Leveraging High Reliability and Transformational Leadership to Create a Healthy Work Environment

Megan Gillespie
mgillespie@usfca.edu

Megan Gillespie
msgilles7@gmail.com

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Leveraging High Reliability and Transformational Leadership to Create a Healthy Work Environment

Megan Gillespie
University of San Francisco
Committee Chair: Dr. Waxman
Committee Member: Dr. Capella
October 31, 2021
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Leveraging High Reliability and Transformational Leadership to Create a Healthy Work Environment

Section I:

The title of this project is Leveraging High Reliability and Transformational Leadership to Create a Healthy Work Environment. The focus of this project was multipronged, addressing both the preparedness of leaders and the environment for staff. The project entailed the application of the five tenets of high-reliability: deference to expertise, sensitivity to operations, commitment to resilience, preoccupation with failure, and reluctance to simplify (Busby & Iszatt-White, 2014). The four principles of transformational leadership were integrated throughout the project and included: idealized influence, inspirational motivation, individualized consideration, and intellectual stimulation (Faupel & Sub, 2019). The framework of the applied education program consisted of four phases plus a preparation period to achieve a healthy work environment: heightening awareness of disruptive behaviors, creating a powerful vision, addressing disruptive behaviors, and sustainability (Thompson, 2019).

Abstract

Background: Nurse leaders must create a collaborative work setting to promote a healthy work environment (HWE). The Joint Commission reported in 2014 that 71% of physicians and nurses reported disruptive behavior was linked to medical errors. The culture of a team sets the foundation of safety for patients and nurses. A HWE is necessary to ensure agility, progress and effectively strive for zero harm. Nurse executives are challenged to empower front-line leaders to create a HWE conducive to open communication, psychological safety and results in a setting where employees can thrive.
**Problem Description:** There is an epidemic of bullying and incivility in nursing and an urgent need to improve culture in healthcare throughout the nation and across the globe. The increased demands and decreasing resources create an environment ripe for incivility and bullying. Incivility and disruptive behavior are known to impact safety and patient care. The Joint Commission called for healthcare systems to address teamwork, communication, and commitment to a zero-tolerance of disruptive behaviors when they issued the Sentinel Event Alert 40: Behaviors that undermine a safety culture. This project aimed to improve the confidence and competency among frontline nurse leaders to address disruptive behaviors and strengthen a healthy work environment. Frontline leaders were provided an opportunity to complete the Eradicating Bullying and Incivility (EBI) course, improve their transformational leadership style and apply high-reliability tenets to create a HWE following a baseline assessment throughout a four-phased educational program.

**Methods:** The data evaluated throughout this project included leadership confidence to address disruptive behavior, nursing-sensitive indicators, and staff perception of culture. The Healthy Workforce Institute's Disruptive Behavior Survey (HWI-DBS) was utilized to collect initial data and consecutive data points at six-month intervals a total of three times. The HWI-DBS is a valid, reliable instrument that measures staff relationships with physicians, leaders, and staff culture. The EBI pre and post-tests included self-assessment appraisals of participants to compare leadership confidence in addressing disruptive behavior. Additional data analyzed includes nursing certification and nursing-sensitive indicators.

**Interventions:** The educational program includes collaboration with a subject matter expert, Dr. Renee Thompson, on incivility and bullying, implementing a high-reliability strategy focused on improving workflows and system opportunities, simulation settings where leaders can
hone their newly learned skills, leadership coaching and mentoring, and collaborative forums to create new department norms in alignment with the vision of a healthy work environment (see Appendix A). The EBI leadership course provided five modules of new content and educational material for front-line leaders: getting clear on bullying, recognizing disruptive behaviors, setting behavioral expectations, confronting disruptive behaviors, and holding employees accountable (Thompson, 2019). The EBI course was held from January 2020 through February 2020. The EBI course provided leadership preparation through didactic modules, cohort-guided discussion, and coaching calls. Following the leadership completion of EBI, the teams embarked on the four-phased Deep Cultural Change Initiative (DCCI) educational program. The DCCI program launched in February 2020 across three patient care services departments and transitioned to the sustainability phase in May 2021.

**Results:** Statistical analysis for overall nurse leader self-assessment showed an average of 72.2% improvement from baseline (N=13) utilizing the EBI leadership assessment instrument. Statistical analysis for DCCI shows an overall improvement of 5.8% in leadership relationships and a 4.9% improvement in team culture, exhibiting an increased perception of healthy relationships. A .8% improvement in physician relationships exhibited improved healthy interactions between staff and physician. Nursing-sensitive indicators were compared utilizing a Safety Priority Index (SPI) rate and showed an improvement from .82-.68, exhibiting a decrease of patient harm of 17%. National nurse certification increased from a baseline pre-intervention of 86 certified nurses to a total of 256 certified nurses a year to date in 2021, exhibiting a 198% increase in nurse certifications.

**Conclusions:** The HWI-DBS total mean score for leadership relationship improved from pre-intervention (M=71.1%) to post-intervention (M=76.9%). The HWI-DBS total mean score
for overall department culture improved from pre-intervention (M=76.4%) to post-intervention (M=81.3%). The total mean score for physician relationships improved from pre-intervention (M=21.5%) to post-intervention (M=20.7%), with a decrease exhibiting decreased incidence of disruptive behaviors experienced or witnessed between physicians and staff. Post EBI course completion, participants improved in their self-assessment of confidence and competency from preintervention (M=92, N=13) to (M=158, N=13). The scores reflect the value of investing in leadership growth, development, and tools to create a HWE.

*Keywords*: healthy work environment, incivility, bullying, nurse culture, leadership, burnout, engagement, empowerment, transformational leadership, high reliability, culture of safety

**Acknowledgments and Dedication**

There is great gratitude to the University of San Francisco faculty, fellow student colleagues, and alumni. The professional environment, inspiration, and encouragement throughout this journey empowered my growth, development as an executive, leader, and lifelong learner. A special thank you to the Doctor of Nursing Practice Committee Dr. KT Waxman and Dr. Elena Capella. Thank you to Dr. KT Waxman for encouraging bold thinking, systemic strategy, and transformational leadership. Thank you for setting the vision at the onset of this journey by beginning with the end in mind and leading us through the chapel that we are to graduate in. Thank you to Dr. Elena Capella for her inspirational expertise, focus on cultural transformation, and reflective insight. The colleagues throughout this class of 2021, endured every iteration of the ongoing global pandemic; while supporting each other throughout this experience.
This work is dedicated to my teams, family, and colleagues who have supported me and recognized the dedicated time necessary to continue to develop this work to benefit our patients, nurses, and healthcare professionals. Thank you to my husband Grant who relentlessly supported and encouraged me throughout the years. Thank you to my children who have inspired me to continue to strive to contribute to this life’s work. A special thank you to Dr. Renee Thompson for her mentorship, transparency, and regarded council. Lifelong learning as nurses, leaders, and executives inspires continuous improvement. Thank you to the many courageous frontline nurses and leaders who have inspired this work and driven improvements in care delivery to patients and our practice environment. Last and not least, thank you to God for sharing this wisdom and the strength to endure it.

**Section II: Introduction**

**Background**

Culture sets the foundation for agility, progress, and the ability to respond proactively to the rapidly changing pace of healthcare. Strategy without a HWE and culture is futile (Whitzman, 2016). The findings from the literature review reinforce the decision to leverage The Healthy Work Institute® phased approach and Dr. John Kotter’s 8-step change model, which empowers a momentum to drive change and achieve the necessary progress to reach the successful outcomes of achieving a HWE. John Kotter’s 8-step change model theory was chosen to apply during this journey of building a HWE. *Leading Change*, written by Kotter in 1996, became a best seller. Dr. John Kotter is a renowned professor of leadership at Harvard Business School and has authored over 20 books. Time magazine listed *Leading Change* by Kotter as one of the “Top 25 Most Influential Business Management Books” of all time (Kotter, 1996). Dr. John Kotter developed the 8-step change model in 1996 to bridge the formidable challenge of
change management. VitalSmarts notes a failure rate of greater than 85 percent for new initiatives within the first year due to a lack of management strategy (2007). Kotter’s change model was selected after recognizing the need for alignment of prioritization to invest and build a HWE that empowered improved outcomes for staff and patients. Kotter’s development of the 8-step model was created through his research of over 100 organizations and recognition that major change efforts often failed (Mento et al., 2002). A powerful coalition and healthy culture are essential to retaining talented professionals. Dr. John Kotter’s 8-step change model theory is referenced and applied to cultivate a HWE (Kotter, 1996).

**Problem Description**

A large-sized hospital in a northern California healthcare system prioritizes employee engagement, patient quality outcomes, and safety while striving to be recognized as the best place to work. Annually, these strategic priorities are linked to annual performance, compensation, and ultimately sustainability for the organization in a highly competitive market.

The initial organizational assessment noted the need to focus on culture, work environment and ensure a climate was built to empower professional practice. A HWE was critical to ensure progress in the mission to achieve staff engagement, nurse leader engagement, nurse leader confidence, and patient satisfaction while delivering high-quality, affordable care. The journey to a HWE is complex, nuanced, requires a call for urgency and a powerful coalition to drive change. Nurse leaders hold accountability to lead their teams to deliver high-quality care and patient experience in a HWE. A four-phased educational plan to address incivility (see Appendix B) and create a HWE leveraging the tenets of high reliability and transformational leadership guided by Kotter’s 8-step change model (see Appendix C) is proposed to achieve improvements for both nurses and patients.
In 2018 and 2019, the years prior were wrought with labor demonstrations, work sympathy strikes, and contingency threats, despite a nurse contract binding agreement in place. There were regularly occurring anonymous compliance hotline complaints and anonymous complaints from staff to the public health department. It was clear that the communication lines were not open between staff and leaders, and urgent action was needed. In January 2020, a 6-day Centers for Medicare and Medicaid Services (CMS) onsite survey generated from anonymous staff complaints in the labor and delivery (L&D) department was held, requiring exhausting leadership resources and time. This survey came on the heels of a contract being signed with The Healthy Workforce Institute® to create a HWE where leaders were empowered to address disruptive behavior and staff were empowered to speak up for improvement in a professional manner.

The first step became apparent; the urgent need to empower frontline leaders with the skill and competency to cultivate a HWE and eradicate bullying and incivility. The implementation of the EBI leadership education program to empower a pilot group of 13 leaders was launched in February 2020. The program’s goal was to invest in leaders’ skills and ability to heighten awareness of incivility, disruptive behaviors, and bullying. The competency and confidence of our front-line leaders were critical to ensuring they could support and empower staff. The front-line leaders needed to be able to have honest, crucial conversations confidently in real-time. There was a clear need to optimize investment coaching, strengthen the partnership with human resources, leverage skills to address disruptive behavior, and inspire the team to achieve a professional practice environment where all can flourish.

Frontline leaders are essential to daily operations and strategic progress across the organization and patient care services. The frontline leaders include nurse managers, assistant
nurse managers, and nurse directors. The roles of frontline leaders have been emphasized as essential components of healthcare operations throughout the pandemic.

Setting

This project took place in an organization organized nationally, regionally, and locally by tiers of leadership. The hospital provides tertiary levels of care, which is quickly expanding to quaternary levels, and additionally provides a continuum of care delivery in mental health, hospice care, home health care, and is adjoined by outpatient, for-profit medical groups and satellite clinics.

The medical center provides high-risk maternal child services, perioperative services, thrombectomy capable services, leukemia and lymphoma services. It is a referral center for cardiac services with a thriving mechanical circulatory system program. The medical center provides care for more than 400,000 community members with more than 20,000 hospital admissions annually. The hospital accounts for more than 4,500 babies delivered annually and more than 18,000 surgical cases annually.

The Chief Nurse Executive (CNE) and the author are accountable for patient care services (PCS) which spans 900 full-time equivalents (FTEs) and is greater than 1,300 employees. The CNE governs the PCS provision of care to ensure nursing care and services provided in clinically licensed space are grounded in current practice standards. The CNEs direct reports are reflected in the organizational chart (Appendix D) and consist of nurse directors accountable for individual service lines (maternal child health, perioperative, adult services, professional development, administrative services, and critical care services), executive consultant, project manager, and administrative assistant. The clinical nurse directors oversee strategic operations across the respective service lines. The leadership structure is matrixed to
include nurse managers to oversee individual departments and assistant nurse managers accountable for daily operations within respective departments. Nurse supervisors provide daily operations across the hospital, reporting directly to the administrative services director.

The organization's mission is to provide high-quality, affordable care to improve the health of the communities served. The professional practice model (PPM) is the foundation for patient care services (Appendix E). The nursing discipline’s professionalism, integrity, excellence, teamwork, and compassion are reflected around the center of patient and family. The values exhibit the goals of leadership, safety, quality, research and evidence-based practice, and professional development. The values translated to practice by creating a healing and caring environment where collaboration improves outcomes to improve the health of the communities served.

**Specific Aim**

The specific aim of this project was to implement a four-phased educational program leveraging high-reliability tenets to strengthen leadership development and provide frontline leaders with the confidence and competence to address disruptive behaviors. Nurse leaders learned to address disruptive behavior through heightened awareness, powerful visioning and practiced application of strategies. Additionally, transformational leadership and high-reliability tenets were leveraged to improve nurse leaders’ communication during staff huddles and interactions. It was hypothesized that the four-phased educational program would improve staff perception of a HWE, improve intellectual stimulation and influence as exhibited by nurse certifications, and decrease harm as exhibited by nursing-sensitive indicators. The phased education plan addressed the gaps in leadership knowledge and competency, provided structure
for communication, and shaped a sustainable culture change to achieve a HWE, which staff and patients can thrive in.

**Available Knowledge**

**PICOT Question**

The literature review focused on the connection between the underpinnings of high reliability and transformational leadership to create a HWE to answer the population, intervention, comparison, outcome, and time (PICOT) question (Melnyk & Fineout-Overholt, 2015). The PICOT question used for this project is, in frontline leaders and staff (P), how does a four-phase education program on healthy work environment and incivility, which leverages components of transformational leadership and high reliability (I), compared to the current state (C), affect the overall work environment, nurse engagement, and perception of incivility within one year by May 2021 (T)?

**Search Methodology**

A comprehensive review of the literature was completed, and abstracts were scanned to limit the inclusion of evidence that incorporated key themes: healthy work environment, transformational leadership, and high reliability. Critical appraisal of the articles was completed utilizing the John Hopkins Evidence-Based Practice tool (Newhouse, Sigma Theta Tau International, Johns Hopkins Hospital & Johns Hopkins University, 2007) (see Appendix F). The methods for search strategy included mainly electronic databases. The databases accessed for the search included Cumulative Index of Nursing and Allied Health Literature Plus (CINAHL Plus), Publisher Medline (PubMed), American Psychological Association (APA) Psychinfo, Scopus, and Cochrane Database of Systematic Reviews. The keywords used for searches included: *healthy work environment, incivility, bullying, nurse culture, leadership,*
burnout, engagement, empowerment, transformational leadership, high reliability, culture of safety. These search terms and keywords were then utilized to search affiliated articles in the Scopus database. Healthy work environment was used as a primary keyword yielding initially 23,155 search results, decreasing to only 16 results when combined with transformational leadership, 12 when combined with high reliability, and 31 when combined with culture of safety as a search subject. Keywords were then searched in various combinations across the six databases to yield a thorough examination of available resources. The timeframe requested included from the year 2000 to current, was restricted to peer-reviewed publications, restricted to the English language, and included journal publications.

Integrated Review of the Literature

Abstracts of articles were reviewed, including a focus on systematic review, qualitative studies, cohort studies, and meta-analysis availability. Secondly, studies were reviewed to delineate a focus on transformational leadership, high reliability, and a healthy work environment. The studies were then categorized by those that focus on measurement of leadership ability and those which measure nurse perception of healthy work environment. Studies that reviewed the relationship between high reliability, transformational leadership, and healthy work environment were prioritized.

An evaluation table was utilized to complete a thorough assessment of studies, including purpose of article, conceptual framework, design/method, sample, setting, variables, measurement of variables, data analysis, study findings, and level of evidence. The additional sources required included: organizational data, union labor contract, Magnet ® Transformational components, and resources from Healthy Workforce Institute ®.
Synthesis of Evidence

Nursing is known to be a primary profession at risk for incivility and bullying (Skarbek et al., 2015). Rosenstein and O’Daniel (2008) surveyed 4,530 nurses, physicians, and administrative executives across 104 hospitals. Results revealed 67% of interviewees linked disruptive behavior to adverse events, and 27% linked disruptive behavior to patient mortality. In a profession where the priority is ‘first do no harm,’ bullying and incivility are too common. The Joint Commission has published a Sentinel Event Alert highlighting the risks of disruptive behaviors undermining a culture of safety (2008). The Bureau of Labor Statistics shows an increasing demand for registered nurses reaching a vacancy gap of 1.2 million by 2022. The healthcare environment is an arena of increasing demands and decreasing resources. There is an urgent need to address the longstanding challenges of achieving a HWE for nurses and healthcare professionals.

Kaiser (2017) notes that the current environment in healthcare poses a threat to professional nurses and the well-being of patients due to the pervasiveness of incivility, ill-equipped nurse leaders, and the lack of infrastructure to address incivility. Interestingly, Skarbek et al. (2015), with a small sample size of six compared to Cervalo et al. (2012) with a large sample size of 4,032 participants, yielded similar results, including awareness of incivility, healthy environment, communication, nurse leader ability and style, and scope of the problem are all key themes to address in order to achieve a HWE. Another strength of the studies reviewed includes the high reliability of results in all studies measured by Cronbach’s alpha, which measures the correlation of variables or consistency. Kaiser (2017) also highlighted regresional analysis that showcased transformational leadership as correlated (r(235)=-.46,
P<0.05) with reduced incivility levels showing the greater the perception of transformational leadership behavior, the lower incidence of incivility. Kaiser (2017) showcases the transformational leadership style was deemed the least common in comparison to transactional leadership as the most prevalent.

Giorgi et al. (2016) completed a research study focused on the cost of the global concern of bullying and burnout among nurses. The sample size included 658 nurses working in Italy, of which forty-eight percent were male, and fifty-two percent were female. Demographics of the 658 nurses were analyzed for correlations among variables. Researchers utilized the health scale and Burnout Indicator tool (BIT) with good reliability as α of .75 and previously validated with 814 healthcare employees. Additionally, results from the Negative Acts Questionnaire-Revised (NAQ-R) and Majer-D´Amato Organizational Questionnaire (MDOQ10) were analyzed. The authors demonstrated a correlation between work environment, nurse perception, and workplace bullying. The study supported the vital need to address incivility, bullying, and the work environment through awareness, education, and leadership competency. Limitations to this study include that causality cannot be assumed secondary to the cross-sectional data. Additionally, the authors note the need to further evaluate the integration of bullying, burnout, and work environment to further understand how to resolve the global challenges and implement programs that can assist in decreasing the negative impact.

The review of research has validated the urgent need to address the disruptive culture in nursing and calls for nurse leaders to be adequately prepared to empower a HWE. In a review of available research, there were zero articles that integrated high-reliability tenets, transformational leadership, and a HWE together in one project. However, there were many articles that addressed these subjects individually.
Healthy Work Environment

Studies were prioritized that targeted nurses in formal leadership roles, those on the frontline line, and those entering the nursing profession. Articles reviewed addressed the correlation of nurse leaders and their role in advancing the HWE. Additional articles were selected that addressed the perception of staff nurses and acknowledged the urgency to tackle the well-known problem of incivility in the nursing profession. Kaiser (2017) notes that the current environment in healthcare poses a threat to professional nurses and the well-being of patients due to the pervasiveness of incivility, ill-equipped nurse leaders, and the lack of infrastructure to address disruptive behavior.

