Strategies for Staff Empowerment and Patient Advocacy in Critical Care

Kathleen M. Vollman MSN, RN, CCNS, FCCM, FCNS, FAAN
Clinical Nurse Specialist / Educator / Consultant
ADVANCING NURSING
kvollman@comcast.net
Northville, Michigan
www.vollman.com

Disclosures

- Consultant-Michigan Hospital Association Keystone Center
- Subject matter expert for CAUTI, CALBSI, CDI, Sepsis, HAPI and culture of Safety for HIIN/CMS
- Consultant and speaker bureau:
  - Sage Products, a business unit of Stryker
  - LaJolla Pharmaceuticals
  - Baxter Healthcare

Objectives

- Explore practical strategies for empowering ICU staff to enhance team collaboration and resilience
- To highlight the critical roles of nurses as advocates for patient rights and quality care
- To equip participants with tools to foster a culture of empowerment and advocacy in critical care settings

Nurse Engagement & Staying
Part of the Quadruple Aim in Healthcare

Work engagement is defined as a positive and satisfying work related state of mind

Bamford M, et al. J of Nursing Management, 2013;21:529-540

Factors That May Chip Away at Nurses:
Making Engagement and Empowerment Challenging

- Lateral violence/verbal abuse
  - Communication issues are 77% of the reason for errors
  - If nurses don’t feel respected, they don’t share information
  - One of the major reasons why nurses leave the profession, complaint of burnout or job dissatisfaction, lose capacity for caring
- How nurses feel about ourselves
  - If nurses feel belittled, patronized it shatters are confidence making it difficult to advocate
- Poor quality of work environment
  - Low autonomy, missing equipment, insufficient staff, poor design in technology
  - Performing non patient care activities

Gurses AP. Applied Ergonomics, 2008:1-10
Silence Kills, AACN

Impact of Nurse Engagement

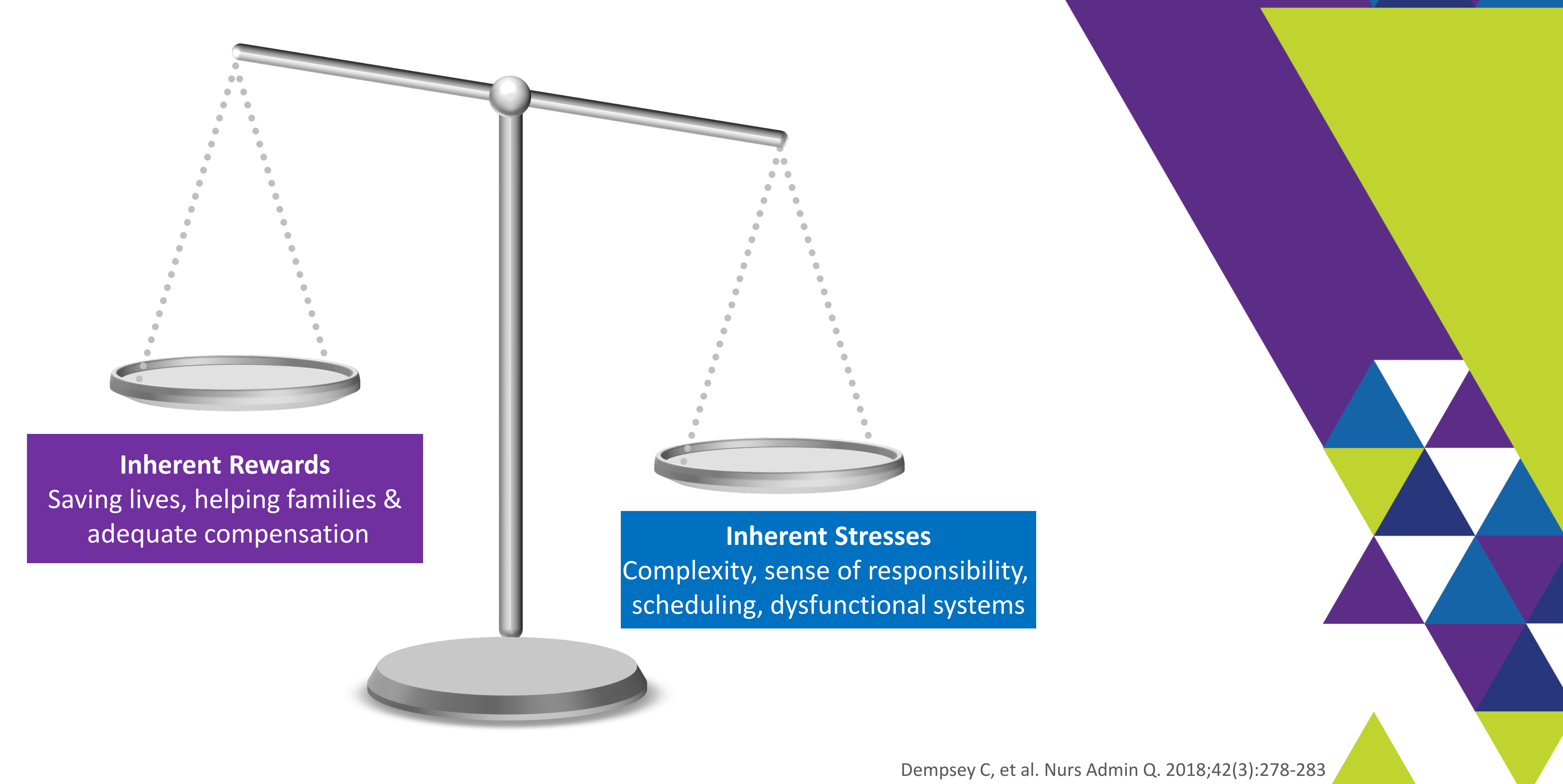
- Influences patient experience
- Improvement in clinical quality (NSO's)
- Patient outcomes
- Nurse retention
- Reduces compassion fatigue & burnout
- Improves teamwork

Impact of Disengaged Nurses

- 15 out of every 100 nurses disengaged
- $22,000 per nurse in loss productivity
- Impact on HCAPS
  - Teamwork, nurse communication & cleanliness as primary drivers
- Turnover

Dempsey C, et al. Nurs Admin Q. 2018;42(3):278-283

Engagement vs. Burnout

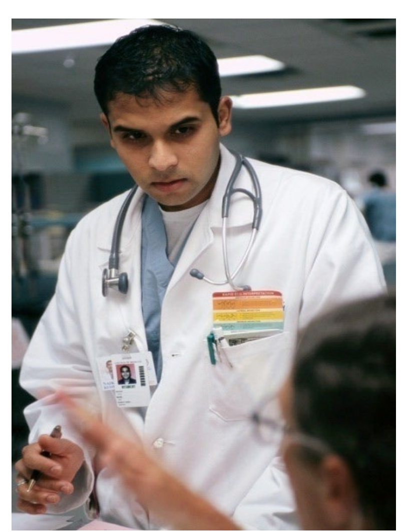


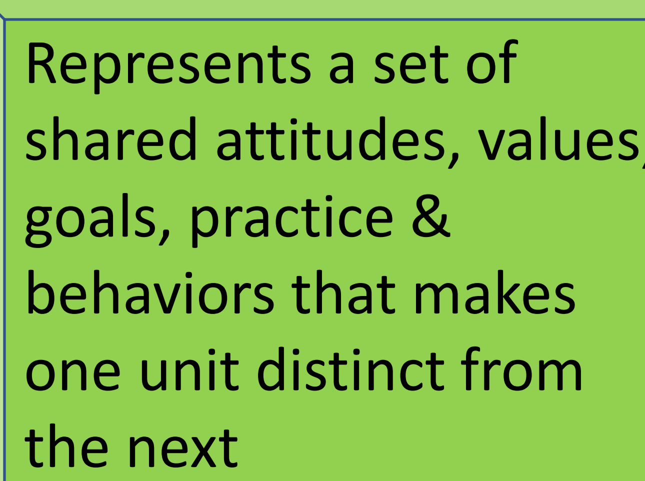
Dempsey C, et al. Nurs Admin Q. 2018;42(3):278-283

Factors Influencing Job Satisfaction/Staying Power

- Work environment/culture
  - Burnout , autonomy , teamwork or peer support , communication, recognition , feedback, routinization of work and pay
- Nursing characteristics or mobility factors
  - Ethnicity, age, martial status, nurse experience, educational level, shift type/ length, type of unit, availability of other jobs in the community, & organizational commitment or loyalty
- Organizational characteristics
  - Fairness, promotions, professionalism, career commitment and value congruence
- Manger/leader characteristics
  - Open communication, leadership style, follow through & support, authenticity

What is a Culture?





Assessing the Culture

Can we change practice through process improvement alone?

Will successful change require an altering of the value structure within the unit?

