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Creating a Healthy Work Environment Using Communication and Recognition

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Abstract

Working in a healthy environment is of interest to nurses at every level of employment. Whether a frontline nurse or a nurse executive, it just feels better to wake up each morning and go to work in a place that respects clear communication and recognizes the great work that is being done. Working in such an environment is engaging and encourages employees to thrive (Shirey, 2006). Teamwork, camaraderie, and work satisfaction will increase in a healthy environment (Hall, Doran, & Pink, 2008). Thus, nurse leaders' imperative is to meet the obligation of creating a healthy work environment (HWE) for the safety of employees and patients (Stichler, 2009). This can be accomplished by a robust and formal strategic plan which includes elements of communication and recognition (American Association of Critical-Care Nurses [AACN], 2005). From this, collaboration, shared governance, meaningful recognition, effective decision-making, and a culture of accountability will lead the charge for an HWE (AACN, 2005; American Organization of Nurse Executives [AONE], 2005). Theories of complexity and transformational leadership were used as a guiding framework for this evidence-based practice change. Tools were created, implemented, and evaluated, using these theories to measure perceptions of frontline nurses regarding the ability of their nurse leader to keep them updated with news and information as well as recognizing them for doing a good job. Results demonstrated that being consistent with communication and recognition had a positive response.

Keywords*: healthy work environment, communication, retention, nurse satisfaction*

Section II. Introduction

Working in a healthy environment is of interest to nurses at every level of employment. Whether a frontline nurse or a nurse executive, it just feels better to wake up each morning and go to work in a place that respects clear communication and recognizes the great work that is being done there. A healthy work environment (HWE) is defined as "a work setting in which policies, procedures and systems are designed so that employees are able to meet organizational objectives and achieve personal satisfaction in their work" (Disch, 2002, p. 3). There is a need to create an HWE for nurses to thrive as they provide healthcare to patients in the acute care setting (Greco, Laschinger, & Wong, 2006).

Being employed in an HWE produces a win-win situation for both the employee and the employer. HWEs make employees want to work, want to produce the best work product possible, and want to retain employment with their current employer (Vogelgesang, Leroy, & Avolio, 2013). One primary benefit of this environment is better collaboration among frontline nurses, which gives nurses perceived autonomy to feel empowered and implement best practices. Another positive benefit is improvement in identified quality metrics such as decreasing length of stay, decreasing the prevalence of pressure ulcers, and decreasing mortality rates (Boyle, 2004; Institute of Medicine [IOM], 2000). In terms of interactive engagement, organizational benefits of an HWE include increased teamwork, increased camaraderie, increased work satisfaction, increased levels of trust, and effective communication (Hall, Doran, & Pink, 2008; Shirey, 2006). When these organizational opportunities are achieved, the end-result will be better patient outcomes (American Association of Critical-Care Nurses [AACN], 2005; Shirey, 2006). Two components that drive this type of environment are effective communication and meaningful recognition plans (AACN, 2005).

Communication

As an organization intentionally creates an HWE, it is imperative for the organization to realize the powerful relevance of communication and the foundational influence it has on the health of the work environment. Communication and collaboration are key for an effective environment (Shirey, 2006). Employees have expressed that when they work in environments where their leaders are transparent in communication, they tend to be more productive with their time at work (Vogelgesang et al., 2013). Vogelgesang et al. added, even if information is not in favor of employees, because the employer exhibits a high level of transparency and trust, employees will continue to effectively produce the expected work. Hence, when an HWE does not exist and ineffective communication and the absence of teamwork prevail, the organization is destined to have less than acceptable patient outcomes (Hartung & Miller, 2013).

Recognition

One of the standards in the bundle for an HWE from the AACN and the AONE is Meaningful Recognition (AACN, 2005; AONE, 2005). This standard is foundational when creating an HWE because recognition gives feedback and acknowledgement to employees (Macauley, 2015). It makes them feel valued, gives them an internal and external perception of self-worth, and makes them believe the work they produce contributes to fulfillment of the organization's mission (AACN, 2005; AONE, 2005; Macauley, 2015).

Meaningful recognition is a powerful tool for nurse leaders that can help establish a positive organizational culture (Stichler, 2009) and is a major catalyst for generating high levels of engagement (Macauley, 2015). It is important to understand however, that to reach high levels of engagement using this meaningful recognition strategy, "is a process, and not an event" (AACN, 2005, p. 193). The expectation is that this process continues through the support of an

organization's formal strategic recognition structure and comprehensive plan so that it is sustainable (AACN, 2005).

A culture enhanced with clear communication cultivates an environment of trust with engaged employees (Schwartz & Bolton, 2012). Attention must be paid to this very important element as clinical units strive for excellence because any insufficiencies in this area are often perceived by nurses as disrespectful (Ulrich et al., 2006).

Authentic leadership is a leadership characteristic that has surfaced as part of the HWE conversation. Definitions for an authentic leader focus on characteristics of the individual. This leader is one who is genuine, compassionate, and truly caring (Shirey, 2006). Authentic leaders have high levels of emotional intelligence, are able to establish and maintain valuable relationships, and are easily trusted (Shirey, 2006). For leaders to be authentic, they must lead from the heart, be a principled champion, and they must truly believe in achieving the HWE model (AACN, 2005; Blake, 2015; Shirey, 2006). It is this level of authentic leadership engagement that will drive evidence-based strategies to make a difference to the nurses.

Research conducted by Simons, Tomlinson, and Leroy (2011), which focused on the concept of behavioral integrity, indicates that when team members believed their leader was being transparent, genuine, and followed through on what was said, the leader would be held in high regard. A nurse leader who understands this has the ability to inspire and embed characteristics of a desired work environment in a clinical unit (Johansson, Miller, & Hamrin, 2014).

Nurse leaders have a leadership imperative and responsibility to keep patients and nurses safe (Schwartz & Bolton, 2012). Governing bodies, professional nursing organizations, and subject matter experts have created laws, policies, guidelines, and specific tools to support this imperative and provide direction to facilitate this process.

Problem Description

The acute care work environment is a setting where all matters involving healthcare may take place. The *environment* as noted by Kramer, Maguire, and Brewer (2011) is defined as "the aggregate of conditions, influences, forces and cultural values that influence or modify an individual's life and work in a community" (p.6). Thus, the acute care work environment is the communal medium for the delivery of care (personal and professional), building of friendships, engagement of educational opportunities, the space for career growth, and eventual retirement. This same medium unfortunately, is also the setting where harm may occur (Page, 2004). Thus, understanding how to create a work environment that is healthy and how to establish a program that will maintain thriving employees can influence better patient outcomes (Schwartz & Bolton, 2012).

A primary way to impact an environment is to understand its culture (Stichler, 2009). Culture can be expressed as the characteristics within the fabric of an environment. It is "characterized by the specific beliefs and values that guide all behavior and actions within the organization" (p. 342) and is a direct reflection of the engagement and leadership style of the nurse leader (Stichler, 2009).

The level of engagement from nurse leaders influences the culture in the environment by their own fundamental standards and ethics, leadership styles, and what they allow or do not allow to occur on the unit (Doody & Doody, 2012; Stichler, 2009). As the responsible person for establishing and maintaining an HWE, a nurse leader needs to engage with employees to understand the status of the environment's health and respond to create the desired outcome (Blake, 2015).

The Setting.

The setting for this project was in a northern California acute care medical center with 144-beds, which provides a conglomerate of specialty care services within its diverse environment. For the purposes of this document, the organization will be identified as the Facility. In the 1980s, the Facility had an average daily census in the 400s and for decades was a bustling city hospital with two specialty Intensive Care Units (ICU). The units within this hospital included a surgical ICU, a medical ICU, a telemetry, oncology, general medical surgical, labor and delivery, skilled nursing facility, rehabilitation, adolescent behavioral health, adult behavioral health, and emergency departments (Anonymous, personal communication, March 2018). Currently the Facility has an average daily census of 72 including one general ICU with the provision of cardiovascular surgery specialty, one telemetry unit with ability to provide post percutaneous coronary intervention, one medical surgical unit with provision of an oncology and orthopedic joint specialty, a rehabilitation unit, an adolescent behavioral unit, and an emergency department.

Due to several periods of governance mergers, restructuring of programs, departments, leadership structures, and high turnover of nurse leaders, the Facility is now considerably smaller. In the past thirty-three years, this acute care facility has been governed/owned by three different organizations and is currently in the process of merging yet again (Anderson, 2017; Grassilli, 2006).

As the dynamics of regulatory quality expectations and financial contingencies in healthcare within the United States (U.S.) changed, so did the demands for a re-analysis of programs, property, and personnel at the Facility. The organization, like

many others, was faced with the need to right-size their assets and community collaborations, which caused their grandeur and environmental work culture to change. These changes created large gaps in communication and recognition between the nursing staff and nursing leadership. Communication and recognition either did not occur, occurred rapidly therefore not reaching all employees, or occurred but at times was ineffective. In part, due to these gaps, the level of trust within the organization declined as evidenced by trends in staff satisfaction surveys and in particular, the results of the May 2016 annual employee experience survey. The Facility's 2016 cumulative leadership engagement score was 3.57. This was 7.5% below the average for the Bay Area Facility service area which was 3.86 (Dignity Health, 2016). The Facility's May 2017 cumulative leadership engagement score, although reaching the organization's 2016 average of 3.57, was still 8.9% below the average for the Bay Area Facility service area. Due to the corporate expectation of annual improvement, the new cumulative engagement score was 3.92 (Dignity Health, 2016).

Through their research outcomes, Byrne, Hayes, and Holcombe (2017) expressed the necessity to understand how employees feel about work specifics by using employee experience surveys. There is great value in being able to use stratification methods to categorize themes of thought, so leaders can intervene and reduce the negative impact in various areas of concern. Understanding the value of employee feedback and the necessity of aligning leadership commitment to improve employee perceptions and feedback results, the Facility annually assesses employee satisfaction levels utilizing a third-party engagement survey. Upon receipt of survey results, nurse leaders complete a thorough review of each question and response with its description, then develops an action plan to improve employee perception in the areas of concern.

In the Facility's annual employee experience survey, there were two key metrics regarding communication and employee recognition identified by the AONE to have influence on creating and maintaining an HWE (AONE, 2005). The first key metric on the survey supporting the communication principle was "*The person I report to makes sure that I am well informed about news and changes"* (Dignity Health, 2017). The second key metric on the survey supporting the meaningful recognition principle was *"The person I report to provides recognition for employees who do a good job"* (AONE, 2005; Dignity Health, 2017). Responses from the overall May 2017 employee experience survey's communication metric scored 3.5% below and the recognition metric scored 10.7% below the Facility service area's acceptable score value (Dignity, 2017).

The significance of this problem at the Facility was that many of the employees did not appear to feel valued; some did not feel like their input mattered; some were unsure of how to carry out implementation of new processes; and some were unaware of initiatives that were in the process of being rolled out. Trying to internally manage these feelings and low-level awareness of expectations caused a majority of the nurses to have low morale, be disengaged, and have a lack of trust in their nursing leadership (Anonymous Nurses 1-11, personal communication, January 6-18, 2017).

In this practice change project, the goal was to improve frontline nurses' perception of receiving news and updated information and performance recognition from nursing leadership by 30% before November 30, 2017. The evaluation of project performance was measured six months after the baseline annual employee experience survey that was given in May 2017. The Chief Nurse Executive's (CNE) approval was received for this practice change project (Appendix A).

The nursing departments that were initially committed to participate in this practice change project were the ICU, telemetry, medical surgical, rehabilitation, and the emergency departments. Secondary to a change in the nursing leadership structure right before the go-live, participating units in this practice change project were limited to the telemetry, medical surgical, and rehabilitation departments. It was determined by the corporate office that a small facility did not need three nursing directors to run efficiently. As adjustments were made, the ICU, dialysis, respiratory, and emergency departments temporarily reported directly to the CNE, while the telemetry, medical surgical, and rehabilitation departments reported to the nurse director that worked directly with the Doctor in Nursing Practice student.

Context

Due to the less than optimal May 2016 employee engagement scores, the new leadership team started placing patient and employee experiences on the same level of importance. Terri Johnson, Director of Patient Care Services (DOPCS), said she took the results of the annual employee experience survey very seriously and truly desired to implement a formal healthy workplace program strategy to let nurses know that they are important (personal communication, November 2016). Kathleen Kuntz, CNE, said the nurses who work at the Facility are very caring and she believes in their ability to be engaged with this program because it will make a difference for them and for the patients (personal communication, December 2016).

Prior to implementation of this practice change project, nurses did not feel like their previous nurse leader was keeping them informed with news and updated information, and they did not feel like they received recognition for the good jobs that they did (Dignity Health, 2017). In addition, among nurses there seemed to be a lack of trust in their nurse leaders as evidenced by the feeling that either communication did not occur, occurred rapidly and did not reach all

employees, or occurred but at times was ineffective. They also felt that either recognition did not occur, occurred but only with certain nurses, and/or occurred but may not have caught the attention of the nurse (Anonymous Nurses 1-11, personal communication, January 6-18, 2017). This sense of lack in trust was evidenced through the results of the 2016 annual employee experience assessment, which showed responses for management's communication decreased by 14.2% from the year prior along with responses for management's acknowledgement through recognition, which decreased by 10.2% from the prior year. Based on these results, the need for implementation of a healthy workplace program was a necessity for aligning the perceptions of nurse leader engagement with clear, transparent communication and meaningful recognition for their staff.

Stakeholders.

For this change to successfully be implemented, it was important to identify key stakeholders and to understand the need for change from their perspectives. It was also important to brainstorm with those closest to the project, and to gain their buy-in and assistance with roll-out plans.

For this project, stakeholders who were invested in creating an HWE were frontline registered nurses, charge nurses, the manager of the nursing units, DOPCS, CNE, and the project manager. The DNP student served as the project manager. Each stakeholder identified had a specific role in the achievement of a positive change in the environment. The CNE was there to primarily support the initiative, provide the resources necessary to see this change come to fruition, and to identify the boundaries and limitations of the project. The role of the DOPCS was to support the initiative, remove any barriers, and identify what could feasibly be implemented to meet the goals of this project while staying within the allotted budget. The role of the nurse

manager was to brainstorm with the team, be hands on with accountability and assist the initiative to move forward. The role of the charge nurses and clinical ladder candidates was to educate the staff and be accountable for feedback to the nurse leaders and project manager. The role of the staff nurses was to be engaged, participate, and provide feedback on the process. The role of the project manager was to keep everyone informed and motivated; be accountable to bring people together for meetings; maintain the timeline so that milestone achievements were attained; stay within the allotted budget; and keep progress notes on all processes. See Appendix B for Responsibility Matrix.

Specific aims.

The specific aim for this evidence-based change of practice project was to develop, implement, and evaluate a healthy workplace program by November 30, 2017 that had the objective of a 30% increase in the perception of nurse leader engagement scores related to communication and meaningful recognition on the December 2017 post intervention evaluation.

The activities to support this aim included:

- Develop, implement, and evaluate weekly communication through huddles
- Develop, implement, and evaluate a weekly visual nurse request progress board
- Develop, implement, and evaluate quarterly nurse collaboration forums
- Develop, implement, and evaluate daily recognition through leader rounding
- Develop, implement, and evaluate a monthly recognition program

The goal of a 30% increase was evaluated six months post implementation through a semi-annual employee experience survey, which was then compared to the May 2017 formal annual employee experience survey results.

