Welsh, 2014). The use of two components of this tool included complex nursing care self-efficacy and fundamental nursing self-efficacy. Total self-efficacy scores correlated highly between time 1 and time 2 ($r = 0.93$, $p < 0.01$). Internal consistency reliability was supported with an alpha coefficient Time 1 = 0.93 and Time 2 = 0.95 (Welsh, 2014). Nurses' characteristics were described using the mean, *SD,* and frequency distribution (Welsh, 2014). Welsh showed that the complex subscale ($M = 8.5$, median 8.6, $SD = 1.0$) was 0.6 lower than the mean on the fundamental ($M = 9.1$, median 9.0, $SD = 0.8$). Single subscale mean ranged from 7.3 ($SD = 1.9$) to 9.3 ($SD = 1$) while complex subscale ranged from 8.8 ($SD = 1.2$) to 9.2 ($SD = 0.9$; Welsh, 2014). The Cronbach's coefficient alphas ranged between 0.87 to 0.94 for the NCSES and its subscales (Welsh, 2014). Single-item

analysis with both the Complex and fundamental supported that nurses felt more

comfortable with pain intervention ($M = 9.3$, $SD = 1.0$), preforming technical skills ($M =$

9.2, $SD = 0.9$), and implementing treatment for patients ($M = 9.0$, $SD = 1.0$; Welsh,

2014). Welsh identified that nurses felt less confident in their ability to use research in

practice ($M = 7.2$, $SD = 1.9$), balancing cultural care ($M = 7.8$, $SD = 1,6$), and managing

interpersonal work conflicts ($M = 8.0$, $SD = 1.6$). The data correlated positively with the

years of hospital experience ($r = 0.20$, $p = 0.01$ and $r = 0.23$, $p = ,001$), while neither

correlated with educational level (Welsh, 2014). Nurses who have higher self-efficacy

beliefs are more confident, remain motivated, and work through challenges within the

health care environment. Nurses with low self-efficacy tend to avoid difficult tasks and

uncomfortable situations and dwell on past negative experiences (Welsh, 2014).

Identifying how nurses develop self-efficacy and focusing on further development of

these skills can decrease stress within the nursing team.

Models for Change

Bandura's (1999) social cognitive theory of self-efficacy was the theory used

within this project. The three points of this concept include personal factors,

environment, and behavior (Bandura, 1999). Human nature often connects behavior,

consequences, and relationship as often being interrelated. How people act usually

depends on their experiences within a given situation. People also learn from each other

through observation, actions, and behaviors. When nurses are floating to unfamiliar

areas, their performance can be altered due to a negative or positive experience with that

nursing team. If nurse leaders can improve this experience by establishing relationships

within neighborhoods, nurses will become more confident when floating to these areas, resulting in a decrease in stress and improved job satisfactions.

Quality Improvement Model

This QI project was developed with the use of the plan, do, check, act (PDCA) model when developing the project (Morgan & Stewart, 23017). The used of the PDCA model within this quality process assisted the team in identified opportunities to improve workflow through a root cause analysis. The PDCA model organized the team to understand the workflow through observation and participation. Once the current floating model was identified, the team developed a plan to improvement the new model within a time frame. The timeframe assisted with the balancing of the process and allow for follow-up as necessary. This quality project was developed within the work group, understanding the process, clarifying, and then developing of standard work for the nursing team. This process was developed, shared, and completed.

Relevance to Nursing Practice

Nurses have used floating due to a decrease in available nursing resources. With floating, the leadership team reassigns a nurse from one unit to another. Current staffing practice is based on a numbers system that ensures all units are equal with staffing related to staffing grids (Kirby, 2003). The process of staffing by numbers was developed with the collaboration of the financial team and the nursing team. Number-based staffing allows the health care system to reallocate their staff to areas that need help balancing the salary dollars and staffing needs (Kirby, 2003). This form of staffing in nursing is unrelated to the patient needs within the units. This type of system does not take skill

mix, patient population, or standards of care for these patient populations into the decisions (Needleman et al., 2002).

In floating, it is assumed that nurses can work on any unit due to the generalist nursing skills developed within the nursing program. Floating is associated with medication errors and increases the length of stay and a decrease in patient outcomes due to nurses being in an unfamiliar environment (Needleman et al, 2002). Floating has been proven to increase nurse stress and decrease self-efficacy, resulting in a decrease in job satisfaction (Martin, 2015). Floating has multiple outcomes, both positive and negative, that can affect job satisfaction and impact nurse self-efficacy.

Nurses who are hired into specialized units develop advanced assessment skills and knowledge of patient population standard of care. This fundamental understanding ensured the standards of care are completed resulting a consistent length of stay for that patient population (Strayer & Daignault-Cerullo, 2008). Improving the nurses' skills and knowledge of the care delivery for these patients has also been identified as a must-have when floating to specialized areas. Nurses who float into specialized areas within the neighborhood could develop that this type of specialized skills to continue with the standard of care for that population.

Nursing leadership has used the process of floating to fill in the gaps within the unit related to staffing vacancies (Bates, 2013). When working within current process, the balance of wants and needs are identified and addressed per staffing grids. The HPPD number is the defining number in developing staffing grid, which are guidelines for the nurse leader or charge nurse. This form of staffing removes the consideration of

any patient acuity, the nurse's skill mix, or the skill mix within the unit (Trossman,2015). This process causes increased nursing stress and decreased self-efficacy, resulting in a decrease in nurse job satisfaction. This method of floating can increase the nurse vacancies rate related to nursing job dissatisfaction. How leadership chooses to adopt the process of floating can impact nurse satisfaction.

Different studies have identified different strategy to deal with floating or vacancy of nurses. McHugh's (1996) study related to cost as it redefined two different models cluster an nonclustered units. Good and Bishop (2011) looked at floating in the different light, address an individual's willingness to walk. This study examined a nurse's desire to float compared to everyone having to float. Ferlise and Baggot (2002) decided to complete a study allowing no floats and only using their staff to care for the unit needs. Floating can solve the potential for vacancies but can result in increased nurse stress, decreased self-efficacy, and decreased nurse satisfaction. Looking at nurse stress related to floating was evaluated. How nurses adapted to the environment has also affect their perception of job satisfaction. Nursing leadership needed to develop strategies to decrease stress and improve job satisfaction within nursing.