Assessment of Safety & Work Culture

- SAQ (Safety Attitudes Questionnaire)
  - Teamwork
  - Safety
  - Working conditions
  - Job satisfaction
  - Stress recognition
  - Perception of upper management
  - Perception of unit management

Strive for 80%, if < 60% SAQ scores correlates to decreases in clinical outcomes

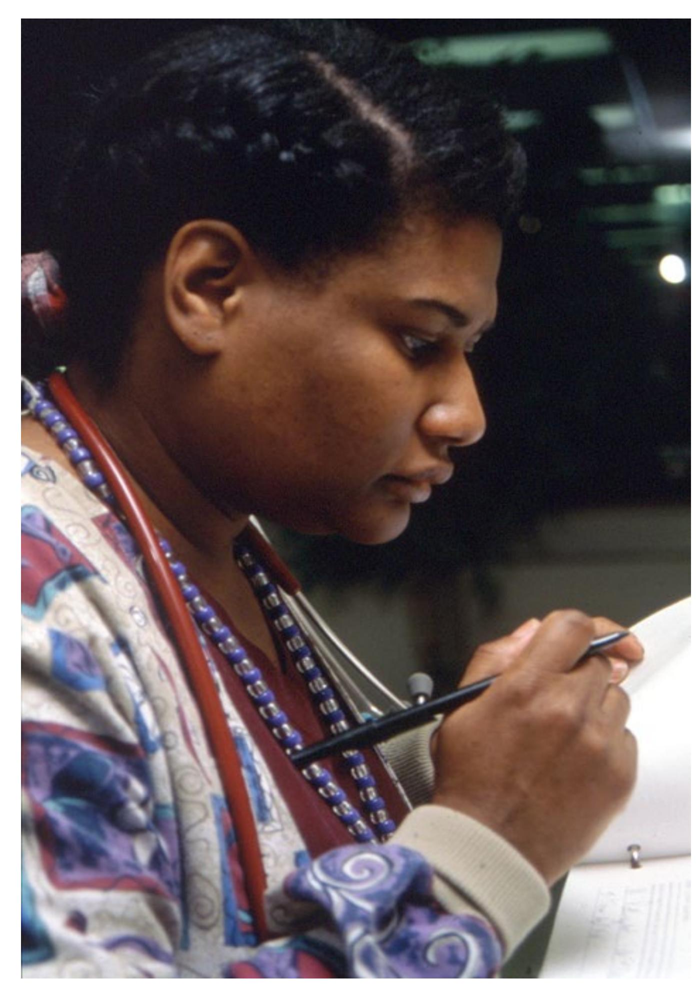
AACN Healthy Work Environment Assessment

- Skilled communication
- True collaboration
- Effective shared decision making
- Appropriate staffing
- Meaningful Recognition
- Authentic Leadership

https://mini.aacn.org/dm/HWE/TabbedAdminHome.aspx

Number	Question
1	Administrators, nurse managers, physicians, nurses and other staff maintain frequent communication to prevent each other from being surprised or caught off guard by decisions.
2	Administrators, nurse managers, and physicians involve nurses and other staff to an appropriate degree when making important decisions.
3	Administrators and nurse managers work with nurses and other staff to make sure there are enough staff to maintain patient safety.
4	The formal reward and recognition systems work to make nurses and other staff feel valued.
5	Most nurses and other staff here have a positive relationship with their nurse leaders (managers, directors, advanced practice nurses, etc.).
6	Administrators, nurse managers, physicians, nurses, and other staff make sure their actions match their words□they "walk their talk."
7	Administrators, nurse managers, physicians, nurses, and other staff are consistent in their use of data-driven, logical decision-making processes to make sure their decisions are the highest quality.
8	Administrators and nurse managers make sure there is the right mix of nurses and other staff to ensure optimal outcomes.
9	Administrators, nurse managers, physicians, nurses, and other staff members speak up and let people know when they've done a good job.
10	Nurses and other staff feel able to influence the policies, procedures, and bureaucracy around them.
11	The right departments, professions, and groups are involved in important decisions.
12	Support services are provided at a level that allows nurses and other staff to spend their time on the priorities and requirements of patient and family care.
13	Nurse leaders (managers, directors, advanced practice nurses, etc.) demonstrate an understanding of the requirements and dynamics at the point of care, and use this knowledge to work for a healthy work environment.
14	Administrators, nurse managers, physicians, nurses, and other staff have zero-tolerance for disrespect and abuse. If they see or hear someone being disrespectful, they hold them accountable regardless of the person's role or position.
15	When administrators, nurse managers, and physicians speak with nurses and other staff, it□s not one-way communication or order giving. Instead, they seek input and use it to shape decisions.
16	Administrators, nurse managers, physicians, nurses, and other staff are careful to consider the patient's and family's perspectives whenever they are making important decisions.
17	There are motivating opportunities for personal growth, development, and advancement.
18	Nurse leaders (managers, directors, advanced practice nurses, etc.) are given the access and authority required to play a role in making key decisions.

Driving Components in a Work Culture



Number 1 Respected Profession

Nursing

Gallup Poll: 82% Honesty & Ethical Rating

So Why Don’t We Feel Respected?

Reclaiming Professional Respect

Work Environment

Quality of Care You Provide to Patient & Families

What Behaviors or Communications Make You Feel the Recipient of Respect?

Feeling of Respect or Not being Respected

- Respected
  - Feeling listen to
  - Feeling revered for their knowledge
  - Feeling trusted
  - Feel part of the group
  - Being acknowledged
  - Sense of belonging/contributing
  - Persons look out for each other and their support
  - Fairness
  - Free to speak
  - Opportunities to excel

- Not Being Respected
  - Disregarded
  - Not revered
  - Not trusted
  - Not supported
  - Not recognized
  - Closed conversation
  - Speaking in a tone that is demeaning
  - Ideas and opinions not considered a value priority
  - Unsafe, guarded, pressured, put down

Bournes DA, et al. Nursing Science Quarterly, 2009;22(1):47-56

Self Respect

External Dialogue

Culture of Respect

- Develop effective methods for responding to episodes of disrespectful behavior
- Initiating cultural changes needed to prevent the episodes
- Organization set up a code of conduct and it must be enforced
- Culture of respect requires building a shared vision

The Road to Respect

I spoke.

You listened.

I felt valued and honored.

You shared your opinion.

I trusted your wisdom.

The circle of respect was complete.

We saw in each other's eyes are common humanity.

Now, moving to a zone of mutual affirmation, we felt safe to trust and learn and nurture in the give-and-take of life.

Yasmin Morais 2006

How do We Get There?

Grass Roots Unit-Based Culture Change

Re-valuing & recognition of nursing unique contribution

Engagement
Safety Climate

Creating an Environment that Fosters Autonomy

- Nurses sense of control over their own practice (Manager)
  - Ability to make decisions about daily nursing practices
  - Ability to perform their job independently by creating clinical decision-making guidelines
  - Through participative leadership support shared governance, involvement in interview process, involvement in evidence-based practice, policy and procedures and find creative ways to engage staff and get opinions.
- More staff engagement over their work (Manager)
  - Self scheduling
  - Open/closed units, on call
  - Set value structure-family, school, etc
  - Time to participate
  - Visability

Tang JHC, et al. Journal of Gerontological Nursing, 2019;45:11-19

Florence Nightingale …

An expert in nursing’s autonomous scope of practice

- Surveillance & monitoring of patient conditions for early detection of problems
- Preventing complications

“I use the word nursing for want of a better. It has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet—all of these at the least expense of vital power to the patient”

Notes on Nursing (1860/1969 p. 8)

Florence Nightingale on:

"… so deep-rooted and universal is the conviction that to give medicine is to be doing something or RATHER EVERYTHING; to give air, warmth, cleanliness, etc., is to do nothing."

(emphasis added) Notes on Nursing, (1860/1969, pg. 9)

Missed Nursing Care

- Any aspect of required patient care that is omitted (either in part or whole) or significantly delayed.
- A predictor of patient outcomes
- Measures the process of nursing care

Kalish, R. et al. (2012) Am Jour Med Quality, 26(4), 291-299.