Rationale

Theoretical frameworks.

To provide structure to this leadership engagement practice change project, two theoretical frameworks were needed to establish cause, provide a rationale, and guide for action; these were complexity and transformational leadership theories.

Complexity theory.

Complexity theory asserts that in a complex system, all moving parts are influenced by the changes that occur within other parts of the same system (Dodds, 2013). No part can make a change without affecting other parts in the environment, and whether strategically planned or not, each part responds to the external change and will eventually adapt in some way to that change (Dodds, 2013).

This theory directed the literature review for the communication portion of this practice change project. Departments in an acute care facility do not function independently of each other. Nurses for example, are customers of pharmacy, laboratory, supply chain, and the infection control department. This means as changes occur in these departments, nurses who are providing care to patients need to be aware of all news and updated information that will impact the care they provide. Examples are the need for nurses to be notified from pharmacy regarding a national shortage on medications, or the need for nurses and environmental services to be notified regarding hand washing product conversions.

Complexity theory was chosen for use because of its relevance to communication regarding the way individual parts affect the whole. The goals of the communication portion of this project was to address the need to keep nurses updated with news and information so that they could be aware of changes and do their work appropriately.

Transformational leadership theory.

Transformational leadership theory provides strategic methods for leaders to motivate their team to achieve maximum potential and gain their greatest outcomes (Burns, 1978). Transformational leadership embraces elements of mentorship support that encourage the mentee with self-development and career growth (Bally, 2007). This leadership theory empowers the team by creating alignment with the employee's individual motivational goals to the strategic objectives of the organization while achieving learning and growth development goals for the leader. Furthermore, achieving this alignment may not only lead to surpassing employee expectations, but it may increase employee satisfaction and their allegiance to the organization (Doody & Doody, 2012).

In addition, inspirational motivation is one of the seven factors in this leadership theory that uses methods of meaningful recognition and communication to encourage employees to utilize their full potential and maximize their ability to reach their personal goals (Doody & Doody, 2012). This theory was chosen to support the recognition portion outlined in this practice change project because it motivates, encourages, develops, and empowers. This gives hope to employees when supporting an HWE.

Review of Evidence

Population, intervention, comparison, outcome, timeframe (PICOT) question.

A PICOT question was formulated to create a framework of guidance for the literature review and critical appraisal of available knowledge. The PICOT question for this practice change project was: With a group of nurse leaders in the acute care setting *(P),* would implementation of a strategic evidence-based leadership healthy workplace program involving clear, transparent communication and meaningful recognition *(I)* compared to the current

practice of no formal healthy workplace program *(C)* increase rates of frontline registered nurse perceptions of being well informed and recognized in their work environment *(O)* in six months *(T)*?

Search strategy.

A search of the literature was completed July 2016 through April 2018 using the key words/phrases: *healthy work environment* and *nurs*, creating a healthy workplace* and *nurs*, authentic leadership* and *nurs** in CINAHL, PubMed, and Scopus databases. This search yielded a total of 529 articles. In addition, key words/phrases: *creating a healthy work environment, creating a healthy work environment and nurs** in the ABI/INFORM database yielded a total of 257 articles. The inclusion criteria were based on quantitative and qualitative studies published within the timeframe of 2000 – 2018 with the exception of an original work in 1978. The articles had to be relevant to the inpatient acute care hospital setting, relevant to nurse leaders with their direct employees, and the original study had to be published in the English language. Exclusion criteria comprised of articles that did not focus on inpatient acute care hospitals in the U.S. and Canada. A total of 176 articles/books were reviewed and 39 were referenced in this document.

Appraisal tools.

The Johns Hopkins Research and Non-Research Evidence Appraisal Tools were used to critically appraise articles (Dearholt & Dang, 2012). Eleven articles were chosen for review. Six of these were appraised as Research Level IIIA because they were high quality quantitative studies; four were appraised as Non-Research Level IVA because they were high quality qualitative studies. One article was appraised as a Research Level IIIB because though the research had quality characteristics, the sample size was not sufficient. See Appendix C for the Evaluation Table for article level ratings.

Relevant studies.

Research from the Institute of Medicine.

At the request of the Agency for Healthcare Research and Quality, the IOM embraced the charge to investigate and establish strategies that will increase the quality of care in the nation (IOM, 2000). Researchers analyzed which vital elements in the nursing work environment affected patient safety and which vital elements identified prospective improvements to positively affect patient safety outcomes (Page, 2004). In 2003 the public was informed that a pioneering connection was made between improving the professional work environment and decreasing the probability of having medical errors and serious negative outcomes (Page, 2004). The topic of creating an HWE then catapulted to the forefront of healthcare conversation as these findings were published.

The conclusion of IOM's research included four perils that emphasized patient safety (IOM, 2000; Page, 2004). They were management practices, workforce capability, work processes, and organizational culture. When presented, all four of these perils had improvement recommendations deeply rooted in respectful and collaborative communication associated in the design to improve patient safety (IOM, 2000; Page, 2004). As IOM's published results identified the connection between work environment improvements with patient outcome improvements, they also cited that once the culture of an environment is reconditioned, outcomes will be aligned with those of an HWE (IOM, 2000; Page, 2004).

Studies by Kramer et al.

Study 1.

Kramer, Schmalenberg, and Maguire (2010) conducted a meta-analysis to understand organizational qualities necessary to cultivate an HWE. Two sources were used to complete the

analysis. One set of information was obtained from 12 publications written by seven professional agencies who support creating an HWE. The other set of information was cited from 18 publications by more than 1,300 nurses, managers, and physicians who at the time of the interview were working in a perceived HWE.

To quantify a clinical unit's healthiness, Kramer et al. (2010) used the Essentials of Magnetism instrument. From the study, researchers were able to identify themes from professional agencies and the expert meta-analysis. Kramer et al. (2010) found significant consensus between the two sources of information and were able to establish nine recommendations for the development of an HWE. To note, two of the nine recommendations were worthy to demonstrate the importance of collaboration, which entails respectful communication.

For the development of an HWE, the nine recommendations from Kramer et al. (2010) are to establish: quality leaders within the health system, promotion of educational advancement, respected levels of nurse autonomy, evidence-based practice, positive interdisciplinary educationally focused collaboration, shared-governance, a patient-centered focus, and an adequate staffing acuity pool. The authors also stated that fostering the aforementioned nine recommendations in a nursing environment will create the needed relationships with nurse employees to provide the delivery of high quality and safe patient care to receive the desired positive patient outcomes.

Study 2.

In another review of magnetic environments, Kramer et al. (2011) completed a descriptive study using the work environment of 34 Magnet® designated hospitals in determining the degree to which nurses in high functioning facilities believed that the

environment in which they worked was healthy. The participant sample came from 34 acute care Magnet® designated facilities and included 12,233 nurses with greater than one-year nursing experience from 717 nursing units. The unit's level of healthiness was quantified by a four-point Likert tool called *The Essentials of Magnetism II* instrument.

The results from the study by Kramer et al. (2011) specified the health level score, which was indicated as either "healthy", "very healthy", or "a work environment needing improvement". The researchers found that 54% of 540 clinical units were rated as a very healthy work environment, 28% as a healthy work environment, and 18% as work environments needing improvement. The number of clinical units unable to meet participation requirements of a 40% response rate was 177 and these units were excluded from the study.

The qualitative outcomes from this study support the imperative for a thriving relationship between the nursing staff and nursing leadership. In addition, there was strong indication that all clinical nursing units, non-dependent on geographical positioning in this country, size of the facility, or the specifics of clinical specialty, require engagement of the nurse leader in a collaborative environment that exhibits visionary promise through leadership, communication, and support (Kramer et al., 2011).

Study by Garon.

Garon (2012) conducted a study using 33 front-line and managerial registered nurses in southern California to research the perception of nurses' aptitude for communicating concerns to their nurse leader. The nurses who participated in this study had to either be a frontline employee or a nurse manager, be in their position for at least one year, and had to either be employed by the participating hospital or part of the participating large southern California university. This descriptive qualitative study collected data through seven 45-60-minute focus group interviews

that were conducted separately with either staff nurses or nurse managers, but not both staff nurses and nurse managers in the same group. Data received were evaluated based on categories with similar characteristics (Garon, 2012).

In this study, the nurses were enthusiastic about their ability to participate and share their thoughts and experiences (Garon, 2012). The results expressed that the comfort of a nurse to escalate a concern by communicating with their nurse leader was influenced by several matters in addition to the environment in which they worked. These additional matters included the way in which the nurses were raised by their family ethics, their educational levels, and their current personal living arrangements/conditions. The outcomes of this study however, also included the strong finding that a nurse leader's clear, transparent communication was a very important key factor in the contribution to sustainability of productive and constructive communication (Garon, 2012). The study continued to suggest that visibility of nurse leaders, their leadership style, and open-door policy for communication is what creates a healthy environment for their nursing staff to thrive.

Study by Huddleston, Mancini, and Gray

Huddleston, Mancini, and Gray (2017) developed a tool called the HWE Scale secondary to the national call of action for creating a healthy work environment. The authors conducted a non-experimental descriptive design used to appraise elements of the HWE Scale for direct care nurses and nurse leaders, and to study the views of nurse leaders and direct care nurses relating to HWEs. This study had a total of 1,300 participants; 314 were nurse leaders and 986 were direct care nurses. There were two phases of this study that tested validity and reliability of the tool. Conclusions proved significance with psychometric character that can accurately assess HWEs in hospitals and medical centers (Huddleston, Mancini, & Gray, 2017).

Studies by professional nursing organizations.

In support of IOM's research findings and concerns raised by registered nurses, the AACN developed a model with six essential standards for creating an HWE. These standards are skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition, and authentic leadership (AACN, 2005). Each standard is essential to the model because evidence has shown that if one of the standards is not implemented, the process will not work. The elements are not discretionary for use and are in alignment with the recommendations of the IOM's 2003 report (AACN, 2005).

American Association of Critical-Care Nurses' six essential standards.

According to the AACN (2005), medical errors occur too frequently and with too much intensity of harm in the hospitals of the U.S. Secondary to concerns raised by acute care and critical care nurses that paralleled the concerns of the IOM, the AACN has been an advocate for specific values supporting interdisciplinary partnership and engaging leadership. This has been critical in developing HWEs (AACN, 2005). Nurse leaders influence patient outcomes by the environment that they create and affect the culture of the environment by their beliefs, values, and leadership styles (Doody & Doody, 2012; Stichler, 2009). Therefore, understanding the six essential standards involved with creating an HWE while understanding leadership impact will bring about meaningful change.

In greater detail, the six standards are identified as follows:

- Skilled Communication: nurses are expected to know how to communicate effectively on behalf of their patients.
- True Collaboration: quality patient care is truly meant to occur with an interdisciplinary team having an equal say with patient interventions.

- Effective Decision Making: nurses' input need to be respected and they must have the ability to participate in a collaborative such as a shared-governance.
- Appropriate Staffing: a staffing strategy must be in place for patient acuity needs to be met with appropriate skill mix, staff competence, and the proper number of staff members for those patients.
- Meaningful Recognition: a positive recognition plan should exist on the unit so that nurses can receive periodic acknowledgement for work done well as a motivator to continue to do a great job.
- Authentic Leadership: nurse leaders need to truly be sincere and believe in the work that is being done; this is considered the linking entity for all of the standards (AACN, 2005).

As with IOM's research findings, these six standards are relationship based and have the elements of respectful communication, collaboration, and meaningful recognition embedded in its design for an environment's improvement. AACN's (2005) "Call to Action" (p. 194) is an urgent call to implement these standards in the work environment and strategically employ them to its highest degree of capability in the most creative and beneficial way possible.

American Organization of Nurse Executives' guiding principles and elements of a healthy work environment.

In understanding the relation between the nurse leader and the levels of health in the clinical environment, AONE has acknowledged the tremendous efforts and challenges faced to create and maintain an HWE (AONE, 2017; Schwartz & Bolton, 2012). This is evidenced by the blueprint found in AONE's *Guiding Principles* which are evidence-based tools available to provide direction for nurse leaders to be successful (AONE, 2017).

The guiding principles provide supportive decision-making building blocks of evidence-based strategies for issues concerning nurse leaders in this modern time. The principles and elements include the following:

- Collaborative Practice Culture: establishes a positive and collaborative environment of respect and diversity.
- Communication-Rich Culture**:** establishes an environment that supports concise and courteous communication.
- Culture of Accountability: establishes an environment that everyone understands their professional expectations and are responsible for their output.
- Presence of Adequate Numbers of Qualified Nurses: establishes enough employees on roster to support staffing for each shift and employee requests for time off.
- Presence of Expert, Competent, Credible, and Visible Leadership: establishes that the nurse leader is a promoter of nursing practice, provides necessary resources for employees to deliver high quality and safe patient care, and engages with shared governance.
- Shared Decision Making at All Levels: establishes that there is a formal structure for shared governance.
- Encouragement of Professional Practice and Continued Growth and Development: establishes that the nurse leader supports and promotes educational enhancement and opportunities.
- Recognition of the Value of Nursing's Contribution: establishes that there are programs of reward and recognition for nursing's contribution to care and supports opportunity for promotion.

- Recognition of Nurses for Their Meaningful Contribution to Practice: establishes that there is recognition for nurses' input to support nursing practice (AONE, 2005; Schwartz & Bolton, 2012).

Each of these principles can be a catalyst for starting a dialogue to plan for a healthy environment that supports the tangible work of management, as well as the soft side of nursing leadership (AONE, 2005; Schwartz & Bolton, 2012).

The great impact in the investment of time and energy into the implementation of AONE's principles and elements, particularly the ones that address communication and recognition will cause positive changes in the work environment. Appealing to frontline nurses for participation in a shared governance model while engaging them in a communication-rich culture for example, is a supported AONE principle and an AACN standard that can be used to create an HWE and motivate nurses to want to participate and be developed as a leader (Schwartz & Bolton, 2012).

In addition to the five principles and elements that are interrelated with communication and recognition, when the other four AONE principles and elements are implemented, they have the potential for being a mechanism to allow the dynamics of an HWE to prevail. When organizations have communication-rich dialogue with employees and acknowledge their value with collaborative input, it will start to create a healing environment that not only caters to the patients, but employees as well (AONE, 2005; Schwartz & Bolton, 2012; Shirey, 2006).

The presented theme from AACN, AONE, and the research studies is that clear communication and meaningful recognition from a leader to her/his employees are key components to successfully creating an HWE (AACN, 2005; AONE, 2005; AONE, 2017; Garon, 2012; Huddleston et al., 2017; Kramer et., al, 2010; Kramer et al, 2011). Applying these key

components into a nurse leader's daily schedule will inspire change and give rise to the important elements needed to create and maintain an HWE.

Section III. Methods

Ethical Considerations

Institutional Review Board.

For this practice change, a DNP Statement of Non-Research Determination Form was submitted and approved as an evidence-based, non-research change of practice project. See Appendix D for the DNP Statement of Non-Research Determination Form.