Smith et al. (2018) focused on the impact of nurse coworker incivility on the work environment. The goal of the study was to further contribute to the minimal knowledge in the United States related to the nurse work environment and nurse incivility. The study leveraged a quantitative and cross-sectional approach through electronic surveys from the Nursing Work Index and Workplace Incivility Scale. Cronbach’s $\alpha$ for this study was .9. The authors took a descriptive and correlational approach for data analysis. It was revealed that nurse manager qualities correlated to coworker incivility. The sample size included 233 staff nurses in five different hospitals located in the southwestern United States. Nurse demographics were reviewed, including age, gender, specialty, education, and experience. Scatterplot, correlational, and linear regression were applied to highlight the nurse work environment related to coworker incivility. This study supported the PICOT question that nurse leaders can positively impact a HWE through transformational leadership and education. The authors also highlighted the importance for hospitals to support nurse managers with resources, policy, and education to
effectively address incivility. The limitations of this study include potential bias since some of the participants belonged to Magnet ® hospitals and had a low response rate of 8%. However, adequate data were collected from the 233 participants. Most importantly, it was revealed that nurse manager competency and efficacy to address incivility are strongly correlated to the work environment. Additional research is needed to ensure nurse leaders are equipped to address incivility and nurses can focus on patient care.

Huddleston and Gray (2016) leveraged a nonexperimental descriptive survey with a total sample size of 321 nurse leaders and direct care nurses. This pilot study was designed to identify a standard evaluation tool to assist in developing targeted interventions to improve the overall HWE. The American Association of Critical Care Nurses (AACN) Synergy Model was described in the framework to compare the patient and family needs in comparison to nursing competencies for synergy. The methods included an electronic survey of nurses that participated in the study with a response period of 3 weeks. Demographics were analyzed and reflected a variety of ages, races, education levels, years on unit, and years of experience. Findings revealed from the AACN Healthy Work Environment Tool (HWEAT) reflected reliability properties across 18 survey questions. Cronbach’s α revealed .97 for nurse leaders and .91 for direct care nurses. The result of this study showed validity and reliability for the AACN HWEAT and provided progress to new tools for standardized measurement of HWE. Findings also revealed additional qualitative studies are needed to further shed light on nurse leaders and how nurses define and HWE (2016). This level III quantitative pilot study marks an opening for additional analysis and reflects the importance of standardized tools necessary to evaluate the HWE.

**High-Reliability Tenets**
High-reliability tenets have infiltrated healthcare and are reflected in some of the most influential healthcare systems. There has been increased attention for adopting highly-reliable principles from the highest risk industries such as nuclear power plants and aviation to translate application to healthcare. Sensitivity to operations, deference to expertise, preoccupation with failure, reluctance to simplify, and commitment to resilience can lend much value in the healthcare realm; however, the healthcare industry has not committed to achieving zero harm (Polonsky, 2019). Change of shift huddles are a vital time to connect with the frontline team and address challenges proactively. It is a key time for frontline leaders to assess the team dynamics and ensure synergy. Studies have emphasized the importance of nurse leaders adopting high-reliability tenets to improve patient safety (Riley et al., 2010).

**Transformational Leadership**

Transformational leadership has been identified as a highly effective leadership style in environments that are as hypercomplex as the healthcare environment. Nurse leaders that reflect the four components of transformational leadership: individualized consideration, intellectual stimulation, idealized influence, inspirational motivation have the potential to improve the quality of care and prevent patient harm. Multiple meta-analyses and decades of research have shown that transformational leadership predicts a wide variety of both individual and team performance outcomes (Bass & Bass, 2008). Structural empowerment of transformational leadership has shown to positively impact nurse job satisfaction, motivation, and increased knowledge sharing (Boamah et al., 2018; Cicolini et al., 2014).

**Rationale**

Dr. John Kotter’s 8-step change model was the conceptual and theoretical foundation leveraging underpinnings of high-reliability and transformational leadership to govern this
project (Kotter, 1996). The four-phased education program to create a HWE created a blueprint for milestones, measurement of progress, and a clear pathway to sustainability. There was significant leadership preparation prior to the implementation of the four-phased DCCI program and ongoing evolutions of the program logistics in response to the pandemic requirements. Nurse leaders participated in the EBI leadership education program prior to the launch of the DCCI program for staff.

*Change Model Theory*

Dr. John Kotter’s eight-stage process for change management is well known. However, there seems to be little research that exhibits how it is applied in practice. The first step in Kotter’s 8-step change model theory is to develop a sense of urgency and emphasize the pain that will continue if change does not occur. This first step is important to harness the energy to create the initial momentum. The urgency is the impetus for step two, which is to form a powerful coalition. Step two is just as important and is driven by those with power and authority, however most importantly, the skill of influence. Step three is to ensure a vision and strategy are clear, why it is needed and how the journey will proceed. The vision must be emotional in addition to being logical. It is essential that people are moved to take part in the mission. Step four emphasizes communication of the vision and paints the picture of potential. Step five is vital to build trust and remove barriers for those who must actively contribute to the journey. Step six is to create short-term wins and provide an incentive to continue. It is essential to continue the positive energy and communicate the change as progress is made through storytelling. Step seven is to build on the change, take appropriate risks and ensure progress is sustained. Step eight is the final stage, however, one that hinges on sustainability to anchor the change (Kotter, 1996).
The pace of change and new challenges, including those posed by the coronavirus, currently create unprecedented financial, social, and political conflicts. The need to cultivate a HWE and psychological safety is critical. Kotter’s 8-step change model balances daily operations and ensures infrastructure is integrated into strategic initiatives to create agility. It is a significant investment initially in time and effort; however, it ensures alignment of key stakeholders to continue momentum and progress (Kotter & Cohen, 2012).

Section III: Methods

Context

The journey towards strengthening a HWE was formally launched in January 2020 and transitioned to the sustainability phase in May of 2021. The journey became harder before it got easier and required a powerful coalition to prioritize HWE across the executives within and external to PCS.

A gap assessment completed during the development of the hospital’s nursing strategic plan (see Appendix G) recognized the urgent need to equip and develop nurse leaders to create a HWE. The EBI and DCCI education program was implemented for leaders and staff over the past two years. The EBI course was specifically for leaders and aimed at supporting leadership development, competency, and confidence to address disruptive behaviors. Simultaneously, the leadership team focused on transformational leadership and high reliability during communication at the change of shift huddles. The organization is well known as a labor union organization and contracts with multiple different labor unions to deliver high-quality, affordable care to members. The urgency for this journey is driven by ongoing challenges in a fractured culture, high tension union labor environment, and fueled by a vision of what is possible when
energy is channeled towards positive outcomes. This journey challenged the ‘this is how it has always been’ philosophy and required key stakeholders to take part to improve the HWE.

There were varying degrees of engagement and participation from nurse leaders in the EBI program. Key stakeholders of the program included nurse directors, nurse managers, and assistant nurse managers. The evidence-based curriculum was provided by The Healthy Workforce Institute (HWI) and included voluntary group cohort discussions. It was essential to include collaborative stakeholders, which encompassed organizational development, portfolio office team, and human resources as vital collaborators in culture change. The organization had met every criterion for Magnet® certification, except the national nurse satisfaction benchmark, which has historically only been measured internal to the organization. Magnet ® accreditation was identified as a medium-term goal to apply within the year 2022. Transformational leadership is a key component throughout the Magnet ® journey (American Nurses Credentialing Center, 2019).

Frontline leaders are accountable for driving strategic initiatives and implementing evidence base practice in an intricate labor union environment. The CNE is accountable for empowering the PCS Directors to continuously improve on the pillars of performance, including patient quality, safety, care experience, affordability, and team engagement. The PCS directors work directly with frontline nurse managers to operationalize action plans to meet intended outcomes. High-reliability and transformational leadership underpinnings were integrated into the education program to address the inconsistencies of vital communication and the tools leveraged during the sacred change of shift timeframe. A qualitative self-assessment high-reliability organizational tool assessment (see Appendix H) was utilized by frontline nurse managers to assess the current state ranging from level one to level three across the three pilot
departments (see Appendix I). Level one was defined as: the visual board displayed in the common area and easy to understand, relevant metrics used to back goal progress, department leaders able to update metrics, evidence of employee connection and recognition, and department leader is accountable to maintain the current board. Level three is defined as the following: visual systems used whenever possible to highlight historical performance, control limits used to validate significant changes in performance, staff empowered to keep broad updated and effectively facilitate huddle, scientific problem-solving reflected utilizing A3s, standard work is visible, continuous improvement system in place, direct report rounding consistently maintained at greater than 90% each month. The initial assessment revealed departments performed in the level zero to level one range and was validated by senior leadership rounds to confirm rating. This baseline assessment provided insight into the urgent need to develop frontline leaders to transform huddles into a time for inspiration, positive influence, relevant information, and competency to address disruptive behaviors to create a HWE. It was hypothesized that leadership would successfully empower staff by transferring new knowledge into practice from EBI and DCCI education. The hypothesis included an improved HWE by leveraging high-reliability tenets and transformational leadership while decreasing the incidence of incivility and bullying. The HWI-DBS reliably measures and quantifies disruptive behaviors in the work environment. Additionally, nursing-sensitive indicators are measured to identify the effectiveness and maturation of change of shift huddles and visual boards.

Interventions

This project summarizes the four-phased educational program leveraging high-reliability tenets and transformational leadership components while being guided by Dr. Kotter’s change model to decrease disruptive behavior and create a healthy work environment. The educational
program includes collaboration with a subject matter expert on incivility and bullying, implementing a high-reliability strategy focused on improving workflows and system opportunities, simulation settings where leaders can hone their newly learned skills, leadership coaching and mentoring, and collaborative forums to create new department norms in alignment with the vision of a HWE.

A fundamental understanding of the characteristics of a HWE, transformational leadership, and high reliability were vital to the leadership team understanding the vision and the potential of positive impact. It is necessary to have effective nurse leaders to navigate the complexity of healthcare. Investment in leadership development programs that integrate empowerment, self-confidence, structural framework, and reflection translates to staff empowerment and effectiveness (Macphee et al., 2012). Nurse leaders require evidence-based interventions to translate knowledge to practice resulting in infrastructures that inspire competency development (Lunden et al., 2017).

The timeframe for the educational program intervention was January 1, 2020, through May 30, 2021, prior to shifting into the sustainability phase. The strategy for the project was to collaborate with HWI® and internal resources to implement effective methods to improve the HWE, improve nursing-sensitive indicators, and enhance leader confidence to address disruptive behaviors. A key variable was to ensure alignment of PCS with collaborative stakeholders such as human resources (HR), organizational development leader (ODL), and area portfolio leader (APL). HR participated in the educational HWE sessions and worked directly with nurse leaders to ensure consistent responses when disruptive behaviors were identified. ODL and APL assisted in the facilitation of visual board maturation assessments and high-reliability education sessions. Simulation, didactic sessions, and debriefing sessions were held in alignment with adult
learning principles. HR, APL, ODL, and nurse leaders participated together in simulation sessions geared to validate effective huddles, addressing disruptive behaviors during huddles, and continuous improvement opportunities.

**Pre-intervention evaluation**

The initial organizational assessment was built on the existing organization’s mission and vision. A nurse executive team offsite was launched in November 2019 to hold a collaborative assessment of current state and vision with the nurse director team who each oversee a large span of control across the service lines: perioperative, maternal-child health, adult services inclusive of critical care, clinical education, and administrative services.

The initial organizational assessment noted the need to focus on culture, work environment and ensure a climate was built to empower professional practice. A HWE was critical to ensure progress in improving patient care delivery and staff engagement. Internally, there were no existing evidence-based resources to equip leaders with the tools needed to address disruptive behaviors and create a HWE. The decision was made to solicit assistance from HWI and adapt additional underpinnings of high-reliability and transformational leadership to align with specific organizational needs. The offsite activities and information gathering resulted in the culmination of the 2020-2021 nursing strategic plan.

The 2020-2021 nursing strategic plan was finalized in February 2020 and organized in pillar format by the following categories: quality and patient safety, patient care experience, growth and stewardship, and professional practice. Launching a HWE strategy was highlighted as a key need to decrease incivility and promote inclusion. The emphasis on HWE noted the need to decrease stress and fatigue while promoting meaningful recognition, high reliability, and transformational leadership.
Creating urgency represents the first step in Kotter’s 8-step change theory and is reflected in the preparation of this project (Kotter, 1996). The project proposal was presented to our executive leadership team along with the nursing strategic plan. The current state reviewed the amount of compliance hotline calls, anonymous complaints to regulatory bodies, stagnant annual engagement scores, and the level of incivility the frontline leaders were subjected to daily. A standout variable in the annual engagement score reflected a correlation of longevity as an employee and a decreased likelihood to speak up, meaning the longer one is employed, the less likely they will speak up for safety. The challenge was presented to the executive operational team to collaboratively commit to psychological safety considering the long-standing historical challenges that can often become normalized. The first step was critical to ensure multidisciplinary executive colleagues supported the dedication of stakeholders as they journey to a HWE proceeded.

**Eradicating Bullying and Incivility Leadership Preparation**

Nurse leaders were offered an opportunity to self-nominate to enroll in the initial EBI cohort. Self-nominations were reviewed by the CNE, director team, and HR to select the initial 13 enrollees. The top three departments consisting of cardiac telemetry, stroke telemetry, and labor and delivery were identified as pilot departments to pilot the DCCI program. They were chosen based on priority needs, engagement of nurse managers, and potential for impact based on the volume of patients cared for. A baseline self-assessment of nurse leaders’ confidence in addressing disruptive behaviors was taken through the HWI® EBI tool. The EBI self-paced course began in January 2020, with all cohort one leaders graduating by June 11, 2020.

The EBI program consists of six modules that include: getting clear on bullying, recognizing disruptive behaviors, setting behavioral expectations, confronting bullying behavior,
and holding employees accountable. There were weekly best practice tips sent via email, weekly cohort open discussions by voluntary participation, and participation in formal coaching calls. The CNE met individually with each participant to discuss progress, challenges, and key learnings to share.

Module one in the EBI course focused on understanding the prevalence throughout healthcare and defining the different types of bullying. Module two built on this knowledge base and reviewed the characteristics of bullying behavior, common themes, and understanding the impact if the behavior is not mitigated. Setting behavioral expectations marked the launch of module three and walked leaders through preparing to set expectations, creating department norms, and communicating the norms. Module four equipped leaders with the ability to name the behavior, talk about it and offer key scripts on how to start challenging conversations, including confronting outcomes. Module five covered the comprehensive perspective of building relationships with HR, identifying processes to address disruptive incidents, and building a case through documentation. Leaders completed a post-assessment upon successful completion and were celebrated locally for their achievement of the EBI certificate.

**Phase 1 DCCI**

Phase I involved formal kick offs which occurred February 10-12, 2020, with leaders and frontline staff during an in-person launch session. The launch session offered insight into what it means to create a HWE and the dedication that will be needed from all involved. The sessions involved ODL, HR, APL, executive leaders, physician leaders, nurse leaders, and staff nurses. The process for a deep cultural change initiative was reviewed, and transparency was referenced as a vital need for improvement to occur across teams. Sessions were attended voluntarily and held in person during change of shift times to solicit as much participation as possible. The in-
person sessions had 165 individuals participate across PCS staff. The participants were instructed they would have an opportunity to complete a baseline assessment of the current work environment. Leaders continued to message information from the phase one launch in huddles and staff forums to communicate to those who did not attend the initial launch session.

A baseline assessment utilizing the HWI-DBS (N=187) took place from March 16, 2020, through April 30, 2020. The survey period was originally slotted to end on April 17. However, it was extended by three weeks secondary to the disruption of the covid pandemic and to increase participation. A quick response (QR) code was utilized for convenience and anonymity. Demographic data were collected, however, de-identified through username and password.

A ‘Be Kind’ campaign was launched following the first sessions, including buttons (see Appendix J) that staff and leaders wore as a visual reminder of the commitment to create a HWE. Leaders distributed Kind™ bars for leaders to distribute in real-time for positive investment coaching. The teams were tasked to nominate healthy workforce champions and create a healthy work environment bulletin board where the most up-to-date information and tips could be displayed for reference. This phase also incorporated an overall assessment of the daily huddle process and how leaders provided vital information to frontline teams.

The huddles were altered to ensure meaningful recognition and intellectual stimulation were integrated into the visual display. The existing national nurse certification campaign was advertised to encourage investment in professional development and to celebrate proven competency in the specialty. The momentum of nurse certification was encouraged through transformational leadership components, including intellectual stimulation, inspirational motivation, idealized influence, and individualized consideration (Boamah et al., 2018).
Preintervention national nurse certification reflected only 86 certified nurses compared to 256 in May 2021 (see Appendix K).

**Phase II DCCI**

Phase II of the DCCI began in May and lasted through July 31, 2020. Phase II included the identification of department champions of at least one assistant nurse manager and three frontline staff. This phase focused on the skill development of leaders and staff. Leaders received weekly messages aligned with the phase II focus of the newly created team norms. Messages encompassed how team norms and newly learned skills are exhibited in daily operations.

The impact of COVID-19 further complicated this phase, and logistics were altered accordingly to ensure social distancing and infection prevention protocols were aligned. Infection prevention was consulted for planning purposes and consented to continue the program. The educational program was debated to be postponed; however, frontline leaders expressed the need for this education ‘now more than ever.’ The journey forged ahead integrating education and communication through the ever-evolving, new-normal daily operations. Staff and nurse leaders contributed to the vision of the desired positive behavior in the department and identified ‘never’ behaviors that should be eradicated. An in-person session attended by 98 participants was completed from May 25-27, 2020. The sessions were held during change of shift times to make it easier for employees to attend and contribute to brainstorming to create the department norms. Staff continued to contribute ideas over two weeks through sticky notes (see Appendix L) of what the ideal HWE department norms should become for the specific departments. The sticky notes posters were displayed in the departments where staff could visualize, reflect on, and add input for a two-week period. The team norms were finalized across the three departments between June 1-3, 2020. The nurse leaders
continued biweekly coaching sessions with a national cohort, allowing open discussion and questions. The finalized department norms (Appendix M) were distributed and communicated broadly across staff and physician leaders. Department norms were unique to each department’s needs, however, consistently aligned with the overarching nursing strategic plan and organization mission.

**Phase III DCCI**

Phase III began August 1, lasting through September 20, 2020, and was built on content from phase II. Phase II and phase III were purposefully overlapped to reinforce the application of the vision to address disruptive behaviors. Phase III focused on strengthening the relationship with HR, identified processes for addressing behaviors, and reinforced how to coach employees. Phase III brought the department norms to life. Department norms were integrated into staff interviews, reviewed with staff returning from leaves of absence, and focused on huddles and staff meetings. Pocket size department norms cards were created and distributed by the HWE champions for convenient reference. Staff was empowered to leverage the department norms to address disruptive behavior when it was observed. Behaviors that conflicted with the agreed-upon norms were recognized, and staff began to hold each other accountable. The HWE committees intentionally recognized when a positive exhibition of a norm was witnessed and created innovative ways to reinforce positive behavior through peer gratitude. One example included a thank you card with the department norm displayed and a small treat attached. The department norms were both similar and different across the three pilot departments. The selection of healthy workforce champions became a key variable in phase three and was empowered to further integrate department norms into daily operations. In phase IV, the
champions also become part of a national cohort of HWE champions and share ideas of inspiration, challenges, and achievements.