Hospital Variation in Missed Nursing Care

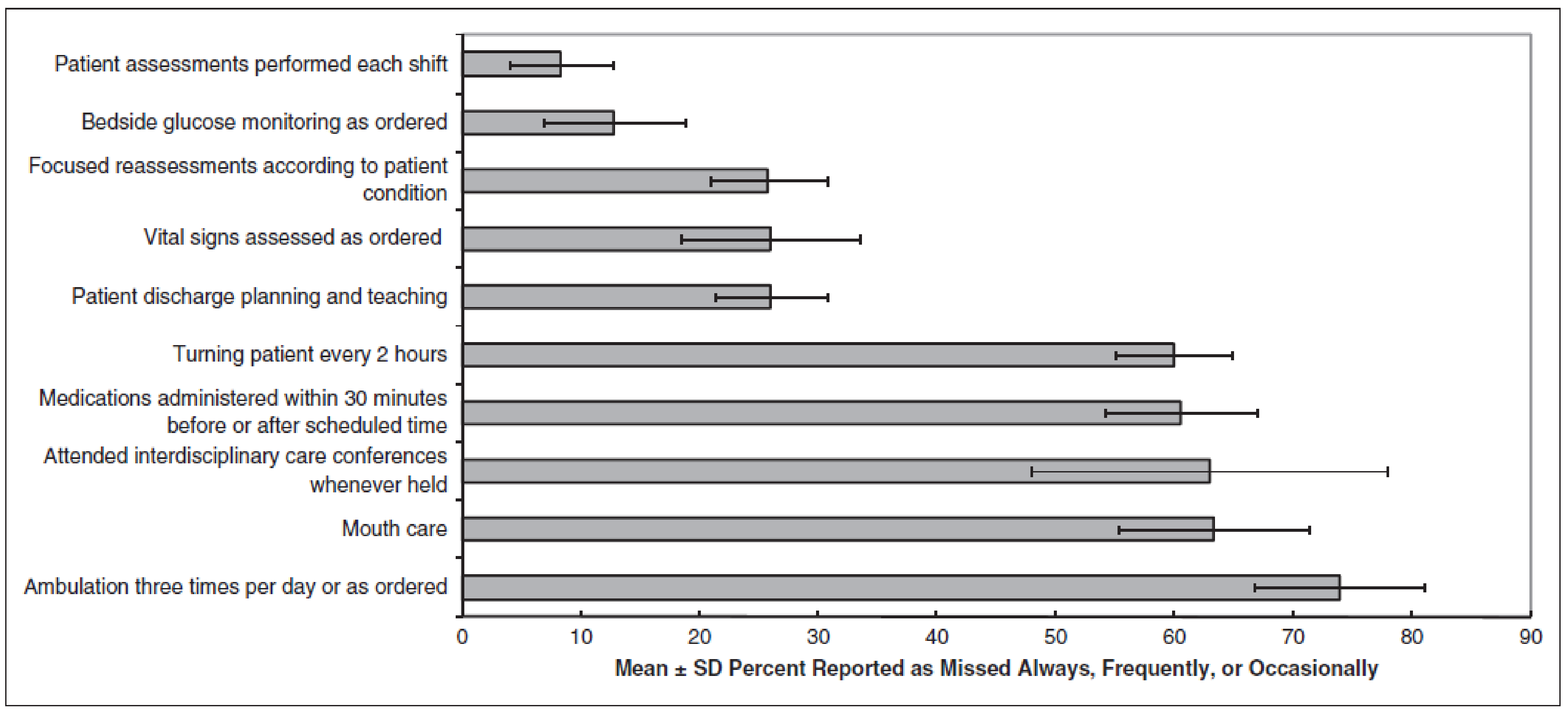


Figure 2. Elements of care most and least frequently missed. The solid bars represent the means across all 10 hospitals, and the range lines indicate the standard deviations.

Kalish, R. et al. (2012) Am Jour Med Quality, 26(4), 291-299.

Patient Perceptions of Missed Nursing Care

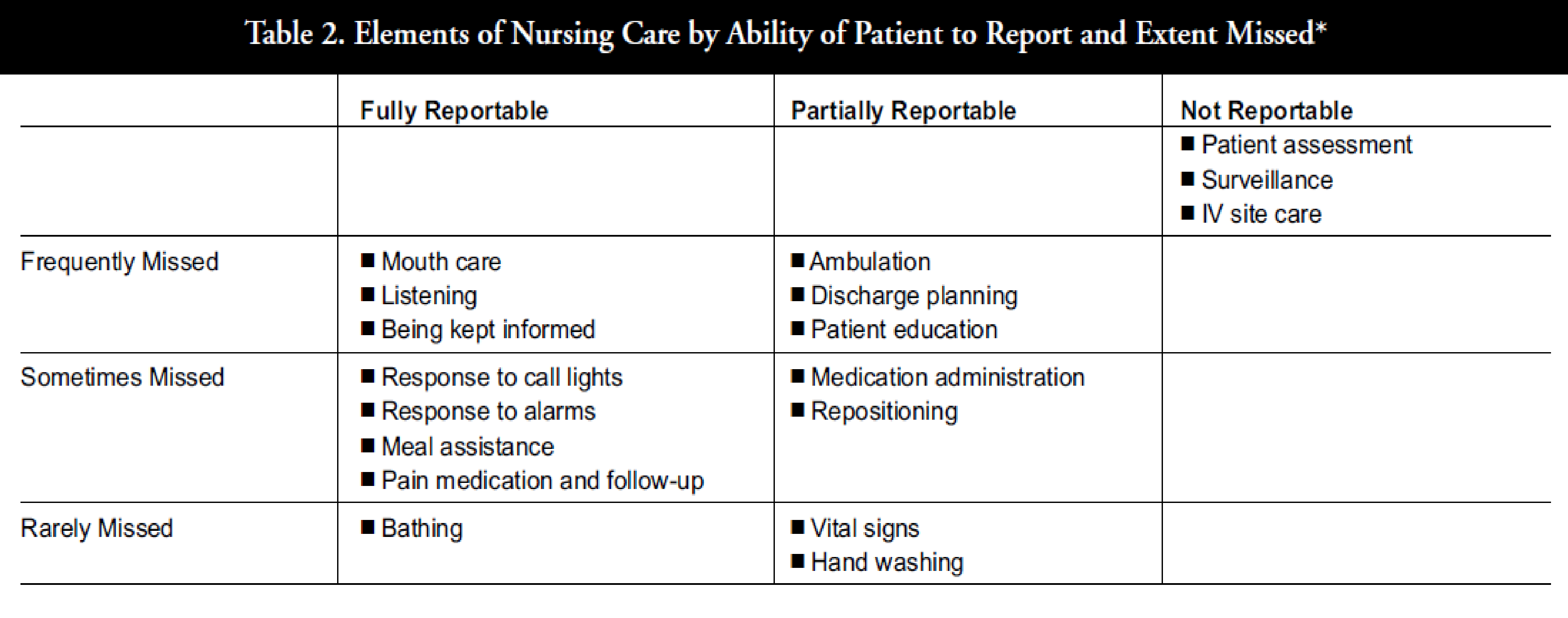


Table 2. Elements of Nursing Care by Ability of Patient to Report and Extent Missed*

	Fully Reportable	Partially Reportable	Not Reportable
			■ Patient assessment ■ Surveillance ■ IV site care
Frequently Missed	■ Mouth care ■ Listening ■ Being kept informed	■ Ambulation ■ Discharge planning ■ Patient education	
Sometimes Missed	■ Response to call lights ■ Response to alarms ■ Meal assistance ■ Pain medication and follow-up	■ Medication administration ■ Repositioning	
Rarely Missed	■ Bathing	■ Vital signs ■ Hand washing	

* IV, intravenous.

Kalisch, B et al. (2012). TJC Jour Qual Patient Safety,38(4), 161-167.

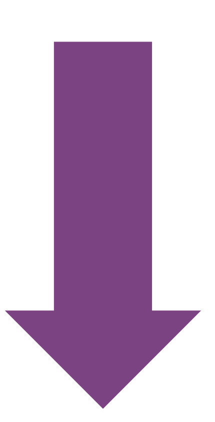
Reconnect With Our Professional Purpose

"It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm."

Florence Nightingale

Advocacy = Safety

Protect The Patient From Bad Things Happening on Your Watch



Interventional Patient Hygiene

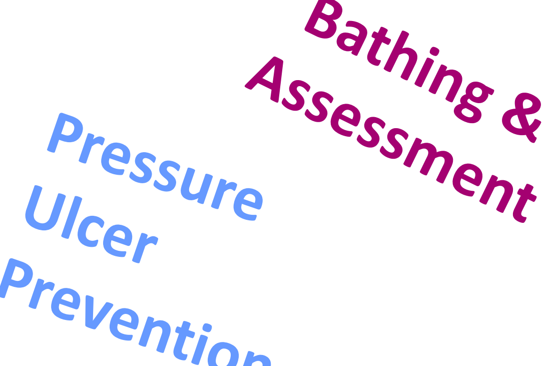
- Hygiene…the science and practice of the establishment and maintenance of health
- Interventional Patient Hygiene….nursing action plan directly focused on fortifying the patients host defense through proactive use of evidence-based hygiene care strategies

