

Journey to Improved Quality Outcomes: Our Leadership Model and Restructuring Unit Based Practice Councils

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IN 2008 Our Model was ...



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Multiple Committees

- Falls
- Pressure Ulcers
- Transforming Care at the Bedside
- Mortality
- Priority for Action Teams
- Quality Committees
- Data Ownership????
- Committee “Silos”
- Lack of Communication
- Outcomes NOT where they needed to be

Practice Council Issues

- Inconsistent UPC Chairs
- Lack of ability to analyze data
- Lack of experience chairing a committee
- What to do with the data?
- How to develop action plans?
- How to hold staff accountable?

Nursing Issues

- Inconsistent Leadership Practices
- Variation in Roles and Responsibilities across organization
- Significant Front Line Leader overtime
- Charge Nurse “Burnout”
- RN turnover 14%
- Difficulty recruiting Front Line Leaders

Background

- Minimal succession planning
- Difficulty integrating evidence-based practice at staff nurse level
- Increased demand to achieve outcomes
- Quantitative and qualitative evidence - patient, nursing workforce, organization and consumer

Background

- Magnet Appraiser Comment to Nurse Executive Committee:

“You have charge nurses in leadership roles that need development.”

Anne Marie Brooks, RN, DNSc,
MBA, FAAN, FACHE

Background

- Consultant, Creative Healthcare Management:

“I would encourage you to look at your nursing organizational structure to see whether you are being as successful as you can be with your current structure.”

Diane Bradley, RN, MSN, NEA-BC



Background

- Feedback from Front Line Leaders:

“We are overwhelmed; more and more is being pushed down on us, and we are still responsible for taking a patient assignment.”

Our Vision

- Support the mission/vision of Ascension Health and Lourdes
- Foster innovation
- Improve care delivery
- Improve health and functioning in the communities we serve



Our Strategy

- Communication is essential to:
Staff
Charge Nurses
Committees
- Use Consultant's suggestions

Nursing Leadership Transformation

- New leadership model
- New committee structure
- Patient Excellence Team
- Unit-based Practice Councils



New Leadership Model

- Nurse Directors
- Nurse Managers
- Clinical Nurse Leaders
- Staff Nurse UPC Chairs
- Nursing Staff

Nurse Director

- Visionary, strategic planner
- Partner with other disciplines and leader in medical community
- Accountable for capital and operational budget, acquisition of resources for function and process
- Facilitator to develop policies, programs, and evidence-based practice consistent with standards



Nurse Director *(con't)*

- Leader in human resources development and management
- Accountable for continuous quality improvement, improving culture of safety
- Facilitator of nurse participation in making decisions

Nurse Manager

- Recruitment & retention
- Staffing and scheduling
- Comprehensive orientation
- Daily monitoring of resources to meet budget targets

Nurse Manager *(con't)*

- Direct and manage personnel
- Be accountable for performance evaluations
- Implement vision, mission, philosophy, core values, evidence-based practice and standards
- Evaluate quality and healthcare delivery for assigned area
- Ensure action plans are developed and implemented



Nurse Manager *(con't)*

- Be responsible for quarterly reporting of quality measures for Magnet
- Empower staff to participate in shared governance

Clinical Nurse Leader

- Facilitate evidence-based practice
- Participate in multidisciplinary rounds
- Inspire loyalty - people are most precious asset
- Direct coordination of care across settings and among caregivers

Clinical Nurse Leader

- Serve in key roles
- Promote participation in professional organizations
- Empower staff
- Assist in recruitment, hiring, retention, staffing

Creation of Unit-based Practice Councils: The Voice of Staff



1 Ross Unit Practice Council



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Benefits of Unit-based Practice Councils (UPCs):

- Empowerment
- Increased responsibility and accountability
- Increased decision making
- Increased employee participation
- Enhanced professional practice

Shared Governance

- Autonomy
- Empowerment
- Collaborative relationships among healthcare providers
- Listening to the voices of nurses & sharing the vision for clinical excellence.



New Unit-based Practice Council Structure

- Chair & Co-chair
- 5-8 members, including unlicensed staff
- Each council member-liaison for 5 other unit staff
- Meeting - first Thursday of the month at 2:00 pm
- Ad-hoc members (experts) brought in as agenda warrants



UPC Chair Workshop Day

- 8-10am: Nursing Professional Practice Council
- 10-11am: Break/Prep time for UPC Meeting
- 11am-1pm: Patient Excellence Team
- 1-2pm: Final Prep time for UPC meeting
- 2PM: UPC Meeting
- Completion of UPC Meeting Minutes



