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Building a Framework for Professional Nursing Practice Across the Continuum of Care

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Section I: Abstract

Nursing professional practice models are designed to unite and align nurses under one vision, set of values, and a professional practice model. The goal of this project was to implement and enculturate a professional practice model of nursing with assistant nurse managers and leaders across the continuum of care at an urban medical center and associated ambulatory medical offices. Staff engagement has been shown to improve satisfaction and decrease turnover and implementation and enculturation of a professional practice model improves engagement. The target population was nurse managers and leaders, as they needed to embrace professional practice before the project was spread to frontline nursing staff. The interventions planned and implemented by the project workgroups resulted in decreased nurse manager and leader turnover and increased engagement. Uniting and aligning nurses under one vision, set of values, and professional practice model across the continuum of care enables the organization to elevate nursing practice, ultimately improving staff satisfaction and patient outcomes. This strategy also ensures that regardless of where members enter the health system, they will know that they have been cared for by a nurse from this health system.

Keywords: nursing practice; professional practice model; nurse engagement; nurse empowerment; union environment; staff satisfaction; nurse manager turnover

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Section II: Introduction

Background

There are numerous challenges in the current health care environment, with many of these driven by changes in the health care landscape. The 2010 enactment of the Patient Protection and Affordable Care Act (PPACA) (U.S. Department of Health and Human Services, n.d.) has allowed millions of Americans to access health care, creating increased demands on health systems. The release of the Institute of Medicine report entitled "The Future of Nursing: Leading Change, Advancing Health" (Institute of Medicine, 2011) brought national attention to the need for qualified, professional nursing practice.

The adoption of the PPACA reflects the biggest change in health care since the creation of Medicare and Medicaid programs in 1965. This legislation has allowed millions of Americans to access health care and has subsequently created an increased demand on health systems and hospitals. The impact on health systems appears to be increased health care utilization with decreased reimbursement. It is more important than ever to provide safe, quality care for patients while protecting resources.

As nursing practice covers the continuum of care, health systems must support excellent nursing care in all areas. Nurses play a critical role in the future of health care, especially related to quality of care, patient satisfaction, and patient outcomes. The Initiative on the Future of Nursing report has eight recommendations for the fundamental transformation of nursing needed to achieve improved health systems. Of these, number seven recommends "preparing and enabling nurses to lead change to advance health" (Institute of Medicine, 2011). Achievement of this recommendation at the hospital level is accomplished through professional nursing practice to achieve optimum outcomes.

The increased demand on health systems to provide care for those with increased access to care requires attention to nursing practice. There are more than three million registered nurses in the United States, who play a critical role in prevention of illness and provision of quality care. Because how well nurses are educated and perform their job reflects on the quality of care provided, promotion of professional practice and professional development are critical (Institute of Medicine, 2011).

These challenges invigorated nurse leaders at a large health system in Northern California to intensify efforts to achieve extraordinary care for patients and families. Senior leadership at this organization recognize that nurse recruitment and retention of nurses who embody professional practice is a priority. Nurse turnover, satisfaction, and engagement are a recognized problem at this health system, including that of nurse managers and leaders. Nurse manager turnover was also a concern. Because of this, the organization was committed to putting resources towards decreasing nurse manager turnover and increasing satisfaction and engagement through implementation of a professional practice model of nursing.

The organization's national Program Office promotes a nursing strategy that is disseminated through a professional practice model. According to this model, nurses are the core of the health care team and deliver expert care while putting patients, families, and members at the center of everything they do (Kaiser Permanente, 2013). Professional nursing practice at this organization is based on trust and compassion, and is supported by other members of the health care team. This professional practice model requires leadership support for nurses across the continuum of care to provide excellent nursing care for every patient every time.

This project took place at an urban level II trauma center with 217 licensed beds. The hospital is part of a large system with 22 acute care hospitals and approximately 300,000

members in the service area. The hospital serves both members of the health plan with inpatient and outpatient care as well as those with other insurance and uninsured patients in the emergency department and through trauma services provided to the community. Approximately 1,300 registered nurses work in the hospital inpatient units, emergency department, and outpatient settings. There are ten nurse managers and 45 assistant nurse managers in the inpatient and emergency departments, with five nurse managers in the ambulatory setting, in addition to two Clinical Nurse Specialists and four Clinical Educators who were the focus of the initial phase of the project. Senior leadership at this organization fully support and authorize the implementation of the professional practice model to improve nursing practice and patient outcomes.

Local Problem

Staff perception of a lack of accountability was reflected in the annual staff satisfaction survey, across all areas of the organization. Staff, including managers and nurse leaders, consistently rated this area low and expressed that more needed to be done to hold others accountable. Managers and leaders also reported that there were variations in practice among nurses and across departments and service areas and across the continuum. Implementation of this professional practice model would help to ensure that nursing practice is consistent regardless of where it takes place within the health system.

There was a contentious environment with an adversarial relationship between nursing and management that was present before the start of the project. The staff nurses were without a union contract and contract negotiations were not progressing. Work stoppages were anticipated during the implementation phase of this project. Over time, the adversarial, contentious relationships were expected to increase, as demonstrated during the project planning session (to be discussed later).

These local issues created a work environment for managers and leaders that was causing them stress and anxiety. This was unacceptable as all needed resilience to navigate the changes in health care reform that resulted in increased membership and hospital patients. Nurse managers and leaders also expressed that the potential upcoming work stoppages were causing them concern and anxiety. Increasing satisfaction and retention will empower nurse leaders and managers to lead their teams more effectively and promote professional practice across the organization, thereby setting the stage for later phases of implementation with staff nurses across the organization.

Intended Improvement

Registered nurses have varied educational preparation and practice experiences. The role of the professional nurse is very technical and task based. They may provide appropriate care but have many different approaches and attitudes, causing patients to experience inconsistencies in care and clinical outcomes (Ondrejka & Bernard, 2011). Integration of a professional practice model into daily care by nurses requires a common language, which is integrated into the model.

The practice improvement project was the implementation of the Voice of Nursing (VON), the system's professional practice model that is based on the organization's nursing strategy. This project focused on enhancing professional practice of managers and other nurse leaders through the development of professional practice awareness, attainment of national certification, and leadership skills.

Implementation and enculturation of a professional practice model promotes a culture that values professional practice and accountability. The rollout and enculturation of the professional practice model was targeted to address the hearts and minds of nurses at the medical center, beginning with nurse managers and leaders (non-union registered nurses). The model is

designed to unite and align all nurses under one vision and set of values across the organization. The goal of this project was to build upon current strengths, integrate the work into what was currently in progress, and align with the strategic goals of the organization. The initial focus on nurse managers and leaders set the stage for future dissemination to all registered nurses across the continuum of care at the organization.

The aim of the intended improvement was to implement the Professional practice model (the Voice of Nursing) by June 1, 2015 as evidenced by:

- Increased nurse manager and leader engagement
- Decreased nurse manager and leader turnover, and
- Attainment of nurse manager and leader professional certification.

The original goal date was December 2014 but this date was adjusted due to organizational challenges related to collective bargaining with the union nurses.

Evidence-based practice projects are appropriate when results lead to improvements in patient health, organization of systems, or education (Newhouse, Dearholt, Poe, Pugh, & White, 2007). Practice changes resulting from this project were intended to improve staff satisfaction and retention of managers and leaders. Increasing the number of managers with professional nurse leader certification will empower them to lead their teams more effectively and promote professional practice across the organization. This project occurred from June 2014 through January 2015, with workgroups meeting regularly. Initial planning and strategy was done with a group of leaders and managers. The entire group also met regularly to facilitate communication between workgroups and report out successes and challenges.

Enhancing professional practice at the leadership level is necessary in order to roll out the model system-wide. If nurse leaders and managers have not embraced their own professional

practice, it will be difficult for them to foster this in others. Implementation of the professional practice model of nursing at the leadership level will set the stage for the second phase of the project, which will commence in 2016. The focus of the second stage will be on implementation of the professional practice model with all frontline (union) registered nurses.

Literature Review

Nationally, it is estimated that 45% of nurse managers and 35% of assistant nurse managers will retire by 2020, largely in part due to the aging nursing workforce (Kallas, 2014). These numbers can be extrapolated to the organization, as the demographics of the nursing management workforce are representative of national averages. In addition, annual turnover rates for nurse managers are estimated to be as high as 50%. Historically, nurses who excel clinically are recruited for leadership positions, sometimes without possessing necessary management skills. Little attention is paid to nurse leader development and appropriate recruitment, which has been found to correlate with nurse manager and leader retention (McLarty & McCartney, 2009). At the hospital targeted for intervention, the position of assistant nurse manager is not sought after nor is it considered an ideal pathway to leadership for staff nurses. Staff nurses have anecdotally expressed that the position of assistant nurse manager is not desirable because of the perception of too much work and not enough time.

Parsons and Stonestreet (2003) found that nurse manager retention was influenced by multiple factors, including professional development and an empowered workforce. Raising nurses' perceptions of empowerment has a motivating effect and raises job satisfaction (Pineau Stam, Spence-Lashinger, Regan, & Wong, 2013). There has been significant research on nurse succession planning, which emphasizes nurse manager professional development and support. While not focusing specifically on succession planning in this project, it is expected that

decreasing nurse manager turnover will assist with this. Empowerment in the organizational environment leads to increased productivity and effectiveness, as opposed to that of the social action arena, which refers to attempts of an oppressed group to attain power (Kuokkanen, Leino-Kilpi, & Katajisto, 2003).

There are varied definitions and interpretations of the concept of work engagement. The generally accepted definition of work engagement is that of Schaufeli, and refers to a positive, fulfilling state of mind that is characterized by high levels of energy, a sense of pride and absorption (Simpson, 2008). Staff nurse engagement is affected by manager and leader engagement (Laschinger, Wilk, Cho, & Greco, 2009). Nurse managers and leaders are responsible for creating an environment of professional practice. Because nurse managers and leaders play such an important role in supporting staff engagement, the focus of this project is on nurse managers and leaders.

A large-scale study by Towers Perrin (2003) showed that engaged employees are more loyal and have no plans to leave their employers (66%) compared to those who were disengaged (12%). The survey pool in this study consisted of 36,000 employees working full time for medium and large organizations in the United States. Only five percent of respondents were from hospitals but the results can be generalized. According to the study, highly engaged respondents chose "strongly agree" to all characteristics (Towers Perrin, 2003). Press Ganey (2006) also found a correlation between engagement and patient satisfaction. The findings were based on comparisons between health care employees and patient satisfaction data from the same institutions. Hospitals with more engaged staff care for patients who are more satisfied and more likely to recommend their hospital for care (Press Ganey, 2006).

Nurse professional certification also has an impact on quality patient care. For every 10% increase in the number of bachelor's prepared nurses who are certified, there is a 2% decrease in patient deaths (Kendall-Gallagher, Aiken, Sloane, & Cimiotti, 2011). Krapohl, Manojlovich, Redman, & Zhang l (2010) found a significant relationship between the percentage of certified nurses and perception of workplace empowerment. Empowerment includes four factors: opportunity, information, support, and resources. When these factors are embedded in the work environment, workers feel good about what they do and are satisfied in their roles.

Creating work environments that foster professional practice by empowering nurses is essential for high quality care (Laschinger & Wong, 2010). A professional practice model has been defined by Hoffart and Woods (1996) as a system that supports nurse control of the delivery of nursing care as well as the environment in which the care is delivered. There are five subsystems of a professional practice model: values, professional relationships, a model of care delivery, a management approach, and compensation and rewards. Each area except compensation was addressed in this project. Compensation is not within the scope of this project due to budgetary constraints. See Appendix A for definition of terms.

Theoretical and Conceptual Framework

Theoretical Framework: Relationship-Based Care

Koloroutis' (2004) Relationship-Based Care model was used as a framework for the implementation of the VON. In this model, the care provider-patient relationship is one in which the provider maintains the patient and family as the central focus of care. Family is defined as any person that the patient identifies as family, regardless of blood relationship or marriage. Nurse relationship with self and others is also central to the framework. The Relationship-Based Care model supports organizations to strengthen and transform these relationships to achieve

desired quality, financial, and organizational outcomes. Use of this model has shown to improve safety, quality, patient satisfaction, and staff satisfaction by improving relationships within an organization (Koloroutis, 2004).

The Relationship-Based Care model recognizes that all members of the health care team work together to deliver excellent care while focusing on the important contribution that professional nurses have on patient care. According to this model, the nurse-patient relationship is the foundation of professional care delivery and nurse accountability for a therapeutic relationship with the patient and his or her family, which is essential to achieving quality outcomes. The six dimensions of Relationship-Based Care are leadership, teamwork, professional nursing practice, patient care delivery, resource driven practice, and outcomes measurement. Health care occurs at the intersection of the patient and professional nurse and is deeply based on and provided through relationships (Koloroutis, 2004).

Conceptual Framework: Inspiration, Infrastructure, Education, and Evaluation (I2E2 Framework):

Inspiration, Infrastructure, Education, and Evaluation (I2E2) is a method for change developed by Felgen (2007). I2E2 defines four equal components: Inspiration, Infrastructure, Education, and Evidence. This framework facilitates engagement by focusing on successes while aspiring to deep culture change within the organization (Felgen, 2007). This framework was used to engage stakeholders and provided structure for the work of the project.

To inspire, leaders must focus on caring and healing relationships at the point of care. This approach allows all member of the organization to become inspired, resulting in an organizational culture in which people are valued and respected as individuals. Infrastructure establishes the processes, systems, and structures necessary to achieve a shared vision. It lays

the foundation that makes change possible and successful. The infrastructure must support the organization's overall vision at strategic, operational, and tactical levels.

Education promotes competence and personal commitment. People want to do a good job and be responsible for their work and actions. Using educational methods to raise self-awareness helps with understanding of patient and family experiences of care, developing and maintaining healthy relationships, critical thinking, and leadership, which promotes a culture where the possibilities for growth are limitless. Evidence allows leaders to demonstrate that change has occurred. Evidence of success lets people know that progress is happening. This framework was used to engage stakeholders at the initial planning session. Leaders were randomly assigned to one of the four areas of focus and supported by the project leads to brainstorm ideas and develop a plan.

Change Framework: Senge's Five Disciplines

Humans want to learn and understand why things are the way they are. Connecting the experiences of life and previous learnings into a more holistic form allows for better understanding and problems solving. During times of rapid change in health care, organizations must be flexible and adaptive to succeed and flourish. A key to this is the ability to learn and grow. Organizations must not only be able to use survival or adaptive learning, they must embrace generative learning to enhance the ability to create (Senge, 2006). Being or becoming a learning organization fosters the ability to recreate or co-create at all levels, as it is embedded into the culture.

A learning organization seeks to discover how to foster commitment and capacity to learn at all levels. Peter Senge's Five Disciplines is a language of change that health care organizations can use to create a workplace that is built around a culture of learning. Each

discipline is a whole unto itself and part of a larger whole. As a learning organization, the health system must manage, apply, grow through, and use this knowledge effectively to create desired changes and improvements. This approach to change is composed of a set of tools and practices for building and sustaining learning leadership capability.

According to Senge (2006), in learning organizations, people continuously expand their capacity to create desired results and new patterns of thinking are nurtured, collective aspiration is present and people constantly seek to learn how to learn together. The five basic disciplines of this model are systems thinking, personal mastery, mental models, building a shared vision, and team learning. Each discipline consists of guiding ideas, tools and techniques, and practices to follow in leadership behavior and approaches. The most influential discipline for the planning and implementation of the VON was creating a shared vision.

For the implementation of the VON, the health system decided what they wanted to create together in the three day planning session. Taking the time early in the change process to create a shared vision and understanding was necessary to build a common language and understanding. This shared vision leverages resources toward the same end with processes and problem solving flowing in a common direction. Typical methods to create a shared vision, such as telling and selling, are less successful than co-creating that shared vision. Bringing the team together to identify opportunities and barriers and to co-create interventions facilitated the shared vision, which was created during the planning session with the group of managers and leaders. Sustainment of the VON implementation required regular, open, and honest communication and feedback by members of the implementation team.

Mental models, or beliefs, values, mindsets, and assumptions that determine how people think and act need to be identified for change success. Mental models determine how we make

sense of the world and how we take action (Senge, 2006). The ability to read the environment accurately requires that mental models are based on real data that supports (or does not) the generalizations held about the world. This was accomplished through the SWOT and Triz assessments completed during the planning session (see Appendices J and K). Use of these tools to identify and clarify assumptions allowed participants to get in touch with their thoughts and feelings and to validate perceptions about the current environment and change process required for implementation of the VON.

Personal mastery, or self-awareness, allows members of the team to see what behaviors and practices are needed to approach the vision. This is accomplished by clarifying what is important and continuously learning how to assess reality in relation to progress toward the vision. The Triz allowed the group to identify behaviors that are vital to the success of the team and those that would impede results.