Hand Hygiene

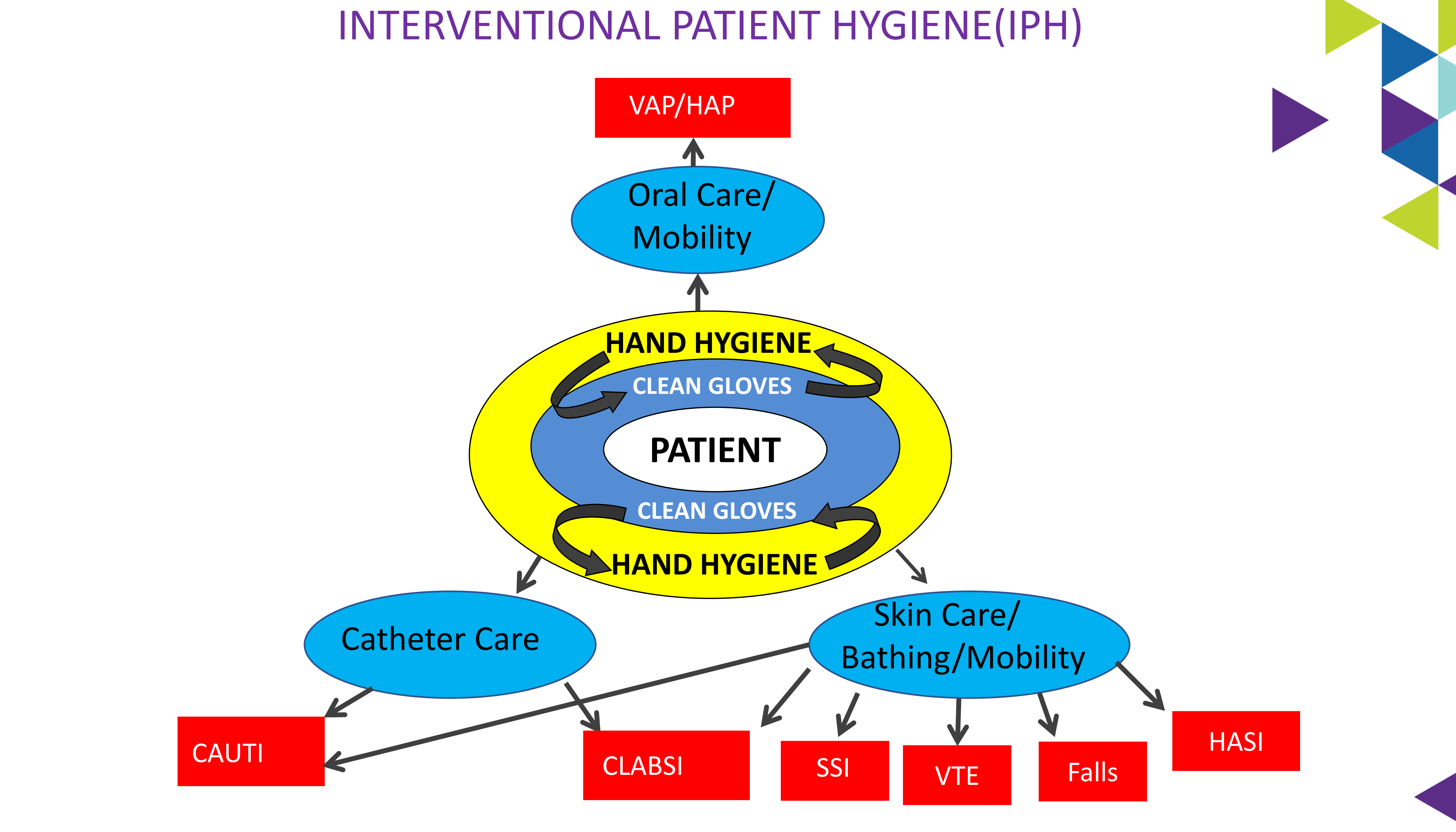
Catheter Care

Comprehensive Oral Care Plan

Incontinence Associated Dermatitis Prevention Program

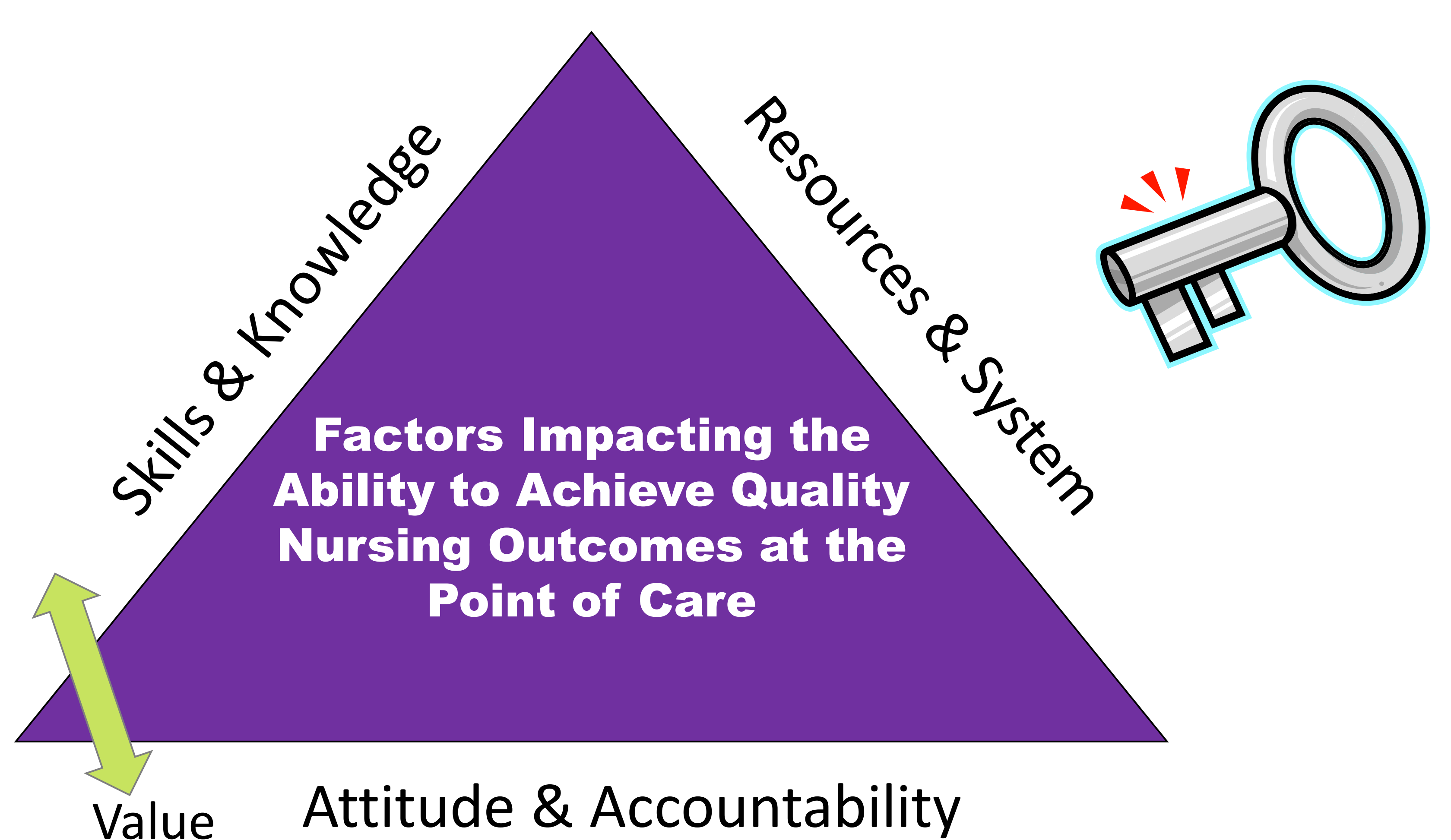


INTERVENTIONAL PATIENT HYGIENE(IPH)



Vollman KM. Intensive Crit Care Nurs, 2013;22(4): 152-154

Achieving the Use of the Evidence



Vollman KM. Intensive Crit Care Nurs, 2013;22(4): 152-154

Organizational & Unit Structures that Supported the Empowerment & Engagement

Shared Governance Model

Professional Practice Model/Clinical Ladder

Unit Based Leadership Model

Educational Support

Continuous Quality Improvement Model

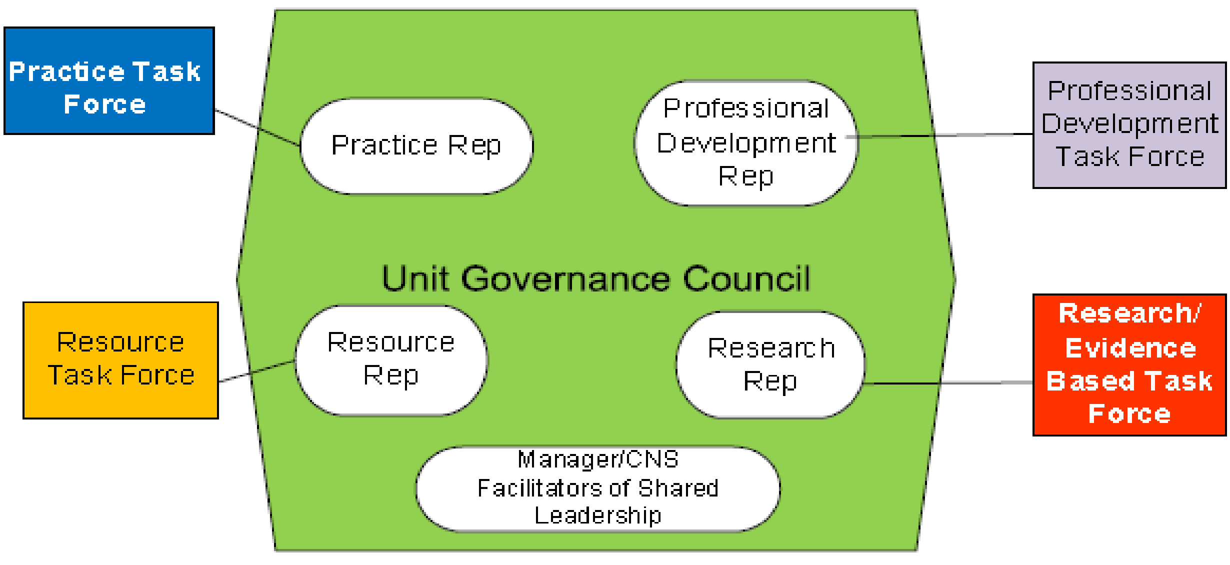
Foundational Principles to Maximize Staff Empowerment & Engagement