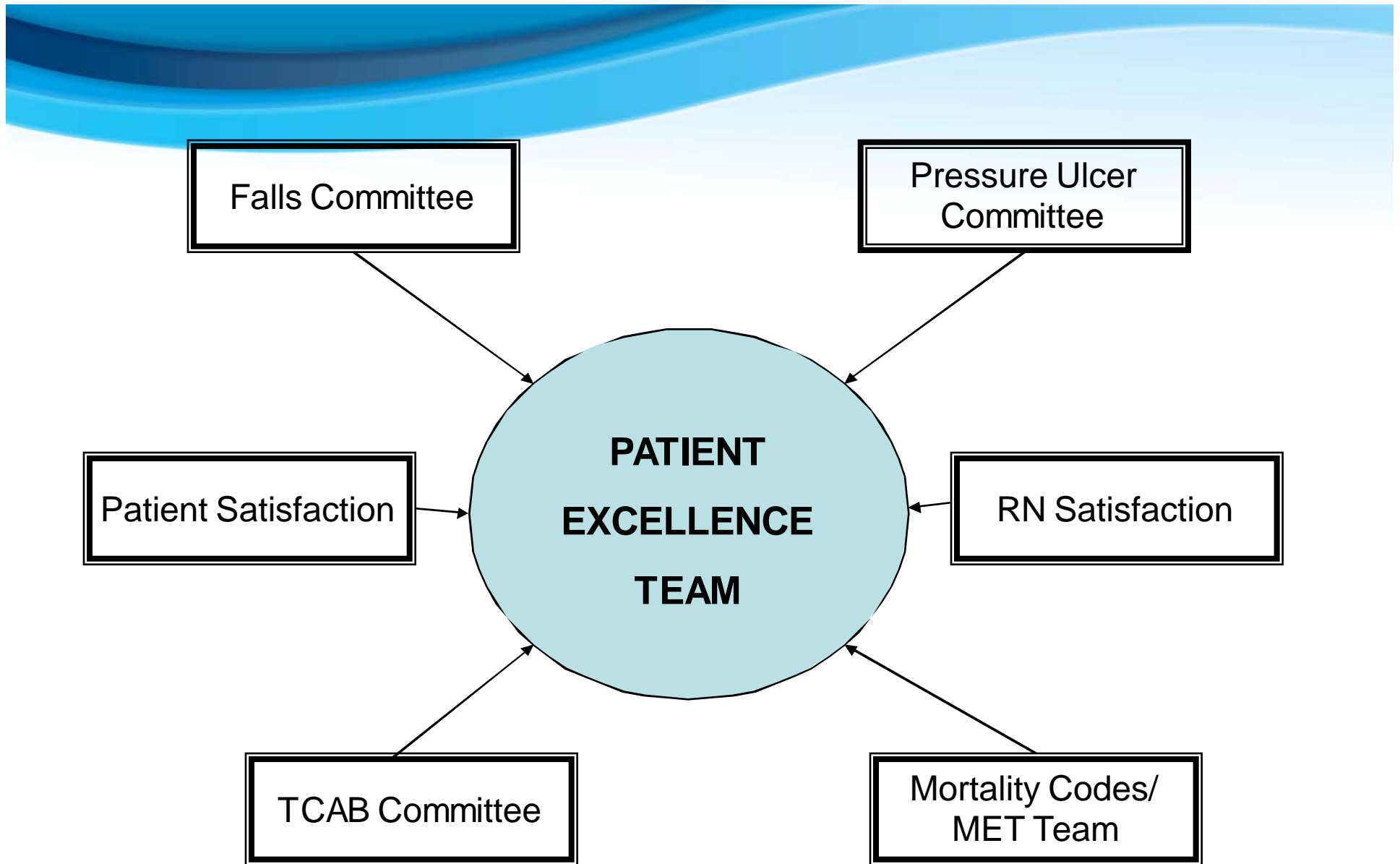
Decisions Made by UPCs

- Budget Neutral
- In compliance with Organizational Policies & Procedures
- Support Lourdes' Mission, Vision & Values
- Drive Patient Excellence Team
- Outcomes (TCAB)



