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An Assistant Nurse Manager Leadership Laboratory Program and its Effect on Nursing Outcomes

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An Assistant Nurse Manager
Leadership Laboratory Program
and its Effect on Nursing Outcomes

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DNP Project

N798E

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Section I

Acknowledgement

I dedicate and share this degree with my mom, Regina Ramirez, who always stressed the importance of an education. I know she is looking down and beaming and I thank her for being my strong role model, throughout my life. I want to thank my family for their love and support and I hope to continually give you the same love and support too, “from here to the moon and back, always and forever”. I want to thank my friends who have also provided me love and support through these last two chaotic years – you are always there for me providing stability, and please know that I am there for you always, too. I’d like to thank Dr. Marjorie Barter, my advisor, who provided calm and clarity, while my journey was not always on the smooth and even path. Without all of you, I would not have had the continued sturdy foundation, to do this work.

Abstract

Aim: This paper summarizes the project development, implementation and outcomes of an Assistant Nurse Manager leadership laboratory program and elements involved in the coursework. Through lecture, simulation, and mentoring components, noted change in leadership ability of novice/advanced beginner Assistant Nurse Managers were assessed over a six-month period and monitored the effects on quality and financial metrics, as well as the self-confidence of the Assistant Nurse Managers. Evaluation conducted included both quantitative and qualitative outcome assessment.

Background: The literature shows that quality leadership produces quality nursing outcomes (Houser, 2003). Leadership style (Wong & Cummings, 2007), communication skills (Vogus & Sutcliffe, 2011), and span of control (Sperling, 2012) are primary leadership aspects that influence these outcomes. The organization went through an extraordinary leadership change allowing the opportunity for new Assistant Nurse Manager positions. This created the need to train these new leaders.

Methods: For the purpose of this evidenced-based project, a leadership laboratory was created, providing both lecture, reflection, simulation, and mentoring opportunities for the Assistant Nurse Managers.

Results: Improvement was noted in six of eight quantitative metric indicators. Personal confidence and leadership competency noted an improvement, using qualitative measurements.

Conclusion: Through this project, tangible evidence reflected that good leadership makes a difference regarding quality of care.

Keywords: nursing, span of control, direct reports, leader, leadership, theory, style, transformational, quality, outcomes, metrics and communication.

Section II

Introduction

This project was performed at a large tertiary and quaternary facility that is part of a large national health system. The facility is a 464 licensed bed, acute care hospital located in Los Angeles, California. Besides providing acute inpatient care, the facility is supported by multiple outpatient clinics and services, including a mental health facility.

The organization has gone through multiple changes over the last few years that has affected current nursing leadership. The hospital had been without a nursing union contract for seven years, with a new contract having been finally agreed to and ratified in February 2017. Through this period, a new Chief Nursing Executive (CNE) was recruited and has been in place since July of 2015. Additionally, the position for Director of Medical Surgical and Telemetry Services had been open, and only recently filled before the beginning of this project, as well as the Director for Critical Care position, which had only been filled as of December 2017.

The CNE's initial organizational assessment noted that the Nurse Managers or Department Administrators (DAs) were struggling with span of control and that the non-exempt Charge Nurses did not have the skill or commitment to change culture or staff behavior as needed. The CNE created a new job description in early 2016 to create 50 new Assistant Nurse Manager positions or Assistant Department Administrator (ADA) roles, which were to be exempt positions. Fifty may appear to be a large number, but in this organization, there are three ADAs per unit, each working 8-hour shifts.

Many of the then current Charge Nurses applied for the new positions, but 60% of the original Charge Nurses were not hired into the new ADA roles, due to fit. This allowed new leaders to step up into the position; eight were hired from outside the organization and 22

internally from the staff. The remaining 40% were original Charge Nurses who were hired as ADAs. This situation had also created an issue where these new, novice ADAs were now in a position of leadership and were now leading many of the old Charge Nurses that were not hired into the new positions. Ultimately, the employees who were given promotions from staff nurse or Charge Nurse to ADA position, were now exempt employees and each of them were having difficulty transitioning to the leader role. In June of 2016, the new ADAs along with their DAs participated in an employee success inventory and then embarked on training regarding role clarity, leadership, quality, and finance, much of which was based on the American Organization of Nurse Executives (AONE), Nurse Manager Competencies (American Organization of Nurse Executives, 2015).

Through the end of 2016, there were multiple strikes and work-stoppages by the staff and the union, and with this, the new ADAs kept being pulled back into the staff nurse position. Because the role of the ADAs was continually switching from leader to staff nurse duties and functions, the ability for most of them to practice and embrace the leader role had been difficult. Since the ratification of the union contract in February 2017, attention to the assessed proficiency gaps and provision of additional support for the ADAs became a primary priority. The CNE and the Administrator for Professional Practice, Simulation and Innovation, identified specific gaps in the ADA's growth and identified the need to augment their education and close these gaps with new information and opportunity, ultimately helping them to grow permanently into their position. This created the demand for a "one year later" course with specific focus on identified ADA needs. These needs were addressed through the creation of a leadership laboratory program known as the Assistant Department Administrator University (ADA-U).

Endorsement for the ADA University and the creation of a leadership laboratory program had been approved by the Chief Nurse Executive at the medical center who provided a letter of support noted in Appendix A.

Problem Description

The goal of creating a leadership laboratory for the Assistant Department Administrators, was to provide hands on education to meet the problem of knowledge gaps of the new ADAs. All of the ADAs had been in place for one year, but each had found difficulty moving from staff nurse to the new leadership role. Ensuring the education and growth of the ADAs, partnered with their Department Administrators, would provide the nursing unit leadership, the capacity to respond quickly to quality and financial metrics through in-the-moment mentoring and guiding of the nursing staff, but the ADAs needed to have a better understanding in regards to how to do this and the tools to make them successful.

The current ADAs were hired due to span of control concerns. Many of the units have 65 FTE within each of the departments. This span of control decreased the effectiveness of the DAs to be present and provide adequate “touch-time” per each staff member. Even the most senior and experienced leader will eventually be ineffective with spans of control that are too large (“Inc.com,” 2016).

Before the hiring of the ADAs, the DAs were responsible for the day to day activities and operations of the unit, and in some cases, multiple units, without additional leader assistance. Charge Nurses were non-exempt employees and were not holding staff accountable as issues arose, nor did they participate in following through, regarding administrative issues. According to section 2(11) of the National Labor Relations Act (2012) the definition of a supervisor has the authority to “...assign, reward or discipline other employees or responsibly to direct them...”

(Mayer & Shimabukuro, 2012) and the Charge Nurses were not willing to participate in these activities. The new ADAs are now exempt employees and have manager responsibilities in regards to coaching, mentoring, and counseling, in addition to assigning, directing or providing discipline. The new leaders, despite other educational programs, had not been able to meet their responsibilities concerning teaching in-the-moment, displaying gravitas or change their thinking and actions from staff nurse to the leader role. This new educational program was specifically designed to target these precise leadership issues that had not been addressed. The program had intended to ensure the success of the ADAs, unit outcomes, the staff, and to provide appropriate support for the DA, by presenting them well trained ADAs. The transition of the new leaders would provide capacity and opportunity to impact communication with the staff and increase the quality and safety of our patients provided for years to come.

Available Knowledge

The PICOT define statement for this project is: In the novice/advanced beginner nurse leader, how does her/his pre-leadership training skill and confidence compare to his/her post-leadership training skill and confidence, affect quality and financial metrics, within a 6 month period of time?

Review of the literature was accomplished and noted a theme regarding strong nursing care outcomes related to leadership. The themes presented themselves in the concepts of: (a) span of control; (b) leadership style; (c) leadership and its impact on quality, and (d) communication with the staff. A systematic search was conducted and critical appraisal of the evidence was completed using the John Hopkins Nursing Evidence Based Practice tool (Newhouse, Sigma Theta Tau International, Johns Hopkins Hospital, & Johns Hopkins University, 2007). An evidence table is available for review on Appendix B. Keywords used in

the literature search included: nursing, span of control, direct reports, leader, leadership, theory, style, transformational, quality, outcomes, metrics and communication. The primary language reviewed was English, articles searched were within academic journals and the years of the articles searched ranged from 1990 – present. Over 100,000 results were listed. Review of the titles and abstracts limited the number of primary articles to 18, which are use in this report.

Span of control.

Span of control is defined as number of staff directly reporting to the manager (Sperling, 2012). Identifying the ideal number of optimized direct reports has varied through the decades, but concepts today have changed from looking at no more than 20 direct reports (“ERC - HR Insights,” 2014) to the notion of looking at the work that needs to be accomplished, to determine a total number of direct reports (Sperling, 2012).

According to Sperling (2012), spans of controls are too large if there is little time for the manager to provide feedback, to provide mentoring of the staff or too little time to communicate. Breaking down larger spans of control into smaller work groups was considered a strategy for more efficient and effective communication with teams (Havaei, Dahinten, & MacPhee, 2015). New (2009) also contributes that a unionized environment should look to narrower spans of control, as structures tend to be more complex. When a manager’s span of control is broad, only allowing the manager’s time to be spent on supervising or being involved with daily operations, there is then little time to think, plan and be creative (Sperling, 2012). Larger spans of control contribute to increase in manager turnover (Laschinger et al., 2008) and nurse turnover, decrease in nurse manager and staff engagement, decrease in patient satisfaction and patient safety (New, 2009) and increase in staff vacancies and increase in poor performance (Sperling, 2012). New

(2009) also comments, that a work environment where an organization is in flux or is unstable, should employ narrower spans of control.

Novice nurse managers are especially vulnerable with large spans of control. Havaei et al. (2015) discusses the lack of organizational commitment of the novice nurse manager, when spans are too large to control due to a lack of managerial experience. This was supported by New (2009) stating that a narrower span of control should be taken into consideration for novice nurse managers, so their position is stimulating, but does not overwhelm.

When nurse manager leadership ability and span of control are in balance, the evidence shows that quality and patient care is directly impacted. Basic themes were noted in the literature regarding quality, safety and their relationship to nursing leadership, primarily that nurse leaders have a great impact of creating stable environments that produce high-quality nurses, who provide safe, quality care.

Leadership and quality outcomes.

Quality is directly related to nursing leadership and the reduction of adverse outcomes (Houser, 2003). Houser (2003) demonstrated that the stability of staff and expertise through that stability, directly affected the clinical outcomes in falls, medication errors, urinary tract infections, and pneumonia. As staff longevity in the nursing unit grows, competence and proficiency develops and poor outcomes decline. This was also demonstrated by Wong and Cummings (2007) through a systematic review describing a relationship between nursing leadership and a decrease in adverse events such as patient mortality, long term care resident fractures, the use of behavioral restraints and an increase in patient mobility. One example noted a decrease in neonatal periventricular hemorrhage when correlated with a strong nurse leader (Wong & Cummings, 2007). A decrease in medication errors has also been shown to correlate

with a quality leader (Vogus & Sutcliffe, 2011). Through this qualitative study, a survey of 1,033 registered nurses and 78 managers, demonstrated the relationship between a trusted leader and the decrease of medication errors and was proven statistically significant ($p < .001$) 95% CI [0.09, 0.31].

Harter et al. (2006) discusses the importance of knowing your staff and understanding their specific needs. Identifying and understanding these needs shows the staff the caring for them as a unique individual and the appreciated value they bring to the team. This commitment to the person and the leader as the employee's champion, contributes in producing staff satisfaction and greater staff performance (Ostroff, 1992) and commitment to the organization ($p < 0.05$) (Shipton, Sanders, Atkinson, & Frenkel, 2016).

Leadership styles.

The systematic review by Wong and Cummings (2007), best illustrated the traits of a quality leader in two specific leadership styles, resonant leadership and transformational leadership. Resonant leadership reflects a leader who has high emotional intelligence and looks for and removes barriers and provides support for her/his direct reports, so they can get the work done. Transformational leadership instills change through coaching, mentoring, providing structure and correcting behavior as needed. This type of support allows the nursing staff to perform at greater levels of clinical care, which in turn produces better outcomes (Wong, Cummings, & Ducharme, 2013). Additionally, it has been noted that strong quality nurse leaders tend to recruit and keep strong quality nurses, producing better outcomes due to the stability of the staff and through established nursing practice (Houser, 2003).

Communication.

Good communication is one important factor used by leaders who create trusting relationships (Vogus & Sutcliffe, 2011). Open communication produces an environment for open and frank discussions and to bring forth concerns about safety and to report errors or potential errors and then disseminate information learned from the event. Good leader communication also encourages the reinforcement of process and policy and sharing a safety vision, which is accomplished through a strong trusting open rapport (Vogus & Sutcliffe, 2011). This sharing in discussion and opinions with staff, even in Shared Governance situations, has provided evidence that nursing retention is better, as well as the patient experience (Kutney-Lee et al., 2016) and instills ownership in unit decisions (Harter, Schmidt, Killham, & Aslund, 2006).

Rationale

Conceptual Framework

The framework utilized to guide this project is Patricia Benner's Novice to Expert model. In this framework, Benner has taken the Dreyfus Model of Skill Acquisition and has modeled its use to categorize skill sets for nursing (Benner, 1982). Benner (1982) describes the Dreyfus Model as having 5 specific stages nurses move through as they acquire skills and proficiency. These stages specifically are: (a) novice, (b) advanced beginner, (c) competent, (d) proficient, and (e) expert. Although this model was originally described and utilized for the bedside nurse, through the decades it has also been utilized as a model used when mentoring and guiding new nurse managers and administrators (Davis & Maisano, 2016).