Knowing floating was something nurses must do what opportunities are there to make it less scary or stressful. In 2013, Bates developed a nurse's guide for floating, trying to improve the experience for the nurse (Bates, 2013). Kane-Urrabazo (2006) looked at the obligation with floating and identified the impact and then developed a standard process that included orientation on units that nurses would be floating to (Kane-Urrabazo, 2006). Burkett (2001) develop a user's guide to floating, addressing

standard work that should be completed during their assigned shift. Development of a tips sheet for floating nurse could be a plan to help improve the perception of floating.

The neighborhood staffing model allowed for the practice of floating to continue while addressing staffing needs, improving nurses' control over their practice. When nurses control the floating methods, this decreased nursing stress, improve self-efficacy, and result in an increase in nurse job satisfaction. The increase in nurse job satisfaction showed a positive influence within nursing. The implementation of the neighborhood staffing model, evaluated the nurse's perceptions with a pre/post-implementation survey. Data was also being collected, identifying hours floating inside/outside the neighborhood before the implementation and at the 4-week timeframe.

Local Background and Context

Floating has been a practice of nursing for years, with the mindset all nurses have the same skill set (Lugo & Peck, 2008). It has been identified that nurses feel anxiety with the thought of floating (Bates, 2013). When nurses experience these symptoms, their perception of job satisfaction decreases. Kany (2000) shared nurses often feel disorganized and unfamiliar in areas they are float too. Strayer and Daighault-Verullo (2008) identified when nurses become familiar with another nursing unit, they gain confidence, become more organized, and develop an understanding of those diagnoses (Strayer & Daighault-Verullo 2008). Whether the nurse's skill mix matches the job, this related job stress can be a predictor of increased nurse dissatisfaction, which leads to increase risk in-turnover (Nicholls et. al, 1996). Burkett (2001) and Bates (2013) both developed tricks and tips to share with nurses when being floated to unknown locations.

Developing a plan to help support the current nursing state while limiting the impact of floating on nursing is a delicate balance for the nursing leadership team

The practice within the healthcare system related to staffing includes set time for the two campuses to communicate and define staffing at each location. This video chat system similar to Skype allows for a face-to-face discussion between the two campuses. This meeting is currently being led by a team of nonclinical support staff from the staffing office (SO). There is a roll call for each area, identifying standard information that includes numbers of patients, potential admission/discharges, number of nurses, and numbers of patient care tech (PCT). They will also identify if there is a critical need. A critical need is established when the unit is unable to practice safety with current staff. The SO team looks over the numbers, arranges to float nurses and patient care tech (pct), to balance staffing per staffing grids. Nursing leadership strategic plan is continued autotomy related to nursing practice. Discussion on floating between units allows for improve communication with continued control with their practice. This project of changing the process of floating to improve nurse satisfaction was at the direction of the Quality of Life (QOL) nursing council.

The QOL team did a literature search regarding nurse satisfaction, floating, and outcomes. The neighborhood staffing model was developed though this search as an opportunity to change the way floating was occurring within the health system. This type model was first presented in the quality of life council (QOL) meeting. The QOL team supported the neighborhood staffing model to be presented at the healthcare system Nursing Coordinating Council (NCC). NCC is a system level nurse-driven council with

representation from clinical staff within the healthcare system. The staffing model was presented in a podium presentation including the evidence regarding floating, outcomes, and the why behind this model. Presenting in this format allow the team to understand the full picture of this change in practice. During the presentation, the NCC voted on what units should be in a particular neighborhood. The change process of allowing the nurse leaders to make the decision was critical to the success of this model. The QOL took volunteers to participate in the neighborhood staffing workgroup. This group meet weekly and assist in the further development and implementation of this pilot.

Defining key words or phrases for this model allows for consistent knowledge for this process improvement project. The word neighborhood will be defined as a group of like nursing units. For this project staffing is referred to as nurses working within each neighborhood. This model defined floating as staff being reassigned to a different unit. The words critical defined when an area cannot manage the unit unless they receive help from other areas. Defining the key words will allow for the team to use common language, avoiding confusion.

The implementation the Affordable Care Act (ACA) allowed for more patients to seek and receive treatment. This change in opportunity for patient to receive care encouraged the Institute of Medicine to understand the impact of nursing, addressing what the future of nursing would need to be. The IOM along with the Robert Wood Johnson's Foundation (RWJF) developed an action plan for future of nursing. The goal of this project was to have the right nurse caring for the right patient, allowing the nurse to work at the top of their license. The practice of floating within nursing is part of this

context. Development of the neighborhood staffing model allowed the patient to receive the right care at the right time from a confident and satisfied nurse.

Role of the DNP Student

I assisted with the neighborhood staffing model as a QI improvement project. The role of the doctoral student was to assist and lead the neighborhood work group with the development and implementation of the pilot. This project was first developed through the QOL council, of which this DNP student is a leadership member. The first step with this project was to identify if the health care system is willing to accept the development of this model. Working with the quality of life nursing team, I developed education on the model, sharing information and ideas, facilitating the literature review. Development occurred though mapping the current practice model allowed the team to understand the full content of their current practice. Clinical observation within the existing staffing office during staffing meetings allowed for better understanding of current practice. Practicum hours were spent with the development of the neighborhood steering team and observations within the staffing office. I worked with nursing leadership on the timing of the implementation of the pilot to allow for the leadership team to fully understand the model. The development of the neighborhood staffing model as a QI project allowed for the nursing team to identify their current practice while develop a strategy for implementing the new process. The neighborhood staffing model was implemented as a pilot QI project for the health system; I student assisted with the workgroup with development, launch, and measurement of the pilot's impact.

This DNP student's interest is related to enhancing nurse leaders to work at the top of their licenses. Staffing is critical when working within the units. The nurse leaders make decisions as to how they are caring for the patients on their unit. The clinical staff, including the nurse leaders, wanted to develop ways to improve nurse satisfaction to decrease nursing stress. The clinical staff presented the process of floating as a positive for nurse dissatisfaction to the QOL council. My role was to assist the team with the development of a staffing model that improved their comfort level with floating while improving their job satisfaction.