Nursing Professional Practice Council





Reporting Structure

Nursing Professional Practice Council



Patient Excellence Team

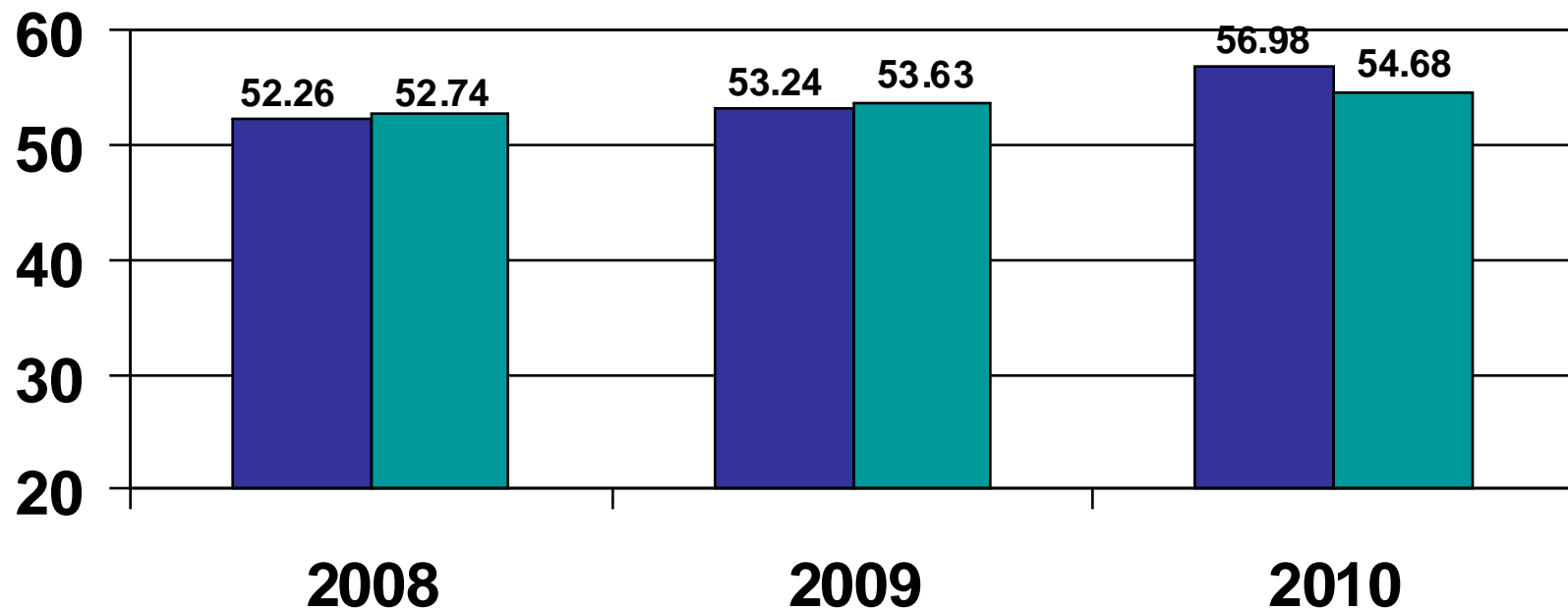


Unit-based Practice Council

Accomplishments

- NDNQI survey results
- Staff Turnover
- Falls, pressure ulcers, NPS

Autonomy 2008-2010 R.N. Satisfaction Survey



■ NDNQI Benchmark Mean ■ Lourdes Hospital

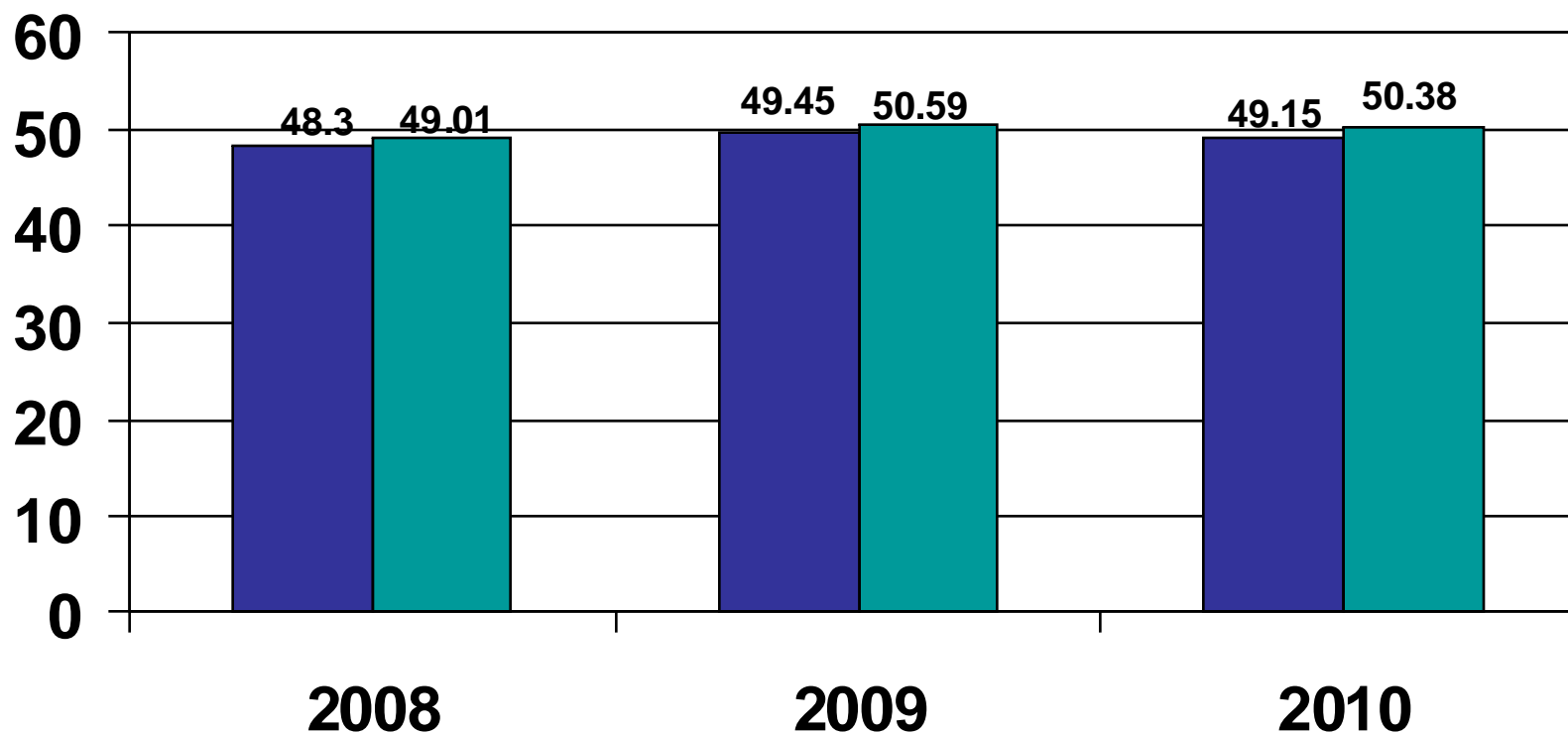


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Decision Making 2008-2010 R.N. Satisfaction Survey