Team learning occurs when the members starts to share experiences, insights, and knowledge with each other. The subsequent reflection, inquiry and discussion developed by the team forms the basis for creating a shared vision of change. There is a flow of information, feedback, and problem solving as well as an awareness of the value of feeling safe to say what they really think and feel. As participants of the strategy session worked as a team, the group moved to a group frame of reference and collective wisdom. Systems thinking allows teams to see the relationships between things rather than bits and pieces, and allows the whole to be understood. Use of the I2E2 framework aligns with systems thinking as each category is independent but interrelated and each affects the other.

Section III: Methods

Ethical Considerations

A critical component of professional nursing practice is the ability to think and act ethically. Implementation of the VON included exposure to the American Nurses Association (ANA) Scope and Standard of Practice and Interpretive Code of Ethics to help nurse managers and leaders develop competence in ethical reasoning and decision-making. The code of ethics (American Nurses Association [ANA], 2015) serves as the framework for professional nursing practice and many managers and leaders reported that they had not had to exposure to these since nursing school.

The Nursing: Scope and Standards of Practice (American Nurses Association [ANA], 2010) provides a guide for professional nursing practice, including standard seven, that registered nurses practice ethically. It is essential that professional registered nurses use the Code of Ethics for Nurses with Interpretive Statements to guide their practice. Nurses are accountable for the judgments made and actions taken in their practice and are therefore responsible for their own lifelong learning and individual competence. Registered nurses are bound by a professional code of ethics and must regulate themselves individually and as a profession to ensure quality performance (American Nurses Association, 2010). This code of ethics explains the goals, values, duties, and commitments to society of professional nursing practice.

This responsibility and accountability is a shared responsibility between the individual nurse and the organization. While nurses are responsible for their own self-assessment and professional growth and development, the organization must also support and promote continuing education and learning for employed professional nurses (Koloroutis, 2004). Interventions in the VON implementation promote both individual and organizational responsibility to adhere to the code of ethics.

Institutional Review Board

Health and Human Services (HHS) Regulations for the Protection of Human Subjects provide ethical principles governing human subjects research ("Human Subject Assurance Training," n.d.). The basic HHS regulations require that there be institutional assurances of compliance, Institutional Review Board (IRB) review, and informed consent to protect human subjects in research or potential research projects. This project does not require IRB review because it is a performance improvement project and does not meet the requirements of a research project. The implementation of the VON is site-specific and the results are not intended to provide generalizable knowledge and focuses on systems and processes. It does not apply a methodology to generate new knowledge or validate existing knowledge based on a theory and does not contain variables that are measured or manipulated (Conner, 2014).

Setting: Organizational and Market Analysis

The Voice of Nursing lays the foundation that makes transformational practice possible and aligns nursing with the mission and values of the organization. The organizational strategies that relate to this implementation are transforming care delivery, solving for affordability, growing membership, implementing infrastructure, and enabling performance through people.

A market analysis was conducted to assess readiness and appropriateness of the planned intervention. It indicated that this was a complete solution and required an approver, decision maker, champion, sponsor, and influencers. The approver and decision makers are the senior leaders of the organization. Individual nurses must also approve and adopt the model for success. Influencers are found in all three stakeholder groups and had targeted messaging directed at them. The market landscape factors considered include the organization’s priorities for quality, safe, and effective care of their members and patients and the need to recruit and

retain nurses who exemplify professional practice. Other market forces include reimbursement tied to value and financial penalties for poor quality care and outcomes.

The organizational analysis revealed that a significant barrier to implementation and enculturation of a professional practice model was the current environment and culture of the nursing staff. Relationships between management and staff tended to be adversarial, with a few nurses, usually union representatives, speaking for many. Because of the strained relationships and contract negotiations, the planning team did not include any staff nurses, creating a skewed analysis. At the time of project implementation, the shop stewards for the nurses were consulted about this project and declined to participate. The second phase of the project implementation, while not the scope of this project, will include union staff nurse representation working in partnership with management.

The VON addresses the hearts and minds of professional nurses to elevate practice, resulting in exceptional patient care. The model aligns with the organizational mission, vision, and strategy to be "Simply the Best." Simply the Best as a strategic branding campaign is unique to this local setting. Methods of strategic branding vary across the region but all are tied to the regional mission and vision. See Appendix B for the organization's mission, vision, and strategy.

For market segmentation, implementation of the VON professional practice model affords differentiation from similar organizations, including other system hospitals. While the organization has no plans to pursue Magnet designation, this is project meets the needs of the organization to facilitate Simply the Best Care. See Appendix C and D for the VON strategic concept and growth and customer analysis.

The health care organization is divided into smaller units that focus on specific areas of care delivery, such as maternal-child, adult services and primary care. This is necessitated by the increase in specialization caused by increasing amounts of health information (Pinelle & Gutwin, 2006). This specialization allows health workers to become well trained in an area of care and decreases the need for them to keep up with advances in all areas of care. This work unit autonomy places control of the department in the hands of unit managers, resulting in loosely coupled relationships between operational units and leadership. These loosely coupled models allow individual units to adjust to local demands and can enable continuous change (Pinelle & Gutwin, 2006).

The department managers are experienced and skilled in their own work and were part of the planning and implementation process. The assistant nurse managers have varying skill levels and are the focus of the intervention so were not involved in the planning process but were made aware of future plans for implementation. The assistant nurse managers have not historically worked to change their own processes, as many are busy "getting their work done."

Planning the Intervention

The chosen intervention was to implement and enculturate a professional practice model with nurse managers and leaders at the local level using the resources developed by the National, or Program Office. This model is available to all local facilities across all regions. The goals of this project were to decrease nurse manager and leader turnover and increase satisfaction. This was a complete package with tools and support from the Program Office. This project was chosen because of reported anxiety and stress from nurse leaders and managers related to changes in health care and an adversarial relationship between leaders and staff and historically low staff satisfaction scores in the area of accountability.

The health system nurses are in a unique position to support and improve the future of health care. According to the VON, nurses who exemplify a commitment to professional practice demonstrate a dedication to patient- and family-centered care and use evidence-based care to guide their practice. They respectfully communicate with their team at all times, participate in continuous process improvements, and are accountable for their own practice. They also provide honest and appropriate feedback toward the development of fellow nurses, mentor new nurses, and advocate for the profession of nursing as a whole (Kaiser Permanente, 2013).

The Chief Nursing Officer and project lead met with Program Office nurse leaders to plan the strategy planning session that would include nurse directors, managers, and select nurse leaders. Non-union nurses are those who are not providing direct patient care, such as nurse managers and clinical educators. Assistant nurse managers and other non-union nurses were not included in this initial planning session as they are the recipients of the intervention. The nurses targeted for the intervention are non-union in any area of the hospital, ambulatory services, and continuum of care. Nurses from these areas include clinical directors, direct patient care unit managers, quality improvement nurses, clinical educators and clinical nurse specialists, ambulatory care managers and leaders, and continuum of care managers and leaders. Union nurses will be targeted after implementation and enculturation with the non-union nurses and after contract negotiations are successfully completed. These areas function as interdependent subsets of the health system and some provide direct patient care while others support those activities.

Senior nursing leadership advocate for change and accountability and devoted time and financial resources to this project. They understand the value of implementation of a

professional practice model and resulting system improvements. The system has undergone changes related to health care reform and organizational redesign that included an employee choice program to promote retirement.

The Model

The organization's vision of nursing at is that their nurses advance the art and science of nursing in a patient-centered healing environment through their professional practice and leadership (Kaiser Permanente, 2013). Engagement of nurse leaders and managers to embed the vision, set of values, and model into everything they do helps them reach their goal of providing extraordinary nursing care for every patient, every time. Implementation of this model enables standardization with customization where appropriate and elevates nursing practice across the entire organization.

The patient and their family are at the heart of the nursing professional practice model (the Voice of Nursing). The nurse-patient and family relationship is the cornerstone of nursing practice and leverages the role human relationships play in creating caring and healing environments. The VON honors the unity of the whole human being and provides the framework through which the health system nurses ensure that they meet the needs of patients and their families (Kaiser Permanente, 2013).

Six nursing values are embedded in the model that are reflected in practice and help to demonstrate what it means to be a nurse at this organization. These six values are: professionalism, patient and family centric, compassion, teamwork, excellence, and integrity. Four key pillars organize the practice and work of nursing in this model: Quality and Safety, Leadership, Professional Development, and Research/Evidence-Based Practice. See Appendix E for a graphic representation of the VON professional practice model.

This infrastructure establishes practices, processes, and systems through which the nursing vision will be achieved. It lays the foundation that makes transformational practice possible and aligns nursing with the organization's mission. The model is designed to move nursing practice forward, and is the framework within which a nursing theory, such as Caring Sciences, can be practiced. It describes how nurses practice, collaborate, communicate, and develop professionally.

The model's schematic design demonstrates how each component is aligned and integrated to support nursing practice across the continuum and to meet the needs of patients and their families. It also demonstrates the contribution nursing makes in fulfilling the organization's mission and vision. Implementation of this professional practice model ensures that practice is consistent regardless of where it takes place within the health care system. Consistently applying this model minimizes variations that can create risk, gaps in care, and missed or overlooked patient needs.

Communication Structures and Processes

A project communication matrix was used to keep the stakeholders informed in a timely, consistent manner to ensure that all were kept informed of the project status to minimize miscommunication. Communication management included planning, information distribution, performance reporting, and issues resolution.

The communication plan for the project involved email, meetings, and information sharing for managers and leaders in the workgroups to others in the organization. Monthly, the leads of each group reported out at a team meeting with all workgroup participants. The project lead also attended workgroup meetings to support and facilitate communication and cohesion

with the other groups. The project lead and Chief Nursing Office reported on progress to the Program Office every six months (see Appendix F for the communications matrix).

Project Implementation

A strategic planning session with nurse managers and leaders from all areas of the inpatient and outpatient setting convened for three days. The composition of the workgroups and leadership support is presented in Appendix G. The project was responsible for overseeing all facets of the project, with responsibility for timelines, deadlines, reporting, and budget.

A work breakdown structure (WBS) was used to guide the project. The hierarchical outline of required tasks to be scheduled, executed, and controlled assists with determination of required resources and scheduling of the work. See Appendix H for the work breakdown structure.

Each group met independently to determine short and long-term goals. The workgroups (Inspire, Infrastructure, Education, and Evaluation) were composed of nurse managers and leaders, with a lead for each group. Each group determined interventions based on evidence and literature sources (see APPENDIX I for the workgroup interventions). Assistant nurse managers and other nurse leaders were not members of the workgroups as they were the targets for the interventions. The interventions chosen by the workgroups were intended to lead to the goals of the project, or to increase satisfaction and decrease turnover.

The Inspire group decided to focus on dissemination of a Nurse Week video depicting nurses' views of what it means to be a nurse. This video was filmed during Nurse Week 2014. They are also determined a plan for promotion of nurse recognition awards such as Daisy and the organization’s national nursing award. They explored developing an intranet page with VON resources and a program for on the spot recognition for caring. The on the spot recognition

program was deferred to the spread, or second phase of the program as it is more appropriate to share with all nurses, not just leaders and managers. Finally, they supported development of the annual Nurse Week celebration.

The Infrastructure group was tasked with defining the nurse manager and leader roles and providing a structure for promoting professionalism and resilience. This structure was necessary to support the work of the other three groups. The group facilitated sessions for all nursing leadership on resilience in turbulent times, which were well attended. Participants gained perspectives and approaches to help them prepare for and manage themselves and their staff during times of turbulence. They also learned techniques to move forward with resilience and strength during these times of uncertainty related to health care reform and contract negotiations. They assisted the Inspiration group with a process for expansion of the nurse recognition programs. The group also sponsored the development of the Nursing Research Council for nurse leaders, managers, and staff to build professional research and evidence based practice skills. Finally, the group developed a plan to assess nurse manager certification and membership in professional organizations.

The Education workgroup determined which national certification preparation course and exam would be offered to nurse leaders and facilitated attendance at the middle management training for assistant nurse managers. This middle management training was provided by the Regional offices of the health system and participation was supported by the Chief Nursing Officer. Finally, an abbreviated Voice of Nursing class for assistant nurse managers and nurse managers and leaders who missed the original sessions was facilitated. This training was conducted by the Core team and involved a significant time commitment for all involved. The

Evaluation team was responsible for determining, designing, and administering the evaluation measures, to be discussed later.

Potential Barriers and Mitigating Tactics

During the planning session, participants identified potential barriers and mitigation tactics. A significant barrier to implementation and enculturation of a professional practice model was the current environment and culture of the nursing staff. Relationships between management and staff tended to be adversarial, with a few nurses, usually union representatives, speaking for many. A SWOT analysis was conducted with the strategic planning team and multiple threats were identified (see Appendix J).

The SWOT analysis revealed strengths, weaknesses, opportunities, and threats. Strengths included leadership, communication, reputation, and people. Weaknesses were strongly related to labor relationships, multiple changing priorities, inconsistencies, and accountability. Opportunities identified were to leverage technology, increase professional practice, and communication. Threats included external agencies, competition, and union activities with associated behaviors of staff nurses.

A Triz assessment, which is a problem-solving tool that can accelerate a group's ability to solve problems creatively, was conducted with the core group at the planning session ("Triz Assessment," n.d.). Participants identified that they had a significant role in the "behaviors" of the clinical staff nurses (see Appendix K). Leaders identified the need to focus more on relationships with staff and to stop allowing and condoning poor professional performance and behavior.

Working in a labor environment created special challenges for project implementation, especially as culture change was involved. The frontline nurses at the project hospital are

members of a union that has an often contentious relationship with leadership. The union contract expired August 2014 and work stoppages were anticipated. Increased tension between leadership and staff nurses was present and was expected to continue. Implementation of the professional practice model and the dialogue that occurred with it was expected to increase the resilience of managers and leaders during this time of stress and conflict related to potential work stoppages resulting from contract negotiations with the union.

It is estimated that approximately 20% of nurses are represented by unions. A widely held belief by unions is that programs that impact employee working conditions are a union matter and that any program that proposes to improve nurse retention is also a union issue (Johnson & Billingsley, 2014). This was very apparent at the targeted organization. All of the nurses at the health system are part of a collective bargaining agreement with the California Nurses Association, with their current contract expiring in August 2014. Successful negotiations resulted in a tentative agreement in January 2015. The environment at the organization was very much an “us against them” one with power struggles and disagreements, even though all claimed the common ground of patient care. It was necessary to address this before any successful spread of the implementation of the professional practice model was possible.

A major threat was identified that related to the changing health care environment and subsequent uncertainty regarding the future of the organization due to health care reform. Staff behavior was a common theme, specifically the perception of a "lack of accountability" and "complacency." It was expected that increasing nurse manager and leader skills through professional development would mitigate this threat. By focusing on the nurse leaders and managers first, the gap between management and staff would be addressed, thereby improving

relationships during the second phase of the rollout. If the nurse leaders and managers do not embody the VON, they cannot spread it to the clinical staff nurses.

Time and financial constraints are consistently a barrier to implementation. These issues were mitigated with project management skills and an awareness of financial limitations. Dollar costs were minimal, with labor costs "in kind." The largest cost for this project was expected to be for nurse leader certification preparation and examination, as discussed later.

A final significant barrier identified was the multiple competing initiatives that were being implemented. These were things that needed to be "done," as opposed to creating culture change across the organization. Manager and leaders at the initial planning session expressed concern that this project was one more thing "to do" and that everyone was "very busy." This was a significant barrier as many leaders were used to checking boxes to signify completion of a project, initiative, or education. Implementation of the Vision of Nursing practice model was championed and strongly supported by the Chief Nursing Officer, Chief Executive Officer and Regional and National leadership.

Project Cost

A cost benefit analysis was used to compare the financial costs with the benefits of the implementation of the professional practice model. Project goals were to increase satisfaction and retention of nurse leaders and managers. Nurse turnover is costly to an organization, with costs ranging from $22,000 to over $64,000 per nurse in studies that ranged from 1999 to 2006 (Jones & Gates, 2007). The differences in cost have been attributed to differences in conceptual definitions at varying levels of detail. In general, turnover costs are estimated to be 1.3 times the annual salary of the departing nurse. Nurse managers and leaders average $160,000 annually, therefore the cost of replacing just one manager would be approximately $256,000.

Project costs, including materials and labor, is estimated to be $155,085. The cost savings for one nurse manager retained is $100,915. Further nurse manger retention would save the organization $256,000 for each nurse leader. Dividing benefits by costs reveals a ratio of 1.6. The benefits exceed the costs and the project is favorable. Costs were not discounted as the timeframe for this project was proposed to be six months (see Appendix L for the project budget and return on Investment).