Biases for this project can be seen in different levels of leadership in nursing. The largest bias I experienced is the idea that units can be self-sustaining, removing the floating altogether. This practice is not supported within this healthcare system.   I worked hard at looking at the larger picture being objective as to what nursing wanted to do. I worked with this neighborhood team while being aware of these bias and make a conscious effort to portray the vision of the leadership team. Assisting the quality of life team in presenting this potential quality project allowed the identification as a doctoral student. Developing leadership skills focusing on strategy and culture is key for this project. The role of this DNP student was accepted within lower level of nursing leadership, allowing for further development of the neighborhood steering team. This team assisted with the implementation of the neighborhood staffing model. This doctoral student was aware of the current bias working to remove this from being an issue within this pilot.

Role of the Project Team

Development of this QI project will be assisted by a subset team within the QOL.
Presenting literature related to staffing models, background information, and evidence
was the role of the doctoral student. This work group developed the details of the plan
for the pilot including implementation. An invitation was extended to anyone within the
NCC or the QOL councils to join the team. It was also shared with the unit-based teams,
announcing that anyone who wanted to be part of this working group could participate.
The ongoing commitment was needed, as the model was implemented and adopted by the
nursing team. This team used and follow the quality model of plan, do, check, and act in
the development of the program. This neighborhood work group has identified the
current practice state, mapping out the paths allowing for the development of the project.
The plan determined what was be beneficial for tracking to identify the success or failure
of this model. The work group assisted in the development and implementation of this
staffing model, including evaluation of the data at the end of the pilot. Previously, the
healthcare system staff using a four-hour black method, this project had a positive effect
on this practice. This type of staffing can result with nurses being reassigned three
different units within a 12-hour period. It has been identified that nurses have an increase
in stress when being moved from area to area to care for patients (Kany, 2000). The
increased pressure can result in an increase in nurse stress that results in job
dissatisfaction. Changing the staff model to a neighborhood model improved the nurses'
stress levels and increase self-efficacy by allowing them to float within a defined area.
Implementation of the neighborhood staffing model allowed for the patient to receive
consistent care due to nurses being familiar and comfortable in the areas they float too.

Weekly meetings were established for the team members where they will develop the plans for a pilot. The meeting allowed for periods of brainstorming when issues have been identified or rise. Communication plans were established; standard work was identified during the planning phase. Education plans were prepared and shared with the nursing team, presenting standard work and roles of nursing and defining changes. Sharing monthly updates with the QOL committee developed two-way communication to prevent any miscommunication. The implementation of a new staffing model needed to take a team approach, allowing all team members to feel empowered to make floating better for everyone. This project was developed over a several week period. Standard work will be outlined and then shared with the leadership team before any implementation. Once the standard work was completed, guidelines were established, and education was completed, the 4-week periods for the pilot will be established.

The role of the doctoral student supported, guided, and assessed the progress of the development and implementation of the neighborhood staffing model. I assisted with many different responsibilities within the workgroup, leadership team, and the health system.

Summary

Nurses are being asked to care for any patient population within any area of the hospital. This practice for nursing is defined as floating. When nurses are involved in this practice, they have a proceeded increase in stress that can leave to poor job satisfaction. Development of the neighborhood staffing model allowed nurses to continue the practice of floating while controlling where they are reassigned to. This

type of model connected nursing units to neighborhoods, allowing floating to occur within their set neighborhoods. When nurses float to an identified neighborhood, their job satisfaction and self-efficacy improved. Nurses who float have an increase in stress and a decrease in self-efficacy, resulting in a decrease in job dissatisfaction. These three variables present a gap in nursing practice. With the implementation of the neighborhood staffing model, the gap in practice was closed by allowing nurses to gain confidence and be comfortable with the floating process, which could result in improved nurse job satisfaction.

Section 3: Collection and Analysis of Evidence

Introduction

Hospitals are charged with caring for all patients who enter their facility. Nursing teams are the key stakeholders in delivering care. Nursing leadership has adopted the practice of floating to cover all patient needs. Floating is occurs when a nurse leaves his or her home unit to assist in giving care on anther unit. This type of practice can affect nurse self-efficacy and increase stress and the nurses' perception of job satisfaction.

Floating affects nurses and their confidence to complete nursing care. When floating within a hospital, nurses move from areas of being an expert to being the novice. Nurses develop advanced assessment skills when caring for patients within their patient population(Ruby & Sion, 2003). During this time of advanced skill development, confidence and comfort levels grow in caring for their patients (Strayer & Diagnault-Cerullo, 2008). Nurses often move from a novice nurses to the advanced or expert nurse during this period of time. In floating, nurses move back into the role of a novice nurse due to the unfamiliarity of the unit and the patient populations. This QI project limited where nurses float, improving nurse self-efficacy, decreasing stress, and improving overall job satisfaction. Implementation of a neighborhood staffing model allows nurses to float within a target group (unit), allowing improved confidences and familiarity of these units. Three elements of Bandura's (1994) social cognitive theory self-efficacy, which include person, behavior, and environment, were interrelated in this project.

Development and implementation of the neighborhood staffing model was the focus of this project. Identifying current practice and investigating available research

assisted in developing a best practice model for nurse staffing. This project consisted of four phases: project, implementation, evaluation, and the outcome. This QI project's goal was to address best practices for a staffing model that ensures self-efficacy, reduces nurse stress, and improves nursing job satisfaction.

Practice-Focused Questions

Nursing leaders are tasked with the process of ensuring that patients have nurses to care for them. Nursing leaders choose floating to provide units with adequate staffing. This process does not allow for the identification of skills but rather a number of patients based on the number of nurses. Floating has filled a gap in practice related to not having enough nurses at the bedside to care for patient. Floating has been identified as a stressor within the nursing work environment, causing a decrease in job satisfaction (Martin, 2015). The practice question that this QI project addresses was the following: Will the development and implementation of a neighborhood staffing model improve nurse job satisfaction? The neighborhood staffing model was designed to continue the process of floating with limitations on where nurses float.

When nurses work within a set environment, they develop familiarity with this area. Advanced skills for their patient population develops, and a comfort for their team emerges. This form of bonding results in a decrease in stress and improved self-efficacy (Good & Bishop, 2011). When floating throughout a health system, nurses can experience a decrease in confidence resulting in a decrease in self-efficacy (Donnelly, 2014). This QI project was designed to address this gap in practice by limiting where floating will occur. Placing the current inpatient units within a neighborhood was the

model for this QI project. The neighborhood staffing model QI project allowed for the process of floating to continue while improving nurse self-efficacy, decreasing their stress, and improving their job satisfaction. The QOL team identified staffing as a stress for nursing. Limiting where nurses will float could decrease some of the stress that nurses are feeling, while improving their self-efficacy and overall job satisfaction (Welsh, 2006). This QI project aligned with the vision of the QOL council, which was to improve nurses' QOL.