■ NDNQI Benchmark Mean ■ Lourdes Hospital

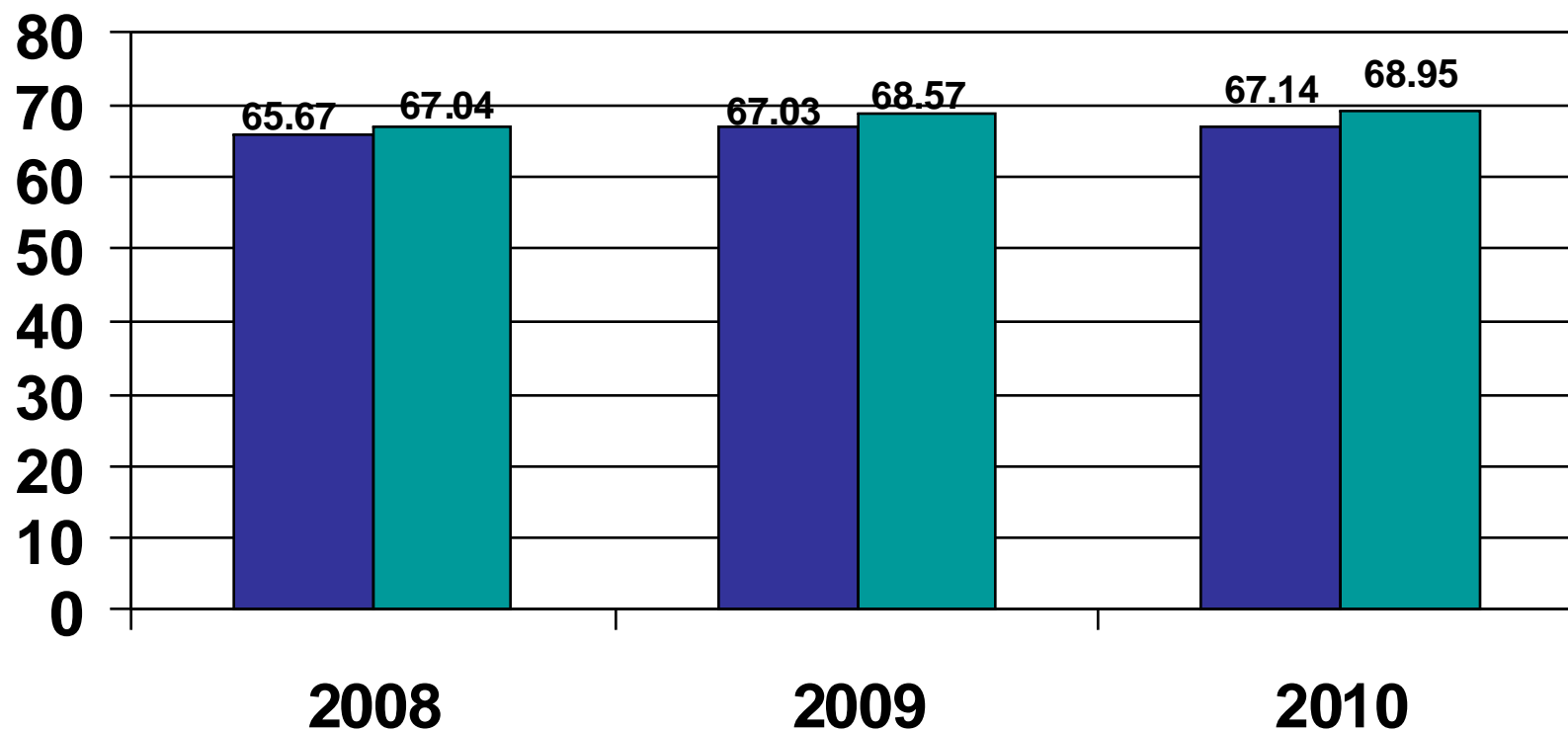


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Professional Status 2008-2010 R.N. Satisfaction Survey



■ NDNQI Benchmark Mean ■ Lourdes Hospital

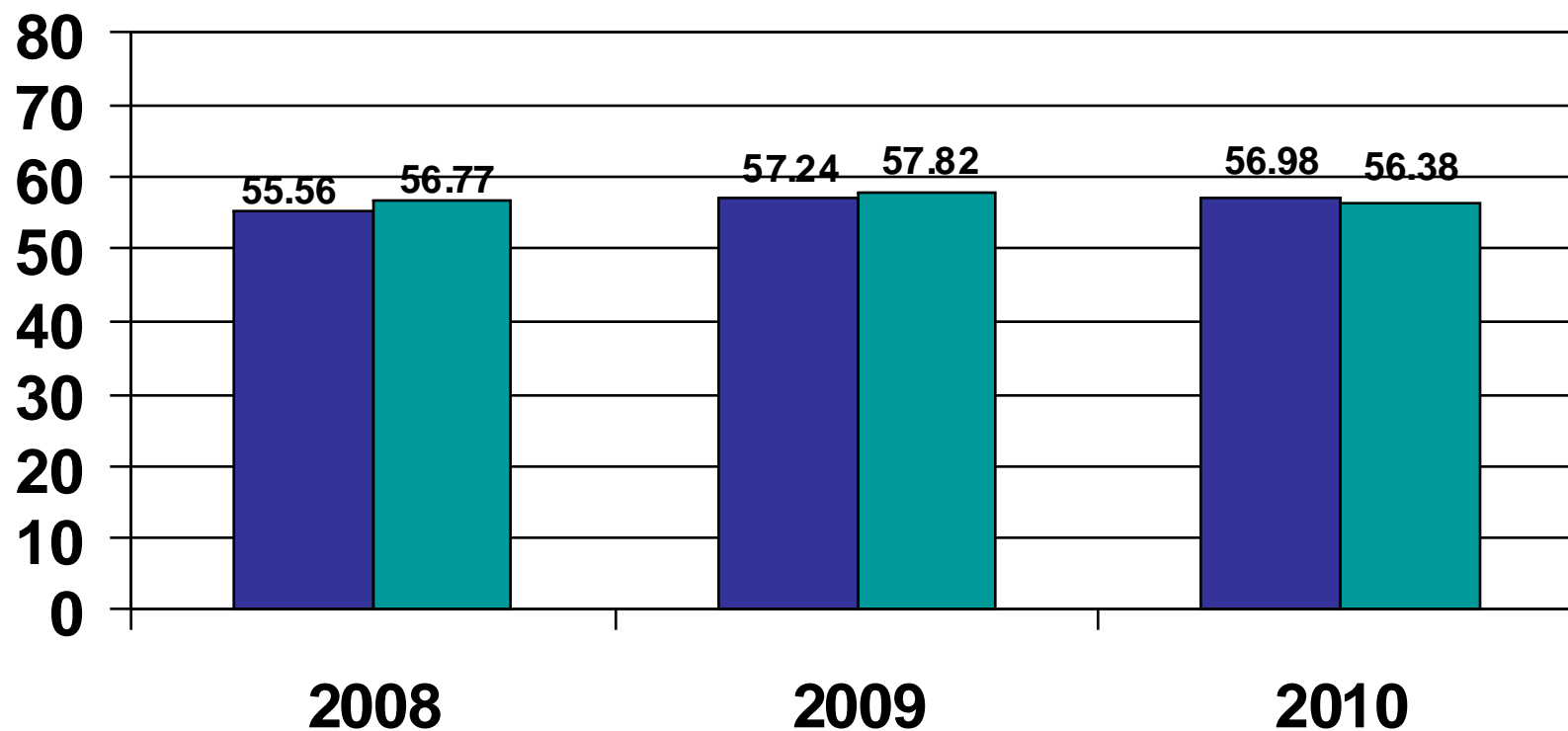


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Job Enjoyment 2008-2010 R.N. Satisfaction Survey