Ethical concerns related to this project were reviewed and none were identified. Participation in the practice change was not optional, however participation in the feedback surveys were voluntary. Participation was anonymous. The results of the surveys were shared with frontline nurses and the nursing leadership team.

Ethics in nursing.

Ethics in nursing represent the ideals of our profession. It is the guide of our values, and the perceptual screen through which an individual or group interprets moral precepts that govern reoccurring life situations (Anonymous, personal communication, March 2018). To make this broad definition more applicable to the nursing profession, the American Nurses Association established a Code of Ethics for Nurses with Interpretive Statements to be very clear and precise to make "explicit the primary obligations, values, and ideals of the profession." (ANA, 2015, p. vii).

The American Nurses Association's Code of Ethics with Interpretive Statements "establishes the ethical standard for the profession and provides a guide for nurses to use in ethical analysis and decision-making" (ANA, 2015, p. vii). Provision 6 states "The nurse,

through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality healthcare" (ANA, 2015, p. 23). Provision 6.3 asserts the need for nurse leaders to work collaboratively with frontline nurses by means of effective communication and collaboration to create a healthy environment for the nurse to work and for patients to receive care (ANA, 2015). This practice change project supports the obligation of the Facility to uphold Provision 6.3.

Reflection: Jesuit values.

Jesuit values were established as a provision to support leaders with a method of leadership and encouragement for the greater good (Creighton University, 2018). From the six Jesuit values, two directly support this practice change project. The first principle, Magis expresses the idea that leaders should always strive for excellence and not be satisfied with the current state. The sixth principle is Forming and Educating Agents of Change, asserts the need for leadership inspiration to invest in others so they, the people, can be aware of themselves and the environment, and to mature in behaviors that encompass objective thinking and disciplined actions (Creighton University, 2018).

There is an important synergy here with implications for practice: the goals of AONE and AACN, which have long supported the need for an HWE as stated in the *Code of Ethics*, also support these two Jesuit values. *Magis* in the investment of time from nurse leaders to engage with their own knowledge of truth when becoming thought leaders; and *Forming and Educating Agents of Change* to ensure that nurse leaders continually strategize to help the nursing profession achieve organizational excellence and develop frontline nurses to be critical thinkers and responsible professionals.

Interventions

The two specific questions in the practice change project were chosen by nurses from the telemetry, medical surgical, and rehabilitation departments. Two 20-minute small focus group meetings and three individual person meetings were held to discuss priority elements of communication and recognition from the annual employee experience survey. Each survey question, its response, and the variation value from the year prior was evaluated in the meetings. The top three questions were then chosen for re-evaluation and discussion. The nurses then scored a 1-3 priority value to each question. The two with the highest responses were chosen for the practice change.

The proposed practice change project involved developing, implementing, and evaluating a healthy workplace program. This program focused on clear, transparent communication regarding news and updated information, as well as employee recognition to make nurses feel like they received recognition for their good work. The practice change project involved creating the time, space, and a vehicle for communication of new information and updates regarding clinical units, hospital, and the organization as a whole. It also involved creating the timed frequency of engagement through recognition from nursing leadership. These proposed changes were projected to achieve a 30% more favorable response to two key nurse leader engagement metrics "*The person I report to makes sure that I am well informed about news and changes"* and *"The person I report to provides recognition for employees who do a good job"* (Dignity Health, 2017) that are assessed annually.

The objective was to be achieved through implementation of a healthy workplace program which encompassed participation from each unit practice council member, each unit charge nurse, informal leaders on the unit, nurse manager, DOPCS, project manager, and the

approval of the CNE. Within the healthy workplace program, the goal was to establish a) a quarterly communication forums with presentations from nursing leadership and frontline registered nurses to their peers; b) a monthly recognition plan involving the presence of nursing leaders on rotating shifts to recognize good performance of an individual nurse or a group in front of their peers; c) a monthly acknowledgement plan which included birthday celebrations via individual birthday cards mailed to each home and a monthly birthday cake; d) a weekly communication plan through weekly topic announcements via daily shift communication huddles, e) a weekly update plan through a visual stoplight nurse request progress board; and f) a daily recognition plan through daily leader rounding on clinical nursing units. See Appendix E for Employee Experience Intervention Plan.

Communication interventions.

Daily shift communication huddle.

The idea of having a daily shift huddle was in response to employees sharing frustrations regarding the lack of communication when processes were changed. They felt that they were not made aware as expectations changed on the unit. In response, daily shift communication huddle messages were created to provide news, updated information, reminders, and educational sharing moments based on events occurring on the clinical units, in the facility, and in the organization. Messages were created collaboratively among the unit practice council chairwoman, the nurse director, and the project manager.

The template.

Prior to creating the template for huddle messages, the project manager queried 11 nurses from different clinical units on different shifts to understand what they felt was important to know. The project manager, who is also the DNP student, then created a basic template that

was shared with individual nurses to get their feedback. Once there was agreement on the basic template, the project manager showed it to the DOPCS and the CNE for approval. The CNE recommended inclusion of governance updates in the template. With this final change, the template was ready for use on June 1, 2017.

The daily shift communication huddle message form consists of:

- A template header which includes the clinical unit's name, the first day of the week in which the huddle was to be shared, a motivating unit message, the name of the charge nurse for each shift, census information for each shift, a line to welcome those who floated into the unit for the shift or new employees, and a line to include information about high risk patients, such as patients who wander, who may fall, or who may get a hospital-acquired pressure ulcer or infection.
- Huddle topics include any corporate, then local facility, then clinical unit news and updated information.
- The message template concludes with a brief encouraging message for nurses to have a great day. To note, each nurse in attendance at the beginning of the shift huddle has to sign the staff roster sheet indicating she/he received the communication. See Appendix F for Daily Shift Communication Huddle Message Template.

The message was created on a Friday and sent to the charge nurses before the end of the day so that by the first shift on Monday morning the message had been distributed. The charge nurses had the authority to add local/shift information to the message for that week. The messages were sent via email, but during the first eight weeks post go-live, messages were also printed by the project manager and brought to the charge nurse on each clinical unit. Also, during

the first eight weeks post go-live, the project manager created the huddle messages in collaboration with the DOPCS and frontline nurses. On the ninth week post go-live, the chairwoman of the medical surgical unit practice council resumed the responsibility of creating the huddle messages in collaboration with her peers and the DOPCS with oversight by the project manager.

Weekly visual nurse request progress board.

The concept of a weekly visual nurse request progress board was a method of being transparent with nurse requests regarding workflow. The concept has been adapted by organizations as a physical board to hang on a wall for all to see, an electronic board on a shared drive for employees to see, or it could be both. The idea of the visual nurse request progress board stemmed from Quint Studer's Stoplight Report which provides clear communication on the progress of employee requests (Studer Group, 2018). This board had four vertical columns and each column had a designated color. The first column was white, and it listed the nurse's requested item or process; the second column was green, and it listed all completed requests; the third column was yellow, and it listed requests that were in progress; and the fourth column was red which was reserved for requests that were unable to be fulfilled with explanations of why (Studer Group, 2018). Oversight of the progress board would be by unit practice council members, DOPCS, and the project manager. Identified roles were to update the progress board as nurse requests were being worked on and completed. For this practice change project, the request to implement the visual nurse request progress board was denied. This request was denied because the idea was tried several years ago without success.

Quarterly nurse collaboration forum.

The new quarterly nurse collaboration forum was created as a time for communication collaboration between nurse leaders and frontline nurses. They partnered to present relevant information to the nursing team with allowance of time for interactive engagement during the forum. The format was such that at the beginning of the event, right after an opening ice breaker and encouraging message from a nurse leader, a frontline nurse who volunteered and prepared, presented an evidence-based practice topic of choice (approved by DOPCS) relevant to practice that was occurring on the clinical units. She or he would present, engage, and answer questions during this section. The goal was to build a discussion for the evidence to be used to update procedures and protocols so that practice would change. During this time the nurse leaders seized the opportunity to recognize nurses in front of their peers for the good job that they were doing. Literature indicates that nurses who receive recognition from their nurse leader feel acknowledged and valued, which gives them a sense of belonging (AACN, 2005). Near the end of the forum, another frontline nurse facilitated a survey type presentation to gain feedback on any situation or topic (approved by DOPCS) occurring on the clinical units that needed attention.

The purpose of this quarterly nurse collaboration forum was to communicate news and updated information to all nurses and to provide recognition for the staff. The agenda for this communication collaborative followed the organizational pillars such as people, service, quality, finance, and community. Quarterly meeting dates were planned and scheduled timely so that nurses were able to arrange their work and personal schedules to attend. During this practice change project, one quarterly nurse collaboration forum occurred.

Recognition interventions.

Daily nurse leader rounding.

The daily nurse leader rounding was an activity completed by the nurse leader every day to communicate with patients about the care that they received. This was an opportunity to hear from patients, get a feel of how nurses were performing when one on one with patients, and to do real-time service recovery if needed.

During these daily nurse leader rounding opportunities, recognition was provided to nurses from their nurse leader based upon real-time feedback from patients, peers, visitors, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys, and from other department leaders. Other department leaders accumulated information for feedback from their 10:00 am rounding activities on the clinical units.

From 10:00 am until 10:45 am, all department leaders rounded on patients and interacted with employees. They then attended the 10:45 am leadership rounding for outcomes meeting where patient feedback was provided regarding the care they received, and employee feedback was provided if names were mentioned or the leader saw the employee go above and beyond to render exceptional customer service. The nurse leader then took this feedback and recognized the nurse(s) while rounding on the units or during the daily shift communication huddle. The recognition was normally a verbal acknowledgement to genuinely say thank you for the great work.

Monthly leader off-shift presence.

Over the years, nurses who work on off-shifts have shared with each other and with their nurse leaders that they do not get to see or interact with leaders often. Though they understood that working the night shift hours of 11:00 pm until 7:00 am, or working only on the weekends

for example, meant they wouldn't see their nurse leader as frequently as they would like, they still preferred to see them frequently.

In response to this appeal for greater interaction, nurse leaders agreed to visit these nurses on the clinical units on a monthly rotating basis during the off-shift and weekend hours. During these monthly visits, nurse leaders arrived unannounced and recognized an individual, a group, or a whole unit for their good work. Time was then spent interacting with the nurses prior to leaving the unit.

Monthly birthday celebrations.

Most people feel special when their birthday is remembered and even more special when a kind gesture is made to recognize that day. To recognize nurses on their birthdays, a personally handwritten birthday card with cheers would be mailed to each employee's home within the month of their birth. In addition, a monthly birthday cake would be provided on a date based on a day that most of the birthday nurses were working together. The birthday nurses would then be celebrated and made to feel special by their nurse leader and peers.

Monthly birthday celebrations were to be initiated in January 2018, which occurred after the evaluation period of the practice change project. Nurse birth dates however, were to be received from the Human Resource department mid-November so that January and February birthday celebrations could be planned timely. The birthday data was to be arranged by month with indication if there was a special milestone birth year to celebrate and make the celebration extra special if needed. This aspect of the project is still a work in progress.

Options.

Three options were reviewed to assess if this practice change project was feasible. The first option was to follow this proposed practice change to achieve a 30% increase in employee

satisfaction which had potential to indirectly cause a 25% decrease in nursing turnover, and a $839,970 return on investment in year one. The second option was to only initiate the communication portion of this proposal. Though this option decreased the original outlay for this project by $15,180, it may not obtain all the benefits of the recognition program. The third option was to do nothing and continue to lose the money being spent on recruitment activities and nursing overtime hours.

The chosen option was the first recommendation, which included implementation of both the communication and meaningful recognition portions of the suggested practice change. This option was chosen because the DOPCS truly wanted to have an impact of change in the perception of leadership in the eyes of frontline nurses. She understood the value of communication and the necessity of nurses having the correct information to do their job. The DOPCS believed that she was effective in providing her employees with positive recognition so when she saw the May 2017 employee experience survey results that indicated she was not doing an effective job in this area, it gave her a moment to pause and consider her activities. The DOPCS was willing to do whatever it took to achieve the 30% increase in employee satisfaction with the probable 25% decrease in nursing turnover.

Gap Analysis.

The goal of the Facility's senior leadership team is to be the provider of high quality, compassionate, and safe care; to be the employment organization of choice for high echelon healthcare providers who demonstrate the principles of Human Kindness®, and to be acknowledged as one of the top 1% of hospitals in the U.S. (T. Johnson, personal communication, January 2017). To achieve these objectives, it was necessary to understand and

align the perception of nurses and the engagement of nurse leaders with the goals of the organization. With this said, a gap analysis was completed (Appendix G).

Current state.

Nurse leader questions from the Facility Annual Employee Experience Survey, which focused on communication and recognition engagement scored low. In the May 2017 survey, the communication metric scored a value of 3.81 which was 3.5% below the Facility service area's acceptable score value of 3.95. The recognition metric scored a value of 3.35 which was 10.7% below the Facility service area's acceptable score value of 3.75. As expressed from the annual employee experience survey, nurses did not feel like they were being kept current with news and updated information, and they felt like they were not being recognized by their nurse leader for the good work that they did (Dignity Health, 2017).

Future state.

The goal was to be within benchmark values comparable to the service area facilities. Because of this, threshold values for statements "*The person I report to makes sure that I am well informed about news and changes"* and "*The person I report to provides recognition for employees who do a good job"* (Dignity Health, 2017) had to be near 100% where nurses felt confident in these statements.

The future state was for nursing leadership to be transparent in their communication. Positive results could incur decreased fear, decreased anxiety, and decreased confusion when it came to process changes and what needed to be accomplished while providing high quality and safe care. The future state also included increased employee recognition. In organizations where this occurs, nurses feel valued with the work that they were doing which affirmed purpose with the organization (AACN, 2005).

Strengths, weaknesses, opportunities, threats analysis.

When probabilities of needed change were being assessed, it was critical to align the purpose of this change with the organization's mission and vision. Performing a strengths, weaknesses, opportunities, and threats (SWOT) analysis helped identify feasibility of this change. Understanding this organization's internal and external risk factors assisted with strategic planning and guided the work that needed to be completed (Dergisi, 2017). For this practice change, a SWOT analysis was completed (Appendix H).

Strengths.

There were several strengths within the organization. The first strength was that the new executive team was composed of leaders who were eager to make positive changes that would align with the mission, vision, and strategic goals of the organization. The second strength at the onset of this practice change was that there were two new nursing directors who came with fresh ideas and positive spirits to make optimistic differences in their service areas. The third strength was that most of the informal leaders truly wanted to align themselves with the vision of the organization and supported positive patient and employee outcomes. To note, the organization had received an "A" grade as a safety score with the Leapfrog Group organization. It had also received certification as a Joint Commission designated stroke and diabetes care center. The fourth strength was that though the organization was part of a larger conglomerate, it was still independent enough that leadership could make standardized changes independent of the larger conglomerate. The last strength to mention was that there had recently been a re-establishment of the Unit and Hospital Practice Councils.

Weaknesses.

When completing a SWOT analysis, it is important to assess all weaknesses. The four identified weaknesses were the lack of financial support for staff meetings, the span of control during the month of go-live was potentially beyond evidence-based recommendations, the lack of standardization with communicating news and updated information to frontline nurses, and the lack of a formal healthy workplace program.