The neighborhood staffing model was implemented in a nonprofit hospital. This QI process was completed as a pilot project over a 4-week period. Nursing units were identified and placed within a neighborhood based on the patient population. This staffing model continued with the current practice of floating, just placing limitation on where nurses will float. The QI project did not leave a patient unattended but limited where nurses floated to allowing for improved self-efficacy, decreased stress, and improved job satisfaction

Sources of Evidence

Caring for patient on a daily basis can be stressful and leave nurses feeling disheartened. In the social cognitive theory, Bandura (19997) shared that self-efficacy is impacted by three factors: personal, behavior, and environment. How nurses react to patient care can be impacted by self-efficacy (Purcell, 2011). The nurses' confidence and comfort for caring for patients can be impacted by this self-efficacy. Research was reviewed for sources of evidence to assist in the development of this project. Data from this research allowed me to address the practice-focused question.

I collected and analyzed the data assist to further understanding on floating, self-efficacy, and the impact on nursing. Evaluating other tools within this evidence allowed for the support to define the best tool for this staffing pilot. Understanding the current practice regarding floating allowed for further knowledge to assist with the change process. Being aware of the evidence for best practice related to staffing helped me to further address the practice question.

Published Outcomes and Research

A systematic review of the literature was completed using the Boolean search method. Search words for this project included *nurse, stress, floating, staffing models, self-efficacy*, and *job satisfaction*. The timeframe for this search was first limited to the last 10 years, but due to a lack of evidence, the timeframe was then unlimited. Databases searched included Thoreau at Walden, CINAHL, Medline, ProQuest Nursing and Allied Health Sources, and Google Scholar. Evidence was collected for this project using these multiple sites that resulted in a comprehensive and exhausted search for evidence.

Welsh (2006) showed that nurses with an increase in self-efficacy showed more confidence, motivation, and willingness to help solve patient issues. Furthermore, nurses with lower self-efficacy were uncomfortable in situations, dwelled on negative experiences, and avoided difficult situations (Welsh, 2006). When nurses float within different units, their self-efficacy may be affected, resulting in increased stress and poor job satisfaction. Kany (2000) shared that when nurses float, they can experience disorganization and unfamiliarity to an area, impacting their self-efficacy. Donnelly (2014) claimed that nurses felt their highest perceived stress when being deployed to

another unit. Placing nurses in an unfamiliar environment with multiple units can impact their self-efficacy in a negative manner. The neighborhood model limited where nurses float, improving their self-efficacy. This model also supports the nurses in developing familiarity and confidence within these units. When caring for patients within defined areas, nurses experienced decrease in stress levels and overall job satisfaction.

Archival and Operational Data

Staffing patterns for this health care system have not been evaluated for efficacy or best practice. The QOL committee requested leadership to identify present conditions between floating and nursing hours to develop a better understanding of the current floating state. I used this data to further develop the model based on nursing hours and floating. The finance manager for the nursing team assisted with obtaining information regarding floating hours. Permission and support for this project and data review were received from the chief nursing executive.

Evidence Generated for the Doctoral Project

The implementation of the neighborhood staffing model was completed with 19 nursing units over a total of an 8-week period of time. Nursing units were divided into neighborhood teams to target their floating base. The team allowed for a 2-week implementation period to allow the nurses to understand the new process and limitations. Education was developed and shared with all nurse leaders regarding the new process. A survey was sent electronically to the nurses within the neighborhood 1 week prior to the implementation of the model and 1-week post implementation. Schwarzer and Jerusalem's (1995) General Self-Efficacy (GSE) scale was used for this survey. The

GSE scale is designed to forecast coping skills with daily activity and responds to stressful situations (Schwarzer & Jerusalem, 1995). Reliability of this scale has been demonstrated 0.76-.90 Cronbach's alphas (Jerusalem & Schwarzer,1992). Construct validity was documented in correlational where researchers found that emotions, work satisfaction, and optimism positively related to self-efficacy (Jerusalem & Schwarzer, 1992). The negative relationships included anxiety, job stress, burnout, and health complications (Jerusalem & Schwarzer,1992). The GSE questions had the words "when floating" added to the original statement. The first 10 questions of the survey included the GSE questions. Six additional questions were added to enhance the construct validity of the tool. These 16 questions were analyzed by summing the totals resulting in a score that could range between 16 and 64 as each item is scored as a forced-choice 1 indicating *not true* and 4 equals *always true*. Higher scores indicated less job stress, increased self-efficacy, and a more positive view, while lower scores indicated increased job stress and less self-efficacy. The reliability of internal consistency of this scale was demonstrated with .72-.84 Cronbach's alphas. This was review by an expert panel that included two researchers and the chief nursing officer. The final four questions were demographic in nature (Appendix A). Due to the sharp increase in patient census, the organization made the decision to add a third self-efficacy survey due to the possibility of the increase in volume in patient that may unduly influence nurses' perceptions of floating even after the neighborhood model was implemented.

The second form of data that were collected were hours regarding where nurses were floating to for this period of time. These data were collected with the assistance of

the nursing finance manager. Data in the form of floating hours were collected over two

4-week periods. The first 4-week period prior to the implementation of the model was

compared to the 4-week post comparisons hours. The hours floated within the

neighborhood were identified separately between hours floated inside and outside of the

neighborhood. This data allowed for the review of the current floating hours before and

after the implementation of the neighborhood staffing model.

The final section of this project included three open-ended questions. These three

open-ended question were sent to the same nursing staff to understand their perception of

the neighborhood staffing model. Open-ended questions allowed for the nurses to share

their own views in their own words. This survey was completed in a de-identified

method. The nursing staff had 10 days to complete the survey.

The three different forms of data assisted in validating this QI project. With the

data sets, I identified if the limitation of floating to defined units improved nurses' self-

efficacy. Nurses also shared their own thoughts of the neighborhood model through the

qualitative survey. The neighborhood staffing model addressed nurses' job stress by

identifying hours within the neighborhoods, their self-efficacy score, and their

perceptions of the model.

