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The Impact of a Nurse Engagement Model Implementation on Patient Outcomes

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My dream of completing a terminal degree in nursing is one that I have had for a long time and one that I expressed often. It wasn't until I began working for a phenomenal organization that supported and encouraged professional development that I was able to pursue that vision. When one completes such a journey it's not without a we that also completed it. Let me explain in the following sentences. My mother, who I owe the most gratitude, was my biggest and most motivating supporter; she believed in me like no other, but unfortunately, she did not live long enough to see it come to fruition. My mother passed away as I was completing my first year of this doctoral program. However, her consistent words of encouragement, support, and wisdom, that only a mother knows, were immeasurable and without hesitation and pushed me toward completion. I am eternally grateful for her gifts, and I know that she, along with my dad, are beaming down on me as I complete this degree.

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Executive Summary

Problem: A strongly engaged workforce is extremely important when addressing the challenges of health care delivery in hospitals. Today's health care organizations face aggressive markets, multiple governmental regulations, accreditation approval, fiscal challenges, patient safety concerns, patient and family satisfaction, sustainable quality metrics, resource stewardship, and workforce issues such as turnover and shortages. As the key figures in any hospital system, nurses have an essential role in the quality of care provided to patients. Linked to key safety, quality, and patient experience outcomes, nurse engagement is critically important for all health care organizations to understand their current state of engagement and its key drivers (Laschinger & Leiter, 2006). Health care leaders are required to build and sustain work cultures that are not just sustainable but also engaging, which ultimately translates to patients and their outcomes (Bailey & Cardin, 2018).

Context: A large integrated health care system leader in California, operating 39 hospital facilities, serving over eight million members, and employing over 53,000 registered nurses (RNs), has been on a journey to achieve a level of performance excellence that ranks among the very best by increasing workforce engagement and delivering on quality outcomes (Kaiser Foundation Hospitals and Health Plan, 2017). This engagement study focused on RNs, including nurse leaders, at one of this system's acute care northern California hospitals, a 169-licensed bed facility in central California that employs 491 inpatient RNs. The facility has had overall engagement scores unchanged over the past four years and is striving to experience improvement in nurses' engagement and inpatient safety and care experience. The area is considered geographically isolated from the other hospital facilities within this system and is in the agriculture hub of the state.

Interventions: The entire acute care nursing staff and 36 nurse leaders were the focus of this project. Eligibility criteria included all patient care adult services and maternal-child health assistant nurse managers, nurse managers, directors, and all RNs working and assigned to those areas of the hospital. The interventions used in the program were the completion of a module on professional practice for RNs, voluntary attendance at chief nurse executive (CNE) hosted community forums, implementation of elements of American Organization for Nursing Leadership (AONL) nursing leadership toolkit with nurse leaders, council member completion of eight hours of caring science (Watson, 2006) modules, and unit council implementation of a patient-centered caring science project. Caring science theory was applied to the work of the unit-based hospital nursing council projects and incorporated into scheduled Patient Care Services community forums held by the CNE and the director team. The work with the nursing leadership team was to provide education and development in leadership skills to understand the interdependence between quality, safety, patient satisfaction, nurse engagement, and leadership.

Financial Impact: This project resulted in cost avoidance in the avoidance of having to incur costs in the future. The cost avoidance measures outlined in this project represent $544,070 of potential increases in costs yearly that could be averted through the project actions. The actual cost avoidance resulted in $428,343 savings during the six months of this project. The total cost of the six-month engagement project was $161,152.

Measures: Tools chosen to study the intervention strategies and outcomes were: 1) RN knowledge assessment regarding professional nursing practice; 2) Caring Factor Survey assessment; 3) staff engagement surveys; 4) patient harm data: catheter-associated urinary tract infection (CAUTI), central line-associated bloodstream infection (CLABSI), hospital-acquired pressure injuries (HAPI), hospital-acquired pneumonia (HAP), and patient falls; 5) community

forum evaluations; and 6) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) care experience data. Each baseline metric was developed from the previous year's results (2018) prior to any intervention, except for the community forum data on the newly formed educational offerings. Intervention activities began on January 1, 2019. Tabulations were calculated at the end of each month and concluded six months after interventions had begun.

Results: The findings after implementing the engagement strategies compared to pre-study findings are as follows:

- Improvement in nurse engagement, as evidenced by professional practice education pre- and post-data, caring attribute survey pre- and post-data results, and RN engagement survey pre- and post-data results.
- Improvements in patient harm data.
- Improvement in care experience data, as evidenced by HCAHPS recommend hospital and RN communication increases.
- Communication via community forums is valued by nursing staff.
- Avoided costs that would have occurred without intervention of $428,343.

Conclusion: Organizations that provide opportunities for nurses to be engaged are more likely to provide favorable nurse-sensitive outcomes and better care experience (Kutney-Lee et al., 2016). The purpose of implementing this project was to demonstrate the effectiveness of a uniquely designed nurse engagement implementation model for nursing and its impact on nurse-sensitive quality indicators, care experience, and nurse engagement.

Keywords**:** nurse engagement, patient satisfaction, professional practice model, nurse quality indicators, staff engagement, patient experience, care experience, shared governance, nurse empowerment, patient outcomes, caring science

Section II: Introduction

Problem Description

A strongly engaged workforce is extremely important when addressing the challenges of health care delivery in hospitals. Today's health care organizations are facing demanding competitive markets, multiple governmental regulations, accreditation approval, fiscal management, patient safety concerns, patient and family satisfaction, sustainable quality metrics, resource stewardship, and workforce issues such as turnover and shortages. Hiring and retaining a nursing workforce that is clear on purpose and engaged in their work can help an organization survive, if not thrive (Dempsey & Assi, 2018). Hospitals are where patients go to receive specialized care, particularly nursing care. Patients cannot be admitted without the need for nursing care. Nurses make up most of the workforce in hospitals; therefore, it is essential for hospitals to promote a culture of engagement among nurses to keep them working in their facilities (Institute of Medicine, 2011).

Linked to key safety, quality, and patient experience outcomes, nurse engagement is critically important for all health care organizations to know and understand their current state of engagement and its key drivers (Laschinger & Leiter, 2006). Patient safety must supersede everything that occurs in a health care setting, and it is nurses who play a key role in delivering quality care and in keeping patients safe.

The U.S. Department of Health and Human Services (USDHHS, 2009) reported that somewhere between 210,000 and 400,000 deaths from preventable errors occur each year in hospitals. In addition, it is estimated that 99,000 patients die because of hospital-acquired infections each year. Errors result in some type of harm to one out of every 25 hospitalized patients (USDHHS, 2009). Hospital-acquired pressure injuries (HAPI), falls, and catheter-

associated urinary tract infections (CAUTI) are just a few of the health-acquired harm events to patients that are directly linked to nursing care quality. Carter and Tourangeau (2012) suggested that improving registered nurse (RN) engagement positively impacts nursing quality indicators of pressure injuries, patient falls, and CAUTIs, which then has a positive impact on the institution's financial metrics. Laschinger and Leiter (2006) also noted that when hospitals supported a standardized nursing model and when nurses were engaged in their work, the result was more positive nurse-sensitive patient outcomes.

The Centers for Medicare and Medicaid's (CMS) value-based purchasing program and cost-containment initiatives have forced organizations to pay attention to nurse engagement, as patient experience results constitute 25% of CMS value-based payment to hospitals (CMS, 2019). CMS also institutes penalties to hospitals for poor quality of care outcomes. Increasing nurse engagement may help organizations avoid costly penalties and maximize their reimbursement (Kutney-Lee et al., 2016). According to Kruse (2015), in a study of over 200 hospitals, nurse engagement levels was the number one variable correlating to patient mortality. Kruse found that improving engagement improves patient satisfaction and clinical outcomes and reduces hospital-acquired conditions and staff turnover. In a cross-sectional study of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys, Kutney-Lee et al. (2009) found that the effect of the nurse work environment is closely associated with patient satisfaction and the patient's ratings of willingness to recommend the hospital to others. This study supports the recommendation of investing in nursing as a strategy to improve hospital performance.

The cost of RN turnover can have a profound impact on a hospital's operating margin. According to the National Healthcare Retention and RN Staffing Report (Nursing Solutions, Inc,

[NSI] 2016), the average cost of turnover for a bedside RN ranges from $37,700 to $58,400. Therefore, nurse retention is paramount, as it has a financial impact resulting in less staff turnover and less cost of replacement. In addition, in 2007, the American Health Care Association reported that one in six RN positions was vacant, and that by 2025, the RN shortage will rise to over 260,000 (Rosseter, 2012). This nursing shortage will cause constraints to any health care system and serves as an alarm to assure that nursing turnover is limited, with engaged staff retention crucial to care delivery.

The operating definition for engagement is an intellectual and emotional connection that employees must have with the organization, their work, and one another (Kaiser Permanente Foundation Hospitals and Health Plan, 2017). Engagement is a concept that is often used to describe the nurses' commitment to their job, to the organization, and to their nursing profession (Dempsey & Reilly, 2016). For nurses, staff engagement is a state of mind that is positive and fulfilling and demonstrated by high vigor, strong dedication, and strong interest in patient care (Carter & Tourangeau, 2012). A practice environment where nurses feel accountable and are involved in decision making by engaging them in their practice, creates an environment that supports the quadruple aim of affordability, quality outcomes, staff engagement, and service delivery to patients (Rees, Leahy-Gross, & Mack, 2011).

Another essential element of an environment that is engaging for the nursing workforce is based in a professional practice model (PPM), which is an environment in which nurses feel empowered in the practice of delivering quality care. A PPM is a standardized, organized set of values, beliefs, and vision that clearly articulates the expectations of the nursing staff and, when implemented, is evident through the delivery of care (Cordo & Hill-Rodriguez, 2017). Several

studies suggest that increasing engagement can improve patient and nurse outcomes, thereby suggesting that PPM implementation may be a method to consider.

Achieving the aspects of the PPM cultivates an environment for nurse engagement by involving nurses in their clinical and professional practice. By applying the model consistently, the variation in nursing practice is minimized, gaps in care are decreased, and promotion of safe patient care and patient outcomes is maximized (Kaiser Permanente Foundation Hospitals and Health Plan, 2017). Kutney-Lee et al. (2016) suggested that a professional practice environment promotes optimum patient and nurse outcomes and that PPM implementation supports nurses' control over their practice and enhances the quality of their contribution to patient care.

The PPM is a foundational element of the Magnet Recognition Program of the American Nurses Credentialing Center (ANCC, 2013) and is defined as the conceptual framework that guides nurses through the delivery of their care and their interprofessional care. Glassman (2016) reported that once an organization has determined the specific PPM for their organization, the PPM needs to be shared with the entire frontline nursing community for adoption and acculturation into bedside practice. Additionally, Glassman stated that the PPM requires an establishment for an ongoing evaluation of the model to ensure relevance to the practice environment. Workgroups and nursing councils are formed that include frontline nurses and nursing leadership that drive evidence-based practice, innovation, and professional development. Enculturation of a PPM can be measured through the establishment of nursing practice councils and the assessment of engagement survey data and patient quality outcomes (Glassman, 2016). PPMs can give meaning to the care nurses deliver through nursing theory, guides nursing practice, and communicates the holistic uniqueness of nursing.

PICOT Question

The PICOT question for this study was designed to determine if acute care RNs and nurse leaders (P), who participate in an employee engagement program (I), when compared to those with no formal program (C), could make an impact on nurse engagement and nurse quality indicators (O) after six months of implementation (T).

Review of Evidence

The PICOT question guided a systematic search using the following key words: nurse engagement, patient satisfaction, professional practice model, nurse quality indicators, staff engagement, patient experience, care experience, shared governance, nurse empowerment, patient outcomes, and caring science. CINAHL, PubMed, Cochrane, and evidence-based journals and textbooks were utilized and produced over 4,500 pieces of literature. The PICOT question assisted in reducing that number to 200 articles to be reviewed. By applying inclusion and exclusion criteria, the focus of the studies was limited to seven studies. The studies identified were critically evaluated using the Johns Hopkins Nursing Evidence-Based Practice Research Evidence Appraisal Tool (Dearholt & Dang, 2012). The results of that review are documented in an evidence table (see Appendix A).

Keyko, Cummings, Yonge, and Wong (2016) conducted a systematic review to determine what is currently known about the outcomes of work engagement in professional nursing practice. Keyko et al. used eight electronic databases: CINAHL Complete, MEDLINE, PsycINFO, PROQUEST, SCOPUS, Web of Science, EMBASE and Business Source Complete, to find qualitative and quantitative research studies that examined the relationships between work engagement and patient outcomes, which resulted in 3,621 titles and abstracts. Data extraction, quality assessment, and analysis were then completed on 113 of these studies, which then yielded

18 studies included in the systematic review. Findings from the studies imply that there is a wide range of reasons for nurses to be engaged in their work, that engagement is important, and that leaders need to offer opportunities that promote engagement. Keyko et al.'s findings from the study indicate that originators for nurse engagement exist at the individual, operations, and organizational levels; they contribute to either positive or negative personal- and performance-related outcomes; and engagement significantly heightens performance in nursing practice. Limitations of this study included response bias, there were no studies excluded based on quality, the findings are not generalizable to all RNs, and there was bias based self-reporting.

Dempsey and Reilly (2016) analyzed Press Ganey's national nurse engagement database of over 300,000 nurses to determine nurse engagement. The researchers found that 15 out of every 100 nurses are disengaged and lack commitment and/or satisfaction in their work. As their research suggested, nurse engagement is critical to the patient experience, to clinical quality, and to patient outcomes. Dempsey and Reilly suggested that each disengaged nurse costs organizations $22,200 in lost revenue as a result of poor productivity. Dempsey and Reilly's analysis suggests that the main drivers with the largest impact on overall nurse engagement are that the organization provides high-quality care and service delivery, employees are treated with respect, and patient safety is a priority. Also cited in their research is the importance of the unit nurse manager in influencing and creating a nursing practice environment that leads to great outcomes for patients. A limitation of this report is that it is a qualitative study. More research is needed to inform strategies, including optimal staffing and scheduling for nurses that may also impact nurse engagement.

In a cross-sectional study in Finland in 2011, Hahtela et al. (2015) investigated connections between nursing quality indicators and workplace culture. The study involved the

completion of questionnaires by patients (n = 53), caregivers (n = 143), and nursing management (n = 14) in 14 inpatient acute care units in seven health care centers. Hahtela et al. found that workplace culture had some correlation to patient outcomes of pressure injuries, deep vein thrombosis, patient falls, and healthcare-associated infections. Hahtela et al. concluded that the results of the study have considerations for those working in health care, as it relates to a need for positive workplace culture. They caution, however, that due to the limited study responses, any conclusions would need to be considered carefully.

Kutney-Lee et al. (2016) used a secondary analysis of cross-sectional data from three data sources to examine differences in nurse engagement in hospitals with a structured shared governance, as compared to those without a shared governance structure in place. This study used three secondary de-identified data sources: (a) Penn Multi-State Nursing Care and Patient Safety Survey of 20,674 direct patient care RNs, (b) the American Hospital Association (AHA) annual survey of 425 hospitals, and (b) HCAHPS patient survey data. The nurse survey used state licensure lists and was collected by mail from a random sample of RNs. The hospital AHA survey results provided hospital characteristics. The CMS Hospital Compare website provided the HCAHPS data. Findings suggest that hospitals that offer nurses opportunities for involvement in shared decision making were more likely to provide better quality of care and better patient experiences, when compared to hospitals where nurses were not engaged in shared governance. The results of this study suggest that shared governance is a business strategy that must be considered and increasing nurse engagement is an approach for improving patient outcomes. The limitations of this study were that it used an observational, cross-sectional design to make only limited causal inferences about the relationship between nurse engagement and patient outcomes. The submission of HCAHPS scores was voluntary and could be viewed as a

limitation, as it may have included only high-quality hospitals who were willingly submitting data.