**Phase IV**

Phase IV launched September 21, 2020, and began the transition to sustainability and continued growth. The celebratory session held on September 28 through 30, 2020, was a hybrid of in-person and virtual participants to ensure social distancing and infection prevention precautions. The initiation of phase IV began with an acknowledgment of the hard work and celebrated the contributions of the frontline healthy workforce champions. An awards ceremony recognized each of the 16 healthy workforce champions and provided an open forum to acknowledge staff who role-modeled specific department norms. This phase lasted through November 30, 2020. The second HWI-DBS survey assessment occurred November 2-30, 2020, and assessed the culture, incivility, and bullying in the department.

**Phase V DCCI**

Phase V is continuous and focused on ongoing improvement and elevating the HWE. This phase is reflected in Kotter’s seventh step to continue to build on the change. The reinforcement of expectations for behavior and leadership accountability remains critical throughout this stage and as a sustainable strategy. The department norms are reassessed and refreshed every six months. The department norms guide the continuous education the team focuses on, which assists in anchoring the change as reflected in Kotter’s eighth step in the change model. This last step also emphasizes the need for transformational leadership components and the leader’s ability to inspire and elevate the team to achieve the best possible outcomes for both staff and patients (Kotter, 1996).

**Gap Analysis**
A gap analysis completed in the early stages of the project’s inception assisted in identifying broad themes of gaps in performance (see Appendix N). It was apparent leaders lacked confidence and competence in addressing disruptive behaviors. Leaders also voiced being intimidated by staff and not feeling they had support from the HR department to address poor performance and disruptive behavior. The four-phased educational program began with a baseline assessment that assisted in validating the gap in competency and confidence of nurse leaders who took the foundational course. The EBI leadership assessment (see Appendix O) emphasized the need to address the competency and skillset of nurse leaders to address incivility, bullying, and disruptive behaviors. The EBI pre and post-score comparisons reflected an average improvement of 72.2 percentage across the cohort of thirteen leaders.

A cultural maturity self-assessment (see Appendix H) was completed independently by the leadership team and the project management office regarding the high-reliability tenets embedded in the change of shift huddle process. The change of shift is a critical time to ensure staff is equipped with priority information. The leaders completed the self-assessment scoring between a 0-1 across the three departments indicating an urgent need to improve the effectiveness of the huddles. The change of shift huddle needed to be optimized, and leaders needed to exhibit confidence, be interactive and ensure it aligned with organizational goals. Highly reliable organizations acknowledge that trust is a vital component in the effectiveness and coordination of operations. The leadership of a HWE is increasingly recognized as a variable within a highly-reliable organization (Cox et al., 2006). The pillars within the visual boards were changed to ensure the following key themes were addressed:

- Quality renamed as ‘Heal Me’,
- Care Experience renamed as ‘Respect Me’
• Workplace Safety renamed as ‘Protect Me’
• People renamed as ‘Hear Me’
• Improvement Idea section in a stop light format
• ‘You asked for it, we did it’ section to provide closed-loop communication to staff

Change of shift huddle requires leaders to inspire, equip their staff with current information, and identify opportunities. The new, improved visual boards reflected a highly reliable process, encouraged a speak-up culture, celebrated meaningful recognition, and reflected progress on a journey to a HWE (see Appendix P). Leader simulation was done in the organizational leadership department. ODL and CNE provided coaching to ensure competence and confidence were gained to address disruptive behavior during huddles, encouraged a speak-up culture, and ensured closed-loop communication regarding challenges that were solved.

The pre-intervention survey reinforced the gap analysis. There was a total of 187 participants in the April 30th survey that represented a mean response rate of 72% for the baseline HWI-DBS staff survey. The stroke telemetry department reflected a responses rate of 63%, with 40 responses received. The cardiac telemetry department reflected a responses rate of 60%, with 42 responses received. The L&D department reflected a response rate of 88%, with 105 responses received.

The HWI-DBS baseline was collected from staff through voluntary, anonymous participation. Analysis of the aggregate data across the three departments revealed perceptions of favoritism, unfair distribution of the work, being micromanaged, ignored by certain co-workers, and general incivility using tactics such as eye-rolling. The survey reflected employees felt comfortable reporting incidents of disruptive behaviors to their leaders; however, they did not believe their leaders were addressing the disruptive incidents.
**Preoccupation with Failure.**

The change of shift huddle designated a place to showcase quality bundle elements and the total number of harm events, including when they occurred. The department identified the specific risk exhibited by data. For example, patient falls were identified as a top risk for the stroke telemetry department with a primary driver associated with going to the bathroom. Therefore, intentional toileting was implemented as an action plan to decrease the risk of falls. The preoccupation with failure is critical to empower mechanisms for learning and to highlight how significant consequences can be when errors occur (Busby and Iszatt-White, 2014). Preoccupation with failure was leveraged to adhere to shared organizational goals and mitigate patient harm. Preoccupation with failure is a vital tenet to address in addition to HWE and culture (Etchegaray et al., 2019). It is equally important for the staff to understand risks and to be alert for opportunities for improvement.

**Reluctance to Simplify.**

The change of shift huddle is not meant as a time to problem-solve. There are two categories that were added to ensure staff was empowered to speak up, and leaders committed to following through on digging deep to resolve. A category was created for escalations for staff to contribute to. A stoplight report was displayed to clearly delineate improvement work in progress, completed, and not started.

**Deference to Expertise.**

The change of shift huddle is a time to recognize the expertise of those on the frontline and ensure a forum exists for interactive exchange. It is critical frontline leaders are present during change of shifts, and time is dedicated to making rounds to validate the practices in effect.
There was a commitment to no-meeting time zones daily from 0700-1130 to ensure nurse managers have sacred time in their departments to round with staff and patients.

**Commitment to Resilience.**

Sustainability and commitment to resilience are vital for the continuous journey to improve a healthy work environment. The huddle serves as a daily time to inspire, recognize high performers, and commit to resilience as a team. The huddle is a brief standing meeting to ensure all leave with an intentional focus on key priorities. The top performers within the team are recognized in the pillars. The nurse leader’s daily rounds incorporate check points and empower the voice of the patient to be brought back to the staff in the huddle forum. The nurse leader rounds represent a relentless and resilient focus on the practices we say we have in place, enable time for patients to recognize staff who have had a positive impact on them, and identify opportunities to improve. The nurse leaders integrate additional detailed information learned during nurse leader rounds into huddles and the direct report rounds with staff.

**Work Breakdown Structure**

Nurse leaders hold accountability to lead their teams to deliver high-quality care and patient experience in a HWE. The four-phased educational plan to address incivility and create a HWE leveraged the tenets of high reliability and transformational leadership guided by Kotter’s 8-step change model. The program proposed to achieve improvements for both nurses and patients, which required the engagement of multiple stakeholders. A work breakdown structure assisted in segmenting the initially intimidating journey into manageable phases of work (see Appendix Q). The work breakdown structure on level 1 was divided into eight project phases, including assessment, charter development, education plan, subject matter experts, stakeholders (powerful coalition), finance, target audience, and appendix evaluation.
SWOT Analysis

A SWOT (strengths, weaknesses, opportunities, threats) analysis was done in the assessment phase (see Appendix R). The SWOT and gap analysis were supplemented by a literature review of evidence-based practice and research that was applied in the current state at the program launch. The literature review included integrating resources involving a HWE, culture change, high reliability, transformational leadership, and Kotter’s change model. The assessment of information empowers a statement of urgency and a need to forge ahead in creating a HWE. The message instills urgency, reflected in Kotter’s first step ‘to create urgency’ (Kotter, 1996). The perception to feel empowered to speak up is critical as professional nurse leaders are, first and foremost patient advocates. The power and urgency in the presentation were vital to ensure a powerful coalition inspired the hard work ahead, cohesively as a team.

The internal strengths reflected the positive opportunities and outcomes of this program, which included a deep dive into the existing culture and long-standing norms that needed to be reconstructed to create a HWE. The content was proven and had bolstered positive outcomes in other large healthcare systems.

Some internal weaknesses included the need to create time for the education of staff and leaders, in addition to the resources needed to assist with logistics and planning. The external opportunities encompassed the ability to enhance leadership competence and confidence in addressing disruptive behaviors and creating a HWE. The opportunities were heightened for nurse leaders in their first leadership role and those actively transitioning into a leadership role from a staff nurse role. The external threats of the program comprised the expense, potential inability to engage the multiple stakeholders, and the need to create a sustainability plan to hardwire the progressive improvement.
Gantt Chart

A Gantt chart (see Appendix S) was completed to enhance the visibility of the targeted timelines and empowered stakeholders to begin with the end in mind. The Gantt chart provided a road map for timelines and milestones. The Gantt chart grew as the journey progressed and served as a living document as the phases were accomplished. The Gantt chart assisted as a key communication document to stakeholders during standing meeting updates and to keep the executive team abreast of progress. The Gantt chart is a blueprint for spread application and replication as the program evolves.

Communication Plan

The communication and marketing plan included data points and research-supported statements as a testimony to the plague of incivility impacting healthcare, nurse well-being, and patient safety. The fourth aim of the Institute for Healthcare Improvement (IHI) represents caring for the caregiver; however, we continue to see the adverse impact of incivility on our nurses and patients (Thompson, 2019; Bowles et al., 2019). The communication plan assisted in articulating the vision and inspired an emotional commitment to the journey, which represents step three in Kotter’s change model (Kotter, 1996). The communication plan leveraged platforms across the organization to communicate the vision, share relevant data regarding the impact of incivility on healthcare, and ensure employees at all levels are informed of what is to come. The marketing plan included a ‘Be Kind’ button worn by those recognized for kindness and speaking up when faced with incivility. The button is also a visual cue and reminder to others of the power of kindness. Weekly information was disseminated across the frontline team in alignment with the phase in progress. Additionally, advertisements for the in-person and virtual sessions for staff
and leaders occurred throughout each phase of the program to encourage registration of attendance.

**Budget and Financial Analysis**

There were multiple variables to consider in the financial implications of this educational program. Primarily is the cost of the contract with the Healthy Workforce Institute, the cost of staff and leaders to attend, and the logistical costs of in-person meetings. Additionally, the time for mentoring of the leadership team was considered; however, one could argue what the cost of failing to provide education would be. Smokler Lewis and Malecha (2011) investigated the effects of workplace incivility on staff nurses related to cost and productivity. Uncivil behaviors were characterized by rudeness, lack of regard, or disrespectful actions towards others. The results again highlighted the epidemic of incivility throughout healthcare, with 85% of respondents reporting experiencing workplace incivility in the past year. The scores from the staff nurse’s perspective of the manager’s inability to handle workplace incivility showed a correlation with lost productivity, which was calculated to $11,581 per nurse per year. A nonexperimental, correlational, comparative, and predictive model design was used, which was approved by the institutional review board. The cost calculated was based on an average salary of a nurse in Texas, which was $60,000 to $64,999 and thus would be higher or lower in comparison if scaled to salary means in other states. Leveraging Smokler Lewis and Malecha's (2011) calculations of $11,581 per nurse to identify cost avoidance of lost productivity secondary to workplace incivility would equate to $3,231,099 for the HWE journey (N=279).

The cumulative cost of the attendees, contract, and formal mentoring time equates to approximately $101,748. The foundational EBI course for the first cohort of leaders was $15,997. The cost for staff in person or virtual sessions for phase one through phase four was
approximately $53,295 plus an additional $27,200 for RN wages to attend. An additional $4,000 was utilized for marketing materials and employee gifts. This cost is not inclusive of staff meetings which encompassed healthy work environment topics as staff meetings and committee priorities were refocused on this content to ensure ongoing momentum and sustainability. There is significant cost avoidance including lost productivity of $3,231,099. The cost avoidance for decreased incidence of patient harm equates to $1,062,584. The operational cost and cost avoidance can be referenced in Appendix T. The ultimate outcome of this project is retention, which would not only improve morale, quality, and retention but also avoid costs associated with recruitment and replacement.

The visual board huddle enhancements integrating transformational leadership and high reliability created a laser focus on nursing-sensitive indicators. The HWE education program empowered staff to speak up for patient safety and reinforced peer to peer accountability. The SPI rate reflected an improvement from pre-intervention .82 in December 2019 to a rate of .68 post-intervention in May 2021, exhibiting a decrease of patient harm of 17% (see Appendix U).

**Study of the Interventions**

The projected outcome of the HWE education program was to create a HWE by increasing the competency of leaders to address disruptive behavior while leveraging transformational leadership and high-reliability tenets. The HWE outcomes were calculated with the HWI-DBS survey instrument. Frontline staff voluntarily completed the HWI-DBS at the launch of the program prior to intervention, six months into the program, and at approximately one-year status post-implementation.

The confidence of nurse leaders was assessed by the EBI self-assessment tool. The frontline leaders who participated in the EBI program completed the EBI self-assessment tool
before the education program as a baseline and following successful achievement of the certification. The pre and post-scores of the EBI assessment were compared to evaluate the success of the program and correlated to the internal organization administered staff engagement survey (see Appendix V).

The SPI rate was measured, which is an internal benchmarking tool for the organization. The SPI and its components use the hybrid target setting model to create consistent medical center targets. The SPI component targets are aligned with the California Quality Collaborative (CQC) health care improvement program. The value of each event type is the observed to expected ratio created from external organizations or internal benchmarks depending on the indicator.

Nursing certification was surveyed through self-reporting and certification reimbursement. National certification was assessed at the department level by nurse leaders and integrated into professional practice councils.

**Data Collection Instruments**

The HWI-DBS was leveraged as a valid and reliable survey instrument that measures disruptive behaviors in the workplace. The HWI-DBS assists in quantifying results and informs how to strategize a HWE through data. The HWI-DBS survey tool was utilized consecutively for three instances at approximately 6-month intervals in April and November in 2020 and in May of 2021.

The EBI leadership assessment was utilized for self-assessment of leaders to evaluate baseline and status-post education of confidence in addressing disruptive behaviors. Baseline assessment took place in January 2020 prior to intervention. A total of thirteen nurse leaders
enrolled in the EBI education program and completed (N=13) in May 2020. The tool leverages 1-5 Likert scale self-assessment exhibiting a maximum score of 200.

**Outcome measures**

The project included two primary tools for measurement. The HWI-DBS reliable survey instrument (Appendix W) was utilized for baseline assessment during the midpoint of the program at six months and at the one-year mark. The HWI-DBS has been scientifically validated at the University of Northern Colorado by The Social Research Lab. The EBI leadership assessment was utilized prior to leader engagement in the education program and status post achievement of the EBI certification. The program boasts an average of 72-point increase in overall score (p<0.0001) and >94% of participants rate as meeting or exceeding expectations (Thompson, 2019).

The validity of the HWI-DBS instrument is grounded in ten years of data collected about disruptive behavior through the HWI (Thompson, 2019). The survey is composed of fifteen questions and reveals overt and covert behaviors ranging in frequency from never to always on a Likert scale. The HWI-DBS tool assesses and quantifies unprofessional behaviors that erode a HWE. The HWI-DBS tool has helped to collect more than 2500 nurses’ perceptions of personal experience with disruptive behavior. The most concerning to patient safety is the prevalence of participants being ignored or given silent treatment. The HWI-DBS valid tool helped to guide individual department response through workshop evaluations to equip leaders and teams to confront disruptive behaviors and eradicate incivility (Thompson, 2012).

The survey enabled a quantifiable assessment of the workplace environment and a qualitative section for staff to provide comments not reflected in the Likert-scale instrument. The
qualitative comments reflected a shifting culture with progress in building relationships across leaders and staff.

Analysis

A nurse leader’s ability is a key variable in promoting a HWE (Thompson, 2019). The proposed outcomes were to optimize standard work to ensure leaders are educated and empowered to address priorities to create a HWE. Increased confidence and competency of nurse leaders’ ability to recognize and eradicate incivility and bullying through completion of an education program and intentional application of learned skills increased the overall index of a HWE from the baseline assessment completed in May 2020. The frontline nurse leader’s competency and confidence are analyzed from a pre and post-survey administered before and after achieving a certificate in the course ‘Eradicating Bullying and Incivility’, administered through the Healthy Workforce Institute®. Nursing-sensitive indicators results are also compared secondary to the emphasis on communication during change of shift huddle and leader-team relationships.

The HWI-DBS was utilized to measure the frequency of passive, covert, and aggressive, overt disruptive behaviors in a work environment. The HWI-DBS is a reliable, valid tool to measure the incidence of disruptive behaviors. Participants assessed the frequency of common disruptive behaviors in relation to three categories: physician relationships, leadership and team relationships, and overall department culture. Participants rated each behavior on a Likert scale. The survey was based on behavior that was either witnessed or experienced. The Likert scale measurement was (1) never, (2) sometimes, or (3) always. The scoring is identified as mild (15-30), moderate (31-59), or severe (60-75) based on HWI-DBS validated instrument. A total of fifteen common disruptive behaviors are assessed for: being yelled at, criticized, or cursed at in
front of others; having someone roll their eyes; receiving an uneven workload based on favoritism; having a coworker break confidence by sharing private information; having a coworker withhold information, leading to a negative impact on performance; being excluded; having accomplishments downplayed; being ignored or given the silent treatment; hearing individuals name-calling, making inappropriate jokes or comments; being micromanaged; being the target of gossip; receiving threats of physical violence; being retaliated against for speaking up; being made to feel incompetent; and being treated nicely in person but mocked behind one's back (HWI, 2021).

Prior to the HWI-DBS baseline assessment, participants received communication describing the program, timeframe, survey methodology, and how the information would be leveraged and shared. The survey notification included information to participants that completion was voluntary, individual data would not be identifiable, and that information would not be used for employment decisions. The data collection process began with a list of all employees in the pilot departments and email addresses. The introductory email was also printed and displayed on the department visual boards for the convenient reference of staff. All participant's responses were anonymous and de-identified through the HWI. Potential variables that could influence outcomes were collected, including age, gender, ethnicity, years of professional experience, and role or position (see Appendix X). Demographic questions were optional and not required for the completion of the HWI-DBS survey. Inclusion criteria included a willingness to complete the survey and employment in one of the three pilot departments.

Nurse leaders received a similar communication prior to the EBI leader baseline self-assessment. The nurse leaders participated voluntarily, and their emails were provided to the HWI for survey communications. The inclusion criteria were commitment to enroll and complete
the EBI program. Nurse leaders enrolled in the EBI program committed to sharing learnings and participating in debriefings within the cohort.

Ethical Considerations

The focus of this educational program was to increase the confidence of nurse leaders to address disruptive behavior and enhance transformational leadership and high-reliability tenets to improve the constructs of a HWE. This educational program was reviewed by the University of San Francisco DNP faculty committee and was approved as a non-research, evidenced-based practice project and met ethical criteria as such. This approval can be referenced in the statement of determination (see Appendix Y).