Participants

The nursing team at the project site agreed to participate in this pilot study. The

nurse coordinating council that consisted of clinical nurses from the project site assisted

in defining the five neighborhoods. Survey results were obtained and delivered to me in

an Excel spreadsheet to protect the identification the participants; this also prevented role

compromise. This type of data collection allowed for anonymous participation. I hoped to achieve a 30% survey response rate of the 535 staff nurses who were eligible to float in both the pre/post phases were the target. The number of surveys completed from the pre survey was 183, the Post survey 1 had 143 and the Post survey 2 had 191 returned. Nursing hours collected by the finance manager were given to me, the DNP project leader, for secondary analysis in a de-identified Excel file. The qualitative survey had 102 responses to the three open-ended questions.

Procedures

Weekly meetings with the neighborhood work team (NWT) began after the final approval for this QI project from Walden. The focus was on developing the standard work for the clinical teams. The team's role was to understand the model and its effect on current staff and implement the pilot. Weekly meetings of the work group allowed for everyone to understand the process and improve their knowledge of the model. These weekly meetings continued through the pilot phase, with a final report compiled after the completion of the pilot.

The GSE scale was given to the nurses within the neighborhood units via an electric survey. This 20-question survey incorporated the 10 general self-efficacy questions plus six other staffing questions and four that obtained demographic information. Refer to Appendix A for details of the survey. The survey that had three open-ended question was developed for the nurses within the pilot units to share their feeling and perceptions related to the neighborhood staffing model. Refer to Appendix A for details of this survey. The survey was completed using a confidential electronic

method. The second form of data collected was in the form of nursing hours for each neighborhood. These data were pulled through the employee payroll system. These hours could be pulled per complement code, unit location, and facility. These data were nonidentifiable and confidential for this project.

Protections

A clinical staffing team brought the idea of the neighborhood staffing model to the QOL team. This clinical team identified that current staffing practices resulted in an increase in turnover, an increase in nursing stress, and frustration. The QOL team identified staffing as a stressor impacting nurses' QOL. This was foundational support for this QI project. The nursing team within this project site had an opportunity to share their thoughts within the survey. These data were collected and shared in an unidentifiable manner. Nursing hours were collected through the payroll system based on job code and cost centers, then grouped into neighborhoods. In addition, written consent for the project was secured from the project site and was presented to the Walden Institutional Review Board (IRB). Completion of the IRB process at Walden following the QI manual was completed with an IRB # 2-21-18-0493378.

Analysis and Synthesis

Initially, I planned to conduct parametric tests, an independent samples *t* test. However, once the data were collected and examined for normality, I had to change the plan to use nonparametric tests because the data did not meet the assumptions of normality. In addition, as the project emerged, the organization identified a need to conduct an additional self-efficacy survey, which was conducted 60 days (8 weeks) after

the start of the neighborhood staffing model. A chi-square was also completed to compare days with no floats outside the neighborhood. In addition, reliability for internal consistency was evaluated on the self-efficacy instrument. Software used with this project was the IBM SPSS statistics package. The data for nursing hours were evaluated based on the numbers of hours floating within and outside each nurse's assigned neighborhood during the pilot period compared to the pre pilot data. Nurses were not paired for the analysis; therefore, a Mann-Whitney U test was used to test for statistical significance in comparing self-efficacy over the three survey periods. To compare the floating hours, I used another nonparametric test, the chi square. The final comparison of data included comparing the census during before the pilot and during the pilot. This was completed using a Mann-Whitney U test for statistical significance.

Summary

Nursing is the key for patients to receive care within hospital settings. Nursing skill can be defined based on the patient population for that unit. Development of advance skills, comfort, and confidence grow in nurses when consistently caring for similar patient populations. Floating is a strategy for nursing to balance the staffing needs within a hospital. This floating or reassignment to another unit has shown to be leading cause for stress in nurses (Martin, 2015). Nurses who have spent time in different units develop familiarity/comfort within these areas. This familiarity can be seen in the form of self-efficacy. Nurses with higher self-efficacy are more apt to be motivated, willing to accept challenges, and more confident (Welsh, 2006). In the development of the neighborhood staffing model, the nurses floated to defined group

units. This model allowed the nurses to develop familiarity, confidence, and comfort with the assigned units. Gaining confidence and understanding of a set neighborhood improved organizational skills and advanced nursing skills. Acquisition of these needed skills consequentially decreases stress, leading to improved self-efficacy.

Section 4: Findings and Recommendations

Introduction

Staffing is an everyday occurrence in hospital settings. Floating is defined as moving nurses from their home units to assist in other units. This is done on a daily basis to ensure that each nursing unit has adequate volume of staff members to care for the patients on the unit. This type of floating can affect nurses by decreasing their self-efficacy, increasing stress, and decreasing job satisfaction. The previous staffing practice allowed nurses to float between different units, critical care and acute. Some nurses had the potential to float to a total of 19 different patient care units. This practice resulted in multiple complaints and was overwhelming for the nursing staff, as they did not have any certainty as to where they might float to on a given day. Nurses develop familiarity when working within a unit; and this familiarity can generate self-confidence, a form of self-efficacy. When floating to multiple units, nurses' self-efficacy can be affected related to the ability to safely manage a different type of patient. The difficulty in establishing relationships with other staff members within a single shift and finding supplies can be a challenge (Bates, 2013). Floating can cause stress and anxiety.

The purpose of this quality improvement project was to place 19 units into five neighborhoods, limiting the choices as to where nurses would be assigned. This QI project was completed in a not-for-profit hospital. The practice focus question asked: Does implementation of a neighborhood staffing model increase nurse job satisfaction through improved self-efficacy? Limiting nurses to a defined neighborhood can improve

self-efficacy, decrease nurses' stress, and improve overall job satisfaction (Good &

Bishop, 2011; Frankhanel, 2016; Nicholls et al., 1996; Welch,2006).

The neighborhood model divided the nursing units into five neighborhoods. Data

related to where nurses floated were collected using the total numbers of hours floated

inside and outside the neighborhood over a consistent 4-week period using the payroll

system. After the implementation of the neighborhood model following a 2-week

educational period, the same data were collected again over a consistent 4-week period.