■ NDNQI Benchmark Mean ■ Lourdes Hospital

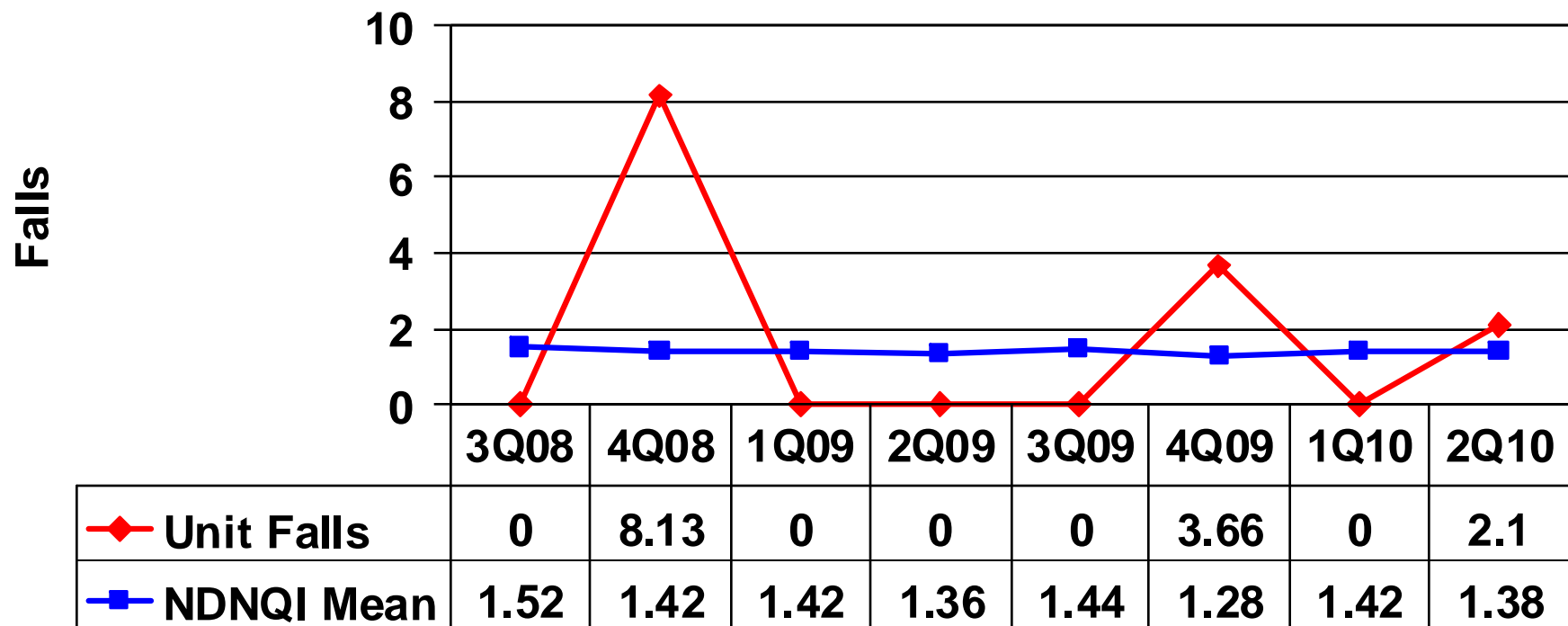


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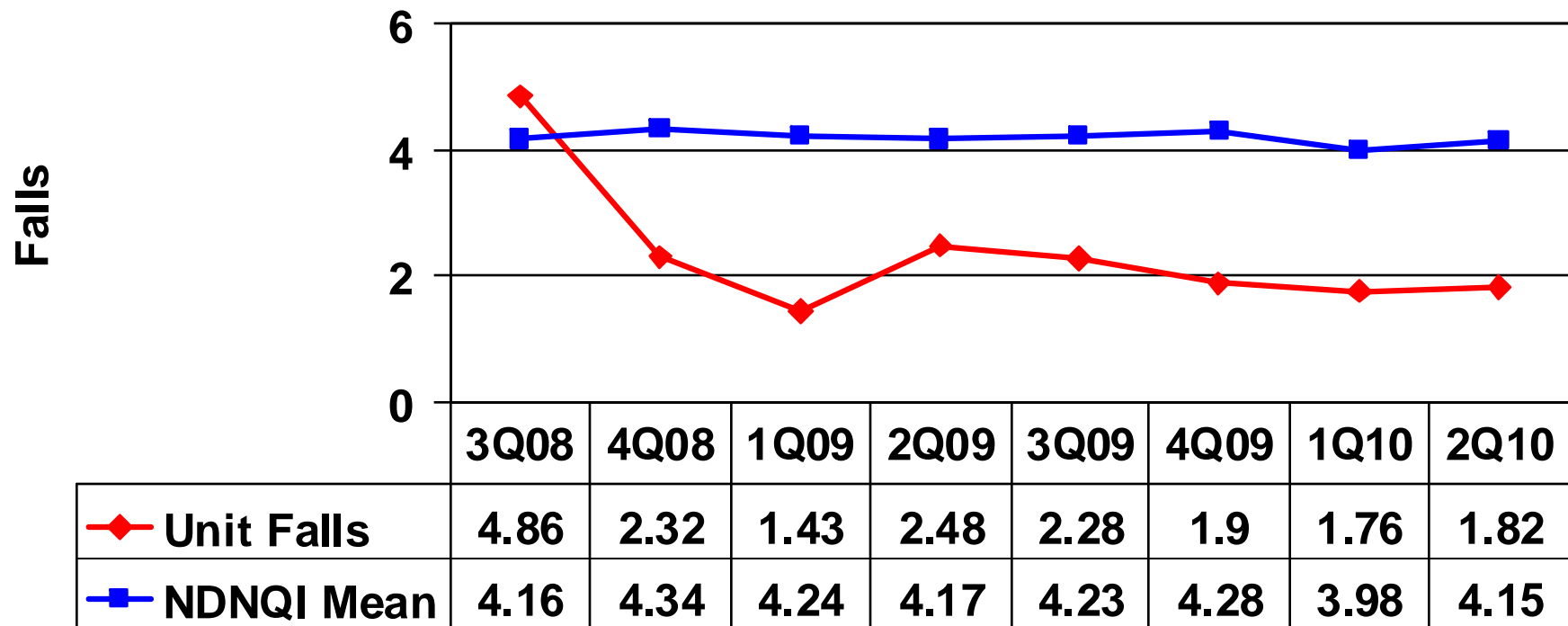


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Total Falls per 1,000 Patient Days Adult Critical