Specific attributes are noted in each phase of learning (Benner, 1982). The Novice nurse is one who has had no experience at all and is in need of specific rules and directions to accomplish tasks. Advanced Beginners utilize real life experiences and patterns in situations and apply them when faced with new opportunities. These nurses move from the use of basic rules,

to the use of guidelines in their daily work. The Competent Nurse is usually one with 2-3 years of experience and uses plans and goals when caring for patients (or staff). These nurses are able to cope easier with day to day pressures, but still do not have the speed of response, as the Proficient Nurse may have. These nurses learn best through new experiences and with a mentor to guide as needed. The Proficient Nurse can identify what is an expected normal path of care for a patient and can distinguish when something has presented itself outside the norm. This is acquired through experience and the Proficient Nurse is able to identify the problem with quicker speed. These nurses learn best through complex case studies. Finally, the Expert Nurse can see the whole picture of care for the patient and family unit using holistic practices. Often these nurses are considered an expert by peers and colleagues. Many times these nurses have gained an intuition in their care and “just know” what the right answer is (National Council of State Boards of Nursing, 2011).

The use of this framework works well for the support of an Assistant Department Administrator program. The majority of the new ADAs come from the staff nurse or Charge Nurse roles. These nurses are proficient to expert nurses at the bedside and have had exposure to the daily operations of patient flow and requirements of quality patient care within their units. Since most of these ADA have been in their position for a year, although there are a few still performing at a novice level, many are now advanced beginners regarding their leadership and managerial expectations and skill. Understanding that there will be novice to advanced beginner learners in the program will set the tone as information is provided.

Specific Aim

The purpose of this project was to provide continued development of the ADAs. The expectation was that the organization provide better trained ADAs that would support the staff

and their DA through better leadership, ultimately creating an environment that supports improved quality of care for our patients and good stewardship of resources.

The AIM statement for this project is to increase the skill of the novice/advanced beginner ADA to affect the quality and financial outcomes and personal confidence level of the ADAs by December 2017 by creating and executing a leadership program with a simulation laboratory and mentoring opportunity to address the identified ADA's gaps in leadership knowledge and skills.

Section III

Methods

Context

The context for this project was to provide training for the Assistant Department Administrators, utilizing an innovative way of teaching leadership to new nurse leaders through the use of a leadership laboratory environment, ongoing mentorship and personal one to one, progressive support and counsel. The creation of this coursework was guided by identified gaps in their capabilities and to meet these needs in a 2-day course that was completed in June 2017 and a second cohort in July 2017. This course provided new information and updated content beyond education and presentations from the 2016 coursework provided and presented new opportunities to learn through role-play and simulation to bridge identified competency deficiencies. Continued support after the program was provided through personal one-to-one mentoring over a 2-month period.

The Chief Nurse Executive (CNE) was keenly aware of the ADA needs, the previous education provided, and how that coursework had not met the total needs of the ADAs. With this, the CNE directed that a full assessment be completed, and that this new coursework provide

a remedy for the ADA gaps. As a stakeholder, the CNE was fully committed to the course and process of using a leadership laboratory concept and the intended outcomes of the program.

Additional stakeholders included the Nursing Directors and the DAs who have been struggling to train the new ADAs, as no additional time had been put aside to provide additional education. The majority of the DAs had been in their roles for just over a year and had also been struggling to learn their own role, let alone mentor new ADAs. The implementation of the ADA University was considered a “gift of help” to meet the needs of the ADAs and both the Directors and the DAs had committed themselves to assist, teach or mentor in the program.

Intervention

The initial portion of the course was presented in lecture style, reviewing coaching and counseling techniques, including how to educate or ensure that the staff member understands the “why” of the process in question. Included in this content was the importance of finding things that are right or going well with the staff member and how to communicate recognition. The concept and discussion of proper rounding was included and how rounding on staff helps the leader to understand the needs and motivations of the individual, and while working with their DA, to provide for those needs.

In class, education included how to “set the tone” for the shift. This came through three distinct discussions. First, leadership bearing and gravitas, such as posture, tone of voice and eye contact and how this encourages confidence in the leader and stimulates the feeling that the leader is the champion of the staff and patients. Active role modeling and return demonstrations were required of each student.

Secondly, the active use of these leader behaviors was used as the ADA learned to prepare for the shift. This was accomplished through the concept of preparing for the day by

planning what needs may come through the shift. This information and other safety and timely content is currently shared with the team just before shift report in a huddle. Demonstration regarding how to present this information through the beginning of shift huddle occurred, stressing the impact the ADA has on the start of the day. Practice of presence, announcements and safety issues to be shared with the team unit was performed by the students during the laboratory portion of the course.

Thirdly, how to provide direction to the staff was presented. The importance of respect and dignity of the individual or group was stressed by reminding the ADAs that appropriate etiquette, through the use of please and thank you with any request, was a part of the dialogue. Presentations described how a request of an action is equal to directing the action and that the ADA must ensure essential follow-through. The staff must understand that continued confirmation of their work will be assessed. As the staff comes to understand this process, the leader's need to follow-up will decrease over time.

The leadership laboratory portion of this activity began on the second day of the program. This activity divided the students into Seminars, or groups who learned together as they move through the laboratory scenarios. Each Seminar rotated through the various laboratory activities together and engaged in active learning by doing. The separate laboratory activities included:

- Performing a beginning of shift huddle and giving direction (assignments) to staff.
- Counseling and coaching a staff member with union representation present
- Simulation of patient and staff nurse rounding with a "staff nurse" (instructor).

The beginning of shift huddle simulation was completed, by Seminar, in their own classroom. Each student received a separate "Huddle Sheet" using the appropriate facility template with mock announcements and safety items. An example of a huddle sheet used is

provided on Appendix C. The students were assessed in regards to leader bearing, including posture, tone of voice, eye contact with “the staff” (the other seminar students), energy level, and the ability to “control the crowd”. The students ran through their announcements two times during the simulation. On the first attempt, intensive coaching was provided sharing both positive aspect of the huddle as well as challenges that could be improved upon. Upon the second run of the huddle simulations, the instructors in the class, providing the role of “staff”, acted out during the huddle time so the ADA could practice group behavior management. The templated huddle sheets provided “assignments” for “the staff”, that were to be given as a direction, by the student. For example, assignment to check the crash cart was one option. Feedback for the student was immediate by the instructors. The other students were also encouraged to provide support and instructive comments to their peer as well.

In another classroom setting, the next Seminar role played by conducting coaching and counseling sessions of a “staff member” with a “union representative” present. Each of the simulations were based on actual events that had occurred in the organization to provide a realistic event and environment. An example of one of the simulations, as well as a summary of the total coaching and counseling simulation events used, is shared in Appendix D. The role of the staff member and the union member was played by senior nurse leaders. This activity was broken into two groups due to the number of students. Immediate feedback was provided by the instructors, including the offering of words or phrases that may make the conversation more effective.

The final simulation laboratory consists of a patient room scenario and the ADA conducting patient and staff rounds with a “staff nurse”. The staff nurse was played by a Department Administrator, who could provide immediate suggestions and counsel. The patient

room had various clinical and environment of care (EOC) issues, which remained consistent for each student. These EOC issues and the competency check off sheet are provided on Appendix E. The student completed this activity with the “staff nurse” in front of an instructor and a videographer, as this activity was videotaped for critique and debriefing. Videography was accomplished by use of an iPad, so the video could be deleted at the end of the debriefing session. The student needed to demonstrate the proper entry into the room using the Acknowledge/Introduce/ Duration/Explanation/Thank you (ADIET) process of entry, capture pertinent issue in the “patient room”, provide appropriate correction or instruction to the “staff nurse” and find something that was correct with compliment to the staff, within a 5-minute timeframe. After the activity, the instructor immediately reviewed and debriefed with the student identifying actions that need correction and finding behaviors of accomplishment. The student was asked what they felt they did well and what they felt they needed to practice. Coaching and guiding regarding these items was in-the-moment with the instructor providing demonstrations as needed. At the end of the simulation, the student was directed to delete the videoed activity to ensure trust that these recorded activities would not be available to be shared.

The final step to this educational plan was the ongoing mentorship for the ADAs. Each ADA was assigned a senior nurse leader or DA (other than their current direct DA) for biweekly 20 – 30-minute mentor sessions. During this period of time, five questions were discussed:

1. What were your “wins” these last 2 weeks?
2. What were your “losses” these last 2 weeks?
3. Did you “practice gravitas” (seriousness, appropriate manner) these last 2 weeks and can you give an example?
4. What did you learn about yourself?

5. What else do you need to learn?

A guide was created for the mentors with instructions regarding mentoring time as well as providing these questions. (See Appendix F)

The first question started the conversation off on a positive note. It allowed the student to “showcase” what they had learned and how they applied the new concepts. The second question allowed the mentor to help the students through difficult situations and scenarios and to set the ADA up for success for the next time the circumstance presented itself. This also supports the AONE Nurse Manager Competencies as they encourage leaders to reflect on personal decisions (American Organization of Nurse Executives, 2015). The third question assisted the ADA to note qualities of gravitas and compelled them to identify how they are strengthening this skill. Discussion of specific situations and the responses of the ADA were discussed and were considered vital in continuing to support the ADAs ability to respond to “real life” events on their unit. The fourth question allowed the student time for personal self-reflection. To know himself or herself better and is also supportive of the Nurse Manager Competencies designed by AONE (American Organization of Nurse Executives, 2015). The final and fifth question helped the student and mentor to look for additional activities to further develop the ADA’s skills or to close any remaining gaps in regards to experience or knowledge. Journaling or note taking through the weeks by the mentee, was encouraged in order to bring specifics to the sessions. These mentoring sessions continued through the two months following the program, at a bi-weekly rate.

Study of the Intervention

Current state.

Through the analysis of needs of the ADAs, it was noted that there were several gaps in their learning as well as a lack of leadership gravitas, which had prevented them from being successful in their role. There was a lack of understanding regarding their relationship as leaders as they coached or counseled their staff. In this, quality and financial metrics were potentially being affected. The ADA's inability to mentor their own employees, prevented them from "lifting" their staff to a higher level of nursing practice excellence. Additionally, there was the issue of peers being promoted and now having to correct many of the nurses that had guided them or had worked side by side with them, as staff nurses. The ADAs showed a lack of confidence in their work and the inability to display the serious manner, as the leader in charge.

Future state.

The was planned to present ADAs with the ability to stand as leaders, to respectfully correct behavior, if needed, while ensuring the dignity of the individual. In the future, the ADAs will be able to support their DAs by being independent leaders, able to coach and counsel in the moment, and continually speak of the quality and financial goals and the "why" behind them, for understanding. After the program, the ADAs will be able to prepare for the day and conduct a full change of shift huddle on their own, providing comprehensive and important information to the team in a clear and succinct manner, while showing confidence even when potentially challenged by staff. Finally, the ADA will be able to walk in a patient room and to note items needing change or adjustment as well as details of the room that are on target. The ADA will be able to convey both elements to the nurse in a respectful and educational manner, as this may need to occur in front of patients and families.

It is expected that this change in the ADA's behavior will affect the metrics of their unit through their personal transformation. This will occur through their increased ability to coach

and teach to the goal. Furthermore, the change in their demeanor and displaying gravitas will demonstrate the seriousness of the work to be done on the unit. The effective huddle will display energy and importance of the work to be done for the shift. This energy will inspire the staff to stay focused and to apply their best work in the care of our patients.

Bridging the gap.

The development of the course went through several evaluations to ensure that the program would be effective and to ensure that the program was well thought out and comprehensive. This included the review of the literature and through discussion with the stakeholders, ensuring that their observations and needs for their ADAs were met.

Coaching and counseling.

Key items were noted that needed to be incorporated in to the program. This included lecture and simulation in coaching and counseling. An additional caveat to this was the ability to coach and counsel, while in the presence of a union representative, as this was a task noted as difficult for the ADAs. Simulation was also added to the lecture content to “bring to life” the content presented. The simulations were devised by adopting actual accounts that occurred in the facility. This included quality or safety errors or behaviors that needed to be addressed by a nurse leader.

Change of shift huddle.

An additional item for the program included the ability to conduct a change of shift huddle. At the time, many of the DAs were not giving the opportunity to their ADAs to display their leadership abilities or provide them the opportunity to increase their leadership responsibilities. A mandate came right after the program that all ADAs should run the change of shift huddles to provide them this opportunity to showcase their leadership skills, as well as to

give them increased responsibility in their leadership roles. By doing this, time for the DAs would also be freed up to attend to other issues.

The course provided training for the ADAs to be prepared for this change in responsibility. In-class instruction discussed the key objectives and details included in a comprehensive huddle. This included a template for the ADAs to ensure that important items would not be left out, including a review of quality metrics to be covered each day. Tactics and strategies were covered so the ADAs could control staff speaking out of turn during the huddle time. Simulation supported this instruction by providing a structured huddle sheet to follow (topics to cover) and instructors who created an environment that forced the ADA to practice group control during huddle time.

Environment of care and patient room rounding. The final piece of the program also included the ability to engage the staff on rounds while looking at the patient care environment for items that need to be addressed as well as those that were correct. One main point covered throughout the program was the effect on others' behavior when observing them doing something right. Through lecture, understanding of what to look for, how to pay attention to detail and how to address each with staff, would be covered. Simulation reinforced learning and was videotaped for review immediately after the competency.

SWOT analysis.

The study was analyzed for feasibility through the method of a SWOT analysis. The SWOT analysis method brings the user to look at the Strengths, Weaknesses, Opportunities and Threats of an endeavor or issue (Mind Tools Content Team, 2018).