- Share Governance = Shared Leadership of Practice/Ownership
- Shared governance is a structural model that frames the professional practice within health care settings (Porter-O'Grady, 2012).
- Shared governance empowers nurses to participate in decision making, nursing practice, and development of nursing policies (Bednarski, 2009).
- The Unit is the center of a shared governance model..the locus of control is at the point of service

Foundational Principles to Maximize Staff Empowerment

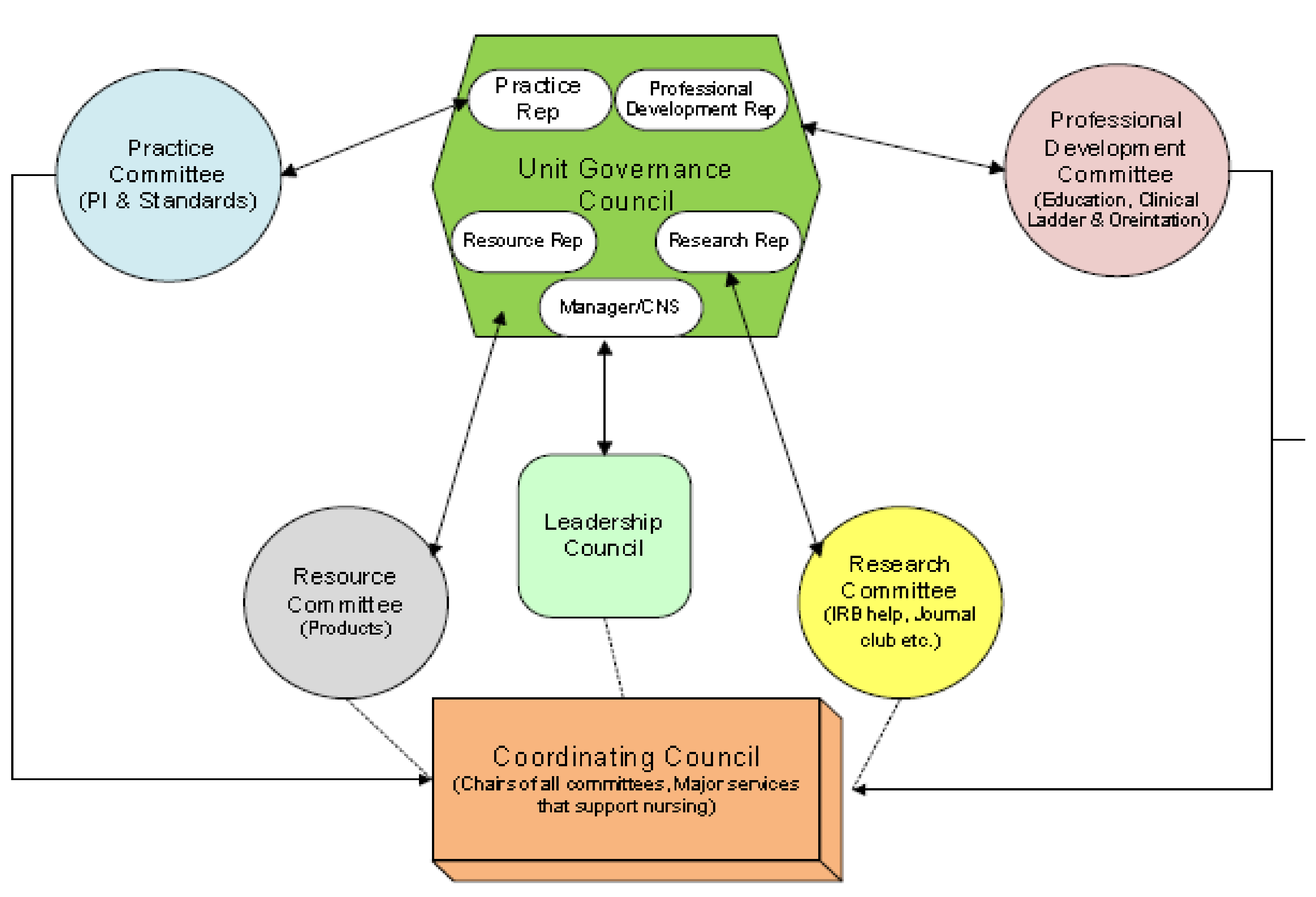
- Staff need mentoring and leadership coaching
- Shared leadership means the clinical and administrative lead of the unit are part of the unit practice/governance council
- Defined accountability of all members
- Sufficient time in meetings to formulate ideas and plan work (unit meeting 4hrs)

Ideas for Unit Model to Enhance Staff Engagement

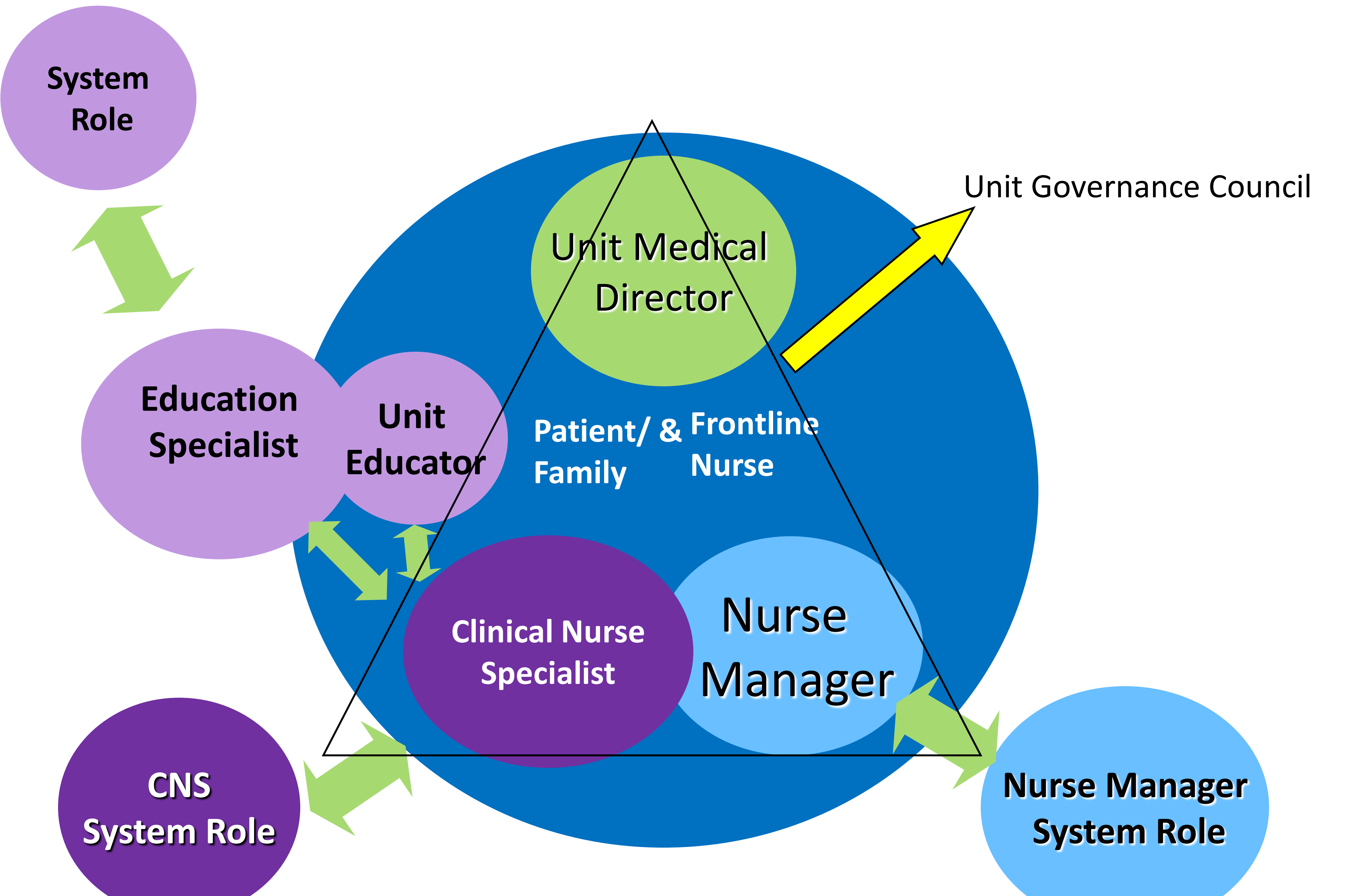


- The number of staff/size of the unit determines the number of members of the UGC
- Representatives to the UCG will be elected for a 2 year term with election rotations that permit only half of the members to off the council at anyone time
- Each member of the UGC (other than leadership) has 5-6 staff that are thier constituents for feedback coming to & from the UGC