While some of the labor costs are "in kind," including the salary for the project lead, they must still be considered when examining costs. Even though the organization will pay this salary whether or not the project is implemented, it is estimated that 0.2 FTE will be required to manage the project. This is time that will be unavailable for other duties. The most significant cost for the project was nurse manager education. The salary cost for 35 assistant nurse managers to attend formal manager training was $112,000 (40 hours each for 35 managers at a salary rate of $80.00 per hour). This is also time they are unable for other duties. The training program was provided at no cost by the Regional office.

Planning the Study of the Intervention

Planning for the assessment of how effectively the intervention was implemented was done during team workgroup meetings after the initial planning sessions. The National Quality Strategy was used to guide this process. The National Quality Strategy was developed in response to the Affordable Care Act requirement that the Secretary of the Department of Health and Human Services establish a strategy to guide efforts toward increasing access to high quality, affordable health care for all Americans (U.S. Department of Health and Human Services [HHS], 2011). The National Quality Strategy has three broad aims: better care, healthy people and communities, and affordable care. There are six priorities to rapidly improve

outcomes and increase effectiveness of care (see Appendix M). Of these, ensuring that patients and families are engaged as partners in their care directly applies to this project, as they are the center of the nursing model. The overarching National Strategy goal to "ensure that all patients receive the right care, at the right time, in the right setting, every time" aligns with the organization's nursing strategy (HHS, 2011, para. 3).

Rigor is an important component of improvement initiatives, not just formal research. Without the availability of hard data and statistical methods of interpretation, it was challenging to establish rigor during these efforts to improve care (Morse, Barrett, Mayan, Olson, & Spiers, 2002). According to Morse et al (2002), reliability and validity are terms that apply to quantitative research, not qualitative inquiry and that new criteria be adopted to establish rigor for qualitative inquiry. Standards for evaluation of the significance, relevance, impact, and utility of qualitative research have replaced reliability and validity. Morse et al (2002) express concern that focusing on trustworthiness strategies rather than on processes of verification during the study can result in missing threats to reliability and validity until it is too late to correct them.

For project implementations, true reliability, validity, or trustworthiness is difficult to measure. Even though the implementation of the VON was not a research study or qualitative inquiry, it was important to examine the trustworthiness and accuracy of results after implementation. This was accomplished through the use of pre and post measure comparison to determine the results of implementation.

A gap analysis (Appendix N) was conducted to determine the current state, where the organization wanted to be, and what was needed to close any gaps. The gap analysis revealed low engagement of nurse managers and leaders. This analysis, in conjunction with the GANTT

chart, helped the group determine where to start and end the project as well as important project milestones (see Appendix O for initial GANTT chart).

As discussed earlier, the project was designed to engage the hearts and minds of nurse leaders and managers across the continuum of care at a large health system. During the initial planning session, the team defined a strategy and vision, as well as developed workgroups. These workgroups selected interventions to promote professional practice and the VON. The Project Assumptions, Scope, and Roles and Responsibilities are presented in Appendix P.

Baseline data before the implementation of the project was obtained from the results of the Practice Environment Scale of the Nursing Work Index Survey (PES-NWI) (Warshawsky & Havens, 2011) administered in May 2014 and the voluntary turnover rate for managers and nurse leaders. In addition, nurse managers and leaders were surveyed regarding their professional certification status.

The results of the PES-NWI showed that overall, nurse managers and leaders were dissatisfied with all dimensions of the workforce inventory (see Appendix Q for results and strengths and opportunities). The survey was sent as an email link to 122 non-union nurses. Four reminders were sent, with a 56.5% response rate. The scores for all questions ranged from 1.6 to 2.3, the subscale means ranged from 1.9 to 2.1 and overall composite mean of 2. A subscale above 2.5 represents a favorable environment, or agreement. A subscale below 2.5 is unfavorable, or disagreement, and the neutral midpoint is 2.5. Strengths were that physicians and nurses had good working relationships and work well together. Respondents also felt that nurse managers were good managers and leaders, there was active staff development, staff nurses had the opportunity to serve on committees, and there was an active quality assurance program. Areas for opportunity related to staffing and support services adequacy, participation

in policy decisions, and nursing administration visibility, authority, and responsiveness. It is important to acknowledge that the results were all very similar and the strengths and opportunities were based on narrow margins of agreement and or disagreement.

Nurse manager and leader turnover in April 2014 was 6.0%. In the first half of 2014, the rate was as high as 19.7% (January 2014) but still lower than some reports in the literature of as high as 50% turnover rates for nurse leaders and managers. It is unclear what contributed to the high rate in January and rates were decreasing when the project started.

Methods of Evaluation

The Evaluation team was responsible for determining, designing, and administering the evaluation measures. This group analyzed pre and post nurse manager turnover and results of staff satisfaction surveys. The People Pulse survey administered to all staff annually does not specifically address nurse satisfaction so the group was tasked with determining appropriate measures. In addition to the outcome measure related to nurse satisfaction, the group analyzed the outcomes related to nurse manager and leader turnover and professional certification. These were all outcome measures. Process measures for this project were based on progress of the group to embed the VON into daily work. The results of the analyses will be used to determine relevance of interventions with nurse leaders and managers, which will guide future interventions with frontline nursing staff. The Evaluation group developed the operational definitions of the measures and took into account the perspectives of assistant nurse managers when developing them.

Work to improve the nursing practice environment required measurement of desired outcomes through the use of valid and reliable measurement tools before and after implementation of changes. The Practice Environment Scale of the Nursing Work Index is a

survey-based measure of the nursing practice environment widely used to assess the state of the nursing practice environment. The PES-NWI is a 30-item survey developed from the Nursing Work Index, which was based on a review of job satisfaction literature and findings from an American Academy of Nursing study that identified characteristics associated with job satisfaction for nurses (Warshawsky & Havens, 2011). The PES-NWI is composed of five subscales: Staffing and Resource Adequacy; Collegial Nurse-Physician Relations; Nurse Manager Ability, Leadership, and Support of Nurses; Nurse Participation in Hospital Affairs; and Nurse Foundations for Quality of Care. The subscales (Nurse Participation in Hospital Affairs and Nursing Foundations for Quality of Care) address facility-level factors, while the other three address unit-level phenomena (Lake, 2002). Multiple United States organizations have recommended the PES-NWI to measure the quality of the practice environment, including the National Quality Forum and the Joint Commission (Warshawsky & Havens, 2011).

The PES-NWI was administered to all nurse managers, assistant nurse managers, and nurse leaders via an electronic survey in June 2015. The post PES-NWI was to be administered with the same methodology the end of January 2015 but due to labor negotiations and organizational initiatives, the survey administration was delayed and planned for July 2015. The union and organization reached a tentative agreement in January 2015. The delay did not impact the results as during this time, project interventions were also delayed.

Turnover rates for nurse managers and leaders in the first half of 2014 were compared to the rate in the second half of 2015. This data was obtained from the Human Resources department. The results of the nurse workforce inventory were evaluated by analyzing results from the initial survey administered in May 2014. The plan was to re-administer this survey in January 2015 but another survey was being planned for administration. To prevent survey

fatigue, the Evaluation group decided to defer re-administration of the PES-NWI. This survey was administered by the Project Lead via an online survey application. The number of nurse managers and leaders with professional certification as of June 2014 were to be compared to the number in January 2015. Nurse managers and leaders were to be surveyed electronically in January 2015 and asked about certification status in June 2014 and January 2015. To assess numbers of nurse managers and leaders who achieved board certification because of this project, evidence was to be self-reported by the nurse managers and leaders.

Formal reporting occurred regularly to the Program office. In addition, workgroups reported out at least monthly to the entire group on progress toward goals. These report out sessions also provided a forum to receive feedback and suggestions from members of the other workgroups.

Section IV: Results

Program Evaluation and Outcomes

There were multiple challenges during the implementation of the project that necessitated changes to the initial plan. The implementation began in May 2014 with the three-day kick off planning session. At the same time, the organization saw an increase in census due to an increase in membership resulting from health care reform with no concurrent increase in nurse staffing.

During the summer and fall of 2014, the Ebola crisis was escalating worldwide and the participating hospital had a “rule out” Ebola patient in August 2014. This patient and resulting preparation to care for potential future patients stretched the resources of the hospital. The facility also embarked on a journey to become an Ebola receiving center for Northern California

and many resources were diverted to this effort. These initiatives and an unusually high census necessitated that the group extend the plan for implementation and enculturation of the VON.

The organization decided to conduct a nurse engagement survey in July 2015 and the PES-NWI was not administered to compare results from the initial survey. The health system also administers a staff satisfaction survey in the fall and the Evaluation team felt that adding another survey (PES-NWI) would cause survey fatigue for nurse managers and leaders. Due to the use of two different surveys, it was necessary to compare both to determine if the data and results could be compared.

The Advisory Board Engagement Survey was developed to correlate nurse perception of workplace attributes with overall engagement levels. The Advisory Board surveyed 4,500 nurses in the United States to isolate the underlying drivers of engagement. This sample was diverse, with varied tenure, educational preparation, specialty types, and magnet designation status of their hospital. To isolate these drivers, the Advisory Board followed a systematic process of surfacing large numbers of factors that potentially influence professional engagement. They reviewed academic literature, other surveys, and interviewed many nurse and human resource professionals, including staff nurses, to isolate the drivers. The final survey covered 60 potential drivers of engagement and the questions address the full range of areas likely to influence nurses' overall work experience (The Advisory Board, 2007). The survey was administered via email to 69 potential respondents with a response rate of 76.8%. The survey administrators at the facility promoted the survey and sent three reminders.

A crosswalk of the PES-NWI and the Advisory Board Engagement Survey was done and showed that multiple items from each survey were comparable (see Appendix R). The survey administered to the facility's nurses contained 42 questions with an additional 13 custom

questions developed by the facility. Of these, 20 were comparable to the PES-NWI questions. Indicators from both surveys were compared to determine any possible correlation. The Advisory Board Engagement Survey contains eight driver categories with 55 questions. Each driver category has five to eight questions attributed to them. The PES-NWI survey has five subscales with five to nine categories in each and 30 questions.

The driver categories from the Advisory Board Survey were compared to the PES-NWI subscales. The eight Advisory driver categories correlated with all five PES-NWI subscales but not all of the PES-NWI categories. None of the PES-NWI subscales related to the Advisory survey's driver category of Baseline Satisfiers. Six of the nine categories of the Subscale for Nurse Foundations for Quality of Care did not correlate with the Advisory survey driver categories. None of the PES-NWI subscales correlated with the Advisory survey driver category Mission and Values.

Scores from both surveys were analyzed to determine scores for Strongly Agree and Agree and Strongly Agree combined. The results of the 20 comparable questions from both surveys were analyzed to see if there was any noticeable improvement (see Appendix S for survey results). As discussed earlier, the overall composite scores for the PES-NWI revealed dissatisfaction with the work environment. The overall Advisory survey revealed a high level of engagement by non-union nurses at the facility.

When the scores for agree and strongly agree combined were compared from both surveys, the results showed mostly lower scores after implementation of the VON. The questions related to manager communication were essentially unchanged but the ratings for those related to manager responsiveness and nurse collaboration were increased significantly. Analysis of the comparison of Strongly Agree scores was much more favorable, with two areas

that were essentially equal: ideas and suggestions valued and good manager and leader. The scores for enough nurses for workload and responsive administration declined significantly.

The annual nurse manager and leader voluntary turnover rate in April 2014 was 6.0% (see Appendix T for data details). While this rate is significantly lower than averages cited in literature, the goal is to decrease this rate by at least 10%. After the implementation of the VON, the rate was zero percent for all of 2015. This is a significant improvement and is reflected in the engagement survey results. The data for nurse certification was not complete and thus the Evaluation group was unable to assess this measure. This data was not available during the timeframe of the project.

The project lead and champions were able to adjust timeframes to accommodate challenges and changes and encourage movement of the project forward. Alternative changes were considered and implemented when different interventions were suggested by the other workgroups. This created difficulty with tracking interventions to outcomes but is the nature of process improvement in health care. There were no obvious changes to the care provided to patients and an analysis of patient satisfaction scores during the implementation of the VON was not done. This is planned for the next phase of the project. No harm was apparent and staff and manager interactions improved anecdotally. It is possible that this improvement of communication and relationships was a result of the successful contract negotiations and resultant contract but that is difficult to determine. The change process did not introduce burdens as the barriers and challenges slowed down the progress of the implementation rather than causing problems for the organization.

Section V: Discussion

Summary

Key successes of the project were increased nurse manager and leader engagement. The strengths of the project were the team approach and strong leadership support. The ability to use an "off the shelf" toolkit made implementation smoother and coordinated and was supported by the Program Office of the health system. There were multiple facilities in the health system implementing the VON at the same time, with regular collaborative calls and presentations to share best practices. The other facilities shared results and data but a comparison between local settings was not relevant as all facilities implemented the VON using different interventions based on their unique assessments.

Difficulties and challenges encountered are addressed in barriers and limitations. In addition to these, managing a large group of people broken into workgroups was challenging, as it was easy for them to go off in different directions and get into the fine details when it was not appropriate. It would be more efficient and effective to have a project lead who can devote at least half time to the implementation of the project. The project lead had multiple responsibilities, some driven by the challenges and barriers experienced during the project implementation, which made it difficult to focus on the project at times.

In order to sustain the changes, it is necessary to keep the momentum going and act as cheerleaders to keep the workgroups moving forward. The next step is to spread to all clinical (union) nurses at the facility. This will take involvement of the workgroups and the other managers and leaders who were not involved in the initial implementation of the VON. The cumulative efforts and leadership required to ingrain and embed the VON into all areas of practice will take a committed effort. The lessons learned are valuable to other facilities who may take on the same project and the community of practice calls and web-based sessions are necessary to keep inspiration and enthusiasm going.

Relation to Other Evidence

A literature review was completed with the topics of professional practice model, nurse retention, nurse manager retention, nurse manager turnover, nurse specialty certification, nurse empowerment, and nurse engagement. The search returned thousands of results, which were narrowed down to 15 that were of significance because the related specifically to nurse manager empowerment, engagement, and retention and were quantitative research results. A limiting factor of the literature review was the volume of information returned from the searches and the need to determine which were most appropriate to the project implementation. The evidence obtained helped define strategies and interventions of the project.

Findings of the setting for the implementation of the VON are typical of other settings undergoing similar changes. Notable differences were that other facilities did not have the same difficulties and challenges with union negotiations and Ebola response. While this facility experienced unique challenges, others did as well. Some of the facilities who implemented professional practice models were in states that do not have staffing ratios and presumably less staff per patient and thus a busier shift. Another difference experienced by the facility was the implementation of the professional practice model across the continuum of care. Many of the other implementations were in only the acute, or inpatient setting. It is difficult to determine whether these challenges had the same impact across organizations and settings.

Barriers to Implementation and Limitations

The potential barrier to implementation related to competing initiatives was realized. While managers and leaders at the initial planning session expressed concern that this project was one more thing "to do" and everyone was "very busy," they were supportive of the project and participated fully as time allowed.

It was expected that implementation of the professional practice model and the dialogue that occurred with it would increase the resilience of managers and leaders during this time of stress and conflict related to potential work stoppages resulting from contract negotiations with the union but the Evaluation team was unable to determine a correlation. The barriers related to time and financial constraints were managed effectively with project management skills and an awareness of financial limitations. Dollar costs were minimal, with labor costs "in kind."

While the barriers that were identified during the planning session were accurate, there were some that were not predicted. In addition to the concerns around Ebola and a high census discussed above, increased tension between leadership and staff nurses was present and continued. Staff behavior continued to be antagonistic with conflict between them and leadership. There were contentious labor negotiations during the fall of 2014 with a 3-day work stoppage in November. Planning for the work stoppage took precedence over other work and initiatives and caused delays in the implementation of the VON. An updated GANTT chart is included in Appendix U.

The lack of comparable surveys before and after the implementation of the VON is a significant barrier to accurate results. It was a subjective process to determine which questions correlated and subsequently a margin of error exists. It would be much better to use the same survey for ease of analysis of results but this was not possible.

Interpretation

Differences between expected and observed outcomes for this project are related to organizational and external influences that affected the implementation. The evidence supporting implementation of a professional practice model is strong with many different approaches to guide organizations. Actual financial costs were estimated accurately and

opportunity costs were not realized. There was no loss of potential gain due to choosing alternatives during the implementation of the VON.

The organization is constantly undergoing change, as is common in health care. There are the customary changes caused by reaction to events such as those that impact patient care. These tend to be reactionary and prompt rapid change, which is frequently not sustained. It is critically important to carefully plan change processes with clear sustainability plans to realize change and sustain that change. The implications of the changes realized during this change process illustrate the importance of leadership support to success and sustainability.

