Summer 8-15-2016

Improving Unit Dynamics: Incorporating Lead Nurse Program on a Medical-Surgical Unit

Kara Mace
University of San Francisco, hammonsk77@yahoo.com

Follow this and additional works at: https://repository.usfca.edu/capstone

Part of the Other Nursing Commons

Recommended Citation
Mace, Kara, "Improving Unit Dynamics: Incorporating Lead Nurse Program on a Medical-Surgical Unit" (2016). Master's Projects and Capstones. 358.
https://repository.usfca.edu/capstone/358

This Project/Capstone is brought to you for free and open access by the Theses, Dissertations, Capstones and Projects at USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. It has been accepted for inclusion in Master's Projects and Capstones by an authorized administrator of USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. For more information, please contact repository@usfca.edu.
Improving Unit Dynamics: Incorporating

Lead Nurse Program on a Medical/Surgical Unit

Kara L. Mace

N653: CNL Role Internship – Summer 2016

University of San Francisco
Clinical Leadership Theme

My culmination project is aimed to improve unit morale on the Medical-Surgical Unit (MSU) by incorporating a lead nurse program (LNP) at the Department of Veterans Affairs (VA) hospital in Sacramento (VA Mather). The leadership theme, or clinical nurse leader (CNL), element I will be focusing on is Clinical Outcomes Management and my CNL role function will be as an Educator. It is important to work on this type of project because the Institute of Medicine (IOM) has recognized clinical nurse leadership as an essential competency to support staff, ensure quality care, improve outcomes, and maximize patient safety (Grindel, 2016, p. 9).

This project will meet the standards of the American Association of Colleges of Nursing (AACN, 2013) CNL competency in quality improvement and safety by “apply[ing] improvement science theory and methods in performance measurement and quality improvement processes (p. 14).

Statement of the Problem

A need I have identified for the MSU is centered on clinical leadership. The Nurse Manager (NM) and CNL on MSU are overburdened with managerial duties and multiple hospital-wide process improvement projects that keep them away from the floor. Registered nurses (RNs) and nursing attendants (NAs) have expressed their opinions of not feeling support from management or at the peer-level, which has led to multiple call-offs, high turnover rates, and a significant amount of new grads on the unit. Carlin and Duffy (2013) explained their concern for new grads, by stating the transition from student to nurse is often stressful, manifests
uncertainty and doubt, which leads to fear. Many staff nurses on MSU are within their first year out of nursing school, so the need for strong clinical leadership is imperative for their careers.

Low employee satisfaction and a lack in clinical leadership not only will affect staff, but patients and their family members as well. Hill (2010) discussed this fact when they stated, “an experienced nurse may assess the same patient as an inexperienced nurse but respond differently based [on] subtle changes (cues) that serve as a forewarning of significant underlying issues” (para.3). Over the past three months, the NM has focused on hiring more staff, which has allowed an opportunity for a lead nurse, or charge nurse role to be assigned on each shift. The support and expertise from a staff-level leader can improve the morale and unit flow on MSU, as well as improve employee satisfaction and patient safety.

**Project Overview**

Through my work on this project, I expect to (1) improve communication breakdown between staff, management, physicians, and other ancillary staff, (2) incorporate a measurement of “real time feedback” from staff and patients through daily rounding, (3) organize care and staffing needs, and (4) establish long term goals/benefits for the unit. To achieve my objective, I will identify the learning needs of prospective lead nurses, collaboratively work with VA staff when devising a leadership program, and then initiate the LNP on MSU. My fundamental goal is that by incorporating a LNP on MSU, employee satisfaction scores will increase by 0.52 in the September 2016 All-Employee Survey.

In order to support the identified need of clinical leadership on the MSU, a group of senior nurses will be chosen to function in the role of lead nurse (LN). The NM and CNL are
LEAD NURSE PROGRAM

seeking nurses with three or more years of nursing experience and/or RN II status, who have been on MSU for at least 6 months. When a nurse is hired by the VA, they are boarded by fellow senior nurses and their RN status and pay are based on their recommendations. The board meets monthly and reviews new employees’ education background, work experience, certifications, and humanitarian service. An RN II will need a minimum of two years of nursing experience and/or have at least one certification. An employee’s yearly evaluation also provides the nurse with an opportunity to promote based on accomplishments throughout the previous year (e.g. acquired bachelors, masters, or doctorate education; professional certification; unit projects).

Once a group of LNs have been selected, the next step in the process includes building a leadership-based educational program that each nurse will attend before acting in the lead nurse role. To better understand the needs of the selected lead nurses, I generated a nursing leadership assessment for them to complete that would assist our efforts when devising their training program (see Appendix A). Four common themes extracted from the LN assessment responses were: team building strategies, conflict resolution, leadership development, and interpersonal communication. The MSU NM and RN Educator contacted the company who are conducting the LN training and they have requested these four themes be integrated into the curriculum. When all LNs are trained, the LNP will be implemented to cover every shift by August 15, 2016. Prior to implementing this project, I reviewed the evidence-based change of practice project checklist, which reflected this project as an evidence-based activity and no Internal Review Board (IRB) is required.