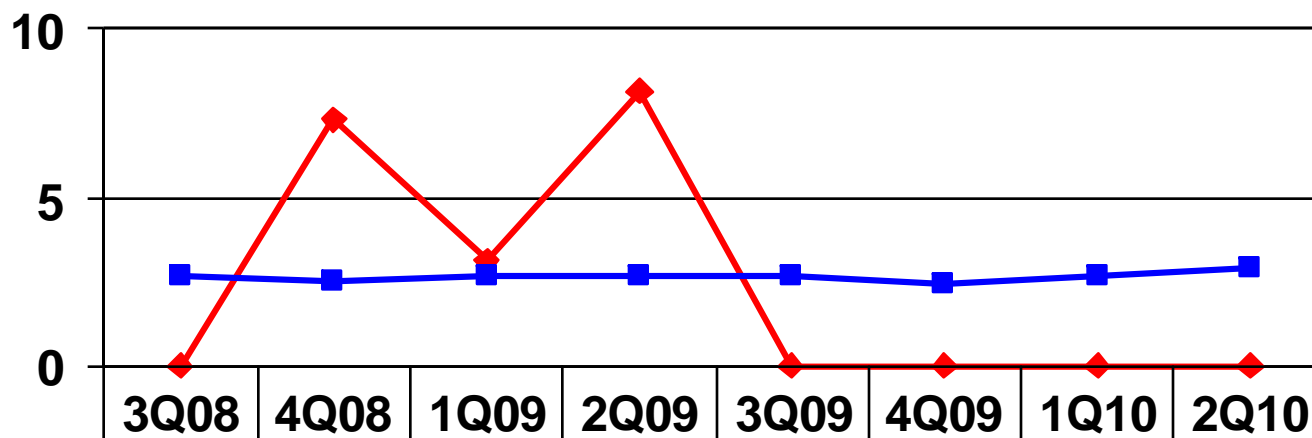


Total Falls per 1,000 Patient Days Adult Medical



Total Hospital-Acquired Pressure Ulcers per 1,000 Patient Days Adult Surgical

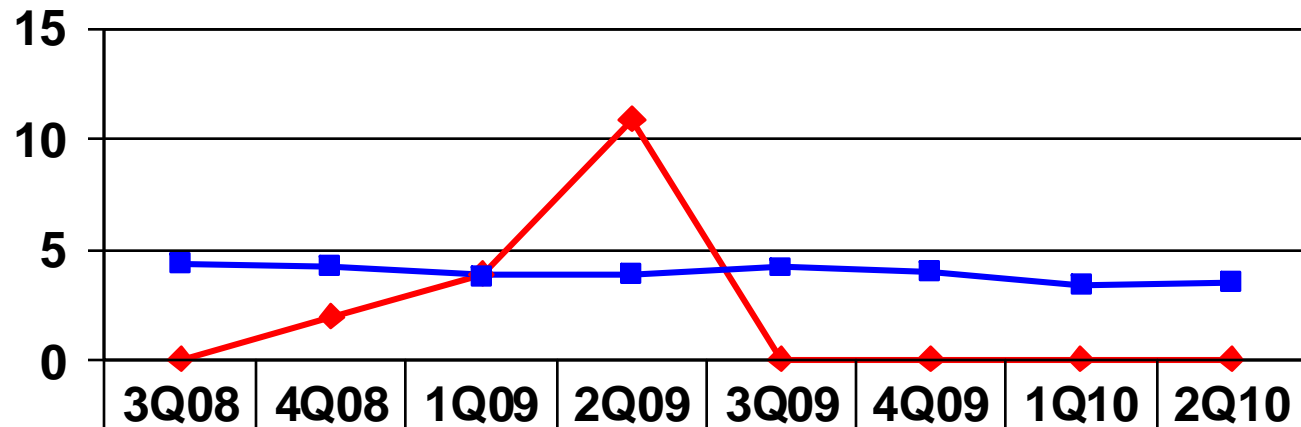
Pressure Ulcers



◆ Unit Falls	0	7.32	3.13	8.13	0	0	0	0
■ NDNQI Mean	2.63	2.49	2.68	2.62	2.68	2.45	2.72	2.88

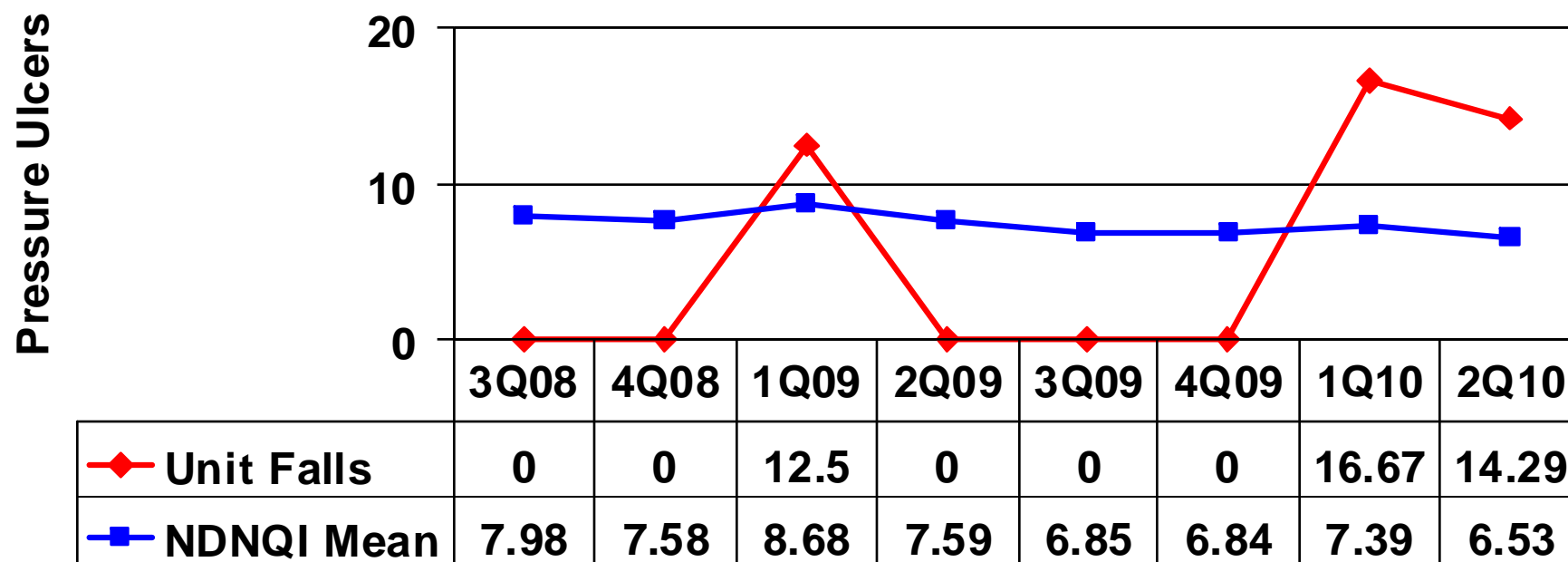
Total Hospital-Acquired Pressure Ulcers per 1,000 Patient Days Adult Medical