All were in agreement regarding the need for change in the culture of the organization and increasing professional practice for nursing. The difficulty keeping the project on track with many having input and ideas for implementation became apparent during the analysis of the implementation and results. With many initiatives occurring at the same time, it was not always clear which interventions were attributed to the success of the project.

Cause and effect were also not clear during the implementation of the VON. With many changes going on at once, it was not a controlled environment to accurately study the impact of selected interventions on the results. When conducting performance improvement projects following lean or six sigma guidelines, cause and effect is generally clear. When the implementation is more generalized, it is difficult to determine if the results are from the project interventions or from other competing projects and initiatives. Competing forces for the project lead and workgroups, as seen when the progress stalled for several months due to external forces that took them away from the work of the project were difficult to manage as noted in the discussion of barriers and limitations. In order to sustain the changes, the organization will need

to continue to embed the VON into practice and spread to frontline nursing staff and then to the other disciplines. This will be challenging without a dedicated project lead to guide efforts.

Future staff and professional development must include the fundamentals of the VON and opportunities for nurse managers and leaders to continue to learn about and improve their own professional practice and leadership skills. If they feel that the organization is investing in their development, they will be engaged and invested in their performance, as evidenced by the literature on engagement and results from this intervention.

Conclusions

The overall usefulness of the project implementation locally has implications for spread to the rest of the organization and to provide support and evidence for other facilities in the health system. Further studies of improvement to consider are frontline staff nurse engagement scores before, during, and after the spread initiative. The implications for practice are numerous: decreased turnover, increased engagement, and improved outcomes for patients. If staff are engaged and empowered, patients benefit.

This experience was fairly intuitive but more formalized than prior projects as there was a clear structure, metrics, and desired outcomes. The lack of clarity around interventions and cause and effect were similar to other improvement experiences and decreased the clarity of what caused the improvements. Not having the same survey pre and post was a significant confounding factor.

The implications from this work for patient care are improved quality of care resulting from improved engagement and empowerment of nurses. From this project, increasing the leadership ability and engagement of nurse managers and leaders provides the tools they need to roll this out to frontline staff nurses. Integrating the VON with new graduate nurse and novice

nurse managers and leaders should increase the development and formation of professional practice integration into their practice. Implementation of the VON with mid-career nurses who may be disengaged should provide the engagement needed to "refresh" their careers and move into the new era of health care and professional practice.

Use of process improvement tools and small tests of change might yield clearer, quicker results rather than over the extended time that occurred with this intervention. Future research is needed to determine the effectiveness of implementation of a professional practice model on staff manager relations during labor contract negation periods. Research on the impact of implementing a professional practice model with new graduates and novice nurse managers and leaders is needed to determine the value and business case for further implementation. Finally, research on what it actually means to implement a professional practice model, or an operational definition of what that means, would provide evidence to develop clear guidelines for future implementations.

The Professional Practice Model is designed to unite and align nurses under one vision, set of values, and a professional practice model across all regions of the health care organization. The goal is to build upon current strengths, integrate the work into what we are already doing, and align the work with what is important to the organization. In order to successfully spread the professional practice model to staff nurses, it is critical to ensure that nurse leaders and managers understand their own professional practice.

The organizational nursing strategy unites and aligns nurses under one vision, set of values, and professional practice model across the continuum of care. This enables the organization to elevate nursing practice, ultimately improving staff satisfaction and patient

outcomes. This strategy also ensures that regardless of where members enter the health system, they will know that they have been cared for by a nurse from this health system.

Section VII: References

American Nurses Association. (2010). *Nursing: Scope and standards of practice* (2nd ed.). Silver Spring, MD: Nursesbooks.org.

American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. Silver Spring, MD: Nursesbooks.org.

Conner, B. T. (2014). Differentiating research, evidence-based practice, and quality improvement. *American Nurse Today*, *9*, 26-31.

Felgen, J. A. (2007). *I2E2: Leading lasting change*. Minneapolis, MN: Creative Health Care Management.

Hoffart, N., & Woods, C. Q. (1996). Elements of a nursing professional practice model. *Journal of Professional Nursing*, *6*, 354-364.

Human Subject Assurance Training. (n.d.). Retrieved , from https://ohrp-ed.od.nih.gov/CBTs/Assurance/default.asp

Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health*. Washington, DC: The National Academies Press.

Johnson, J. E., & Billingsley, M. (2014). Convergence: How nursing unions and magnet are advancing nursing. *Nursing Forum*, *49*, 225-232.

Jones, C., & Gates, M. (2007, September 30). The costs and benefits of nurse turnover: A business case for nurse retention. *The Online Journal of Issues in Nursing*, *12*(4). http://dx.doi.org/10.3912/OJIN.Vol12No03Man04

Kaiser Permanente. (2013). *Kaiser Permanente Nursing Strategy* [White Paper]. Oakland, CA: Author.

Kallas, K. D. (2014). Portrait of an excellent nurse manager: Identifying and developing health care team leaders. *Nursing Administration Quarterly*, *38*, 261-268. http://dx.doi.org/10.1097/NAQ.0000000000000032

Kendall-Gallagher, D., Aiken, L., Sloane, D., & Cimiotti, J. (2011). Nurse specialty certification, inpatient mortality, and failure to rescue. *Journal of Nursing Scholarship*, *43*, 188-194.

Koloroutis, M. (2004). *Relationship-based care: A model for transforming practice*. Minneapolis, MN: Creative Health Care Management.

Krapohl, G., Manojlovich, M., Redman, R., & Zhang, L. (2010). Nursing specialty certification and nursing-sensitive patient outcomes in the intensive care unit. *American Journal of Critical Care*, *19*, 490-498.

Kuokkanen, L., Leino-Kilpi, H., & Katajisto, J. (2003). Nurse empowerment, job-related satisfaction, and organizational committment. *Journal of Nursing Care Quality*, *18*, 184-192.

Lake, E. T. (2002). Development of the practice environment scale of the Nursing Workforce Index. *Research in Nursing and Health*, *25*, 176-188.

Laschinger, H. K., Wilk, P., Cho, J., & Greco, P. (2009). Empowerment, engagement and perceived effectiveness in nursing work environments: Does work experience matter? *Journal of Nursing Management*, *17*, 636-646.

Laschinger, H. K., & Wong, C. (2010). Staff nurse empowerment and collective accountability: effect on perceived productivity and self-rated work effectiveness. *Nursing Economics*, *17*, 308-319.

McLarty, J., & McCartney, D. (2009). The nurse manager: The neglected middle. *Healthcare Financial Management*, *63*, 74-80.

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and valididty in qualitative research. *International Journal of Qualitative Methods, 1*, 13-22.

Newhouse, R. P., Dearholt, S. L., Poe, S. S., Pugh, L. C., & White, K. M. (2007). *Johns Hopkins nursing evidence-based practice model and guidelines*. Indianapolis, IN: Sigma Theta Tau.

Ondrejka, D., & Bernard, D. (2011). Implementing a professional nursing practice philosophy and model: using affective methods to address resistance. *Creative Nursing, 17*, 139-147. http://dx.doi.org/10.1891/1078-4535.17.3.139

Parsons, M. L., & Stonestreet, J. (2003). Factors that contribute to nurse manager retention. *Nursing Economics, 21*, 120-126.

Pineau Stam, L. M., Spence Lashinger, H. K., Regan, S., & Wong, C. A. (2013). The influence of personal and workplace resources on new graduate nurses' job satisfaction. *Journal of Nursing Management*. http://dx.doi.org/10.1111/jonm.12113.

Pinelle, D., & Gutwin, C. (2006). Loose coupling and healthcare organizations: Deployment strategies for groupware. *Computer Supported Cooperative Work, 15*, 537-572. http://dx.doi.org/10.1007/s10606-006-9031-2

Press Ganey. (2006). *The loyalty connection: Patient loyalty starts with employees*. : .

Senge, P. M. (2006). *The fifth discipline: The art and practice of the learning organization*. New York: Doubleday.

Simpson, M. R. (2008). Engagement at work: A review of the Literature. *International Journal of Nursing Studies, 46*, 1012-1024.

The Advisory Board. (2007). *Engaging the nurse workforce: Best practices for promoting exceptional staff performance*. Washington, DC: The Advisory Board Company.

Towers Perrin. (2003). *Working today: Understanding what drives employee engagement*. Stamford, CT: Towers Perrin.

Triz: A powerful methodology for creative problem solving. (n.d.). Retrieved from http://www.mindtools.com/pages/article/newCT_92.htm#

U.S. Department of Health and Human Services. (2011). *2011 report to Congress: National strategy for quality improvement in health care* [Report to Congress]. Retrieved from http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.htm

U.S. Department of Health and Human Services. (n.d.). http://www.hhs.gov/healthcare

Warshawsky, N. E., & Havens, D. S. (2011). Global use of the practice environment scale of the nursing work index. *Nursing Research*, *60*, 17-31.

Section VIII: Appendices

Appendix A: Definition of Terms

Professional Practice Model: a system (structure, process, and values) that supports registered nurse control over the delivery of nursing care and the environment in which care is delivered (Hoffart & Woods, 1996, p. 1)

Voice of Nursing: The Professional Practice Model

Nursing Mission: Our nurses advance the art and science of nursing in a patient-centered healing environment through our professional practice and leadership

Organizational Vision: Extraordinary nursing care. Every patient. Every time

Patient and Family Centered Care: an approach to the planning, delivery, and evaluation of health care that is based on mutually beneficial partnerships among providers, patients, and their families (http://www.ipfcc.org/faq.html)

Appendix B: Mission, Vision, and Strategy

The organization's mission is to provide high-quality, affordable health care services to improve the health of our members and the communities we serve.

The organization's vision is to be the leader in Total Health by making lives better.

Strategic Pillars

These pillars are designed to enable the organization to become "Simply the Best"

Appendix C: VON Strategic Concept

VOICE OF NURSING

Customers:
- Nursing Leadership

Product:
- Voice of Nursing professional practice model

Customer Benefits:
- Functional: Provision of extraordinary care to patients & their families
- Emotional: Feeling of professional pride by nurses
- Social: Recognition by nurses of the value they bring to patients & families

Use Cases:
- Promotion of excellent, quality care by registered nurses
- Promote nurse autonomy, nurse accountability, professional development

Problems to be solved:
- Increased quality of care
- Increased patient satisfaction
- Increased manager and staff satisfaction and retention

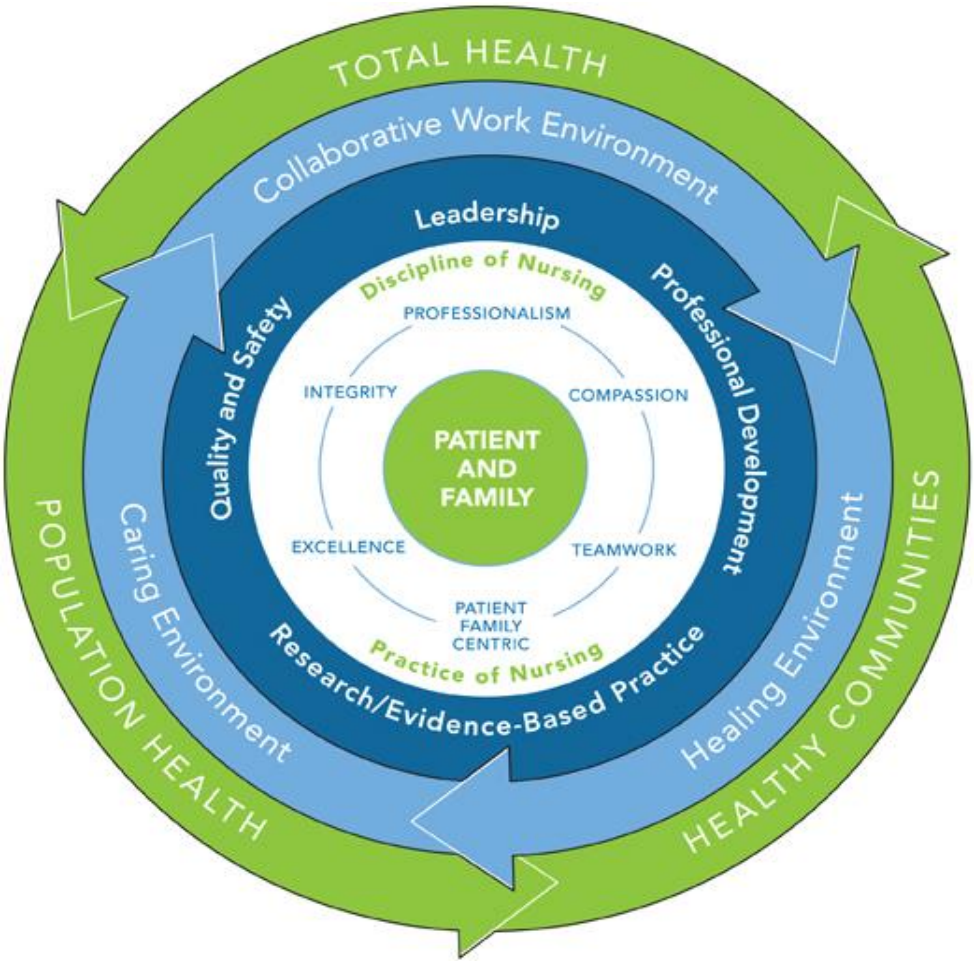
Design Points:
- Customizable
- Cohesive infrastructure
- Based on evidence

Appendix D: Growth and Customer Analysis

1. Growth Strategy:
    a. Market penetration:
        i. Sell the Voice of Nursing (VON) professional practice model to the entire organization (Northern California region).
    b. Market development:
        i. Market/sell service to other regions of the health system or other health systems.
        ii. Expand consultant capacity to meet increased market share.
    c. Alternative channels:
        i. Use the internet to increase customer exposure/access.
        ii. Contract with nursing schools to provide a curriculum based on the VON.
        iii. Offer services to other disciplines in health care.
    d. Product development:
        i. Develop an internet site to "sell" the VON; the website will provide access to books and resources, some paid and some free.
        ii. Develop and offer "Do it yourself" modules that will decrease the cost to the customer and increase exposure and customer base.
    e. Product diversification:
        i. Adaptation of the professional practice model for other disciplines, such as physicians, senior executives, allied health professionals, etc…
        ii. Provide consultancy for nurse residency/mentoring programs, critical thinking development, clinical decision support, etc...
2. Competitors:
    a. Professional practice consultants (for example, leadership development or Magnet certification consultants).
3. Competitor Strengths:
    a. Experience
    b. Many clients
    c. Narrow focus (can be strength or weakness)
    d. Consultants with extensive experience in field

   e. Website and books available
   f. Free consultation
   g. Focus on interdisciplinary collaboration
   h. Less expensive: if consultants offer similar services for a lower cost, whether inside or outside the organization.
4. Competitor Weaknesses:
   a. Narrow focus (i.e. Magnet)
   b. More expensive
   c. Difficult to navigate website
   d. Lack of experience or customer testimonials
   e. Not easy to find via internet search
   f. Lack of long term follow through unless you pay extra