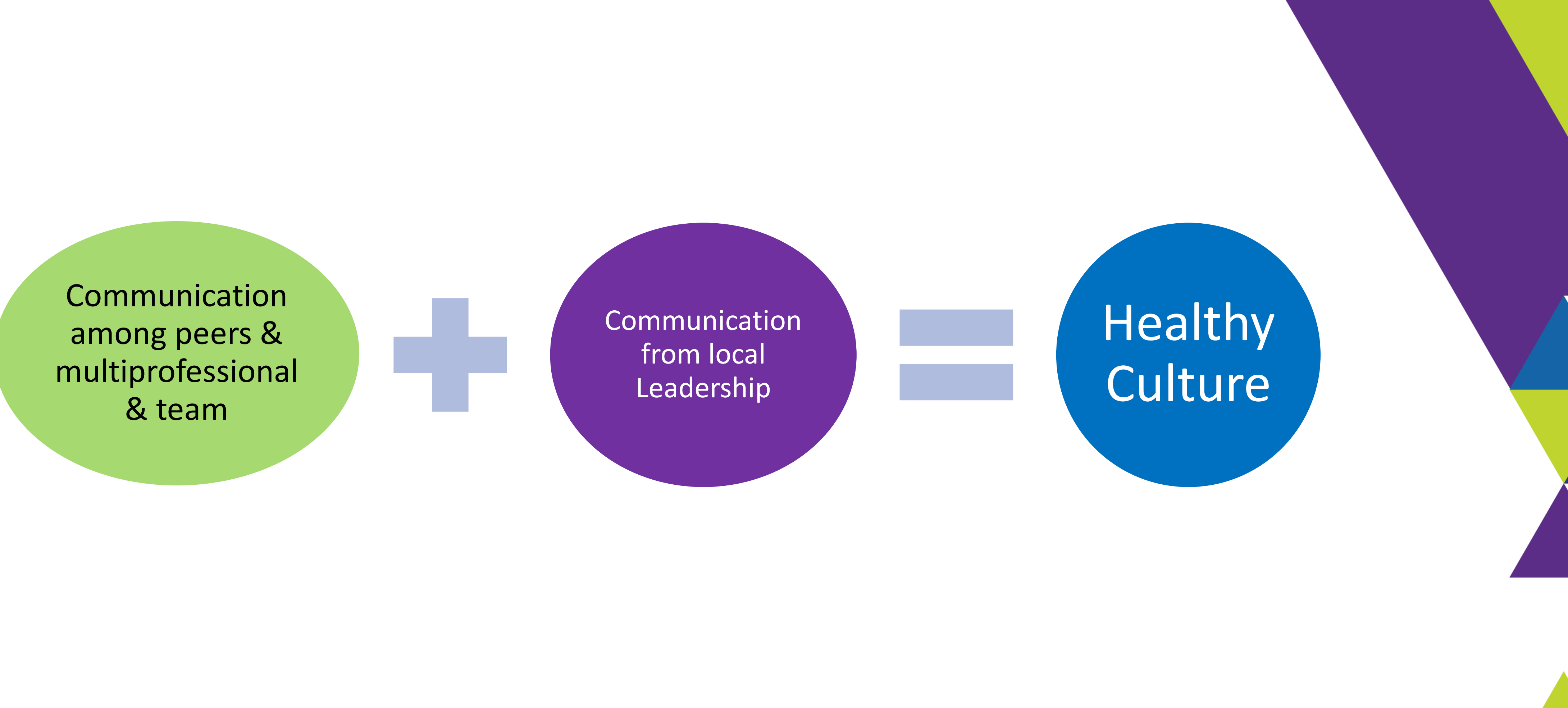
Shared Governance Ideas



Empowered Work Environment



Communication



Why Effective Communication May Be Challenging for Nursing

Self Respect

Communication

Advocacy

Patient Safety

This Photo by Unknown Author is licensed under CC BY-SA

The single biggest problem with communication is the illusion that it has taken place

George Bernard Shaw

The Silent Treatment: April 2011

- 85% of workers- safety tool warned them
- Safety tools include: handoff protocols, checklists, COPE, automated medication dispensing machines.
- 58% said they got the warning but didn't speak up

Why:

- 1/2 say shortcuts lead to near misses
- 1/3 say incompetence leads to near misses
- 1/2 say disrespect prevented them from getting others to listen or respect their opinion

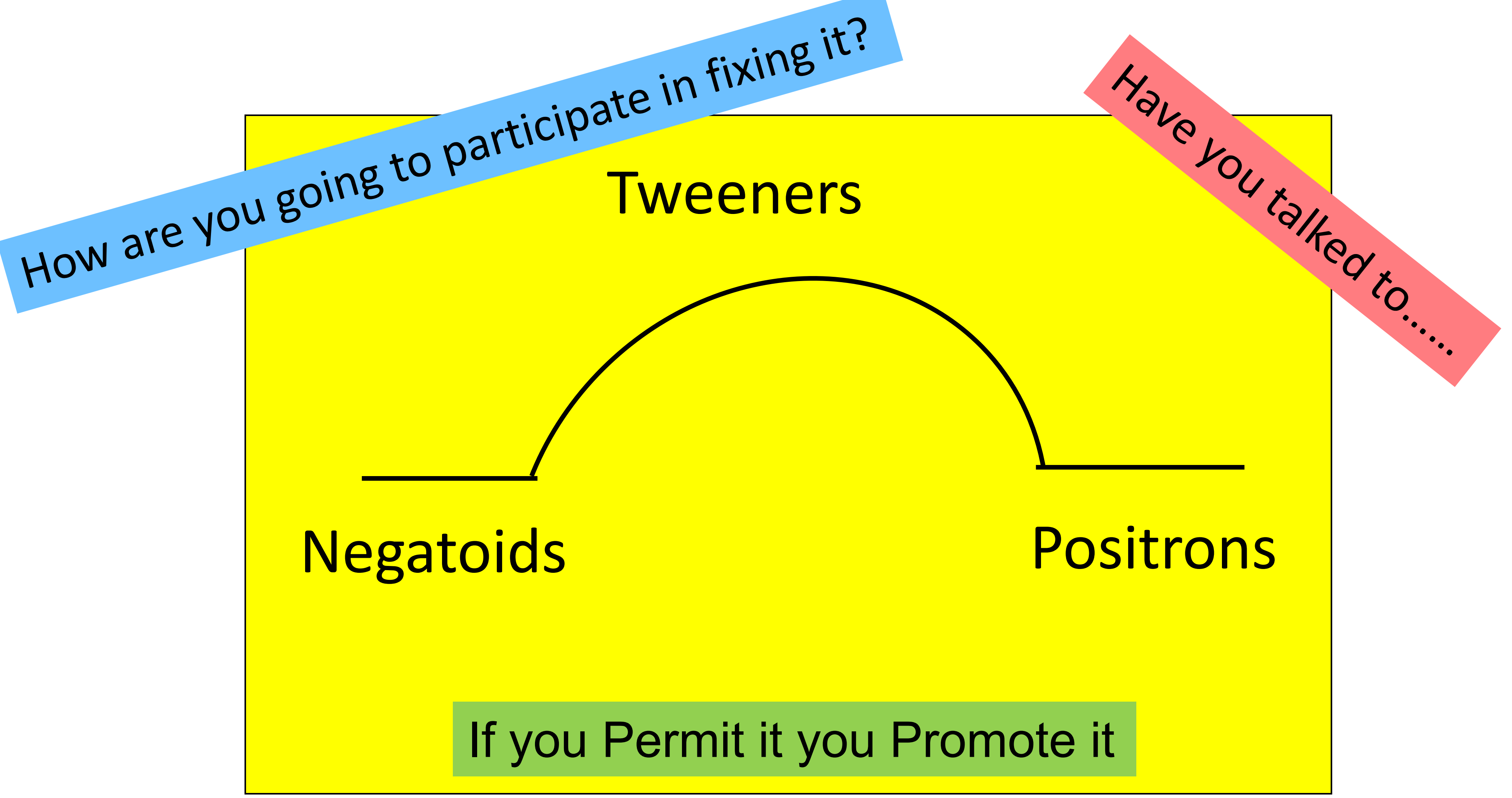
Only 16% confronted the disrespectful behavior

http://www.silenttreatmentstudy.com

“Our lives begin to end the day we become silent about things that matter”

Martin Luther King Jr.