Rationale
Since the 1999 IOM report, *To Err is Human*, there has been a vast amount of research and literature addressing the topics of leadership and change. In the past, nurses were taught to focus solely on their clinical skills to ensure the safety of their patients and maintain the status quo in their working environments, whereas NMs were seen as the leaders among the healthcare units. Unfortunately, this led to nurses mistrusting NMs and not understanding the true concept of leadership due to poor role modeling (Carlin & Duffy, 2013, p. 29; Ebrahimi, Hassankhani, Negarandeh, Azizi, & Gillespie, 2016, pg. 187). Stanley (2005) discussed an important issue pertaining to clinical leadership and suggested senior staff nurses be coached as leaders in order to improve communication, patient outcomes, and efficiency among the units. Duygulu and Kublay (2010) support this evidence by stating effective leadership can improve satisfaction among nurses and positively affects the productivity at both the individual and organizational levels.

Castaneda and Scanlon (2014) stated current nursing literature often cites a common reason nurses are leaving the profession is due to job dissatisfaction. How a nurse expresses their dissatisfaction is manifested in many ways and often spreads within the unit. The VA composes an annual, online All-Employee Survey (AES) and the results are broken down by region, facility, and unit. Each question is answered using a 5-point Likert scale: 1= strongly disagree, 2= disagree, 3= neutral, 4= agree, and 5= strongly agree. In 2015, the survey result in the employee satisfaction category was 3.48 for the MSU, which was lower compared to years prior. Noting these findings and assessing the microsystem’s day-to-day functions has led me to the conclusion that a lack of clinical leadership is affecting the morale on MSU, which ultimately affects patient care.
The MSU is located on the third level and is a 19-bed inpatient unit with a five-bed expansion unit on the fourth floor (4 MSU). Due to the geographical separation of 4 MSU from the main unit, the most stable medical-surgical patients should be admitted to the fourth floor. The average daily census (ADC) on the MSU was 18.96 for fiscal year (FY) 2015, which had increased from the previous year. Though FY 2016 has not closed, MSU’s ADC has increased again and is projected to be in the range of 20-21 patients. Due to this increase, the 4 MSU overflow unit has been consistently at capacity. One RN and one NA are responsible for providing care to patients on 4 MSU. The concept of having a split floor is not ideal, but it was a quick solution to MSU’s need of more beds. This temporary fix has been a source of consternation among nursing staff (RNs and NAs) over the past year. Throughout my assessment on MSU, I spoke with many staff members who revealed they feel isolated on 4 MSU, often do not have the appropriate supplies, and are not feeling supported when they are requesting help.

Thomasos et al. (2015) explained how excessive workload due to financial constraints and the push to decrease the average length of stay (ALOS) can lead to staff burnout and high turnover rates in hospitals. Currently, the length of stay varies among the services on MSU, but ALOS for medical patients is 4.45 days and 3.15 days for surgical patients; overall ALOS between both services is 3.96 days. Due to the aging population of our country’s veterans, many patients on MSU have multiple comorbidities, need assistance with all activities of daily living (ADL), and require a 1:1 sitter due to dementia or high fall risk. Multiple patients requiring full care are demanding for MSU staff and leads to many RNs accumulating overtime (OT) to finish their charting. And there is the issue of OT costs incurred due to the need of a 1:1 sitter. On
average, one extra NA is needed each shift, every day in order to accommodate patients who require a 1:1 sitter. In FY 2014, the unexpected costs for sitters on MSU was approximately $316,000, which is equivalent to 10,500 staff hours.

Another key finding, I came across when performing a microsystem assessment on MSU, was a pattern of daily call-offs. According to James (2014), 17.5 percent of newly licensed RNs are leaving their first job within one year and the number almost doubles for those leaving within two years – 33.5 percent. It is difficult for administrators to determine causes for high turnover rates since it may be due to promotion or lateral transfers among units, dissatisfied employees, or circumstances that cannot be controlled. Though it may be unpredictable, the effect of low staff numbers causes a shift of workload on the staff members who do come to work and can lead to overworked staff. Not only are staff burdened with being overworked, there are financial repercussions that falls on VA Mather due to high call-off rates and nursing turnover. For FY16, October to January, there was a total of 1,429 OT hours accrued by MSU nursing staff [a 260% increase from FY15 Oct-Jan quarter (Q1)]. Based on the average wages of RNs and NAs on MSU, $40/hour and $25/hour respectfully, the total costs accrued for OT in FY16 Q1 was $44,860. The majority of these hours have come from call-offs, which required the MSU manager to ask staff if they would be willing to extend their work day hours, call staff who are scheduled off, and/or request staff from the VA registry list.

Evidence based practice (EBP) has suggested high turnover rates affect healthcare costs, job satisfaction, and the quality of care patients receive (Lartey, Cummings, & Profetto-McGrath, 2013, p. 1027). It is my hope the lead nurse project implemented on MSU will realign nursing flow within the unit, improve overall staff satisfaction, and increase retention. Jones and
Gates (2007) discussed the costs incurred from nursing turnover and estimated the rates to be 0.75 to 2.0 times the departing employee’s salary. The costs accrued to implement the LNP will far outweigh the costs the VA is paying to accommodate the exorbitant amount of OT and turnover costs generated on MSU alone. The CNL student wages is another area VA Mather will be reducing their costs since clinical hours are unpaid hours. Based on our 220 clinical hours x an approximated CNL wage of $55/hour, my cost savings for VA Mather equates to $12,100. Estimated savings from FY16 Q1 OT and my CNL wages have totaled to $56,960.