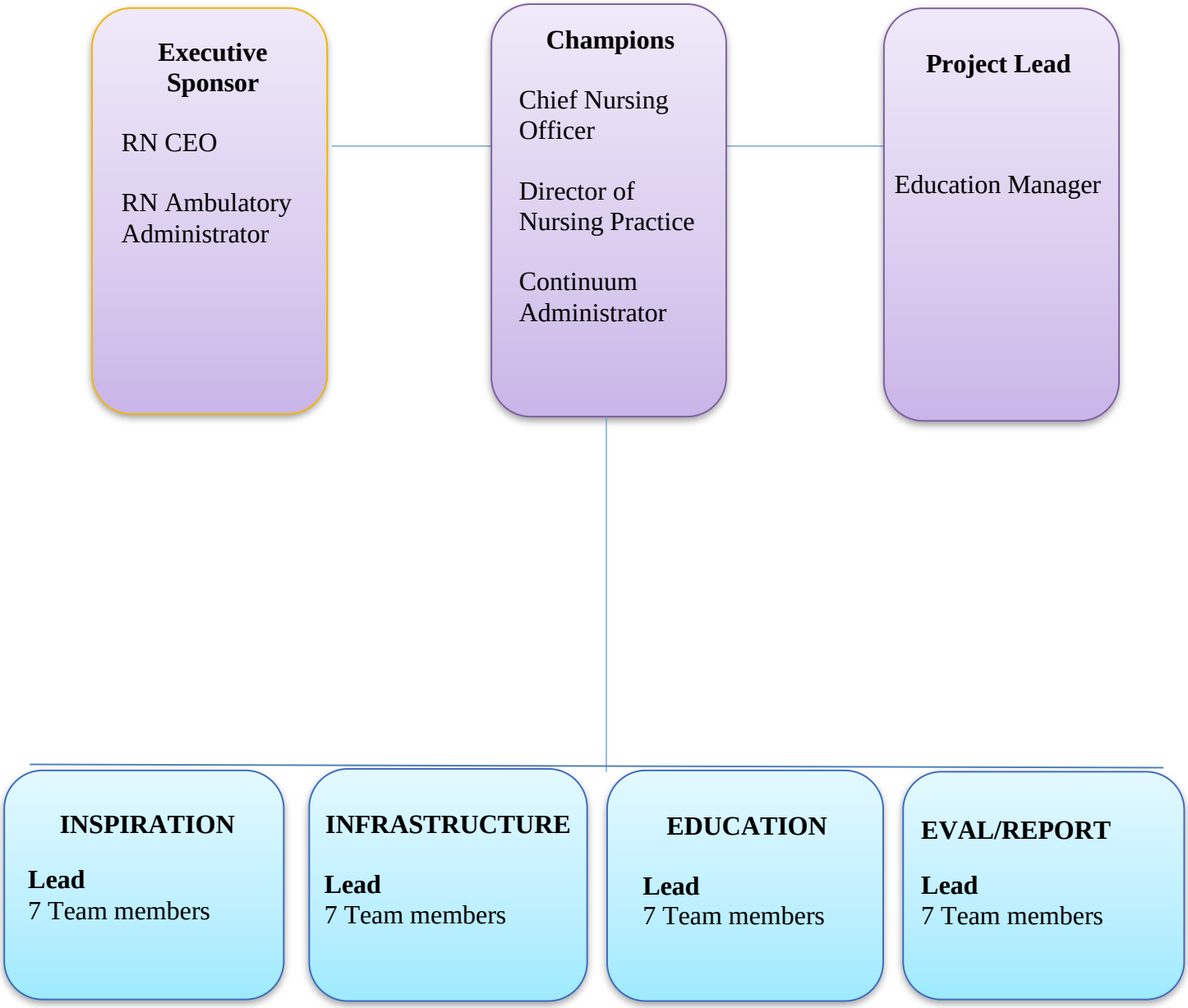
Appendix E: Voice of Nursing Professional Practice Model



Appendix F: Communication Matrix

AUDIENCE	CATEGORY	INFORMATION	METHOD	FREQUENCY	DETAIL
Core Team	Project execution/ status	Project progress, accomplishments, issues, challenges	Core Team meeting	Monthly	Info/ Action
Senior Leaders	Status	High-level project status	Email	Monthly	Info/ Action
Program Office	Status	High-level project status	Meeting (site visit)	Semi-annually	Info
Community of Practice	Status	High-level project status	Webex	Quarterly	Info
Entire Team	Project execution/status	Project progress, accomplishments, issues, challenges requiring management support	Meeting	Monthly	Info/ Action

Appendix G: Workgroups and I2E2 (Framework)



Appendix H: Work Breakdown Structure

Level	WBS Code	Element Name	Definition
1	1	Determine Scope	CNO and project manager work to define scope of project and sign agreement with Program Office
2	1.1	Strategic planning session	Strategic planning session
3	1.1.1	Determine workgroups	Initiation
3	1.1.2	Workgroup recommendations	Evaluation & Recommendations
3	1.1.3	Framework	Develop framework for future team work
3	1.1.4	Execution	Work involved to execute the project.
3	1.1.5	Deliverable: report to team	Deliverable: report to entire team
2	1.2	Milestone: Program Office visit	Project assessed with visit by Program Office
3	1.2.1	Control	The work involved for the control process of the project.
3	1.2.2	Project Management	Overall project management for the project.
3	1.2.3	Project Status Meetings	Weekly team status meetings.
3	1.2.4	Update Project Management Plan	Project Manager updates the Project Management Plan as the project progresses.
3	1.2.5	Project Status Meetings	Weekly team status meetings.
3	1.2.6	Update Project Management Plan	Project Manager updates the Project Management Plan as the project progresses.
2	1.3	Final Evaluation	Project lead and team evaluate progress

Level of Effort: How much work is required to complete a task.
WBS Code: A unique identifier assigned to each element for the purpose of designating the elements hierarchical location within the WBS.
WBS Element: A single WBS component and its associated attributes located anywhere within a WBS.

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Appendix I: Workgroup Interventions

INSPIRATION	INFRASTRUCTURE	EDUCATION	EVALUATION
• Nurse Week Video: Why I Became a Nurse • Develop VON Intranet page • I Care button program • Facilitate Nurse Week celebrations • Central areas for nurse recognition in departments	• Define nurse leader roles • Develop structure for promotion of professionalism and resilience • Facilitate leadership session: Resilience in Turbulent Times • Nursing recognition (Daisy, National award, Clinical Ladder) • Nursing Research Council and Practice Committee	• Evaluate onsite professional certification courses and provide recommendations • Facilitate assistant nurse manager attendance at middle management training sessions • Plan and facilitate a Voice of Nursing education session for assistant nurse managers and those who missed the initial sessions	• Evaluate and recommend survey tool for pre and post evaluation of satisfaction • Develop process to analyze nurse manager and leader turnover • Analyze results related to nurse manager certification pre and post

Appendix J: SWOT Analysis of Current State

Strengths	Weaknesses
▪ Communication ▪ Leadership ▪ Collaboration ▪ Technology ▪ Community/reputation ▪ Vision ▪ People	▪ CNA/Union ▪ Communication ▪ Collaboration ▪ Workplace culture ▪ Education ▪ Emotions ▪ Task-focused RMs ▪ Multiple changing priorities ▪ Inconsistencies ▪ Accountability
Opportunities	**Threats**
▪ Leverage technology ▪ Quality ▪ Professional practice ▪ Resources ▪ Workflows ▪ Communication ▪ Membership ▪ Continuum ▪ Education/training	▪ Business practices ▪ External agencies/competition ▪ Union ▪ Behaviors

Strengths

- Communication

    - Open communication between department and Senior leaders
    - Policies and procedures are clear, well standardized and evidence-based
    - Improved clarity on expectations and enforcement of accountability
- Leadership
    - Our leaders are the examples of what we want to be
    - Our leaders have the right focus: on what is best for patients
    - Strong collaborative team that really tries to find common solutions
    - Caring and committed Senior leaders and nurse managers
- Collaboration
    - Collaboration strong between inpatient and outpatient
    - Good RN and MD collaboration
    - Easy to confer with specialists
    - Nursing partnerships across the continuum, hospital-ambulatory
- Technology
    - Network access
    - Integrated health care delivery system
    - iPhone, iPad, Cortext
- Community/reputation
    - Integrity
    - Member access and reputation in the community is good; hasn't always been so
    - Known as a great place to work
    - Baby Friendly designation (Center of Breastfeeding Excellence)
- Vision
    - Model of care throughout the world
    - Collaborations – openness for ideas; engaged leaders
    - Physician involvement, energetic leaders, visible leaders
    - Innovators; willing to take risks and lead the pack. We are the "FIRSTS" for many pilots/projects
- People
    - Empowerment – positive reinforcement, positive coach and mentor
    - Meaningful recognition: Daisy awards to recognize nurses
    - RNs have passion for what they do
    - Creative, motivated, and innovative people
    - Many RNs recognize that they are very well compensated for their work
    - Supportive rather than punitive environment
    - Enthusiasm, positive attitudes, knowledgeable, caring, credible, motivated, hardworking, creative, innovative, detailed oriented, clinically strong
    - Our staff are our members

Weaknesses

- CNA/Union

    - A lot of people in the room haven't gotten raises this year and many managers will be upset if the staff nurses get another 5% raise
    - Nurses fear and anxiety about upcoming contract negotiations; they feel they are being pulled into something they don't really want to be engaged in
    - Our nurses don't own being a professional nurse (they say they are CNA nurses)
- Communication
    - Within organization with staff and patients across continuum
    - With staff information doesn't get filtered down consistently
    - Too much stuff for huddle messages
    - Real conversations with staff difficult – unclear guidelines, not clear in the contract. Lack of clarity about what the contract says and how to interpret it
- Collaboration
    - Need collaboration between management/leadership and CNA
    - Multiple silos in the system; top down freedom to do what you want to do
    - No accountability
- Workplace culture
    - A lot of cultural groups and families working together and there are leaders of these groups.
    - Bullying of staff on social media, text messages, after work; it overflows to the work environment
    - Pressure for staff to "wear red on Friday" in order to be in "good standing" with the union
    - High turnover of management: burnout
    - Staff and leader fear of economic insecurity
- Education
    - Lack of training for nurses, continuing education or cross training
    - Nurses are not formally educated (ADN)
- Emotions
    - Nurses do what they must, not what they should or could do
    - Frustration when nurses underperform
- Task-focused RNs
    - RNs not embracing their professional practice
    - Culture of nurses that reinforces task orientation
    - Excessive charting needs to be reduced
    - Too much dependence on meeting metrics without encouraging the heart/spirit to crave excellence
- Multiple changing priorities
    - Conflicting directions
    - Too many regional demands that are not value added and no collaboration for reduction of these demands

    - Top driven methodologies
    - Too many meetings, everything is a priority and not enough time on the units
    - Too many initiatives that do not get completed
    - Too many visions, values, and missions – not on the same page. Local facility in conflict with region and region in conflict with national office
- Inconsistencies
    - Management inconsistent with holding staff accountable, staffing, or expectations
    - Priorities are always shifting
    - Lack of consensus among the care team
- Accountability
    - Lack of accountability for patient practices, patient rounding, NKE, purposeful hourly rounding
    - Too many different reports and all different ways for many different departments
    - No fortitude to counsel or fire for poor performance
    - We get many policies shoved down through region and they are 15-30 pages long

Opportunities

- Leverage technology
    - Opportunities for improvement
    - Difficult time getting data which makes it difficult to identify opportunities for improvement
- Quality
    - Magnet Journey
    - Organizational position as a national leader for quality and access
- Professional practice
    - Join together with frontline staff to engage, motivate, to grow future leaders
    - Succession planning
    - Consistencies of practice throughout the organization
    - Get back to the reason we became nurses, because we care
    - Be patient-centric in all practices
    - Coach and mentor high performers and empower them to elevate low-mid performers
    - Consistent practice throughout the organization
    - Elevate staff to become autonomous
- Resources
    - Infrastructure support from region
    - Financial realignment
    - Clinical Ladder should be used and given more responsibility
- Workflows
    - Define our work and standardize when possible
    - Improve the processes and be more efficient

    - Make care less hospital-centric
    - Bring the program forward to relationship based care
- Communication
    - Give the rationale when asking to do something
    - Better communication with CNA (upcoming negotiations)
    - Inpatient and outpatient relationship and continuity of care
- Membership
    - Optimize services to provide value for members with increased co-payments
- Continuum
    - Leverage and enhance care across the continuum
- Education/training
    - Bring back new grads
    - Specialty RNs
    - Design and develop new to practice nursing trainers and then ongoing coach-mentor model

Threats

- Business practices
    - Workforce themes: no new blood, mass retirements, layoffs
    - Hiring freezes; can't hire externally
    - Too many initiatives/data/too much to focus on
    - Rising costs – Affordable Care Act
    - Administrative services redesign
- External agencies/competition
    - Economic downturn, reputation, public beliefs
    - Competition for market share
- Union
    - Many one word: "Union"
- Behaviors
    - Lack of accountability
    - Entitled workforce
    - Nursing turnover – loss of experience/knowledge
    - Many tenured employees doing things because they have always done it "this way"
    - Fear-based employees
    - Gossip – having one voice we can eliminate this
    - Inability to move quickly
    - Complacency
    - Inefficient practices

Appendix K: TRIZ Assessment Results

Design a highly reliable process that will ensure that the Voice of Nursing will **FAIL**

- Throw away the binder
- Create competencies
- Managers take it back and create a list and a competency
- Wear RED on Friday
- Telling staff this has no benefit
- Audits
- Sit back and watch
- Top down approach
- Explain to RNs but do not integrate into culture
- Talk about in huddle (only) to get message out
- Focus on the negative

What does the work environment look like?

- Nurses want to be spoon-fed
- High alert medication errors – process issues
- We spend our time putting out fires
- Not acceptable to say "I'm too busy"
- Every year there are new ideas, projects, process changes...and we don't follow through
- The culture is not accountable. We are trying to change this but nurses see this as being "mean"
- Task-oriented: professional practice is not seen as important. Trouble connecting the dots
- Lots of nurses in it for the money. How do we ignite the flame?
- 10% of the population is negative. Most are positive.

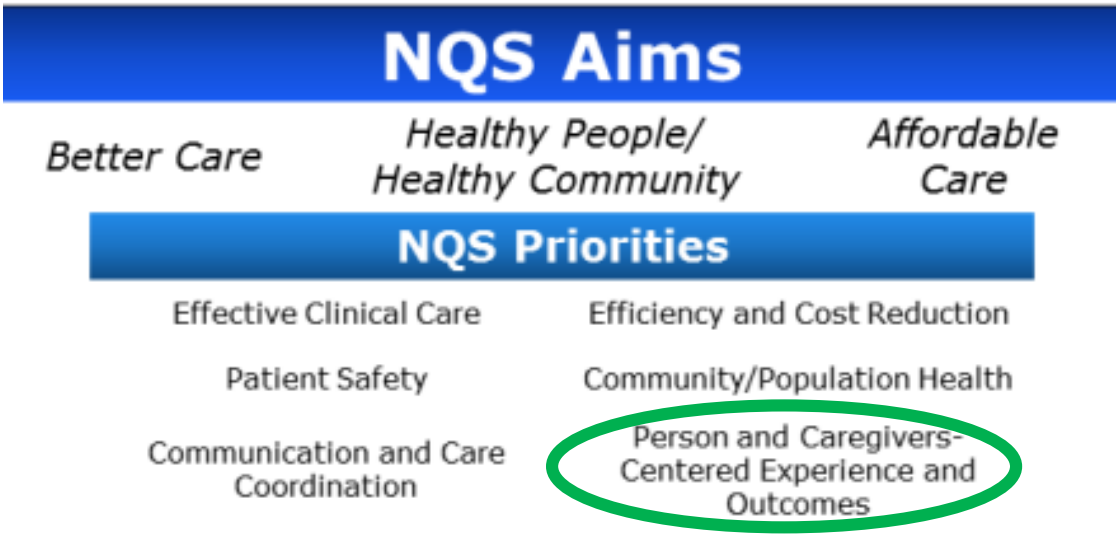
What needs to stop happening to make the Voice of Nursing successful?