The project was also reviewed by the organization’s Research Determination Office (RDO), which concluded that it did not require IRB approval as it did not meet the criteria for research with human subjects (see Appendix Z). This project was endorsed by HWI and Dr. Renee Thompson with a letter for proof of permission (see Appendix A). The data was anonymous, and individual data elements were deemed not identifiable. Participants received communication of voluntary survey participation via huddles, displayed via hard copy on department visual boards, and via email. A QR code was leveraged for convenience and included the same message (see Appendix AA). These logistics supported the participants’ privacy and psychological wellbeing.

Ethical considerations are synonymous with fulfilling the role of a licensed registered nurse per the American Nurses Association (The American Nurses Association, 2015); however, this guide is not always referenced in carrying out responsibilities and ethical obligations of the profession of nursing. Provision 1 encompasses the need to practice with compassion and respect for the dignity of every person. Every person must also include our colleagues if we are to
provide the best possible care to those who rely on the healthcare system when they are most vulnerable. A HWE requires respect, team norms, and professionalism aligned with provision 1. Provision 8 specifically calls out the need to collaborate with other health professionals to promote health and reduce disparities, none of which can be effectively achieved when incivility and bullying remain a challenge. Provision 6 notes the duty to ensure and improve the ethical environment of the work setting, which directly connects to the purpose of this project to create a HWE. This project assisted to safeguard resilience and psychological wellbeing of the participants during ongoing trauma throughout the global pandemic.

The University of San Francisco’s Jesuit values aligns with this project. The core value number 7 reflects the importance of social responsibility to apply knowledge to benefit all people, including future generations. The cultivation of a HWE reflects a social responsibility and one of safety. The core value 8 depicts how we choose to exhibit the behavior. Perhaps most importantly, core value 10 reflects the need to respect and promote the dignity of others. The core values as a whole summarize the vital need to uphold personal accountability of how actions can have a positive impact on others (2001).

Moore et al. (2013) compound on the existing foundation of why building a HWE is critical for nurse wellbeing. Moore et al. (2013) expanded the perspective of the survey to address the environmental characteristics that staff believed were necessary for a HWE. Four central themes were identified when participants responded, including positive interpersonal relationships with peers, positive leadership actions, teamwork, and effective communication.

Bullying and incivility in nursing and healthcare have been noted to have a significant impact on the stress level of nurses, patient quality outcomes, and workforce implications. It is vital for leaders to identify innovative strategies to address the root causes and change the culture
so staff and patients can heal (Vessey et al., 2009). Incivility and bullying behavior negate the ability of nurses to work where they are respected and treated with dignity. It is essential leaders role model by example, set the tone, and champion respect to creating a HWE. Cleary et al. (2009) found it is vital for the leader to develop a HWE that maintains a professional environment and fosters collaboration with zero tolerance for bullying.

Section IV: Results

Results

Demographic Data

The population for assessment of the EBI leadership education program included frontline leaders who volunteered to participate in the project, including nurse managers, assistant nurse managers, and nurse directors. The population for assessment of HWE included frontline staff consisting of registered nurses, patient care assistants, surgical technicians, and unit assistants. The participants were employed in the following three departments: labor and delivery, stroke telemetry department, and cardiac telemetry department. A total of thirteen participants were nurse leaders for the EBI cohort, and the remaining participants were the frontline staff. The baseline number of frontline staff participation varied throughout the year secondary to attrition, leaves of absences, FTE adjustment, and recruitment. However, it started with a baseline of N=279.

Demographic data were collected, however not required for survey completion. HWI-DBS instrument responses included 32% of participants in the age range of 26-35, 38% of participants in the age range of 36-45, 20% of participants in the age range of 46-55, and 9% of participants older than 55 years. Forty percent represented Asian or Asian American, 27% of the respondents represented Caucasian ethnicity, 5% represented Latin, Latino, LatinX, 5%
represented African American with the remaining percentage of respondents distributed across native Hawaiian/pacific islander, Another race(s), or prefer not to answer. Eighty-one percent of respondents identified as female, 11% identified as male, and 8% preferred not to answer. Professional experience reflected the majority of respondents with greater than ten years. Eight percent reported 0-2 years of experience, 24% reported between 3-10 years of experience, 48% reported between 11-20 years of experience, and 18% reported> 20 years of experience.

**HWI-DBS Department Score**

The pre-intervention average score for HWI-DBS was 25 for all three departments and fell into the mild category (15-30). The three departments were consistent with the most frequently reported behaviors being: receiving an unfair assignment or workload, seemingly based on favoritism; having someone roll their eyes, and being micromanaged and repeatedly reminded of mistakes. Three categories of a HWE were evaluated: physician relationships, leader relationships, and overall culture.

Baseline department scores reflected cardiac telemetry department with an average score of 27, L&D with an average score of 26, and stroke telemetry with an average score of 23. Department scores at six months revealed an improvement in all three departments reflected cardiac telemetry department with an average score of 22, L&D with an average score of 25, and stroke telemetry department with an average score of 21. The third data point collected at one year in May 2021 reflected cardiac telemetry department with an average score of 30, L&D with an average score of 26, and stroke telemetry department with an average score of 25 (see Appendix BB).

**Physician Relationships**
Physician relationships were assessed within the HWI-DBS tool with a lower score reflecting improvement in the nurse-physician relationship. Five components were measured across the three departments. L&D reflected an improvement in ‘experiencing mistakes but fear of speaking up from 21% at baseline to 15% at one year, reflecting an improvement of 40%. Conversely, L&D showed a decline of 28% in the category ‘being talked to in a condescending manner or made to feel incompetent. L&D showed a slight decline overall in physician relationships from a baseline of 20 to the one-year assessment of 21.6 (See Appendix CC). The cardiac telemetry department reflected an overall mean improvement of 17.7% physician relationships. Significant improvement of 34% was exhibited in the category of ‘not feeling comfortable contacting a particular physician regarding patient care situation’ (See Appendix DD). The stroke telemetry department exhibited similar results to L&D, with overall physician relationship scores declining by 7%. The most notable improvement in the stroke telemetry department was in the category of ‘not feeling comfortable contacting a particular physician’ improving by 35%. The most notable decline was in being talked to in a condescending manner showing a 60% decline from a baseline of 20% to the one-year score of 32% (see Appendix EE).

Leadership Team Relationships

Leadership team relationships were assessed within the HWI-DBS tool with a higher score reflecting improvement in leadership and team relationships. Five components were measured across the three departments, including setting clear expectations, accountability, leaders' ability to address disruptive behavior, positive leadership role modeling, and approachability of leader.

L&D reflected an improvement in ‘my leader sets clear expectations for professional behavior’ from 77% at baseline to 90% at one year. L&D increased from a baseline of 66% in
the category ‘my leader makes me feel comfortable in approaching them to discuss behavioral issues regarding my coworkers’ to 81% at one year. In the category ‘my leader is a positive role model for professional behavior,’ the L&D team exhibited an improvement from 61% of staff agreeing or strongly agreeing to an improvement of 75% at one year. The L&D increased from 54% in the category ‘my leader holds everyone accountable for their actions’ from 54% to 74% at one year. The category ‘my leader addresses disruptive behavior in my department’ increased from 51% to 76%, showing an improvement of 25% (See Appendix FF).

The cardiac department reflected congruent improvements as L&D in leadership relationships from baseline to one year. The cardiac department reflected an improvement in ‘my leader sets clear expectations for professional behavior’ from 62% at baseline to 68% at one year. Department 220 increased from a baseline of 61% in the category ‘my leader makes me feel comfortable in approaching them to discuss behavioral issues regarding my coworkers’ to 62% at one year. In the category ‘my leader is a positive role model for professional behavior,’ the 220 teams exhibited an improvement from 62% of staff agreeing or strongly agreeing to an improvement of 68% at one year. The cardiac department decreased slightly in the category ‘my leader holds everyone accountable for their actions’ from 53% to 49% at one year. The category ‘my leader addresses disruptive behavior in my department’ increased from 50% to 62%, showing an improvement of 12% (See Appendix GG).

The stroke telemetry department reflected a slight decrease in ‘my leader sets clear expectations for professional behavior’ from 100% at baseline to 94% at one year. The stroke telemetry department from a baseline of 89% in the category ‘my leader makes me feel comfortable in approaching them to discuss behavioral issues regarding my coworkers’ to 88% at one year. In the category ‘my leader is a positive role model for professional behavior,’ the
stroke telemetry department team exhibited an improvement from 91% of staff agreeing or strongly agreeing to an improvement of 94% at one year. The stroke telemetry department decreased slightly in the category ‘my leader holds everyone accountable for their actions’ from 95% to 88% at one year. The category ‘my leader addresses disruptive behavior in my department’ decreased from 94% to 88% (See Appendix HH).

**Overall Department Culture**

Overall, department culture was assessed within the HWI-DBS tool with a higher score reflecting an improvement of team culture. A total of seven components were measured across the three departments, including treating staff with respect, treating agency and travelers with respect, encouragement from manager to speak up when disruptive behavior occurs, not tolerating abusive behaviors, supporting new persons to the department, confidence to address disruptive behaviors in the department, and fair resolution of conflicts.

L&D reflected an improvement in ‘we treat all staff with respect’ from 81% at baseline to 85% at one year. L&D increased from a baseline of 79% in the category ‘we treat agency, travelers, and float staff with respect’ to 85% at one year. In the category ‘my manager encourages employees to speak up when they witness of experience disruptive behavior,’ the L&D team exhibited an improvement from 76% of staff agreeing or strongly agreeing to an improvement of 86% at one year. The category ‘abusive behaviors are not tolerated here improved 20% from 69% to 89%. The L&D increased from 68% in the category ‘new persons to the department are given appropriate support’ from 68% to 80% at one year. The category ‘I feel confident in my ability to address disruptive behaviors in my department’ increased from 65% to 84%. Lastly, the category ‘conflicts are resolved fairly here’ improved markedly from 46% to 75% (See Appendix II).
The cardiac telemetry department reflected a slight improvement in ‘we treat all staff with respect’ from 73% at baseline to 74% at one year. The cardiac telemetry department increased from a baseline of 79% in the category ‘we treat agency, travelers, and float staff with respect’ to 88% at one year. In the category ‘my manager encourages employees to speak up when they witness or experience disruptive behavior’, the cardiac telemetry department exhibited an improvement from 68% of staff agreeing or strongly agreeing to an improvement of 71% at one year. The category ‘abusive behaviors are not tolerated here improved 68% from 80%. The cardiac telemetry department decreased from 63% in the category ‘new persons to the department are given appropriate support’ to 60% at one year. The category ‘I feel confident in my ability to address disruptive behaviors in my department’ increased from 59% to 68%. Lastly, the category ‘conflicts are resolved fairly here’ decreased from 62% to 54% (See Appendix JJ).

The stroke telemetry department reflected a slight decrease in ‘we treat all staff with respect’ from 89% at baseline to 91% at one year. The stroke telemetry department decreased from a baseline of 95% in the category ‘we treat agency, travelers, and float staff with respect’ to 91% at one year. In the category ‘my manager encourages employees to speak up when they witness or experience disruptive behavior’, the stroke telemetry department revealed a baseline of 100% of staff agreeing or strongly agreeing to 97% at one year. The category ‘abusive behaviors are not tolerated here improved from 86% at baseline to 91% in one year. The stroke telemetry department decreased from 94% in the category ‘new persons to the department are given appropriate support’ to 88% at one year. The category ‘I feel confident in my ability to address disruptive behaviors in my department’ went from 94% to 88%. Lastly, the category ‘conflicts are resolved fairly here’ decreased from 89% to 82% (See Appendix KK).
**EBI Results**

The nurse leader self-assessment for EBI was completed by each nurse leader prior to the educational program as a baseline and status post achievement of the completion certificate. The EBI Essential Skills for Healthcare Leaders instrument was utilized to address five categories of leadership skills. The first main category was getting clear on bullying and included acquiring skills needed to address bullying behavior, having the ability to explain why bullying is so prevalent in nursing, being able to articulate the difference between bullying and incivility, and feeling confident inability to recognize and address bullying. Recognizing disruptive behaviors encompassed being able to recognize overt and covert bully behavior, knowing the difference between bullying, harassment, and discrimination, knowing which employees are at high risk for becoming targets of bullying, and understanding the impact bullying has on employees organizations, and patients. The third category assessed by leaders and rated was ‘setting behavioral expectations’ and included clarity about expectations of professional behavior, established department norms for professional behavior, following step by step process to set behavioral norms with employees, and having a process to introduce new employees to expectations of professional behavior upon hire. The last category, ‘confronting disruptive behaviors’ includes four assessment variables: knowing how to respond when employees report they are being bullied, using assertive communication with employees that is honest and respectful, being skilled at how to document disruptive behavior in a way that supports organizations code of conduct, and being confident inability to confront disruptive behavior with employees (see Appendix O).

Prescore values ranged from 23-179 compared to post score ranges of 129-191. The average prescore was 100. The average postscore rating was 176. The percent change for each
leader ranged from 6.7% to 565.2% showing wide variation in baseline knowledge and confidence across the leadership cohort of thirteen. The average percent change was 72.2% (see Appendix LL). The leaders completed coaching calls with consultant Dr. Renee Thompson and the chief nurse executive prior to completion of the program. All 100% of the leader cohort reported improved confidence and self-perception of ability upon completion of the program as exhibited by percent improved from pre-intervention self-assessment (see Appendix MM).

**Nursing Sensitive Indicators**

Nurse-sensitive indicators were reviewed secondary to the high-reliability work focused on the change of shift huddle and the emphasis on creating a speak-up culture to identify when there is an opportunity to improve. There was a laser focus on the nurse leader’s ability to coach staff in real-time and celebrate success. The visual boards were modified with input from our assistant nurse managers, managers, and staff across all adult services departments. Staff and leaders were asked to identify what information is most critical to ensure the team is set up for success to begin their shift, celebrate the team’s progress, and create a preoccupation with failure to ensure there is a proactive focus on mitigating error (Etchegray et al., 2019). The total events were compared from the historical baseline in 2019 to incidences status post-implementation of visual boards and leadership education in 2020 with a sustainability measurement comparison in 2021. The performance for comparison purposes was assessed by quarterly comparison (see Appendix NN). The SPI rate was utilized to accurately capture observed versus expected in addition to a comparison of actual events. The visual boards were tailored to identify the top risk of the individual department to further focus on priority needs for improvement.

**Hospital-Acquired Pneumonia.**
Hospital-acquired pneumonia (HAP) increased by one case from 2019 to 2020; however, the cluster of events occurred in the first quarter of 2020 from October 2019 to January 2020. The 2021 performance year revealed a decrease of one case from 2020. Changes were made to include oral care and mobility in the visual board, and nurse leaders reported out to ensure the best practice bundle elements, which prevent HAP, were within compliance. The nurse leaders recognized the need to ensure physician documentation reflected those patients admitted with community-acquired pneumonia to avoid the coding to be listed as hospital-acquired and collaborated with the physician team to create a check and balance daily rounding from the electronic medical record of new admissions that fell into the pneumonia risk category.

**Clostridium Difficile.**

Clostridium Difficile (C.Diff) reflected a reduction from 27 total cases in 2019 to 18 total cases in 2020 and 17 total in 2021. The staff was engaged in ensuring high-touch surfaces were wiped down; hand hygiene compliance increased, including peer auditing. The continual message during huddles centered around the need for us to serve as safety nets for each other, shifting the typical defensive response when someone was called out for not performing hand hygiene to one of thank you. The nurse leaders included the date of the last C. Diff infection in the shift change huddle and learnings to share. The study completed by the National Institutes of Health showed the average cost of hospital-acquired C. Diff was shown to be $34,157 (Zhang et al., 2016). Therefore, the cost savings from the reduction of C. Diff infections equates to $307,413 from 2019 to 2020. A $34,157 savings is accounted for from 2020 to 2021.

**Hospital-Acquired Pressure Injury.**

Hospital-acquired pressure injuries (HAPI) reflect a decrease from 23 in 2019 to 14 in 2020, showing an improvement of 9. In 2021 HAPI was again reduced to 5. The cost of hospital-
acquired pressure injury correlates with the severity of the stages from stage I through stage 4. The biggest change in the process began when nurses spoke up to request additional assistance in identifying the assessment and prevention of HAPI in a department during the change of shift huddle. This idea was taken to the director of the wound care nurses and further discussed at a nurse manager forum. The nurse managers and assistant nurse managers collaborated with the wound care nurses to do rounds together three times weekly and engage the front-line staff during rounds on high-risk patients. The wound care nurses also prepared education presentations for the nurse leadership team, which marked the first time a staff nurse was hosted as a guest speaker and a key moment to the continued focus on deference to expertise, regardless of role. The wound care nurses presented to the professional practice council and continued to share findings and learnings. The previous culture lacked collaboration, and wound care nurses worked in silos notifying the manager when opportunities were identified during the consultation. The new model empowered the wound care nurse to partner with the primary nurse and included the assistant nurse manager.

Pressure injury care is complex and requires a collaborative systems approach and reliable process to ensure prevention. This change to create a standard process, incorporate learnings from experts, including hosting wound care nurses during huddles and forums for at-risk departments, was critical to empowering those with expert knowledge. The Agency for Health Research and Quality (AHRQ) estimates $9.1 to $11.6 billion is spent within the United States on pressure injuries (2014). The average cost of a hospital-acquired pressure injury is $43,180, therefore reflecting a savings of $388,620 from the performance year 2019 to the performance year 2020. An additional savings of $172,720 from the performance year 2020 to the performance year 2021 year to date.

Central line-associated bloodstream infections (CLABSI) improved from 14 total events to 8 total events in the performance year 2020, reflecting prevention of 6. The chlorhexidine bathing compliance and daily focus on line necessity were incorporated into the visual boards and nurse leader rounding. The partnership with the physician team and the ability to escalate concern for line necessity played a key role in ensuring lines were removed, and nurse leaders communicated with attending physicians upon disagreement with the resident team.

CLABSI is one of the costliest events impacting the healthcare system. Zimlichman et al. (2013) estimate an average of $45,000 for each hospital-acquired CLABSI, recognizing there is much more to do when it comes to the prevention of complications. Utilizing the cost of $45,000, the reduction of CLABSI events equates to $270,000 savings from 2019 to the performance year 2020. A projected additional savings of prevention of 2 CLABSI in the performance year 2021 to date to $90,000 is accounted for.

Catheter-Associated Urinary Tract Infections.

Catheter-associated urinary tract infections (CAUTI) showed a reduction from 16 in the performance year 2019 to a total of 9 in 2020. The standard process was reflected in the visual board and huddle information to highlight which patients had catheters and determine if the line was necessary. The huddle and nurse leader round also incorporated compliance with perineum care for all patients who had a catheter in place, as well as collaboration with the physician team for removal of the catheter as soon as medically able to. The average cost of a CAUTI was shown to be $13,793, according to the AHRQ (2017), which is much higher than previously believed based on a research review of multiple studies inclusive of cost data. Reflecting on the prevention of 7 CAUTIs in 2020, the savings equates to $96,551.
Section V: Discussion

Summary

The resounding theme in the literature is that a HWE is essential for teams to perform optimally, provide the best patient care, and create an environment where nurses can thrive (Thompson, 2019; Albashayra et al., 2019; Babiker et al., 2014; Baker et al., 2006; Bishop Mills et al., 2018). Nurse leaders set the tone for teams and the ability to navigate the challenges of healthcare. It is vital for nurse leaders to be equipped with the skills and knowledge to apply transformational leadership and execute on the constructs of high reliability (Boamah et al., 2017; Busby & Iszatt White, 2014; Polonsky, 2019; Faupel & Sub, 2019; Vessey et al., 2009; Frankel & Leonard, 2018). Nurse leaders must be able to address disruptive behaviors, apply individualized consideration, exhibit inspirational motivation, role model idealized influence, and empower intellectual stimulation (Kramer & Schmalenberg; 2010; Levine et al., 2020; Mcphee et al. 2012). Nurse leaders that exhibit confidence to address disruptive behaviors create environments that are safer for patients and nurses, improve communication, increase engagement, and enhance nurse retention (Thompson, 2019; Bawafaa et al., Clark et al., 2013; Clark et al., 2014; Grant et al., 2010; Zadeh et al., 2018). Transformational leadership improves nurse satisfaction and creates supportive, empowered HWEs (Lunden et al., 2017; Boamah et al., 2018).