The predicted costs to initiate the LNP on MSU will be due to LN meetings, the cost of training, and assessment handouts. There were 18 nurses between the first three meetings who were scheduled off, but attended the meeting. Approximate OT pay is $75/hour x 1.5 hours x 18 nurses, which comes to $2,025. The majority of our costs will be for the training we are providing the LNs prior to initiating the LNP. Approval was granted to hire an outside company who specialize in leadership training courses. The cost of training will be $12,500 for one 8-hour training session. Please refer to Table 1 in Appendix B for a breakdown of the projected cost analysis for the lead nurse project. With the estimated overall cost savings of $56,960 less the total project cost of $25,553 (first and second year costs), VA Mather would garner $31,407 in revenue.

It is imperative that I be engaged with key stakeholders to determine if the meso- and macrosystem evaluation is in line with the microsystem’s assessment. The role of the stakeholders will be to assist projects by ensuring resources are available and to provide essential feedback of potential reactions or setbacks I may have when implementing this project. Potential barriers to any project are a lack of communication or lack of utilizing resources that will
facilitate its success or sustainability (e.g. stakeholders). To successfully implement the lead nurse project, I must clearly delineate the purpose, goals, and objectives of the project to the stakeholders and highlight how it will positively impact the staff and patients.

Bender (2016) discussed how a CNL project is an important asset to a microsystem because it redesigns nursing care delivery. Though costs are accrued for all projects, the outcomes are limitless if it is successfully implemented and maintained. A key element needed prior to implementing a process improvement project is an analysis of the unit’s readiness to change. In order to properly identify MSU’s readiness for the LNP a SWOT analysis was performed to determine the strengths, weaknesses, opportunities, and threats to our project. Refer to Appendix C for the results of our SWOT analysis. Once the team had a basic understanding of our internal and external dynamics that would assist and/or detract from our progress, we brainstormed to find the causes leading to the MSUs decline in staff satisfaction scores and unit morale. From this brainstorming session, a fishbone diagram was created and can be viewed in Appendix D.

After performing a microsystem assessment and reviewing employee satisfaction results from the 2015 AES, I determined there is a high volume of call-offs and turnover rate on the MSU. Employees were feeling overworked due to a lack of staff and felt a disconnect between them and management. Grindel (2016) made a strong point when she stated patient care and efficient work processes are improved when clinical nurses (bedside staff level) assume a role in leadership. Following extensive research, I have found that strong leadership at the clinical nurse level promotes learning, improves morale, increases nurse retention, and improves patient outcomes. It is my goal to promote those attributes on MSU by implanting a LNP and improving
employee satisfaction scores in the 2016 AES. I have chosen to measure staff morale, or satisfaction rates due to evidence of improved patient outcomes being a by-product of this measurable outcome. Though I am measuring one outcome, the benefits of having strong leadership will be manifested in other areas of the unit (e.g. patient outcomes, turnover rates).

An appropriate change theory that guided the LNP on the MSU was Lippitt’s Phases of Change Theory. This seven-phase framework is an expansion of Lewin’s three stages of change model and centers on the roles and responsibilities of the change agent instead of the change itself (Kritsonis, 2005). Although a CNL student is considered a change agent and will be helping to execute the project, the LN will be placed in a position to be a change agent on the MSU unit once trained. Mitchell (2013) evaluated Lippitt’s change theory and paralleled his change model to the nursing process: Assessment, diagnosis, planning, implementation, and evaluation (see Appendix E). Using this model and evaluating the responses from the LN assessment tool will guide the interdisciplinary team when establishing the LN curriculum, while the connection to the nursing process will assist the lead nurse trainee to adopt the role of leader and understand the schematics of the change process more clearly. A process map using Lippitt’s model can be viewed in Appendix F.

Incorporating change is difficult, which is why the application of essential leadership skills is a necessary accompaniment to a change strategy in order to produce positive outcomes and sustainability within the microsystem. Transformational leadership is an increasingly popular model and widely known to be successful. Effective communication and team building techniques are key components used to transform the attitudes and goals of those working in the microsystem. Bennis and Nanus further emphasize the benefits of transformational leadership by
linking it to increased job satisfaction among staff members, improved productivity, and potentially converting leaders into change agents (as cited in Duygulu & Kublay, 2010, p. 634).

Wilson et al. (2013) described outcomes as “quantitative and qualitative evidence related to the impact of structure and processes on patient, nursing workforce, organization, and consumer” (p. 177). The LN redesign team will need comparative information in order to measure if the initiation of the LNP on MSU resulted in positive outcomes. During Phase 2 of Lippitt’s change model a pre-assessment Likert-Scale questionnaire will be circulated among MSU staff. Once the LNs have been trained and working on the floor, a post-assessment Likert Scale questionnaire will be circulated (Phase 7 of Lippitt’s model). To view the pre- and post staff questionnaire refer to Appendix G. Both the pre and post-assessment Likert Scales will be analyzed to give real-time feedback if the LNP was effective since the results from the 2016 AES aren’t calculated and distributed to the corresponding facility/unit until December 2016. Using qualitative outcomes manifests knowledge centered around real-life situations and outcomes. This type of information, or clinical examination, will allow the redesign team to be more effective change agents and seek areas needing improvement. My quantitative prediction is there will be an improvement in employee satisfaction scores and MSU will generate a score of 4 (0.52 increase) or better in the 2016 AES, which was the projected goal we established when writing the aim statement. Ensuring the desired goals are met increases the sustainability of the LNP on MSU and will provide an opportunity to incorporate the LNP on other units at VA Mather.