Stallings-Welden and Shirey (2015) evaluated the effectiveness and predictability of a PPM for nursing by studying its ability to show impact on select nurse and patient outcomes. Using a 6-year retrospective/prospective, pre/post implementation research design, the researchers collected secondary data from 2,395 inpatient staff nurses from two acute care hospitals. Using ANOVA, Stallings-Welden and Shirey analyzed the data for three years pre-PPM implementation and three years' post-PPM implementation. Pearson correlation coefficients were calculated to evaluate the relationships between nurse and patient variables and predictive inferences. Based on evidence from the study, the authors concluded that the PPM for nursing is predictive of improved nurse and patient outcomes. Limitations were that there was not a standardized instrument to validate and assess the PPM, making it unrealistic to generalize the findings, especially since the study was conducted at only two campuses (Stallings-Welden & Shirey, 2015).

Havens, Gittell, and Vasey (2018) explored how relational coordination (process of communicating and relating) impacted work engagement and improved the care experience. Using a non-experimental survey design of 382 nurses in five acute care community hospitals, Havens et al. found compelling evidence to support that relational coordination does matter, not only for patients but also for the wellbeing of nurses. Their findings provide evidence-based justification for hospital leaders to shape and support the practice environment that will enhance and improve the delivery of safe quality care.

Fischer and Nicholas (2019) hypothesized that frontline nurse managers practicing transformational leadership practices were associated with achieving quality patient outcomes in

their units. Using an observational study design of 50 nurse managers in six hospitals (four Magnet hospitals and two non-Magnet hospitals) in Michigan, they examined the relationship between leadership practices and nurse-sensitive patient outcomes, including falls, CAUTIs, HAPIs, and CLABSIs using the Leadership Practices Inventory (LPI). The LPI is a 30-question tool designed to measure the frequency of leader engagement in five leadership practices. The nurse-sensitive outcomes were reported from the National Database of Nursing Quality Indicators database. Fischer and Nichols found that putting structure around the pursuit of Magnet recognition by having nurse managers practice with higher transformational leadership skill is advantageous for both patient outcomes and nurse engagement. Limitations of the study were the unit's size, number of staff members employed on the unit, longevity of staff experience, staffing ratios, percentage of BSN-prepared nurses, and availability of support staff working on the unit were not considered.

Conceptual Framework

Through a review of the literature, increasing evidence suggests that improvement efforts that consistently stress initiatives to improve the patient care experience and create and support a highly engaged nursing workforce are key to achieving excellence in quality and safety outcomes (Dempsey & Assi, 2018). PPMs give purpose to the work of nurses. Embracing and implementing a PPM can serve as a source of pride with which nurses engage in, improving all aspects of the care they deliver.

The following conceptual framework guided the implementation of this nurse engagement project. The framework used was composed of Watson's theory of human caring (Watson, 2008), Lewin's change theory (Mitchell, 2013), Kanter's theory of structural power in organizations (Sarmiento, Laschinger, & Iwasiw, 2003), and the PPM called The Voice of

Nursing (Kaiser Foundation Hospitals and Health Plan, 2017). Each of these components of the framework is described in detail.

Human Caring Theory

Jean Watson's (2008) theory of human caring, developed in 1979, involves making human caring and relationship-centered care the groundwork for patient care and healing. The theory involves looking at the holistic being, while paying attention to and creating a healing environment. Caring and nursing arts are essential to Watson's theory, which results in the healing experience, while positively affecting patient outcomes (Watson, 2008). Watson's theory describes caring as a professional and ethical covenant nurses hold with their patients during times of vulnerability. Watson states that carative factors exist that can strengthen the science of nursing through their application, which will then result in positive patient outcomes. The carative factors include compassion, authentic presence, healing environments, unity of being, caring healing modalities, loving kindness, and transpersonal relationships (Watson, 2008). The theory incorporates the science of nursing's clinical judgment with the art of caring for the whole unique individual to nurture their wellbeing (Watson, 2008). Understanding the core concepts of Watson's theory, human care process and human care transactions, combined with nursing processes that influence positive changes in health status of patients, served to establish a change in the previous practice model in the health facility. The theory connects the hearts and minds of the bedside nurse and is referred to as caring science. Caring science was used as a framework for process and culture change in the facility by providing a language, values, and behaviors to nurses and their care delivery. The caring science model has been integrated into the nursing practice framework in this organization to guide and define all patient relationships.

Change Theory

Kurt Lewin's change theory, developed in 1947, is based on stages of change: unfreeze (when change is needed), change (when change is initiated), and lastly, refreeze (when equilibrium is established). The theory establishes a framework for when important change is needed, with minimal disruption, and teaches how it will be sustained (Mitchell, 2013).

Lewin's 3-step change model was developed for implementing changes when dealing with people and provides guidance on how to go about the change, implement the change, and then sustain by making the change permanent (Mitchell, 2013). Lewin theorized that driving forces exist that facilitate change as they push to the desired change, while opposing forces push in the opposite direction. The focus is on improving or strengthening those forces or factors that can support change and restraining the forces that interfere with change. Lewin's model shifts the balance in the direction of the desired change. Unfreezing involves finding a method of making it possible for people to let go of an old way of doing something. Using different methods to unfreeze can lead to the achievement of unfreezing. Methods include increasing driving forces that direct behavior away from the existing current situation, decreasing restraining forces that affect the movement from the existing status quo, or a combination of the two (Mitchell, 2013). The change phase of the theory is a process that involves a change in thought, behavior, or feeling that liberates one to make the change. Refreezing is the stage where the change becomes the new standard and is sustained (Mitchell, 2013). Managing change was and is the way this project will continue to move into the sustainable future state and reduce resistance to an alternative way of delivering care.

Structural Empowerment Theory

Kanter's theory on structural empowerment was also used as a change management framework for this project, as Kanter claims that workers (in this case, the nurses) are

empowered when they perceive that their work environments provide opportunity for growth and are given the power to carry out job demands (McDermott, Laschinger, & Shamian, 1996). Kanter's theory states that with tools, information, and support, workers will improve their skills and make better-informed decisions, thereby accomplishing more for the organization. The use of the existing unit-based council structure and educational opportunities assisted in driving elements of this project as supported in Kanter's theory.

Voice of Nursing

The Voice of Nursing, this organization's PPM, lays the foundation for transformational practice and alignment with the organization's mission and value compass through its nursing vision, set of values, and model of care (see Appendix B). It is meant to standardize practice where there is evidence and elevate nursing at this organization. Introduced in 2018 at this hospital, the PPM is in the early phases of its development. Nursing unit councils have been formed on each inpatient unit and are co-chaired by the unit manager and a staff co-lead. The unit council structure includes eight to 15 frontline staff nurses and their unit manager. Each council meets monthly and empowers staff to engage in shared decision making, drive evidence-based practice, and develop processes to improve employee engagement and patient outcomes on their unit.

Specific Aim

The primary aim of this project was the implementation of interventions focused on improving nurse engagement among frontline RNs and nursing leadership (see Appendix C: Work Breakdown Structure). Through a more engaged RN workforce, specific performance initiatives were highlighted for improvements related to the patients' experiences and quality outcomes. The project objectives were to: (a) establish and implement an employee engagement

program for all acute care hospital RN staff and nursing leadership beginning January 2019 and completing by July 2019 (see Appendix D: Gantt Chart: Engagement Implementation), (b) improve RN staff engagement scores from 2017 baseline by 5% at the end of the project, (c) reduce the number of falls by five cases and prevent any HAPI from 2018 year-end baseline, (d) avoid at least one case of each CAUTI, CLABSI, and HAPI infection from 2018 year-end baseline, and (e) increase HCAHPS 2% from 2018 year-end baseline in recommend hospital and in nurse communication. The end goal is to create a profound culture change within the facility.

Section III. Methods

Context

A large integrated health care system leader in California, operating 39 hospital facilities, serving over eight million members, and employing over 53,000 RNs, has been on a journey to achieve a level of performance excellence that ranks among the very best, by increasing workforce engagement and delivering on quality outcomes (Kaiser Permanente Hospital and Health Plan, 2017). A gap analysis (see Appendix E) and SWOT analysis (see Appendix F) were completed prior to beginning the project to identify the internal and external factors that would affect the organization's performance and the success of the project.

The engagement study focused on RNs, including nursing leadership, at one of this system's acute care northern California hospitals, located in the agricultural area considered the central valley of California. The hospital has a 169-licensed bed capacity and employs 491 acute care RNs. The nursing units that were the focus of the project were one critical care unit, two telemetry medical units, two medical surgical units, and the maternal-child health unit. All staff nurses in this study are members of a nurse's union. Nursing leadership is non-unionized. Although the organization had an established PPM, this local hospital initiated a PPM in 2018. The hospital has had overall engagement scores unchanged over the past three years and would like to see improvement in acute care nurses' engagement, patient safety, and patient care experience. The engagement scores are published, posted, and communicated to the nurse leaders and RNs each year, and unit action plans have been developed collaboratively to improve scores. The lack of sustainable improvements in nurse engagement is and has been a concern for several years.

Study of Interventions

The entire nursing staff of 491 acute care nurses and 36 nurse leaders were the focus of this project. Eligibility criteria included all patient care adult services and maternal-child health assistant nurse managers, nurse managers, directors, and all RNs working in and assigned to those areas of the hospital. The interventions used in the program were the completion of a module on professional practice for all RNs, voluntary participation in nursing community forums led by the CNE, implementation of the AONE nursing leadership toolkit (see Appendix G) to the assistant nurse managers and nurse managers, unit RN, and nurse manager council member completion of caring science (Watson, 2008) education, and implementation of a patient-centered caring science project by each unit council (see Appendix H: Caring Science Projects).

Outcome Measures

Mitigating the financial impact of poor patient outcomes and a disengaged nursing workforce is crucial to any hospital's financial health. Efforts to retain engaged nurses is significantly important, as employee engagement is interwoven into an organization's business outcome. Studies have found a positive relationship between employee engagement and performance outcomes of the organization, which include employee retention, productivity, profitability, safety, and customer satisfaction (Ellis & Sorensen, 2007; Heintzman & Marson 2005). This project's aim to improve RN staff engagement and improve patient safety through avoidance of cost has been demonstrated (see Appendix I: Budget with Cost Avoidance and Appendix J: Cost Avoidance Measures).

Both primary and secondary data were utilized in this study to gain information on the short- and long-range questions to be answered. Primary data were collected and collated from

the selected annual employee engagement survey People Pulse questions pre-intervention (2017) and using a convenience sample post-intervention via voluntary written surveys (see Appendix K for the People Pulse survey tool). All responses were kept confidential. The post-survey results calculated the central tendencies of mean, medium, and mode from the respondents and were then compared to the People Pulse baseline survey (see Appendix L for the results). Class pre- and post-assessments were completed by RN participants in all educational sessions. Nurse leader pre- and post-assessments using the AONE competency assessment was completed by all assistant nurse managers, managers, and directors involved in the six-month educational series (see Appendix M for survey results). Nurse leaders were assigned an anonymous number that they used to complete pre- and post-surveys.

Secondary data were collected on nurse-sensitive quality indicators of falls, HAPIs, CAUTIs, CLABSIs, and HAPs from the hospital's data systems for baseline data, as well as post-intervention. A simple comparison was done on these nurse-sensitive quality measures from the baseline and at the end of the project (see Appendix N)

The HCAHPS survey items were compared using 2017 nurse-specific survey results to 2019 post-intervention survey data. Most closely associated with nurses' delivery of care were the two ratings of willingness to recommend the hospital and nurse communication (see Appendix O for HCAHPS data).

Three community forums were held during the six months of the project, at two-month intervals. Evaluations were voluntarily submitted by participants in writing at the end each forum held (see Appendix P for community forum results). Participants were asked to complete a written evaluation that included rating the value of the forum using a Likert-scale from 1 to 5. In addition, open-ended questions asked for suggestions for future topics.

Analysis

The National Strategy for Quality Improvement in Health Care (NQS) brings together organizations to focus on improvements in health care for all Americans (Finkelman, 2018). The project aligns with one of NQS' current strategies of making care safer by reducing harm caused in the delivery of care, as it is a stimulating study on a system-level engagement strategy related to engagement. Analysis of the project utilized descriptive, qualitative, and quantitative statistics. Calculations of central tendency, pre-intervention patient outcome metrics and a comparison to post-intervention patient outcome metrics, and aggregated descriptive data were obtained. Information and feedback obtained from unit council meetings, class discussion, educational sessions, and community forums were incorporated into subsequent meetings to meet the wants and needs of participants. An additional tool that was utilized during the project was the gap analysis that examined the current state of engagement and where the facility's nursing staff wanted to go with engagement. During the project, we utilized brainstorming during all patient care staff and leader meetings, along with written evaluations after community forums, to engage frontline staff and leaders in the change process. Safety, engagement, and quality were the focus areas throughout the project implementation and measurement phases of the project.

Ethical Considerations

The Statement of Determination form was submitted to the committee chair (see Appendix Q) for evidence of non-research and subsequent project approval, which confirmed that the project was not research and did not require University of San Francisco Institutional Review Board (USF-IRB) approval. In addition, an internal IRB committee review was conducted by the health care organization, and the project was found to be non-research and did not need IRB approval, and a waiver was granted. Permission was granted by the organization in

support of the engagement project (see Appendix R). No patients were identified or directly involved in this project. Staff and leaders who were included in the project were on a voluntary basis. It was not mandatory for any manager or staff to participate in any of the work of the project, other than participation of unit council members in a caring science project of their choice. By implementing these staff engagement strategies, the ethical intent was to assist nurses to espouse respect for self and all others, provide excellence in care that is compassionate, and uphold professional practice. The project was designed to provide the participants with psychological safety throughout its entirety.

The nursing profession is firmly grounded in ethics through their obligation to enact the values of the profession. The American Nurses Association has created a nationally accepted Codes of Ethics for Nurses with Interpretative Statements which act as a guide for the nursing profession and is a dynamic resource used in the healthcare setting (Epstein & Turner, 2015). This code of ethics addresses how nurses treat each other, how nurses act and do with patients and why. The various components of this project were meant to influence nurse's work engagement and nursing practice, ultimately, the delivery of ethical care.

The two Jesuit values that have been at the center of this project are those of tending to the whole person; *cura personalis*, which unites the mind and heart and the being and creating people for others (Parmach, 2011). The *cura personalis* value and the creating people for others is consistent with the values of Jean Watson's human caring theory and was the center of the interventions of this project. Watson's theory based in holistic approaches to human caring focuses on caring for patients through the promotion of growth, caring environments, by accepting a person as he or she is and looking to what one can become (Watson, 2008). It also focuses on caring for self in order to be able to provide holistic care to patients. The nurses and

leaders, through actively engaging in the caring practices taught and reinforced during this project, were able to provide guidance, care and support to themselves, each other as well as to the patients. The Jesuit values have been foundational and instrumental to this project and have remained at the core of the work as the project occurred during a time of great challenges and unrest in the work environment. Staying committed and steadfast to these values was most important in the continuation of the work of staff engagement and guided our actions.

There are no identified conflicts of interest to declare. There are no other ethical issues identified.

Section IV. Results

Evaluation and Outcomes

Professional Practice

The intent of the education provided at the beginning of the project was to provide RNs with baseline education and knowledge gain of the full scope of nursing professional practice. The number of nurses initially participating in the pre-PPM assessment was 294 (60%) respondents. The number of nurses participating in the post-assessment survey, six months after their initial survey, was 205 (42%). Answers to the pre- and post-assessment were tabulated in the aggregate and a Chi-square test for association was conducted to determine if any statistically significant improvement was achieved in knowledge or exposure to the PPM. The nurse pre- and post-results demonstrated a positive change in the self-assessment of importance of the vision, values, and PPM, moving from 91.84% to 92.2%. However, the only statistically significant improvement (p = .016) noted from pre- to post-survey was in the RNs' responses to having been exposed to the PPM; moving from 59% to 70%. Interestingly, the written responses made by RN respondents, using high-level insight, demonstrated a shift in the wording that nurses used to describe professional nursing practice (see Appendices S, T, and U).

Staff Engagement and Culture

The establishment of an engagement program, involving ongoing education of staff nurses and nursing leadership, regularly scheduled community forums, and empowerment activities such as the caring science unit-based projects, has been essential to engaging staff and leaders. The unplanned completion of the Caritas Coach program through the Watson Caring Science Institute by the CNE and one of the directors assisted in the ongoing development and incorporation of caring science among the nursing leadership team. The Caring Factor Survey,

which self-assesses each respondent's sense of their level of caring, demonstrated an improvement in all elements of caring for both staff RNs and nursing leadership (see Appendices V, W, and X). Staff engagement from pre- to post-intervention implies a more engaged workforce. The People Pulse survey (the yearly staff engagement survey) data suggest that improvement is noted, particularly in staff feeling more engaged with nursing leadership (see Appendix L).