Highly-reliable organizations reflect the five primary tenets: a preoccupation with failure, reluctance to simplify, sensitivity to operations, deference to expertise, and commitment to resilience. Baker et al. (2006) note that most healthcare teams are challenged with hierarchy compared to highly-reliable teams, which focus on teamwork training to exhibit assertiveness, mutual trust, willingness to admit mistakes, a high level of accountability, and an appreciation
for the feedback. These tenets of high reliability are reflected throughout the phases of the education program. Collaboration of frontline nurses and leaders to improve huddles at the change of shifts was necessary to ensure the short time at change of shift is leveraged to set the nurses up for success with key knowledge (Martin & Ciurzynski, 2015; Huddleston & Gray, 2016).

This project had multipronged priorities to improve the confidence among frontline nurse leaders to address disruptive behaviors, instill transformational leadership qualities, and strengthen the HWE to create improved patient outcomes. A hybrid approach to the intervention utilized existing resources and external consultation. The collaboration across key stakeholders was critical, including organizational development, human resources, and patient care services. The conceptual foundation leveraged Kotter’s 8-step change theory (Kotter, 1996) while applying transformational leadership and high-reliability tenets to create a HWE. Culture sets the foundation for agility, progress, and proactivity in an organization. Strategy without a HWE and culture is futile. Dr. John Kotter’s 8-step change model empowered a momentum to drive change and achieve the necessary progress to reach successful outcomes. A powerful coalition and healthy culture are essential to compete on any level in today’s rapidly changing healthcare environment and are vital to retaining talented professionals. Dr. John Kotter’s 8-step change model theory is referenced and applied throughout the project for the cultivation of a healthy work environment (Kotter, 1996).

The key findings of the EBI education program showed an improvement of 72.2% (N=13) in leaders’ confidence to address disruptive behavior. The data confirms this project’s aim was achieved. Thirteen nurse leaders participated in the EBI education program, followed by the implementation of DCCI across three pilot nursing departments. Education was didactically
focused on HWE, transformational leadership, and the application of high reliability. Individual coaching, team coaching, inspirational motivation, individualized consideration, intellectual stimulation, idealized influence were focus themes throughout the journey to create HWE. The DCCI education program showed improvements in leadership team relationships, overall culture, and physician relationships by project transition to sustainability in June 2021.

An additional project-specific aim was to increase the leader’s confidence to address disruptive behavior from the pre-intervention score to the post-intervention score by July 30, 2020, when the EBI course concluded. The EBI and DCCI educational programs supplemented with internal resources aimed to enhance leadership and staff relationships, team relationships, and physician relationships beginning in January 2020 through May 30, 2021. The outcomes of the DCCI program are exhibited by the scores on the HWI-DBS and further contribute to the knowledge base on the value of equipping leaders and teams with the ability to cultivate a HWE. The key findings were that cumulative overall culture improved from pre-implementation of (M=76.4) to post-implementation (M=81.3) (see Appendix=OO). The physician relationships reflected slight improvement from pre-implementation (M=21.5) to post-implementation (M=20.7), with a lower score demonstrating decreased incidence of experienced or witnessed disruptive behaviors with physicians (see Appendix=PP). The leadership and team relationships increased from preintervention baseline (M=71.1) to post-intervention (M=76.9) see Appendix=QQ).

The epidemic of bullying and incivility in nursing represents an urgent need to improve culture in healthcare. The increased demands and decreasing resources create an environment ripe for incivility and bullying. Incivility and disruptive behavior are known to impact safety and patient care (Albashayreh et al., 2019; baker et al., 2006; Bishop Mills et al., 2018). The
culmination of this project exhibited valuable information and the necessity to equip leaders with the skills needed for success. Watson et al. (2018) note that Caring Science is an evolved moral-ethical framework of relationships that both promote and nourish health. Relationship building has been a key need to strategize differently since the pandemic impact has shifted in-person forums to primarily virtual platforms. This connectedness is also vital across leadership team relationships. It has taken intentionality to ensure the trust is built across leaders and team norms are reflected consistently in leadership behavior and the environment. A peripheral benefit of enhancing the culture is exhibited by improved patient outcomes reflected in the safety patient index score.

The dissemination of the project was continuous and ongoing. Participants were invited to sessions held during key milestones marked by data collection at preintervention, six months, and one year. Participants engaged in a discussion regarding data collection and results. HWE professional practice committees engaged in department-specific action plans in collaboration with leaders to heighten awareness, operationalize the department norms, and address disruptive behaviors. Highly visible meetings were leveraged throughout the project implementation to communicate information on HWE. The progress of the EBI and DCCI programs was shared by the CNE across executive and staff forums. The journey to create a HWE was featured in the Annual Nursing Excellence report (January 2020-April 2021). The L&D nurse manager was featured as the HWE valedictorian for the wide-sweeping culture change led across the department, as exhibited by the significant improvement in the overall culture and leadership relationships with staff.

This project presented a scientific foundation and momentum to continue an evidence-based journey to equip leaders and staff with the skills needed to create a HWE. The curriculum
scrutinized the impact of relationships between leaders and staff, staff and physicians, and the
dynamics across a department to promote a HWE leveraging transformational leadership and
high reliability. This project created groundwork for additional spread across the medical center
to bolster the pathway to achieve Magnet designation (American Nurses’ Credential Center,
2019).

**Interpretation**

The HWE project embedded with transformational leadership and high-reliability tenets resulted in improved culture across the departments. Leader and staff relationships, overall
culture, and physician relationships improved post-intervention. The data suggest that
participants experienced a heightened awareness of disruptive behaviors, improved the ability to
address disruptive behaviors, improved relationships with leaders, improved relationships with
physicians, and improved overall work environment.

The intervention required agility and flexibility secondary to the multiple challenges
created throughout the global pandemic. The project experienced minor delays. However, the
teams expressed dedication and desire to continue the journey. The underpinnings of the
intervention assisted leaders in navigating the multitude of variables beyond control, such as a
pandemic, societal unrest, and constrained hospital operations. The project maintained a focus
on variables within control, such as how to treat others and accountability for behavior.
Infrastructure that aligned with HWE, transformational leadership, and high reliability were
empowered throughout the intervention. The HWE councils took on department-specific
challenges, including those generated by the pandemic. A covid response committee was created
and co-chaired by leaders and staff. The committees created bylaws that leveraged HWE as a key
underpinning to address the unprecedented stress on the frontline staff and leaders. The HWE
councils focused on the care of self and care of each other, which was vital for resilience throughout the pandemic. The evidence of how psychological safety and the ability to communicate regardless of role is critical for patients’ outcomes and staff engagement (Briner et al., 2013; Cheng et al., 2011; Feather, 2015). The councils leveraged actual scenarios to assist staff and empowered them to share stories of their own to continue to communicate the HWE vision. The resounding message that raised awareness was to “Do no harm,”; whether that referred to colleagues or patients (Thompson, 2012).

Learning methods included reflective practice, demonstration of the application of transformational leadership during huddles, role play, individual coaching, peer coaching, and collaborative case scenario review. The learning forums remained flexible throughout the project to comply with pandemic infection prevention requirements. Small groups, one on one, virtual platforms through Zoom and Microsoft Teams, and education on the application of high-reliability tenets were utilized. Transformational leadership examples were integrated throughout the curriculum and created a catalyst for leaders to empower staff to reach their goals while improving the HWE. Transformational leadership has been shown to directly affect care delivery to patients, team confidence, respect for others, and psychological safety (Wang et al., 2021).

The project enhanced the participant's leadership growth and development regarding the ability to address disruptive behaviors and to create a HWE. The initial stages of project implementation were vital to create a sense of urgency and harness the energy toward a collective powerful shared vision (Kotter, 1996). Culture change is a challenging undertaking; however, it is necessary for healthcare and nursing. Incivility and bullying have become expected within healthcare and are known to be linked with medical error, patient safety, and
workplace safety (Mills, 2019). Individual encouragement of leader participants was vital as the impact from the pandemic created distractions and increased stress in an already challenging setting. The organization has historically utilized an internal benchmarking staff engagement survey to measure the speak-up index, team effectiveness, respect across departments, and approachability of leaders. This project serves as a supplemental data point to address department-specific opportunities to build a HWE. The organization is shifting to utilize a national benchmark tool in the last quarter of 2021, which will yield a comparison to correlate progress from pilot departments. The 2020 internal staff engagement survey revealed marked improvement in nurse leaders' results that had data from direct reports. The pandemic created unparalleled challenges, provoked disruptive behavior with increased stress, and threatened safety with depleted supply chains. The leaders’ abilities were essential to help empower the team to innovate to achieve the best possible outcomes and remain focused on variables within control to create a HWE.

Sustainability and empowerment through this foundational project will be anchored in initial leaders disseminating and transferring knowledge to their colleagues. A pilot spread plan has been initiated with the a manager participant fulfilling the facilitator role. HWE principles are integrated into daily operational processes including huddles, direct report rounding, staff meetings, and means of communication. The team norms are leveraged to align the priority of what is best for patients first, the team second, and individual next. As new rituals are created, they source to sustain the positive momentum of the necessary culture change to a HWE.

Limitations
It is critical to note that this program took place during a global pandemic that disrupted the healthcare industry. Project timeline and logistics were continuously adjusted to meet the needs of infection prevention parameters, participant needs, and daily operation needs.

The pre and post-survey instruments were based on self-assessment, perceptions, and awareness, which contributes to generalization and causality. The HWI-DBS is a proven reliable instrument. The EBI leadership survey instrument is based on self-assessment and perception of confidence. Nurse leaders were invited to participate in the project on the pilot departments to ensure they were equipped with the skills necessary to navigate the DCCI project implementation across the staff. EBI was a self-paced program with all 13 participants successfully achieving a completion certificate. The project was limited to the 13 nurse leader participants in the EBI course.

The DCCI included an invitation to staff across the three participating departments on a voluntary basis. Survey instrument completion was based on voluntary and anonymous participation. The number of participants varied across the three milestones for survey collection for pre-intervention (N=187), six-month measurement (N=174), and one-year project completion (N=156). Reminders to complete survey instruments were sent via email and included in huddle announcements with displayed access to QR codes for staff convenience. Participating leaders received weekly messages via outlooks with tips that reflected the appropriate stage of the DCCI program.

A monthly summary overview was provided for each month, February through October; however, the one-on-one coaching consultation calls were not specifically reflective of detailed conversations, only themes. The simulation sessions were evaluated and refined based on the participants’ feedback. The additional limitation to consider is the ability to defer to a national
expert versus leveraging internal resources to spread strategies developed as the program progressed.

Lastly, the literature reviewed did not yield specific education to apply to create a HWE through the application of transformational leadership and high reliability. There is an absence of publications related to leveraging transformational leadership and high reliability to achieve a HWE. There is a multitude of available works that address transformational leadership individually, however not in combination with high reliability. Additional resources and research are needed to identify effective strategies to promote and sustain a HWE to benefit both nurses and patients.

Conclusion

In conclusion, the journey to create a HWE through applied tenets of transformational leadership and high-reliability was successful. This project exhibited scientific measurement to evaluate HWE. The application of this program served as a foundational curriculum to contribute to ongoing leadership growth and development and overall culture change across the organization. Culture change is complex, requires strategy, and most importantly, an environment where learning can occur and be applied. This educational program continued throughout the COVID-19 pandemic and required the team to fully leverage the tenets of high reliability in applying a reluctance to simplify, sensitivity to operations, commitment to resilience, preoccupation with failure, and deference to expertise. Transformational leadership tenets were critical to remain committed to progress, inspiration, and learning despite distractions and rapidly changing information. This pilot across the hospital is serving as a catalyst to the needed culture change that must occur to break away from the plateaued historical performance and create a HWE.
Sustainability will be achieved through ongoing spread efforts and peer-to-peer coaching. The tenets of transformational leadership and high reliability will remain as constructs in the journey to create a HWE. The department norms will continue to be evaluated and refreshed every six months to ensure relevancy to the evolving department culture. The maintenance of HWE councils and professional practice governance is a key priority as the journey to Magnet application and accreditation is continued.

Patient care services are the largest workforce, and the multidisciplinary leadership team must continue to partner closely to hardwire the sustained culture shift and continual improvement. Bullying and incivility have been shown to be reduced through empowering leaders with strong communication skills. Nurses that exhibit expert technical and clinical skills often find themselves promoted to be nurse leaders. Leadership education that focuses on building transformational leadership skills is not gained in the typical nursing school curriculum. Nurse leaders who learn to inspire their team and build a culture with respect and trust are vital to improving patient quality and safety. If staff is not distracted by disruptive behaviors, they can better focus on providing care to patients (Bishop Mills et al., 2018; Thompson, 2019).

The Joint Commission called for healthcare systems to address teamwork, communication and commit to a zero-tolerance of disruptive behaviors when they issued the Sentinel Event Alert 40: Behaviors that undermine a culture of safety (2014). Accreditation, professional, and patient safety organizations have weighed in on the importance of resolving disruptive behaviors in the workplace, yet research continues to show bullying and incivility goes unaddressed by leadership (Mills, 2019; Thompson, 2019). Nursing is a profession that grants witness to the most vulnerable times in the lives of other human beings, and therefore, it is vital the practice environment is healthy, positive and provides infrastructure for the delivery of high quality, safe
care. There is much to learn from services outside of healthcare about how to best apply highly-reliable science and transformational leadership to create a HWE. The changes do not need to be complex to be powerful, as reflected in the staff-created department norms. The time is now for nurse leaders to promote a HWE, eradicate incivility and bullying, and commit to resiliency across professional nursing teams. A HWE is necessary to develop the next generation of nurses and to effectively strive for zero harm. Nurse executives are challenged to create a HWE that empowers leaders and staff to practice to the top of licensure and ability. Hardwiring and sustaining a new norm represents a continuous, final phase that encompasses employee-led best practice initiatives and incorporates healthy workforce topics throughout daily operations.

**Funding**

The hospital of mention funded this project following approval support by the chief executive officer.
References


*Complete list-the 25 most influential business management books*. (2011). Time. [https://doi.org/content.time.com/time/specials/packages/completelist/0,29569,2086680,00.html](https://doi.org/content.time.com/time/specials/packages/completelist/0,29569,2086680,00.html)


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Smokler Lewis, P., & Malecha, A. (2011). The impact of workplace incivility on the work environment, manager skill, productivity. *The Journal of Nursing Administration, 41*(1), 41–47. [https://doi.org/10.1097/NNA.0b013e3182002a4c](https://doi.org/10.1097/NNA.0b013e3182002a4c)


Appendix

Appendix A: Proof of permission from Healthy Workforce Institute®

Renee Thompson, DNP, RN, CSP
6007 Palm Key Ave
CEO & Founder
Oldsmar, FL 34677
Healthy Workforce Institute
renee@healthyworkforceinstitute.com
www.healthyworkforceinstitute.com
412-445-2653

To Whom It May Concern:

We give Megan Gillespie permission to use the name of our agency (Healthy Workforce Institute) in their DNP Comprehensive Project Paper and in future presentations and publications.

Sincerely,

Dr. Renee Thompson
Appendix B: Phased Education Program Topics

<table>
<thead>
<tr>
<th>Start Date</th>
<th>Education Phase</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2020</td>
<td>Phase I</td>
<td>Heighten Awareness</td>
</tr>
<tr>
<td>5/1/2020</td>
<td>Phase II</td>
<td>Create a Powerful Vision</td>
</tr>
<tr>
<td>8/1/2020</td>
<td>Phase III</td>
<td>Address Disruptive Behaviors</td>
</tr>
<tr>
<td>6/1/2020</td>
<td>Phase IV</td>
<td>Completion and Sustainability</td>
</tr>
</tbody>
</table>
Appendix C: Dr. John Kotter’s 8-Step Change Model

Framework Model: Kotter’s Change Theory

Create
- Create Urgency

Form
- Form a powerful coalition

Create
- Create a vision, and make it emotional

Communicate
- Communicate the vision

Remove
- Remove obstacles

Create
- Create short term wins

Build on
- Build on the change

Anchor
- Anchor the change
Appendix D: Organizational Chart

Patient Care Services Leadership

CHIEF NURSING EXECUTIVE
Megan Gillespie, DNP(C), MBA, MSN, RN, NHA-BC, FACHE

ASSOCIATE CNE
vacant
FTE 1.0

EXECUTIVE STAFF ASSISTANT
vacant
FTE 1.0

EXECUTIVE CONSULTANT
FTE 1.0

DIRECTOR CLINICAL EDUCATION, PRACTICE & INFORMATICS
FTE 1.0

DIRECTOR MCH SERVICES
FTE 1.0

DIRECTOR PEDIATRIC SERVICES
FTE 1.0

DIRECTOR ADMINISTRATION SERVICES
FTE 1.0

CARE EXPERIENCE LEADER
Regional Resource

RNS PROJECT COORDINATOR
vacant
FTE 1.0

OPERATIONS SPECIALIST
FTE 1.0

OPERATIONS SPECIALIST
FTE 1.0

PROJECT MANAGER
FTE 1.0

HOSPITAL EMERGENCY DEPARTMENT
RADIOLOGY NURSING
INTERVENTIONAL RADIOLOGY, OPCC
CATH LAB NURSING

CANCER TREATMENT CENTER
BEHAVIORAL HEALTH CENTER
Appendix E: Professional Practice Model
## Appendix F: Evidence Base Evaluation Table

**Evaluation Table**

<table>
<thead>
<tr>
<th>Purpose of Article or Review</th>
<th>Conceptual Framework</th>
<th>Design / Method</th>
<th>Sample / Setting</th>
<th>Major Variables Studied (and their Definitions)</th>
<th>Measurement of Major Variables</th>
<th>Data Analysis</th>
<th>Study Findings</th>
<th>Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) / APA Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose was to identify a standard evaluation tool to assist in developing targeted interventions to improve the overall HWE.</strong></td>
<td>The AACN Synergy Model was described in the framework to compare the patient and family needs in comparison to nurse competencies for synergy</td>
<td>Nonexperimental descriptive survey. The methods included an electronic survey to nurses that participated in the study with a response time period of 3 weeks.</td>
<td>sample size of 321 nurse leaders and direct care nurses setting: 293 bed acute care hospital</td>
<td>AACN Healthy Work Environment Tool (HWEAT) reflected reliability properties across 18 survey questions.</td>
<td>Demographics were analyzed and reflected a variety of ages, race, education level, years on unit, and years of experience. Findings revealed from the AACN (HWEAT) reflected Cronbach’s αs of .97 for nurse leaders and .91 for direct care nurses reflects strong reliability and validity of the HWEAT tool. 13 of 18 variables were placed in the correct category</td>
<td>Study showed validity and reliability for the AACN HWEAT and provided progress to new tools for standardized measurement of</td>
<td>Level III B</td>
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<td><a href="https://doi.org/10.1097/NNA.000000000000000361">https://doi.org/10.1097/NNA.000000000000000361</a></td>
</tr>
</tbody>
</table>

This quantitative pilot study marks an opening for additional analysis and reflects the importance of standardized tools necessary to evaluate the healthy work environment. This is feasible to apply to other settings and needed to ensure we address the needs of the complex healthcare arena holistically.
<table>
<thead>
<tr>
<th>Purpose of Article or Review</th>
<th>Conceptual Framework</th>
<th>Design / Method</th>
<th>Sample / Setting</th>
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<th>Measurement of Major Variables</th>
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<th>Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) /</th>
</tr>
</thead>
<tbody>
<tr>
<td>reliability properties across 18 survey questions.</td>
<td>and reflects the opportunity for further study and tool development.</td>
<td></td>
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</tbody>
</table>


The goal of the study was to further contribute to the minimal knowledge in the United States related to the nurse work environment and nurse incivility.