The strengths reflected the positive opportunities of this program, which included new information, the use of simulation and mentorship, and coursework that could be utilized the next day of work for the ADA.

Some weaknesses identified the need to pull the ADAs off their units for 2 full days and the need to replace them with Relief Charge Nurses for that time, the need to also pull Senior Nurse Leaders to the simulation day, which was an all-day event, and noting that the event was expensive due to these issues.

The opportunities reflected the increased ability of the ADAs and the potential prevention of young leaders falling into leadership “pitfalls” as they received tenured knowledge from the Senior Nurse Leaders through mentorship. The best opportunity noted was the increase in leadership skill, which would result in better quality.

The threats of the program included expense and inability of the organization to afford the course, the stagnant chance of the ADA’s knowledge, if they could not attend the course, and the potential of knowledge loss from the multitude of Senior Nurse Leaders, without the formal handoff of knowledge, through mentorship. The SWOT analysis is presented in Appendix G.

Work breakdown structure and Gantt chart.

In the development of the course, a work breakdown structure (WBS) was created. This assisted in identifying the detailed elements needed to create the coursework and the specific work packages necessary to create a comprehensive program. Seven project phases were noted on Level 1 of the WBS. This included: (a) defining the project; (b) identifying human resource partnership; (c) identifying partnership in the education department; (d) creating a budget; (e) developing the coursework; (f) implementing the class; and, (g) understanding the metrics. The Work Breakdown Structure is presented in Appendix H.

After the development of the WBS, a Gantt chart was created to understand when each work package needed to begin and the deadline for each. Sharing these two documents with partners in human resources, the education department and the Chief Nurse Executive, provided a road map for all parties to understand and agree to what needed to be accomplished and by when. The Gantt chart is reflected in Appendix I.

Measures

Quality is directly related to nursing leadership and the reduction of adverse outcomes (Houser, 2003) and has shown a relationship between leadership and a decrease in actual adverse events (Wong & Cummings, 2007). In this regard, it was important to understand the quality changes that would happen based on the education of the ADAs. With this in mind, the quantitative metrics to be followed in this study comprised of the Nurse Sensitive Indicators (NSI), including falls, hospital acquired pressure injuries, catheter associated urinary tract infections, and central line associated blood stream infection data. Nurse Sensitive Indicators were chosen as these represent the healthcare interventions and outcomes that are particularly sensitive to nursing practice and care (National Quality Forum, 2004). The metrics were followed for 6 months and an annual total for 2016, compared to 2017, was planned.

Financial aspects were also monitored, specifically the use of overtime and the amount of attendance hours utilized, compared year to year. These metrics were chosen as an increase in overtime was noted and nursing leadership needed to curtail the upward trend of use. These were also good metrics to follow as they are directly associate with the work done by the ADAs.

Qualitative data were also monitored through a pre and post self-assessment regarding leadership tasks and skill that were identified as necessary to the role of the ADAs. The three questions rated on a 1-5 Likert-like scale were:

- I can coach and counsel my staff, with a union representative present at our meeting.
- I feel competent and confident when I run a Beginning of Shift Huddle.
- I can conduct a constructive coaching of my staff, in a patient room, in front of family and a patient.

These questions reflected gap areas for the ADA and represented opportunity where gravitas and confidence could be exhibited.

Baseline data.

Baseline data were collected in May of 2017. This included annual 2016 data for all measures. Data were gathered through specific colleagues in the organization. Nurses Sensitive Indicator metrics were discussed and recorded with the Director of Nursing Quality and the Quality Analyst assigned to the nursing department. Data for the financial metrics were created and shared through collaboration with the Director of Finance. These contacts remained stable through the project and allowed for clear needs and consistency with post evaluation data.

Nurse Sensitive Indicator data were collected on an organization, as well as on an individual unit basis, to observe any change, unit to unit, over the two-year comparison. All inpatient nursing units were included in the data, including the Mother/Baby departments. Baseline data for NSI metrics are reflected in Appendix J.

Financial data were also collected unit to unit and a comparison was completed contrasting 2016 to 2017 totals in attendance hours as well as overtime hours. All inpatient units were included in this data, including the pre-operative area, the operating room department and post-anesthesia recovery unit as the ADAs of these areas report up to the CNE, and these ADAs also attended the course. Baseline data for these financial metrics are reflected in Appendix J.

Analysis

Analysis of all data was done by the project director. Any calculations were done utilizing a calculator or an excel spreadsheet. The excel spreadsheets assisted in creating the graphs and charts for this study. No other computer software or program was used to analyze the data and outcomes.

Ethical Considerations

Certain ethical responsibilities are required of all registered nurses per the Code of Ethics as stated by the American Nurses Association (The American Nurses Association, 2017). Specific Provisions of the Code specify structure related to the accountability of the nurse. Provision 4.1 discusses the responsibility for one's own practice and the care of the patient provided. This includes accepting responsibility, exercising judgement, and seeking the counsel of others, if in doubt. Provision 4.3 states that nurses in leadership positions, although they may not give direct care to the patients, are responsible for the care provided to patients by the nurses they are responsible for. Finally, Provision 6.3 discusses the nurse leader's responsibility to establish a "moral environment" (The American Nurses Association, 2017). All these Provisions consider the ethical necessity of a leader doing what is moral or ethically right for the patient.

We understand that quality is affected by strong positive leadership (Wong & Cummings, 2007), and that this leadership promotes outcomes of safety (Smith, 2017), therefore it should be asked, should anything but strong positive leadership be tolerated? In a survey about understanding ethics and behavior in the workplace, 48% of respondents correspond unethical behavior on the job to poor leadership (Heeley, 1998). As a registered nurse the principle of non-maleficence requires that we do not harm through the care we provide (Grace, 2018). As a

leader, one may infer that it is the responsibility and moral and ethical duty to be a strong positive leader to ensure nursing excellence and the best care possible for the patient.

Review of ethical considerations for the study.

To ensure that the program for this study affirmed ethical consideration, the project was reviewed by the DNP faculty committee, through the University of San Francisco and was approved as a non-research evidenced-based practice change project. This approval is reflected in the Statement of Determination noted on Appendix K. The program was also presented to the organization's IRB, who also approved the study as a non-research practice change. This approval is presented in Appendix L.

Results

Assessment of results reflected both quantitative and qualitative outcomes. Quantitative data are represented through Nurse Sensitive Indicators including: (a) central line associated blood stream infections (CLABSI); (b) catheter associated urinary tract infections (CAUTI); (c) hospital acquired pressure ulcers (HAPU); and, (d) patient falls. Also included in the data collection, were two staffing standards, specifically attendance hours and overtime hours. Total summary outcomes of these indicators are reflected in Appendix M.

In regards to qualitative outcomes, a pre and post self-evaluation of the ADAs was taken, specifically questioning leader skills determined to be necessary by the senior nursing leadership. Total participant numbers (51) included both cohorts from the June and July 2017 courses.

Nurse Sensitive Indicator Outcomes

The Nurse Sensitive Indicators were measured by total events comparing 2016 to 2017. Both CLABSI and CAUTI were measured by total event count per each year. Hospital acquired

pressure injuries were measured by total number of events per stage of injury. Patient falls were also measured by total number of fall events per level of fall.

Central line associated blood stream infections.

Central line infections increased from 2016 to 2017 by one case. Four individual units maintained low numbers of CLABSIs and six additional units improved their outcomes. Central Line Associated Blood Stream Infection costs have been calculated using the Texas Medical Institute of Technology (TMIT) calculator (Texas Medical Institute of Technology, 2010). This calculator is capable of estimating costs of various hospital acquired infections using organization specific information. According to this calculator, CLABSIs were determined to be a cost of \$34,151.00 each. The baseline calculations for the CLABSIs in 2016, for 29 cases totaled \$990,397.00. With the additional one CLABSI in 2017, this increased the cost of all 30 CLABSIs to \$1,024,530.00. This increased the cost of CLABSI to the organization by \$34,151.00. (See Appendix N)

Catheter associated urinary tract infections.

Overall outcome change for CAUTIs were not significant from year to year. There was a decrease of 3 total CAUTIs from 81 in 2016 to 78 in 2017. Various units either maintained their total number of events or improved. Three specific units maintained their low total number of events, including two of these that maintained at zero CAUTIs. Four units varying from intensive care to telemetry to medical surgical units decreased their number of CAUTIs ranging from one less event to seven less events. (See Appendix N)

Catheter associated urinary tract infections can be costly to an organization. The TMIT calculator was once again utilized to determine the cost of the 81 baseline CAUTIs in 2016, at the cost of \$5,520 each, which ran the facility a total of \$447,120.00. With the decrease of three

CAUTIs in 2017, the 78 CAUTIs ran the organization a total of \$430,560.00 as noted in Appendix N, a total cost avoidance of \$16,560.00.

Hospital acquired pressure ulcers.

Hospital acquired pressure ulcers are noted based on the level of injury. There are 4 stages of pressure injury (Stage I – IV) indicating the amount of tissue damaged and loss (The National Pressure Ulcer Advisory Panel Staging Taskforce, 2016). The National Pressure Ulcer Advisory Panel (2016) also notes that there are also categories of unstageable and deep tissue injury pressure ulcers, but because these ulcers are covered by intact skin, they cannot be staged. For the sake of consistent measurement, this study only considered Stage I – IV injuries to maintain clear measurements. For both years, there were no Stage IV pressure ulcers noted. For all other stages, I – III, there was a decrease in number for each stage. Total Stage I pressure ulcers decreased from 25 in 2016 to 12 in 2017, nearly a 50% decrease. Stage II pressure ulcers went from 68 in 2016 to 63 in 2017, almost a 7% decrease. Stage III pressure ulcers went from 5 in 2016 to 4 in 2017, a 20% decrease. Total pressure ulcers in 2016 (98) to 2017 (79) accounted for a 20% decrease.

Certain units not only decreased the number of pressure ulcers, but also decreased the severity of the injuries as well. As an example, the Observation Unit had a total of six pressure ulcers in 2016, including four of these ulcers as a Stage II. In 2017, the unit had decreased the total number to 1 injury with this being a Stage I pressure ulcer. Of eleven adult units representing data in both 2016 and 2017, eight units had a decrease in pressure ulcers including four of these units representing a 60-88% decrease in injuries.

The estimated cost per stage was captured in 2012 in the literature, noting that the cost to heal a Stage I pressure ulcer was \$1,912.00, Stage II was \$8,255.00, Stage III was \$14,240.00

and Stage IV costs were \$22,222.00 per ulcer (Dealey, Posnett, & Walker, 2012). Each of these costs were placed in the Customer Price Index (CPI) calculator from the U.S. Bureau of Labor Statistics, to convert the 2012 costs to 2016 pricing (U.S. Bureau of Labor Statistics, 2017). This resulted in the cost to heal a Stage I pressure ulcers at \$2,008.00, Stage II pressure ulcers at \$8,670.00, Stage III pressure ulcers at \$14,956.00 and Stage IV pressure ulcers at \$23,339.00. Total cost for all 2016 pressure ulcers, based on these converted costs and total number of events is \$714,765.00. Because of the decrease in pressure events and severity in 2017, the total cost avoidance for the year is \$84,527.00, which is reflected in Appendix O.

Falls.

Fall metrics were quantified based on number of falls and severity of falls, primarily falls without injury or minor injury (Level I or Level II falls) and falls with injury (Level III or Level IV falls) following definitions from the Collaborative Alliance for Nursing Outcomes (Collaborative Alliance for Nursing Outcomes, 2017). An additional definition regarding falls is death (Level V), but no deaths, due to falls, occurred at the facility for these two years.

Level I/II falls decreased from 157 (2016) to 144 (2017), but there was an increase in falls with injury (Level III/IV) from 3 in 2016 to 7 in 2017. Two units were particularly successful in reducing falls – the Neurology unit which decreased falls by 60% (36 falls in 2016 to 15 falls in 2017) and the Cardiac Intensive Care Unit decreasing their falls by 60% (9 falls in 2016 to 4 falls in 2017) and decreasing severity; seven Level I falls and 2 Level II falls in 2016 compared to 4 total Level I falls in 2017.

The average cost of falls with minor injury in 2008 was \$425.00 and falls with injury costing \$6,37.00 (Tzeng & Yin, 2008). Using a Customer Price Index (CPI) calculator from the U.S. Bureau of Labor Statistics, a calculation of the 2008 costs were converted to 2016 pricing

(U.S. Bureau of Labor Statistics, 2017). These costs converted to \$469.00 for Level I/II falls and \$7,090.00 for Level III/IV. No information was found regarding costs for falls with death. This was not pursued since no deaths had occurred. Based on this calculation the total cost in care of Level I-VI falls in 2016 was \$94,903.00. Although there was a decrease in Level I/II falls, due to the increase in Level III/IV falls, the total additional cost to care for patients with falls in 2017 rose to \$117,166.00, which is reflected in Appendix P.

Staffing Standard Outcomes

The ADAs have a direct effect on two key financial metrics, specifically attendance hours utilized and overtime use. During the ADA's coursework, coaching and counseling was reviewed so the ADAs had the tools to address each, either in-the-moment or in a more formal setting with the staff. Key phrases, how to set expectations, and how to present a formal counseling, if necessary, with union representation present was included.

Attendance was a key concept to monitor due to the ballooning number of hours of sick leave time taken. It was made clear that certain leave hours were protected by law and discussion regarding distinguishing the difference between the two was introduced.