Pressure Ulcers

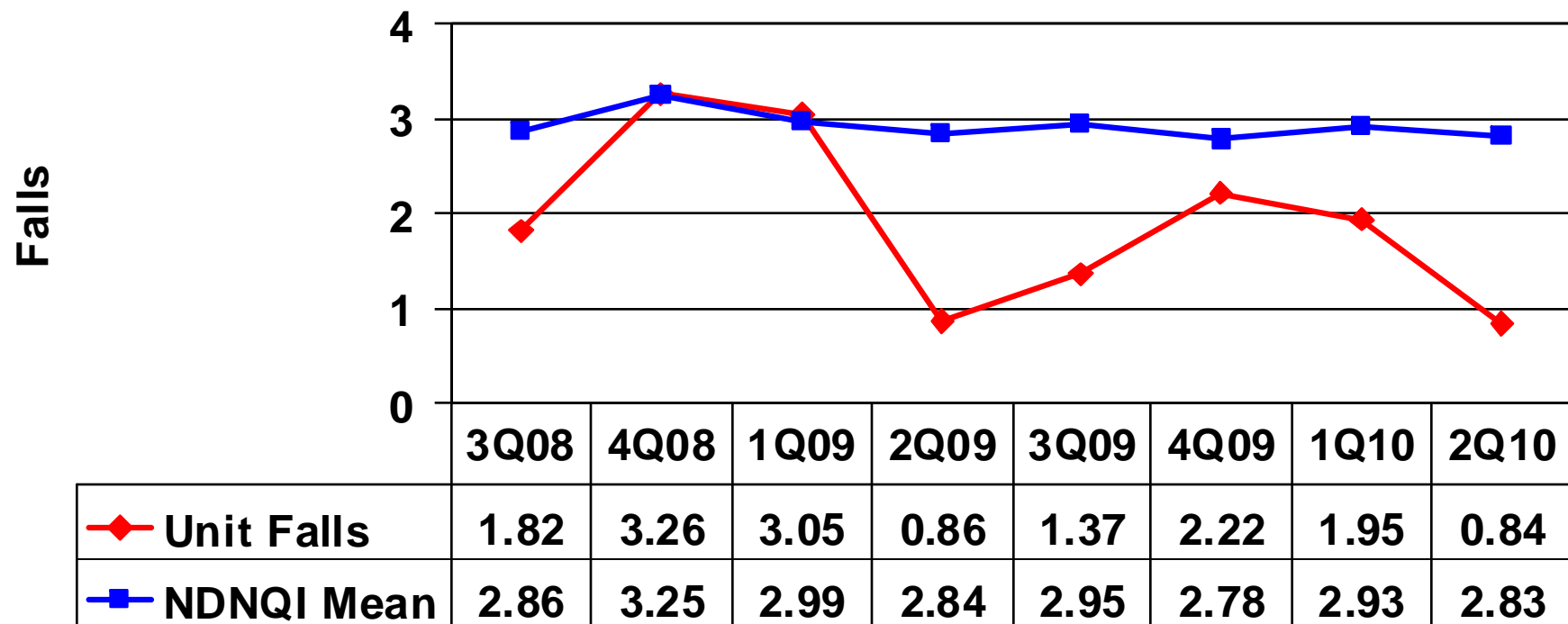


◆ Unit Falls	0	1.92	3.85	10.88	0	0	0	0
■ NDNQI Mean	4.36	4.26	3.79	3.91	4.1	3.99	3.44	3.48