Unit Culture Assessment & Communication



What to Do?

- Prevent from occurring through training on effective communication
- Deal in real time to prevent staff or patient harm
- Initiate post event reviews, action and follow-up
- Make it as transparent as possible
- Zero-tolerance policy and procedure
- Intervention strategy: code white

Leadership Communication Critical to Engagement

- Establish strategic clinical plan and goals with unit governance council
- Listening, sharing and follow up
- Be visible and available for staff to ask questions, express concerns
- Solicit opinions
- Multimodal communication
  - Huddles
  - Bulletin boards
  - Emails
  - Suggestion boxes
  - Newsletters
  - Generational communications

This Photo by Unknown Author is licensed under CC BY-NC-ND

Tang JHC, et al. Journal of Gerontological Nursing, 2019;45:11-19

Factors Influencing Job Satisfaction/Staying Power

- Work environment/culture
  - Burnout , autonomy, communication, teamwork or peer support , recognition , feedback, routinization of work and pay
- Nursing characteristics or mobility factors
  - Ethnicity, age, martial status, nurse experience, educational level, shift type/ length, type of unit, availability of other jobs in the community, & organizational commitment or loyalty
- Organizational characteristics
  - Fairness, promotions, professionalism, career commitment and value congruence
- Manger/leader characteristics
  - Open communication, leadership style, follow through & support

Recognition Strategies

- Provide verbal acknowledgement and feedback to frontline nurses (immediate & private)
  - Sincere
  - Directed at an action/behavior
- Written acknowledgement
  - Handwritten thank you's/place in file
  - Any patient/family letters
- Acknowledge Performance & achievements publicly
  - Nominate a nurse for outstanding performance
  - Congratulate in front of peers
  - Post hand written family/patient letters
- Provide opportunities for staff growth
  - Provide support/resource to shared governance roles
  - Help staff develop a specialty
  - Help pursue higher education

New Culture
New Rules
New Values
Shift Culture from Individual Blame to System/Process Errors

Initial Assessment of the MICU

- Focus on pathophysiology
  - Lack of value & practice of basic nursing care
  - Sporadic functional status assessments
  - Minimal focus on psychosocial assessment & planning
- Medical model of clinical decision making
- Reward structure based on early identification of medical problems & the ability to anticipate treatment

This Photo by Unknown Author is licensed under CC BY-SA

Clinical Indicators of Nursing Practice Problems

- 23% incident in pressure ulcers
- Limited use of mobility techniques
- Limited use of PT/OT & social work
- Complication of foot drop
- Absence of oral care

Strategies to Impact Nursing Value Structure & Engagement

- Patient Care Conferences
- Role Modeling
- Bedside Consultation
- Infrastructure for staff projects (clinical ladder)
  - How to develop an in-service
  - Review of a research article
  - Format for documentation of activities/committees (shared governance)
- Engage staff in unit process improvement projects

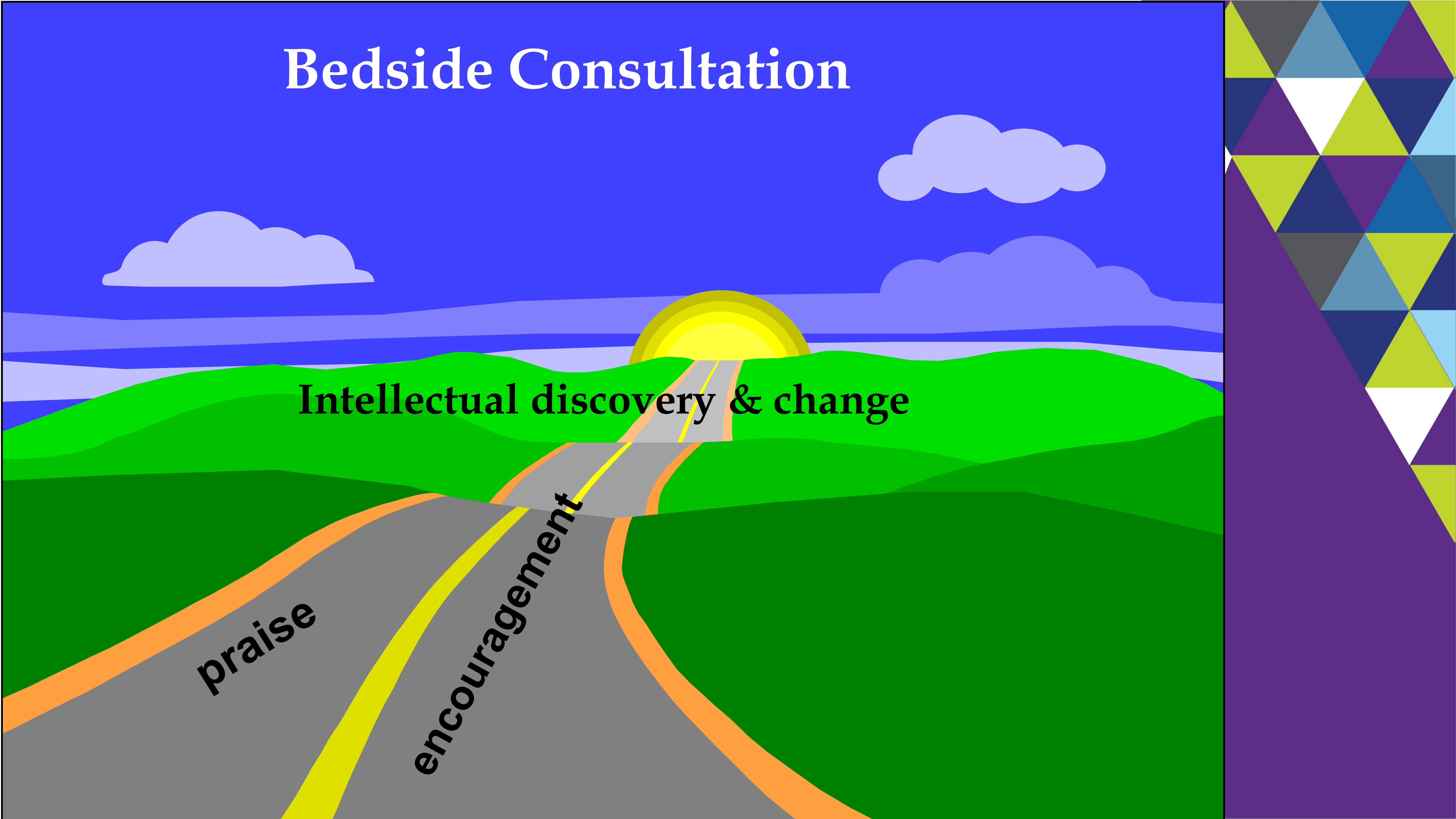
Strategies for Valuing Basic Nursing Care & Engagement

- Patient Care Conference
- Alternating medical focus with nursing therapeutics focus
- Evolution into nursing round
  - Impact care practices which have the potential to prolong LOS or create complications
  - Reinforce Ownership of nursing practice
  - As a Nursing practice reward structure
  - To enhance continuity of care
  - To build intellectual confidence
- Evolution into structured multidisciplinary rounds

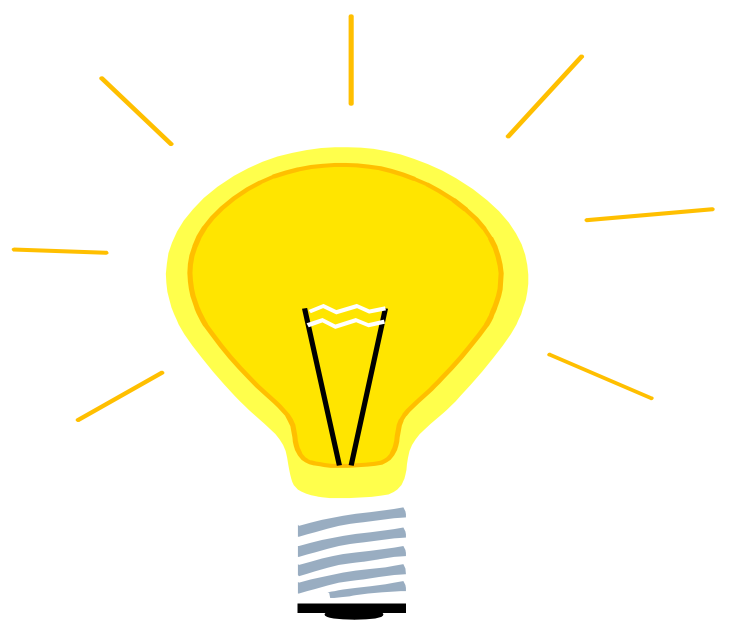
Nursing Rounds Format

1) **Brief Medical History:** Past history, reason for admission, stable/unstable
2) **Pulmonary:** Secretions/type and amount, single use or in-line catheter, ability to tolerate repositioning, assess need for continuous lateral rotation therapy and/or the prone position, assessment of functional readiness to wean
3) **Psych/Coping:** Assess for agitation/ Dx of anxiety, pain and/or delirium, safety issues, sleep/rest pattern, use of diversional activities, Dx of powerlessness
4) **Family:** Coping, support systems, discussion of code status, evaluation of home environment/discharge needs
5) **Activity:** Physical therapy needs, activity/exercise schedule, prevention of contractures
6) **Skin:** Braden score, support surface/specialty bed, preventive measures, skin status, management of incontinence, nutrition/goal achievement
7) **Communication issues:** Family, collegial, collaborative

Vollman KM, Stewart KH. AACN Clin Issues. 1996 May;7(2):315-23.