Regarding overtime, the converse of the ADA starting the shift was discussed, including ensuring that staff got off shift on time and to assure that no unnecessary overtime was incurred. The ADAs were taught that at the end of the shift, the oncoming as well and the off going ADAs should tag-team through the unit to "sweep" staff off shift. Discussion during class brought forth, that many staff still had items to complete at the end of shift, such as documentation, causing overtime, especially incidental overtime. As a class, determination regarding what would be considered "appropriate" overtime was compared to unnecessary incidental overtime. Events, such as Code Blues or patients deteriorating were some specific incidents where all felt

overtime was appropriate. Leaving charting to the end of the shift or continuing “standard patient care” was not considered appropriate. Tactics were discussed, including a mini-huddle with the team, 3-4 hours before end of shift to see if anyone was having issues with time management or had feelings of being overwhelmed. This allowed the ADA to deploy resources to the nurse to ensure that they had the opportunity to leave on time. Another suggestion was a 1 to 1 check-in with each staff member mid-shift and asking directly, “Are you going to be able to leave on time today?” This check-in allowed the ADA to get a verbal agreement from the staff that they would be off shift on time, or again, be allowed the opportunity to mitigate any time or patient care issues, partnering with the staff, regarding the concern at hand.

Attendance hours.

In 2015, sick leave hours in all nursing departments totaled up to 122,720 hours. This increased in 2016 to 133,591 hours targeting it as a standard to monitor. The first quarter of 2017 amounted to 42,591 hours of sick time and second quarter at 31,483 hours. ADA University occurred in June and July of 2017, setting expectations as well as giving direction how to address appropriate coaching and counseling. Third quarter of 2017 produced 29,470 hours and the final quarter of 2017 yield 28,724 hours of sick time. This continued decrease in sick hours in the last quarter was unexpected as the flu season accounted for an increase in sick time taken by the staff in the nursing division. Through the beginning of the flu season (in November and December of 2017) as many as 20-40 staff called off ill each shift, due to flu or flu-like symptoms. The total hours of sick time taken in 2017 was 132,118 hours, resulting in a decrease of 1,473 sick hours taken as compared to 2016 reflected in Appendix Q.

Overtime.

In 2015, overtime hours concluded with 142, 214 hours for the year. This increased in 2016 to 151,502 hours caused it to be a standard to track. Due to the flu season and the predicament of numerous staff calling in ill due to flu or flu-like symptoms, it was expected that overtime hours would continue to increase over time, as many staff who were not ill were asked, if available, to work extra shifts.

During the first quarter of 2017 overtime resulted in 40,792 hours and second quarter totaled 36,107 hours. Again, ADA University took place in June of 2017 and the second cohort in July of 2017. Third quarter hours yield 34, 329 and despite the flu season beginning in November and December, the final quarter sum of hours was 29,779. The total sick time hours in 2017 resulted in 140, 231 hours or 10,756 hours less compared to 2016.

The 151,502 hours of overtime in 2016 were earned by registered nurses (RN) and nursing assistant (NA) staff. Of the hours, 55% (or 83,300 hours) were earned by the RNs and 45% (68,200 hours) by the NAs. The average salary for the RNs is \$61.94 resulting in \$5,159,602.00 in RN overtime costs. The average salary for the NAs is \$21.74 resulting in \$1,482,668.00 in NA overtime costs. These costs consequently, add up to \$6,642,270.00 in total overtime dollars. Using the same model in 2017 to understand costs, RN overtime would result in 77,127 hours or \$4,777,246.00 and NA hours would result in 63,104 hours or \$1,371,880.00. The total cost in NA and RN overtime hours for 2017 is \$6,149,126.00 or a saving of \$493,144 in overtime costs comparing 2016 to 2017 as reflected in Appendix Q.

Pre and Post Self-Evaluation Comparison

The pre and post evaluation consisted of three questions that reflected leadership skills that the ADAs needed to possess, as determined to be necessary by the senior nursing leadership. This included questions regarding capability on coaching and counseling staff with a union

representative present with the employee, the self-assessment regarding competency and ability to run a beginning of shift huddle, and the ability to assess the patient room environment and provide constructive coaching of staff in the presence of the patient or family. The self-evaluation questionnaire is displayed in Appendix R.

The evaluation questions required each student to read and rate themselves in regards to ability, on a 1-5 Likert-like scale. This self-evaluation was taken at the beginning of the first day, before instruction began. A reflective comment section was provided for each question to allow the student to provide comments about their thoughts concerning their skill.

A post self-evaluation was completed using the same questions at the end of the program. Since there was a 2-month mentoring section of the program, the self-evaluation did not take place until the end of the mentorship portion of the course. The data were analyzed from two specific viewpoints, looking at the mathematical median and the mode for the descriptive results.

Question 1 reads:

- I can coach my staff, with a union representative present at our meeting.

The pre-evaluation median for this question is a score of 4 with 47 participants responding. The post-evaluation does not change with a median score of 4 with 33 participants responding. The mode tells a different story regarding this question. In the pre-self-evaluation, the mode is a score of 4 with 50% of the participants answering with this score. The post self-evaluation mode continues to be a 4, but the number of participants answering at a score of 4 rises to 59% showing an increase in comfort of the ADAs regarding the ability to coach or counsel an employee in the presence of a union representative. The graphs representing these outcomes are noted in Appendix S.

Various comments made in the reflective section, before the program content was presented, included comments such as:

- Scary!
- I had no exposure – what do I do?

After the program, many of the comments mirrored:

- I can say that I am confident, but need more practice.
- ADA University gave me the opportunity to practice represented meetings in a safe environment.
- I feel more confident in conducting coaching/counseling a staff with union representative. Practice makes perfect and this is what I learned from my class and my great mentor.

Question 2 reads:

- I feel competent and confident when I run the beginning of shift huddle.

This question was identified as important by the Senior Nursing Leadership because it was an opportunity for the ADA to share important information while displaying gravitas and remain in control in a group setting. In reality, a segment of the ADAs were not allowed to conduct the shift huddle, or if they did, they were not displaying confidence during the huddles nor were the huddles being effective in regards to sharing important information. The median of question 2 on pre-evaluation was a score of 5, with 45 respondents. The post evaluation median score was also a 5 with 32 respondents. With the mode, there was a notable shift. The pre-self-evaluation was a mode score of 5 for 56% of the students. The post self-evaluation showed a notable change with a mode score of 5 for 91% of the students. This again showed a change in

confidence due to in class discussion, practice through simulation, and discussion during mentorship. These outcomes are reflected in Appendix T.

Before the program, the students commented on this question with reaction such as:

- There is no standard for huddles
- This is challenging with staff creating distractions.

After the program, comments reflected:

- I can now get the attention of the staff
- I am more confident
- Simulation was accurate – good practice

The third question reads:

- I can conduct a constructive coaching of my staff in a patient room in front of family and a patient.

This was an interesting question as it brought up many feelings of the ADAs stating they “would never do” in front of others, but through the discussion and sharing of techniques, the perceptions of the students changed. This is reflected in the median score, pre-self-evaluation scored at 3.5 with 48 respondents and comparing to the post self-evaluation median score moving to a 5 with 32 students responding. The mode also reflects this change with a pre-self-evaluation score of 3 for 31% of the respondents and a mode of 5 for 63% of the respondents in the post self-evaluation. These outcomes are reflected in Appendix U.

For this question, prior to the coursework, the students commented:

- I would never coach my staff in front of patients or family
- This is difficult to do
- I worked with them as peers

- Not comfortable, need the skill

At the end of the program, comments received reflected:

- You can do it by showing respect
- Use the right approach and tone
- Offer suggestions and stay positive
- I have more courage, techniques and approach

Gathering post evaluations after the mentorship portion of the program, two months after the in-class coursework, was more difficult than expected. Some of the ADAs did not turn in their post evaluation in a timely manner and the due date was extended by a month. The DAs of the ADAs, were contacted and provided a copy of the post evaluation to present to their ADA for completion. The DAs were instructed to not be present while the ADA completed the post evaluation. Additionally, a personal email was sent to each of the ADAs with the post evaluation attached and requested they complete and send back completed, to be included in the analysis. Through this process of the original 51 participants, 33 students returned their post evaluation or 70% of the original group.

Financial Considerations

There were several considerable costs associated with this course. Primarily were the salaries of the instructors and the students, but also the replacement Relief Charge Nurses needed to cover the units to allow the ADAs to attend the classes needed to be considered. In addition, the time for the mentorship over the two months also needs to be accounted for and counted toward the overall salary costs for the program. Between the costs of the students, instructors, and relief staff, in addition to the mentorship time, these salaries add up to \$128,100.00. This operational cost and expense detail is displayed in Appendix V

Additional costs for the course include the meals; breakfast and lunch, snacks and drinks for each day for 60 people (students, instructors and mentors) created a charge for \$3,651.00. Office supplies were also accounted for at \$82.00. The total cost of the program, is \$131,833.00.

In contrast was the cost avoidance in quality events and overtime costs deferred. The largest saving was the overtime costs at \$493,144.00. Additional cost avoidance is shown through the decrease in events in CAUTIs (\$16,560.00), and HAPUs (\$84,527.00). Increase in costs were associated with CLABSI (\$34,151.00) and falls (\$22,263.00). Overall change in cost avoidance for quality and financial metrics is \$537,817.00. Subtracting the cost of the course (\$131,833) allots for \$405,984.00 in total cost avoidance. This is reflected in Appendix W.

Discussion

Summary

It took the collaboration of the Senior Nursing Leadership to create the learning environment for the students. Each of them dedicated time in simulation with the students and time, over several months, mentoring multiple mentees. It was creating the environment of learning, dedication to the students and their growth, that created this program overall.

As mentioned in the beginning of this report, the organization is going through a great culture shift, change in leaders and leadership style, expectations of the staff and the young nurse leaders. To change the culture may take time, but it is the leadership that will carry the division of nursing forward and change the practice of nursing for the better. This is only a part of that journey.

Presentation of the ADA University concepts and subject matter has been shared with colleagues in the region within the healthcare system, with requests from several organizations for the syllabus for this program. In addition, the national home office for the healthcare system

has also contacted the author for details on the program, due to their interest. The education designers at the national level are especially interested in the simulation content and its use in educating leaders. Finally, the author will be presenting this work, interventions and outcomes at a formal presentation for senior executive leaders within the region of the healthcare system and will provide any assistance to spread the course work.

The culture change through improved leadership continues. As a result of this program, the author has been requested by the Chief Nurse Executive to develop a Nurse Manager or Department Administrator (DA) leadership program. The course structure will remain the same, including lecture, simulation and mentorship. The content will focus on the needs of the DA, which will include how to create a vision for his/her units and how to convey this vision to the staff, transformational leadership concepts and the importance of self-care.

Interpretation

Leadership affects outcomes, as reflected in this study. Falls (level I/II), CAUTI, HAPU (Stage I-III), attendance hours and overtime hours all decreased comparing 2016 to 2017. Both CLABSI and falls (level III/IV) had an increase from 2016 to 2017. In all three of the qualitative metrics, each one showed an increase in confidence related to leadership skills and the self-assessed abilities of the ADAs. Although the culture is still in a mode of change, these are cues that the culture is moving in the right direction.

The use of Benner's model (1982) proved to be helpful in conveying the information to the novice and advanced beginner ADAs. Benner (1982) stated that specific attributes are noted in each phase of learning. For the novice learner, direction with specific rules is the best way to convey material. In the ADA University, templates were utilized that directed the novice ADAs

with regards to what to cover during huddle periods. Steps in how to cover information, including how to present oneself, was included in the didactic material.

For the Advanced Beginner ADA, Benner's model (1982) discussed the use of real situations or use of patterned experiences to share instruction. In the ADA University, situations in each of the simulations were presented from actual and real circumstances and conditions that occurred within the organization. The use of mentorship also supports Benner's model for the Advanced Beginner learner.

The combination of lecture, simulation and mentoring over a period of time has proved to be both beneficial to the learning leader as well as to the organization. This method may be considered for use in the future, as education for the DAs or the Relief Charge Nurses is considered.

Limitations and Additional Work

There were limitations to the study of this project during this period of change. It is important to recognize that during the year, there were other quality projects and initiatives that may have also influenced the outcomes of the metrics followed. Also, with the addition of a new Director of Medical Surgical and Telemetry Services, leadership expectations and required actions and behaviors of all the DAs and ADAs may also have influenced these outcomes. As an observation, these initiatives and the leadership requirements by the new Director also supported change in the ADAs by ensuring the content of the program was being used in the day to day operations of the work to be done on the units.

In regards to additional needed work, the measurements of outcomes regarding the mentoring portion of the program were difficult to capture. Since mentoring is a private consultation between the mentor and the protégé, discussions in this private setting should not be

shared, to ensure the trust between the two. There is more work to be done to consider the best way to measure the product of this portion of the work.

The post self-assessment survey was requested to be completed by the participants two months after the in-class coursework. Due to the passing of time, only 70% of the participants returned the survey. The development of future tactics, including different timing and several requests to increase the return rate closer to 100%, will be considered as future coursework is developed.

Conclusions

In 2016, the ADAs had struggled when moving from staff nurse to leader. Due to various factors, such as multiple strikes and work stoppages, and pulling the ADAs back into staffing positions caused much role confusion. With the newly ratified union contract, attention on providing the ADAs the support and tools to complete their training was a priority. It was this commitment through the creation of a specialized program that demonstrated the belief that leadership changes culture, quality care, financial results, and better outcomes for our patients. This study provides assurance that there is tangible evidence that good leadership counts and makes a difference in nursing practice.

Other Information

Funding

Funding for the project was provided by the home organization through a mandated continued education program for the ADAs.