**Data Source/Literature Review**
Conducting a thorough literature review to identify leadership characteristics and the effects lead nurses have on their prospective units was made easier once I constructed a PICO search strategy. The PICO statement I created was: Does having a lead nurse on a hospital unit, compared to having no lead nurse improve the dynamics of the unit? A search of PubMed and CINHAL databases using the keywords: Leadership, charge nurse, change theory, job satisfaction, and leadership theory were sufficient to gather the necessary content to begin the research for my project. Once the problem was identified and PICO search strategy was used to gather evidence, I collaborated with my team to discuss the relevance of each article compared to our aim statement and my PICO statement. Six articles were chosen with dates ranging from 2005-2016; all were appropriate, relative, and directed me towards my measurable outcome for the LNP on MSU…to improve employee satisfaction.

In the article, Job Satisfaction in Nursing: A Concept Analysis, Castaneda and Scanlan (2014), utilized Walker and Avant’s concept analysis methodology to examine the phenomenon of job satisfaction in nursing. The authors’ goal was to perform a concept analysis, examine how it is currently demonstrated in the hospital setting, and propose a definition of job satisfaction particular to the nursing profession. Based on their discussion, job satisfaction is a complex phenomenon to examine since it is an intrinsic feeling impacting multiple areas within a work environment. From the analysis, Castaneda and Scanlan (2014) defined three attributes that are significant to nurses’ job satisfaction, which are autonomy, interpersonal relationships, and patient care. Though the authors feel more research must be conducted since this concept analysis was only based on nurses in a hospital setting, they were able reach a conclusion that job satisfaction is an affective, or emotional reaction resulting from the person’s actual outcomes.
versus those that are desired, expected, and deserved. Being aware of these findings allows the redesign team to be cognizant of what staff are needing to feel fulfilled in their work environment. In order to properly change the unit dynamic and improve satisfaction rates, the lead nurses will be trained to understand the needs of their nurses and how they can accommodate them.

A qualitative study using interpretive phenomenological analysis (IPA) was performed in Carlin and Duffy’s (2013), *Newly qualified staff’s perceptions of senior charge nurse roles* article, and aimed to develop an understanding of leadership from the perspectives of newly graduated nurses in the hospital setting. The authors chose the IPA methodology because it allows participants to be forthcoming and offers detailed accounts of their experiences. This small study of five nurses who had worked less than one year in the nursing profession, generated enough information for the authors to identify three overarching themes discussed by the new grads; perceptions of leadership, expectations, and barriers to the role. Each theme had subthemes, but overall the evidence reflected that charge nurses are burdened by managerial duties, often are not visible, and staff could not trust their decision making capabilities pertaining to their wards. The concept of gaining insight from a new graduate’s perspective was an appropriate tactic in order to understand what they are looking for in their staff-level leadership. Though the study was small, the concept of researching from the bottom up offers more substance to the challenge of leadership and what staff are requiring. The authors findings reflected the need for empathetic and engaged lead nurses who are prepared to tackle daily responsibilities as well as coach their nurses to become confident in their abilities.
Grindel (2016) discusses the topic surrounding the IOMs plea for clinical leadership at the bedside in her article, *Clinical Leadership: A Call to Action*. The IOM suggested clinical leaders should be at the forefront of change initiatives in the nursing practice. The author identifies clinical leaders as effective agents to challenge processes since they are at the frontline of care and can motivate fellow nurses to initiate change and improve outcomes within their units. In order for this to happen, Grindel (2016) explained clinical leaders need to be trained to have a core knowledge of clinical leadership, practice environment, and leadership competency skills. Based on the review of literature from the IOM, the author cites clinical leadership as a key component in the fight to augment patient care, improve outcomes, and energize the concept of improving the practice environment (e.g. low staffing, inefficient work processes, etc.). This article highlights the national perspective of clinical leadership in nursing, which offers validation for the implementation of a LNP on MSU in order to improve their practice environment.

In the article, *Recognizing and defining clinical nurse leaders*, Stanley (2005), addresses the concepts of clinical leadership and how it can be defined. The author applies qualitative and grounded theory research methodologies to define what clinical leadership is and proposed a new leadership theory, congruent leadership, based on his research findings; congruent leaders are often followed because their values and beliefs are in-line (congruent) with their actions. The methods he used to obtain information came from questionnaires (phase 1), focused interviews (phase 2), and clinical leader interviews (phase 3). In phase 2 and 3 interviews, the author was able to identify characteristics of clinical leaders as those with: Clinical competence, clinical knowledge, effective communication, decision-making skills, motivation, and openness.
(approachability). Stanley (2005) also described clinical leaders as role models and visible participants in the daily workings of the unit. Though this article was published 11 years ago, it was beneficial to my project because it gave extensive information pertaining to the characteristics of clinical leadership.