Staff turnover rates, although consistently well below the national rate of 17.2% (NSI, 2016), demonstrated a slight improvement from baseline (see Appendix Y). Community forum evaluations, which rated the value of the meetings, indicated that 85% of those staff attending found value in them (see Appendix P)

Leadership Development

The results of the AONE survey comparing pre- to post-implementation indicated a statistically significant improvement ($p<.001$) in aggregate mean rating of the AONE survey, a self-assessment of skills for conflict management, situation management, relationship management, influencing behaviors, and promoting professional development. Caring science development among the nurse leaders was significant and measured through the caring attribute survey. A two-sample t-test comparing pre- vs. post- survey results showed a statistically significant improvement in 8 out of 10 questions assessing caring attributes (see Appendix M).

Quality Metrics

The nurse-sensitive quality indicator outcomes are most impressive during this project period. Patient falls, HAPI, CAUTI, HAP, and CLABSI events all demonstrated improvement or remained unchanged during the intervention and post phases of this project (see Appendix N).

Care Experience

The overall results of HCAHPS demonstrated no statistical improvement in overall hospital rating and nurse communication at the end of the project, when compared to the last six months of the previous year (see Appendix O).

Section V: Discussion

Summary

The project's aim was to implement interventions focused on improving nurse. engagement among frontline RNs and nursing leadership. Despite a few implementation barriers, the program was deemed successful. Occurring during a very challenging time for this facility, the project itself came with a sense of accomplishment among staff and nurse leaders. Specific indicators of success were articulated as improvements in employee engagement scores, turnover rates, and nurse-sensitive quality indicators. The results of this project that demonstrate improvement in care after implementing engagement strategies when compared to pre-study findings are as follows:

-Improvement in nurse engagement, as evidenced by professional practice education pre- and post-data, caring attribute survey pre- and post-data results, and RN engagement survey pre- and post-data results.

-Improvements in patient harm data.

-Nurse leadership development as evidenced by improvement in the self-assessment pre- and post-data results of conflict management, situation management, relationship management, influencing behaviors and professional development skills.

-Improvement in nurse leadership engagement, as evidenced by improvement in caring attribute survey pre- and post-data results.

-Communication via community forums valued by nursing staff.

-Avoided costs that would have occurred without intervention of $544,070.

The influence of nursing in the acute care setting cannot be understated. Success in the current and future health care environment will require an engaged nursing workforce.

Furthermore, this everchanging setting will require nurses to continually develop to be best equipped to meet the increased challenges and needs of patients and to assure expertise in clinical care and outcomes and patient satisfaction. Nurse executives who can devote time and effort into increasing and sustaining an engaged workforce will be instrumental.

Implementation Barriers

At the beginning stages of implementing this project, the union representing all the RNs imposed a sympathy strike of five days in support of another union. The sympathy strike was unanticipated by the organization, as the nurses' union had previously settled on their five-year contract nine months previously. The overall crossover rate at this facility was 25% for RN nursing staff, with contingent RNs filling in the gaps. Every nurse leader was required to work 12-hour shifts and rotate to shifts they were not accustomed to. This all occurred during a busy holiday season, during which nursing leadership was not allowed to take any time off. The strike and its intense, concentrated preparatory time resulted in many of the nursing leaders expressing frustration, disappointment, and animosity with the nursing staff for several months after it was over. During the last three months of the project, another non-nursing union, representing 60% of the workforce of the entire organization, were embroiled in tense contract negotiations and threatening to strike, which created unrest and tension among the hospital staff, with the potentiality for the largest strike in the United States since 1997. During this time, the involved union circulated flyers calling for a strike, picketed the facility, and appeared on local television and local newspapers. At times, this created distraction and preoccupation with what was happening with the union discussions.

Another barrier related to implementation was when the winter season census surge occurred at this hospital during the initial phase of project implementation, which never

decreased, and the census remained at 26% higher than budgeted plan. This unrelenting high census, without approval to hire additional staff, resulted in many nurses working above their hired position, often in the form of doubles and additional weekends, and resulted in fatigue of many.

Data management required a great deal of time by the CNE, as there were many elements of the project that were being monitored, which created a time management dilemma at times.

Interpretations

When interpreting the outcomes of the DNP project, the data collected post-intervention was aligned with the current evidence. The current evidence indicates that there is a correlation between staff engagement and patient outcomes. The changes in the various outcome measures, for the most part, did not change as much as once predicted; however, several did change positively, even if slightly. The most significant impact was on patient safety outcomes, which is impressive and should be noted.

Staff and nurse leaders are more engaged, as evidenced by attendance at community forums, involvement of staff nurses in unit councils, the spread of the caring science unit council work, and by the increase in the engagement scores and caring attribute survey results. Patient data obtained through HCAHPS and quality outcomes supported evidence of an improving engaged nursing workforce.

Limitations

The project was one of many initiatives underway during this period and occurred during very intense daily operational needs, resulting in competing priorities, fatigue, and at times, lack of available time to focus on the project work by leaders and staff. The collection of the employee engagement data, both pre- and post-implementation, was purely voluntary, which

could impact responses and produce self-reporting bias. The post-engagement survey was collected using a random convenience sample of nurses, who voluntarily completed a written survey during the change of shift huddles. Due to the project coming to an end, not all nurses were offered the opportunity to complete a post-engagement survey.

The nurses' union attempted several times to block participation in the program or influence results, as they indicated that it was not part of their negotiated contract. The union representatives also continued to express concern about the *brainwashing for Magnet* and expressed this concern to the nursing workforce.

Fluctuations in high census and increased staffing needs resulted in occasional lack of participation in planned unit project activities, requiring these nurses to work delivering direct patient care instead of project work. This potentially could have influenced the nurses and leaders feelings of devaluing the Caring Science work.

The results of the engagement survey and patient quality outcomes could have also been influenced by several extrinsic factors unrelated to the project and thus, must be considered.

The findings must be carefully considered and cannot be generalizable, as its setting, sample size, and project time were limited. Future work should focus on various sample sizes, conducted in different settings and extended time periods, to broaden the understanding of nurse engagement and patient outcomes and its ability to be sustained.

Conclusions

There is no doubt, health care delivery is challenging, and those of us who are fortunate to be nursing leaders can be at the forefront of making improvements and delivering on excellent quality outcomes and safety to patients. The question is not should organizations focus on the patient experience, rather, how can we improve the patient experience. Improvement efforts that

consistently stress initiatives to improve the patient's care experience and create and support a highly engaged nursing workforce are key to achieving excellence in quality and safety outcomes (Dempsey & Reilly, 2016). A PPM gives purpose to the work of nurses. Embracing and implementing a PPM can serve as a source of pride with which nurses engage in improving all aspects of the care they deliver. Hospitals need to consider efforts focused on improving nurse engagement among frontline RNs and nursing management. Nurse engagement has been demonstrated in some studies as correlational to patient experience and the nursing quality of care. The vital connection of nurse engagement to quality outcomes and patient experience must be further studied. Further qualitative research will be necessary to correlate the project findings with improved employee engagement and improved patient outcomes.

There is a key role to be played by nursing leadership in ensuring that nurses are engaged in their work and that patients receive quality of care. Leaders help create the work environment and, as a result, must be considered in the equation of engagement of staff. The development of nurse leaders must be at the forefront of any strategic decisions made by the nurse executive for sustainable nurse engagement (see Appendix Z: Communication/Responsibility Matrix).

This study, although focused on one facility and lasting only a short period of time, suggests that by employing methodologies aimed at improving nurse employee engagement, patient outcomes can be improved. The project findings suggest that nurses and nurse leaders who find meaning in their work, have a more positive perspective and deliver on improved quality of care.

As a last note, and perhaps the ultimate compliment of sustaining this project work, the Director of Education, another nurse leader at this facility, decided to pursue her doctoral studies and continue project work on staff nurse engagement. This will continue to be instrumental in

the development of this facility's culture and in viewing that engagement is an ongoing journey. Engaging and retaining highly skilled staff and leaders needs to be priority in delivering quality patient care.

Section VI: Other Information

Funding

No additional funding sources were established during this DNP project. Funding was supported through the existing budget established by the facility.

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VII. Appendices

Appendix A

Johns Hopkins Evidence-Based Appraisal Evaluation Tables

Citation	Conceptual Framework	Design/ Method	Sample/ Setting	Variables Studied and Definitions	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
Dempsey & Reilly (2015)	N/A	Qualitative, non-experimental surveys	300,000 clinicians, non-clinicians, and patients.	Nurse engagement, nurse job satisfaction, and the nurse work environment.	Press Ganey National Database of Nursing Quality Indicators® (NDNQI®) measuring nurse satisfaction, practice environment, and nurse-sensitive measures.	Press Ganey measures nurse engagement through proprietary survey instruments designed to assess multiple facets of the nurse experience, including nurse engagement, nurse job satisfaction, and the nurse work environment. Based on performance of nurse employees at one standard deviation (*SD*) below the mean using the Press Ganey employee engagement database.	15 of every 100 nurses are considered disengaged (thus lacking commitment and/or satisfaction), suggesting that each disengaged nurse costs organizations $22,200 in lost revenue as a result of lack of productivity. Data demonstrated nurse engagement is critical to the patient experience, clinical quality, and patient outcomes. Nurse engagement with the organization reduces compassion fatigue, burnout, and turnover, while improving teamwork, the patient experience, and organizational outcomes across multiple measures: clinically (fewer hospital-acquired conditions), operationally (staffing and efficiency), culturally (positive work environment and empowerment), and behaviorally (ability to connect with patients and colleagues).	**Strengths:** Demonstrates that nurse engagement is critical to the patient experience, clinical quality and patient outcomes. **Limitations:** Did not study optimal staffing and scheduling that may influence these findings. **Critical Appraisal Tool & Rating:** II-B

Citation	Conceptual Framework	Design/ Method	Sample/ Setting	Variables Studied and Definitions	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
Fischer & Nichols (2019)	N/A	Observational design using the Leadership Practices Inventory (LPI) tool and deriving scores from it and nurse-sensitive patient outcome data from National Database of Nursing Quality Indicators (NDNQI) from each hospital	50 nurse managers in 2 non-Magnet hospitals and 4 Magnet hospitals in Michigan.	Transforma-tional leadership skills and nurse-sensitive patient outcome data.	Self-assessment Patient outcomes	Descriptive and inferential statistical techniques using Pearson correlation coefficient analysis, *t*-tests, multiple regression analysis.	Significant differences between the nurse-sensitive patient outcomes in Magnet and non-Magnet hospitals, along with a difference on the LPI subscale of "inspiring a shared vision" and a trend in the positive direction for "challenging the process." The Magnet units produced results that were significantly better than the non-Magnet units for patient falls with injury, CAUTI, and CLABSI rates.	**Strengths:** Use of a well validated tool: LPI to measure leadership practices. Consistent methodology used by all the hospitals using NDNQI. **Limitations:** Only used 6 hospitals so not generalizable. Variable not considered were unit size, number of staff members employed on unit, years of nursing experience, staffing ratios, availability of support staff and the percentage of BSN-prepared nurses working on the units. **Critical Appraisal Tool & Rating:** II-C

Citation	Conceptual Framework	Design/ Method	Sample/ Setting	Variables Studied and Definitions	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
Hahtela et al. (2017)	N/A	Cross-sectional design and collected between November 2011 and March 2012	14 inpatient acute care units in Finland, 7 health care centers. Patients ranged from 50 to 89 years.	Nurse managers answered questions related to workplace culture. Patients or family members answered questions about demographics, reason for admission, and patient care experience. Patient outcome data targeted four complications: deep vein thrombosis, healthcare-associated infections, patient falls, and pressure injuries.	Data collected via questionnaires completed by patients (n = 53), RNs (n = 65), LPNs (n = 77) and nurse managers (n = 14). Data collected voluntarily over one-month period.	Descriptive statistics used to analyze socio-demographic data. Spearman's correlation, Kruskal-Wallis and Mann-Whitney test were used to assess the correlational between workplace culture and patient outcomes.	Findings demonstrate that workplace culture has some correlations with patient outcomes. Some aspects of workplace culture were related to prevalence of complications of pressure injuries and patient falls and communication errors. Results indicated that there was significant association between workplace culture and complication are important.	**Strengths:** Results have implications for both practice and research. Demonstrates that organization must acknowledge implications of a good workplace culture to enhance safe and effective patient care. **Limitations:** Further work is need with larger sample sizes and various settings to broaden the understanding and connections between culture of the setting and patient outcomes. Replication needed in the United States. **Critical Appraisal Tool & Rating:** II-B

Citation	Conceptual Framework	Design/ Method	Sample/ Setting	Variables Studied and Definitions	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
Havens et al. (2018)	Theoretical: Relational coordination-communicating and relating for task integration	Non-experimental surveys	Five community, nonprofit, private hospitals in Pennsylvania, ranging from 75 to 179 licensed beds. 382 volunteer direct care RNs responded.	Relational coordination (RC), job satisfaction, work engagement, burnout.	7-item relational coordination survey for patient care measured nurse-reported experiences of relational coordination (RC) with 5 other care providers. Scored on a 5-point Likert-type scale. Used the RC index 9a validated construct and reassessed its validity as a construct.	Pearson correlations and ordinary least-squares regression used to assess relationships. Regression models included the RC index as the independent variable and nurse outcomes as dependent variables	Respondents were over 43 yrs. old, reported a mean of 12.3 years in nursing, 9.4 years in hospital, majority reported associate degree prepared. Relational coordination was significantly related to increased job satisfaction, increased work engagement, and reduced burnout.	**Strengths:** Provides evidence to deliberately shape practice environments to enhance relational coordination. Supports RC theory to improve experience of providing care, linked to patient outcomes. **Limitations:** Only 2nd study to assess RC among nurses. Involved only nurses in one state. Difficult to generalize to nurses in different states and types of healthcare facilities. **Critical Appraisal Tool & Rating:** II-B

Citation	Conceptual Framework	Design/ Method	Sample/ Setting	Variables Studied and Definitions	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
Keyko et al. (2016)	N/A	Systematic review	113 manuscripts for full text review, resulting in 18 included studies. Quantitative and qualitative studies were included. Qualitative studies were if they directly explored work engagement in nursing practice.	Work engagement, job resources, professional resources, personal resources, job demands, and demographics.	Eight databases: CINAHL, MEDLINE, PsycINFO, PROQUEST, SCOPUS, Web of Science, EMBASE, and Business Source Complete. Search was conducted in October 2013. Extracted data synthesized through descriptive and narrative synthesis. For descriptive synthesis, study characteristics were examined to identify common threads and possible inferences based on common characteristics. Statistical analysis for work engagement: regression analysis. Only the total score for work engagement was utilized for analysis	18 studies were grouped into outcomes of work engagement or influence. Only full sample data were analyzed for this review if results from sample sub-sets were also reported, which enabled the greatest degree of power in analysis and generalizability of findings. Influencing factors placed into 7 themes: job resources, organizational climate, job demands, professional and personal resources, demographic variables. Adopted Job Demand Resource Model (JD-R) for work engagement.	Wide variety of antecedents related to RNs' work engagement. The NJD-R model offers nursing a framework to understand current evidence, further direct nursing research, and to guide policy and practice. The findings also indicate that factors influencing registered nurses' work engagement are present at various levels, from broad organizational climate to specific job, professional, and personal resources.	**Strengths**: Personal and professional resources influence and predict work engagement implications for nursing practice. **Limitations**: Only included studies that centered on work engagement. Variability limited ability to statistically summarize through meta-analysis. Response bias, and no studies excluded on basis of quality. Limits generalizability of findings to all RNs. Potential bias due to self-reporting. **Critical Appraisal Tool & Rating**: II-B