APA Citation:
<table>
<thead>
<tr>
<th>Purpose of Article or Review</th>
<th>Conceptual Framework</th>
<th>Design / Method</th>
<th>Sample / Setting</th>
<th>Major Variables Studied (and their Definitions)</th>
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<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td>ment related to coworker incivility.</td>
<td></td>
<td></td>
<td></td>
<td>correlated to work environment. Additional research is needed to ensure nurse leaders are equipped to address incivility and nurses can focus on patient care.</td>
</tr>
</tbody>
</table>

Definition of abbreviations:

APA Citation:


[https://doi.org/10.1111/ijn.12376](https://doi.org/10.1111/ijn.12376)
<table>
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<th>Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>study focused on the cost of the global concern of bullying and burnout among nurses.</td>
<td>utilized the health scale and Burnout Indicator tool (BIT)</td>
<td>Negative Acts Questionnaire Revised (NAQ-R) and Majer-D’Amato Organizational Questionnaire (MDOQ10) were analyzed.</td>
<td>size included 658 nurses working in Italy</td>
<td>bullying behaviors across 22 items.</td>
<td>the 658 nurses was analyzed for correlations among variables.</td>
<td>the health scale and Burnout Indicator tool (BIT) with a good reliability as $\alpha$ of .75 and previously validated with 814 healthcare employees. The results were then correlated with the results from the NAQ-R and MDOQ10.</td>
<td>demonstrated correlation between work environment, nurse perception, and workplace bullying.</td>
<td>environment, nurse perception, and workplace bullying. The study supported the vital need to address incivility, bullying and work environment through awareness, education, and leadership competency. Limitations to this study include that causality cannot be assumed secondary to the cross-sectional data. Additionally, the authors note the need to further evaluate integration of bullying, burnout, and work environment to further understand how to resolve the global challenges and implement programs that can assist in decreasing the negative impact.</td>
</tr>
<tr>
<td>Purpose of Article or Review</td>
<td>Conceptual Framework</td>
<td>Design / Method</td>
<td>Sample / Setting</td>
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<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>This study investigated the impact of transformational leadership style on incivility, lateral violence and work environment.</td>
<td>Clegg’s Circuits of Power theory also referenced to relationships.</td>
<td>Regression analysis</td>
<td>237 staff nurses in acute care setting</td>
<td>Nurse leader leadership styles, levels of incivility among nurses</td>
<td>Vannsmpco Leadership Survey (15 questions)</td>
<td>Regression analysis showed transformational leadership most strongly reduced incivility levels &amp; were correlational</td>
<td>Leadershi p style is not definitive factor to incivility however, leaders who empower staff have the strongest impact on decreasing incivility</td>
<td>Level IIIB Valuable to practice highlights the need to prepare nurse leaders with skills to address conflict resolution, empower teams and adopt transformational leadership skills. Emphasizes need to continue to further define how leader behaviors have a positive effect on incivility and healthy work environment.</td>
</tr>
</tbody>
</table>


Definition of abbreviations: HWE=healthy work environment; AACN= American Association of Critical Care Nurses

### Purpose of Article or Review

#### Conceptual Framework

#### Design / Method

#### Sample / Setting

#### Major Variables Studied (and their Definitions)

#### Measurement of Major Variables

#### Data Analysis

#### Study Findings

| Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) / |


### The focus of this study was to assess the nurse leaders’ perspectives on

Ray’s theory of bureaucratic caring framework

Exploratory, qualitative. Purposeful sampling to achieve a focus group

6 nurse managers from non-urban acute

Perspectives & lived experiences of NMs

Interview questions translated into words and phrases in alignment

Exploratory, qualitative study used phenomenological techniques

Consensus on all nurse managers that workplace

Level III

This study can fulfill a basis to address bullying and work together to identify a solution to achieve a healthy work environment.

The findings reveal there is a
<table>
<thead>
<tr>
<th>Purpose of Article or Review</th>
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<th>Sample / Setting</th>
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</tr>
</thead>
<tbody>
<tr>
<td>interventions that are most effective in creating a healthy work environment.</td>
<td>of 6 NMs with inclusion criteria to participate in in-depth interviews utilizing Ray’s theory of bureaucratic caring framework.</td>
<td>care hospitals ranging from 100-700 beds</td>
<td>with Saldana’s opinion to categorize emerging themes and trends</td>
<td>to examine workplace bullying. Themes identified: awareness, scope of problem, quality of performance, healthy env.</td>
<td>bullying impacts patient care negatively and there is a need to implement interventions.</td>
<td>need for organizations to identify interventions, equip nurse leaders to resolve conflict and heighten awareness of bullying.</td>
<td></td>
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</tbody>
</table>


<p>| Purpose of article was to evaluate an educational program to improve communication to decrease incivility and lateral violence | Quality Improvement project to reduce incivility and lateral violence | Longitudinal study of 3-year period including 4,032 nurses participated in 60-90 min. educational sessions. Describes pre | 5 hospitals located in NE U.S. and 4,032 registered nurses | Survey questions adapted from the Verbal Abuse Survey including feeling respected, supported, and able to safely | The educational workshops proved to decrease incivility, lateral violence and decreased turnover. Data was | Study revealed a decrease in verbal lateral violence from 90% to 76% following intervention | Level II NMs must heighten awareness of incivility and be equipped with assertive communication. This article highlights the importance for organizations to implement education programs to address and heighten awareness on incivility. This |</p>
<table>
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<tr>
<th>Purpose of Article or Review</th>
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</tr>
</thead>
<tbody>
<tr>
<td>achieve a healthy work environment.</td>
<td>and post intervention survey of RNs perception of incivility and turnover.</td>
<td>200 workshops held for &gt;4000 RNs</td>
<td>express opinions.</td>
<td>analyzed using Statistical Package of Social Science (SPSS).</td>
<td>ns of educational program.</td>
<td>study and quality improvement project could be replicated. Train the trainer modality is effective to empower staff and build bench strength and sustain a healthy work environment.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Kramer, M., Schmalenberg, C., & Maguire, P. (2010). Nine structures and leadership practices essential for a magnetic (healthy) work environment. *Nursing Administration Quarterly, 34*(1), 4–17. [https://doi.org/10.1097/NAQ.0b013e3181c95ef4](https://doi.org/10.1097/NAQ.0b013e3181c95ef4)
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<th>Major Variables Studied (and their Definitions)</th>
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<th>Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) /</th>
</tr>
</thead>
<tbody>
<tr>
<td>to ensure the best care delivery.</td>
<td>assessment include: structure, process and outcome</td>
<td>to identify the best structures &amp; models conducive to a healthy work environment.</td>
<td></td>
<td></td>
<td>into 9 organizational structures to represent healthy work environment.</td>
<td></td>
<td></td>
<td>link to patient outcomes. There is a need for additional research to evaluate the interventions needed to improve nurse work environments.</td>
</tr>
</tbody>
</table>


| Article focused on the effectiveness of education on incivility to nursing students | Kirkpatrick’s model for evaluation: reaction, learning, behavior, results | Qualitative study to evaluate level of learning after simulation role play, problem | 65 nursing students in one nursing school in the NW | 4 research questions based on Kirkpatrick’s model of evaluation. | evaluation: reaction, learning, behavior, results | Nursing students showed an increased awareness of incivility and increased confidence in their ability | Nursing students exhibited an increased awareness of incivility and increased confidence | Level IIIB Limitations include convenience sampling secondary to utilizing senior nursing students, as a result findings may not represent the same findings at other schools. |
### Purpose of Article or Review


This article offers a follow up to findings from a previous article completed on nursing students based on Level 3 of Kirkpatrick’s model of evaluation.

### Conceptual Framework

- Kirkpatrick’s model for evaluation: reaction, learning, behavior, results

### Design / Method

- 10 month follow longitudinal study, qualitative with prior participants now working as RNs

### Sample / Setting

- U.S.

### Major Variables Studied (and their Definitions)

- 18 new RNs who had previously received training as student nurses in class setting

### Measurement of Major Variables

- Researchers observed and assessed the following in role play regarding incivility:
  - Evaluation
  - Reaction
  - Learning
  - Behavior
  - Results

### Data Analysis

- Evaluation: reaction, learning, behavior, results

### Study Findings

- Participants reported increased ability to address, recognize and respond to nurse incivility from the training they received as students.

### Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) /

- Level III B
  - Classroom centered problem based learning proved to be effective for this group of nursing graduates.
  - Limitations include convenience sampling secondary to utilizing senior nursing students, as a result findings may not represent the same findings at other schools.
Appendix G: Nursing Strategic Plan 2020-2021

QUALITY & PATIENT SAFETY

Strengthen teamwork, collaboration, communication, and decision-making to improve patient outcomes.

Commitment to becoming a highly-reliable organization - preoccupation with failure, reluctance to simplify, sensitivity to operations, commitment to resiliency, deference to expertise.

Decrease NSIs (<NDNQI Benchmark/org goal)

- Falls with injury per 1000 patient days
- CAUTI per 1000 patient days
- CLABSI per 1000 patient days
- HAPI per 1000 patient days
- HAP per 1000 patient days
- C. diff per 1000 patient days

Increase Clinical Efficiency and Care

- Increase percentage of discharges by noon from a baseline of 12.6%
- Decrease ALOS from an average of 4.4 through targeted DRG interventions

Increased Role in Addressing Mental Health:

- Abuse/neglect screening
- Depression/Si screening
- Assess/address delirium and post-ICU syndrome

Social Determinants of Health:

- Medication knowledge of assessment and education, especially for elderly
- Assess/Address refer patients to resources to improve health outcomes (leverage PCCs/SW)
- Tobacco cessation/screening
- Create an environment where the genuine care and comfort of our patients is consistent in all interactions Cultivate a professional and supportive workforce culture where both Team Members & Patients thrive
- Practice self-care and resiliency

PATIENT CARE EXPERIENCE

Create an environment where the genuine care and comfort of our patients is consistent in all interactions.

Cultivate a professional and supportive workforce culture where both Team Members & Patients thrive.

Practice self-care and resiliency.

Increase patient satisfaction >NRC/HCAHPS 8M:

- Courtesy & Respect
- Nurse Communication
- Discharge Information
- Staff Responsiveness

Implement HWI and HWE strategies and AACN’s HWE to decrease healthcare fatigue, stress, burnout:

- Heighten awareness of incivility/disruptive behaviors
- True & Skilled collaboration
- Meaningful recognition
- Authentic leadership
- Appropriate staffing

Increase Nurse Engagement > Glint 8M

- Leadership Access/Responsiveness
- Teamwork
- Autonomy
- Speak up
- Leaders listen

Launch HWE Spread Plan: Promote HWE to decrease incivility, disruptive behaviors and promote inclusion
GROWTH & STEWARDSHIP

Make KP Santa Clara the best place to work by attracting, recruiting, and retaining top talent.

Increase Recruitment & Retention
- Decrease RN vacancy
- Decrease RN turnover
- Establish Leadership mentor program
- Establish Nurse residency program
- Monitor RN transition to practice retention >90% at 1 year

Achieve RN Professional Development Plan:
- Specialty Certification >30% on all units
- Establish succession plan for CL<IV
- Standardize onboarding on all levels
- Establish multidisciplinary forum for simulation/case review

Achieve National Accreditation & Distinction as a center for Nursing Excellence:
- Magnet journey
- NICHE (Nurses Improving Care for Health system Elders)
- Continued Cardiac Services Expansion, Top 50 Best Hospitals Newsweek, LVAD accreditation

Decrease Excessive Costs:
- Decrease OT by 30%
- Decrease Agency expense by 30%
- Explore staffing cost effective models and roles

PROFESSIONAL PRACTICE

Commitment to advancing nursing professional practice through targeted education and research opportunities focused on Leadership Development, Professional Development and Advanced Practice.

RN participation and engagement in professional practice governance to improve nursing work environment and practice outcomes:
- Increase interprofessional knowledge dissemination
- Increase patient and family involvement for knowledge dissemination

RN participation in nursing research to improve outcomes and disseminate new nursing knowledge:
- Support DNP/PHD scholars
- Increase nursing publication

Active RN participation of professional nursing organizations:
- Bring evidence driven practice interventions to SCL
- Influence nursing practice at the local (potentially regional/national) level

Increase Special Pathogen & Surge Planning Response Knowledge:
- Cross training and adaptability leveraging team nursing
- Enhance and hardware Isolation & PPE principles
- Leverage HH champions to enhance awareness and speak up proper HH
  - 200 audits per unit per month
Appendix H: High Reliability Organization Maturity Assessment

### High Reliability Organization (HRO) Maturity Assessment

The following survey will assess your area’s daily management system maturity.

1. Please select your area from the options below. *
   - Please Select —

2. Level 1: Demonstrating key elements of Visual Systems and Huddles. *

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Visual System: Visual board located in a common space with easy access for staff &amp; leaders</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Visual System: Visuals are simple and easy to understand</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Visual System: Relevant metrics are used to track goal progress</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Visual System: Department leaders can update performance measures daily</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Huddles: Evidence of employee connection (recognition/upcoming events/announcements/etc.)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Huddles: Department Leader is trained to keep board updated and effectively facilitate huddle</td>
<td>☐</td>
<td>☐</td>
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</table>

3. Did you answer ‘yes’ to all of the above elements? *
   - Yes
   - No

4. **5. Level 2: Consistent use of DMS focused on driving to strategic outcomes.**

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<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Visual System: Information is current (has been updated in the last 24 hours)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Visual System: Evident team is focused on patient safety quality &amp; data is current</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Visual System: Evident team is focused on workplace safety &amp; data is current</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Visual System: Evident team is focused on care experience &amp; data is current</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Visual System: Outcome AND Process metrics are present and routinely filled out every shift</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Visual System: Metrics clearly indicate a goal and actual performance</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Huddles: Evident feedback system is in place where concerns are escalated</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Huddles: Department Assistant Leader(s) is trained to keep board updated and effectively facilitate huddle (if applicable)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Continuous Improvement System: A simple method is used to share and track improvement ideas</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Leader Standard Work: Unit/Dept Leaders have Leader Standard Work and are actively using to sustain best practices</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Direct Report Rounding: Unit/Dept Leaders consistently (&gt;80% month) complete 1 Direct Report Round per direct report per month</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

5. Did you answer ‘yes’ to all of the above elements? *
   - Yes
   - No
7. Level 3: Best in class. (Expected after many years on DMS journey).

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend lines are used whenever possible to show historical performance</td>
<td></td>
</tr>
<tr>
<td>Control limits are used to validate or signal changes in performance</td>
<td></td>
</tr>
<tr>
<td>Staff/Clinical leaders are trained to keep board updated and effectively facilitate huddle</td>
<td></td>
</tr>
<tr>
<td>Pareto Charts are used to help analyze problems</td>
<td></td>
</tr>
<tr>
<td>5W’s are used to solve complex problems</td>
<td></td>
</tr>
<tr>
<td>Standard Work for key processes are visible and it’s evident when it’s not being followed</td>
<td></td>
</tr>
<tr>
<td>Continuous Improvement System: You asked for it, we did it: Stop light report is present and up-to-date</td>
<td></td>
</tr>
<tr>
<td>Continuous Improvement System: Issues raised/problems solved are archived and easily searchable</td>
<td></td>
</tr>
<tr>
<td>Direct Report Rounding: Unit Dept Leaders consistently (&gt;90%) per direct report per month</td>
<td></td>
</tr>
</tbody>
</table>

8. Did you answer 'yes' to all of the above elements? *

- Yes
- No
Appendix I: High Reliability Organization Maturity Assessment Pilot Department Results
Appendix J: Be Kind Button Campaign
Appendix K: National Nurse Certification Year over Year Progress

![Bar chart showing RN National Certification progress from 2019 to 2021. The numbers 86, 208, and 256 are displayed on the bars for each year, respectively.]
Appendix L: Staff Engagement to Creating Department Norms

Healthy Workforce Culture Change Initiative
Creating a Powerful Vision
Appendix M: Sample of Labor and Delivery Department Norms

Our Intent:
To make Labor & Delivery a professional, kind, and healthy place to work, where everyone goes out of their way to support and help each other learn and grow, where all roles are valued and celebrated.

Our Commitment:
As members of the L&D team, WE make decisions based on what’s best for patients first, then what’s best for our team, and then what’s best for ourselves.

My Commitment:
As an employee on L&D, I commit:

- I treat my coworkers fairly and make a concerted effort to avoid favoritism or uneven workload.
- I go out of my way to help my coworkers and never watch them do the work or struggle without pitching in.
- I communicate honestly, respectfully, and avoid saying anything disrespectful about my coworkers behind their back.
- I never talk down to my coworkers in a condescending manner, judge them, and treat them like they don’t matter, or make them feel less important to our team.
- If I have issues or concerns with my coworkers’ behavior or performance, I speak directly to them and not behind their backs (no gossip).
- I demonstrate professional communication by being aware of my tone, body language, and avoid eye rolling.
- I choose a positive attitude with a smile, being kind, acknowledging my coworkers, by saying “hello” and by treating others the way I would want to be treated.
- I give and accept direct feedback from others with a positive attitude, knowing we are all on the same path towards continuous improvement.