Opportunities.

An opportunity that was being assessed during the preliminary phase of this project was collaboration with a major local university medical center (LUMC). It was planned for hospitalists from this LUMC to be given privileges to admit patients directly into the facility's clinical units. This strategic plan had the goal to decrease patient wait times in the emergency department of the local collaborator and increase the average daily census (ADC). Increasing the ADC is considered a direct opportunity that may affect the outcomes of this project because one of the reasons nurses were resigning was because their work shifts were frequently being cancelled secondary to a low census.

Threats.

When completing a SWOT analysis, it is also very important to assess all threats, so they can be minimized. There were two identified threats to the improvement of the work environment. The first identified threat during the onset of this practice change was the census had steadily been decreasing. The second threat was that a sister facility from the same corporate structure was providing the same healthcare services three miles away in the same community. These threats may have been the cause for nurses to leave the organization.

Timeline and implementation plan.

A calendar of time and events were established for the successful implementation of this practice change project. See GANTT Chart in Appendix I. The bulk of literature review was completed October 2016 through December 2016, then again in February 2017 through June 2017 with additional searches for specific topics January 2018 through April 2018.

To control progress of the practice change, a series of meetings with stakeholders took place when needed to adjust implementation activities. The initial planning meeting in November 2016 was a high-level meeting held with nurse directors and the project manager to discuss the status of their clinical units regarding communication, recognition, and the need for a strategic plan to roll out activities geared toward its improvement. Six other meetings were held with informal leaders on the nursing units, unit practice councils, and the general hospital practice council to share results of the 2016 employee experience survey, discuss their concerns, and hear their thoughts regarding implementation of a new healthy workplace program with nursing leadership.

To control possible variances in this practice change, it was important that the responsible persons attend required meetings, were engaged in productive conversations during sessions, provided updates and feedback, as well as carried out all designated responsibilities. The plan for control included a 30-minute weekly review using the Plan Do Study Act (PDSA) model to discuss how implementation was going. The goal for attendance was to include the nurse directors, unit practice councils, clinical ladder candidates, and the project manager. Nurse directors were only required to attend the first eight weekly meetings then attend monthly then quarterly meetings thereafter until the practice change was hardwired. It was important that concerns were addressed to the PDSA workgroup as soon as they arose so that clarification of

process was provided prior to the onset of any confusion or resistance, and prior to the go-live date. See Appendix J for Communication Matrix.

In continuing with the timeline, a gap analysis was completed in January 2017 with comparison to the outcomes of the 2016 baseline data. Project kickoff meetings occurred in April 2017 and were received very well by the nurses as indicated by their enthusiasm and sharing of information with their peers. The 2017 Facility Annual Employee Experience Survey was rolled out in May 2017. The communication portion of the healthy workplace program was rolled out in June 2017. The recognition portion of the healthy workplace program was rolled out in August 2017. The six months post intervention evaluation survey was rolled out in December 2017, and finally the analysis of outcomes was initiated soon after.

Reporting requirements.

The reporting structure was designed to include nurse leadership, unit practice council members, clinical ladder candidates, frontline nurses, and the project manager. At the onset and during this practice change, the project manager had to be fully engaged with all communication components of this project. As time progressed however, communication responsibilities were reassigned so this practice change could continue and thrive on process and not person.

Unit practice council members and clinical ladder candidates were designated as the primary communication leaders to frontline nurses. They were the ones to communicate PDSA meeting agreements and updates to support implementation activities. These teams were also designated to bring feedback from the nurses to the PDSA working groups. See communication matrix in Appendix J.

Work Breakdown Structure.

The functional deliverables in this practice change project encompass three major areas: discussion meetings, implementation activities, and the evaluation plan. During the first eight weeks of implementation, the work breakdown in each of these segments was the responsibility of the project manager. The project manager maintained the responsibility for the discussion meetings throughout the life of this project.

At the beginning of the ninth week, responsibility for collaboration with creating the daily shift communication huddles transferred to the lead UPC chairperson of the medical surgical unit. For the quarterly nurse collaboration forum, collaborative oversight was to remain between the DOPCS and the project manager until the third forum. At this time only one forum has been completed.

Full responsibility for the healthy workplace program was transferred to the DOPCS upon completion of the post evaluation survey. Mini surveys were spearheaded by the project manager and the six-month post implementation evaluation survey was spearheaded by the corporate team. See Appendix K for Work Breakdown Structure.

Financial impact.

The total expense for this project was $51,230 (Appendix L). The breakdown of the investment was as follows: $3,360 for clinical ladder nurses when meeting for a total of eight meetings; $4,200 for the Unit Practice Council (UPC) members when meeting for a total of ten meetings; $9,230 for the charge nurses to collaborate with nurse directors in creating the huddle messages; $28,120 for the nurse directors for all of their meetings and preparation time; and $4,320 for all of the project manager’s meetings and preparation time. An additional ten hours of pre-planning time was included in the budgeted hours for the project manager. A total of $2,000

was added for document/survey copies, and recognition/celebration activities. The total predicted expense of $51,230 was a small investment for the organization to realize a great return.

The return on investment included overtime avoidance and retention/recruitment cost savings. The nurse turnover rate in 2016 at the Facility was 9.8%, which was a total of 32 nurses per year and eight nurses per quarter. The nurse turnover rate in 2017 was 7.4% with an adjusted rate of 3.4%. The 2017 calculation showed a decrease of 25% from the 2016 value with an adjusted percentage decrease of 65.6%. In 2017, a total of 24 nurses transitioned out from the unit that they worked in 2016. Of the 24 nurses, eight of them stayed within the organization and transitioned to other units. Two of the 24 nurses retired from the organization; two had family situations out of state that they needed to tend; and one graduated as a nurse practitioner so she transitioned for career growth.

The current recruitment costs for replacement of a registered nurse in California is $88,000 (Kovner, Brewer, Fatehi, & Jun, 2014). The average replacement time is 54 -109 days depending on the nurse's specialty and the rate for any one percent increase or decrease in the turnover rate is $373,200 (Nursing Solutions Inc, [NSI], 2016). The cost avoidance for recruitment efforts with the implementation of this project was $704,000 ($88,000 x 8 RNs), and $895,200 ($373,200 x 2.4) for the 2.4% decrease in avoiding the resignation of eight nurses for the year, which was the plan.

The cost/benefit of this program stems from retention of registered nurses. Studies have shown that an HWE keeps employees engaged (Shirey, 2006). Appealing to frontline nurses to engage them in a communication-rich culture will cause them to want to participate and be a leader, thus maintain employment with their current employer (Schwartz & Bolton, 2012). With

this program, the 2017 annual goal was to retain 25% of nurses that had high probability of turning over that year. This was accomplished.

The total investment for the implementation of this communication and recognition practice change project was $51,230. Following the initial outlay for the establishment of the program and its roll-out, finances for consecutive years will require the weekly 30 minutes needed for the chairwoman/man of the Unit Practice Council to communicate with council members, charge nurses, frontline nurses, and nurse leaders to collaborate regarding the daily shift communication huddle; the weekly 10 minutes needed for the three nurse directors and one nurse manager to review and include information in the huddles; and for the three hours per month needed for the three nurse directors to engage with their employees for recognition. The time invested by nurse leaders in this healthy workplace program was financed from their normal salary obligation. The total return on investment was calculated to be $1,599,200 ($704,000 + $895,200 - $51,230) which included the needed outlay of $51,230 to perform this project change project. Hardwired activities to sustain this healthy workplace program will cost $678 per month and $8,136 per year.

Measures

Evaluation plan.

In December 2017, the outcome of the healthy workplace program was evaluated. An electronic survey was provided to all nurses who wanted to participate in the evaluation process. The goal for the two-key metrics of focus, "*The person I report to makes sure that I am well informed about news and changes"* and *"The person I report to provides recognition for employees who do a good job"* (Dignity Health, 2017) was to improve by 30%. To create this expected outcome, the development, implementation, and evaluation of the daily shift

communication huddles took place. To be hardwired, there was expectation of a 90% participation rate at the beginning of each shift on all participating units by November 30, 2017. The monthly visual nurse request progress board was to be developed, implemented and utilized by each Unit Practice Council by November 30, 2017. To be hardwired, there was an expectation that 100% of nurse request items had weekly updates posted. The first quarterly nurse collaboration forum was held in August 2017 with an immediate anonymous evaluation for feedback on the structure and topic relevance. Monthly shift leader presence began in September 2017. Monthly birthday celebrations were to begin January 2018, which was after the end of the practice change evaluation period.

Surveys.

When deciding which measure of evaluation to use, the nurses' perspective of time allotment and complexity of questions were taken into consideration. The goal was for the survey to be completed in as little time and with as little stress as possible.

The official roll-out of the healthy workplace program started in June 2017. Therefore, starting in July 2017, a monthly electronic survey was to be available for clinical unit employees to provide feedback on the PDSAs occurring on each unit. The survey was to be based on consistent communication and recognition efforts of nurse leaders. Each survey was to be available for four days only to maintain urgency for the need to submit input. Frontline nurses would know when the surveys were available through daily shift communication huddle messages and through word of mouth by the unit practice council members, the clinical ladder candidates, and the project manager. The responsibility of gathering monthly survey results was that of the unit practice council members and the clinical ladder candidates. Their responsibility was to tally the questions and present the findings at the weekly/monthly meetings for

assessment. Based on survey feedback, each PDSA activity was to be adjusted accordingly until November 30, 2017.

The description of the approach to the ongoing assessment originally included monthly electronic surveys until the process was hardwired, then the surveys would be administered quarterly for two quarters, then bi-annually for a year, then resume to assess the results through the annual survey. What actually occurred was one assessment for the effectiveness of the daily communication huddle messages, one assessment of the effectiveness of the first quarterly nursing collaborative forum both using a hardcopy paper survey which was manually tallied and interpreted, and one electronic assessment of the program as a whole.

From the feedback of the surveys, adjustments were made to the process. For example, nurses shared that there were too many huddle messages in one 4-minute huddle, so messages were limited in number so that it did not become overwhelming. The four questions asked on the daily shift communication huddle feedback survey included:

1. Are the shift huddle messages helpful?
2. Are there too many messages in one session?
3. Are shift huddle messages relevant to what is going on in the unit?
4. What if anything would you change ***related*** to daily shift huddles?

The word *related* in the fourth question was purposefully written in bold and italicized so that responses could be focused on the new huddling process itself and not focused on staffing or resource concerns. Thirty-nine of the 67 participating nurses provided comments to question number four: What if anything, would you change ***related*** to daily shift huddles? See Appendix M for the Daily Shift Communication Huddle Message survey template. See Appendix N for

detailed results of the Daily Shift Communication Huddle Message survey. See Appendix O for the Daily Shift Communication Huddle Message survey result comments.

The five questions asked on the quarterly nurse collaboration forum survey form were:

1. Was this meeting helpful?
2. Was the peer presentation helpful?
3. At what frequency do you think this meeting should take place?
4. What is one thing that you have learned from this meeting?
5. What is one thing that you will do differently?

There were 23 nurses who participated in the first quarterly nurse collaboration forum. There were 21 nurses who provided comments to question number five: What is one thing that you will do differently? See Appendix P for the Quarterly Nurse Collaboration Forum survey template. See Appendix Q for the detailed results of the Quarterly Nurse Collaboration Forum survey.

The recognition program was initiated in August 2017 with the first quarterly nurse collaboration forum. Immediately after the first meeting, a manual hardcopy survey was utilized for its evaluation. Additionally, in early December 2017, the corporate team spearheaded their first six month post annual employee experience survey to re-evaluate the effectiveness of leadership interventions since June 2017. Because this survey used the same statistical analysis software as the annual employee experience survey provided in May, and the coefficients were the same, this was the assessment of choice for comparison. The next survey will be released in May 2018.

Analysis.

Qualitative and quantitative methods were used to analyze the data. The qualitative method used was to receive individual feedback in the form of comments on hardcopy surveys.

The quantitative form was through the specific software used by the organization to analyze employee responses. The author was unable to obtain specific information on the instrument used to analyze data received by employees during the annual and six-month post intervention survey. Though instrumentation is considered to be confidential to the organization, the consultant contracted for talent assessment to understand key drivers in behavior is Strategic Management Decisions (SMD). For analysis and outcome focused action responses, SMD uses their patented technology called SMD Links.

Section IV. Results

Results

Contextual element interactions.

The contextual elements that interacted with the interventions which could have accounted for the outcomes with communication was related to the nurses wanting and needing the news and updated information to complete the work in their shift. The outcomes for the daily shift communication huddle was that 87% of the nurses felt that the news and updated information provided within the huddles were relevant to the work being done on their clinical unit; 72% felt that the huddle messages were helpful, and 46% of nurses felt that there were too many messages in one session.

The responses in the May 2017 survey which indicated that the nurses were not receiving news and updated information, made it clear that this was something they were requesting. Because of this, creating the venue for the opportunity to receive news and updated information every day before the shift began met their need.

As far as the 46% of nurses indicating that there are too many messages given in one huddle, it was indicated by the nurses that at the beginning of the shift, they go on the unit a little

early to review patient assignments and start reviewing patient charts before receiving report. Because of this, at the beginning of the shift nurses were usually scattered throughout the unit getting information, and the charge nurses had to go look for them to start the huddle. This caused the time allotted for the daily shift communication huddle to decrease which meant the information was presented in a quick manner causing nurses to feel like too much information was being crammed into a less than 4-5-minute time slot. Secondary to this delay, the daily shift huddle started a little later than it should, which meant the nurses got report late and started their shift later than the designated time. Consequently, this also meant that nurses stayed later to give report, in turn this started causing a great amount of accumulated overtime minutes per shift.

Another PDSA for the shift huddles included a reminder. A few minutes before the beginning of the shift, the off-going and on-coming charge nurses, the DOPCS, and the project manager, when she was on site, reminded everyone to be on time in the conference room where the daily shift communication huddle took place. The results of this new PDSA decreased overtime minutes secondary to the huddle, but not fast enough. In response, the daily shift communication huddles were placed on a pause in December 2017 until the full complement of nurse shift managers are available to provide more oversight on the process.

The contextual elements that interacted with the interventions, which could have accounted for the outcomes relating to recognition, is that the responsibility scope of the DOPCS changed a few times within the six months of this practice change. The scope went from including her initial two medical surgical and rehabilitation units to including the previously mentioned two units plus the telemetry, ICU, emergency, respiratory, and the dialysis departments. The recognition portion of the program has been placed on a pause until the full complement of eighteen nurse shift managers are in place.

Process Measures.

Process measures are the details of each step needed for an established process to change an outcome (Burton, 2018). It is the meticulousness in these details that will allow another individual or group to replicate the work.

Daily shift communication huddle.

For the original roll-out, the creation of the huddle messages was to be a collaborative among the unit lead of each Unit Practice Council with the assistance of the DOPCS. What occurred is for the first eight weeks, the project manager created the communication messages based on her communications with the DOPCS, the CNE, the process flows, and throughput issues that needed improvement on the clinical units. On the ninth week, the communication messages became a collaboration led by the medical surgical chairwoman of the UPC and the DOPCS. When completed, the lead then shared the information with the telemetry, medical surgical, and the rehabilitation units.