Citation	Conceptual Framework	Design/ Method	Sample/ Setting	Variables Studied and Definitions	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
Kutney-Lee et al. (2016)	N/A	Secondary cross-sectional observational data	20,674 RNs working in 425 nonfederal acute care hospitals, hospital and Hospital Consumer Assessment of Healthcare Provider Systems survey data.	Nurse engagement, nurse job outcomes, HCAHPS, hospital characteristics.	Comparisons using $X^{2,}$ for categorical variables and from *F* tests analysis for continuous variables. Mean HCAHPS. Ordinary least-squares regression models. Logistics regression for clustering hospitals.	Hospital characteristics were compared based on their nurse engagement survey.	Engagement varied widely across hospitals. In hospitals with greater levels of engagement, nurses were significantly less likely to report unfavorable job outcomes and poor ratings of quality and safety. Higher levels of nurse engagement were associated with higher HCAHPS scores. Findings suggest that factors at a broader organizational level, leadership styles, and structural empowerment influence nurses' work engagement directly and indirectly.	**Strengths:** Broad sample offers evidence to support nurse engagement improves patient outcomes. Findings suggest that a passion for nursing, the discovery of the core value of nursing, and an interest in nursing have all been identified to influence nurses' work engagement. **Limitations:** Research design limits causal inferences about relationship between nurse engagement and outcomes. Hospitals HCAHPS data submission was voluntary; may have been higher quality institutions. **Critical Appraisal Tool & Rating:** II-B

Citation	Conceptual Framework	Design/ Method	Sample/ Setting	Variables Studied and Definitions	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
Stallings-Welden & Shirey (2015)	Kings Theory of Goal Attainments and Donabedian's Quality Model-support concept of predictability of a nursing PPM and its impact on nurse and patient outcomes	Retrospective prospective pre-/post-implementation design Quasi-experimental 6-year retrospective/ prospective research, pre/post implementation IRB approval NDNQI RN satisfaction survey	Secondary data from 2008 to 2013 of 15 non-pediatric and non-mental health inpatient nursing units.	7 nurse-dependent variables: RN-RN and RN-MD interactions, autonomy, decision making, job enjoyment, quality of care, RN turnover, and 5 patient-dependent variables: patient falls, pressure ulcers, CAUTIs, patient satisfaction with attention and information. Four independent study variables include PPM education, time, nursing units and RN workforce.	Four hospital-owned databases utilized.	Used ANOVA for 3 yrs. pre- and 3 yrs. post-implementation for analysis of variable mean values to determine whether PPM affected nurse and patient outcomes. Pearson correlation coefficient to evaluate relationships between nurse and patient variables and predicative inferences.	Statistically significant evidence to suggest that PPM for this hospital did make a difference and is predictive of nurse and patient outcomes. Both studied campuses showed improvement in professional development post-implementation.	**Strengths:** Evidence of two campuses reaching statistical significance with the initiation of a PPM model. **Limitations:** Lack of a standardized instrument to assess PPM. Findings cannot be generalized. Pearson correlations only assigns correlations not causation. **Critical Appraisal Tool & Rating:** II-C

Evidence Synthesis Table

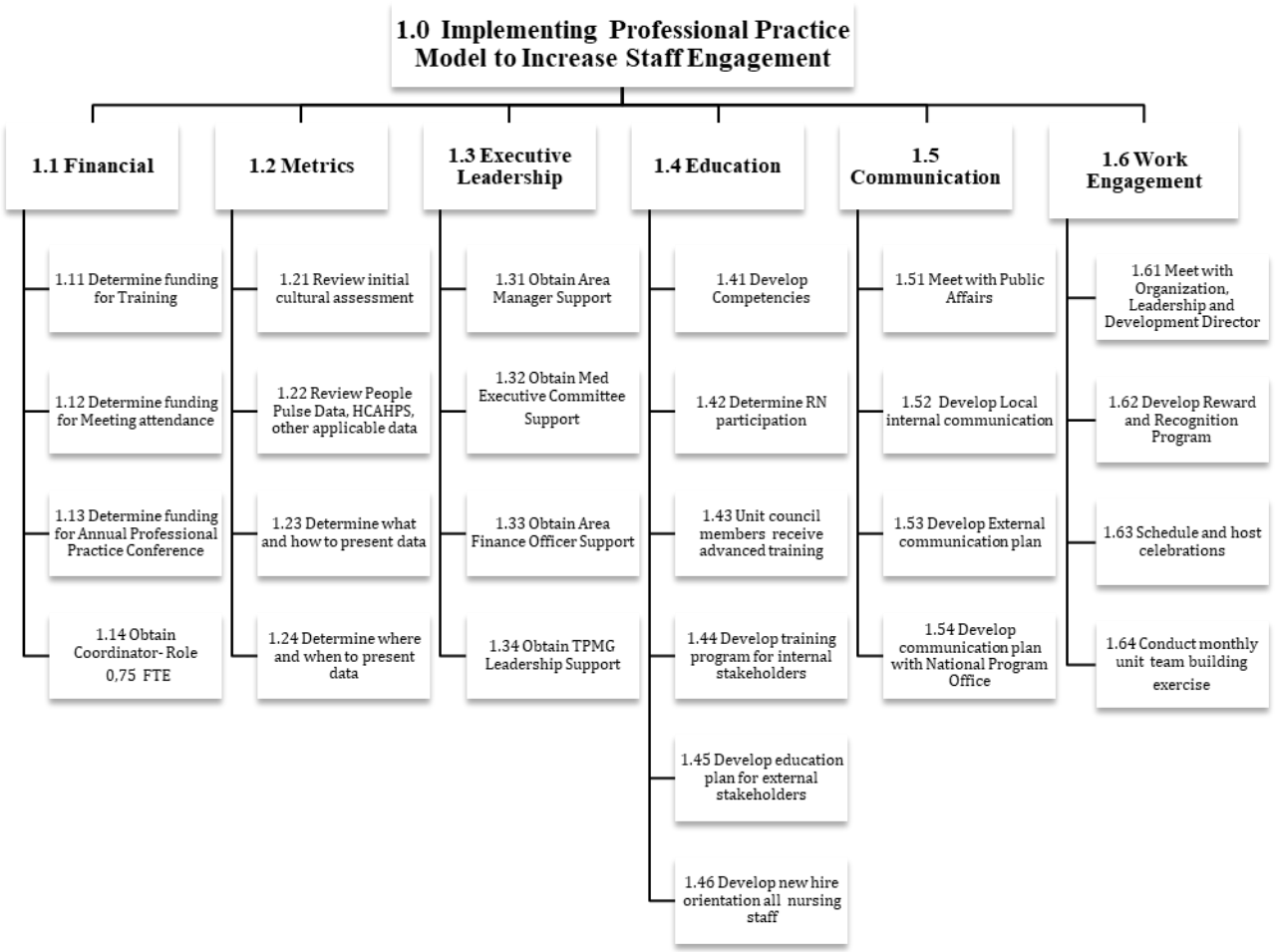
Studies (Author & Year)	**Dempsey & Reilly (2016)**	**Fischer & Nichols (2019)**	**Hahtela et al. (2017)**	**Havens et al. (2018)**	**Keyko et al. (2016).**	**Kutney-Lee et al. (2016)**	**Stallings-Welden & Shirey (2015).**
Design	Non-experimental surveys	Observational design using the Leadership Practices Inventory (LPI) tool and deriving scores from it and nurse-sensitive patient outcome data from National Database of Nursing Quality Indicators (NDNQI) from each hospital.	Cross-sectional design and collected between November 2011 and March 2012.	Non-experimental surveys	Systematic review	Secondary cross-sectional observational data	Retrospective prospective pre-/post-implementation design. Quasi-experimental 6-year retrospective/ prospective research, pre/post implementation, IRB approval. NDNQI RN satisfaction survey.
Sample	300 clinicians, non-clinicians, and patients	50 nurse managers in 2 non-Magnet hospitals and 4 Magnet hospitals in Michigan.	14 inpatient acute care units in Finland seven healthcare centers, patients ranged from 50 to 89 years.	5 community hospitals in Pennsylvania, ranging from 75 to 179 licensed beds, 382 volunteer direct care RNs	113 manuscripts for full text review, resulting in 18 included studies	20,674 RNs working in 425 nonfederal acute care hospitals, hospital and Hospital Consumer Assessment of Healthcare Provider Systems survey data	Secondary data from 2008 to 2013, of 15 non-pediatric and non-mental health inpatient nursing units.
Outcome	Nurse engagement and nurse job satisfaction	Significant differences between the nurse-sensitive patient outcomes in Magnet and non-Magnet hospitals, along with a difference on the LPI subscale of "inspiring a shared vision" and a trend in the positive direction for "challenging the process." The Magnet units produced results that were significantly better than the non-Magnet units for patient falls with injury, CAUTI, and CLABSI rates.	Findings demonstrate that workplace culture has some correlations with patient outcomes. Some aspects of workplace culture were related to prevalence of complications of pressure injuries and patient falls and communication errors. Results indicated that there was significant association between workplace culture and complication are important.	Nurse engagement	Nurse engagement	Nurse engagement	Professional practice model implementation, nurse engagement.

Appendix B

Voice of Nursing

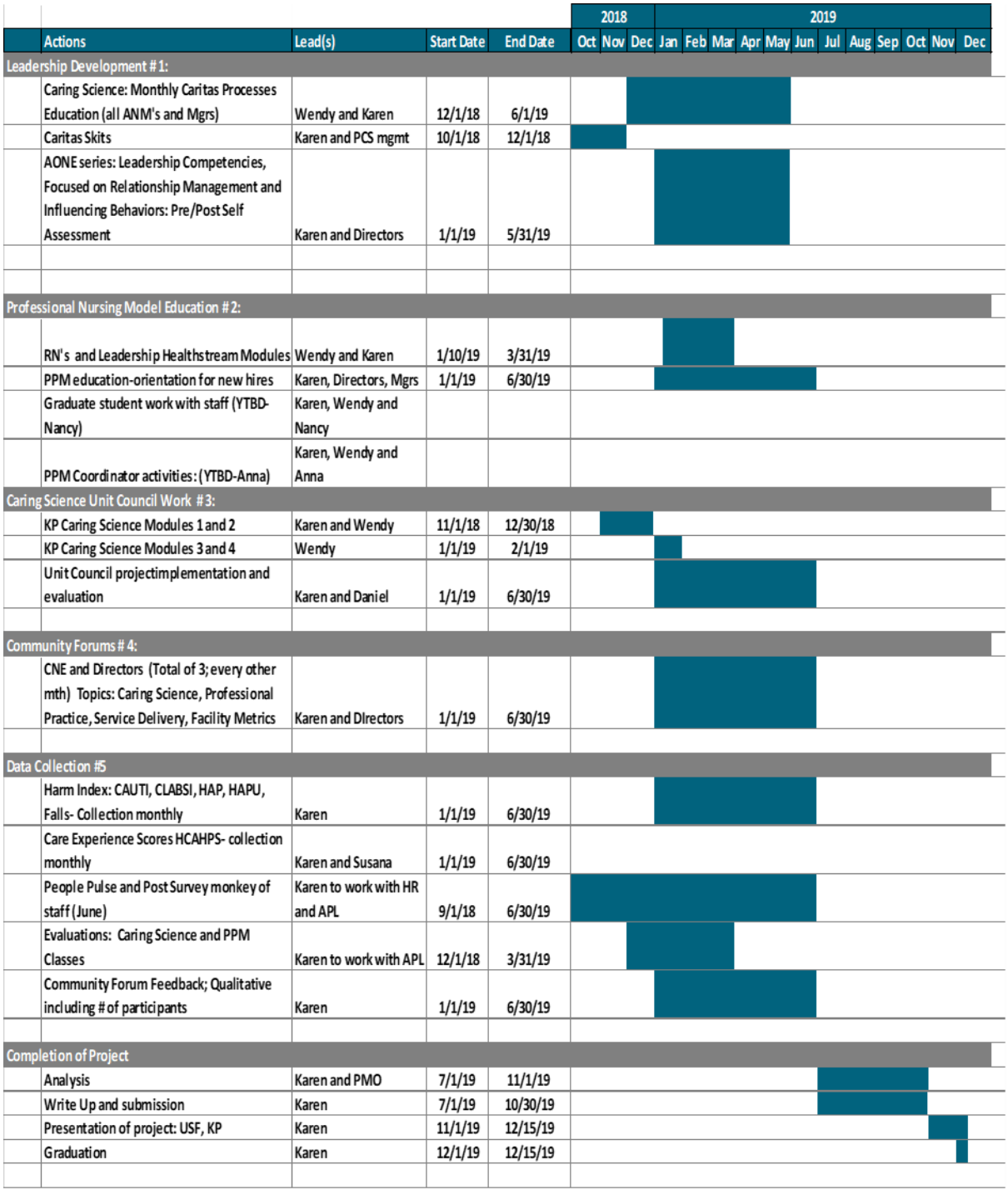
Appendix C

Work Breakdown Structure



Appendix D

Gantt Chart: Engagement Implementation



	Actions	Lead(s)	Start Date	End Date
Leadership Development # 1:				
	Caring Science: Monthly Caritas Processes Education (all ANM's and Mgrs)	Wendy and Karen	12/1/18	6/1/19
	Caritas Skits	Karen and PCS mgmt	10/1/18	12/1/18
	AONE series: Leadership Competencies, Focused on Relationship Management and Influencing Behaviors: Pre/Post Self Assessment	Karen and Directors	1/1/19	5/31/19
Professional Nursing Model Education # 2:				
	RN's and Leadership Healthstream Modules	Wendy and Karen	1/10/19	3/31/19
	PPM education-orientation for new hires	Karen, Directors, Mgrs	1/1/19	6/30/19
	Graduate student work with staff (YTBD-Nancy)	Karen, Wendy and Nancy		
	PPM Coordinator activities: (YTBD-Anna)	Karen, Wendy and Anna		
Caring Science Unit Council Work # 3:				
	KP Caring Science Modules 1 and 2	Karen and Wendy	11/1/18	12/30/18
	KP Caring Science Modules 3 and 4	Wendy	1/1/19	2/1/19
	Unit Council projectimplementation and evaluation	Karen and Daniel	1/1/19	6/30/19
Community Forums # 4:				
	CNE and Directors (Total of 3; every other mth) Topics: Caring Science, Professional Practice, Service Delivery, Facility Metrics	Karen and Directors	1/1/19	6/30/19
Data Collection #5				
	Harm Index: CAUTI, CLABSI, HAP, HAPU, Falls- Collection monthly	Karen	1/1/19	6/30/19
	Care Experience Scores HCAHPS- collection monthly	Karen and Susana	1/1/19	6/30/19
	People Pulse and Post Survey monkey of staff (June)	Karen to work with HR and APL	9/1/18	6/30/19
	Evaluations: Caring Science and PPM Classes	Karen to work with APL	12/1/18	3/31/19
	Community Forum Feedback; Qualitative including # of participants	Karen	1/1/19	6/30/19
Completion of Project				
	Analysis	Karen and PMO	7/1/19	11/1/19
	Write Up and submission	Karen	7/1/19	10/30/19
	Presentation of project: USF, KP	Karen	11/1/19	12/15/19
	Graduation	Karen	12/1/19	12/15/19

Appendix E

Gap Analysis Tool

Gap Analysis Tool

Facility: Fresno Region: NCAL Executive Sponsor(s): Karen Strauman, CNE

Champion(s): Daniel Scroggins, CASD, Terri Lutz, ASD, Earl Laih, Peri-Op Service Director Project Lead(s): Wendy Gospodnetich, DCEPI

Check if: Inpatient ☑ Ambulatory/Continuum of Care ☐ Date Submitted: 1-Sep-18

Instructions *: Champions and Project Managers/Leads are required to complete and submit the Gap Analysis Tool every June & December annually. The purpose of this tool is to track the progress of the Kaiser Permanente Professional Practice Model, Vision, and Values at your region/site. Results of this tool are reported to the National Nursing Professional Practice Council (NNPPC) and National Nursing Leadership Council (NNLC). Regions/sites are encouraged to develop a strategy on an annual basis to identify the tasks needed to close the gaps. To submit this tool or for questions, please contact Linda.Leavell@kp.org, Executive Director, NPCS and Pamela.X.Jensen@kp.org, Sr Project*

Rating Index Descriptors - Instructions: After each item below note the corresponding rating index number in the specified rating index column			Enculturation Score
0	○	Activity has not started / **no evidence** this element is in development	0%
1	◔	Activity has started and some content available / **we intend** to make a change in behavior, practice, and/or process	25%
2	◑	Progress in fulfilling element is evident / we are **implementing** a change in behavior, practice an/or process	50%
3	◕	Element is nearly operational / we have **evidence of change** in behavior, practice and/or process	75%
4	●	Element is fully operational / **data shows a change** in outcome measures	100%

Rating Index Instructions: Use either the drop down box or input numbers, 0, 1, 2, 3, or 4 in rating index. Once the number is input the appropriate harvey ball will appear next to each item. In addition, the enculturation score will automatically populate.