Normand, Black, Baldwin, and Crenshaw (2014) published the findings of their quality improvement project implemented on a medical-surgical floor in *Redefining “charge nurse” within the front line*. The purpose of this project mirrors the concept of the LNP I am implementing on MSU, which is to design and offer leadership training in order to improve nurse retention. The authors use key elements of the American Organization of Nurse Executives competencies and discuss how they used the Plan-Do-Study-Act (PDSA) cycle when generating their leadership training program. Each phase in their implementation strategy is examined and offers areas of improvement for their next training class. Though this article was not research based, the content was instructive and its concept is based on best practices in nursing.

In Mitchell’s (2013) article, *Selecting the best theory to implement planned change*, he explains the importance of using a change theory when attempting to implement, manage, and evaluate change in the nursing practice. The author introduces three common change theories; Lewin, Rogers, and Lippitt’s and then assesses important elements of leadership that are needed when implementing change. The author chooses one change theory to discuss in detail that he feels is most effective when implementing change, which is the change theory I used when designing my project. Lippitt’s seven-phase theory is more detail specific on how to implement change and is strengthened by the four elements of the nursing process; Assessment (includes
diagnosis), planning, implementation, and evaluation. Mitchell’s (2013) article was useful because it compared change theories and offered an example of its effectiveness when implementing change.

Timeline

Nelson, Batalden, and Godfrey (2007) explained how the 5 P’s can be used as a starting point when designing or redesigning clinical Microsystems; purpose, patients, professionals, processes, and patterns. Once I had performed the 5 P’s, I was able to clearly characterize the needs of the unit and focused my attention on one need that would impact MSU the most. To ensure the efficacy and sustainability of my project it was essential I generate a timeline. A key problem when working on projects deals with those who are involved not appreciating the value of time…theirs and others (Headspace, 2010). Another difficulty during project implementation is setting realistic goals based on your objectives and understanding feedback will not always be instantaneous. Allowing a “buffer zone” for unexpected delays alleviates stress and does not jeopardize the project’s deadline.

I have been working as a CNL student on MSU since January 2016 and participated in trainings on the Mather campus, so I was familiar with staff and the organizational processes of this facility. I had completed the microsystem assessment prior to our first LN meeting (in previous semester), which made it easier when I presented my findings. In order to be more efficient with our time and not deal with rescheduling issues, the team decided there would be four scheduled meetings throughout the project (phase 1, 3, 5, & 7) and impromptu meetings could be scheduled if necessary.
Using Lippitt’s change theory has been valuable when planning our meetings and generating a timeline since its detailed phases act as a “roadmap” for our project’s implementation. I devised an action plan to ensure the team meets each phase of Lippitt’s theory throughout our planning, which can be viewed in Appendix H. This action plan was reviewed by the team and approved for use. Between meetings, I have had one-on-one conversations with the RN Educator, MSU NM, MSU CNL, and some of the lead nurses to discuss aspects of the project and/or gain approval for my LN assessment tool, pre- and post-assessment Likert scale questionnaire, and finalize the LN Daily Tasks list (see Appendix I).

Our projected start date of training has been pushed back due to our need to hire an outside company to perform the training. VA Mather’s RN Educators are overburdened with multiple projects and there are no prospects of new RN educators being hired in the coming FY; therefore, the NM of MSU wrote a proposal to administration for approval to fund a training course. This took more time than we anticipated, but approval was finally given on June 15, 2016. Our next hurdle and time constraint pertains to the start date of training and the rollout date of our LNs working on the floor. Our projected start date was August 15, 2016, but this may be pushed back as we continue to work with the contractor regarding our training course. Refer to Appendix J for a Gantt chart depicting the project’s timeline.

**Expected Results**

Literature has established that interdisciplinary collaboration and teamwork among nurses is tied to a rise in work/staff satisfaction, improved patient outcomes, and an increase in the quality of care patients receive (Bender, Connelly, Glaser, and Brown, 2012, p. 326; Duygulu
Based on these findings, the lead nurse project on MSU will support national standards in patient care and improve nursing practice in the role of clinical leadership. Throughout the process of planning and implementing this project, there has been an obvious change on MSU surrounding the perception of leadership. From this small change, I am expecting the results from implementing this project will improve the morale and dynamics of the MSU and we will meet our aim statement goal.

**Nursing Relevance**

Based on the need for continued change and evidence supporting effective leadership at the unit level is producing positive outcomes, implementing a LNP within a healthcare microsystem is an appropriate change strategy. Establishing a group of LNPs is necessary in order to improve communication among staff nurses, upper management, and ancillary staff. The leadership role of the LN will also be supportive and coordinative, which ensures “continuity of patient care and thereby making a difference in the process of healthcare service” (Duygulu & Kublay, 2010, p. 634).

The Patient Protection and Affordable Care Act of 2010, provides fiscal incentives to healthcare facilities if they surpass the expectancies in multiple domains, including the experience of care domain (Normand, Black, Baldwin, & Crenshaw, 2014, p. 49). Normand et al. (2014) goes on to state Medicare paid out $964 million in 2013 to facilities that met the domain of patient satisfaction, which has caused a shift in how healthcare facilities are utilizing their nursing staff to improve satisfaction among patients and their family members. Developing leadership and mentor programs for senior nurses has been researched more in order to better
understand how healthcare facilities are responding to a stronger presence of leadership and the overall effect it has on the units (Carlin & Duffy, 2013, p. 24).