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Letter of Support – Appendix A



Kaiser Foundation Hospitals

Date 3.8.17

To Whom It May Concern:

I am writing to acknowledge support for Alexandra Wiggins in completion of her evidenced-based quality improvement DNP project, the development of continued education program for the Assistant Department Administrators through the creation of a leadership laboratory environment in partial fulfillment of her Doctor of Nursing Practice degree in the Executive Leadership Program at the University of San Francisco. The Chief Nursing Executive will have an opportunity to review any manuscripts that identifies Kaiser Los Angeles Medical Center submitted, prior to submission.

This letter also verifies that Kaiser Permanente has a memorandum of understanding with the School of Nursing and Health Professions at the University of San Francisco for student clinical course work that is supervised by USF faculty.

Sincerely,

Patricia Clausen BSN, MBA, RN-CENP

Patricia Clausen
Chief Nursing Executive

Evidence Table – Appendix B

Evaluation templated from Melnyk & Foneout – Overholt (p.552)

Citation: Author, Pub. Date Title	Conceptua l Framework	Design Method	Sample/ Setting	Major Variables Definitions	Measurement of Variables	Data Analysis	Study Findings	Appraisal of Worth Strength of Evidence Quality
Harter, J., et al. (2006). Q12 Meta-Analysis. Gallup, Inc.	Human Needs Concept	Cohort Study	23,910 “business units” in 125 companies related to Gallup	DV: Use of the 12 Questions (Q12) from Gallup IV: Employee Engagement measured by Q12	Customer metrics, profitability, turnover, safety and health, absenteeism, shrinkage	Engagement 90% CI [.22-.32], High performer using Q12 questions 0.81 SD compared to lower performer (inconsistent use of questions)	Increase in metrics and employee satisfaction related to the Q12 questions.	W: Y Large pool of participants S: Level III – Cohort of “business units” being followed by Gallup Q: Good Due to sample size (companies) all related to Gallup Limitations – specific to one patient engagement company and its data
Havaei, F., et al. (2015). The effects of perceived organisational support and	None	Cross-sectional	69 Novice Nurse Managers	DV: Organizational commitment IV: Span of Control	Organizational Commitment Questionnaire	Perceived Organizational Support ($\beta = 0.41$ $P < 0.01$)	Wider the span of control for novice nurse managers, the lower	W: Yes S: Level II Company commitment to organization is related to novice

span of control on the organisational commitment of novice leaders					Perceived Organization Support Scale		the commitment to the organization	nurse manager span of control Q: Good
Houser, J. (2003). A model for evaluating the context of nursing care delivery	Meeting needs of many	Mixed Method: Qualitative and Quantitative	46 patient care units and 3 long term care facilities. 55 Nurse Managers and 1142 Staff RNs	DI: Leadership Traits IV: Multiple quality metrics	Leadership Practices Inventory Work Environment Scale	Leadership to Staff Expertise: 1.918 p < 0.05 Staff Expertise: -2.133 p < 0.05 Staff stability: -0.990 p < 0.05 Resources: 3.093 p < 0.05	Leadership affects quality metrics	W: Y Identifies leadership's direct affect to quality S: Level III Mixed method Q: High Return of surveys 91% from Nurse Managers and 70.3% from staff RNs
Kutney-Lee, A., et al. (2016). Nurse Engagement in Shared Governance and Patient and Nurse Outcomes	None	Cross-sectional	425 acute care hospitals 20,674	DV: Shared Leadership IV: Staff engagement	Practice Environment Scale Maslach Burnout Inventory HCAHPS	Engaged (with shared leadership) vs. Least engaged (without shared leadership) Engaged 43% vs least engaged 13% (p < 0.001) Burnout – Engaged 23% vs. Least engaged 52% (p < 0.001)	Shared leadership = increase in patient experience and quality	W= Y S = Level II very good number participants Q = Good

<p>Laschinger, H., et al. (2008). A profile of the structure and impact of nursing management in Canadian hospitals</p>	<p>Self-created based on health services and organizational literature. Including concepts of: Structural Leadership Characteristics, Organizational Characteristics, Personal Characteristics, Integrative Mechanisms producing Outcomes</p>	<p>Descriptive Quantitative Qualitative</p>	<p>Nurse leaders from 28 academic health centers, 38 community hospitals totaling 1,164 participants</p>	<p>DV: Communication & Coordination Mechanisms IV: Unit-management relationship, management responsibilities and span of control, decision making, leadership style, organizational support</p>	<p>Nurse Executive Questionnaire Union-Management Relationship Scale Degree of implementation of restructuring activities Communication & Coordination Questionnaire Communication Satisfaction Subscale Organization of Nursing Characteristics; Nursing Involvement in Organizational Governance; Span of Control Program/Portfolio Characteristics;</p>	<p>Regression analyses were used to test the relationship between the structural characteristics of each level of management and their own outcome related to age and experience. Descriptive statistics were used to profile the characteristics of nurse leaders Qualitative survey resulting in interview based themes</p>	<p>Nurse leaders with high average age (47-50 years) Senior leaders felt influential and empowered Middle managers with high span of control had lower organizational support and had higher intent to leave organization</p>	<p>W= Y S – Level III multiple designs Q = High Multiple ways of looking at the problem Limitation – Multiple variables competing – might be more effective to publish separate articles using same data</p>
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					View of SNL's Role in Nursing Involvement in Organizational Governance			
					Participation in Strategic Decision-Making Scale			
					Revised Participation in Strategic Decision-Making Scale			
					Index of Centralization – Hierarchy of Authority Subscale			
					Nurse Executive Profile			
					Leadership Practices Inventory			
					Demographic Questionnaire			

					developed by researchers Index of Centralization – Participation in Decision- Making Subscale Work Alienation Scale Nursing Work Index – Revised Conditions of Work Effectiveness – II Global Job Satisfaction Survey Alienation from Work Scale Organizational Support Scale Nursing Work Index – Revised			
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<p>Ostroff, C. (1992). The relationship between satisfaction, attitudes and performance: An organizational level analysis.</p>	<p>None</p>	<p>Qualitative</p>	<p>298 schools 352 principals 13,808 teachers</p>	<p>DV: Employee satisfaction IV: Character of school Organizational performance</p>	<p>Teacher Satisfaction – 5 point Likert scale (Did not appear to be based on a valid measurement scale Job related tension scale Student achievement and school outcomes (this may be influenced by school location and support)</p>	<p>Employee satisfaction at 0.28 SD compared to Performance at 0.63 SD to Intent to Quit at 0.30 SD</p>	<p>Correlation or Employee Satisfaction to overall performance and outcomes of students</p>	<p>W = Y Describing outcome of work to employee satisfaction S = Level III many surveys Q = Good using established measurements. Limitations – One scale that appeared to be self-calculated by author</p>
<p>Shipton, H. et al. (2016). Sense-giving in health care: the relationship between the HR roles of line managers and employee commitment.</p>	<p>Sense-giving theory</p>	<p>Quantitative</p>	<p>509 employees 67 line managers 4 Dutch hospitals 74% female</p>	<p>DV: Employee commitment IV: Line managers</p>	<p>Employee commitment (Not based on valid measurement scale) 5 point Likert scale</p>	<p>Employee commitment ($p < 0.05$) Males are less committed Possible relationship between managers and “staff</p>	<p>Commitment of the leader to the employee contributes of employee commitment to the organization</p>	<p>W = Yes Staff commitment and engagement when line manager is committed to staff S = III Quantitative study Q = Good Large sample size, but use of non-valid survey</p>

						champions” (0.17, p <0.01)		
Tzeng, H. et al. (2008). Nurses’ solutions to prevent inpatient falls in hospital patient rooms.	Joint Commission National Patient Safety Goals	Qualitative	9 register nurses interviewed	DV: Inpatient falls IV: Registered nurses	The Joint Commission perspective vs. nurse perspective regarding the prevention is inpatient falls	Qualitative study resulting in interview based themes	Fall dimensions: Caregiver competency Communication Staff training Patient assessment Care planning	W = Y Provides the cost of falls S = Level III qualitative study Q = Low Only 9 nurses interviewed
Vogus, T. (2011). The impact of safety organizing, trusted leadership, and care pathways on reported medication errors in hospital nursing units.	None	Cross-sectional	88 adult care units 78 nurse managers 1033 staff RNs	DV: Safety (medication errors) IV: Trust in managers Medication Errors Care pathways	Safety Organization Scale Trust in Manager Scale	Safety and trusted leadership ($\beta = -0.68, p < 0.001$) [95% CI 0.08, 0.31]	Communication and reinforcement of safety, safe environment to discuss and report safety concerns associated with decrease in medication errors	W = Y S = Level III Q = High Well defined Limitations – regarding medication errors only
Wong et al. (2013). The relationship	Complexity Theory	Systematic review	7 quantitative	DV: Patient outcomes-	Nurse Sensitive Indicators	Patient Sat and transactional	Patient satisfaction associate	W = Y S = Level I Q = High

<p>between nursing leadership and patient outcomes: a systematic review.</p>	<p>Complex Adaptive Systems Aiken Model of Organizational Characteristics Transformational Leadership Managerial motivation theory</p>		<p>research studies SNF, LTC, adult and pediatric units 274 nurse managers 2014 staff registered nurses</p>	<p>Patient satisfaction Mortality Patient safety Adverse events complications IV: Leadership-Style Relationship with staff Communication Participative decision making</p>	<p>Quality Metrics- Mortality Medication Errors Leader Practices Inventory Communication Openness Scale Nursing Work Index Patient Judgement of Nursing Care ICU Nurse- Physician Questionnaire</p>	<p>leadership = increased Patient sat and positive leader behaviors = increased Adverse events and nurse participation = decreased Restraint use and leader communication /openness = decreased Fractures and leader relationship with staff = decreased HAIs and greater staff experience = decreased Neonatal PIVH/PVL and</p>	<p>with positive leader behaviors Span of control influences relationship with staff Relationship to mortality and adverse events and complications Positive leader practices and decrease of adverse events in nursing homes – falls and med errors Higher leader</p>	<p>Systematic Review Metrics followed</p>
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						higher leader subscales = decreased	ratings related to decrease in periventricular hemorrhage and leukomalacia. Pneumonia and UTI	
Wong et al. (2013). The relationship between nursing leadership and patient outcomes: a systematic review update.	Donabedian	Systematic Review	Cross-sectional design of 20 articles Acute adult, nursing home, ED, Home Health and NICU	DV: Patient outcomes IV: Leadership	13 tools – most used: Multifactor Leadership Questionnaire Leader Practices Inventory	Transformational leader/Resonant Leader (TL) and patient satisfaction = increase TL and patient mortality = decrease High resonant leader and fractures/med errors = decrease Communication/openness and	TL decreases staff turnover, mortality HAIs and med errors, adverse outcomes, complications, healthcare utilization TL increases staff expertise and patient sat	W = Y S = Level I Q – High Limitations – 20 articles with 13 tools, only 2 mentioned.

						restraint use = decrease Consensus leadership and catheter use/pressure ulcers = decrease TL and HAIs (pneumonia and UTI) = decrease Manager support and length of stay = decrease	Relational leader increases patient sat Large Span of control decreases ability to be in contact with staff Trust decreases falls, HAPU and med errors Relational practices decreased adverse events, med errors, restraints, HAI, mortality And increases patient sat.	
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W =Worth S = Strength Q = Quality DV = Direct Variable IV = Indirect Variable

Huddle Simulation Example – Appendix C

Standardized Huddle Unit X

Huddle Elements	July 7 ,2017
1. Greetings	Good Morning/Evening Team Thought of the day: “Action without study is fatal. Study without action is futile.” – Mary Ritter Beard
2. Census	Today we have 28 patients in the unit/floor.
3. Staffing - # Call in sick - #OT - #Floaters	We have 7 RNs, 3 NAs, 1 WCT or ___ WKT. (indicate number above) We had 1 sick call We have a relief RN and she is Cathy. Staffing is GREEN
4. Patient Specifics - NO. OF ISOLATIONS - Patients on VENTILATORS - Combative patients - - # of chemo patient - Procedures	We have 2 isolations in rooms 2283 and 2284 We have watcher patients: 1 sitter patient Rooms___2273_____ We have 7 patients who are risk for Falls. Bed alarms on please.
4. Safety Messages. Changes weekly	WASH YOUR HANDS!! Hand wash missed opportunities was 9 last month (share attached graph with staff)
5. Focus of the Day (Service, communication, Safety)	<ul style="list-style-type: none"> • Please attend Mandatory Meeting on July 26, Wednesday. • Please complete by July 30th: *Mask Fit Testing • The Joint Commission is due any day now!! • 2 RNs skin check upon getting new patients • We will have a youth volunteer available to us this summer to help on the unit.
6. Celebrations	Mary Jo has just graduated and received her BSN! Rachael received peer recognition from the team for coordinating the skin rounds
7. Meals Breaks/Coverage	Please do not forget to take your breaks. Your break time must match your time card
8. Potential Discharge	We have 4 possible discharges today. We can beat our goal for Discharge Process time of less than 2 hours!
9. Admissions	We are expecting 3 admissions today
10. End with a Goal in Mind	Let’s work together and our goal is to keep our patients safe and go home on time.

-Give someone the assignment of checking the crash cart

Simulation

Graph Associated with Huddle Simulation



Example of a Simulations used for Coaching and Counseling – Appendix D



Coach/Counseling Scenario #3 – Incorrect administration of Haldol

A new grad had a highly agitated patient and had Haldol 1mg ordered for agitation. The new grad was so concerned with the patient, she drew up Haldol and gave it to the patient, then scanned the medication after it was given.

Error:

On scanning the medication after administering the drug, the new grad discovered that she gave 5mg of Haldol instead of the 1mg ordered.