Do not Input In this column

Performance Objectives	Rating Index		Comments/Gaps	Recommended Actions	Responsibility	Enculturation Score
1. Inspiration						**39%**
1.1 Champion(s) create a powerful story 1.1.1 Has your story been socialized	3	◕				75%
1.2 Socialize Professional Practice Model, Vision, and Values with senior Kaiser Permanente executives, medical directors and others	3	◕				75%
1.3 Socialize Professional Practice Model, Vision, and Values with inpatient management	2	◑				50%
1.4 Socialize Professional Practice Model, Vision, and Values with ambulatory management	0	○	Declined Participation			0%
1.5 Socialize Professional Practice Model, Vision, and Values with continuum of care management	0	○	Considering Participation			0%
1.6 Professional Practice Model, Vision and Values socialized with nursing leaders to frontline staff 1.61 Develop a shared vision for the Voice of Nursing at site	1	◔		Ongoing. All Clinical management, nurs ing unit council members, new hire RNs and original attendees complete.	PCS Clinical Director and Managers	25%
1.7 Nurse recognition: 1.7.1 Daisy Award 1.7.2 National Nursing Pin Recognition Program 1.7.3 National Nursing Recognition Program (Extraordinary Nurse Award) 1.7.4 Other recognitions and awards	2	◑	Daisy Award is now monthly. Submission of Extraordinary Nurse Nominees with Pinning Ceremony, Submission of Nominees-NLC, continuous survey readiness, Everyday Heroes, Stroke Re-Cert celebration, Clinical Nurse Ladder Reception, Good Catch-In the moment recognition-service area inclusive.	Schwartz Rounds-The caregivers voice and experience has been implemented.	PCS Clinical Director and Managers	50%

2. Infrastructure						41%
2.1 Establish local planning oversight, committee(s), and/or council(s) to align, integrate and standardize the Kaiser Permanente Nursing Professional Practice Model, Vision, and Values into current work. 2.1.1 Create shared decision making model. Inform how work will be communicated with one another.	1	◔	**Will continue to develop process. All unit councils are in place and are functioning in their infancy state. Directors and CNE take turns attending unit councils to observe shared decision making process and provide manager mentoring. Councils are reporting out quarterly to the PCS directors and CNE. All Nurse Managers and frontline council members are invited to the report out sessions.**	Continuing with current structure.	Wendy/Karen	25%
2.2 Nurse leaders informed and have accessed the Voice of Nursing Toolkit on the Nursing Pathways website - http://kpnursing.org	1	◔	**All have access have validated that leaders can locate.**	Continuous refreshing of tools availability and usability.	Wendy	25%
2.3 Develop councils to implement professional practice strategy, such as: 2.3.1 Research & Evidence Based Practice 2.3.2 Quality Service & Safety 2.3.3 Professional Development 2.3.4 Leadership 2.3.5 Governance Council 2.3.6 Charters reflect ANA Standards 2.3.7 Other: _____	2	◑	**Councils are formed. Standard charters are consist across nursing units which include 2.3.1.-2.3.6. Each council had the opportunity to provide some individualize unique to their work area.**	Manager's continue to have agenda planning sessions, develop managing meeting skills and facilitative leadership skills. In addition, unit council members will continue to develop emotional intelligence skills as part of their professional development.	Nurse Managers and Clinical Directors.	50%
2.4 Interview process to include alignment of new hire values and the Kaiser Permanente nursing values	4	●	**Validation complete. All nurse interviews align with defined values.**	Future planning to align values with all PCS role interviews.	PCS Directors/Managers	100%
2.5 The Kaiser Permanente Nursing Professional Practice Model is embedded into nursing standards, systems, policies, and practices. 2.5.1 ANA Scope and Standards of Practice & Code of Ethic for Nurses	1	◔	**This is ongoing work.**	Will discuss in July 2018. To determine action plan for completion.	PCS Directors and CNE	25%
2.6 Inpatient requirements: Current practices compliant with established processes in all units/departments *(Inpatient is to answer, Ambulatory/Continuum of Care are not to answer)* 2.6.1 Nurse Communication 2.6.2 NKE+ 2.6.3 Hourly Rounding 2.6.4 Leadership Rounding	2	◑	**Validations for these practices are completed bi-annually. Care Experience Leader supports this ongoing process**	Validation practices will continue ongoing.	PCS management in partnership with Care Experience Leader.	50%
2.7 Develop standards of practice for top 10 diagnosis at site/region.	1	◔	**Information being gathered. Will begin socialized top ten diagnosis through population specific annual education in 2018.**	Continue to cross check/match diagnosis to current processes and evidence based practice. To locate gaps.	Clinical Education Department.	25%
2.8 Identify opportunities which improves quality and safety.	2	◑	**Being identified through workgroups that focus on patient quality and safety, frontline staff on work place safety teams, unit councils member during meetings.**	Continue to work on information and process spread from one workgroup to another and single nursing unit to multiple nursing units.	CNE, PCS Directors and Nurse Managers. Nursing Quality Forum members are a focus group that have been engaged. NQF-working on IA project to improve blood draw and labeling workflows and patient hand off.	50%

2.9 Communication plan completed: 2.91 Communication goals 2.92 Communication strategies 2.93 Audiences 2.94 Key stakeholders 2.95 Key messages 2.96 Measurement 2.97 Timeline	1	◔	**Communication Plan in progress.**	Improvements in our overall communication have had some improvements. Most notiable improvement: nurse unit councils are creating a communication tree, identifying a small group that they will disseminate information and bring feedback to unit councils. Also using CNE Newsletter, Visions Communication, Unit Specific Newsletters.	Clinical Directors and Managers	25%
2.10 Communication messaging includes: 2.10.1 Region/site commitment to the Voice of Nursing program 2.10.1.1 Professional Practice Model, Vision, and Values 2.10.2 Defines performance expectations 2.10.3 Defines desired outcomes 2.10.4 Aligns and integrates with region/site current work/goals 2.10.5 Clear and comprehensive plan to accelerate understanding and buy-in	1	◔	**Communication remains inconsistent.**	Working on a strategy for leader professional development in transformational leadership.	Karen and Wendy	25%
2.11 Stakeholder groups have been addressed - ***Check all that apply*** ☑ 2.11.1 Executive groups ☑ 2.11.2 Clinical leaders ☐ 2.11.3 Nursing staff ☑ 2.11.4 Labor ☑ 2.11.5 Ancillary Services ☐ 2.11.6 Patient and families ☑ 2.11.7 New hires ☑ 2.11.8 Physician groups ☐ 2.11.9 Determine who else to bring into the conversation	2	◑	**Many of the stakeholders have been addressed. Including Care Experience, PMO, Leadership Development, Risk, and Quality.**	Will be action item on 2018 Planning Calendar to address the larger group of nursing and patient council.	Karen-Pt Advisory Council Wendy/Patti nursing staff.	50%
3. Education						**20%**
3.1 Professional development/education strategy includes: 3.1.1 Needs assessment 3.1.2 Training objectives 3.1.3 Competency 3.1.4 Outcomes assessment 3.1.5 Continued quality improvement 3.1.6 Update/revision schedule	1	◔	**Nursing CEU class developed, not implemented**	Working on a strategy for attendance.	CNE and PCS Directors.	25%
3.2 Evidence of staff awareness of the Professional Practice Model, Vision and Values and can articulate how it informs clinical practice	1	◔	**Small number of staff are able to address this.**	PPM will be introduced during CEU course.	PCS Clinical Director and Managers	25%
3.3 Professional development tools incorporated to support, nurses learning about the Professional Practice Model, Visions, and Values 3.31 Encourage units/departments to engage with UBT's	1	◔	**Tools being used by a small group.**	Continue to socialize tools, provide support in the untilization.	PCS Clinical Director and Managers	25%
3.4 Utilize e-learning Professional Nursing Practice: On KP Learn or HealthStream - (NNPPC "Must Have") 3.4.1 Site using Professional Nursing Practice on KP Learn and/or HealthStream *Located on Nursing Pathways under Nursing Strategy/ VON Toolkit* *ttp://kpnursing.org/*	0	○	**Budgetary Planning**		Wendy and Karen	0%
3.5 National Nursing Orientation (NNPPC "Must-Have") Outcome: Track utilization of Orientation to the Nursing Vision, Values, & Professional Practice Model: Facilitators Guide 3.5.1 Region/site track National Nursing Orientation *Located on Nursing Pathways under Nursing Strategy/ VON Toolkit* *http://kpnursing.org/*	1	◔	**Only new hires since June 2017, unit management teams and orginal work group members have received this content.**	**All of those who have attended have documented attendance.**	Wendy	25%

4. Evaluation and Evidence						50%
Instructions for Evaluation and Evidence: ***NNPPC ("Must Have's")*** *Inpatient is to complete sections 4.1 to 4.10* *Ambulatory/Continuum of Care are to complete sections 4.1-4.3 and 4.10* *National Nursing Professional Practice Council will track NNPPC "Must Have's"*						
4.1 Complete Pre and Post Survey to measure Professional Practice knowledge NNPPC ("Must Have") *Outcome: Complete pre and post survey and compare results* *4.1.1* Pre-Survey completed-enter month/year in comments/gaps section 4.1.2 Post-Survey completed-enter month/year in comments/gaps section 4.1.2.1 Briefly summarize strengths, opportunities and next steps 4.1.2.2 Encouraged to document gaps and to create action plan *Located on Nursing Pathways under Nursing Strategy/ VON Toolkit* *http://kpnursing.org/*	**0**	○	**Will perform in January of 2019 and repeat measure in Spring 2019.**		PCS Directors and CNE	0%
4.2 Measure Nurse Engagement with a National Data Base to support professional practice locally NNPPC ("Must Have") *Outcome: Complete Nurse Work Environment Survey* 4.21 Enter month/year nurse work environment survey completed in comments/gaps section 4.221 Briefly summarize strengths, opportunities and next steps 4.222 Encouraged to document gaps and to create action plan	**1**	◔	**Initial workgroup used People Pulse engagement index as initial measurement. Comparitive measure in 2018 will be used to determine gaps and future planning pre implementation and post**	**This is ongoing work using People Pulse engagment index**	Terri	25%
4.3 Track Nurse Recognition Programs NNPPC ("Must Have") *Outcome: Track nurse recognition programs: Daisy Award, National Nursing Pin, Extraordinary Nurse Award, and other awards.* 4.3.1 Track Nursing pins and awards distributed to nurses annually. *National Nursing Pin & Extraordinary Nurse Awards can be located on Nursing Pathways under Nursing Strategy/VON Toolkit* *http://kpnursing.org*	**2**	◑	**Tracking Daisy currently.**	**Jan 2018 to current. 7 Extraordinary Nurse, 7 National Nursing Pins, 1 Regionally Recognized Fresno Extraordinary Nurse in May 2018, 8 Daisy Awardees thus far in 2018.**	Heather/Felicia	50%
4.4 Nurse Communication Composite Score (NNPPC "Must Have") Inpatient is to answer goal- Ambulatory/Continuum of Care are not to answer *Outcome: Increase nurse communication composite score. Baseline score is score at time of Voice of Nursing Strategy Planning Meeting* 4.4.1 Enter Nurse Communication Composite score for (1) baseline score and (2) current state score under comments/gaps 4.4.2 Report recommended action steps, if score has not changed or has decreased 4.4.3 If score increased, briefly state actions that caused an increase in score	**2**	◑	**Baseline 2017 Nurse Communication 90.5. Performance YTD through September 2017 is 91.5. FRS performance Target is 91.5. We are demonstrating a steady increase in all PCS areas in nursing communication. July 2018 performance is at 90.7**	Telemetry Unit has experienced a notible decrease in performance. CEL is performing confidential 1:1 meetings with frontline caregivers to understanding what maybe influencing/impacting RN Communication.	PCS Directors and CNE	50%
4.5 HAPU 2+ Unstageables (NNPPC "Must Have") Inpatient is to answer goal- Ambulatory/Continuum of Care are not to answer *Outcome: Decrease HAPU 2+ Unstageables from baseline score. Baseline score is score at time of Voice of Nursing Strategy Planning Meeting* 4.5.1 Enter HAPU 2+ Unstageables (1) baseline score and (2) current state score under comments/gaps section 4.5.2 Report recommended action steps, if score has not changed or has increased 4.5.3 If score decreased, briefly note actions that caused a decrease in score	**3**	◕	**2016 Baseline: 7 2017 YTD is 7. No reportable pressure ulcers in FRS for 2017. The medical and nursing team noted and documented appropriately upon admission. No reportable progression during hospitalization. YTD 2018 The medical and nursing team noted and documented appropriately upon admission. No reportable progression during hospitalization.**	This is attributed to the work of our full time wound and ostomy RN and LVN care team. MD and RN referral process in place. Day (5 days/wk and evening (4 eves/wk) shift wound team rounding.	PCS Directors and Nurse Managers	75%
4.6 Falls Moderate to Severe Injury (NNPPC "Must Have") Inpatient is to answer goal -Ambulatory/Continuum of Care are not to answer *Outcome: Decrease Falls Moderate to Severe Injury from baseline score. Baseline score is score at time of Voice of Nursing Strategy Planning Meeting* 4.6.1 Enter Falls (1) baseline score and (2) current state score under comments/gaps 4.6.2 Report recommended action steps, if score has not changed or has increased 4.6.3 If score decreased, briefly note actions that caused a decrease in score	**2**	◑	**2016 Baseline: 1. In January 2017, 1 fall and in July 2017, 1 fall. That is a total of 2 falls in this category for 2017. Multiple work groups are addressing falls. YTD 2018 same as initial baseline.**	Quality and Safety-intiated a visual que for moderate to high risk of fall patients through out the inpatient area. Fall risk is discussed during nursing rounds and at patient hand off, developing a delirium rounding program.	PCS Directors and Nurse Managers	50%
4.7 Pain Management (NNPPC "Must Have") Inpatient is to answer goal-Ambulatory/Continuum of Care are not to answer *Outcome: Decrease Pain Management from baseline score. Baseline score is score at time of Voice of Nursing Strategy Planning Meeting* 4.7.1 Enter Pain Management (1) baseline score and (2) current state score under comments/gaps 4.7.2 Report recommended action steps, if score has not changed or has increased 4.7.3 If score decreased, briefly note actions that caused a decrease in score	**2**	◑	**Baseline 2017 was 89.0. Target was 89.5. We exceeded target at 89.6. CMS New survey test questions created.**	Pain management is being addressed in many committees and workgroups. The most significant change has been that our facility became an early adopter of ERAs with all surgeries.	PCS Directors and CNE. Will watch response results during this testing phase to monitor improvement of service and member perspective as it related to pain management.	50%

4.8 CAUTI (Catheter-associated Urinary Tract Infections) NNPPC "Must Have") Inpatient is to answer goal-Ambulatory/Continuum of Care are not to answer *Outcome: Decrease CAUTI from baseline score. Baseline score is score at time of Voice of Nursing Strategy Planning Meeting* 4.8.1 Enter CAUTI (1) baseline score and (2) current state score under comments/gaps 4.8.2 Report recommended action steps, if score has not changed or has increased 4.8.3 If score decreased, briefly note actions that caused a decrease in score	**3**		**Baseline 2016: 13. YTD in 2017: 7. YTD 2018 = 0.4**	This decrease can be attributed to the partnership and workgroups between PCS, Risk, Quality, Infection Control and HBS. Foley utilization and necessity is discussed during nursing rounds.	PCS Directors	75%
4.9 CLABSI (Central line-Associated Bloodstream Infections) NNPPC "Must Have") Inpatient is to answer goal-Ambulatory/Continuum of Care are not to answer *Outcome: Decrease CLABSI from baseline score. Baseline score is score at time of Voice of Nursing Strategy Planning Meeting* 4.9.1 Enter CLABSI (1) baseline score and (2) current state score under comments/gaps 4.9.2 Report recommended action steps, if score has not changed or has increased 4.9.3 If score decreased, briefly note actions that caused a decrease in score	**3**		**Baseline 2016: 5. YTD in 2017: 3. YTD 2018 = 1.**	This decrease can be attributed to the partnership and workgroups between PCS, Risk, Quality, Infection Control and HBS. Increased utilization of PICC lines. Currently, exploring the utilization of midlines to further central line usage.	PCS Directos	75%
4.10 Action Plan/Timeline (Enculturation Process) 4.10.1 Complete GAP Analysis every 6 months (June and December) and forward to NPCS. 4.10.2 Complete VON Site Visit 4.10.3 Incorporate GAPs into action plan and forward updated action plan to NPCS. Action plan should be updated at least annually and forward to NPCS.	**2**		**Original site visit was in April 2017 for VON kickoff. Initial gap analysis completed in June 2017. Current gap analysis completed in September 2018. Site visit on hold.**			50%