During the roll-out process, the initial goal for huddle facilitation was for it to be done by the oncoming charge nurses on each unit for each shift. What actually occurred during the first three weeks was that the project manager started facilitating the daily shift communication huddles at 7:00 am, at 3:00 pm, and attempted to be at all three unit huddles at the same time by facilitating one huddle, then going to support the end of another unit's huddle, then following up to see if there were any questions from the third unit's huddle. After three weeks of this process it was clear that phase one was not a sustainable model. Another PDSA cycle was needed for an easier transition.

During the beginning of the fourth week, the charge nurses on each participating unit continued with the daily shift communication huddles. After three additional weeks of the charge

nurses facilitating the daily shift communication huddles with oversight from the DOPCS and the project manager, the huddle surveys were performed. See Daily Shift Communication Huddle Message survey template in Appendix F.

Communication survey results.

A total of sixty-seven nurses participated in the survey from all three shifts. The motivation to eliminate differentiating surveys by shift was so that there can be a greater respect to anonymity to encourage greater participation for an acceptable *N* value. The results for each question are shown in the following figures.

Figure 1.1 Daily Shift Communication Huddle Survey Results: Question #1

Question	Number of Yes Responses	Number of No Responses	Number of Surveys Not Answered	Total
Are shift huddles helpful?	48 72%	5 8%	14 20%	67 100%

Result: Seventy-two percent of participating nurses believed the shift communication huddle messages were helpful; eight percent of participating nurses believed the shift communication huddle messages were not helpful; and twenty percent of nurses who participated in this survey did not respond to this question.

Figure 1.2 Daily Shift Communication Huddle Survey Results: Question #2

Question	Number of Yes Responses	Number of No Responses	Number of Surveys Not Answered	Total
Are there too many Messages in one session	31 46%	26 39%	10 15%	67 100%

Result: Forty-six percent of participating nurses believed there were too many messages in one session; thirty-nine percent of participating nurses believed there were not too many messages in one session; and fifteen percent of nurses who participated in the survey did not respond to this question.

Figure 1.3 Daily Shift Communication Huddle Survey Results: Question #3

Question	Number of Yes Responses	Number of No Responses	Number of Surveys Not Answered	Total
Are shift huddle messages relevant to what is going on in the unit?	58 87%	3 5%	6 8%	67 100%

Result: Eighty-seven percent of participating nurses believed the huddle messages were relevant to what was going on in the units; five percent of participating nurses believed the huddle messages were not relevant to what was going on in the units; and eight percent of nurses who participated in the survey did not respond to this question.

For the last question number four, it was written as an open-ended question to solicit feedback. Fifty-five percent, which was thirty-seven participating nurses responded to this question. See Appendix O for Daily Shift Communication Huddle Message survey results.

Figure 1.4 Daily Shift Communication Huddle Survey Results: Question #4

Question: What if anything, would you change ***related*** to daily shift huddles?

Result: Twenty-four percent of participating nurses wrote “keep it short, less than five minutes please”; eleven percent of participating nurses wrote “focus only on most important inpatient issues”; eight percent of participating nurses wrote “don’t want huddles everyday”; eight percent wrote “information is too repetitive”.

Quarterly nurse collaboration forum.

The purpose of the new quarterly nurse collaboration forum was to provide an opportunity for more detailed communication and recognition for nurses. This collaborative brought nurses on the telemetry, medical surgical, and rehabilitation units together so that the nurses received the same consistent information and was recognized in front of their peers. This was an opportunity to provide news and updates to nurses, and to allow frontline nurses to participate with data presentation on their choice topic (with DOPCS approval) for an evidence-based practice idea that would improve clinical processes. The first meeting was held in August 2017.

Quarterly nurse collaboration survey results.

Twenty-three nurses were in attendance for the quarterly nurse collaboration forum and twenty-three nurses participated in the feedback survey. The results are shown in the following figures.

Figure 2.1 Quarterly Nurse Collaboration Forum Survey Results: Question #1

Question	Number of Yes Responses	Number of No Responses	Number of Surveys Not Answered	Total
Was the meeting helpful?	23 100%	0 0%	0 0%	23 100%

Result: One hundred percent of the attending nurses believed the meeting was helpful.

Figure 2.2 Quarterly Nurse Collaboration Forum Survey Results: Question #2

Question	Number of Yes Responses	Number of No Responses	Number of Surveys Not Answered	Total
Was the peer presentation helpful?	21 91%	0 0%	2 9%	23 100%

Result: Ninety-one percent of attending nurses believed the peer presentation was helpful; zero percent of attending nurses believed the peer presentation was not helpful; nine percent of those who participated in the survey did not respond to this question.

Figure 2.3 Quarterly Nurse Collaboration Forum Survey Results: Question #3

Question: At what frequency do you think this meeting should take place?

Result: Eighty-three percent of attending nurses believed the meeting frequency should be quarterly; the DOPCS believed this meeting frequency should be quarterly as well; seventeen percent of the attending nurses believed the meeting frequency should be monthly; the CNE believed this meeting frequency should be monthly.

The second quarterly meeting was to be held in November 2017. This meeting did not occur because during the November and December months, the average daily census increased by almost 50% causing the availability of nurses to attend the meeting and to take the time to research presentation content to be null. In addition, November and December were not the best times to plan for a multi-unit meeting secondary to the increases in winter census, holiday vacations with nurses away from home, and sick calls secondary to the active flu season. The quarterly nurse collaboration forum will resume in the first quarter 2018.

A decision that will assist with the sustainability of this healthy workplace program is the decision of the corporate team to once again restructure nursing leadership. This time however,

the decision was made to add 10.8 FTEs of shift manager positions to assist the DOPCS with the management of the ICU, telemetry, medical surgical, emergency, dialysis, and respiratory departments. The nurse manager over the rehabilitation department will remain in the structure.

Nurse leader off shift presence.

In September a frontline nurse was recognized by nursing leaders because she provided such excellent individualized care to a patient who was slowly dying that the patient's daughters recognized the nurse by name in their mother's obituary. In October, each chemotherapy nurse was recognized during breast cancer awareness month individually and in small groups to say thank you for their unequivocal commitment and desire to support the oncology program. In November, the telemetry and medical surgical units as a whole were acknowledged for their gradient increase with patient satisfaction scores. In December, all employees were celebrated during the holiday season.

Birthday celebrations.

A second portion of the new monthly recognition program is scheduled to begin in January 2018, which is after the evaluation portion of this practice change. This practice change includes celebrating birthdays. This will consist of a personally handwritten birthday card mailed to each employee's home. In addition, a monthly birthday cake will be provided to the celebrants on a day that has the most birthday recipients working so that nursing leaders and peers can celebrate and cheer the birthday nurse.

Quarterly recognition activity.

Quarterly recognition was through the quarterly nurse collaboration forum using the same method of feedback gathering as the daily and monthly recognition plan to recognize the individual, group, or unit for the good work that they were doing. Feedback at the quarterly

meeting also included recognition for metrics and benchmark improvement. The quarterly nurse collaboration forum was an upbeat and exciting meeting. Prizes were given to the first ten people who showed up on time and random questions regarding what was said during the presentations were asked, and if answered correctly, a surprise gift was given. An evaluation survey was given to the nurses immediately after the forum. See Appendix Q for Quarterly Nurse Collaboration Forum Survey Feedback Results.

Observed associations.

The observed associations between the outcomes, the interventions, and the relevant contextual elements for communication were that the nurses and the nurse leaders were excited about this practice change because it met the need for the nurses to be updated with news and information, and it met the need for nurse leaders to be perceived as the provider of this information. Observed associations between outcomes, interventions, and relevant contextual elements for recognition were that nurses felt like they were appreciated for the work that they produced, and it met the need for the nurse leader to fulfill her responsibility of motivating her nurses with meaningful recognition. Associations for both communication and recognition that influenced the outcome was the resource of time. The nurses needed more time to do chart reviews prior to the time for the daily shift communication huddles, and the nurse leader was being stretched thin and was unable to support the many touch points of interaction to meet the needs of the practice change. Because of these key elements, it was difficult to gain full nurse participation and hardwire the daily shift communication huddles.

Unintended consequences.

Unintended consequences need to be taken into consideration when any practice change is implemented to understand the whole effect of the change. Within complexity theory, whether

the unintended consequence is positive or negative, manageable or not, there is another part within the system that will be affected by the change (Dodds, 2013). No one part can change and not influence another part.

As indicated by complexity theory, there were unintended consequences with this practice change. It was understood that there would be some overtime accumulation in minutes during the roll-out of the practice change, however, the actual accumulation of overtime in hours was not acceptable. These overtime hours were paid out secondary to the delays caused with starting the daily shift communication huddles late. The need to minimize delays caused the DOPCS and the project manager to be on the units to redirect the flow. As this occurred, there was a fruitful realization that bedside shift report was not always occurring at the bedside to involve the patient. This knowledge provided the opportunity to remind and re-educate nurses of the necessity for patient inclusion when shift report occurred.

Evolution of project.

Changes occurred with each communication PDSA mainly due to the need of decreasing unplanned overtime utilization. On the telemetry and medical surgical units, overtime minutes for this project caused an accumulation of roughly 15 minutes per shift per nurse for the three shifts with an average of 14 nurses per shift for three shifts equated to 42 nurses per day with an average pay rate of $68 per hour totals an average of 42 nurses times roughly $17 per 15 min which equated to $714 per day times seven days a week was $4,998 per week or could be roughly $150,654 a month. This amount was definitely not figured into the budget. The calculated 15 minutes of additional overtime during the post go-live period was a measurement provided by the DOPCS. The number of nurses who accumulated the additional time varied

during the week depending on which charge nurse facilitated the huddle and if the DOPCS or the project manager was present.

To mitigate excessive overtime hours being paid, the DOPCS and project manager sporadically started to attend the daily shift communication huddles to reassess the flow and help with a timely start and finish. This however only made a miniscule improvement in overtime minutes so it was decided to place this portion of the healthy workplace program on a pause until a full complement of the shift nurse managers are in place to have better oversight and accountability to the process.

Another evolution in this practice change was the involvement of one of the units who although was committed to being part of this project, did not follow through completely. This unit displayed inconsistency in the process because they felt that they had the information they needed, were kept up to date, and did not need to read the huddle messages as frequently as required. The unit received all communication information throughout this process change. Mid process however, there was a drift; nurses were not as engaged as the initial days of implementation. It was discovered that their participation in the daily shift communication huddle varied with which charge nurse was on assignment.

This unit performed their own PDSAs. The nurses on this particular unit felt that the huddles took too much time at the beginning of the shift, and they wanted to get started with their work right away. Depending on who the charge nurse was, the huddles either occurred with everyone at the very beginning of the shift like on the other units, with everyone right after they took report, so the previous shift could go home on time, or they simply passed the communication huddle sheet to individual nurses for reading during the shift as they had time. Many of the charge nurses did not repeat the process during the week if the nurse already read

the message. When this was brought to the attention of the DOPCS, she was in the process of deciding if this unit needed to place the daily shift communication huddles on a pause until the nurse shift managers were in place for efficient oversight. Interestingly, in the December 2017 intervention evaluation, this particular unit's scoring with the question "*The person I report to makes sure that I am well informed about news and changes"* decreased 9.9% from the May 2017 annual employee experience survey (Dignity Health, 2017a). This result was not surprising secondary to the drift. The tools that are now in place within the organization will help mitigate this perception.

Opportunities realized from SWOT.

An opportunity for collaboration with the major LUMC came to fruition during the life of this project. Within this collaboration, hospitalists from the LUMC were given privileges to admit and care for patients. Because the patients were admitted directly from the LUMC's emergency department into the medical surgical or telemetry units at the Facility, this collaboration benefited both medical centers. The census for the facility increased thereby provided additional stability in the census to support the need for the nurses to maintain their scheduled shifts. This collaboration was initiated in February 2018, after the evaluation period of this practice change. Both medical centers look forward to the assumed benefits that it will bring.

Effects on organization.

There was a positive correlation of increased scores with quality improvement metrics during the time that the communication portion of the healthy workplace program was started. An example was the improvement of use with high alert intravenous pump medication safeguards called the guardrails. In June 2017, which was the start of the daily shift communication huddles, use of the medication safeguards was at 78%. In July it increased to

87%, and in August use of the safeguards for high alert intravenous medications increased to 90%. This increase was attributed to reminders being placed in the daily shift communication huddle, the DOPCS speaking to the nurses about it, and the pharmacy team reminding nurses while doing rounds. See Appendix R for Medication Safety Guardrails.

In addition, there was a positive impact on the return on investment and nurse turnover rate. The return on investment encompassed overtime avoidance and retention/recruitment cost savings. The total return on investment was $1,599,200. In 2016, the nurse turnover rate was 9.8%, which was a total loss of eight nurses per quarter. A partial goal of this program was to retain at least two nurses per quarter for a 2.5% return on investment. In 2016, 32 nurses transitioned out of the organization. In 2017, a total of 24 nurses transitioned out from the unit which they worked in 2016, achieving the project goal to decrease the turnover rate by 25% to 7.4%.

Section V. Discussion

Summary

Key successes.

A key success from this practice change was when improved communication of news and updated information was given to frontline nurses, it created an increase in performance metrics related to medication safety through the use of safety guardrails. This indicates that reminders for focused metrics through use of the daily shift communication huddle can be used to improve nurse performance. It is believed this increase was related to the communication practice change because frequent reminders were in the daily communication huddle messages.

A key success also to note was the small gain achieved in the December 2017 post intervention survey. Even with all the changes in nursing leadership, scope of responsibility, and

budgetary flexibility with this practice change project, there was a 5.2% increase in the rehabilitation unit survey score indicating that the nurses felt that their nurse leader recognized them for doing a good job. There was also a small gain of 2.5% on the medical surgical unit indicating that their nurse leader provided them with news and updated information needed to do their job.

Project aim.

The purpose of this project was to increase the perception of communication engagement and performance recognition from nursing leadership to frontline nurses by 30% before November 30, 2017. The objective of this practice change was partially met. Of the three units that participated, the nurses on the rehabilitation unit had a six-month post intervention evaluation score showing a 5.2% improvement with the question "*The person I report to provides recognition for employees who do a good job"* (Dignity Health, 2017a). The nurses on the medical surgical unit had a 1.2% decrease, and the telemetry unit had a decrease as well, but by 8.3% in perception (Dignity Health, 2017a). As it relates to the question, "*The person I report to makes sure that I am well informed about news and changes"*, the medical surgical unit had a positive perception change of 2.5%, the telemetry unit had a 11.8% decrease in perception, and the rehabilitation unit had a decrease as well, but by 5.2% in perception (Dignity Health, 2017a). An examination of these numbers may also conclude that the project aim of 30% increase in perception was too high.

As this practice change evolved, there were three lessons learned surrounding strategic implementation of a new process. The first was the need for leadership commitment to the process. Despite various changes in the leadership structure and responsibilities, the DOPCS stayed committed to the successful implementation of this practice change and she did all that

she could to make sure barriers were minimized as much as possible. The second lesson was the need to always maintain a positive perspective and be flexible to adjust when unexpected changes occur, so the project can be completed. The third lesson was that no matter how much one believes a practice change can occur without allotted financial support, this is not possible. There was a cost for the investment of time and utilization of resources. Whether the time allotted for the work to be done is embedded in the leader's workday as opposed to hiring a project manager, the time spent on the project is time taken away from other productive work.