The second form of evidence to evaluate this model included an electronic survey

for the nursing staff, which was administered before and after implementation of the

neighborhood model. The survey identified a level of self-efficacy at the time of data

collection within the nurses who completed the survey. This tool addressed the nurses'

comfort, efficiency with floating., and several demographics. The second form of an

electronic survey was completed with open-ended question seeking the nurses'

perceptions related to the model. These forms of data permitted me to evaluate the

effectiveness of the neighborhood model including the nurses' feelings towards the

neighborhood model.

Findings and Implications

Descriptive Statistics: Demographics

Nurses participated in the self-efficacy surveys in three different applications.

The first self-efficacy survey was conducted during a 2-week timeframe prior to the

launch of the neighborhood staffing model. The second administration of the self-

efficacy survey was held 4 weeks after the implementation of the neighborhood staffing

model (Post1) and a third time, 4 weeks later, or 8 weeks after the pre survey data

collection (Pre *n*=175; Post1 *n*=133; Post2 *n*=189). These nurses had a range of tenure

with the organization, role (RN or NL), education level, and varying ages (see Table 1).

Table 1

Demographic Characteristics Nurses' Self-Efficacy Surveys

	Age Ranges	Education	Tenure	Role
Pre-Implementation (Pre)	22-48	Diploma/ASN 57 BSN/MSN 118	1-3= 61 4-14=79 >15=36	RN=133 NL=36
Post Implementation 4 weeks (Post1)	22-51	Diploma/ASN 44 BSN/MSN 92	1-3=49 4-14=63 >15=27	RN=108 NL=25
Post Implementation 8 weeks (Post2)	25-53	Diploma/ASN 61 BSN/MSN 127	1-3=67 4-14=82 >15=40	RN=13 NL=44

There were no statistically significant differences in age, education, tenure, or role

between the groups. Tests of normality showed moderate skewness and kurtosis.

Because the Kolomorov-Smirov and Shapiro-Wilk tests of normality were statistically

significant, both parametric (ANOVA) and nonparametric tests (Mann-Whitney U) were

used.

Floating Hours Before and After

Data related to nursing hours of floating were compared before and after the

implementation of the neighborhood staffing model. I found that there was a significant

increase in the average of hours floated inside the neighborhood (13.1 vs 20.9; t=3.98,

p<.001), and there was a significant decrease in hours floated outside the neighborhood

(26.3 vs 18.0; t=5.15, p<.000) after the implementation of the staffing model (Table 2).

In the staffing trial, I also tracked days with no floating at all inside and outside

the neighborhoods. I found a significant decrease in days with no floated hours inside the

neighborhood (33.6% vs 22.1%; chi-square=4.55, p=.003, while there was a significant

increase in days with no float hours outside the neighborhood after the intervention

(14.3% vs 24.3%; chi-square=4.50, p=.034). A comparison of hours within the

neighborhood was also completed. These resulted in an increase in floating within the

neighborhood, while decreasing floating outside of the neighborhoods. The one

exception to this was the heart-specific neighborhood; due to previous floating standards,

there was no difference between floating inside (p=.279) or outside (p=.887) after the

intervention.

Table 2 *Floating Hours Inside vs Outside the Neighborhood*

	Hours floated inside neighborhood	Hours floated outside the neighborhood
Mann-Whitney U	7256.000	4383.500
Wilcoxon W	16986.000	10054.500
Z	-3.629	-3.952
Asmp sig (2-taileds)	.000	.000

Within the DNP staffing trial, I also tracked days with no floating at all inside and

outside the neighborhoods. I found a significant decrease in days with no floated hours

inside of the neighborhood (33.6% vs 22.1%; chi-square=4.55, p=.003), while there was

a significant increase in days with no float hours outside the neighborhood after the intervention (14.3% vs 24.3%; chi-square=4.50, p=.034). Comparison of hours within the neighborhood was also completed. These resulted in an increase in floating with the neighborhood, while decreasing floating outside of the neighborhoods. The one exception to this was the heart-specific neighborhood; due to previous floating standards, there was no difference between floating inside (p=.279) or outside (p=.887) after the intervention.

Impact on Self-Efficacy

The survey that was developed included Schwarzer and Jerusalem's (1995) self-efficacy scale, with six questions related to floating and four demographic questions. The Mann-Whitney U test results showed that there was a statistically significant decrease in self-efficacy (U=5305, p<.001) between pre and the first post self-efficacy survey, which was not expected. Believing the Post 1 survey was possibility unexpectedly impacted by the sharp increase in census, the leadership team requested a third survey, 60 days after the implementation of the neighborhood staffing model. These data did present statistically significant findings between the pre and the third survey (Post2), (28.5 vs. 33.5; t=12.1, p<.001).

Perceptions of the Staffing Model

The neighborhood staffing model was implemented in a pilot over a 4-week period. With the completion of the pilot, it was decided to gather the nurses' perceptions of the model. A three, open-ended question survey was sent to the nurses in an electronic format. The data were collected in an anonymous fashion. When evaluating these

qualitative data, I found that there were three themes that were present. The two themes emerged included communication and leadership style and practice.

The first theme focused on communication, either in a negative or positive manner. The negative feeling was related to a lack of communication with the other neighborhoods leading to a feeling of increased stress. This lack of communication appeared more during the patient flow meetings. The staff members in the neighborhoods expressed that they developed a plan for their areas successfully only to have this plan changed an hour before the beginning of the shift by the house supervisor. Little explanation was shared with the neighborhood team when this occurred. It was also perceived that the communication between the two campuses had decreased. The positive communication was related to the neighborhoods working together. It was stated that "the nurse leaders from different neighborhoods have developed better teamwork through open communication related to staffing." These two neighborhoods began to meet together to look at the staffing needs for both areas.

The communication theme also related to building trust through transparency. Trust and transparency can be two difficult words when looking at the neighborhood model. When the neighborhood teams developed their staffing plan, if the house supervisor changed the plan and this was not adequately communicated, it resulted in a trust issue. The lack of transparency resulted in comments like: "why work out a plan if they are going to change it?" Trust was another issue when neighborhoods would share their staffing numbers. Prior to the neighborhood model, the nurse leaders would come together around the table sharing their numbers, all 19 of them. This took over an hour to

resolve a staffing plan; now it is done in smaller neighborhood groups. In addition, in the new neighborhood model, the staffing numbers for each neighborhood are posted on an electronic dashboard that all nursing leaders have access to, enhancing transparency and building trust in the process.