Why this is important:

1. This is not the dose that was prescribed for this patient.
2. To ensure patient safety, the process to administer medications requires that the drug is scanned before administration.

Slowing down and following the steps of medication administration helps to safe-guard our patients. If the new grad was overwhelmed, other resources to assist are available including the Relief Charge Nurse, the ADA, the DA or the House Supervisor.

How you would coach/counsel this nurse?

Summary of a Simulations used for Coaching and Counseling

	Scenario
1.	Fentanyl and Midazolam Discrepancy
2.	Incorrect Administration of Dilaudid
3.	Incorrect Administration of Haldol
4.	Coordination of Care – Patient with Tracheostomy
5.	Transfer Assessment
6.	Sitter Assignment
7.	Refusal to Float
8.	Refusal to be the Relief Charge Nurse
9.	Attendance
10.	Patient Fall
11.	Catheter Associated Urinary Tract Infection
12.	Hospital Onset – Clostridium Difficile

Environment of Care Validation – Appendix E



Room Rounds and Immediate Coaching - Simulation

This simulation is to allow the ADA practice to scan a patient care room for clinical opportunities as well as identifying items that are correct. Within 5 minutes, the ADA must:

1. Scan room for items that are correct and items that need attention.
2. Provide immediate feedback to staff regarding what went well and what is not on target. This technique can be used in any patient care setting – not just inpatient.
3. Assist the nurse in moving forward with items to be attended to.
If you see something that needs to be done – “Just do it”
4. How to coach in front of family and patient and getting deadline for when it will be Completed.
“I see the dressing is due – when do you think you can this done by?”
5. Find something good, compliment, manage up nurse and thank nurse.

Simulation – 11 items:

1. “Stain” on the ceiling
2. “Urinal full” near food on bedside table
3. Central line dressing is overdue (Extra points if they ask the nurse why the patient has the line)
4. Pillow on the floor
5. IV bag has wrong patient name
6. Name of nurse is not on the whiteboard
7. Flushes left at bedside
8. An extra armband noted by the computer
9. Bed is not plugged in
10. “Pill” by the bedside
11. “PHI”

Environment of Care Competency Checklist

Room Simulation Competency



Student _____

- _____ “Stain” on the ceiling
- _____ “Urinal full” near food on bedside table
- _____ Central line dressing is overdue (Extra points if they ask the nurse why the patient has the line)
- _____ Pillow on the floor
- _____ IV bag has wrong patient name
- _____ Name of nurse is not on the whiteboard
- _____ Flushes left at bedside
- _____ An extra armband noted by the computer
- _____ Bed is not plugged in
- _____ “Pill” by the bedside
- _____ “PHI”

Mentor Guidelines – Appendix F

Guidelines for Mentoring ADAs
Summer 2017

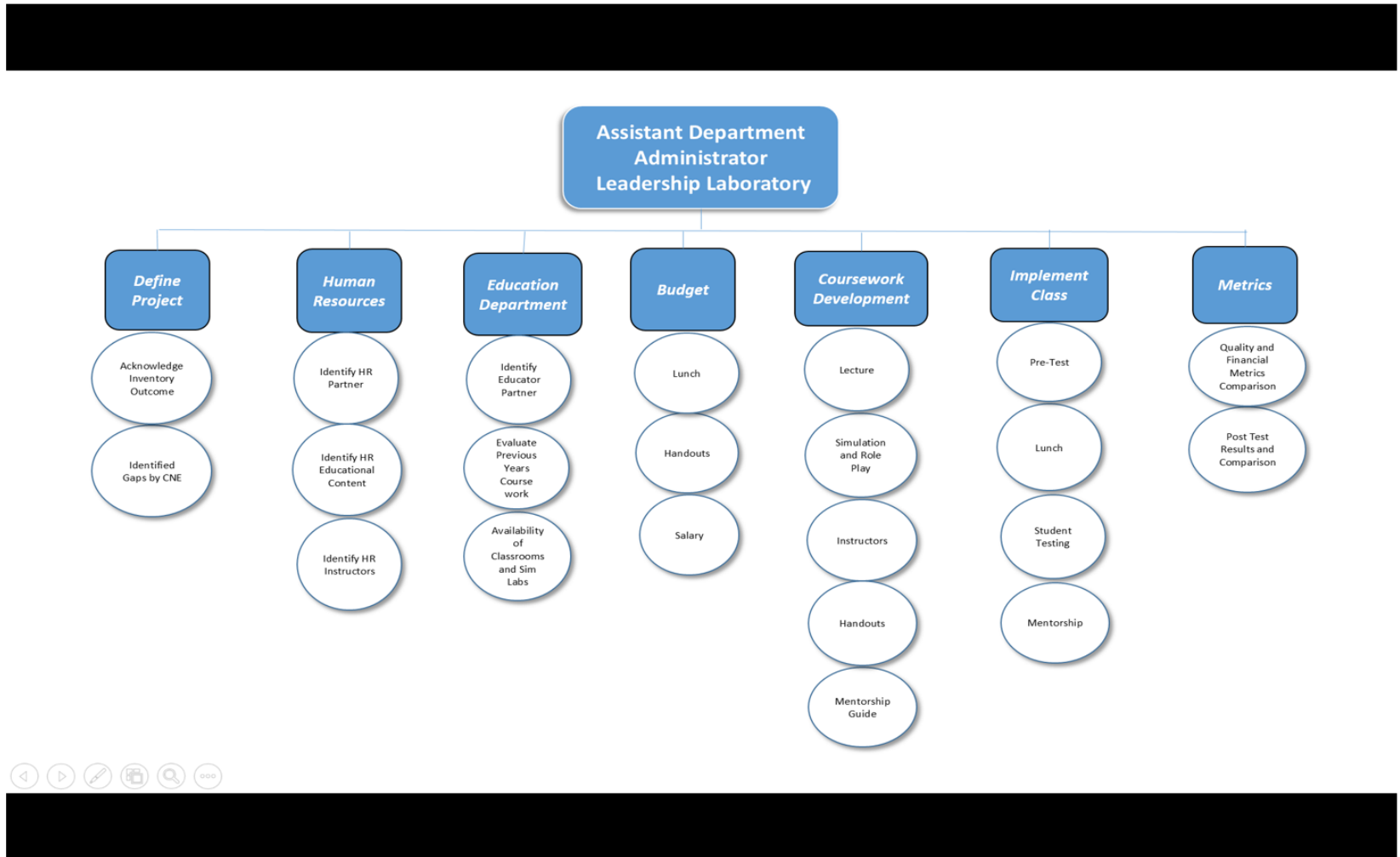
1. Mentorship is designed to discuss their day to day work and how to utilize the educational content presented to them in June 2017.
2. Mentoring is to occur every 2 weeks until the end of August. Each session should be calendared for 20 – 30 minutes. You may find that your time may run over if specific issues are brought up and need attention.
3. Provide a quiet, private place for your discussion.
4. Five specific questions should be discussed during your mentoring time together:
 1. *What were your “wins” these last 2 weeks?*
 2. *What were your “losses” these last 2 weeks?*
 3. *Did you “practice gravitas” these last 2 weeks and can you give an example?*
 4. *What did you learn about yourself?*
 5. *What else do you need to learn?*
5. Discussion of “wins” allows the student to showcase their work for the last 2 weeks. This is an opportunity to praise good work accomplished.
6. Discussion of “losses” allows the mentor/mentee team to discuss strategies for a situation should it present itself again. Providing ideas, verbiage or strategies is encouraged.
7. The practice of gravitas may take the form of how the student educated the staff, remained calm during an intense situation or how they were able to maintain leader bearing during a counseling. This question allows for discussion regarding situational issues as well as how the leader responds. The student must be prepared for each session by providing examples.
8. Self-reflection and learning about oneself is supported by the AONE Nurse Manager competencies. Encourage this activity to be incorporated throughout the ADA’s personal career.
9. Identification of future learning may be small which can be provided immediately though mentor counseling or by providing a small activity to practice during the next 2 weeks. Any large learning items should be brought to the next Mentor roundtable.
10. Please encourage your mentee to journal or take notes through the weeks so your time together is meaningful.

Assistant Department Administrator University SWOT Analysis– Appendix G

Strengths	Weaknesses
<ul style="list-style-type: none"> ●Course builds on concepts from last year ●New information presented ●Simulation with immediate feedback from senior nurse leaders ●On-going mentorship for 2 months ●Coursework material can be used the next day on the unit 	<ul style="list-style-type: none"> ●2 days with ADAs off their unit ●Need Relief Charge Nurses to cover ●Senior nurse leaders needed all day to run simulation day ●Expense of course
Opportunities	Threats
<ul style="list-style-type: none"> ●Increase leadership ability of ADAs ●Assist in preventing “pitfalls” of new leaders through knowledge sharing by senior nurse leaders ●Better preparation of organization for any surveys- quality outcomes 	<ul style="list-style-type: none"> ●Potentially unable to support program due to the financial costs ●If the program is not approved, ADAs will maintain current knowledge and ability ●Loss of knowledge from senior nurse leaders – how else to share?

Assistant Department Administrator Work Breakdown Structure – Appendix H

i



Assistant Department Administrator Gantt Chart – Appendix I

Gantt Chart - Kaiser ADA-U	March	April	May	June	July	August	September
<i>Design Program</i>							
<i>Work Breakdown Structure</i>							
<i>Gantt Chart Development</i>							
<i>Identify Education Department Partner</i>							
<i>Identify Human Resources Partner</i>							
<i>Identify Resources to support ADA-U</i>							
<i>Develop Coursework/Outlines</i>							
<i>Identify Senior Nurse Leader Support</i>							
<i>Identify Instructors</i>							
<i>Baseline Metrics</i>							
<i>Course Implementation</i>							
<i>Mentorship</i>							
<i>Post-course Metrics and Analysis</i>							

Activity
 Action Duration

Baseline Nurse Sensitive Indicator Data – Appendix J

Metric	Baseline Data 2016
Falls	160
<i>Level I/Level II</i>	157
<i>Level III/IV</i>	3
Catheter Associated Urinary Tract Infections	81
Central Line Associated Blood Stream Infections	29
Hospital Acquired Pressure Ulcers	93
<i>Stage I</i>	25
<i>Stage II</i>	68
<i>Stage III</i>	5
<i>Stage IV</i>	0

Baseline Financial Data –

Staffing Standards

Metric	Baseline Data 2016
Attendance/Sick Leave Hours	133,591
Over Time Hours	151,502

Statement of Determination – Appendix K

**DNP Statement of Non-Research Determination Form****Student Name:** Alexandra Wiggins**Title of Project:**

Development and Implementation of an Assistant Departmental Administrator (ADA) Leadership Laboratory

Brief Description of Project:

In 2016, Kaiser Los Angeles Medical Center's new CNE noted that many of the Department Administrators (DA - Nurse Managers) were struggling with their spans of control, as many of the DAs had over 65 FTE direct reports. The DAs each had non-exempt Charge Nurses, but these nurses were not inclined to assist with changing culture or staff behavior as needed. The CNE decided to change the Charge Nurse positions to a new exempt position: the Assistant Departmental Administrator (ADA). The previous Charge Nurses were offered the opportunity to apply for the new positions, but sixty percent of the original Charge Nurses were not hired into these new roles. This opportunity allowed new staff nurses to apply and to be hired as the new Assistant Department Administrators. Education for these new leaders was presented and attended in June of 2016 including role clarification, basic finance and understanding quality metrics. During this time, the facility had been without a union contract for 7 years and multiple strikes occurred, often pulling these new novice leaders back into the staff nurse position, causing difficulty for the ADAs to practice and embrace their new roles.

A new union contract has just now been signed and focus on the ADAs and attending to their leadership gaps is now a priority. This will be accomplished through the creation of a leadership laboratory.

A) Aim Statement:

The goal and aim of this project is to provide training for the Assistant Department Administrators utilizing an innovative way of teaching leadership to new nurse leaders through the use of a leadership laboratory environment, ongoing mentorship and personal one to one, progressive support and counsel, guided by identified gaps in their capabilities in a 2 day course by June 2017.

B) Description of Intervention:

Course content targeting the specific needs of the group has been identified



through a pre-assessment inventory and through the assessment of the senior nursing leadership team. Some of the identified issues include, responding to situational leadership dilemmas, the ability to using good communication while portraying a leadership presence, setting the tone on the unit and creating a safe, healthy, professional environment that supports the staff. Topics would be addressed through readings, didactic content to reinforcing concepts and the use of role-play and simulation. Ongoing mentorship will occur biweekly with a senior nursing leader to discuss wins and losses during the weeks, self-reflection regarding what the ADA has learned about themselves, whether the student felt they embodied emerging gravitas and provide examples, and to determine what gaps in knowledge has been self-identified for next step learning.

This Leadership Laboratory will divide the students into Seminars, or groups who will learn together as they move through the laboratory scenarios. Each Seminar will rotate through the various laboratory activities and engage in active learning by doing. The separate laboratory activities will include:

- Performing a beginning of shift huddle and giving direction (assignments) to staff.
- Counseling and coaching a staff member.
- Simulation of patient and staff rounding with a “staff nurse” (instructor).

Ongoing mentorship will be followed immediately after the program through senior nurse mentor/ADA mentee partnerships. Mentor sessions will occur bi-weekly for 2 months.

C) How will this intervention change practice?

Strong positive leadership creating a safe, healthy work environment through coaching and mentoring and open communication affects the stability of nursing workforce, and quality outcomes and creates open cultures to question problems, call-out issues and allows for the leader to develop a robust mentoring/collegial relationships with their staff. This can only be done by well-educated leaders.