Leadership commitment to the process.

At the conception of this practice change, which included strategic planning meetings in November 2016 through March 2017, the nurse leadership structure consisted of one director over the ICU and telemetry units, one over the medical surgical and rehabilitation units, and one over the emergency departments. These nursing directors committed their units to participate in this practice change and was very excited about engaging in the process. To note, a nurse manager position was not included in this structure at the onset of the project.

In April 2017, which was a month prior to the go-live date for this practice change, the first nursing leadership structure change occurred. The structure changed to one director over all of the nursing units with the inclusion of one nurse manager over the rehabilitation unit. Although the nurse director and nurse manager were committed to the practice change, they had to realistically adjust due to their new scope of responsibilities.

In support of establishing a nursing leadership structure that was set up to succeed and meet the mission, vision, and values of the organization, in December 2017 there was an announcement noting another new leadership structure to start in January 2018. The new structure eliminated the position of the rehabilitation unit nurse manager, however included a

new nurse manager of patient care services position and included six new nurse shift managers for the telemetry unit, six new nurse shift managers for the medical surgical unit, and six new nurse shift managers for a combined ICU and emergency department team. The rehabilitation unit was not allotted new nurse shift managers and reports directly to the nurse manager of patient care services, who reports to the DOPCS.

The recognition portion of the practice change was heavily reliant on the engagement and the investment of time from the initial nurse directors which shifted to the one DOPCS, who as of March 2018 had not found a permanent nurse leader to fill the position for nurse manager of patient care services. The DOPCS, Ms. Terri Johnson, RN, BSN, MHA, was very supportive, very engaged, very motivated, and tried very hard to implement the elements of the recognition portion of the practice change and to hardwire them so this practice change project could be successfully implemented. The reality of the situation was that as time unfolded during this thirteen-month commitment, there were three different nursing leadership structures of which her responsibilities shifted. In November 2016, Ms. Johnson was the nurse director of two clinical units and by November 2017 she was the director of seven departments. As much as she was committed to the process, she could not be every place at the same time for effective oversight, and thus the last structure change occurred to meet evidence-based span of control limits and provide her with the supportive oversight needed for clinical accountability.

Planned financial resources.

The duration of this practice change experience post go-live was from June 2017 until November 2017. Although the total expenses for this practice change were indicated as $51,230 on paper, there were zero dollars allotted for this project. The goal was to implement

the changes with as little financial impact as possible. Being excited to start the practice change, this author was agreeable to have a zero-budget balance because she believed it could be done within the processes that already existed. This was not so.

This author did not take into account the amount of time in weeks that it would take to change the mind of nurses to start a new process despite the number of communications that took place regarding the change. The nurses were kept in the loop about the strategic meetings that were being held in 2016, they were aware of the need for the practice change based on their responses to the 2016 and 2017 annual employee experience survey, they knew the time limits for the communication huddles and their expectation to participate, they knew the go-live date, and they understood the open door for them to provide topics that they would have liked to discuss during the huddle time. Despite all of this information, some of the nurses were not efficient with following through with practice change requirements causing a gap in planned financial expectations.

Success contributions.

The author thanks the CNE for allowing this practice change project to take place at the Facility. Successes of this program occurred due to the commitment of the CNE, DOPCS, and the informal nursing leaders on the clinical units. The commitment of the DOPCS to continue engaging with this practice change in the midst of the many changes that occurred within the organization's nursing structure was key to keep the project's momentum. This author is grateful to her for believing in the process and wanting to help the project be successful. Even as the unintended overtime was occurring, the DOPCS gave the opportunity to do another PDSA and be on the units to reassess and direct the flow for the huddles. As well, even if her scope of responsibility almost quadrupled, she was still willing to engage with the entire healthy

workplace program and was committed to having weekly meetings to make sure everything was going as planned the best that it could.

In addition, informal nurse leaders and charge nurses on the clinical units were key in supporting the practice change and doing all that they could to keep nurses engaged with participation. The successes of this project were also greatly attributed to the unit practice council's chairwoman who is a wonderful and flexible frontline registered nurse for the medical surgical unit who graciously accepted the responsibility to be the lead collaborator to create the daily shift communication huddle messages on week number nine.

As we reviewed the successful results of the rehabilitation unit with a 5.2% increase in recognition and the medical surgical unit with a 2.5% increase in communication scores from the six-months post intervention survey in December 2017, it is impressive that it was accomplished at a time of significant changes within the nursing leadership. Now that a full complement of eighteen nurse shift managers will be in place soon, the elements of this practice change project will be easier to facilitate. There is greater hope for more relationship building opportunities between the nurses and the nurse shift managers because they will consistently be on the nursing units supporting the details of their shift and they will have a more meticulous understanding of individualized personalities and can shape the specific type of recognition given to the nurse. Therefore, the dissemination plan is that the eighteen nurse shift managers will be accountable to upholding the elements of the healthy workplace program.

Implications for nursing practice.

The need to understand the elements necessary for creating and sustaining an HWE is imperative to the successful future of any clinical nursing unit. The importance of creating this type of work environment cannot be underestimated or ignored (Kramer et al., 2010). The

implications for nursing practice is that creating this type of work environment will engage nurses which will help them feel valuable and provide an avenue to feel connected with the mission and vision of the organization. Doing this will not only benefit nursing practice (AACN, 2005), but according to the IOM (2000), it will decrease negative patient outcomes such as mortality.

Interpretation

The elements of this healthy workplace program were established from listening to feedback of nurses from the annual employee experience surveys and from personal interactions with individuals and groups of nurses. The program had great potential to be successful if the elements were followed according to the plan. In reviewing secondary successes of the performance improvement metrics that correlated with the months in which a formal and consistent mode of communication regarding news and updated information was provided, it is safe to say that continuing with this process will reap great benefits.

Reasons for any differences between observed and anticipated outcomes.

Whether on a macro, meso, or micro level, there are multiple reasons why organizations may experience a drift in process. Three of the major reasons why a drift may occur is due to persons not wanting to take accountability, persons having their own interests at stake, and/or if there is a lack of appropriate oversight (Schillemans & Busuioc, 2015).

The partial cause for the differences between the observed and anticipated outcomes in this practice change project was because of a drift in priorities and oversight. This was primarily due to the time investment needed for nursing leadership to engage in this program. Because of the increasing scope of responsibility, it was quite difficult for the DOPCS to do so. Although she had the will and desire to participate, her new span of control and scope of responsibility

warranted diurnal reorganization of her daily activities. When the full complement of nurse shift managers is in place, and there is better oversight of details on the clinical units, this healthy workplace program is sure to flourish.

Opportunity cost.

For the recognition portion of this healthy workplace program, opportunity costs were the personal monies that the DOPCS utilized to do special things for the nurses. She bought them food for the quarterly nurse collaboration forum and for shift acknowledgements; she bought the oncology nurses gift bags and provided them with certificates of appreciation embodied in quality cotton folders; she had purchased flowers and surprise gifts; and bought a Keurig® coffee maker for one of the units. The balancing metric of this opportunity from personal expenditure was that nurses felt recognized for the great work that they did which helped in creating a healthier work environment and will assist with increasing employee experience scores in this area.

Implication of findings for leadership of change.

The implications for the findings in this practice change project suggest that with a standardized and consistent communication method for providing news and updated information, and with a strategic plan for a time-managed nurse recognition program, frontline nurses will be engaged. Engaging them will help them participate in creating an HWE, which according to Aiken et al. (2008) and Kramer et al. (2010) will positively influence nursing job satisfaction and increase employee retention.

Limitations.

Projections, assumptions, and limitations.

The projection for this practice change was that activities would be implemented, the nurses felt like they were valued, and survey outcomes after six months would improve by 30%. The assumption was that because time was not allotted for staff meetings, there may have been a bit of overtime as the daily shift communication huddles were being initiated and hardwired. Another assumption was because time was not allotted for meetings since the onset of this project, it may have taken some time to assess, plan, implement, evaluate, and re-evaluate project steps causing a mild delay in each step. Another assumption made was since everyone wanted the desired outcome of increased communication, collaboration, and recognition, everyone would be fully engaged and participate to create the desired healthier level in the work environment.

A key assumption that frontline nurses were eager to receive the news and updated information was made. As time progressed during this practice change, this author noticed that although they wanted to know the information, they preferred to gather chart information regarding their patients before the shift, they did not make time during their shift to read the messages, and near the end of their shift there was usually a rush to complete their work, so time was not made to update themselves. To note, news and updated information were also sent to the nurses via email and most of them did not read their emails at work secondary to shifts full of patient priority activities, or at home secondary to detaching from the workplace or wanting to get paid for the time spent reading work related information, or at all because they may have been uninterested.

Limitations to this practice change included unexpected multiple changes in the nursing leadership structure. This is identified as a limitation because the scope of responsibility for the DOPCS increased almost four-fold during the committed thirteen months of this practice change project. This meant that detailed focus on her nursing units had to continuously expand to

include the additional five departments. The DOPCS had to learn the mannerisms of her new employees, and the new employees had to learn the leadership style of their new DOPCS. Doing this was great because it was building rapport, however it took time to do and because this was a new relationship, the baseline data for previous interactions were not available.

Another limitation was that the project manager worked three twelve-hour days per week from 7:00 am until 7:00 pm. This allowed for great interaction regarding the project with the day shift and evening shift nurses. Though it afforded the time to participate in the 7:00 am and 3:00 pm shift huddles, she was unable to interact with the night shift as much because when she arrived to work in the mornings, the night shift nurses were ready to leave. Also because of her work schedule, the project manager did not attend the 11:00 pm daily shift communication huddles but affirmed how it was going through conversations with evening shift charge nurses who were the persons facilitating the night shift huddles. In addition, because the project manager worked three days a week, she was unable to have a seven-day per week oversight of the project.

As the project manager had time limitations, she also had resource limitations. The project manager's hired role within the organization during this practice change project was as a nursing house supervisor which meant she did not have the responsibility of leading any direct reports and did not have budget allocation to a cost center of which she managed. This limitation meant that people did not have to do what she asked of them. The project manager had to use the power of relationship and influence to gain the original agreement from the CNE, to get acceptance from the initial nurse directors as well as the informal nurse leaders, and to maintain the engagement of the current DOPCS as her position continued to morph.

Another limitation during the months of the practice change was that nurses were transitioning out of the organization at a high rate and were temporarily replaced with travelers. The transition of nursing peers and nurse leaders from the organization at such a quick rate without quick replacement, created an environment of low morale. To minimize the influence of these changes as a limitation, the DOPCS was avid about communicating how she planned to mitigate the vacancies created by the transitions. She made sure to support vacancies with temporary traveling nurses so that the units were staffed to provide high quality care. The temporary travelers that were supporting the vacancies were chosen carefully to support the HWE that was being nourished. Though they adapted into the culture very well and were an excellent part of the team, their employment was temporary. Therefore, they did not participate in the surveys and we were unable to capture the great rapport that was established.

The last and greatest limitation, was the timing of the December 2017 six months post intervention survey. The survey was made available in early December, which was about two weeks after the announcement was made to eliminate the charge nurse position and add the eighteen new nurse shift managers. The charge nurses, staff nurses, and nursing union were very upset about this change. This change however was made secondary to the responses in the May 2017 survey, which led the corporate team to believe that there was a demand for leadership presence beyond the normal business hours of 8:00 am until 5:00 pm. What the nurses did not realize was that though the charge nurse title was being removed, the units would still have a resource nurse to assist with breaks, meals, and assignment support. Partially due to this announcement, as the survey was released for participation, most of the nurses did not participate. Eighteen percent of nurses participated in the survey from the telemetry unit, 31% of

nurses participated in the survey from the medical surgical unit, and 22% participated from the rehabilitation unit.

All of these limitations point to a need for stronger formative evaluations during the implementation phase. This would allow for corrective actions early in the process.

Barriers to implementation.

Identifying barriers for implementation in this project was very important so that a mitigation plan could be established. What was most helpful when establishing the plan was to know that most of the registered nurses who worked in this organization appeared to be open and willing to learn what they needed to do and how they could participate in creating the goal of an HWE.

For this project, the first identified barrier was that employees may not be fully transparent on surveys because they feared being identified as a naysayer or may be seen as someone who did not support organizational initiatives. To mitigate this, employees were encouraged to participate as much as possible and were assured that all surveys and communication feedback remained anonymous.

A second barrier to implementation was the lack of financial support for meetings, project time, and supplies. To mitigate this, creativity had to be king in this project so that overtime was not accrued or accrued to the least amount possible. Also, the allotted time set aside for pre-scheduled Unit Practice Council meetings, shift communication huddle moments, and the individual work time required for nurses on the clinical ladder track was considered for use to move the Deming Cycle of quality forward.

A third barrier to implementation was the amount of time commitment needed from the nursing leadership team to follow up on engagement activities. There was commitment to

follow through with this practice change. However, the continued fluidity and constant requirement of reprioritization in daily activities trumped the frequent interactions necessary to meet the requirements of the healthy workplace program. An example was the need to recognize at least one nurse during the leader's daily rounding. This may not have taken place if morning meetings started late, finished late, or the calendar had too many competing priorities.

Conclusions.

As the nursing profession continues to grow with dynamic opportunities to advance and change positioning, it is very important for nurse leaders to learn how to assess and improve the work environment that exists in their healthcare organization (Stichler, 2009). Nurse leaders are key to the progression of the discipline. It is their strategic engagement that will influence the micro-culture of a clinical unit, the meso-culture of a medical center, and the macro-culture of an organizational healthcare system. The nurse leader determines the accountability level regarding fundamental standards, ethics, and values within an organization (Doody & Doody, 2012). It is their leadership style and ability that will truly make the difference (Stichler, 2009).

Creating an HWE for nurses to work and thrive is developing an opportunity for growth and achievements to flourish. An HWE will increase teamwork, increase camaraderie, increase work satisfaction, increase levels of trust, and will increase available modes of effective communication (Hall, Doran, & Pink, 2008; Shirey, 2006). There is a need for this type of environment (Greco, Laschinger, & Wong, 2006), and there is an obligation to create this type of environment (Schwartz & Bolton, 2012).

Governing bodies, professional nursing organizations, and subject matter experts have created laws, policies, standards, guidelines, and specific tools to support this leadership imperative and provide direction to facilitate the meeting of this need. Nurse leaders must keep

patients and nurses safe (Schwartz & Bolton, 2012) by utilizing evidence-based research that is available for reference to achieve the principles outlined in an HWE (AONE, 2005; AONE, 2017; Schwartz & Bolton, 2012).

Whether working with a large conglomerate or a smaller facility, the sustainability of this work is achievable. To begin creating an HWE, nurse leaders must be honest and acknowledge to themselves and to their employees the state of the unit and organization. They must then engage employees from innovators to laggards to go through the brainstorming process so that all can feel like their input is valued and they are a stakeholder in the process. It is imperative during this time to be honest, to be transparent, and be realistic to gain the genuine trust of the team. Leaders who take the time to be transparent in their message will have a greater level of employee commitment (Vogelgesang et al., 2013). Creating an HWE is a team effort and can be achieved.