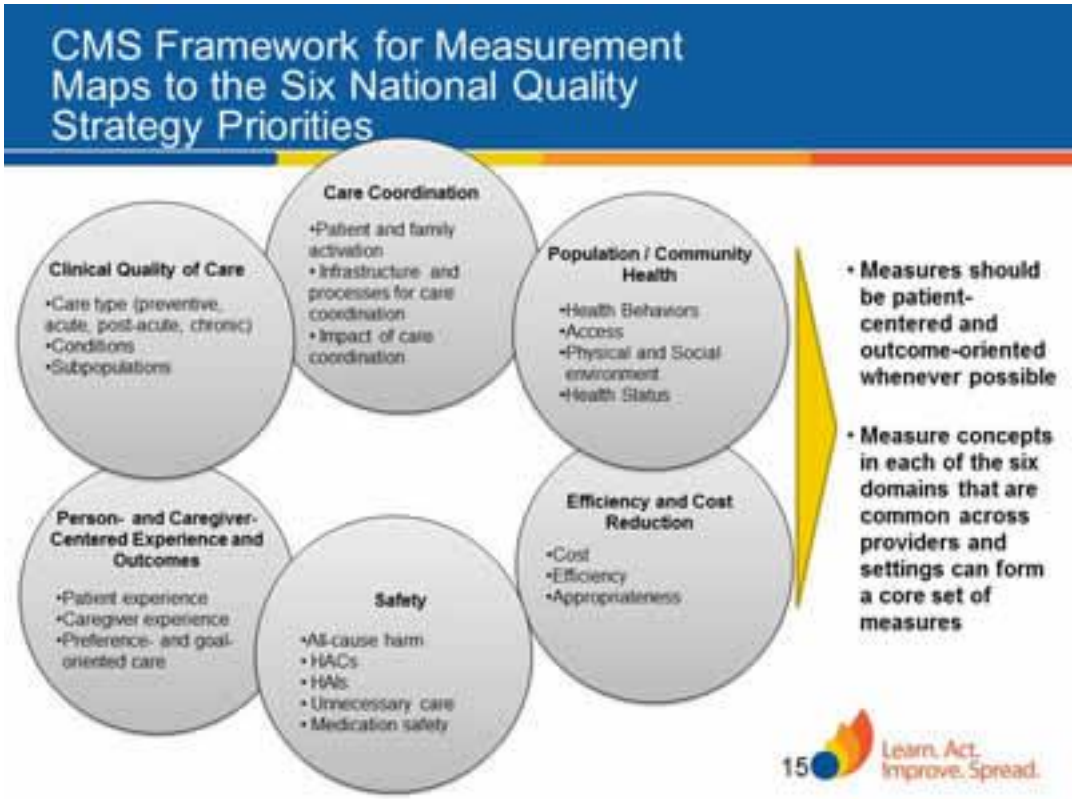
- Stop focusing on the 10%.
- Stop allowing poor performance
- Stop talking to our staff like they are children or sheep
- Stop the excuses
- Stop fearing the Union
- Stop managers, assistant managers owning everything. Get the staff to own it
- Stop micro-managing. We have to stop letting the negative 10-20% influence us

Appendix L: Budget and Return on Investment

Type of Expense	Cost
Project Lead (.20 FTE X 6 months; 192 hours)	$80 X 192 = $15,360
CNO Time (40 hours)	40 X $90 = $3,600
Nurse Manger Education (40 hrs X 35 Managers)	$80 X 40 hrs X 35 = $112,000
Training (3 Program Office Consultants X 24 hours each)	$60 X 72 hrs = $4,320 (in kind)
Regional consulting (24 hours)	$60 X 24 hrs = $1,440 (in kind)
Materials and supplies	$2,000
Food/water	$2,000
Certification Prep Course	$270 X 35 = $9,625
Certification Exam	$300 X 35 = $10,500
Total	$160,845 ($5,760 in kind)
Net Cost	$155,085
Annual Salary: nurse manager	$160,000
Replacement Cost: nurse manager	$256,000
Project Cost (Investment)	$155,085
Net Savings for 1 nurse manager:	$100,915

Appendix M: Quality Improvement Design: National Quality Strategy

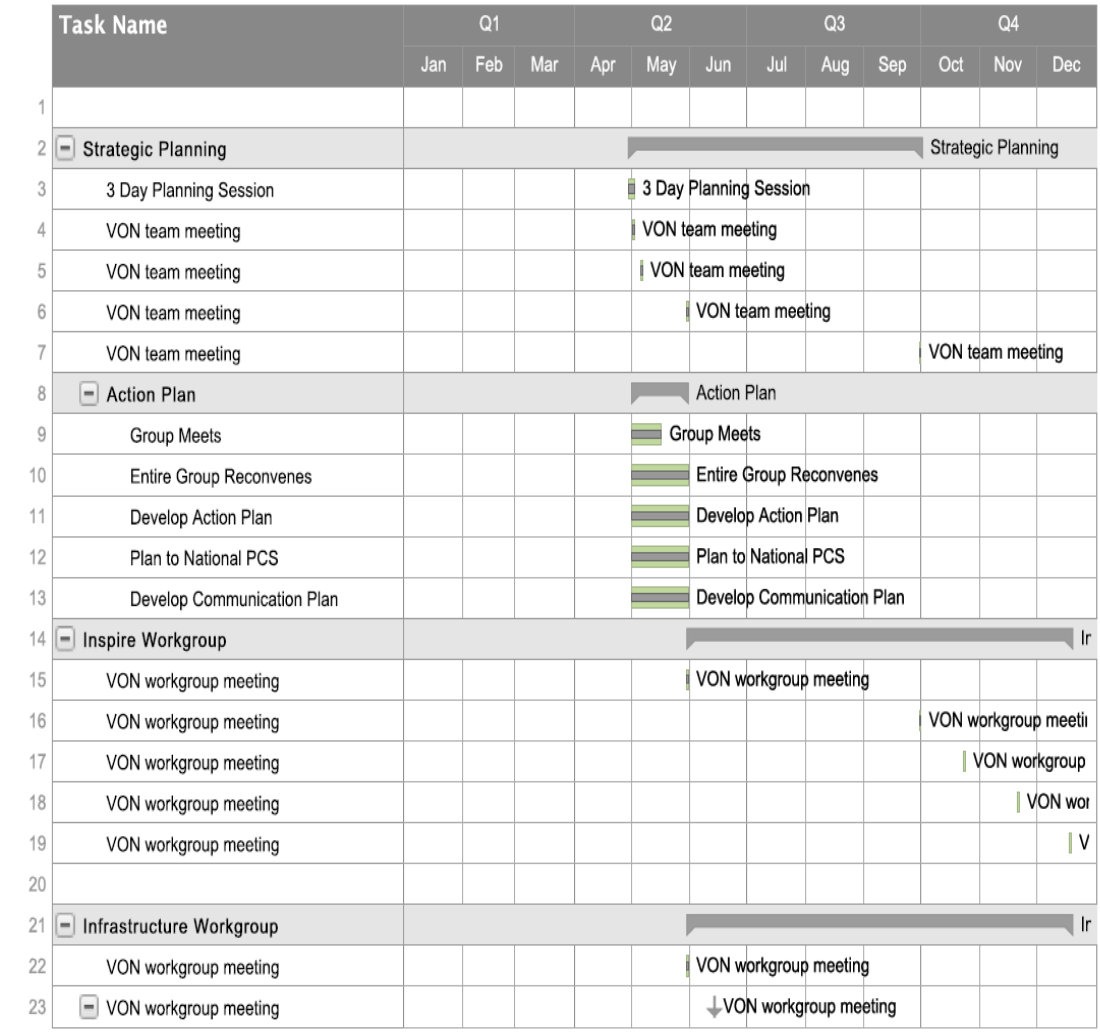




Appendix N: Gap Analysis

Future State	Current State	Actions Needed
• Develop leadership skills of nurse leaders and managers • Enhance professional practice at the leadership level • 75% of nurse managers/leaders with national certification • Decrease nurse manager/leader turnover by 10%	• Low engagement of nurse mangers/leaders • Lack of perception of professional practice • 0% of nurse managers/leaders with professional national certification • Nurse manager/leader turnover rate: 6.0%	• Administer the PES-NWI to nurse managers/leaders before and after interventions • Determine number of nurse managers/leaders with national professional certification before and after interventions • Implement interventions determined by workgroups

Appendix O: GANTT Chart



	Task Name	Q1			Q2			Q3			Q4		
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
24	Determine goals for 6 mos, 12 mos, etc						Determine goals for 6 mos, 12 mos, etc						
25	VON workgroup meeting							VON workgroup meeting					
26	Gaining Resilience in Turbulent Times								Gaining Resilience in Turbulent Times				
27	VON workgroup meeting										VON workgroup meeti		
28	VON workgroup meeting											VON workgroup	
29	VON workgroup meeting												VON wor
30	VON workgroup meeting												V
31	Education Workgroup												E
32	VON workgroup meeting						VON workgroup meeting						
33	Determine goals for 6 mos, 12 mos, etc						Determine goals for 6 mos, 12 mos, etc						
34	VON workgroup meeting										VON workgroup meeti		
35	VON workgroup meeting											VON workgroup	
36	VON workgroup meeting												VON wor
37	VON workgroup meeting												V
38	Evaluation/Report Workgroup												E
39	VON workgroup meeting						VON workgroup meeting						
40	Determine goals for 6 mos, 12 mos, etc							Determine goals for 6 mos, 12 mos, etc					
41	VON workgroup meeting										VON workgroup meeti		
42	VON workgroup meeting											VON workgroup	
43	VON workgroup meeting												VON wor
44	VON workgroup meeting												V
45	Evaluate outcome measures						Evaluate outcome measures						

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	Task Name	Q1			Q2			Q3			Q4		
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
46	PESN-WI pre						PESN-WI pre						
47	Nurse Manager retention/turnover						Nurse Manager retention/turnover						
48	Participation in VON training for ANMs		Participation in VON training for ANMs										
49	Nurse Manager certification course completion		Nurse Manager certification course completion										
50	Nurse Manager certification completion		Nurse Manager certification completion										
51	PESN-WI post		PESN-WI post										
52													
53													
54													
55													

Appendix P: Project Scope and Assumptions

IN SCOPE	OUT OF SCOPE
• Nursing vision, values and professional practice model • Nursing culture • Nursing infrastructure • Policies, procedures, and standards • Nursing Scope of Practice • Quality metrics	• Hospital and facility planning • Staffing issues • Labor issues

Assumptions:

- Voice of nursing is time bound
- Program office will provide toolkit materials to facility at strategy planning meeting
- It is the decision of the facility to have inpatient and ambulatory attend the 3 day strategy planning meeting together
- The Voice of Nursing is focused on registered nurses
- The facility is to take the learnings from the strategy planning meeting and embed the Voice of Nursing into current work
- The facility is to monitor outcome measures and report on execution plan and metrics to the National Nursing Professional Practice Council every 6 months for 2 years

Roles and Responsibilities

Groups	Roles/Responsibilities	Title
Executive Sponsor	• Provides clear direction for the VON and alignment with goals • Communicates objectives and expectations • Ensures the VON is on time, on budget, and on scope • Secures project resources • Receives status updates • Resolves conflicts not resolved at project level • Promotes success	• Chief Executive Officer

Groups	Roles/Responsibilities	Title
Champions	• Lead through the planning and execution phases • Prepares a powerful leader story…What this means to me • Delivers the VON to senior executives, medical directors, and others • Equips nurse leaders with information and tools to educate and inform others • Incorporates budget planning for successful execution of the VON for facility • Provides status updates to sponsors • Ensures report on execution plan and metrics are communicated	• Chief Nursing Officer • Director or Nursing Practice • Continuum Administrator
Project Manager/Lead	• Provides overall direction to the team • Develops comprehensive project plan and ensures all activities are completed on time and in scope • Develop status reporting materials for meetings with sponsors, champions, and team members • Escalates issues	• Clinical Education Director
Project Section Lead: Inspiration Workgroup	• Cheerleader • Identified as a leader that inspires and engages with others in developing a shared vision • Provides status updates and escalates issues • Contributes and advances to spread the VON • Inspires to embed the VON to improve the experience of patients, families, and colleagues	• Administrative Services Director

Groups	Roles/Responsibilities	Title
Project Section Lead: Infrastructure Workgroup	• Best at setting standards and policies • Develops and oversees standards, policies, systems, and practices that advance the VON • Provides status updates and escalates issues • Integrates the VON into culture and relationships of daily lives to assure VON embedded into the environment	• Clinical Service Director
Project Section Lead: Education Workgroup	• Leader responsible for professional development • Provides status updates and escalates issues • Assess learning programs in place to advance the VON • Assess knowledge and skill-building leaders and managers will need to adopt and sustain the VON • Determine how managers and leaders will acquire knowledge and skills necessary to embed the VON	• Clinical Education Director
Project Section Lead: Evaluation Workgroup	• Leader who knows metrics and is analytical by nature • Provides the status updates and escalates issues • Captures and reports outcome measures and metrics at the unit, department, facility, and regional level to show VON embedded and sustained • Determine behaviors, outcomes, and tangible changes that provide evidence the VON is advancing at facility	• Area Quality Leader

	• Report on execution plan and metrics to Program Office	
Team Members		• Chief Nursing Officer • Director of Nursing Practice • Continuum Administrator • Service Directors • Clinical Educators • Clinical Nurse Specialists • Department Managers • Lead Hospitalist • Hospital Operations Physician • Care Experience Leader

Appendix Q: PES-NWI Baseline Data

The Practice Environment Scale of the Nursing Work Index					
Subscales	**Categories**	**Questions**	**Item Level Mean**	**Subscale Mean**	**Overall Composite Mean**
Staffing and Resource Adequacy	Adequate support services	Adequate support services allow me to spend time with my patients.	2.2	2.1	2
	Time to discuss patient problems	Enough time and opportunity to discuss patient care problems with other nurses.	2.1		
	Enough nurses for quality care	Enough registered nurses to provide quality patient care.	1.9		
	Enough staffing	Enough staff to get the work done.	2.1		
Collegial Nurse-Physician Relations	Nurse-physician relationships	Physician and nurses have good working relationships.	1.8	1.9	
	Nurse and physician teamwork	A lot of team work between nurses and physicians.	2.0		
	Collaboration	Collaboration (joint practice) between nurses and physicians.	1.9		
Nurse Manager Ability, Leadership, and Support of Nurses	Supportive supervisory staff	A supervisory staff that is supportive of the nurses.	1.9	2	
	Supervisors learning experiences	Supervisors use mistakes as learning opportunities, not criticism.	2.2		
	Nurse manager and leader	A nurse manager who is a good manager and leader.	2.1		
	Recognition	Praise and recognition for a job well done.	2.0		
	Nurse manager backs up staff	A nurse manager who backs up the nursing staff in decision making, even if the conflict is with a physician.	1.9		
Nurse Participation in Hospital Affairs	Care development	Career development/clinical ladder opportunity.	2.0	2	
	Participation in policy decisions	Opportunity for staff nurses to participate in policy decisions.	1.9		
	CNO visibility	A chief nursing office who is highly visible and accessible to staff.	2.1		
	CNO authority	A chief nurse officer equal in power and authority to other top-level hospital executives.	1.9		
	Advancement opportunities	Opportunities for advancement.	2.1		
	Administration listens and responds	Administration that listens and responds to employee concerns.	2.0		
	Staff nurses hospital governance	Staff nurses are involved in the internal governance of the hospital (e.g., practice and policy committees).	1.9		
	Nursing committees	Staff nurses have the opportunity to serve on hospital and nursing committees.	1.7		
	Nursing administrators consult	Nursing administrators consult with staff on daily problems and procedures.	2.3		
Nurse Foundations for Quality of Care	Continuing education	Active staff development or continuing education programs for nurses.	2.0	2	
	High nursing care standards	High standards of nursing care are expected by the administration.	1.6		
	Philosophy of nursing	A clear philosophy of nursing that pervades the patient care environment.	1.9		
	Nurses are competent	Working with nurses who are clinically competent.	2.0		
	Quality assurance program	An active quality assurance program.	1.9		
	Preceptor program	A preceptor program for newly hired RNs.	2.3		
	Nursing care model	Nursing care is based on a nursing, rather than a medical, model.	2.0		
	Patient care plans	Written, up-to-date nursing care plans for all patients.	2.1		
	Continuity of patient assignments	Patient care assignments that foster continuity of care, i.e., the same nurse cares for the patient from one day to the next.	2.1		

Legend: Subscale for a 4 point response set — **n=48**

Agreement = subscale above 2.5 (favorable environment)

Disagreement = subscale below 2.5 (unfavorable environment)

Neutral midpoint = 2.5

Strengths	Opportunities
1. Physician and nurses have good working relationships	1. Adequate support services
2. A lot of team work between physician and nurses	2. Enough nurses for quality care
3. A nurse manager who is a good manager and leader	3. Enough staffing
4. Staff nurses have the opportunity to serve on hospital and nursing committees	4. Participation in policy decisions
5. Active staff development or continuing education programs for nurses	5. CNO visibility
6. A clear philosophy of nursing that pervades the patient care environment	6. CNO authority
7. An active quality assurance program	7. Administration listens and responds

Appendix R: Engagement Survey Crosswalk

Advisory Board Nurse Engagement Driver Categories	Correlating PES-NWI Subscales	Correlating PES-NWI Categories
Baseline Satisfiers	None	None
Communication and Input	Nurse Participation in Hospital Affairs	• Care Development • Participation in Policy Decisions • CNO Visibility • CNO Authority • Advancement Opportunities • Administration Listens and Responds • Staff Nurses Hospital Governance • Nursing Committees • Nursing Administrators Consult
Employee Support	Staffing and Resource Adequacy	• Adequate Support Services • Time to Discuss Patient Problems • Enough Nurses for Quality Care • Enough Staffing
Feedback and Recognition	Nurse Manager Ability, Leadership, and Support of Nurses	• Recognition
Manager Effectiveness	Nurse Manager Ability, Leadership, and Support of Nurses	• Supportive Supervisory Staff • Supervisors Learning Experiences • Effective Nurse Manager and Leader • Nurse Manager Backs Up Staff
Mission and Values	None	None
Professional Growth	Nurse Foundations for Quality of Care	• Continuing Education • Nurses are Competent • Preceptor Program

Advisory Board Nurse Engagement Driver Categories	Correlating PES-NWI Subscales	Correlating PES-NWI Categories
Teamwork	Collegial Nurse-Physician Relationships	• Nurse-Physician Relationships • Nurse and Physician Teamwork • Collaboration
None	Nurse Foundations for Quality of Care	• High Nursing Care Standards • Philosophy of Nursing • Quality Assurance Program • Nursing Care Model • Patient Care Plans • Continuity of Patient Assignments