D) Outcome measurements:

Outcomes of the program will be measured through two methods which will include (a) quality, HR and financial metrics and (b) outcomes of a pre/post-test self-assessment.

Quality metrics will reflect current work being accomplished on each unit which includes monitoring the outcomes of patient falls, hospital acquired pressure ulcers, central line associated bloodstream infections and catheter associated urinary tract infections. Human Resources metric monitoring will include turnover rates for the ADAs, and staff from each unit and Financial metrics will compare hours and dollars associated to overtime and sick leave use before the program as compared to the end of the program – post mentorship.



Additionally, to ensure that the ADA participant has gained something from the course, a pre/post questionnaire will be completed on the first day before instruction and just after the final mentoring session at the end of 2 months. The questionnaire will determine if, through self-reflection, the ADA has noted personal growth and a sense of change regarding their confidence and competence as a leader.

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/ohrp/categories/1569>

XX 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:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

Instructions: Answer YES or NO to each of the following statements:

Project Title:	YES	NO
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.	X	
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.	X	
The project is NOT 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 NOT follow a protocol that overrides clinical decision-making.	X	
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 NOT develop paradigms or untested methods or new untested standards.	X	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does NOT seek to test an intervention that is beyond current science and experience.	X	
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.	X	
The project has NO funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	X	



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., not a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	X	
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: <i>“This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board.”</i>	X	

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 files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

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

STUDENT NAME (Please print):

Signature of Student:

Alexandra R. Wiggins **DATE** 3-11-17

SUPERVISING FACULTY MEMBER (CHAIR) NAME (Please print):

Signature of Supervising Faculty Member (Chair):

Dr. Marjorie Barter **DATE** 3/15/17

Organization Approval from IRB – Appendix L

From: Andie W. Ho
Sent: Tuesday, May 23, 2017 2:55 PM
To: Alexandra R. Wiggins <Alexandra.R.Wiggins@kp.org>
Subject: Assistant Department Administrator Leadership Laboratory

Assistant Department Administrator Leadership Laboratory

Good afternoon Ms. Wiggins:

A designated reviewer on the Kaiser Permanente Southern California (KPSC) Institutional Review Board (IRB) reviewed your submission and determined that this is not human subjects research as defined by 45 CFR 46.102 (d) and (f).

If you have any questions, please do not hesitate to contact either myself, or Marcela Sanchez at (626) 405-6124 (Tie Line 8-335-6124), my number is below.

Regards,
Andie Ho

Kaiser Permanente Southern California
Institutional Review Board
393 E. Walnut St., 4/F, NW
Pasadena, CA 91188
Tel. (626) 405-5965 (Tie Line 8335)
KPSC IRB eMail Box: kpsc.irb@kp.org
Welcome to KPSC IRB website: <http://irb.kp-scalresearch.org>
IRB Applications / Forms website: <http://iris.kp-scalresearch.org>

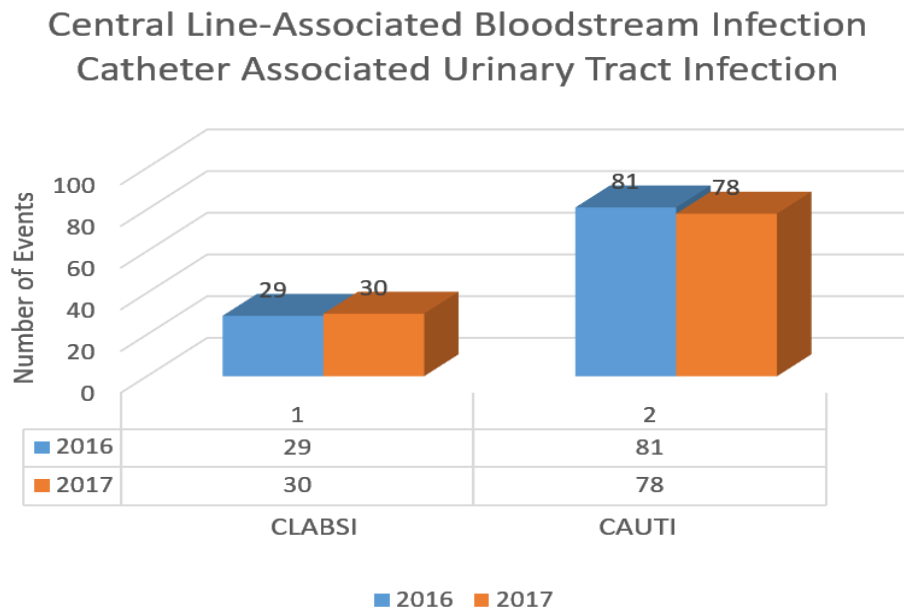
Summary Outcomes – Appendix M

Metric	Baseline Data 2016	Post Program 2017
Falls	160	151
<i>Level I/Level II</i>	<i>157</i>	<i>144</i>
<i>Level III/IV</i>	<i>3</i>	<i>7</i>
Catheter Associated Urinary Tract Infections	81	78
Central Line Associated Blood Stream Infections	29	30
Hospital Acquired Pressure Ulcers	93	79
<i>Stage I</i>	<i>25</i>	<i>12</i>
<i>Stage II</i>	<i>68</i>	<i>63</i>
<i>Stage III</i>	<i>5</i>	<i>4</i>
<i>Stage IV</i>	<i>0</i>	<i>0</i>

Metric	Baseline Data 2016	Post Program 2017
Attendance/Sick Leave Hours	133,591	132,118
Over Time Hours	151,502	140,251

Change in Outcome and Operational Cost Avoidance/Revenue Detail: Central Line Associated

Blood Stream Infections and Catheter Associated Urinary Tract Infections – Appendix N



1. **CLABSI**

2016 – 29 CLABSI

2016 total cost due to CLABSI 29 x \$34,151.00 = \$990,379.00

2017 – 30 CLABSI

2017 total cost due to CLABSI 30 x \$34,151 = \$1,024,530.00

Total additional cost \$ 34,151.00

2. **CAUTI**

2016 – 81 CAUTIs

2016 total cost due to CAUTI 81 x \$5,520.00 = \$447,120.00

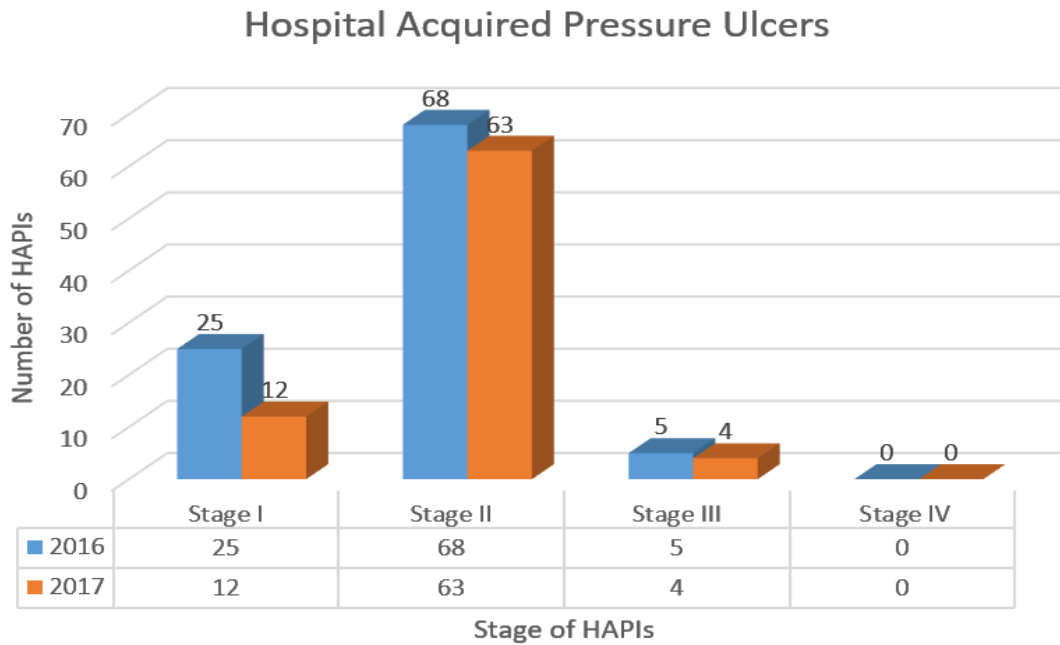
2017 -78 CAUTI

2017 total cost due to CAUTI 78 x \$5,520.00 = \$430,560.00

Total cost avoidance \$ 16,560.00

Change in Outcome and Operational Cost Avoidance/Revenue Detail: Hospital Acquired

Pressure Ulcers – Appendix O



HAPU

2016 – 98 HAPU

Stage 1 HAPU 25 x \$2,017.00 = \$ 50,425.00
 Stage 2 HAPU 68 x \$8,670.00 = \$589,560.00
 Stage 3 HAPU 5 x \$14,956.00 = \$ 74,780.00
 Stage 4 HAPU 0 x \$23,339.00 = \$0
 Total = \$714,765.00

2017 – 79 HAPU

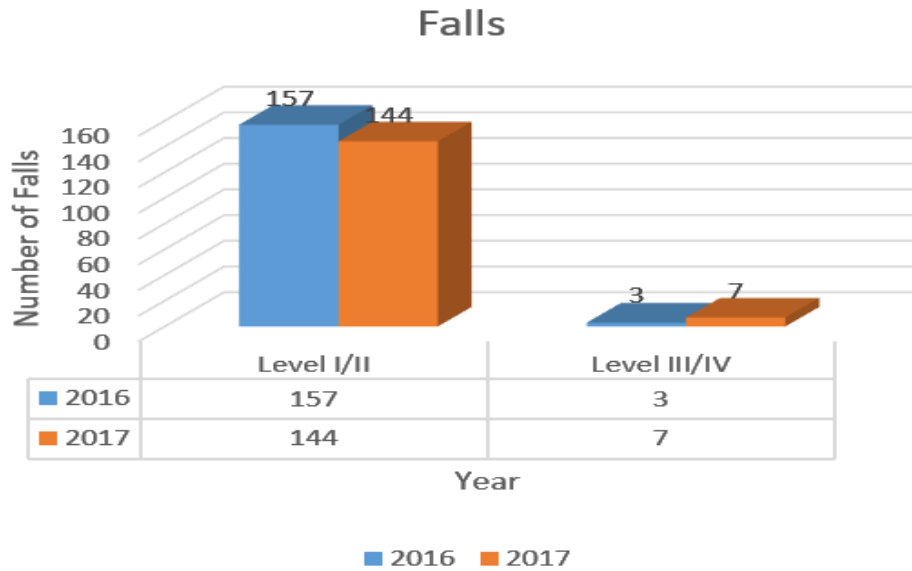
Stage 1 HAPU 12 x \$2,017.00 = \$ 24,204.00
 Stage 2 HAPU 63 x \$8,670.00 = \$546,210.00
 Stage 3 HAPU 4 x \$14,956.00 = \$ 59,824.00
 Stage 4 HAPU 0 x \$23,339.00 = \$0
 Total = \$630,238.00

Cost Avoidance

Stage 1 HAPU \$ 50,425.00 - \$ 24,204.00 = \$26,221.00
 Stage 2 HAPU \$589,560.00 - \$546,210.00 = \$43,350.00
 Stage 3 HAPU \$ 74,780.00 - \$ 59,824.00 = \$14,956.00
 Stage 4 HAPU 0

Total cost avoidance: \$714,765 - \$630,238.00 = \$84,527.00
 (2016) (2017)

Change in Outcome and Operational Cost Avoidance/Revenue Detail: Falls – Appendix P



Falls

2016 – 160 falls

Level I/II falls – 157 x \$469.00 = \$73,633.00

Level III/IV falls – 3 x \$7,090.00 = \$21,270.00

2016 total cost due to falls \$94,903.00

2017 – 151 falls

Level I/II falls – 144 x \$469.00 = \$67,536.00

Level III/IV falls – 7 x \$7,090.00 = \$49,630.00

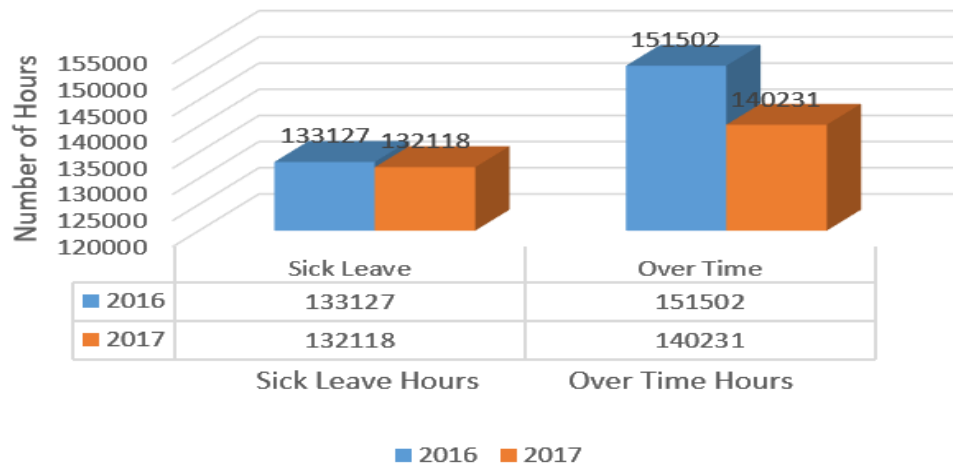
2017 total cost due to falls \$117,166.00

Total additional cost - \$22,263.00

Change in Outcome and Operational Cost Avoidance/Revenue Detail: Attendance and Overtime

Hours – Appendix Q

Sick Leave Hours
Over Time Hours



Overtime Costs

2016 Total OT hours – 151,502 hours of OT

Average Salary for all RNs is \$61.94

Average Salary for all CNAs is \$21.74

RN hours account for 55% of OT hours = 83,300 hours

RN hours 83,300 x \$62.94 = \$5,159,602.00

CNA hours account for 45% of OT hours = 68,200 hours

CNA hours 68,200 x \$21.74 = \$1,482,668.00

Total OT costs for 2016 = \$6,642,270.00

2017 Total OT hours –140,231 hours of OT

Average Salary for all RNs is \$61.94

Average Salary for all CNAs is \$21.74

RN hours account for 55% of OT hours = 77,127 hours

RN hours 77,127 x \$62.94 = \$4,777,246.00

CNA hours account for 45% of OT hours = 63,104 hours

CNA hours 63,104 x \$21.74 = \$1,371,880.00

Total OT costs for 2016 = \$6,149,126.00

Total overtime cost avoidance: \$6,642,270 - \$6,149,126.00 = \$493,144.00
(2016) (2017)

Pre/Post Self-Evaluation Survey – Appendix R

ADA University

Unit: _____

Pre and post program evaluation and reflective work.