Section VI. Funding

Funding

Additional funding was not allotted for this practice change project. The invested participant time for assessment, analysis, planning, implementation, and evaluation steps in this process took place as participants were working in their hired capacity. All financial payments to the participants were paid through the employer. All paper and ink supplies were utilized from the clinical units to make copies of information for the nurses. Food sources were donated by Terri Johnson, Director of Patient Care Services. There were no external sources of funding for this practice change project.

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Section VIII. Appendices

Appendix A

CNE Support Letter

St. Mary's Medical Center
450 Stanyan Street
San Francisco, CA 94117

November 11, 2016

Dr. Juli Maxworthy
Director of DNP Program
School of Nursing & Health Professions
University of San Francisco
2130 Fulton Street
San Francisco, CA 94117

Dear Dr. Maxworthy:

I give approval for Rachel Coicou to complete her DNP project titled *Creating a Healthy Work Environment in the Acute Care Setting* at St. Mary's Medical Center in San Francisco, California between now and December 2017.

Respectfully,

Kathleen Kuntz
Chief Nurse Executive

Appendix B

Responsibility Matrix

Deliverable	Description	Delivery Method	Frequency	Owner	Audience
Letter of Support from the CNE	Approval for performing practice change project in the Facility	Verbal and email communication with hardcopy signature	Once	Project Manager	CNE
Nurse director communication and approval	Approval from nurse directors to participate and support their units with this practice change project	Verbal and email communication with verbal agreements	Once	Project Manager	Nurse Directors of: ICU, Telemetry Medsurg, Rehabilitation Emergency
Gap Analysis	Investigation of current and future goals	Email hardcopy	Once	Project Manager	Nurse directors CNE
Assessment of communication plan	Gauge of daily shift communication huddle	Surveys provided to employees	monthly	Project Manager	Frontline Nurses Charge Nurses Nurse directors
Assessment of recognition plan	Gauge of recognition plan	Surveys provided to employees	monthly	Project Manager	Frontline Nurses Charge Nurses Nurse directors
Assessment of the Healthy Workplace Program	Six-month post intervention assessment of practice change project	Electronic survey	Once	The Facility	

Appendix C

Evaluation Table

Citation	Design/Method	Sample/Setting	Outcome	Appraisal: Strength and Quality
AACN, 2005	Systematic Review	Sample Healthcare organizations in general Setting A work environment where there is the delivery of healthcare.	There is a "Call to Action" from the AACN to create HWEs. Six essential standards have been established to create an HWE. These "represent evidence-based and relationship-centered principles of professional performance."	*Johns Hopkins Non-Research Evidence Appraisal Tool Level IVA
Cohen, J., Stuenkel, D., & Nguyen, Q. (2009).	Five-year longitudinal quantitative study that utilized a descriptive design	Sample Convenience Sample having a final participant value of 29% with *N*= 453 Setting Frontline nurses working on inpatient acute care units from three hospitals in Northern California	Using the Insel and Moos' Work Environment Scale, there was a statistically significant value with nurses who left their clinical unit secondary to perceptions of their nurse leader's support and the low level of health in their work environment.	Level III A
Doherty, D., Mott, S., Lyons, A. & Conner, J. (2013).	Survey methodology of the AACN Healthy Work Environment Assessment Tool and follow up focus groups	Sample 163 multidisciplinary participants, *N*=89 which is 55% participation. Setting Pediatric medical ICU in a northeast urban teaching hospital	Results showed a score of 3.78 which is interpreted as a "good" score for HWEs. Focus groups were conducted after the survey to better understand concerns of the staff. Concerns raised were the lack of skilled communication and inconsistency found with attempts for meaningful recognition.	Level III B

Citation	Design/Method	Sample/Setting	Outcome	Appraisal: Strength and Quality
Huddleston, P., Mancini, M. E., & Gray, J. (2017).	Non-experimental descriptive design used to appraise elements of the HWE Scale Tool for direct care nurses and nurse leaders. This design was also used to study views of nurse leaders and direct care nurses relating HWEs.	Sample 314 nurse leader participants 986 direct care nurse participants Setting Acute care facilities in Texas	Tests of validity and reliability of the HWE Scale expressed significance with psychometric character that can accurately assess HWEs in hospitals/medical centers. For both nurse leaders and direct care nurses, the tool had a p=<.001. Reliability testing with Cronbach's *[alpha]* of .97 which shows internal consistency. Leaders believed nurse collaboration and meaningful recognition were the top two elements that created an HWE.	Level III A
Kelly, L. A., & Lefton, C. (2017).	Quantitative descriptive online survey	Sample 1,136 nurses participated Setting There were 726 nurse participants from 14 ICUs in hospitals with meaningful recognition programs and 410 nurse participants from 10 ICUs in hospitals that did not have a meaningful recognition program. These hospitals spanned across the nation.	Nurse burnout, compassion fatigue, and job satisfaction were expressed from all hospitals that participated. However, hospitals who had a meaningful recognition program had reduced burnout and increased levels of compassion satisfaction.	Level III A
Kramer, M., Maguire, P., & Brewer. (2011).	Quantitative Descriptive Study Design/ Use of The Essentials of Magnetism II (EOMII) instrument to quantify if clinical units were scored as very healthy, healthy, or needs improvement	Sample 12,233 experienced nurses from 717 nursing units working at 34 Magnet hospitals. Initially 40 magnet hospitals were requested to participate, but only	There were 34 of 40 Magnet hospitals that obtained a greater than 40% response rate to participate. ~54% of 540 units rated a Very Healthy Work Environment	Level IIIA

Citation	Design/Method	Sample/Setting	Outcome	Appraisal: Strength and Quality
		34 hospitals were able to achieve 40% or greater response rate. Setting Inpatient acute care Magnet hospitals	~28% of 540 units rated a Healthy Work Environment ~18% of the 540 units rated Work Environment Needing Improvement	
Kramer, M., Schmalenberg, C., & Maguire, P. (2010).	Research meta-analysis Use of The Essentials of Magnetism II (EOMII) instrument to identify themes from professional agencies and expert meta-analysis.	Sample ~One source retrieved 12 publications from 7 professional agencies ~One source retrieved information cited in 18 publications by > 1300 nurses, managers, and physicians who at the time of the interview were working in an HWE. Setting Inpatient acute care hospitals with HWEs.	The eight recommendations for an HWE are to establish: 1.Quality leaders within the health system 2.Promotion of educational advancement 3.Respected levels of nurse autonomy 4.Evidence-based practice 5.Positive inter-disciplinary educationally focused collaboration, 6.Shared-governance 7.Patient-centered focus 8.An adequate staffing acuity pool	Level IIIA
Pearson, A., Laschinger, H., Porritt, K., Zoe, J., Tucker, D., & Leslye, L. (2007).	Systemic review of quantitative and qualitative research studies focusing on the development and management for nurse leaders to create an HWE.	Sample One hundred and sixteen papers where identified; 44 were analyzed Setting Within healthcare systems	Using the Joanna Briggs Institute Assessment and Review Instruments, eight composites were identified for developing and maintaining an HWE which included collaboration, organizational climate, and a supportive environment. When leaders exhibited supportive and positive behaviors toward staff such as being engaged, motivating, and flexible, they were successful at creating an HWE.	Level IV A

Citation	Design/Method	Sample/Setting	Outcome	Appraisal: Strength and Quality
Schmalenberg, C., & Kramer, M. (2008).	Survey methodology using tools: 1.Essentials of Magnetism 2.Global Job Satisfaction 3.Nurse-Assessment Quality of Care	<u>Sample</u> 2,990 frontline nurses employed in 206 acute care units <u>Setting</u> In eight Magnet® hospitals	One of the three questions aimed to answer in this study is "Which clinical units report the healthiest, most productive work environment". It was determined that the top three units are the outpatient care clinics, oncology units, and the neonatal ICUs.	Level III A
Shirey, 2006	Systematic Review	<u>Sample</u> Review of 16 articles focused on HWEs that answered one of the three questions: 1. "What is an HWE?" 2. "How is an HWE manifested?" 3. "How is an HWE created and sustained?" Review of 8 articles focused on authentic leadership that answered one of three questions: 1. "What is authentic leadership?" 2. "How does authentic leadership differ from other types of leadership?" 3. What are the mechanisms by which authentic leaders create an HWE for practice?" 4. "How does one become an authentic leader?" <u>Setting</u>	HWEs can be created by the engagement of the nurse leader. There are certain characteristics of an HWE that need to be established. It is through the establishment of a trustworthy, respectable, collaboration with clear and transparent communication that HWEs can be created. An authentic leader has to truly believe in the mission/goals that she/he wants to achieve. An authentic leader has great emotional intelligence, is a servant leader, leads with a genuine heart, and is authentic.	Level IV A

		A work environment where there is the delivery of healthcare.		
Stichler, J. F., 2009	Literature Review	Sample Healthcare organizations in general Setting A work environment where there is the delivery of healthcare.	Creating an HWE is not an option, but an imperative for nurse leaders. As nurse leaders focus on the personality characteristics and employee engagement, it is just an important and relevant to focus on the design of the physical environment.	Level IV A

Dearholt, S. L. & Dang, D. (Eds.). (2012). *Johns Hopkins nursing evidence-based practice: Model and guidelines* (2nd ed). Indianapolis, IN: Sigma Theta Tau International Honor Society of Nursing.

Appendix D

DNP Statement of Non-Research Determination Form

Title of Project:

Creating A Healthy Work Environment Using the Means of Communication

Brief Description of Project:

St. Mary's Medical Center is a 148-bed acute care facility in San Francisco, California which provides a conglomerate of specialty care within its diverse environment. The culture within the facility has changed over time and there are concerns related to communication between the staff and leadership.

The leadership of the organization wants to improve their relationship with employees by increasing communication transparency and nurse leader engagement with employee recognition. This topic has been identified as a concern based on anonymous employee feedback from the results of the 2016 Dignity Health Employee Experience Survey. In review of the questionnaire results, it has been identified that individual nursing units have scored below average with questions relating to management engagement such as *"The person I report to makes sure that I am well informed about news and changes" and "The person I report to provides recognition for employees who do a good job"* (Dignity Health, 2016).

As the responsible person for establishing and maintaining a healthy work environment, a nurse leader needs to engage with her/his employees to understand the status of the environment's health and respond to the results (Blake, 2015). This will not only improve the morale on the unit but will also positively affect patient outcomes. Quantitative and qualitative studies have been conducted which have linked nurse and patient outcomes to the health in the environment of which nursing care took place (Aiken, Clarke, Sloane, Lake, & Cheney, 2008).

Evidence shows that nurse leader engagement is vital as it influences the overall health of the unit (Zwink et al., 2013). In support of this statement, employees have expressed that when they work in environments where their leaders are transparent in communication, they tend to be more productive with their time at work (Vogelgesang, Leroy, & Avolio, 2013). In

addition, when employees receive meaningful recognition it helps to affirm alignment of their purpose with the organization which increases a sense of self-value and pride in their work (AACN, 2005).

A) Aim Statement:

By January 1, 2018 identified communication and rewards/recognition metrics with inpatient clinical units will increase by 30%.

Goals include:

- The employee experience survey metrics *"The person I report to makes sure that I am well informed about news and changes" and "The person I report to provides recognition for employees who do a good job"* will improve by 30% (Dignity Health, 2016).

- Implementation and evaluation of daily shift huddles will take place at the beginning of each shift.

- The visual nurse request update board will be implemented and utilized by each Unit Practice Council.

- Ten employee recognitions/acknowledgements will be distributed per month and hardwired by January 1, 2018.

B) Description of Intervention:

To determine the baseline state, the 2016 annual employee experience survey results will be reviewed with nurse leaders, the Hospital Practice Council, and the Unit Practice Council to determine opportunities for improvement on two key metrics. The nurse leaders and the councils will analyze the results for the metrics *"The person I report to makes sure that I am well informed about news and changes" and "The person I report to provides recognition for employees who do a good job"* (Dignity Health, 2016). The current plan is to utilize evidence-based research to identify key strategies to improve the identified metrics. The Unit Practice Council will convene weekly for two months, then every two weeks for four months, then

monthly for the duration of the project. The Hospital Practice Council will meet monthly for the duration of the project. The nurse leaders will meet every week for one month, then twice a month for two months, then once a month for the duration of the project to develop, implement and evaluate the strategies. Changes to the plans will be made based on PDSA cycles.

C) How will this intervention change practice?

The implemented strategies will change practice in that it will create a community of transparency that will decrease fear, anxiety, and confusion in the clinical environment. It will increase employee recognition which will affirm employee purpose with the organization and ultimately align their personal goals with the mission and vision of the organization. This will in turn increase positive employee engagement which has been proven to positively affect patient outcomes (Burns, 1978).

D) Outcome measurements:

1. By January 1, 2018 the employee experience survey metric *"The person I report to makes sure that I am well informed about news and changes" and "The person I report to provides recognition for employees who do a good job"* will improve by 30%.

2. Development, implementation and evaluation of daily shift huddles will take place at the beginning of each shift with 90% participation on units by January 1, 2018.

3. The visual nurse request update board will be implemented and utilized by each Unit Practice Council by July 1, 2017.

4. Ten employee recognition/acknowledgements will be pursued per month and will be hardwired by January 1, 2018.

Appendix E

Employee Experience Intervention Plan

Frequency	Activity	Detail
Quarterly	Nurse Collaboration Forum	A gathering for nurses and nurse leaders to provide an opportunity for communication exchange and recognition. Suggested Topics: Patient Experience, Evidence-Based Peer Presentation, Initiative Updates, Staff Acknowledgement and Recognition, Quality and Performance Updates, Financial Updates, and Q&A session.
Monthly	Recognition: Employee Birthday Cards	Each employee will receive a personalized birthday card mailed to their home wishing them a happy birthday cheer.
Monthly	Recognition: Off-Shift Presence to Reward Great Work	Once a month on rotating shifts the units will be visited and presented with rewards based on results of a chosen metric. A person, group, or unit will be recognized for the good work that they do.
Weekly	Shift Communication Huddle	Each week, during or prior to the first shift on Monday a detailed daily communication huddle message will be provided for the staff to receive relevant unit information and updates.
Daily	Recognition	As daily leader rounding occurs on the units, individual employees will be recognized for the good work that they do based on real-time feedback from patients during rounding, other leader feedback, or input from peers.