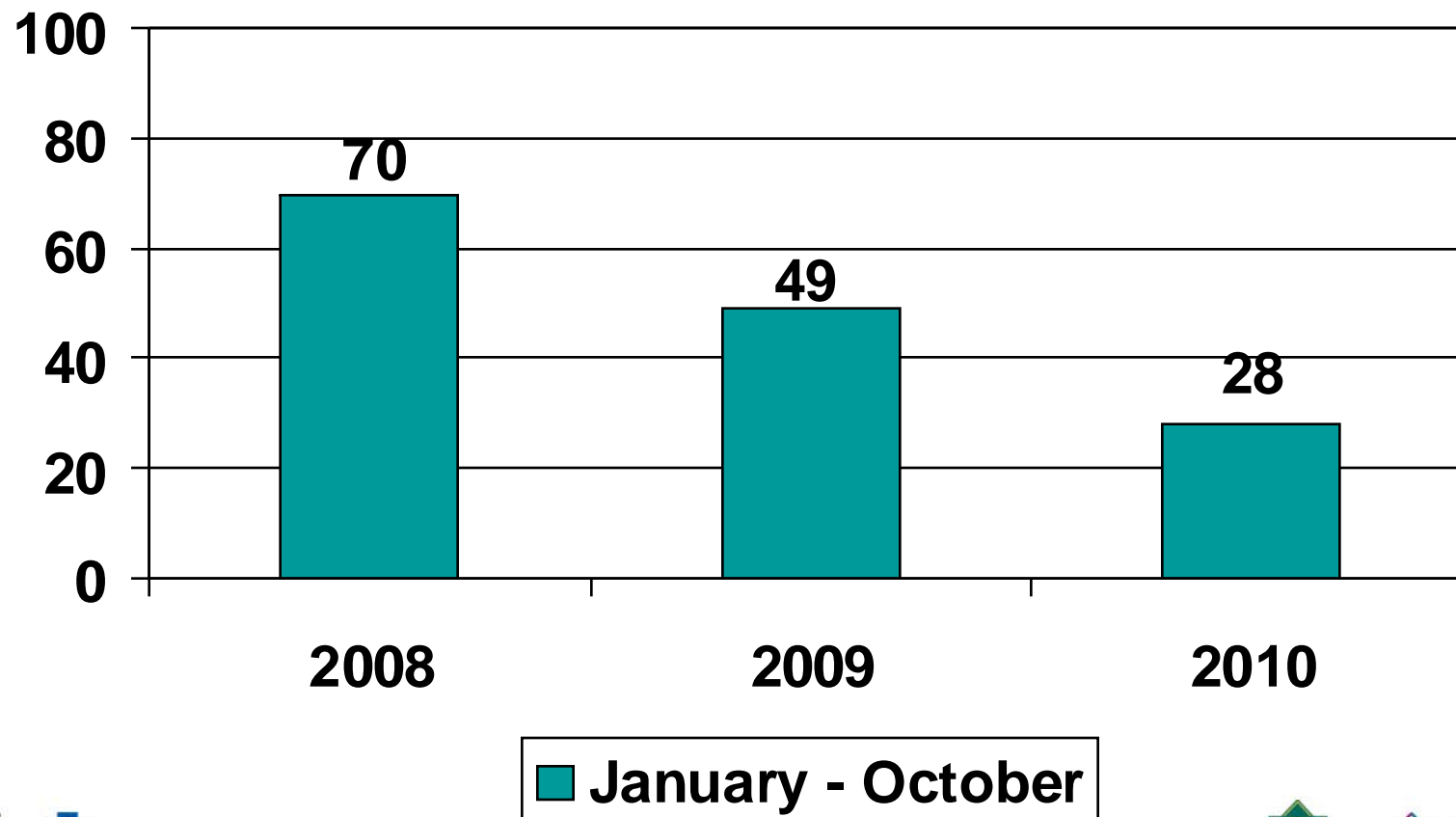
Total Hospital-Acquired Pressure Ulcers per 1,000 Patient Days Adult Critical Care



Total Falls per 1,000 Patient Days Adult Surgical



Total Hospital-Acquired Pressure Ulcers January - October

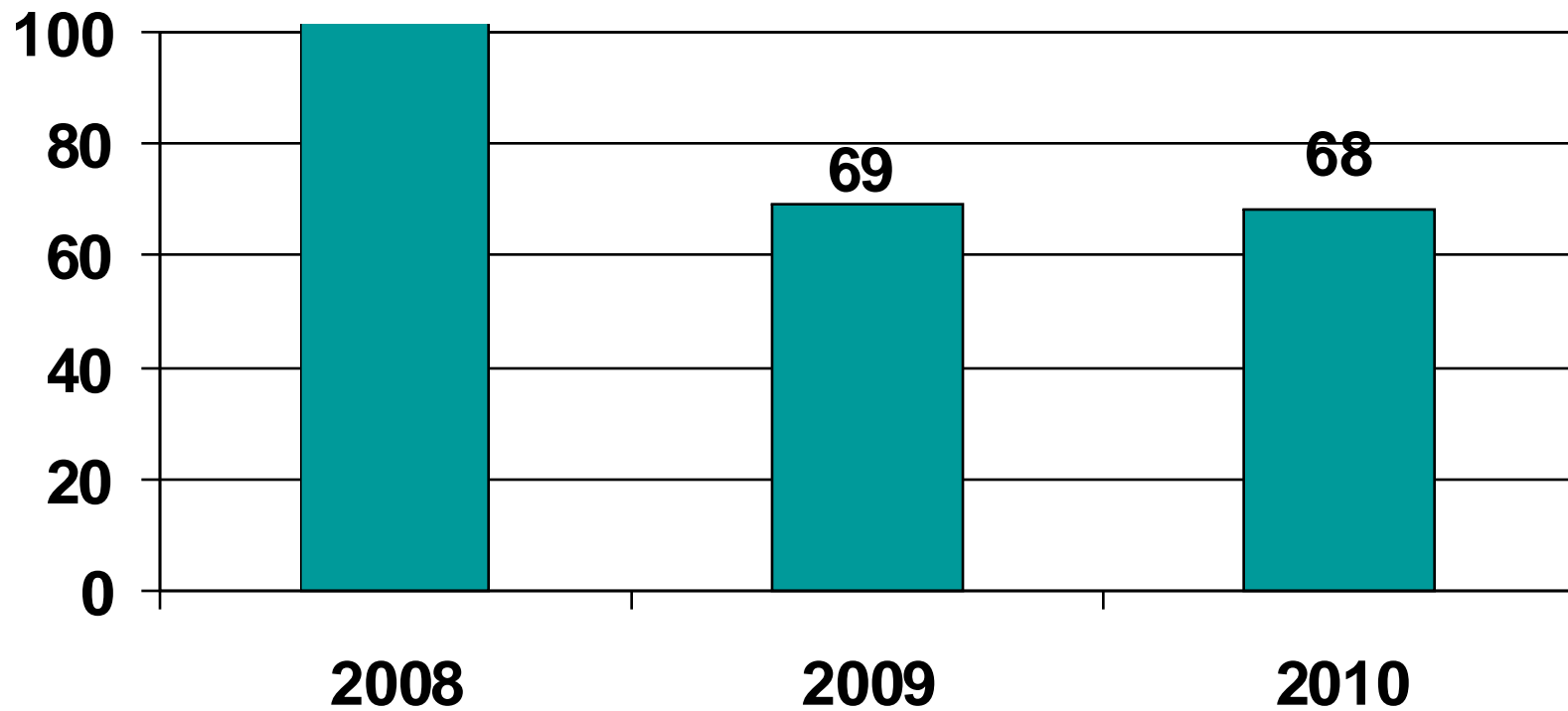


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Total Patient Falls January - October



■ January - October



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Questions?