Answer the question using the rating on a 1 - 5 scale.

- 1 – Strongly disagree.
- 2 – Disagree
- 3 – Somewhat agree
- 4 – Agree
- 5 – Strongly agree

1. I can coach and counsel my staff, with a union representative present at our meeting.

1 2 3 4 5

Reflective comment:

2. I feel competent and confident when I run the Beginning of Shift Huddle.

1 2 3 4 5

Reflective comment:

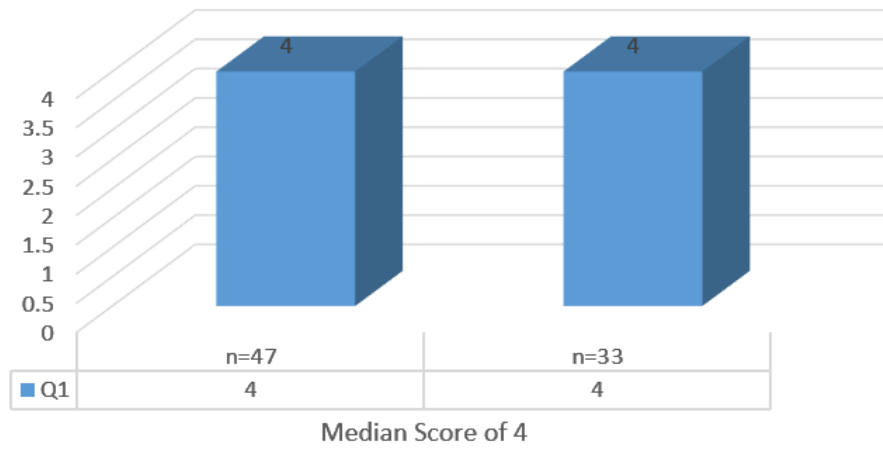
3. I can conduct a constructive coaching of my staff in a patient room in front of family and a patient.

1 2 3 4 5

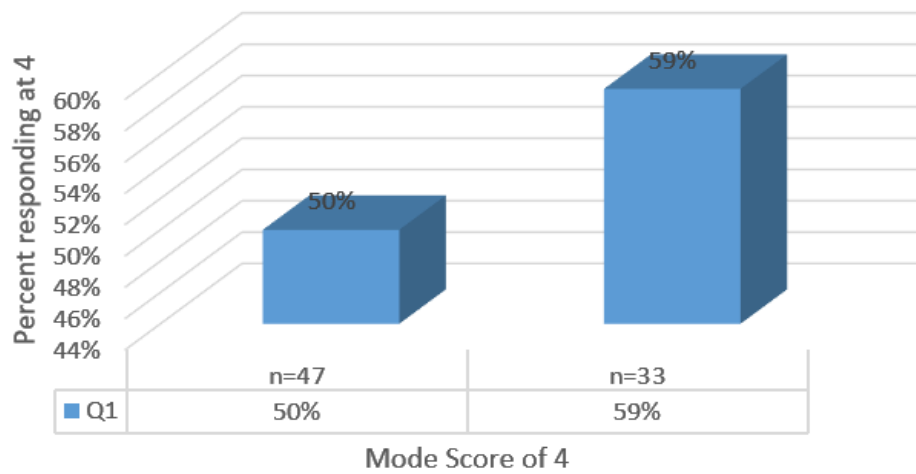
Reflective comment:

Question 1- Median and Mode Outcomes – Appendix S

Q1: I can coach my staff with a union representative at our meeting

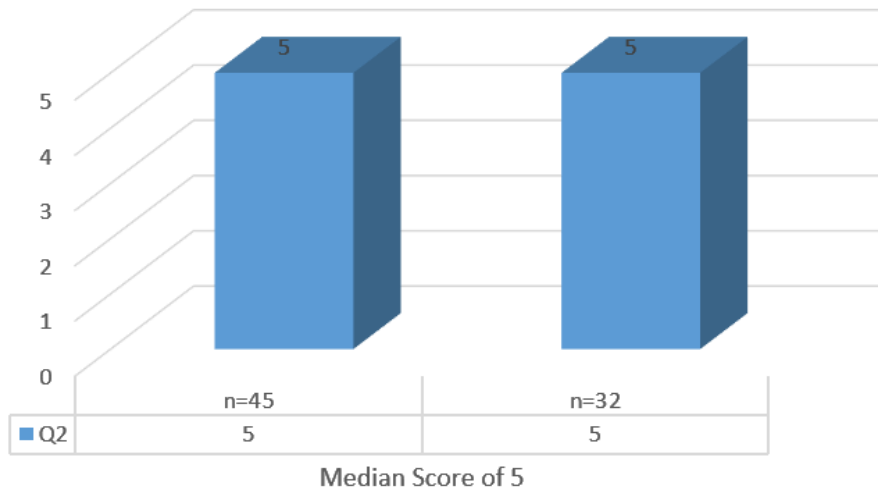


Q1: I can coach and counsel my staff with a union representative at our meeting

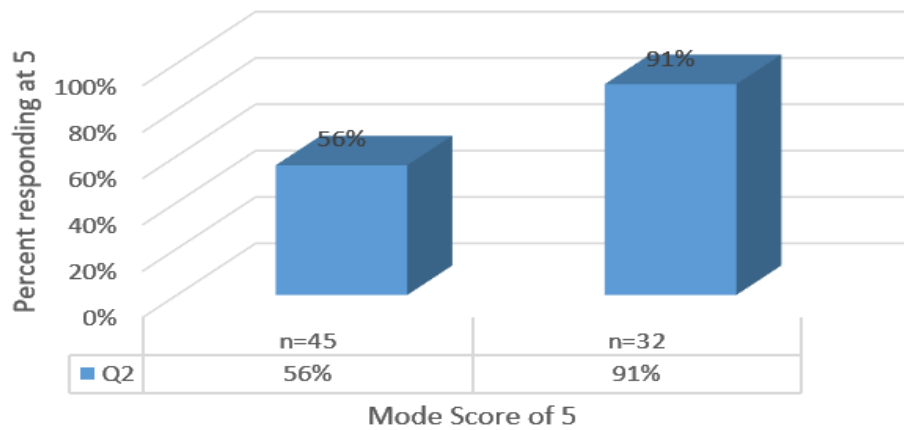


Question 2 - Median and Mode Outcomes – Appendix T

Q2: I feel confident when I run the Beginning of Shift Huddle

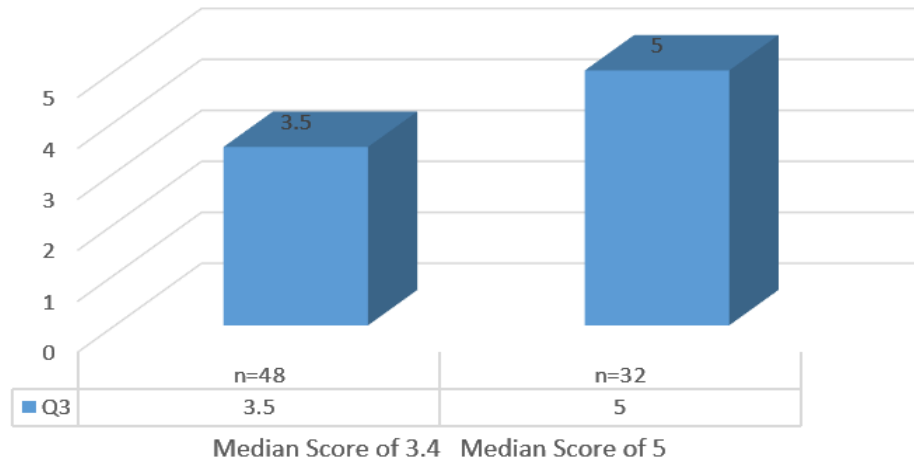


Q2: I feel competent and confident when I run the Beginning of Shift Huddle

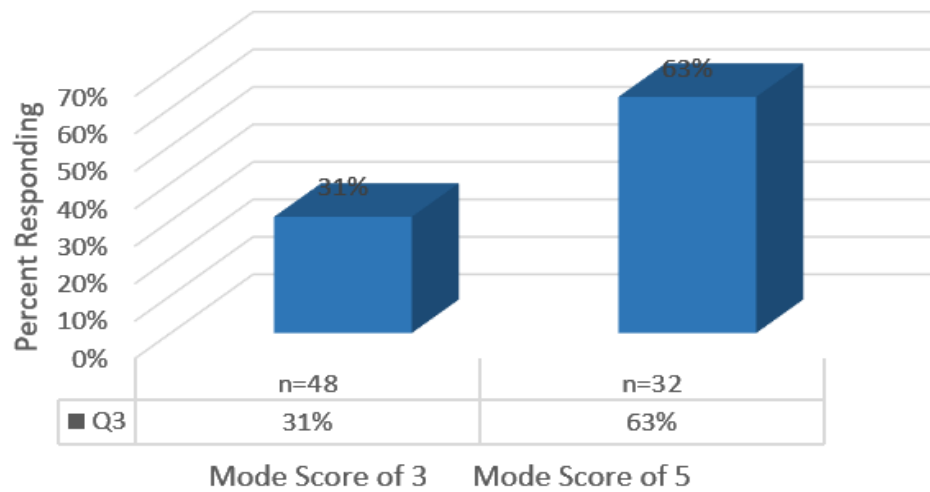


Question 3 - Median and Mode Outcomes – Appendix U

Q3: I can conduct a constructive coaching of my staff in a patient room in front of family and a patient.



Q3: I can conduct a constructive coaching of my staff in a patient room in front of family and a patient.



Operational Costs and Expense Detail – Appendix V

Salaries and Wages1. ADA Salary

Average salary for 50 ADAs: $50 \times \$63.00 = \$3,150.00$

50 ADA salary for 2 training days: $\$3,150.00 \times 16 \text{ hours} = \$50,400.00$

2. Instructor Salary

10 instructors at \$81.00 for 2 days of instruction:

$\$81.00 \times 10 = \$810.00 \times 16 \text{ hours} = \$12,960.00$ (\$13,000.00)

3. Relief Charge Nurse

Coverage for ADAs attending class-

50 Relief Charge Nurses at \$57.00/hr. for 8 hours for 2 days:

$\$57.00 \times 50 = \$2,850.00 \times 16 \text{ hours} = \$45,600.00$

4. Mentorship

Each ADA is provided 4 - 30-minute mentoring sessions by a senior nurse leader

Senior nurse leader salary \$81.00 for 30 minutes = $\$40.50 \times 50 \text{ ADAs} = \$1,620.00$

$\$1,620 \times 4 \text{ sessions each} = \$6,400 \text{ mentor costs}$

ADA salary \$63.00 for 30 minutes $\$31.50 \times 50 \text{ ADAs} = \$1,575.00$

$\$1,575.00 \times 4 \text{ session each} = \$6,300.00 \text{ mentee costs}$

Total mentorship costs $\$6,400 + \$6,300.00 = \$12,700$

Other Costs

1. Lunch for 60 people (50 ADAs and 10 instructors) for 1 day at \$10.00 a meal

$60 \times \$10.00 = \600.00

Lunch for 60 people (50 ADAs and 10 instructors) for 2 days at \$10.00 a meal

$60 \times \$10.00 = \$600.00 \times 2 \text{ days} = \$1,200.00$

Total Cost Avoidance - Appendix W

ADA University	Costs	Totals
REVENUE (Cost Avoidance)		
Cost Avoidance – see Appendix N - Q for calculation details		
Quality Cost Avoidance		\$ 44,673.00
Overtime Cost avoidance		\$493,144.00
<i>Total Revenue</i>		<i>\$537,817.00</i>
EXPENSES		
Salaries and Wages - See Appendix V calculation details		
ADA in training – 2 Days	\$50,400.00	
Instructors	\$13,000.00	
Relief Charge Nurse coverage	\$45,600.00	
Senior Nurse Leader Mentor salaries	\$ 6,400.00	
ADA Mentee salaries	\$12,700.00	
Subtotal S/W		\$128,100.00
Food – See Appendix V for calculation details	\$ 3,651.00	
Stationary and Supplies	\$ 82.00	
Subtotal Other		\$ 3,733.00
<i>Total Expenses</i>		<i>\$131,833.00</i>
	REVENUE	\$537,817.00
	EXPENSES	\$131,833.00
TOTAL COST AVOIDANCE		\$405,984.00