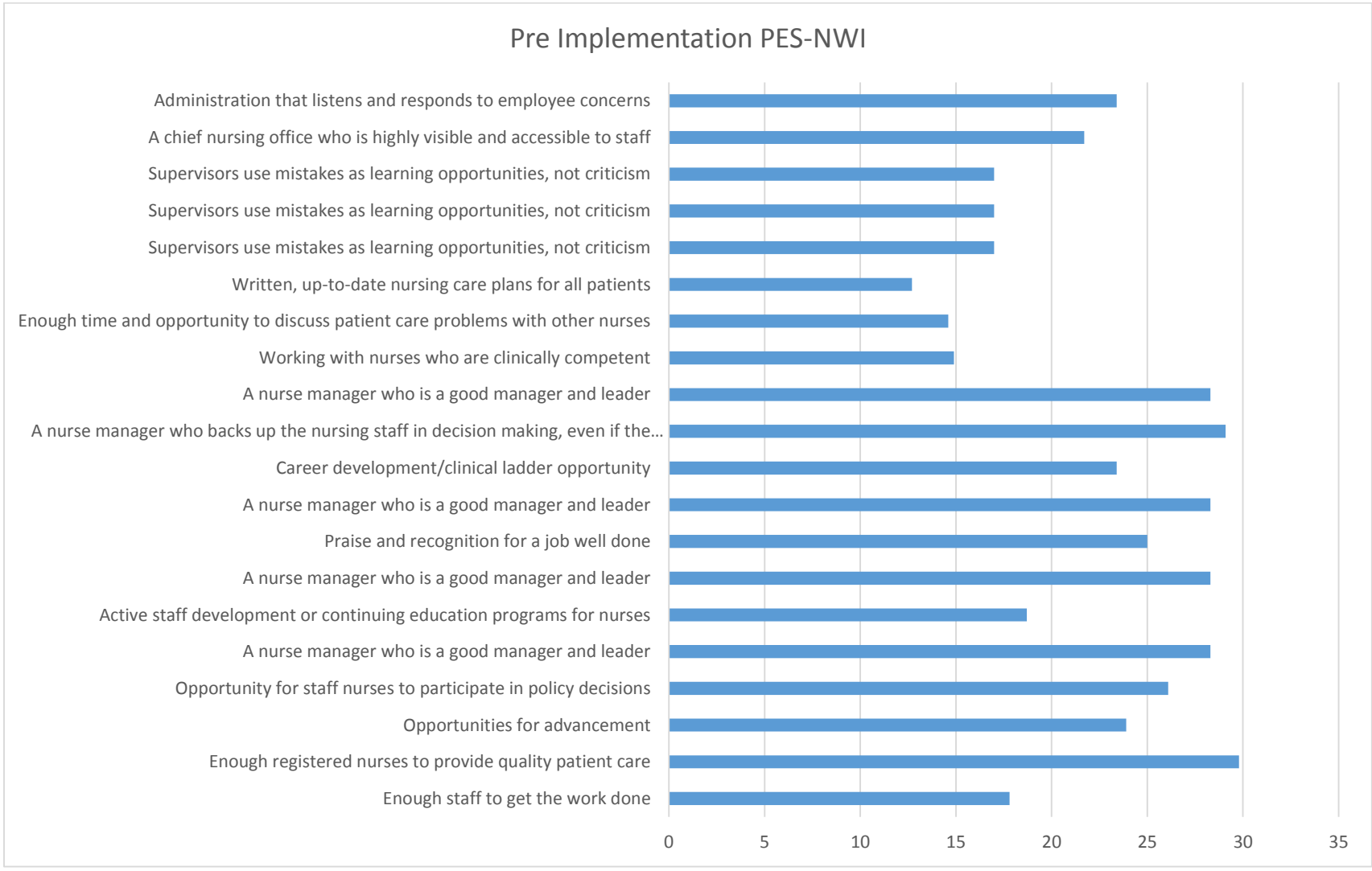
Advisory Board Nurse Engagement Survey Items	Corresponding PES-NWI Survey Items
My unit/department has enough staff	Enough staff to get the work done
I have a manageable workload	Enough registered nurses to provide quality patient care
If I wanted to explore other jobs within the organization, my manager would help me do that	Opportunities for advancement
My ideas and suggestions are valued by my organization	Opportunity for staff nurses to participate in policy decisions
My manager helps me balance my job and personal life	A nurse manager who is a good manager and leader
I receive effective on the job training	Active staff development or continuing education programs for nurses
My manager helps me learn new skills	A nurse manager who is a good manager and leader
My organization recognizes employees for excellent work	Praise and recognition for a job well done
My manager communicates messages that my coworkers need to hear, even when the information is unpleasant	A nurse manager who is a good manager and leader
Training and development opportunities offered by my organization have helped me to improve	Career development/clinical ladder opportunity
My manager stands up for the interests of my unit/department	A nurse manager who backs up the nursing staff in decision making, even if the conflict is with a physician
My manager is open and responsive to staff input	A nurse manager who is a good manager and leader
My coworkers do a good job	Working with nurses who are clinically competent

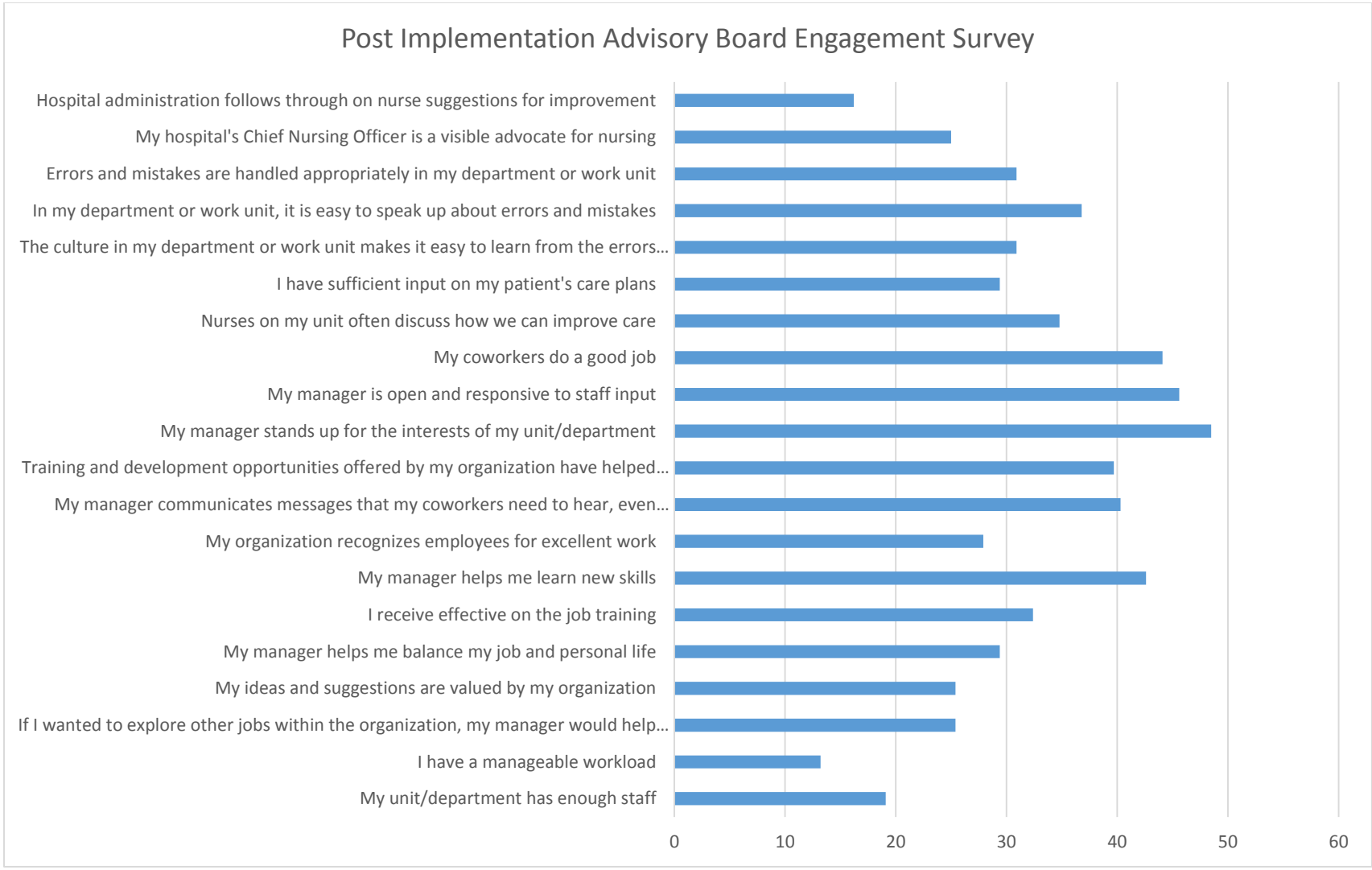
Advisory Board Nurse Engagement Survey Items	Corresponding PES-NWI Survey Items
My organization helps me deal with stress and burnout	None
I have job security	None
I have helpful discussions with my manager about my career	None
Conflicts are resolved fairly in my unit/department	None
Executives at my organization respect the contributions of my unit/department	None
I receive the necessary support from employees in other units/departments to help me succeed in my work	None
My organization does a good job of selecting and implementing new technologies to support my work	None
My organization supplies me with the equipment I need	None
My most recent performance review helped me to improve	None
I am kept informed of the organization's future plans and direction.	None
I am interested in promotion opportunities in my unit/department	None
I receive regular feedback from my manager on my performance	None
Abusive behavior is not tolerated at my organization	None
Over the past year I have never been asked to do something that compromises my values	None
I receive the necessary support from employees in my unit/department to help me succeed in my work	None
The actions of executives in my organization reflect our mission and values	None
I have the right amount of independence in my work	None
My organization understands and respects differences among employees (gender, race, age, religion, etc.)	None
My organization provides excellent customer service to patients	None
My organization supports employee safety	None
The benefits provided by my organization (such as health care, retirement savings, etc.) meet my needs	None
I understand how my daily work contributes to the organization' mission.	None

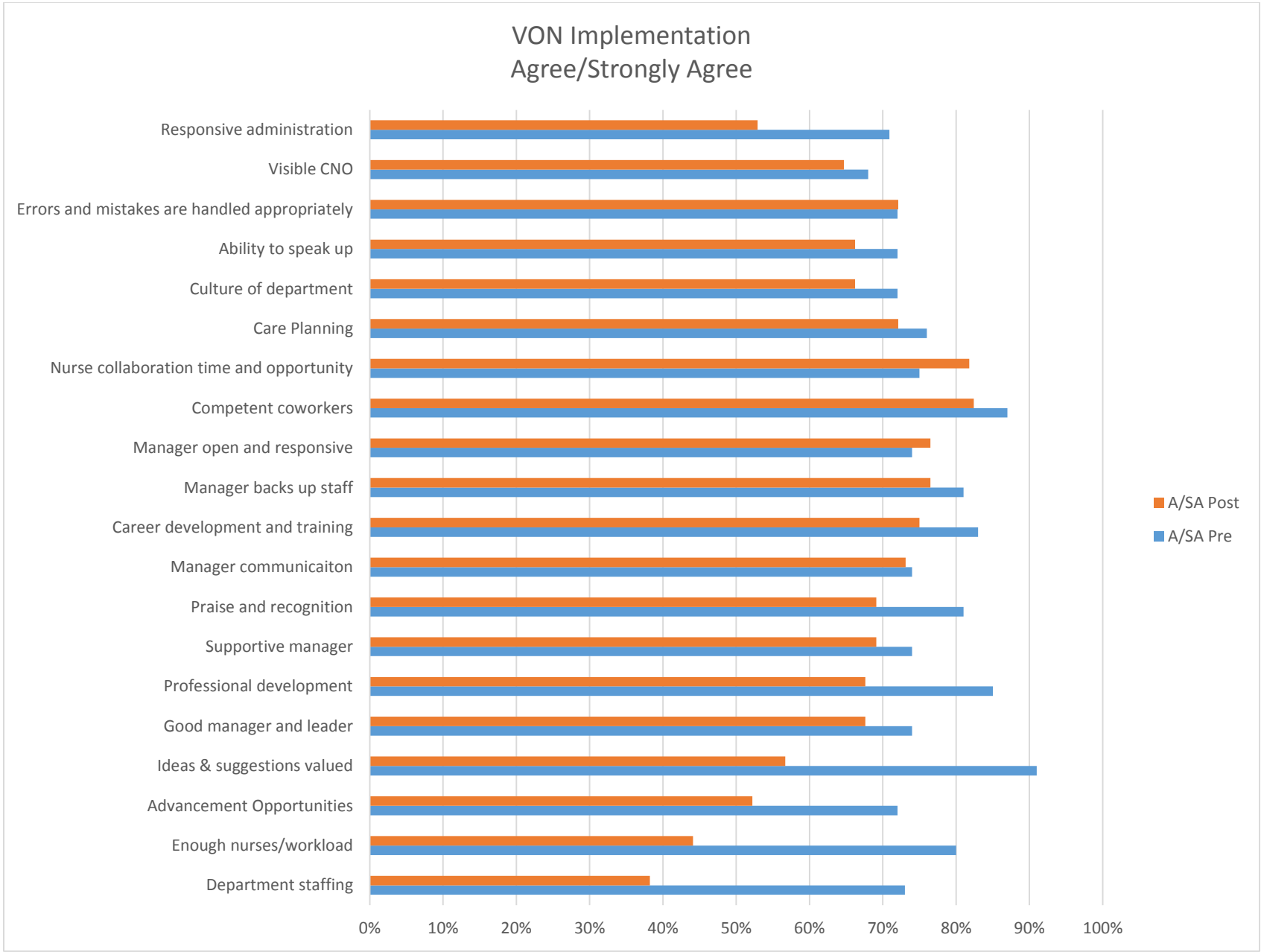
Advisory Board Nurse Engagement Survey Items	Corresponding PES-NWI Survey Items
My organization provides excellent care to patients	None
My current job is a good match for my skills	None
My organization pays me fairly for my job	None
My organization gives back to the community	None
I know what is required to perform well in my job	None
I believe in my organization's mission	None
I have good personal relationships with coworkers in my unit/department	None
Advisory Board Nurse Engagement Survey Items	**Corresponding PES-NWI Survey Items**
CUSTOM QUESTIONS	
Nurses on my unit often discuss how we can improve care	Enough time and opportunity to discuss patient care problems with other nurses
I have sufficient input on my patient's care plans	Written, up-to-date nursing care plans for all patients
The culture in my department or work unit makes it easy to learn from the errors of others	Supervisors use mistakes as learning opportunities, not criticism
In my department or work unit, it is easy to speak up about errors and mistakes	Supervisors use mistakes as learning opportunities, not criticism
Errors and mistakes are handled appropriately in my department or work unit	Supervisors use mistakes as learning opportunities, not criticism
My hospital's Chief Nursing Officer is a visible advocate for nursing	A chief nursing office who is highly visible and accessible to staff
Hospital administration follows through on nurse suggestions for improvement	Administration that listens and responds to employee concerns
I have good personal relationships with nurses on my unit (duplicate)	n/a
People in my work unit are comfortable checking with each other if they have questions about the right way to do something	None
I feel comfortable raising concerns with other nurses on my unit when I see something that may negatively affect patient care	None
During surges in work intensity, nurses on my unit proactively offer to help one another	None