The second theme that emerged from the open-ended staff responses addressed leadership style and practice. This theme also included positive and negative. The negative was identified as feelings of frustration with the nursing leadership team. Balancing the staff scheduling is the responsibility of the managers. This was true prior to the implementation of the neighborhood model and it is also implicit within this new scheduling plan. Some nurse managers do this well, and some do not. This does not relate to floating, but it surfaced in the written comments. Several comments referenced a lack of responsibility in submitting an incomplete staffing plan, which by default, necessitates floating. Words like "no leadership accountability" were stated in the survey. The leadership team was to meet with the neighborhood units on a weekly basis to identify opportunities for being proactive with staffing numbers.

Although there were some negative comments that emerged, the positive management comments represented the majority. Words like empowered, teamwork, proactive, and limited floating surfaced. The positive management theme was related to the leaders being proactive with staffing on a daily basis. Limiting the floating between the two campus was also part of the survey data. These qualitative data assisted the leadership team in developing a standard practice and continue with this staffing model.

Unanticipated Limitations and Outcomes

One positive outcome that was identified was the relationship that developed within the one campus. The nursing leader teams within these two neighborhoods developed strong communication skills, personal relationships, and strong team work between the neighborhoods. They supported each neighborhood during difficult times that resulted from a sudden influx of patients. The overall impact was a strong positive team on the one campus.

The implementation of the neighborhood staffing model was completed over a 4-week period. During this time, the hospital experienced a sharp increase in patient volume. In the course of this period of time, there was a need to open and support three different overflow areas within the two campuses, with additional patients held overnight or boarded within the emergency rooms. Between the two campuses, there was a need for 11 extra nurses and four patient care techs. This sharp increase of patient census impacted the morale of the nursing teams at times. Consistently working at minimal staffing can be difficult, especially when caring for patients in an unfamiliar environment. This was different from the original data collection period, during which time the patient census had been much lower. The sharp increase in census affected the nurses' confidence and was a concern of the leadership team. Being aware of this variable, it was decided to pull the census data comparing the 2 months used for this project. The distribution of the census was highly skewed to the right with a skewness index larger than one. The census was tested for normality using the Kolmogorov-Smirnov and the Shapiro-Wilk, which both showed a statistical significance, indicating the lack of a

normal distribution and the need for nonparametric statistics. The census was divided out into neighborhoods for data analyses. There were 18 days with overflow patients in the pre invention data. The neighborhood pilot data showed 54 days with overflow patients. The chi square was used to compare days with overflow patients pre and post intervention. The data showed a statistically significant increase in the proportion of days with overflow (12.9% vs 38.9%): chi-square=24.2, p=.001, which may explain why the self-efficacy data at the second survey administration (Post1) went down, the opposite direction other than expected.

The flexibility of the neighborhood model did allow the different teams to focus on overflow areas. This created a temporary unit within each neighborhood. Allowing each neighborhood to focus on a set area gave them some sense of control during a difficult situation. This flexibility was one of the benefits that the neighborhood model demonstrated.

The neighborhood staffing model intended to group nursing units within teams. These groups were proposed in relationship to their patient population and location within the two hospitals. The statistically significant decrease in floating hours outside of the new defined neighborhood was a positive for this QI project. The encouraging results endorsed the continual development and consistent practice within the neighborhoods.

Self-efficacy can be identified has having confidence in the skills a person has developed. This self-reliance ability to adapt to the environment a person is subjected to can be altered related to other variables. The initial decrease in self-efficacy could be correlated to the increase in the sheer volume of patients during the implementation. I

identified that floating was a useful process in the health care environment that helps to balance the needs of the patients with available nurses, especially during dramatic changes in census that are unrelated to anticipated seasonality. Although this model did not result in an increase in nurse self-efficacy initially, it was thought the uncontrollable variable of the sharp increase in census created an unexpected impact on the nursing team.

Though I expected a return to preimplementation census levels, this did not occur. Regardless, the organization continued to implement the neighborhood staffing model beyond the initial 4-week trial. To further evaluate the impact of the neighborhood model, a third self-efficacy survey was completed 8 weeks after the neighborhood staffing model was implemented. The third survey showed that there was change in the self-efficacy results between the first two surveys that showed a decrease in self-efficacy and the last survey. The data demonstrated a statistically significant increase over the Pre- and Post 1 survey levels. This statistical significance could be related to the consistent use of the neighborhood model. Consistent use of neighborhood model over time may have contributed to nurses' development of improved self-efficacy.

Recommendations

The recommendation for this QI project will be to continue the neighborhood model for the nursing teams due to the positive response from the nursing team. I found improved self-efficacy with the third survey, which allowed the nursing team to develop comfort with the model. I identified that the census may have been a negative influence in the nurses' feelings of self-efficacy. It is almost impossible to control fluctuating

census in the hospital setting. However, reducing uncertainty as to the nursing units where nurses float may decrease their anxiety and stress. The decrease in floating outside the neighborhoods was a positive improvement for the organization. The leadership team completes rounding on staff on a monthly basis. During this rounding, the neighborhood staffing model was shared as a benefit for the nursing staff related to the increase in communication and team work.

The next recommendation will be to develop an educational path for the different neighborhoods allowing nurses to experience each of the units within their neighborhood prior to their first independent float experience. This can be done during a new staff member's orientation while they are with a preceptor. This will support the nurses feeling more confident within their skills and the environment while having that one-on-one support.

Finally, I am recommending the development of a neighborhood advisory committee. This committee with serve as a governing body for the staffing throughout the two county hospitals. The members of this team will come from the original steering team and expanded to include nursing members from other neighborhoods that are not currently represented. This committee with have a one or two year term, allowing half of the membership to be replaced every year. This model will also develop a level beneath the advisory committee which is considered the neighborhood operations team. This group would continue to work within the neighborhood- addressing any barriers or issues with may occur. The operational team include members from within each of the nursing units that are members of that neighborhood. These key developmental plans will assist

the nursing teams in the continued development and an the sustainability of the neighborhood staffing model.

Strength and Limitations

Clinical nurses were champions in supporting the neighborhood model conceptually, even before the pilot began. The nursing team within the two hospital campuses were frustrated with floating to as many as 19 different units. The neighborhood model emerged as a way to improve nursing self-efficacy by developing a model that limit where nurses would float to. I believe this is the single largest strength of this project. The bedside nurses were a driving force behind this model, this allowed for easy acceptance of the concepts of the neighborhood staffing model.