Region/Site Average for This Timeperiod	Inpt	AMB/ Con Care
	2	1

OVERALL ENCULTURATION SCORE	40%

Ambulatory/Continuum of Care excludes 2.6 and 4.4 - 4.9)

"It is vitally important that the Kaiser Permanente nursing vision, values and model come alive with every patient encounter. We must take bold action to become the Best Health Care system in the nation. It will require all 45,000 (now 48,000) of us to work together, individually and collectively, to bring these words to life every day and in every interaction with our patients and with one another"
Marilyn Chow 2009

Voice of Nursing	
NNPPC	NNPPC -National Nursing Professional Practice Council – National Oversight Council for the Voice of Nursing
NNLC	National Nursing Leadership Council – National Sponsor for the Voice of Nursing
NPCS	National Patient Care Services – NPCS consultants work with region/site to develop a strategy plan in how the Voice of Nursing can support, leverage and

Version May 2016

Appendix F

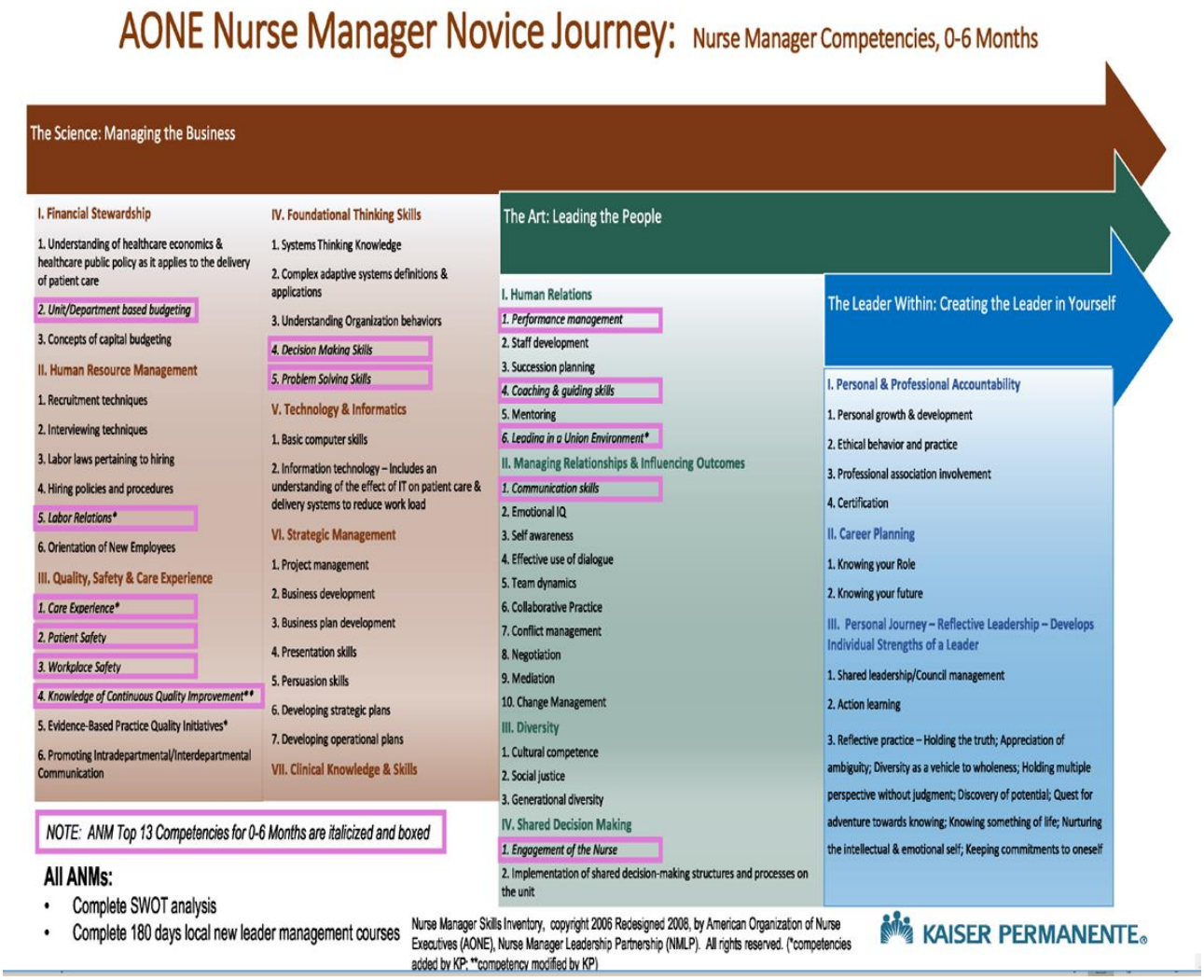
SWOT Analysis

Strengths	Weaknesses
• Staff passionate about patient care • Commitment of the PCS team • Teamwork amongst all levels • Work harder willing to help others and think of the patient first • Strong willed • Highly diversified staff • Good direction from leadership & teamwork • Dedicated employees • Small community environment • Treat others we would "treat our family" • Compassionate & caring team • KP is an integrated care system • Patient and family centered • Stable care long term management team • Managers do not hesitate to do bedside cares when help is needed • Recognition of good/hard work of staff • RN & MD communication & collaboration • Passion for improvements • Leadership united with same purpose • Investment of senior leadership team in making the Fresno service area great • Dedicated leadership • Union can present concerns/issues hindering patient-centered care to leadership • Moving in a growth direction avoiding stagnation • Education and development of leaders • Data-rich • Membership growth for last 5 years (15%) • Everything is one place • One KP –KP system – Medical Group – Hospital in one • "One stop shop" • RN's experience – many years of experience and years of life experience to bring to the table	• Methods used don't always reach all levels of the organization • Need understanding of each other's position & willingness to cooperate • Stand-alone (No other Kaiser is close-limited support) • Many committees with many ideas – not enough follow through or implementation on existing ideas • Lack of independency from region- difficult at times to drive local change • Communication between all departments • Transparency of communication between KFH and TPMG • Preconceived notions us against them attitudes – staff vs management • Fragmented services at times between outpatient services and inpatient services • Unable to move patients in a seamless manner • Aging facility. Space constraints • Limited number of ANM's to cover bedded units with same expectations to get all work done • No department educator in the specialized setting of the birthing center or peri op services • Minimal support for education training and/or professional development of leaders • Fresno's push towards efficiency has led to a perception as a decrease in patient/nurse time – message comes across as "we are too busy" • Limited space to expand • Budget constraints • Too much dialogue about "us" and "them" • Closed minded individuals at times • Union involvement often times reduces the effect the skill and compassion of the unit patient care staff • Unions trying to drive nursing practice • Some have prioritized earnings over professionalism • Teamwork across all lines – RN's to PCT's, to UA's to EVS • Slow to adapt & change to the market and needs • Nurses bully each other and allow union to dictate their practice
Opportunities	**Threats**
• Develop staff by supporting personal/professional development rather than other organizations offering& enticing them to their organization • Realignment of departments to refocus purpose • Improve collaboration with TPMG and KFH • RN's at all levels (including management) should work together to focus on professional nursing practice • CNA – KFH relationships • Higher Education opportunities for staff & leaders • Leveraging more technology for use at bedside • Advance professional practice – engagement of RN's • Nursing taking ownership of nursing practice; establishment of shared decision making • Tremendous opportunities to improve patient experience • High poverty in Fresno presents KP opportunity to deliver on its mission to improve the health of the community • Explore technological methods that work best for communicating • Growing city population, economics so still time to grow as a service area • Ability to grow our membership larger	• Politically diverse – we undercut the cohesiveness that could bring our community together and better serve those on the margins who need good healthcare • Other hospitals in Fresno pursuing Magnet status • Community hospitals providing / servings the complete needs of families – resulting in loss of membership • Ongoing possible/probable strike action • Brand tarnish • Direction of the company; diverting local priorities • Resistance to change • Failure to recognize ownership – insight to how we contribute to issues • Other companies progressing i.e. concierge service • Other companies outpacing KP • Belief KP is "too big to fail" • Strong union peer pressure with insecure or inexperienced staff • Unwilling or inability to change • Union partnership can be a threat to our success and can promote negativity • Over regulation

• Ignite the professional passion to unite all of us as ONE • Improve relationships with staff, management & union partnerships	• Kaiser Permanente Fresno past management team more punitive – not allowing a positive movement in culture • Very isolated from region • Recruitment of leaders to other NCAL areas • Action OI- Budget cuts

Appendix G

AONE/KP Leadership Toolkit Materials



Appendix H

Caring Science Projects

Caring for Each Other/ Taking Care of the Caregivers: Unit 1
The Unit Council team member passes out caring stones during change of shift huddles and/or during a shift and staff are encouraged to pass the stone to a peer if they feel called to do so. The purpose is to hold your stone in moments that might be challenging. To take a moment to pause, center oneself so one can then be authentically present. It was developed with caritas process 2 (Inspire) and 4 (Nurture) to show each other "I care about you" (passing the stone).

Caring for our Patients: Unit 2
Standardize and improve the care of our patients on comfort care. It includes placing a visual sign on the patient door that identifies that this is a comfort care patient. A card is gotten that the staff signs and then places a handprint of the patient inside the card (if the family consents) and then mails after the patient has passed. A care package is given to the family that includes an essential oil card that can be used for a calming aromatherapy and lotion to be used for hand massages for the patient. The unit council is educating staff to discuss with the family the comforting power of touch and to encourage the family to provide massage as well. Staff are now given educational resources to provide to the families on the process of dying so they know what to expect.
A gift is also given to the family after the patient passes, which is an ornament with a feather and a poem that is included. This is meant to be a reminder of their loved one.

Caring for our Patients: Unit 3
Developed a welcome packet for the family including what to expect while in the intensive care unit. Developed a "get to know me" poster for families to complete regarding their loved one so all staff and physicians understand who the patient is; not just a trauma or disease entity. Pictures of the family member are encouraged to be included. Poster is placed near the patient bedside and can be added to at any time.

Caring for the Caregiver: Unit 4
Developed a caring science portable cart for staff to use during times of emotional unrest. The cart has items for the staff's use, for the purpose of promoting a caring consciousness and heart-healing environment. Essential oils, food items, relaxing music, eye masks, ear plugs, candles, poetry and other self-care readings.

Appendix I

Budget with Cost Avoidance

	Labor hours	**Labor cost**	**Other costs**	**$ Total**
EXPENSES				
Salaries and Wages (includes benefits at 15%)				
CNE	200	$120		$24,000
Directors (4)	20	$84		$1,680
Nurse Managers (5)	24	$80		$1,920
Assistant Nurse Managers (27) 6 hrs.	162	$76		$12,312
Registered Nurses (491) 2 hrs. PPM	982	$90		$88,380
Registered Nurses (40) 8 hrs. Caring Science	160	$90		$14,400
Administrative Assistant	40	$29		$1,160
Analyst	20	$65		$1,300
Subtotal S/W				**$145,152**
Supplies Expense				
Training materials			$5,000	$5,000
Survey /Results			$500	$500
Caring Science Projects			$2,000	$2,000
Community Forum refreshments			$500	$500
Subtotal supplies				**$8,000**
Equipment (if needed)			N/A	
Subtotal equipment				**$0**
Purchased Services (if needed)				
CNE Leadership Conference			$8,000	

Attendance/Airfare (2)				
Subtotal purchased services				**$8,000**
Total expenses (cost of engagement project)				**$161,152**
Cost Avoidance (for 1 year)				
Retain five RN's				$240,250
One CLABSI reduction				$46,186
Five Patient Fall reduction				$171,470
One CAUTI reduction				$3,285
No HAPI				$43,000 (per case)
Reduce one HAP cases				$39,879
Total cost avoidance				**$544,070**

Operational Cost Assumptions:

- average RN hourly rate of $90
- average CNE hourly rate of $120
- average hourly rate for analyst and administrative assistant
- benefits at 30%
- cost of turnover is $48,050
- RN retention- Five RN's
- average hourly rate for all additional roles (non-staff RN)
- reduction in two CLABSI
- reduction in five patients falls
- reduction in three CAUTI costs
- reduction in five readmission costs
- reduction in two SSI
- executive leadership meeting presentations incorporated into standard scheduled meetings
- AONE and Caring Science curriculums no charge or previously developed
- General Supplies cover cost of paper, teaching aids, refreshments, publications

Source template: Waxman, KT. (2012).

Appendix J

Cost Avoidance Measures

	1st year	Cost Avoidance Measure
Falls	5	$34,294 Average hospital cost per fall
CLABSI	1	$23,093 Average cost per CLABSI
CAUTI	1	$1,095 Average cost per CAUTI
HAPI	0	$43,000 cost per patient
HAP	0	$39,879 cost per case
RN Turnover	5	$48,050 per RN turnover

Abbreviations: CAUTI, catheter-associated urinary tract infection; CLABSI, central line-associated bloodstream infection; HAP, hospital-acquired pneumonia, HAPI; Hospital-Acquired Pressure Injury

Source: Centers for Disease Control Agency for Healthcare Research and Quality/ CMS.gov (Falls, CLABSI, CAUTI, SSI)
Source: Centers for Medicaid and Medicare Services. (HAPI)
Source: Giuliano, Baker, & Quinn (2017). (HAP)
Source: Li & Jones. (2013). RN Turnover costs.

Cost Avoidance Results

	1-year Projection	Cost Avoidance Measure	6 mth Results
Falls	5	$34,294 Average hospital cost per fall	27 Reported **Decreased by 5** ($171,470)
CLABSI	1	$23,093 Average cost per CLABSI	0 reported **Decreased by 1** ($46,186)
CAUTI	1	$1,095 Average cost per CAUTI	No change
HAPI	0	$43,000 cost per patient	0 Reported ($43,000)
HAP	0	$39,879 cost per case	0 Reported **Decreased by 3** ($119,637)
RN Turnover	5	$48,050 per RN turnover	**Decreased by .2%** = 1 RN ($48,050)
Total Cost Avoidance	**$544,070**		**$428,343**

Appendix K

People Pulse RN Pre- and Post-Survey Tool

Nursing Experience Unit: _____ Date: _____

As an RN who provides direct patient care, your input it essential to continue to elevate the practice environment. Your insight is appreciated.

How much do you agree or disagree with the following statements? Please choose only ONE response per statement.