Bender et al. (2012) defined the CNL role beautifully by stating they are “agents of change, practicing where most decisions about patient care are made and helping to assist the entire healthcare team in transforming their practice from fragmented, discipline-focused care to collaborative, patient-centered care” (p. 331). Using EBP and knowledge of the CNL role, I proposed and implemented a process improvement project to improve employee satisfaction rates on MSU. Lippitt’s change theory and transformational leadership were highlighted as effective concepts needed in order to successfully implement the LNP that ultimately will improve employee satisfaction, interpersonal communication, productivity, and patient outcomes.

**Summary Report**

Multiple call-offs and high turnover rates has left staff feeling overworked and not appreciated on the MSU at VA Mather. This downtrodden attitude was expressed quantitatively when the employee satisfaction rates from the AES were at an all-time low of 3.48 (out of 5.0) in 2015. The objective of this project was to improve unit dynamics through the implementation of a LNP on MSU at VA Mather. The implementation of a LNP on the MSU offers an opportunity for LNs to empower their coworkers using clinical leadership skills they will acquire in a leadership training class. The MSU has 19 beds located on the third floor and a five-bed overflow unit located on the fourth floor. Based on an average daily patient census of 20-21, there is a need of five RNs and 3-4 NAs for each shift. Increasing staff on MSU has been a
priority for the NM and the unit will soon be able to accommodate a LN to be staffed on every shift.

Castaneda and Scanlon (2014) contextually compared morale with job satisfaction and claimed that an increase in staff morale leads to an improvement in the productivity of employees. Once LNs were chosen, they were asked to complete a leadership assessment questionnaire to obtain their views on the qualities a leader should possess, what they see as their strengths and weaknesses as leaders, and leadership responsibilities they find challenging when in the role. The initial date for the training was to begin on August 1, but it has been pushed back two weeks due to time constraints between nurse educators and the contract company developing the training curriculum. At this time, no published material or teaching aids have been used. The training program will consist of learning material professionally drafted and each LN will be given a copy as a reference throughout the class.

Initially, I believed the staff on MSU would not be receptive to the LNP project, but they exceeded my expectations and have welcomed the ideas and processes strategized throughout the implementation of this project. Our goal was to have at least seven LNs who met the qualifications, and we ended up with 11. We had difficulty planning meetings at times, but the NM began to offer a teleconference option, which helped for people who were off or on night shift. The most frustrating aspect of this project has been the constant delays and mesosystem involvement with the leadership training class. I naively believed the interdisciplinary team would be able to construct a training course focusing on leadership theories, leadership building skills, and potential scenarios, but I quickly was introduced to the interworking’s of a large healthcare organization and the complexities that accompany it. Administration was notified of
our desire to build a leadership class, but our RN Educators are already busy with multiple other projects and we were instructed to propose another idea. After multiple meetings (many I could not attend due to my work schedule), administrators accepted our proposal and agreed to fund a class taught from an outside source.

The last delay the team was met with pertained to new hire start dates. Unfortunately, the hiring process is lengthy and unpredictable in the federal system (some receive clearance from background checks sooner than others), but at this time all the staff were approved and have started orientation or will start the first week of August. All new hires are experienced nurses; half did not require a lengthy orientation and the other half transferred from other units or VA facilities and have already been working on their own.

Due to a delay in training, the LNP project has not been officially implemented, but when staffing permits a LN has been assigned to work the floor. I gave the NM my clinical days more than a month in advance, so she was able to ensure staffing was adequate on those days and I would work with the LN throughout the shift and offer support when needed. Since the training class has not been implemented we are not gathering data at this time, but feedback from the mid-shift huddle has been positive. On one occasion, the NM and I were discussing delegation practices when a side conversation emerged and a few of the RNs and NAs voiced their approval of the LN role and stated it has helped the flow and morale on the unit.

Once the training course has been fully implemented, weekly post-assessment questionnaires will be offered to all MSU staff (see Appendix G). After one month of weekly assessments, the assessments will then be offered on a monthly basis x 11 months. This data will
be gathered and plotted on run charts. The data we receive will be beneficial to our efforts by offering quick results so we can then modify the project to ensure its sustainability throughout the year. The data results of the 2016 AES will not be returned until December, but this information will reveal if our aim statement was met. Data will be collected throughout 2017 in order to compare the rates with that of 2016. This data is necessary to show the sustainability of our project and offers support when our stakeholders review the LNP project’s worth within their organization.
References


Lartey, S., Cummings, G., & Profetto-McGrath, J. (2014). Interventions that promote retention


Appendix A

Leadership assessment distributed to lead nurses prior to building training curriculum.

List three qualities you feel are essential for success in the leadership role:

1. 
2. 
3. 

Which of the following three responsibilities do you find most challenging in your current leadership role? (check using 1, 2, and 3 with 1 being the most difficult).

___ Delegating care to others
___ Management of patient flow (admission/discharge/transfer)
___ Supervising the work of others
___ Making patient care assignments
___ Managing conflict between staff
___ Promoting effective communication among team members
___ Keeping patients and family satisfied
___ Maintaining safe patient care environment
___ Coaching and mentoring staff
___ Communicating with MD’s and consulting staff
___ Staying current with changes in policy/procedures

What do you see as your strengths in a leadership role?

What do you see as your weaknesses in a leadership role?

What kind of training do you need to assist you in your leadership role?
Table 1. Projected cost analysis of Lead Nurse Program on MSU.