Appendix F

Daily Shift Communication Huddle Template

Unit Daily Shift Communication Huddle
Week Starting Monday, Month, Date, Year
Join Us for the Journey Through Excellence…
Charge Nurse Days_____ Charge Nurse Evening_____ Charge Nurse Nights_____
Welcome: New Employees, Float in Staff_____ Census Day_____ Census Evening_____ Census Night_____ High Risk Pts: Wanderers, Falls, HAPU, Violent_____
Messages for The Week

Appendix G

Gap Analysis

Current Practice	Best Practice	Deficiency	Recommended Actions
News and updated information are verbally given to employees with the expectation that the information will be passed along to peers. Emails are also sent to employees with a low read rate.	Being transparent with employees and keeping them up to date will increase employee loyalty and make them want to produce their best work. Vogelgesang, Leroy, & Avolio, 2013	The lack of a consistent process for communicating news and updated information	Develop, implement, and evaluate communication activities that will keep employees up to date with news and information.
Employees are recognized sporadically without a planned process.	Having a meaningful recognition program decreases nurse burnout and increases compassion satisfaction. Kelly, L. A., & Lefton, C. (2017).	The lack of a consistent meaningful recognition program	Develop, implement, and evaluate a formal meaningful recognition program with strategically timed interactions

Appendix H

SWOT- Analysis

Strengths

- New executive team who are people oriented and eager to make positive changes that will align the activities of Facility A with the goals of its governance
- New nurse directors to Facility A with fresh ideas
- Compassionate informal leaders who truly want to align to support positive patient and employee outcomes
- Small facility so can adapt change quicker
- Part of a distinctive health system, but can make rapid individual changes
- Most employees are willing to listen to new ideas for change
- Recent re-initiation of Unit Practice Councils

Weaknesses

- Lack of financial support for staff meetings
- Lack of standardization with communicating news and updated information to frontline employees
- Span of control beyond evidence-based recommendations
- Lack of a formal employee recognition process

Opportunities

- Collaboration with a major local university medical center
- Merge of Facility A's governance with Catholic Health Initiatives
- Renting of vacant real estate in the medical center

Threats

- Census had steadily been decreasing causing nurses to have their shifts cancelled; this is a dissatisfier
- Facility A has a sister facility in the same governance structure that is providing the same healthcare services in the same service area community. The sister facility is only 3.0 miles away.
- When thinking about average daily census and factors affecting this number, take note that there are a total of ten major hospitals and medical centers within the service area city limits.

Appendix I

GANTT Chart

	2016			2017												2018			
Course	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Literature Review																				
Initial meeting with nurse leaders																				
Complete gap analysis																				
Establish baseline scores																				
Identify key nurse workgroups/ Define roles and responsibilities																				
Work on manuscript																				
First workgroup meeting / Present Research																				
Hold kickoff meeting with all unit employees																				
Submit Quals documents for approval																				
GoLive new communication plan																				
Prospectus First Draft Due																				
First Communication Activity																				
Weekly meetings with nurse directors to discuss learnings																				
2017 Annual Employee Experience Survey																				
Meet with stakeholders to adjust in PDSA format																				
Send out anonymous survey to unit employees																				
Meet with nurse directors monthly to discuss feedback and plan accordingly																				
Evaluation Period																				
Submit Final Paper																				
Residency																				
Graduation – R. Coicou, DNP																				

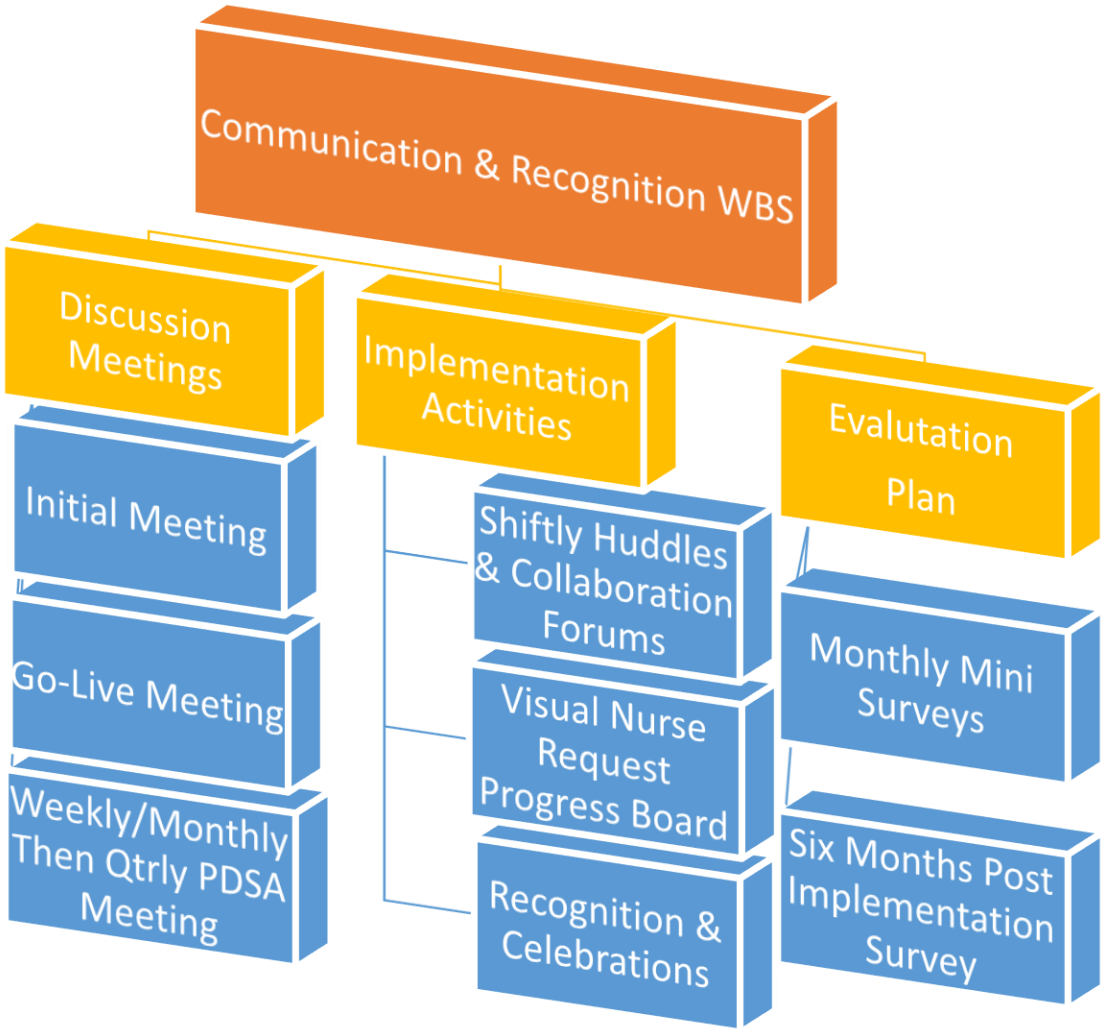
Appendix J

Communication Matrix

		Project Manager	Nurse Leader	Unit Practice Council	Clinical Ladder Candidates
Attend initial planning meeting		Facilitator	Oversight	Participant	
Go-live meeting		Facilitator	Assist and Support	Participant	Participant
Weekly PDSA analysis		Facilitator	Oversight	Participant	Participant
Monthly PDSA analysis & progress meeting		Facilitator	Participant	Gathers Unit Information for Report Out	
Recorder of discussions					Recorder
Follow up monthly surveys		Facilitator	Oversight	Encourager of Peers to take survey	Encourager of Peers to take survey

Appendix K

Work Breakdown Structure



Appendix L

Financial Impact

Metric	Cost Avoidance Measure	Financial Cost
Recruitment Cost	Average cost for recruiting one Registered Nurse	$88,000 X 8 RNs per year = $704,000
ROI	Cost avoidance for retaining an RN and decreasing turnover rate	$704,000 + $895,200 = $1,599,200

Involved Party	Daily Shift Communication Huddles	Visual RN Request Progress Board	Recognition Program	Number of Attended Meetings (1 hour)	Number of Participants	Hourly Salary	Projected Annual Invested Hours	Total Annual Financial Investment
Clinical Ladder RN	Yes	Yes	No	8	6	$70	48	$3,360
Charge Nurse	Yes	No	No	52 (30 min weekly)	5	$71	130	$9,230
UPC Member	Yes	Yes	No	10	6	$70	60	$4,200
Nurse Directors	Yes	Yes	Yes	12 (1hr for roll-out) + 52 (30 min weekly) + 1 (3 hr monthly)	4 4 4	$95 $95 $95	48 104 144	$4,560 $9,880 $13,680
Project Manager	Yes	Yes	Yes	30 (1hr for roll-out) + 8 (30 min weekly) + 20 additional hrs for meeting preparation	1 1 1	$80 $80 $80	30 4 20	$2,400 $320 $1,600
Documents/ Survey/ Celebration	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$2,000
Total								$51,230

Appendix M

Daily Shift Communication Huddle Message Survey

Question	Responses Yes No	Comments
Are the shift huddles helpful?	Yes No	
Are there too many messages in one session?	Yes No	
Are shift huddle messages relevant to what is going on the unit?	Yes No	

Appendix N

Daily Shift Communication Huddle Message Survey Results

Total Number of Employees eligible to participate = 118

Total Number of Employees Who Participated = 67

Total Percent Participation = 57%

Question	Number of Yes Responses	Number of No Responses	Number of Surveys Not Answered	Total
Are the shift huddles helpful?	48 72%	5 8%	14 20%	67 100%
Are there too many messages in one session?	31 46%	26 39%	10 15%	67 100%
Are shift huddle messages relevant to what is going on the unit?	58 87%	3% 4%	6 9%	61 100%

Appendix O

Daily Shift Communication Huddle Message Survey Results' Comments

Question: What, if anything, would you change *related* to daily shift huddles?

Keep it short to 5min or less please Said 9 Times	A more thorough yet brief description of all the pts on the floor like you get in ICU huddles	Can we do it at the nursing station? It takes too long to gather the nurses and go all the way to the conference room	Each shift should have one specific to themselves and not just a repeat	Eliminate and include info in the RN-RN report	Info is repetitive Said 3 Times	The pm shift is too long. Sometimes they get out at 4:15p then they look up info on their patient which creates dayshift OT
Include time for questions and feedback during the huddle	Email staff with the messages instead Or Post huddle in pantry or break room	Would not change anything Said 2 Times	Sometimes it doesn't start on time due to waiting for nurses to show up	The purpose of huddles: to discuss census and patient acuity, fall risks, isolations, and chemo patients, not about survey results	Ready people to get to huddle first Or Start huddle earlier than beginning of shift	End huddles on a positive note such as what RNs are doing good for the floor
I don't feel we need huddles for charge nurse to charge nurse info	Don't want huddles everyday Said 3 Times	Affirmation if someone did a good job	When a busy day and don't have time for long huddle, let everyone read and sign it during the shift	Focus on most important inpatient issues Said 4 Times	CNAs answer lights during the time of huddles. We don't participate. Said 2 Times	Most night shifts don't get huddle, but huddle should be about safety issues for pts and new changes RNs should be aware of or that now night RNs have to risk injury transporting the deceased to the morgue

Appendix P

Quarterly Nurse Collaboration Forum Survey

Question	Yes or No	Comments
Was this meeting helpful?	Yes or No	
Was the peer presentation helpful?	Yes or No	
At what frequency do you think this meeting should take place?	Monthly or Quarterly	
What is one thing that you have learned from this meeting?	Comment on right	
What is the one thing that you will do differently?	Comment on right	

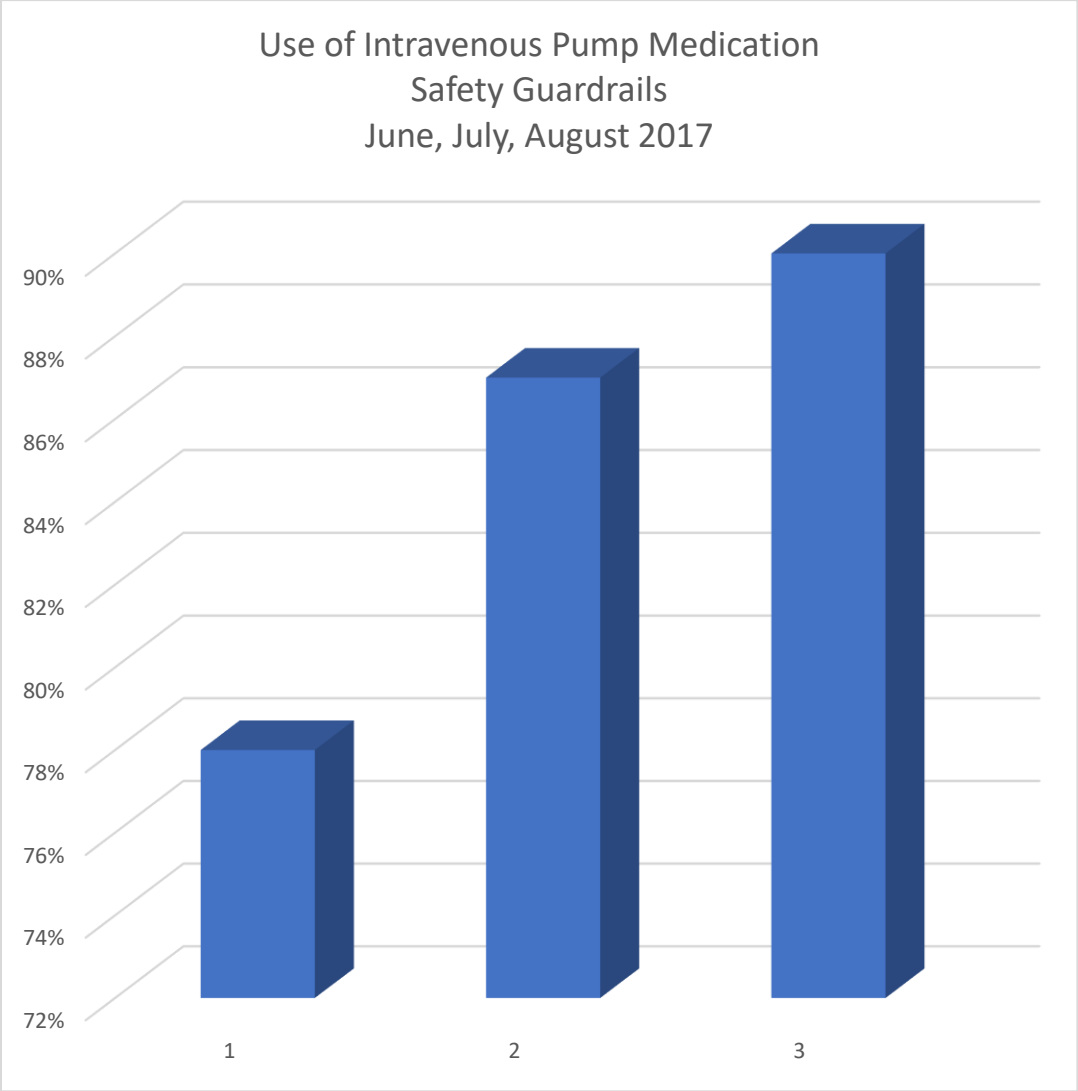
Appendix Q

Quarterly Nurse Collaboration Forum Survey Results

Question	Number of Responses Yes	Number of Responses No	Number of survey question not answered
Was the meeting helpful?	23 100%	0 0%	0 0%
Was the peer presentation helpful?	21 91%	0 0%	2 9%
At what frequency do you think this meeting should take place?	19 83%	4 17%	0 0%

Appendix R

Medication Safety Guardrails



During the months of June, July, and August 2017 the use of intravenous pump medication safeguards steadily increased as there were medication safety reminders in the daily shift communication huddles and direct communication from the DOPCS as she rounded on the clinical units. The percent compliance in June was 78%, July was 87%, and August was 90%.