	Strongly agree	**Agree**	**Partly agree/ Partly disagree**	**Disagree**	**Strongly disagree**	**Don't know/Not applicable**
The way we deliver care is aligned to and integrated with the mission, vision and values of the organization.	☐	☐	☐	☐	☐	☐
This organization does a good job using technology to deliver the learning and development opportunities available to me.	☐	☐	☐	☐	☐	☐
Nursing leadership sets high expectations for the quality of care we deliver.	☐	☐	☐	☐	☐	☐
Nursing leadership are visible and accessible to employees.	☐	☐	☐	☐	☐	☐
Nursing leadership has a sincere interest in nurse satisfaction and well- being.	☐	☐	☐	☐	☐	☐
Nursing leadership is responsive to nurses' ideas for change.	☐	☐	☐	☐	☐	☐
Management does a good job of involving nurses in decisions that affect them.	☐	☐	☐	☐	☐	☐
I am satisfied with my involvement in decisions affecting my practice.	☐	☐	☐	☐	☐	☐
I have the authority to make nursing care decisions in the clinical care of my patients.	☐	☐	☐	☐	☐	☐
Inter-disciplinary team meetings effectively result in better patient outcomes.	☐	☐	☐	☐	☐	☐
People from different disciplines in my unit work together as a team.	☐	☐	☐	☐	☐	☐
Nurses in my unit work together as a team.	☐	☐	☐	☐	☐	☐
The nurses in my unit use evidence-based findings and standards in the delivery of patient care.	☐	☐	☐	☐	☐	☐

The nurses I work with are clinically competent.	☐	☐	☐	☐	☐	☐
The nurses I work with have the knowledge and abilities needed to work effectively in a clinical setting.	☐	☐	☐	☐	☐	☐
The nurses I work with partner with patients to diagnose, plan and deliver individualized patient- centered care.	☐	☐	☐	☐	☐	☐
Nurses collaborate across units.	☐	☐	☐	☐	☐	☐
Nurses can collaborate across units without seeking approval from the chain of command.	☐	☐	☐	☐	☐	☐

Appendix L

People Pulse RN Pre- and Post-Survey Results

People Pulse Questions	Pre	Post	Improvement	Change?
# Completed	417	65		
The way we deliver care is aligned to and integrated with the mission, vision and values of the organization.	80	83	3	
This organization does a good job using technology to deliver the learning and development opportunities available to me.	76	72	-4	
Nursing leadership sets high expectations for the quality of care we deliver.	84	86	2	
Nursing leadership are visible and accessible to employees.	61	86	25	↑
Nursing leadership has a sincere interest in nurse satisfaction and wellbeing.	52	72	20	↑
Nursing leadership is responsive to nurses' ideas for change.	52	71	19	↑
Management does a good job of involving nurses in decisions that affect them.	51	65	14	↑
I am satisfied with my involvement in decisions affecting my practice.	56	63	7	↑
I have the authority to make nursing care decisions in the clinical care of my patients.	70	68	-2	
Inter-disciplinary team meetings effectively result in better patient outcomes.	74	74	0	
People from different disciplines in my unit work together as a team.	80	75	-5	
Nurses in my unit work together as a team.	80	74	-6	
The nurses in my unit use evidence-based findings and standards in the delivery of patient care.	88	85	-3	
The nurses I work with are clinically competent.	89	89	0	
The nurses I work with have the knowledge and abilities needed to work effectively in a clinical setting.	89	88	-1	
The nurses I work with partner with patients to diagnose, plan and deliver individualized patient-centered care.	89	88	-1	
Nurses collaborate across units.	72	57	-15	
Nurses can collaborate across units without seeking approval from the chain of command.	65	54	-11	

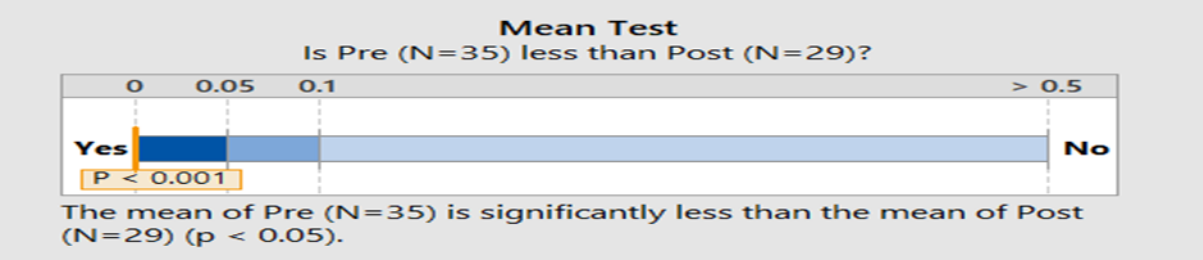
Appendix M

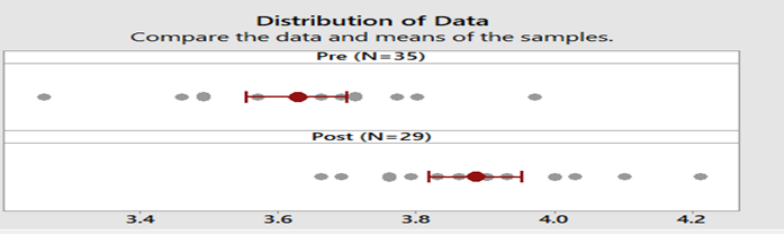
AONE Nurse Leadership Survey Results

Overall mean rating 3.62 pre vs 3.89 post showed statistically significant improvement ($p < .001$))

AONE Nurse Manager Assessment	Pre (N=35)	Post (N=29)	Improvement
Q2: Manage Conflict	3.46	4	0.54
Q3: Situation Management: Identify issues that require immediate attention	3.8	4.1	0.30
Q4: Situation Management: Apply principles of crisis management to handle situation as necessary	3.63	4	0.37
Q5: Relationship Management: Promote team dynamics	3.71	3.79	0.08
Q6: Relationship Management: Mentor and coach staff and colleagues	3.71	3.83	0.12
Q7: Relationship Management: Apply communication principles	3.66	3.76	0.10
Q8: Influence Others: Encourage participation in professional action	3.69	3.9	0.21
Q9: Influence Others: Role model professional behavior	3.97	4.21	0.24
Q10: Influence Others: Apply motivational theory	3.26	3.76	0.50
Q11: Influence Others: Act as a change agent	3.63	3.76	0.13
Q12: Influence Others: Assist others in developing problem-solving skills	3.49	3.86	0.37
Q13: Influence Others: Foster a healthy work environment	3.77	3.9	0.13
Q14: Promote professional development: Promote stress management	3.49	3.66	0.17
Q15: Promote professional development: Apply principles of self-awareness	3.57	3.93	0.36
Q16: Promote professional development: Encourage evidence-based practice	3.71	4.03	0.32
Q17: Promote professional development: Apply leadership theory to practice	3.49	3.69	0.20

Permission for use granted on 1/7/2019 from Marthe Lyngås Forster | Program & Operations Specialist | AONE Chicago, IL 60606
mforster@aha.org





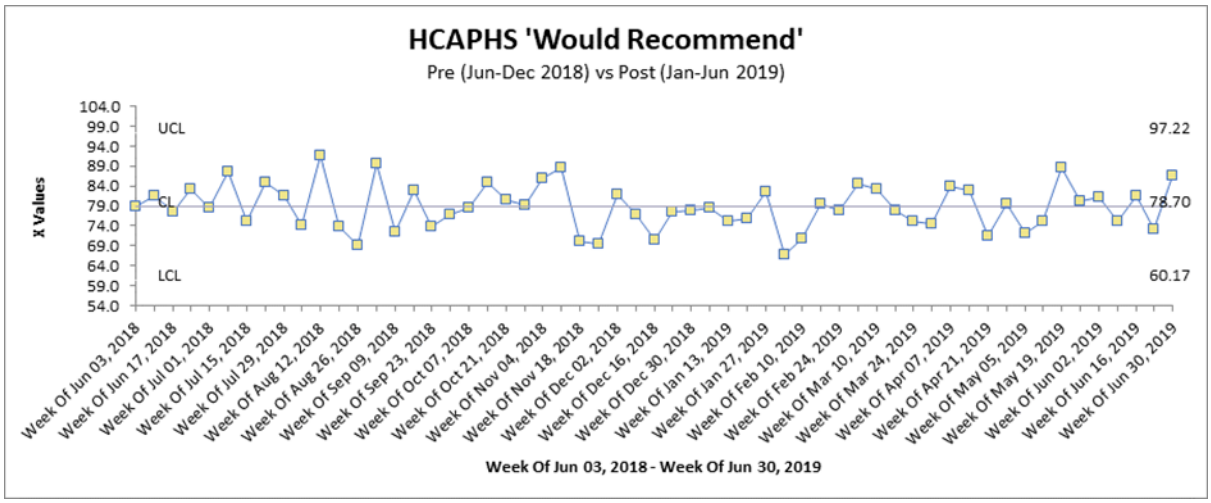
Appendix N

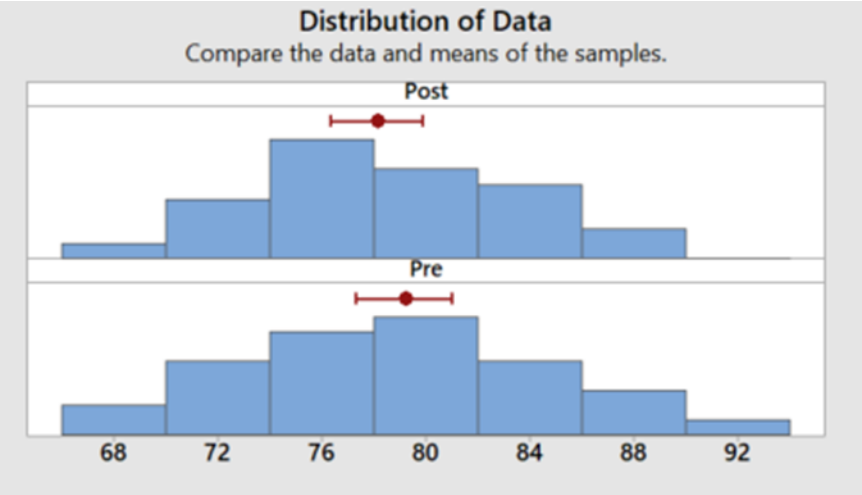
Nurse-Sensitive Quality Indicators # Harm Events

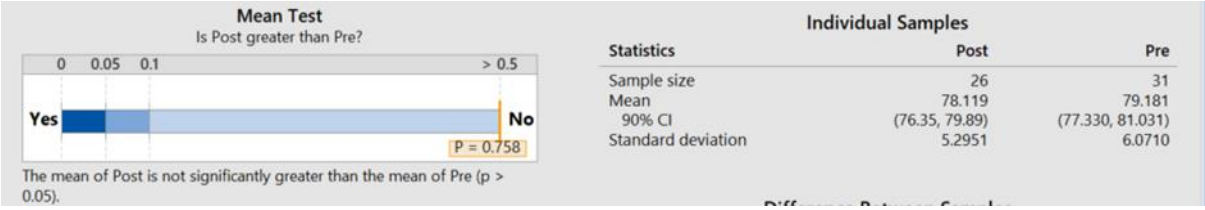
Harm Events	**2018 (July- Dec)**	**2019 (Jan-June)**
HAPI	0 cases	0 cases
CAUTI	3 cases	3 cases
CLABSI	1 case	0 case
Pt. Falls	33 cases	27 cases
HAP	3 cases	0 case

Appendix O

HCAHPS Pre- and Post-Survey Data

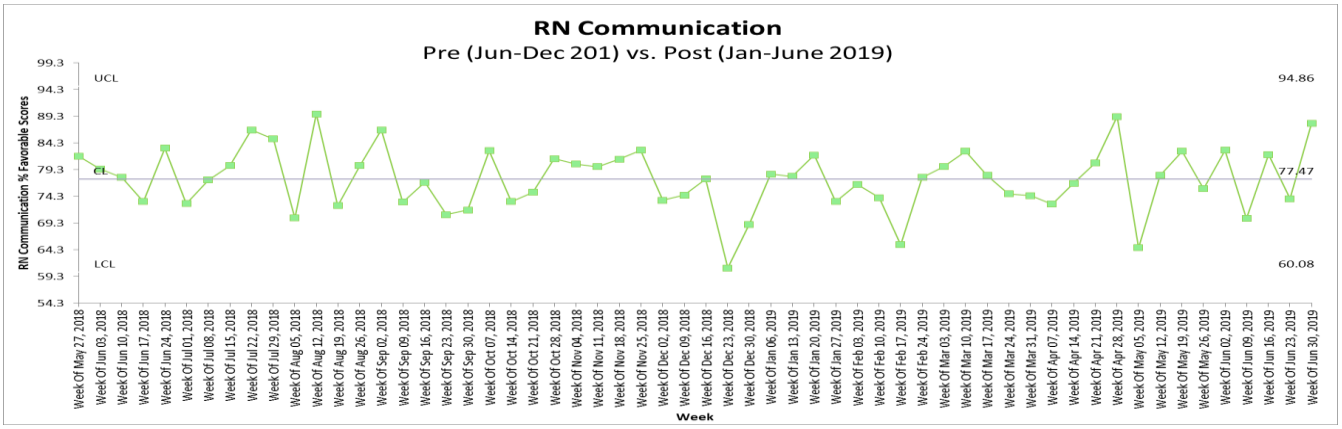


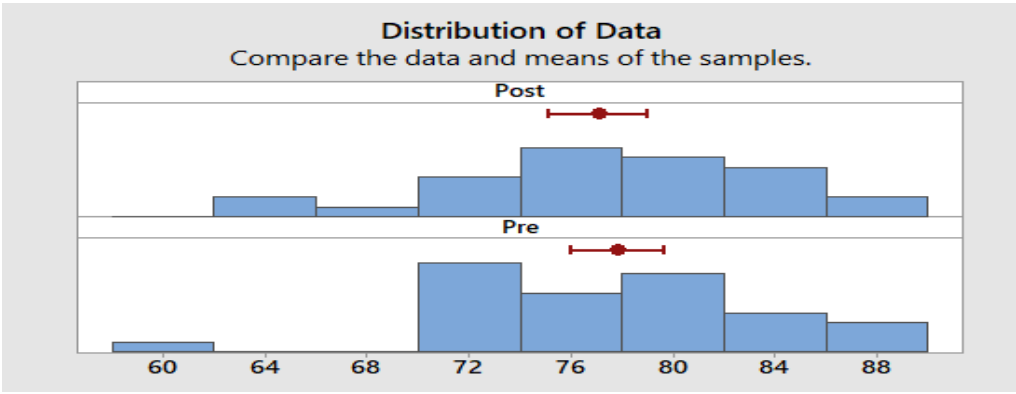


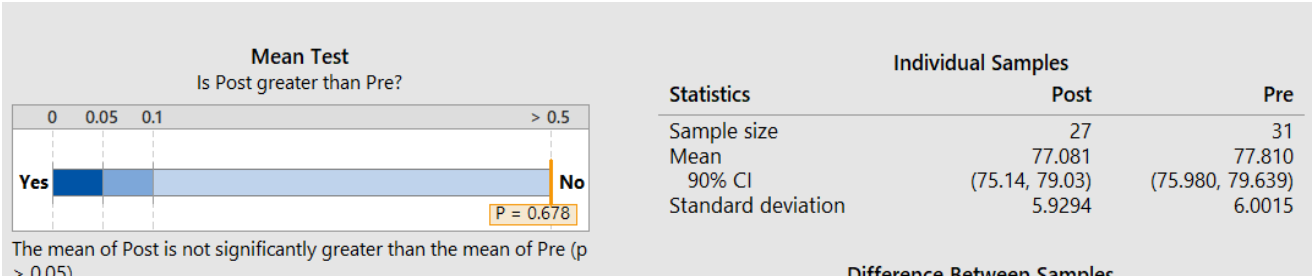


HCAHPS Pre- and Post-Survey Data

HCAHPS RN Communication







Individual Samples

Statistics	Post	Pre
Sample size	27	31
Mean	77.081	77.810
90% CI	(75.14, 79.03)	(75.980, 79.639)
Standard deviation	5.9294	6.0015