Bedside Consultation
Intellectual discovery & change
praise
encouragement

Bedside Consultation:



Creating the

Ah-hah

Experience

Bedside Consultation: Changing Care Practices

Bowel Habits

Task Force

Medical Assessment & Interventions

journal clubs

self study modules

bedside consultations

Unit Process Improvement Projects

- Clinical nurse specialist guidance
- Staff led: designed, implemented & evaluated
- Developed sense of ownership, pride & accomplishment

Clinician and Financial Outcomes

Unit Process Improvement Projects:
Evidence of Practice Ownership

- Standards of practice
- Reduction of pressure injuries
  - Air overlay followed by mattress replacement
  - Multiple skin product evaluations
- Bowel protocol
- Agitation protocols
- Warm & Fuzzy program (staff peer rewards)
- Product/Policy & Procedure
  - Continuous lateral rotation/Prone position
  - Oral care product evaluation
  - Bath evaluation
  - Hair care product evaluation
  - Heel boot product evaluation
- Staff lead research/Abstracts/Presentations
  - Cooling by convection
  - Noise reduction
  - Bereavement program

How Do We Measure Staff Empowerment & Engagement

Measuring Success:

Retention of

Qualified Experienced Staff

Professional Growth: MCC Staff Statistics

Classification	**1996**	1998	2001
BSN's	**42%**	**53%**	**50%**
CN I's	18%	19%	10%
CN II's	60%	66%	69%
CN III's	23%	19%	21%

≥ 5 Years of Experience in MCC 70%

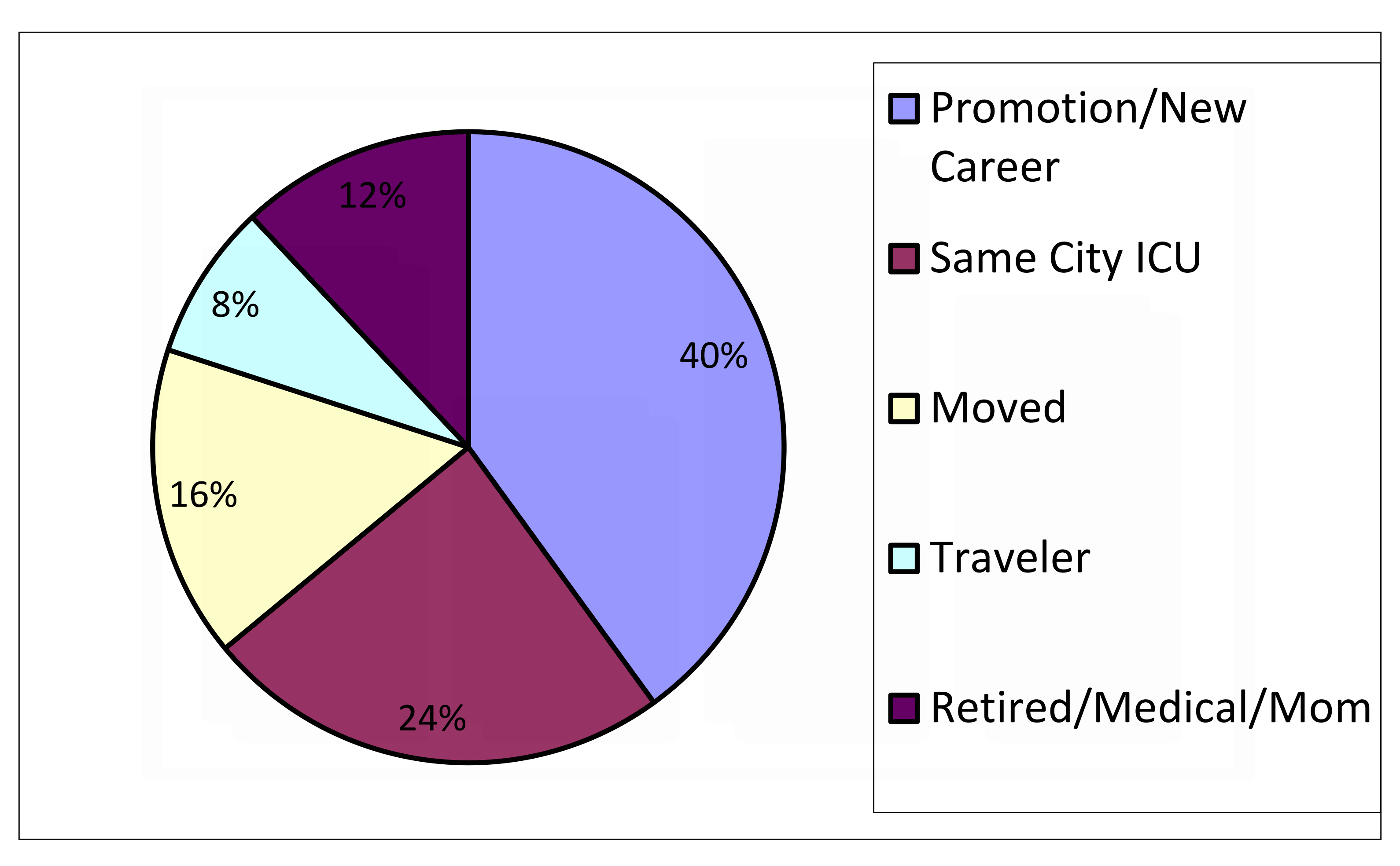
MICU Bed / Staff / Turn Over Indices

Beds staffed	1990 8	1991 8	1992 8	1993 8	1994 8	1995 10	1996 10	1997 10	**1998** 12	1999 32	2000 32	2001 32
Authorized Positions	24	--	24.4	24.3	22.7	28.9	28.2	28.2	37.5	90	90	90
Average Positions Filled	21.6	--	21.5	22.7	20.0	28.9	28.2	28.2	35.0	86	87	87
Est Avg. Vacancy Rate	9.75		11.3%	6.5%	11.75%	--	--	--	7.0	1.04%	3.33%	1.03%
Resigns.	1	4	3	6	2	2	7	2	2	7	7	5
Turnover Rate	4%	16%	12.3%	24.7%	8%	6.9%	24.75%	7%	7%	8.1%	9.0%	6%
Wastage Raste	--	--	--	1	--	--	--	--	--	0	1	--

5 Year Orientation Cost Avoidance: $1,920,000.00

	1997	1998	1999	2000	2001
National Turnover Rate (Hospital Nursing)[1,2]	12%	12%	18.3%	18.3%	18.3%
MCC turnover rate	7%	7%	8%	9%	6%
% difference converted to RN positions that would have required orientation	2 RN's	2 RN's	8 RN's	8 RN's	10 RN's
Estimated cost of ICU nurse orientation[3]	$64,000	$64,000	$64,000	$64,000	$64,000
Yearly orientation cost savings secondary to retention	$128,000	$128,000	$512,000	$512,000	$640,000

Reasons for Leaving
(5 Year Period)



Participation in Change

Bereavement program

Engagement in Shared Governance at all levels

Staff Designed & Interview Process

The Recipe for Success: Transformational Leadership

- Vision for the future
- Pursing change to create unwavering focus on quality and safety of care
- A culture of respect
- Visibility
- Promotion of autonomy support professional development
- Interprofessional rounds and team building
- Huddles to improve communication and teamwork
- Use of data and evidence to support decisions in practice

Dempsey C, et al. Nurs Admin Q. 2018;42(3):278-283

WHEN WOULD NOW BE A GOOD TIME TO DO THIS?

Kathleen M. Vollman MSN, RN, CCNS, FCCM, FCNS, FAAN
Clinical Nurse Specialist / Educator / Consultant
ADVANCING NURSING
kvollman@comcast.net
Northville, Michigan
www.vollman.com