Our Core Commitments:
- Communicate with honesty and respect
- Smile and be positive
- Help each other as a team – no matter what
- Talk TO each other – Not ABOUT each other
- Practice kindness towards each other

always
be kind
## Appendix N: Gap Analysis

<table>
<thead>
<tr>
<th>CURRENT STATE</th>
<th>ACTION</th>
<th>FUTURE STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership team is incompetent and lacks confidence to address disruptive behavior</td>
<td>Provide structured four-phased education plan to enhance competence and confidence to address disruptive behavior and incivility.</td>
<td>Leaders confident and competent in ability to create a healthy work environment and address disruptive behavior.</td>
</tr>
<tr>
<td>Departments lack awareness of disruptive behavior and incivility.</td>
<td>Provide structured four-phased education plan to heighten awareness of disruptive behavior. Staff create department norms through identification of always and never behaviors.</td>
<td>Staff will recognize and address disruptive behavior that is not in alignment with identified department norms.</td>
</tr>
<tr>
<td>Huddles lack focus and organization of information.</td>
<td>Leadership and staff will provide feedback to create a standard visual board to guide key information to enhance staff’s knowledge and preparation for shift.</td>
<td>Leaders will conduct huddle leveraging high reliability tenets using a visual board that displays meaningful information and data to assist in achieving quality outcomes, staff satisfaction, and setting the tone for a healthy work environment.</td>
</tr>
<tr>
<td>Professional certification is low among staff and leadership.</td>
<td>Staff and leaders will be educated on options to achieve certification and the benefits of committing to professional certification achievement.</td>
<td>Professional certification rates will increase in compared to previous year.</td>
</tr>
<tr>
<td>Department culture survey baselines will be determined for each pilot department to assess incidents of incivility.</td>
<td>Survey will be repeated every 6 months for 3 consecutive data points.</td>
<td>Department culture survey baselines will improve for each pilot department to show decreased rates of incidents of incivility.</td>
</tr>
<tr>
<td>Leaders are not confident in addressing best practice compliance accountability with staff regarding nursing sensitive indicators.</td>
<td>Leadership forums will include standard reports of current performance of nursing sensitive indicator in compared to national benchmarks and include sharing of best practices. Visual boards will include department level performance and learnings from root cause investigations.</td>
<td>Leaders will confidently address noncompliance with best practices to promote increase patient safety and quality as exhibited in the safety priority index rates.</td>
</tr>
<tr>
<td>Leadership and human resources currently operate in silos which results in lack of accountability for staff and inability to address disruptive behavior.</td>
<td>Human resources and leadership will embark on four-phased education plan together and participate in simulation exercises to build confidence and competence.</td>
<td>Leadership and human resource department will work cohesively to create a healthy work environment.</td>
</tr>
</tbody>
</table>
Appendix O: EBI Leadership Assessment Instrument, Pre and Post Survey Questions

ERADICATING BULLYING & INCIVILITY
Essential Skills For Healthcare Leaders

Pre and Post Assessment Questions

Getting Clear on Bullying
1. I’ve done my part as a leader to learn the skills required to address bullying behavior.
2. I can explain why bullying is so prevalent in the nursing profession.
3. I can clearly articulate the difference between bullying, incivility, or an employee just having a bad day.
4. I feel confident in my ability to recognize and address bullying in my department.

Recognizing Disruptive Behaviors
1. I can easily recognize overt and covert bullying behaviors.
2. I know the difference between bullying, hazing, harassment, and discrimination.
3. I know which employees are at high risk for becoming targets of bullying.
4. I understand the impact bullying has on individual employees, the organization, and patients.

Setting Behavioral Expectations
1. Each employee is clear about my expectations regarding professional conduct.
2. I have established department norms with regards to professional behavior.
3. I have a step-by-step process that enables me to set behavioral expectations with my employees.
4. I have a process whereby all new employees are introduced to expectations regarding professional behavior upon hire.

Confronting Disruptive Behaviors
1. When my employees tell me that they are being bullied, I know exactly how to respond.
2. I communicate with my employees using an assertive communication style (honest & respectful).
3. I am skilled at how to document disruptive behaviors in a way that supports our organization's code of conduct.
4. I am confident in my ability to confront disruptive behavior with my employees.

Holding Employees Accountable
1. I have a process for addressing complaints of workplace bullying & incivility.
2. I feel supported by my Human Resources Department when I want to hold my employees accountable for unprofessional behavior.
3. I meet regularly (at least monthly) with my employees to discuss professional conduct.
4. I feel confident in my ability to hold my employees accountable for professional behavior.
Appendix P: Visual Board Example for Department Huddles
Appendix Q: Work Breakdown Structure
Appendix R: SWOT Analysis

2020 Nursing Strategy Plan: SWOT Analysis

Strengths

<table>
<thead>
<tr>
<th>Education</th>
<th>Wellness</th>
<th>Leadership</th>
<th>Integrated Care/COE</th>
<th>Professional Practice</th>
<th>Voice of Nursing</th>
<th>Misc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Educational opportunities</td>
<td>• Wellness programs</td>
<td>• Leadership engagement</td>
<td>• Integrated care centers</td>
<td>• Foundation of professional practice: readiness to engage</td>
<td>• Voice of Nursing Council</td>
<td>• Diversity</td>
</tr>
<tr>
<td>• Funded educational time, advancement through KP scholars</td>
<td>• Consistent care teams with focus on prevention and wellness</td>
<td>• Director expertise and strength</td>
<td>• Centers of Excellence: Oncology, Cardiac (LVAD, TAVR), Lymphoma,</td>
<td>• Access to Evidence Based Practice and playbooks</td>
<td>• Staff making strides toward Magnet through empowerment</td>
<td>• Supportive environment</td>
</tr>
<tr>
<td>• Staff certifications opportunities paid KPC</td>
<td>• Collective support of executive team and collaboration with Finance</td>
<td>• Leadership model</td>
<td>• Service line specialists</td>
<td>• Magnet journey</td>
<td>• Supportive environment</td>
<td>• Lean resource management</td>
</tr>
<tr>
<td>• Staff growth opportunities via committee participation (e.g. QIO/E)</td>
<td>• Clearly defined structure and chain of command</td>
<td>• Many staff Nurses &amp; Nurse Leaders with strong clinical expertise</td>
<td>• NCF</td>
<td>• Unit based committees lead by frontline RNs (advisory councils)</td>
<td>• Consistent staff</td>
<td>• Consistent staff due to low turnover</td>
</tr>
</tbody>
</table>

Weaknesses

<table>
<thead>
<tr>
<th>Accountability / Sustainability</th>
<th>Clinical Advancement</th>
<th>Leadership Turnover &amp; Succession Planning</th>
<th>Union</th>
<th>EBP, Research, Professional Practice</th>
<th>New Grad</th>
<th>Misc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sustain success, leadership accountability</td>
<td>• Recruitment current with new, treatment equipment</td>
<td>• CAN influence</td>
<td>• Lack of research leaders</td>
<td>• Nursing students trained at KP get hired elsewhere</td>
<td>• Real estate (not enough beds)</td>
<td>• Real estate</td>
</tr>
<tr>
<td>• Firing and retaining to sustain – change management, new initiatives, fundamental practices (RTP, RPM, P&amp;O)</td>
<td>• Staff interest in certification or advancing education</td>
<td>• Inadequate labor management, partnership</td>
<td>• Can’t identify or understand new, fresh positions</td>
<td>• Incorporating new grad RN’s who feel they are back in school</td>
<td>• Affordability of healthcare plans</td>
<td>• Affordability of healthcare</td>
</tr>
<tr>
<td>•Spread of initiatives is difficult without frontline staff influence</td>
<td>• Many do not have specialty certification – doesn’t allow for elevation of practice</td>
<td>• Relationship with union</td>
<td>• Professional practice model that enables spread of shared learnings</td>
<td>• Nursing students trained at KP get hired elsewhere</td>
<td>• Real estate (not enough beds)</td>
<td>• Real estate</td>
</tr>
</tbody>
</table>

Opportunities

<table>
<thead>
<tr>
<th>Union</th>
<th>Systems Level Thinking</th>
<th>Enhanced Services: Care &amp; Marketing</th>
<th>Recruitment</th>
<th>Technology</th>
<th>Training &amp; Education</th>
<th>Collaboration</th>
<th>Misc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Partner with CMA</td>
<td>• Systems level thinking</td>
<td>• Increased psych services</td>
<td>• Recruitment of talented professionals</td>
<td>• Technology</td>
<td>• New grad training programs</td>
<td>• TMAG / KPC partnership</td>
<td>• Work towards culture of safety</td>
</tr>
<tr>
<td>• Incentive NQF to promote quality initiatives</td>
<td>• Leverage ideas to address safety concerns (climate, change, humility, quality)</td>
<td>• More service lines</td>
<td>• External recruitment</td>
<td>• Health Technology</td>
<td>• New technology</td>
<td>• New technology</td>
<td>• Work towards culture of safety</td>
</tr>
<tr>
<td>• Getting more frontline staff on different shifts to become more active</td>
<td>• Create additional transparency and visibility</td>
<td>• Recognize and support strengths with various established lines: cardiac – SFO SCL, Neuro – RWC, MCH – SCL</td>
<td>• Aisle to hire new employee w/ ESN certification and skills needed</td>
<td>• Leverage Health Contract Capabilities</td>
<td>• New grad training programs</td>
<td>• New technology</td>
<td>• Work towards culture of safety</td>
</tr>
<tr>
<td></td>
<td>• Best practices from peers in region</td>
<td>• Stand alone MAT C H</td>
<td>• Technology</td>
<td>• New Robotic Technology</td>
<td>• Development of additional PI processes</td>
<td></td>
<td></td>
</tr>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
# 2020 Nursing Strategy Plan: SWOT Analysis

## Threats

<table>
<thead>
<tr>
<th>Union</th>
<th>Regulatory</th>
<th>Competition</th>
<th>Cost of Living</th>
<th>Membership Growth &amp; Reputation</th>
<th>Recruitment &amp; Retention</th>
<th>Misc.</th>
</tr>
</thead>
</table>
| • CHA apathy  
• Labor management conflict  
• Labor unions / contracts promote mediocrity | • California regulations  
• Ever increasing regulatory requirements  
• Reimbursement factors | • Competition in community — Stanford does not pay attention to competition  
• Robotic presence greater at our competitors | • Cost of living  
• Increased cost of living relative to other KP locations  
• Many members may be forced to leave the area based on cost of living | • Continued membership growth  
• Increased membership growth, decreased retention  
• Consumer perceptions that KP model may not always be accurate — marketing? | • Lack of external recruitment and social media presence  
• New Stanford recruitment initiatives  
• Job selection by seniority vs. qualifications  
• Substandard employees with the system — not able to hire new grads  
• Recruitment challenges  
• Aging workforce  
• Too many initiatives being rolled out — staff dissatisfaction, burn out and possible turn over  
• BSN summer students gain variety of experiences cost opportunity for hiring  
• Time investment — educate with VON and then leave to go to another facility outside KP | • Insulated way of thinking  
• Inadequate interdisciplinary collaboration  
• Slow technology adoption  
• Suboptimal data analysis |
### Appendix S: GANTT Chart

#### Healthy Workforce Institute
**Bill & Department Culture Change Initiative**

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Start</th>
<th>End</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
</tr>
</thead>
</table>

**Some tasks marked with an asterisk (*) indicate that they are dependent on other tasks.**
<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 2: Create a Powerful Vision</strong></td>
</tr>
<tr>
<td>Education &amp; Training</td>
</tr>
<tr>
<td>Identify Unit Training</td>
</tr>
<tr>
<td>Collaboration with Multifaceted Programs</td>
</tr>
<tr>
<td>Tools, Tech</td>
</tr>
<tr>
<td>Professional Practice Agreement (PhPA)</td>
</tr>
<tr>
<td>Skill Development Plan</td>
</tr>
<tr>
<td>• Support Visit</td>
</tr>
<tr>
<td>• Review Observations and Case Study Specific</td>
</tr>
<tr>
<td>•ominating Team Leaders</td>
</tr>
<tr>
<td>• Underpinning with Policies</td>
</tr>
<tr>
<td>• Assess Staffing</td>
</tr>
<tr>
<td>• Review Staffing</td>
</tr>
<tr>
<td>• During the Meeting</td>
</tr>
<tr>
<td>• After the Meeting</td>
</tr>
<tr>
<td>• Send Signal to Team to Continue</td>
</tr>
<tr>
<td><strong>Communicating</strong></td>
</tr>
<tr>
<td><strong>Managing Work</strong></td>
</tr>
<tr>
<td><strong>Moving to Plan</strong></td>
</tr>
<tr>
<td><strong>Phase 3: Organize</strong></td>
</tr>
<tr>
<td>Education &amp; Training</td>
</tr>
<tr>
<td>Create and Use Standards</td>
</tr>
<tr>
<td>Create a Partnership with HR</td>
</tr>
<tr>
<td>Identify and Implementing Change for the Organization</td>
</tr>
<tr>
<td>Staff Training</td>
</tr>
<tr>
<td>Implement the Process</td>
</tr>
<tr>
<td>Communication Plan</td>
</tr>
<tr>
<td>Coaching (RMT)</td>
</tr>
<tr>
<td><strong>Phase 4: Implement</strong></td>
</tr>
<tr>
<td>Education &amp; Training</td>
</tr>
<tr>
<td>Implement the Standards</td>
</tr>
<tr>
<td>Implement the Process</td>
</tr>
<tr>
<td><strong>Managing Change</strong></td>
</tr>
<tr>
<td>Department Culture Change Coaching Calls</td>
</tr>
<tr>
<td><strong>Support</strong></td>
</tr>
</tbody>
</table>

**Notes:**

- [ ] Completed
- [ ] In Progress
- [ ] Not Started
## Appendix T: Operational Budget

<table>
<thead>
<tr>
<th>Revenue (Cost Avoidance)</th>
<th>Costs</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN retention</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>SPI (Quality cost avoidance of nursing sensitive indicators)</td>
<td></td>
<td>$1,062,584</td>
</tr>
<tr>
<td>Lost productivity due to workplace incivility</td>
<td></td>
<td>$3,231,099</td>
</tr>
</tbody>
</table>

### Expenses

<table>
<thead>
<tr>
<th>Phase I-IV education</th>
<th>$53,295</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN wages for education sessions I-IV</td>
<td>$27,200</td>
</tr>
<tr>
<td>Travel fee for consultant</td>
<td>$1,256</td>
</tr>
<tr>
<td>EBI Course (Cohort I)</td>
<td>$15,997</td>
</tr>
<tr>
<td>Marketing materials</td>
<td>$4,000</td>
</tr>
<tr>
<td>Subtotals</td>
<td>$101,748</td>
</tr>
<tr>
<td>Total Cost Avoidance</td>
<td></td>
</tr>
</tbody>
</table>
Appendix U: Safety Priority Index

SPI rate

Dec-19: 0.82
Jan-20: 0.78
Feb-20: 0.8
Mar-20: 0.74
Apr-20: 0.72
May-20: 0.69
Jun-20: 0.67
Jul-20: 0.68
Aug-20: 0.65
Sep-20: 0.65
Oct-20: 0.66
Nov-20: 0.62
Dec-20: 0.61
Jan-21: 0.62
Feb-21: 0.62
Mar-21: 0.65
Apr-21: 0.67
May-21: 0.68

SPI rate
Appendix V: EBI Scores Pre & Post Education

Eradicating Bullying & Incivility (EBI) Pre and Post Assessment Results
Cohort 2020

Pre Score vs. Post Score for Students 1 to 13.
# Appendix W: HWI-DBS Survey Instrument

## Healthy Workforce Institute Disruptive Behavior Survey

The following 15 questions assess the frequency of witnessed and experienced incidents of disruptive behaviors. The results can be used to determine the most common ways disruptive behaviors are occurring within a department or across an organization so that appropriate interventions can be determined. Using a Likert Scale, the following questions are framed as “witnessed” and “experienced”.

Use this survey to establish baseline data prior to an intervention to address disruptive behaviors within a department or across an organization. The recommendation is to repeat the survey in 6-months and then yearly after implementing strategies to reduce incidence of disruptive behaviors. The survey may be distributed manually or converted into an electronic format.

### Have you witnessed or experienced these behaviors?

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Witnessed</th>
<th>Experienced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being yelled at, criticized, or cursed at in front of others</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Being mocked or having a nurse roll his/her eyes</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Receiving an uneven workload assignment, seemingly based on favoritism</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Having a co-worker break confidence by sharing private or embarrassing information</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Having a co-worker withhold information, leading to a negative impact on performance</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Being excluded by certain nurses from routine lunches, celebratory, or social events</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Having accomplishments downplayed, such as awards, advance degrees</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Being ignored or given the silent treatment by certain nurses</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Seeing nurses treated nicely to their faces but mocked or insulted behind their backs</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Hearing nurses name calling, making ethnic slurs, jokes, or inappropriate sexual comments</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Being micromanaged and repeatedly reminded of your mistakes</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Being the target of gossip or false rumors</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Receiving threats of physical violence</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Being retaliated against for speaking up or not following the crowd</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Being made to feel stupid or incompetent</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

**TOTAL WITNESSED: _________**  **TOTAL EXPERIENCED: _________**

*The Healthy Workforce Institute Disruptive Behavior Survey has been scientifically validated by The Social Research Lab at the University of Southern California (www.usc.edu), which is run by Jon Packard, Ph.D. The factor loadings of items are propriety and may not be used without the consent of Renee Thompson, DNS, R.N., CSII. Healthcare organizations are encouraged to utilize the HWI Disruptive Behavior Survey as long as they maintain the integrity of the survey, cite appropriately, and request permission by contacting the Healthy Workforce Institute at 902C@HealthyWorkforceInstitute.com.*

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Appendix X: HWI-DBS Demographics

**Percentage of Respondants to Age**

- > 55 years
- 46-54 years
- 36-45 years
- 26-35 years

**Years of Professional Experience**

- prefer not to answer
- 0-2
- >20 years
- 3-10
- 11-20
Gender

- Prefer not to answer
- Male
- Female

Description of Race/Ethnicity of Respondants

- African American
- Latin/LatinX
- another race(s)
- prefer not to answer
- Caucasian
- Asian or Asian American
Appendix Y: USF RDO Approval

A healthy work environment is critical to providing high quality care delivery and retaining talented professionals. According to the American Nurses Association (ANA), a healthy work environment is one that is safe, empowering, and satisfying. A place of physical, mental, and social well-being supporting optimal health and safety.

A critical element in creating a professional, nurturing, and supportive workforce is for leaders to be skilled and confident to address disruptive behavior and serve as role models for professional practice. The department culture change initiative is a four-phased educational program to support leaders with resources and additional skills to cultivate a healthy work environment where staff and patients thrive.

---

Doctor of Nursing Practice
Statement of Non-Research Determination (SOD) Form

The SOD should be completed in NURS 7005 and NURS 7016P or NURS 7421E

General Information

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>Gillespie</th>
<th>First Name:</th>
<th>Mean</th>
</tr>
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<tr>
<td>CWD Number:</td>
<td>215949932</td>
<td>Semester/Year:</td>
<td>Summer semester 2020, Year 1</td>
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<tr>
<td>Course Name &amp; Number:</td>
<td>Cohort 11 Practicum II Focus: Monosystem N-791E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chairperson Name:</td>
<td>Dr. Waverly</td>
<td>Advisor Name:</td>
<td>Dr. Capella</td>
</tr>
</tbody>
</table>

Project Description

1. Title of Project

Creating High Reliability and Transformational Leadership to Create a Healthy Work Environment

2. Brief Description of Project

Clearly state the purpose of the project and the problem statement in 250 words or less.
3. AIM Statement: What are you trying to accomplish?
   - What do you hope to accomplish with this project? Aims should be SMART, specific, clear, well-defined, and at a minimum describe the target population, the desired improvement, and the targeted timeframe.
   - To improve (your process) from (baseline) % to (target) %, by (timeframe), among (your specific population)

   Complete this statement:

   To increase / decrease: 1) To increase the competence and confidence of department nurse leaders from the pre-assessment score in comparison to the post assessment score after completion of the Education (Bullying and Inciting States).
   2) To improve the department culture change assessment from a score of 25 to a score of 20 or lower. A score of 25 or less indicates a healthy work environment has been achieved, however typically takes longer than 1 year. The goal will be to achieve a score indicative of progress towards a healthy work environment. (process/impact)

   by: May 2021 (for 1&2) (date: 3-6-month timeframe)

   1) 13 Nurse managers, assistant nurse managers, and directors of nursing
   2) Approximately 200 staff nurses and leaders across three departments.