Difference Between Samples

HCAHPS Results Recommend Hospital

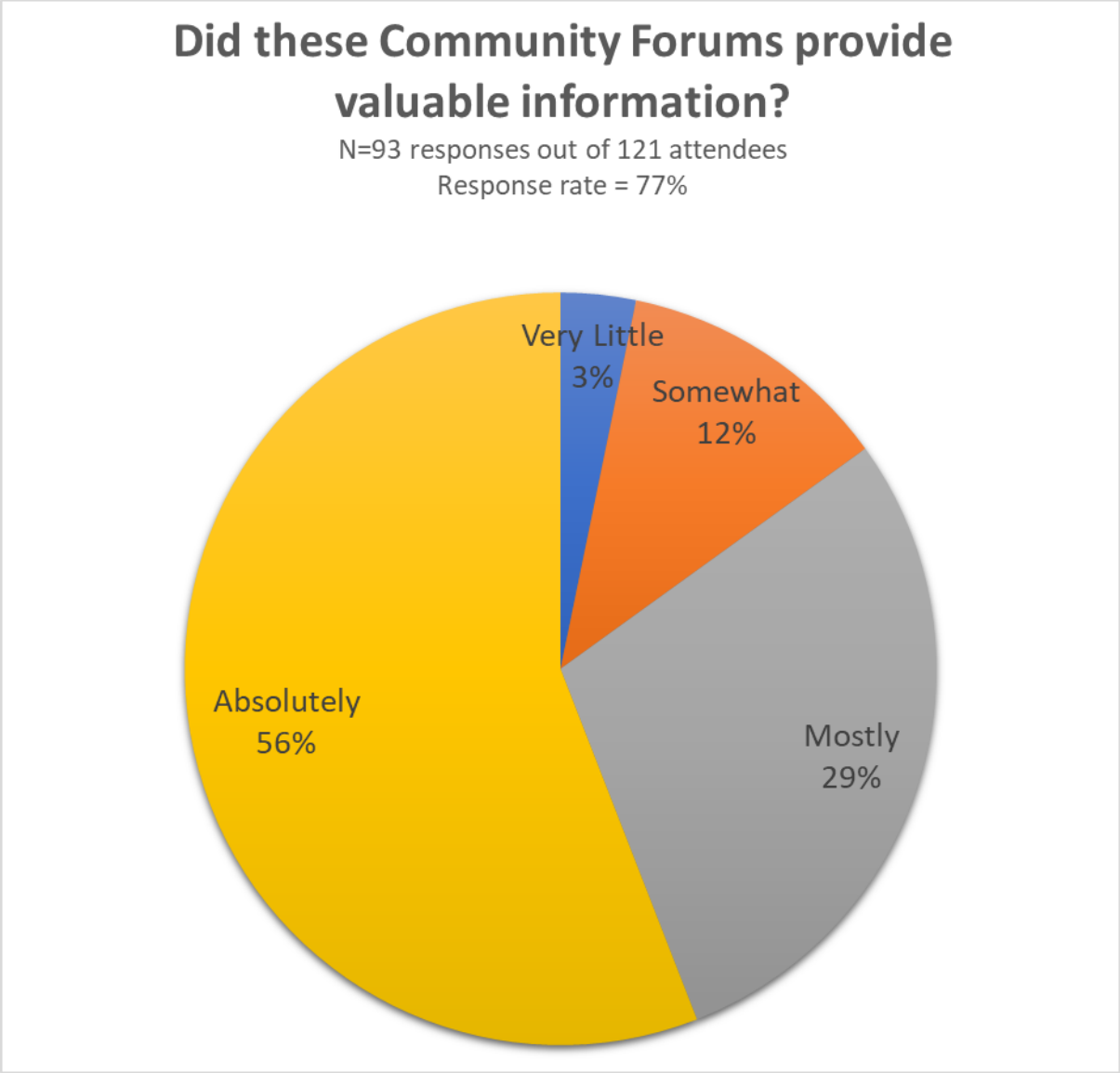
	2018	***N***	**2019**	***N***
January			91.4	158
February			86.5	148
March			91.6	127
April			91.0	137
May			92.2	132
June			92.1	139
July	92.2	119		
August	91.2	136		
September	90.5	148		
October	91.3	120		
November	92.2	122		
December	90.9	155		
MEAN	**91.3**		**90.8**	

HCAHPS Results Recommend Hospital

	2018	***N***	**2019**	***N***
January			91.4	161
February			88.7	150
March			92.4	132
April			90.9	141
May			91.0	138
June			90.6	147
July	92.1	119		
August	92.6	142		
September	90.6	153		
October	90.5	124		
November	93.3	127		
December	88.6	160		
MEAN	**91.28**		**90.83**	

Appendix P

Community Forum Results Aggregated



Appendix Q

Statement of Non-Research Determination Form

UNIVERSITY OF SAN FRANCISCO | School of Nursing and Health Professions

DNP Statement of Non-Research Determination Form

Student Name: Karen Strauman

Title of Project: Development, Implementation and Evaluation of an Employee Engagement program impacting acute care registered nurses and nursing quality indicators.

Brief Description of Project: Development of a standardized employee engagement model of acute care registered nurses within Kaiser Permanente Fresno Medical Center. The model will be delivered to front line clinical acute care registered nurses and clinical nurse leaders of this medical center.

A) Aim Statement: To examine current evidence supporting implementation of an employee engagement program in a medical center that will potentiate the improvement of nursing quality indicators.

B) Description of Intervention: Implement an employee engagement program of all acute care RN staff and nursing leadership in January 2019.
The project will include:

- Each nursing unit RN staff as part of the hospital's annual skills training will complete a module on Professional Practice.
- CNE will host a series of nursing community forums with the staff.
- A nursing leadership toolkit (ANCC nurse leader competencies) will be presented to and implemented with the nurse leaders on each unit.
- A caring science module will be presented to of all nursing unit-based RN council members.
- Unit council patient-centered caring science project will be completed by each unit council.

C) How will this intervention change practice? The intent is to reconnect the nursing staff to the art and science of the nursing profession and move beyond task-focused care.

D) Outcome measurements:

Annual engagement survey results will be used for baseline data. Post implementation

RN staff and leaders will be re surveyed. Baseline hospital nursing sensitive quality indicator data will be obtained from the Quality department (Nursing sensitive indicator data will be collected for the year prior to implementation and compared to the data collected during implementation). Those indicators are Falls, CAUTI, CLABSI, HAP, and HAPI. HCAHPS/Patient Satisfaction Survey data of recommend hospital, and nurse communication will be obtained. All outcome data will be obtained at baseline and post implementation. Post community forum data will be obtained to assess themes and value regarding the culture.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used:
(http://answers.hhs.gov/ohrp/categories/1569)

☐ This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

☐This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

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

Project Title: The Efficacy of Caring Science education series, impacting the nurse's personal perception of caring behaviors and patient's perception of treated with loving kindness.	**YES**	**NO**
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	**X**	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. ALL participants will receive standard of care.	**X**	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that overrides clinical decision-making.	**x**	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.	**X**	

The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	**X**	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	**X**	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	**x**	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	**X**	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	**X**	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

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

STUDENT NAME (Please print):

Signature of Student: Karen Strauman (electronic) **DATE** July 12, 2018

SUPERVISING FACULTY MEMBER (CHAIR) NAME (Please print):
Dr. KT Waxman
Signature of Supervising Faculty Member (Chair): Electronic Approval
DATE July 2018

Appendix R

Letter of Support from Kaiser Permanente

KAISER PERMANENTE®

University of San Francisco
School of Nursing and Health Professions
2130 Fulton Street
San Francisco, CA 94117

To Whom It May Concern,

I am writing to acknowledge the support for Karen Strauman, CNE at Fresno Medical Center, in completion of her evidence-based quality improvement DNP project, The Impact of Nurse Engagement Model Implementation on Patient Outcomes, in partial fulfillment of her Doctor of Nursing Practice degree in the Executive Leadership program at the University of San Francisco (USF).

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

Sincerely,

Wendy Gospodnetich, RN, MSN, CNS
Director of Clinical Education, Practice and Informatics

Kaiser Permanente, Fresno
7300 North Fresno Street
Phone: (559) 448-3119
Wendy.A.Gospodnetich@kp.org

Appendix S

Professional Practice Model Pre- and Post-Survey Results

What is a Professional Practice Model? (Choose the best response)

Answered: 294 Skipped: 0

		Refers to the organizational characteristics that inhibit professional nursing practice.	Refers to a schematic design that describes how nurse practice, collaborate, communicate and develop professionally.	Refers to a list of responsibilities for patient care and work is coordinated among members of the nursing staff.	Refers to how we practice by identifying a few key elements of professional nursing practice that can be found in all we do.	Total
Pre	Q1: Inpatient	6.80%	62.59%	12.24%	18.37%	100%
	Total Respondents	20	184	36	54	294
Post	Q1: Inpatient	5.85%	64.88%	11.22%	18.05%	100%
	Total Respondents	12	133	23	37	205

Differences among results pre vs. post are not statistically significant (p=.944)

Why do we want a Professional Practice Model? (Choose the best response)

Answered: 294 Skipped: 0

		Our professional nursing practice is consistent with other organizations.	We eliminate practice variations that can create waste of resources.	It promotes safe patient care and optimal patient outcomes.	It takes into consideration the whole staffing patterns to ensure that we are meeting all of the patient's needs.	Total
Pre	Q1: Inpatient	4.76%	1.70%	79.59%	13.95%	100%
	Total Respondents	14	5	234	41	294
Post	Q1: Inpatient	7.80%	0.98%	79.51%	11.71%	100%
	Total Respondents	16	2	163	24	205

Differences among the results pre vs. post are not statistically significant (p=.427)

Why are the Vision, Values and the Professional Practice Model important? (Choose the best response)

Answered: 294 Skipped: 0

		Through these elements we can meet TJC requirements.	The vision, values, and professional practice model help us drive to an extraordinary care experience for our patients and families.	The vision, values, and professional practice model are expectations from senior leadership, and we are held accountable to meet these expectations.	Total
Pre	Q1: Inpatient	0.00%	91.84%	8.16%	100%
	Total Respondents	0	270	24	294
Post	Q1: Inpatient	0.49%	92.20%	7.32%	100%
	Total Respondents	1	189	15	205

Differences among the results pre vs. post are not statistically significant (p=.462)

In general, how would you describe the quality of nursing care delivered to patients on your unit?
Answered: 294 Skipped: 0

		Excellent	Good	Fair	Poor	Total
Pre	Q1: Inpatient	60.54%	34.69%	4.76%	0.00%	100%
	Total Respondents	178	102	14	0	294
Post	Q1: Inpatient	55.61%	39.51%	4.88%	0.00%	100%
	Total Respondents	114	81	10	0	205

Differences among the results pre vs. post are not statistically significant (p=.530)

Have you seen or been exposed to the KP Professional Practice Model or the Vision and Values?
Answered: 294 Skipped: 0

		YES	NO	TOTAL
Pre	Q1: Inpatient	59%	41%	100%
	Total Respondents	174	120	294
Post	Q1: Inpatient	70%	30%	100%
	Total Respondents	143	62	205

Differences among the results pre vs. post are statistically significant (p=.016)

Kaiser Permanente (2015). Voice of Nursing Professional Practice Pre-Post Survey.
Kaiser Permanente National Patient Care Services.
Retrieved from https://www.kpnursing.org/nursingstrategy/toolkit/index.html

Appendix T

Word Cloud PPM Survey Results

Word cloud for staff nurse question: What does professional practice mean to you?

Pre

Post

Appendix U

Staff RN Top Responses: What Does PPM Mean to You?

Top Response	Pre-	Post-	Change
Quality Care	20	21	↑
Professional Practice	66	68	↑
Evidence-Based	10	16	↑
Excellent Care	19	31	↑
Exceptional Care	4	9	↑
Standard	17	20	↑

Appendix V

Caring Factor Survey Pre- and Post-Training Results – Staff RN

Fresno Medical Center	Weighted Average		
	Pre-Education (N=60)	Post-Education (N=48)	Change
Overall the care I give is provided with loving kindness.	5.82	5.96	↑
As a team, my colleagues and I are good at creative problem solving to meet the individual needs and requests of our patients.	5.47	5.77	↑
I help support the hope and faith of the patients I care for.	5.78	5.96	↑
I am responsive to my patients' readiness to learn when I teach them something new.	5.77	5.96	↑
I am very respectful of my patients' individual spiritual beliefs and practices.	5.8	5.96	↑
I create an environment for the patients I care for that helps them heal physically and spiritually.	5.75	5.96	↑
I am able to establish a helping-trusting relationship with the patients I care for during their stay here.	5.77	5.96	↑
I respond to each patient as a whole person, helping to take care of all of their needs and concerns.	5.78	5.96	↑
I encourage patients to speak honestly about their feelings, no matter what those feelings are.	5.82	5.96	↑
I am accepting and supportive of patients' beliefs regarding a higher power if they believe it allows for healing.	5.82	5.96	↑

Permission granted Caring Factor Survey on 1/3/2019 by John W. Nelson, PhD, MS, RN
President and Data Scientist, Healthcare Environment
www.hcenvironment.com

Appendix W

Caring Factor Survey Pre- and Post-Training Results – RN Unit Council

Fresno Medical Center	Weighted Average of 1 to 6 rating		
	Pre-Education (N=60)	Post-Education (N=48)	Change
Overall the care I give is provided with loving kindness.	5.82	5.96	↑
As a team, my colleagues and I are good at creative problem solving to meet the individual needs and requests of our patients.	5.47	5.77	↑
I help support the hope and faith of the patients I care for.	5.78	5.96	↑
I am responsive to my patients' readiness to learn when I teach them something new.	5.77	5.96	↑
I am very respectful of my patients' individual spiritual beliefs and practices.	5.8	5.96	↑
I create an environment for the patients I care for that helps them heal physically and spiritually.	5.75	5.96	↑
I am able to establish a helping-trusting relationship with the patients I care for during their stay here.	5.77	5.96	↑
I respond to each patient as a whole person, helping to take care of all of their needs and concerns.	5.78	5.96	↑
I encourage patients to speak honestly about their feelings, no matter what those feelings are.	5.82	5.96	↑
I am accepting and supportive of patients' beliefs regarding a higher power if they believe it allows for healing.	5.82	5.96	↑

Permission granted Caring Factor Survey on 1/3/2019 by John W. Nelson, PhD, MS, RN
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Appendix X

Caring Factor Survey Pre- and Post-Training Results – Nursing Leadership

Unweighted ave. of 1 (strongly disagree) to 6 (strongly agree) rating

	Pre (*N* = 33)	**Post (*N* = 31)**	**Improvement**	**Change**	**Statistically Significant?**
Overall the care I give is provided with loving kindness.	5.42	5.74	.32	↑	Yes (p = .018)
As a team, my colleagues and I are good at creative problem solving to meet the individual needs and requests of our patients.	5.15	5.42	.27	↑	No (p = .086)
I help support the hope and faith of the patients I care for.	5.45	5.77	.32	↑	Yes (p = .024)
I am responsive to my patients' readiness to learn when I teach them something new.	5.15	5.55	.40	↑	Yes (p = .036)
I am very respectful of my patients' individual spiritual beliefs and practices.	5.78	5.94	.18	↑	Yes (p = .024)
I create an environment for the patients I care for that helps them heal physically and spiritually.	5.24	5.68	.44	↑	Yes (p = .006)
I am able to establish a helping-trusting relationship with the patients I care for during their stay here.	5.30	5.74	.44	↑	Yes (p = .011)
I respond to each patient as a whole person, helping to take care of all of their needs and concerns.	5.30	5.87	.57	↑	Yes (p < .001)
I encourage patients to speak honestly about their feelings, no matter what those feelings are.	5.48	5.90	.42	↑	Yes (p = .004)
I am accepting and supportive of patients' beliefs regarding a higher power if they believe it allows for healing.	5.82	5.84	.02	↑	No (p = .415)

Appendix Y

RN Turnover Results

Jan-Jun 2018

RN Turnover Rate 2018 6-month MEAN = 4.87

Turnover rate (annualized) grouped by Role over time

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Grand total	5.9%	4.4%	4.8%	4.6%	4.2%	5.2%
RN (PCS)	5.9%	4.4%	4.8%	4.6%	4.2%	5.2%

RN Turnover Jan-Jun 2019

RN Turnover Rate 2019 6-month MEAN = 4.67

Turnover rate (annualized) grouped by Role over time

	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019
Grand total	4.8%	4.6%	3.4%	5%	5.2%	5%
RN (PCS)	4.8%	4.6%	3.4%	5%	5.2%	5%

Appendix Z

Communication / Responsibility Matrix

Communication Type	Objective of Communication	Medium	Frequency	Audience	Deliverable	Responsible Owner
Presentation to Sr team	Introduce the project. Review project objectives and management approach.	Face to face	One time	Medical Center Senior Administrative team	-Agenda -Meeting minutes	Project Manager/CNE
Kickoff meeting to nursing leadership	Introduce the project team and the project. Review project objectives and management approach.	Face to face	One time	Nursing managers, directors	-Agenda -Meeting minutes	Project Manager/CNE
Training Caring Science on line learning module	Education	Electronic learning module	One time	All frontline acute care nurses	Unit project implemented	Director of Education
In person Community Forums	Transparency of leadership	Face to face	2- every other month	Frontline acute care nurses and leaders	-Scheduled and conducted. -Open agenda	Project Manager and Nursing Directors
On-line Professional Practice Model (PPM)Training	Education	Electronic learning module	One time	Frontline acute care nurses and leaders	All acute care nurses have completed the PPM training	Project Manager/CNE, Directors and Managers