This model was developed intending to improve nursing job satisfaction related to floating through improved self-efficacy feelings. Duffield, Diers, O'Brien-Pallas, Aisbett, Roche, et al (2011) showed that nurses, when floating, had a decrease in time management skills, there was a decrease in patient progression and potential for safety risks for the patient. This model allowed the nurses to define a certain peer group and develop skills and comfort within each of the neighborhood units. This allows for better time management and overall improved patient care. The increased patient volume beyond seasonality projections presented an unexpected limitation during project implementation. There were three overflow areas as well as patients waiting in the emergency room for admission that resulted in an extreme anxiety within the clinical teams. Limiting what neighborhood would staff overflow areas allowed for some confidence within the neighborhoods.

Section 5- Dissemination Plan

Dissemination Plan

Sharing information and best practices are the keys to continuing to promote and inspire nursing practice. This QI project was motivated by the clinical nurses within one of the neighborhoods. Sharing data can be completed in several ways, and identifying the audience is the first step. There are currently four groups that will need to understand the results and how this affects nursing. A report on this DNP project will be shared with the neighborhood steering team and the nursing QOL committee in the form of graphs and a small presentation to explain the information. Both of these groups were invested in this project from the beginning. The two other groups include the professional practice committee and the nursing leadership team. Presenting the project in a manner that allows for understanding help share this information.

Nursing development and sharing of knowledge should the goal of every nurse. Nursing projects need to be shared outside of a person's health system to continue to demonstrate application of evidence in a variety of settings. Sharing projects or best practices allows other professionals to see what has been accomplished. Nursing is part of a network that shares information that allows others to follow in their path. This project will be submitted to the DNP's state nursing association as an abstract for a poster presentation or a podium presentation. This staffing model that could be used in many different professionals' teams. Sharing knowledge at different levels along with different

venues allows for the spread of knowledge and best practice. Developing a manuscript for journal publication will also be a part of my future agendas.

Analysis of Self

My role as the DNP project leader and facilitator has been exciting, overwhelming, frustrating, and fulfilling. I experienced the role as scholar while working with the nursing team through the planning, implementing, and the result phase. This type of information was completed in many forms that included research, evidence-based practice, and model for behavior changes. The nursing team wanted to develop a model that could work for all of the nurses within the two hospitals. The neighborhood staffing model was developed after assisting the team in the literature review, identifying evidence that was developed as a best practice.

The project manager role was one of those roles that allowed me to expand my knowledge, increase my visibility with different leadership levels within the hospital, and be a catalyst change within nursing. Permitting me to be the face of the neighborhood brought an unofficial level of support from the leadership team. Distinguishing that this idea emerged from the clinical nurses protected the development of the project. Knowing it was designed to be staff-driven made it even more personal for me. One of my long-term goals has been to be a supporter of the clinical staff at whatever level of leadership I take on. Taking on the development and implementation of the neighborhood staffing model as my DNP project kept me connected with the clinical staff working with them side by side. In working with this group, it permitted the lines of communication to stay open, supporting the clinical staff while working through this project.

The largest challenge for me personally was overcoming negative attitudes and prejudices of my peers. This project was the result of clinical staff members' collective voice, addressing their frustration with staffing. My leadership peers struggled with this project because the bedside nurses who brought it forward had limited nurse vacancies within their nursing units. This led to the fear their nurses would be mandated to staff some of the neighborhood teams having a higher rate of nurse vacancies. The team set boundaries for this actual concern, stating that the patient would continue to be the focus of the staffing. It was a continual process of communication to keep them informed and supported and ensuring they had what they needed. It was fascinating to see how three of the five neighborhoods experienced better team work and collaboration of their neighborhoods related to staffing. The process challenged me to focus differently, allowing the culture of different neighborhoods to be the driving force of change. Continuing to practice at the leadership level within this health care system supporting staff-driven projects will continue to be my focus.

Summary

Hospital staffing is difficult at many levels within nursing. Ensuring every patient has a nurse with the right skill set who can care for them is significant. The neighborhood staffing model was developed by clinical staff to allow the practice of floating to continue within set boundaries. This model allowed nurses to float within a defined neighborhood that connected like units. Nurses who float to specific neighborhoods developed a comfort level with these areas that resulted in improved self-efficacy. I examined nursing hours within the neighborhood, outside the neighborhood,

and the nurses' self-efficacy scores before and after the pilot on two separate occasions. Although the self-efficacy scores did not show improvement during the original trial, repeating the self-efficacy survey after 60 days of implementation of the neighborhood model did show improved self-efficacy. Developing consistent practice would allow for nurses to develop comfort with the model resulting in improved self-efficacy.

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Appendix A: Nurse Survey

1 = Not at all true   2 = Hardly true   3 = Moderately true   4 = Exactly true

1. When floating I can always manage to solve difficult problems if I try hard enough.

2. When floating to an area and someone opposes me, I can find the means and ways to get what I want.

3. When floating it is easy for me to stick to my aims and accomplish my goals

4. When floating I am confident that I could deal efficiently with unexpected events.

5. When floating –due to my resourcefulness, I know how to handle unforeseen situations.

6. When floating I can solve most problems if I invest the necessary effort.

7. When floating I can remain calm when facing difficulties because I can rely on my coping abilities.

8. During floating if I am confronted with a problem, I can usually find several solutions

9. When floating if I am in trouble, I can usually think of a solution.

10. When floating I can usually handle whatever comes my way.

11. When I float I feel comfortable with the units I am assigned to

12. When I float my stress level increases when I have to go to a unit I am unfamiliar with

13. When floats come to my unit I feel they are prepared

14. When floating it is consistent with the nurse leader making the decision.

15. When floating I can handle any patient population

16. When floating with the neighborhood I am familiar and have peer to assist me

17. What is my age group: 22-30, 31-45, >45

18. What is my experience: 1-3 yrs., 4-8yrs, 9-15, >15

19. Education level: Diploma, ASN, BSN, MSN

20. Role: RN, NL

Nurse Perception- Open ended questions

1. Tells us your thought of the neighborhood staffing model?

2. Tell us about your experience within your neighborhood?

3. How does your team work with the neighborhood model?