   (population impacted)

---

A healthy work environment is critical to providing high quality care delivery and retaining talented professionals. According to the American Nurses Association (ANA), a healthy work environment is one that is safe, empowering, and satisfying. A place of physical, mental, and social well-being supporting optimal health and safety.

A critical element in creating a professional, nurturing, and supportive workforce is for leaders to be skilled and confident to address disruptive behavior and serve as role models for professional practice. The department culture change initiative is a four-phased educational program to support leaders with resources and additional skills to cultivate a healthy work environment where staff and patients thrive.
3. AIM Statement: What are you trying to accomplish?
   - What do you hope to accomplish with this project? Aims should be SMART, specific, clear, well-defined, and at a minimum describe the target population, the desired improvement, and the targeted timeframe.
   - To improve (your process) from (baseline)% to (target)% by (timeframe), among (your specific population)

   Complete this statement:

   To increase / decrease: 1) To increase the competence and perception of confidence of department nurse leaders from the pre assessment score in comparison to the post assessment score after completion of the Eradication Bullying and Ineffectiveness Course.
   2) To improve the department culture change assessment from a score of 26 to a score of 20 or lower. A score of 15 or less indicates a healthy work environment has been achieved, however typically takes longer than 1 year. The goal will be to achieve a score indicative of progress towards a healthy work environment. (process/outcome)

   by: May 2021 (for 1&2) (date, 3 - 6-month timeframe)

   in: 1) 13 Nurse managers, assistant nurse managers, and directors of nursing
   2) approximately 200 staff nurses and leaders across three departments. (population impacted)
4 Brief Description of Intervention (150 words).

Phase 1: (February 2020-May 2020) focuses on heightening awareness of incivility, bullying and creating a healthy work environment. This phase teams engage in honest conversations regarding status and opportunities to promote a culture of professionalism.

Phase 2: (May 2020-July 2020) leaders and teams come together to create a vision for the department, establish department expectations, and begin targeted skill development for leaders and staff regarding professional behavior. The team identify "always and never" department norms (see attached example from labor and delivery department norms that was created by staff and frontline leaders).

Phase 3: (July 2020-September 2020) this phase focuses on building strong partnerships with human resources and follow a process to promote and build healthy work environment.

Phase 4: (September 2020-October 2020) the goal of this phase includes hardwiring and sustaining a new normal, incorporate healthy workforce into existing

4a. How will this Intervention be implemented?

- Where will you implement the project?
- Attach a letter from the agency with approval of your project.
- Who is the focus of the intervention?
- How will you inform stakeholders/participants about the project and the intervention?

Project will be implemented at Kaiser Permanente Santa Clara. Focus of the intervention is nurse leaders (assistant nurse managers, managers, and nurse directors) and staff in departments 210, 155, and labor and delivery.

Participants were informed of project and intervention through townhall communications, huddles, and in person voluntary education programs.

5. Outcome measurements: How will you know that a change is an improvement?

- Measurement over time is essential to QI. Measures can be outcome, process, or balancing measures. Baseline or benchmark data are needed to show improvement.
- Try to define your measure as a numerator/denominator.
  - What is the reliability and validity of the measure? Provide any tools that you will use as appendices.
  - Describe how you will protect participant confidentiality.
Baseline leadership confidence and competence will be measured by baseline survey assessment and compared to a survey administered when educational program ‘Eradicating Bullying and Incivility’ is completed.

Department culture surveys include a baseline survey administered in May 2020 which yielded 74% response rate overall totaling 187 responses. Surveys are planned sequentially at 6-month intervals for three consecutive data points to assess the incidents of disruptive behavior and relationships across the staff teams. The information from the baseline survey is used to create a custom plan for each department so the staff leadership team can address common issues and improve perceptions.

The surveys are anonymous and voluntary routed confidentially through the Healthy Workforce Institute as a contracted third-party vendor.

I plan to analyze the pre and post surveys to assess the improvement during the course of the educational program and a status post survey assessment.
**DNP Statement of Determination**

**Evidence-Based Change of Practice Project Checklist**

The SOO should be completed in NURS 7005 and NURS 7016P or NURS 740/A/E

**Project Title:**

Leveraging High Reliability and Transformational Leadership to Create a Healthy Work Environment

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>The aim of the project is to improve the process or delivery of care with established/accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>The specific aim is to improve performance on a specific service or program and is a part of usual care. All participants will receive standard of care.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>The project is <strong>not</strong> designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control. The project does <strong>not</strong> follow a protocol that overrides clinical decision-making.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does <strong>not</strong> develop new paradigms or untested methods or new untested standards.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does <strong>not</strong> seek to test an intervention that is beyond current science and experience.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>The project has <strong>no</strong> funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., <strong>not</strong> a personal research project that is dependent upon the voluntary participation of colleagues, students and/or patients.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: <strong>&quot;This project was undertaken as an Evidence-based change of practice project at X hospitals or agency and as such was not formally supervised by the Institutional Review Board.&quot;</strong></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

**Answer Key:**

- If the answer to all of these items is "Yes", the project can be considered an evidence-based activity that does **not** meet the definition of research. IRB review is not required. Keep a copy of this checklist in your file.
- If the answer to any of these questions is "No", you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Heimann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.*

To qualify as an Evidence-Based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: [http://answers.hhs.gov/hsqscategories/1569](http://answers.hhs.gov/hsqscategories/1569)
DNP Statement of Determination
Evidence-Based Change of Practice Project Checklist Outcome
The SOD should be completed in NURS 7005 and NURS 7015P or NURS 742A/E

Project Title:
Leveraging High Reliability and Transformational Leadership to Create a Healthy Work Environment

X This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). **Student may proceed with implementation.**
☐ This project involves research with human subjects and **must be submitted for IRB approval before project activity can commence.**

Comments:

<table>
<thead>
<tr>
<th>Student Last Name:</th>
<th>Gillespie</th>
<th>Student First Name:</th>
<th>Megan</th>
</tr>
</thead>
<tbody>
<tr>
<td>CWID Number:</td>
<td>20594902</td>
<td>Semester/Year:</td>
<td>2020</td>
</tr>
</tbody>
</table>

Student Signature: ___________________________ Date: ___________________________

Chairperson Name: Dr. KT Waxman

Chairperson Signature: ___________________________ Date: 2020

DNP SOD Review Committee Member Name: Dr. Elena Capella
Appendix Z: Organization RDO

Date: October 23, 2020
Subject: RDO KPNC 20 - 163
Title: Leveraging High Reliability and Transformational Leadership to Create a Healthy Work Environment

Dear Ms. Gillespie:

The Research Determination Committee for the Kaiser Permanente Northern California region has reviewed the documents submitted for the above referenced project. The project does not meet the regulatory definition of research involving human subjects as noted here:

Not Research

The activity does not meet the regulatory definition of research per 45 CFR 46.102(d): Research means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

This determination is based on the information provided. If the scope or nature of the project changes in a manner that could impact this review, please resubmit for a new determination. The word “research” should not appear in any posters or publications resulting from this project. Further, if publications, presentations or posters are generated from this project the following wording must be used to reference to the project research determination outcome:

“The Research Determination Committee for the Kaiser Permanente Northern California region has determined the project does not meet the regulatory definition of research involving human subjects per 45 CFR 46.102(d)”

You are expected, however, to implement your study or project in a manner congruent with accepted professional standards and ethical guidelines as described in the Belmont Report (http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html).

Additionally, you are responsible for keeping a copy of this determination letter in your project files as it may be necessary to demonstrate that your project was properly reviewed.

Provide this approval letter to the Physician in Charge (PIC), your Area Manager, and Chief of Service, to determine whether additional approvals are needed.

Sincerely,

The Research Determination Committee
KPNC-RDO@kp.org
Appendix AA: Example of Staff Survey Participation QR code

You are invited to complete the cultivating professional and supportive workforce culture survey. Survey participation is voluntary, and results are anonymous. Results will assist our team to understand the opportunities and progress as we advance together in our journey to creating a healthy work environment.

Cultivating a Professional and Supportive Workforce Culture Survey

Labor & Delivery
Appendix BB: HWI-DBS Department Scores

![Bar chart showing department scores over time for different departments: L&D, 135, 220. The chart includes baseline, 6-months, and 1-year data points.]
Appendix CC: HWI-DBS, L&D Physician Relationships

Physician Relationships – Note: The lower the score, the better.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Occasionally, Frequently, or Very Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being talked to in a condescending manner or made to feel incompetent</td>
<td>Baseline 6 Month 1 Year</td>
</tr>
<tr>
<td>Not feeling comfortable contacting a particular physician regarding a patient care situation for fear of being yelled at</td>
<td>32% 47% 41%</td>
</tr>
<tr>
<td>Experiencing mistakes they make or about to make, but fear of speaking up in the moment</td>
<td>21% 19% 15%</td>
</tr>
<tr>
<td>Being yelled at or openly criticized in front of others</td>
<td>14% 16% 15%</td>
</tr>
<tr>
<td>Experiencing their being reluctant or refusing to answer questions, return phone calls, or respond to pages</td>
<td>9% 20% 10%</td>
</tr>
</tbody>
</table>

![Physician Relationships Chart](chart.png)
Appendix DD: HWI-DBS, Cardiac Telemetry Department Physician Relationships

**Physician Relationships – Note: the lower the score the better.**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Very Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experiencing mistakes they make or about to make, but fear of speaking up in the moment</td>
<td>21%</td>
<td>17%</td>
<td>17%</td>
</tr>
<tr>
<td>Being yelled at or openly criticized in front of others</td>
<td>24%</td>
<td>20%</td>
<td>17%</td>
</tr>
<tr>
<td>Experiencing their being reluctant or refusing to answer questions, return phone calls, or respond to pages</td>
<td>27%</td>
<td>33%</td>
<td>26%</td>
</tr>
<tr>
<td>Being talked to in a condescending manner or made to feel incompetent</td>
<td>34%</td>
<td>33%</td>
<td>28%</td>
</tr>
<tr>
<td>Not feeling comfortable contacting a particular physician regarding a patient care situation for fear of being yelled at</td>
<td>35%</td>
<td>27%</td>
<td>28%</td>
</tr>
</tbody>
</table>

**Physician Relationships**

![Bar chart showing the percentage of physician relationships over time](chart)

Legend: Baseline, 6 Month, 1 Year
Appendix EE: HWI-DBS, Stroke Telemetry Department, Physician Relationships

Physician Relationships – Note: the lower the score, the better.

<table>
<thead>
<tr>
<th>Statement Dept. 135</th>
<th>Occasionally, Frequently or Very Frequently</th>
</tr>
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<tbody>
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<td>Baseline</td>
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<tr>
<td>Experiencing mistakes they make or about to make, but fear of speaking up in the moment</td>
<td>9%</td>
</tr>
<tr>
<td>Being yelled at or openly criticized in front of others</td>
<td>9%</td>
</tr>
<tr>
<td>Experiencing their being reluctant or refusing to answer questions, return phone calls, or respond to pages</td>
<td>17%</td>
</tr>
<tr>
<td>Being talked to in a condescending manner or made to feel incompetent</td>
<td>20%</td>
</tr>
<tr>
<td>Not feeling comfortable contacting a particular physician regarding a patient care situation for fear of being yelled at</td>
<td>25%</td>
</tr>
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</table>

![Physician Relationships Graph](image-url)
Appendix FF: HWI-DBS, L&D Manager/Leader Relationships

Manager/Leadership Team Relationships

<table>
<thead>
<tr>
<th>Statement L &amp; D</th>
<th>Agrees/Strongly Agrees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
</tr>
<tr>
<td>My leader sets clear expectations for professional behavior</td>
<td>77%</td>
</tr>
<tr>
<td>My leader makes me feel comfortable in approaching them to discuss behavioral</td>
<td>66%</td>
</tr>
<tr>
<td>issues regarding my co-workers</td>
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</tr>
<tr>
<td>My leader is a positive role model for professional behavior</td>
<td>61%</td>
</tr>
<tr>
<td>My leader holds everyone accountable for their actions</td>
<td>54%</td>
</tr>
<tr>
<td>My leader addresses disruptive behaviors in my department</td>
<td>51%</td>
</tr>
</tbody>
</table>

Leadership Relationships

- My leader sets clear expectations for professional behavior
- My leader makes me feel comfortable in approaching them to discuss behavioral issues regarding my co-workers
- My leader is a positive role model for professional behavior
- My leader holds everyone accountable for their actions
- My leader addresses disruptive behaviors in my department

Legend:
- Baseline
- 6 Month
- 1 Year
# Appendix GG: HWI-DBS, Department 220, Manager/Leader Relationships

## Manager/Leadership Team Relationships

<table>
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<tr>
<th>Statement Dept. 220</th>
<th>Agree/Strongly Agree</th>
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<tbody>
<tr>
<td></td>
<td>Baseline</td>
</tr>
<tr>
<td>My leader is a positive role model for professional behavior</td>
<td></td>
</tr>
<tr>
<td>My leader sets clear expectations for professional behavior</td>
<td></td>
</tr>
<tr>
<td>My leader makes me feel comfortable in approaching them to discuss behavioral issues regarding my co-workers</td>
<td></td>
</tr>
<tr>
<td>My leader holds everyone accountable for their actions</td>
<td>53%</td>
</tr>
<tr>
<td>My leader addresses disruptive behaviors in my department</td>
<td>50%</td>
</tr>
</tbody>
</table>

![Leadership Relationships Chart](chart.png)
Appendix HH: HWI-DBS, Department 135, Manager/Leader Relationships

Manager/Leadership Team Relationships

<table>
<thead>
<tr>
<th>Statement Dept. 135</th>
<th>Agree/Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
</tr>
<tr>
<td>My leader sets clear expectations for professional behavior</td>
<td>100%</td>
</tr>
<tr>
<td>My leader holds everyone accountable for their actions</td>
<td>95%</td>
</tr>
<tr>
<td>My leader addresses disruptive behaviors in my department</td>
<td>94%</td>
</tr>
<tr>
<td>My leader is a positive role model for professional behavior</td>
<td>91%</td>
</tr>
<tr>
<td>My leader makes me feel comfortable in approaching them to discuss behavioral issues regarding my co-workers</td>
<td>89%</td>
</tr>
</tbody>
</table>

Leadership Team Relationships

- My leader sets clear expectations for professional behavior
- My leader holds everyone accountable for their actions
- My leader addresses disruptive behaviors in my department
- My leader is a positive role model for professional behavior
- My leader makes me feel comfortable in approaching them to discuss behavioral issues regarding my co-workers
Appendix II: HWI-DBS, L&D Overall Department Culture

Overall Department Culture

<table>
<thead>
<tr>
<th>Statements L &amp; D</th>
<th>Agrees/Strongly Agrees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
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<tr>
<td>We treat all staff with respect</td>
<td>81%</td>
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<tr>
<td>We treat agency, travelers, and float staff with respect</td>
<td>79%</td>
</tr>
<tr>
<td>My manager encourages employees to speak up when they witness or experience disruptive behavior</td>
<td>76%</td>
</tr>
<tr>
<td>Abusive behaviors are not tolerated here</td>
<td>69%</td>
</tr>
<tr>
<td>New persons to the department are given appropriate support</td>
<td>68%</td>
</tr>
<tr>
<td>I feel confident in my ability to address disruptive behaviors in my department</td>
<td>65%</td>
</tr>
<tr>
<td>Conflicts are resolved fairly here</td>
<td>46%</td>
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</tbody>
</table>

Note: Some of these scores may reflect the challenges faced during COVID-19 pandemic.
Appendix JJ: HWI-DBS, Cardiac Telemetry, Overall Department Culture

<table>
<thead>
<tr>
<th>Statement Dept. 220</th>
<th>Agree/Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
</tr>
<tr>
<td>We treat agency, travelers, and float staff with respect</td>
<td>79%</td>
</tr>
<tr>
<td>We treat all staff with respect</td>
<td>73%</td>
</tr>
<tr>
<td>Abusive behaviors are not tolerated here</td>
<td>68%</td>
</tr>
<tr>
<td>My manager encourages employees to speak up when they witness or experience disruptive behavior</td>
<td>68%</td>
</tr>
<tr>
<td>New persons to the department are given appropriate support</td>
<td>63%</td>
</tr>
<tr>
<td>Conflicts are resolved fairly here</td>
<td>62%</td>
</tr>
<tr>
<td>I feel confident in my ability to address disruptive behaviors in my department</td>
<td>59%</td>
</tr>
</tbody>
</table>

Note: Some of these scores may reflect the challenges faced during COVID-19 pandemic.
Appendix KK: HWI-DBS, Stroke Telemetry Overall Department Culture

### Overall Department Culture

<table>
<thead>
<tr>
<th>Statements Dept. 135</th>
<th>Agree/Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
</tr>
<tr>
<td>My manager encourages employees to speak up when they witness or experience disruptive behavior</td>
<td>100%</td>
</tr>
<tr>
<td>We treat agency, travelers, and float staff with respect</td>
<td>95%</td>
</tr>
<tr>
<td>New persons to the department are given appropriate support</td>
<td>94%</td>
</tr>
<tr>
<td>I feel confident in my ability to address disruptive behaviors in my department</td>
<td>94%</td>
</tr>
<tr>
<td>We treat all staff with respect</td>
<td>89%</td>
</tr>
<tr>
<td>Conflicts are resolved fairly here</td>
<td>89%</td>
</tr>
<tr>
<td>Abusive behaviors are not tolerated here</td>
<td>86%</td>
</tr>
</tbody>
</table>

**Note:** Some of these scores may reflect the challenges faced during COVID-19 pandemic.
Appendix LL: EBI Pre and Post Self Assessment with Percentage Improvement
Appendix MM: Leadership Self-Assessment EBI Percentage Improvement
Percent Change Comparison Pre and Post EBI Education Intervention
Appendix NN: SPI Rate By Quarter Comparison

![SPI Rate Comparison Chart]

- Q4 2019 pre-intervention: 0.82
- Q1 2020: 0.77
- Q2 2020: 0.69
- Q3 2020: 0.66
- Q4 2020: 0.63
- Q1 2021: 0.63
- Q2 2021: 0.67
- Q3 2021: To be determined
Appendix OO: Pre-Intervention and Post Intervention Cumulative Comparison, Overall Culture

![Cumulative Overall Department culture](chart.png)

- **base**: 76.4
- **6mo**: 80.5
- **1yr**: 81.3

Higher = improvement
Appendix OO: Pre-Intervention and Post Intervention Cumulative Comparison, Physician Relationships
Appendix QQ: Pre-Intervention and Post Intervention Cumulative Comparison, Leadership/Team Relationships

<table>
<thead>
<tr>
<th></th>
<th>baseline pre-implementation</th>
<th>6mo</th>
<th>1yr</th>
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</thead>
<tbody>
<tr>
<td>Cumulative</td>
<td>71.1</td>
<td>82.5</td>
<td>76.9</td>
</tr>
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<td>Leadership Team</td>
<td>higher=improvement</td>
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<td>Relationships</td>
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![Cumulative Leadership Team Relationships](chart_url)