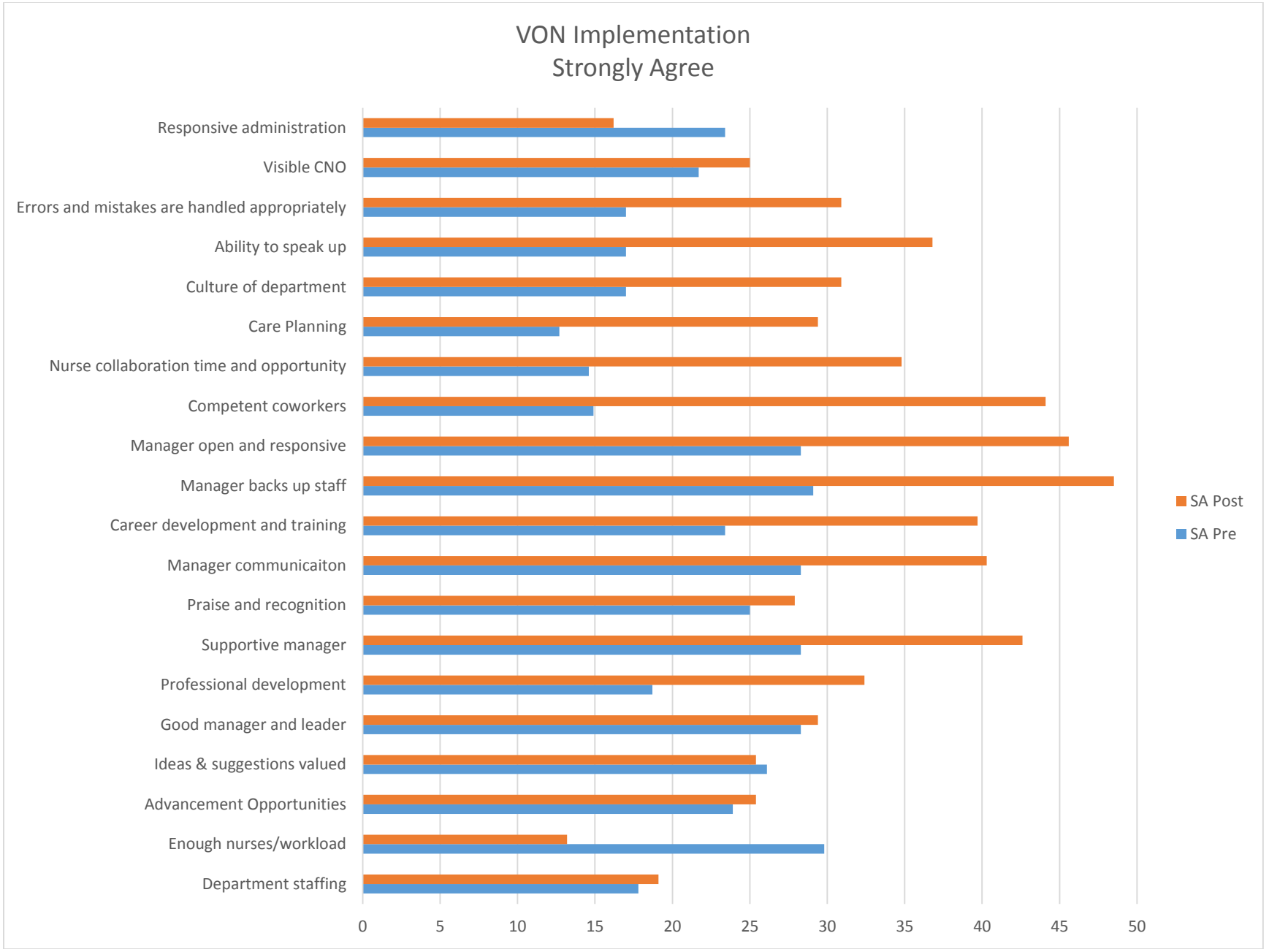
Advisory Board Nurse Engagement Survey Items	Corresponding PES-NWI Survey Items
CUSTOM QUESTIONS	
I have an appropriate level of independence in caring for my patients (duplicate)	n/a
Nurses on my unit take an active role in contributing to decisions that affect our work	None
None	Adequate support services allow me to spend time with my patients
None	Physician and nurses have good working relationships
None	A lot of team work between nurses and physicians
None	Collaboration (joint practice) between nurses and physicians
None	A chief nurse officer equal in power and authority to other top-level hospital executives
None	Staff nurses are involved in the internal governance of the hospital (e.g., practice and policy committees)
None	Staff nurses have the opportunity to serve on hospital and nursing committees
None	Nursing administrators consult with staff on daily problems and procedures
None	High standards of nursing care are expected by the administration
None	A clear philosophy of nursing that pervades the patient care environment
None	An active quality assurance program
None	A preceptor program for newly hired RNs
None	Nursing care is based on a nursing, rather than a medical, model
None	Patient care assignments that foster continuity of care, i.e., the same nurse cares for the patient from one day to the next

Appendix S: Pre and Post Implementation Data

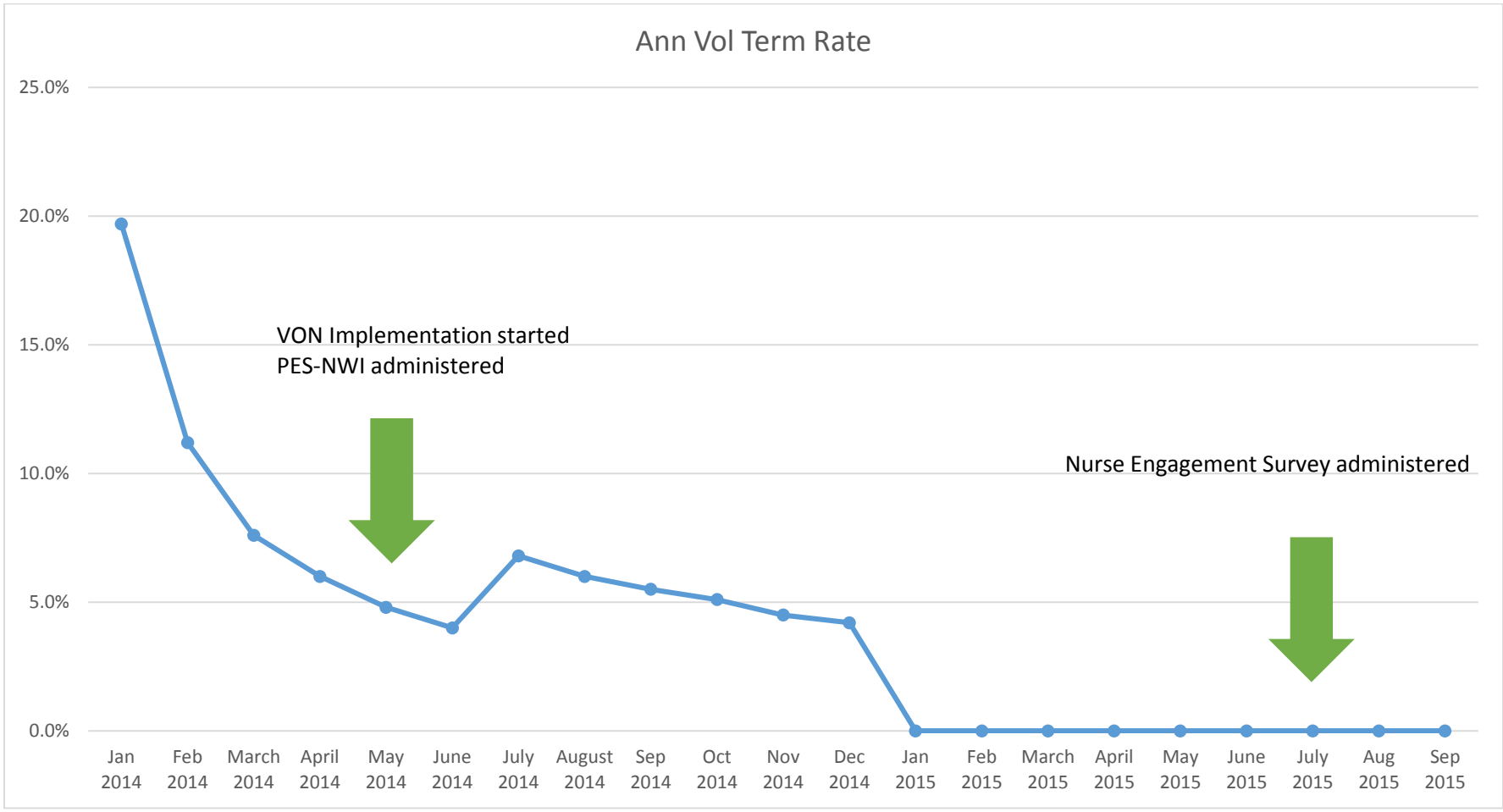



Post Implementation Advisory Board Engagement Survey
Hospital administration follows through on nurse suggestions for improvement
My hospital's Chief Nursing Officer is a visible advocate for nursing
Errors and mistakes are handled appropriately in my department or work unit
In my department or work unit, it is easy to speak up about errors and mistakes
The culture in my department or work unit makes it easy to learn from the errors...
I have sufficient input on my patient's care plans
Nurses on my unit often discuss how we can improve care
My coworkers do a good job
My manager is open and responsive to staff input
My manager stands up for the interests of my unit/department
Training and development opportunities offered by my organization have helped...
My manager communicates messages that my coworkers need to hear, even...
My organization recognizes employees for excellent work
My manager helps me learn new skills
I receive effective on the job training
My manager helps me balance my job and personal life
My ideas and suggestions are valued by my organization
If I wanted to explore other jobs within the organization, my manager would help...
I have a manageable workload
My unit/department has enough staff
0
10
20
30
40
50
60

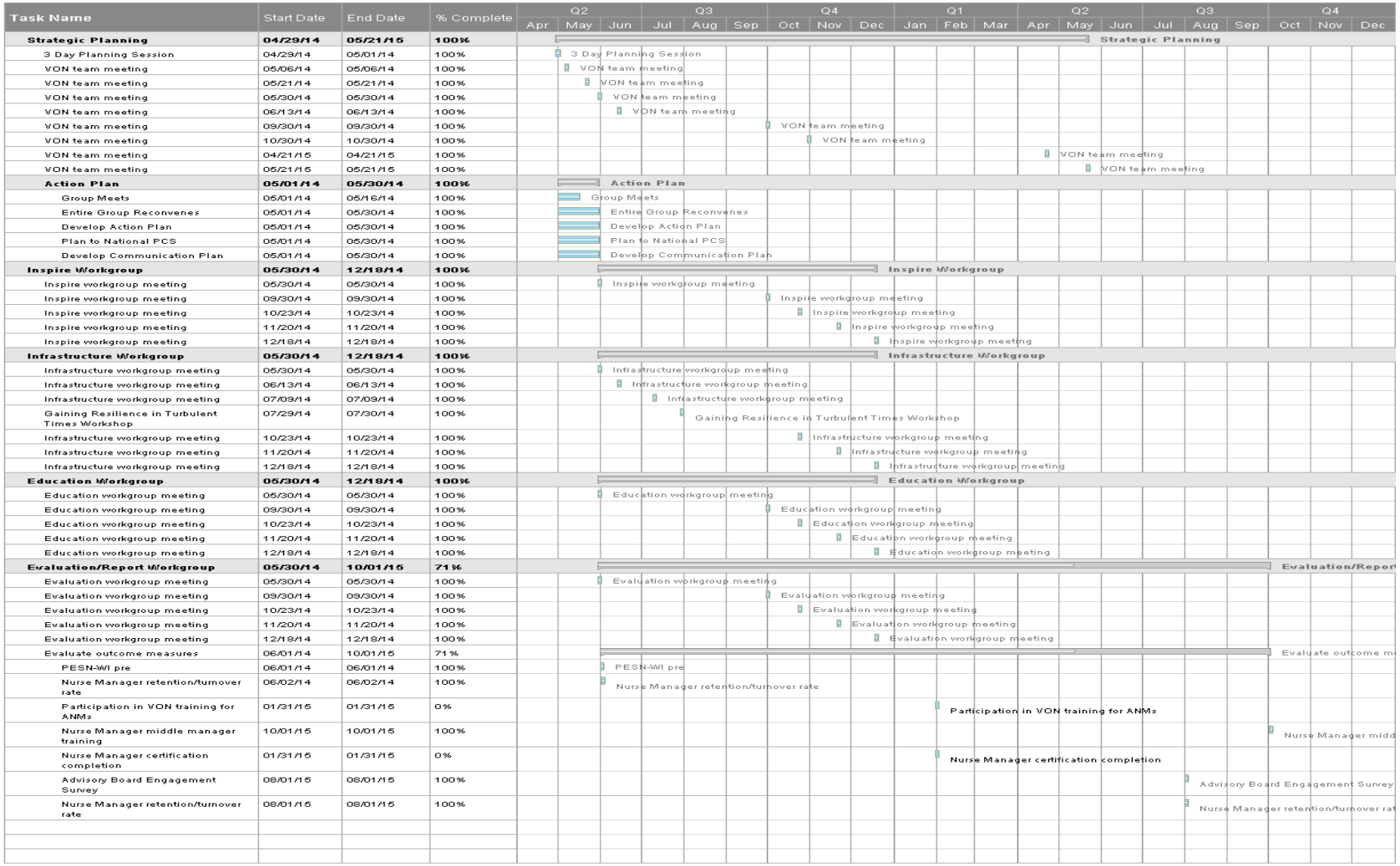

VON Implementation
Agree/Strongly Agree
Responsive administration
Visible CNO
Errors and mistakes are handled appropriately
Ability to speak up
Culture of department
Care Planning
Nurse collaboration time and opportunity
Competent coworkers
Manager open and responsive
Manager backs up staff
Career development and training
Manager communicaiton
Praise and recognition
Supportive manager
Professional development
Good manager and leader
Ideas & suggestions valued
Advancement Opportunities
Enough nurses/workload
Department staffing
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
A/SA Post
A/SA Pre


VON Implementation
Strongly Agree
Responsive administration
Visible CNO
Errors and mistakes are handled appropriately
Ability to speak up
Culture of department
Care Planning
Nurse collaboration time and opportunity
Competent coworkers
Manager open and responsive
Manager backs up staff
Career development and training
Manager communicaiton
Praise and recognition
Supportive manager
Professional development
Good manager and leader
Ideas & suggestions valued
Advancement Opportunities
Enough nurses/workload
Department staffing
0
5
10
15
20
25
30
35
40
45
50
SA Post
SA Pre

Appendix T: Voluntary Turnover Rates



Appendix U: Updated GANTT Chart



	Task Name	Start Date	End Date	% Complete
1	**Strategic Planning**	**04/29/14**	**05/21/15**	**100%**
2	3 Day Planning Session	04/29/14	05/01/14	100%
3	VON team meeting	05/06/14	05/06/14	100%
4	VON team meeting	05/21/14	05/21/14	100%
5	VON team meeting	05/30/14	05/30/14	100%
6	VON team meeting	06/13/14	06/13/14	100%
7	VON team meeting	09/30/14	09/30/14	100%
8	VON team meeting	10/30/14	10/30/14	100%
9	VON team meeting	04/21/15	04/21/15	100%
10	VON team meeting	05/21/15	05/21/15	100%
11	**Action Plan**	**05/01/14**	**05/30/14**	**100%**
12	Group Meets	05/01/14	05/16/14	100%
13	Entire Group Reconvenes	05/01/14	05/30/14	100%
14	Develop Action Plan	05/01/14	05/30/14	100%
15	Plan to National PCS	05/01/14	05/30/14	100%
16	Develop Communication Plan	05/01/14	05/30/14	100%
17	**Inspire Workgroup**	**05/30/14**	**12/18/14**	**100%**
18	Inspire workgroup meeting	05/30/14	05/30/14	100%
19	Inspire workgroup meeting	09/30/14	09/30/14	100%
20	Inspire workgroup meeting	10/23/14	10/23/14	100%
21	Inspire workgroup meeting	11/20/14	11/20/14	100%
22	Inspire workgroup meeting	12/18/14	12/18/14	100%
23	**Infrastructure Workgroup**	**05/30/14**	**12/18/14**	**100%**
24	Infrastructure workgroup meeting	05/30/14	05/30/14	100%
25	Infrastructure workgroup meeting	06/13/14	06/13/14	100%
26	Infrastructure workgroup meeting	07/09/14	07/09/14	100%
27	Gaining Resilience in Turbulent Times Workshop	07/29/14	07/30/14	100%
28	Infrastructure workgroup meeting	10/23/14	10/23/14	100%
29	Infrastructure workgroup meeting	11/20/14	11/20/14	100%
30	Infrastructure workgroup meeting	12/18/14	12/18/14	100%
31	**Education Workgroup**	**05/30/14**	**12/18/14**	**100%**
32	Education workgroup meeting	05/30/14	05/30/14	100%
33	Education workgroup meeting	09/30/14	09/30/14	100%
34	Education workgroup meeting	10/23/14	10/23/14	100%
35	Education workgroup meeting	11/20/14	11/20/14	100%
36	Education workgroup meeting	12/18/14	12/18/14	100%
37	**Evaluation/Report Workgroup**	**05/30/14**	**10/01/15**	**71%**
38	Evaluation workgroup meeting	05/30/14	05/30/14	100%
39	Evaluation workgroup meeting	09/30/14	09/30/14	100%
40	Evaluation workgroup meeting	10/23/14	10/23/14	100%
41	Evaluation workgroup meeting	11/20/14	11/20/14	100%
42	Evaluation workgroup meeting	12/18/14	12/18/14	100%
43	Evaluate outcome measures	06/01/14	10/01/15	71%
44	PESN-WI pre	06/01/14	06/01/14	100%
45	Nurse Manager retention/turnover rate	06/02/14	06/02/14	100%
46	Participation in VON training for ANMs	01/31/15	01/31/15	0%
47	Nurse Manager middle manager training	10/01/15	10/01/15	100%
48	Nurse Manager certification completion	01/31/15	01/31/15	0%
49	Advisory Board Engagement Survey	08/01/15	08/01/15	100%
50	Nurse Manager retention/turnover rate	08/01/15	08/01/15	100%
51				
52				
53				