<table>
<thead>
<tr>
<th>Materials &amp; Labor</th>
<th>First-Year Costs</th>
<th>Second-Year Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Nurse (LN) wages for all LN meetings prior to project start date (OT rate)</td>
<td>$75/hr x 1.5 hrs x 18 LN’s** = $2,025</td>
<td>N/A</td>
</tr>
<tr>
<td>**A total of 18 LN’s accrued OT from 3 meetings held prior to project start date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly LN wages for meetings in FY 2017</td>
<td>N/A</td>
<td>$50/hr x 11 LN’s x 12 months = $6,600</td>
</tr>
<tr>
<td>LN training course – contracted with outside company</td>
<td>8-hour training course x 1 = $12,500</td>
<td>N/A</td>
</tr>
<tr>
<td>LN wages for attending 8-hour training course</td>
<td>$50/hr x 8 hrs x 11 LN’s = $4,400</td>
<td>N/A</td>
</tr>
<tr>
<td>Pre/Post Unit Assessment handouts</td>
<td>$0.35 x 80 handouts = $28</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$18,953</td>
<td>$6,600</td>
</tr>
</tbody>
</table>
### Appendix C

**SWOT Analysis**

#### Readiness to Change: SWOT Analysis for Lead Nurse Program on MSU

<table>
<thead>
<tr>
<th>I</th>
<th>N</th>
<th>T</th>
<th>E</th>
<th>R</th>
<th>N</th>
<th>A</th>
<th>L</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengths</strong></td>
<td>Mesosystem support</td>
<td>Financial stability</td>
<td>Experienced in process improvement projects</td>
<td>CNL on unit</td>
<td>Sufficiently staffed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Weaknesses</strong></td>
<td>Resistance to change</td>
<td>Barriers in communication</td>
<td>Split floor - 4 MSU separated from main unit</td>
<td>Call-offs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E</th>
<th>X</th>
<th>T</th>
<th>E</th>
<th>R</th>
<th>N</th>
<th>A</th>
<th>L</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opportunities</strong></td>
<td>Evidence supporting clinical leadership</td>
<td>Support for autonomy among nursing profession</td>
<td>Leadership training contract</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Threats</strong></td>
<td>Nurses leaving for higher paying positions</td>
<td>Increase in leadership training course overtime; loss of funding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix D

Fishbone Diagram

Technology & Communication
- Outdated systems & not quickly repaired
- Ineffective communication
- Afraid to ask for help or don't voice concerns
- Software updates – work stoppage
- Not enough computers for charting

Processes
- Delays in hiring
- Lead nurses have patient assignments
- High patient ratios & acuity
- Not executed properly & no follow through
  - Redundancy in charting

Environment
- Split Floor
- No storage space – cluttered hallways
- Shortage of single rooms
- Multiple new grads
- Lead nurse not accessible – assigned patients

People
- Lack initiative & poor attitude
- Call-offs
- Resistant to change
- Multiple new grads
- Lack confidence

Low staff satisfaction scores & unit morale
Appendix E

Lippit’s Phase of Change Theory

<table>
<thead>
<tr>
<th>Nursing process elements</th>
<th>Lippitt's theory</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
<td>Phase 1. Diagnose the problem</td>
</tr>
<tr>
<td></td>
<td>Phase 2. Assess motivation/capacity for change</td>
</tr>
<tr>
<td></td>
<td>Phase 3. Assess change agent's motivation and resources</td>
</tr>
<tr>
<td><strong>Planning</strong></td>
<td>Phase 4. Select progressive change objective</td>
</tr>
<tr>
<td></td>
<td>Phase 5. Choose appropriate role of the change agent</td>
</tr>
<tr>
<td><strong>Implementation</strong></td>
<td>Phase 6. Maintain change</td>
</tr>
<tr>
<td><strong>Evaluation</strong></td>
<td>Phase 7. Terminate the helping relationship</td>
</tr>
</tbody>
</table>

Key:  
* Assessment = Lewin's unfreezing stage  
** Planning/Implementation = Lewin's moving stage  
*** Implementation/evaluation = Lewin's freezing stage

Appendix F

Process map using Lippitt’s Change Model (Based on a 90-day project timeframe)

Phase 1: Diagnose the problem (Assessment)

Phase 2: Assess motivation/capacity to change - SWOT Analysis

Phase 3: Assess change agents motivation & resources - LN Assessments & Staff questionnaires

Phase 4: Select progressive change objective (Planning) - Fishbone diagram & PDSA's

Phase 5: Choose appropriate role of change agent - LN Responsibilities list & Training curriculum

Phase 6: Maintain change (Implementation) - Training of LN's

Phase 7: Terminate the helping relationship (Evaluation) - Post Implementation questionnaires
Appendix G

Pre & Post MSU Assessment for staff

1. Scale 1 strongly disagree - 10 strongly agree. Do you feel management provided support when floor is short staffed?

2. Scale 1-10. How supported do you feel by other staff members?

3. Scale 1-10. How important is communication among staff members?

4. Scale 1-10. The Nurse Manager is readily available when interpersonal conflicts with staff arise.

5. Scale 1-10. Do you think having a Lead Nurse (LN) will benefit the MSU?

6. What do you think a LN’s role on your unit is?

7. What type of support do you think a LN should provide to staff?

8. What behaviors do you think would make an effective LN?
Appendix H

Detailed lead nurse action plan using Lippitt’s Change Model

**Prior to first meeting:** 1. CNL Student will form interdisciplinary team (redesign team) composed of: CNL, NM of MSU, senior nurses from MSU, Nursing Attendants (NA) from MSU, and RN educator. 2. CNL Student will set up first meeting once team established and send via email a brief explanation detailing potential project and agenda of first meeting. 3. Microsystem assessment performed in previous semester; will present this data at first meeting.

**Phase 1:** Diagnose the problem
- Go over agenda, rules, assign roles
- Discuss microsystem assessment
- Discuss issues of concern from MSU staff

**Phase 2:** Assess motivation/capacity for change
- Assess MSU unit for change: Are there other projects being implemented at this time? Is the staff willing to participate? Will there need to be patient involvement? If so, to what extent? (i.e. SWOT analysis)
- AIM statement of project (use SMART goals)
- Generate Leadership Assessment (for lead nurses only)
- Write out questions for pre/post-assessment Likert Scale (staff will be asked to fill out questionnaire)
- Set up next meeting and assign duties

**Phase 3:** Assess change agents motivation & resources
- Discuss results of pre-assessment questionnaire. Note any patterns, areas of improvement, etc.
- Determine if senior nurses are willing to accept responsibility and duties of LN on unit
- Request MSU NM seek out volunteers for program (Day and Night shift)
- MSU NM will assist with training schedule to ensure all LN’s receive training
- Set up next meeting and assign duties

**Phase 4:** Select progressive change objective (Planning)
- Brainstorm session (Fishbone diagram)
- Start first PDSA worksheet *this will be a continuous cycle
- Evaluate current floor dynamics: roles/competencies charge nurses have (if any), review questionnaire results, etc.
- Set goals, determine plan of action, data collection
- Decide on leadership training dates
- Decide when roll out of LN’s on floor will be
- Set up next meeting and assign duties

**Phase 5: Choose appropriate role of the change agent**
- Work on curriculum for leadership training program; NM & RN Educator to discuss with contract company offering training course
- Outline skills, competencies, and roles of LN (i.e. leadership models, effective communication, shift responsibilities, etc.)
- Finalize curriculum within 1.5 months of start date
- Determine how many hours training will be

**Phase 6: Maintain change**
- Begin training volunteer LN’s
- List of duties, competencies, and skills finalized
- Post-assessment Likert Scale questionnaire to be drafted and finalized
- LN’s begin working on floor

**Phase 7:**
- Post-assessment questionnaires to be dispersed at end of week x 4 weeks
- Measure data and feedback to determine changes needing to be made
- LN’s will complete a self-assessment at end of project to elaborate on improvements in their leadership skills
- CNL will not be leader involved in training and measuring data after 90-day timeline unless major issues with project. Otherwise, MSU NM will take over.
- Final data and write-up of project success will be presented to Chief Nurse, NM from all units at VA Mather, RN educators, etc.
- Goal is to spread the LNP to each unit and other VA facilities (primary care, urgent care, etc.).
Appendix I

Lead Nurse Daily Tasks list

Goal:
To oversee that the unit functions in a professional and efficient manner. The lead nurse serves as a resource person for decision making and directing patient care. They also serve to assist the manager, staff members, patients, family and members of the interdisciplinary team as needed. Please use this task list as a guide throughout your shift.

- Crash cart checked and ready for immediate use
- Verification of staffing and update any changes in staffing book
- Check GlideScope and ensure it is brought to all codes and rapid responses
- Code (DNR/DNI) status is verified for all patients
- Patients have appropriate isolations precautions in place and are identified
- Patients are evaluated daily for appropriate level of care / need for telemetry
- Attends daily interdisciplinary rounds at 11:15 am
- Ensures CHF folders are provided to staff for patient education / follow up
- Performs leadership rounding with patients
- Close observation (CO) patients are evaluated q4 (at minimum) for need
- Pts. on restraints have active orders / and evaluated per protocol
- Check PRN Effectiveness / Missed Medications (0600, 1200, 1800, 2400)
- Ensure Post Falls / EPIR / Rapid Response documentations are completed
- Ensure admit / transfer / MRSA swabs are completed on all transfers
- High fall risk patients are identified and appropriate accommodations made
- Complete and review 24hr report sheet as needed
### Appendix J

## Gantt Chart

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1</strong> Diagnose Problem</td>
<td>CNL Student, CNL, &amp; NM - Completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CNL Student, CNL, &amp; NM, Redesign team - Completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Phase 2</strong> Assess Motivation/Capacity for Change</td>
<td>*CNL Student &amp; Redesign team - Completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Phase 3</strong> Assess Change Agent's Motivation &amp; Resources</td>
<td>CNL Student, CNL, &amp; NM - Completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Phase 4</strong> Select Progressive Change Objective (Planning)</td>
<td>CNL Student &amp; Redesign team - Completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Phase 5</strong> Choose Appropriate Role of Change Agent</td>
<td>CNL Student, CNL, NM, RN Educator, &amp; Training company - Completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Phase 6</strong> Maintain Change</td>
<td>CNL student, CNL, NM, Training company - Completed (except training course)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Phase 7</strong> Terminate Helping Relationship</td>
<td><strong>CNL Student - Not Completed (estimated to begin 9/1)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Pre-assessments
** Post-assessments