Providing a Structure for Collaboration
A Leadership Challenge

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Objectives
Providing a Structure for Collaboration: A Leadership Challenge

1. Identify structure and process elements essential to a collaborative work environment and their impact on outcomes

2. Discuss ways to overcome barriers to a collaborative work environment

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Nursing shortage has resulted in higher nurse workloads, fewer support resources, greater nurse dissatisfaction and burnout, making it more difficult to provide optimal patient care (Aiken, Clarke, Sloane, Sochalski & Silber, 2002).

Inadequate transfer of information among healthcare professionals puts patients at risk for increased morbidity and mortality (TJC 2006).

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As many as 98,000 people die in hospitals each year as a result of medical errors, which could have been prevented (Kohn, Corrigan & Donaldson, 2000).

Beyond the cost of human lives, between $17 and $29 billion dollars are spent for additional care which resulted from medical errors (Kohn, Corrigan & Donaldson, 2000).
One of the factors having contributed to the nation’s epidemic of medical errors is the decentralized and fragmented nature of the health care delivery system (Kohn, Corrigan & Donaldson, 2000).

Lack of collaboration is a contributing factor to the fragmentation of care, as well as poor outcomes which plague our healthcare system (Henneman, 1995).
To provide high quality care and meet public expectations with such limited resources collaboration has become a necessity.

– Knaus, Draper, Wagner, and Zimmerman (1986) found that hospitals where collaboration was present reported a mortality rate forty one percent lower than the predicted number of deaths. Hospitals where there was limited or no collaboration exceeded predicted mortality by as much as fifty-eight percent.

• Although empirical evidence in support of collaboration in the health care environment are readily available in the literature there is little evidence on **how to create this environment** (Tschannen, 2004)
A true partnership, in which the power on both sides is valued by both, with recognition and acceptance of separate and combined spheres of activity and responsibility, mutual safeguarding of the legitimate interests of each party, and a commonality of goals that is recognized by both parties.

Common Elements of Collaboration
Providing a Structure for Collaboration: A Leadership Challenge

- Shared power
- Occurs between at least 2 individuals
- Acknowledges the expertise of each member
- Open Communication
- Shared decision making
- Goal oriented
- Action
- Interdependence

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Antecedents of Collaboration

1. Team Orientation
2. Respect/Approving Atmosphere
3. Culture of Problem Solving
4. Clinical Accountability
5. Social Bond
6. Effective Communication Skills

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Barriers to Collaboration

- Hierarchical structure of acute care environment
- Lack of clarity of structures, processes and desired outcomes
- Knowledge deficit; own and others
- Communication Skills
- Mistrust
- Time
- Gender and Status Differentials

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Collaboration as a Process Measure

**Inputs:**
- **Patient:** Diagnosis, Case Mix Index
- **System:** Type of Unit, Model of Care

**COLLABORATION**
- **Structure:** Model of Care, Delivery, Type of Unit
- **Process:** Time, Tools, Information Exchange

**Outcomes:**
- **Patient:** Discharged Alive
- **System:** LOS, Cost per Case

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Overcoming Barriers to Collaboration with Clinical Integration

- Unit based Case Managers, Social Workers and Educators to support Nursing Manager
- Pharmacy and Physician availability
- Change in Model of Care Delivery

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Defining and Clarifying Roles

<table>
<thead>
<tr>
<th>Staff Nurse</th>
<th>Case Manager</th>
<th>Social Worker</th>
<th>Educator CNS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create, Coordinate and deliver the “Plan for the Day”</td>
<td>Manage Plan for the “Stay and Pay”</td>
<td>Facilitate “Plan for the Way”</td>
<td>Assist with development &amp; implementation of plan for ”Day and Stay”</td>
</tr>
</tbody>
</table>
• Create **time** to collaborate where common goals were articulated.
  o Care Coordination Rounds M-W-F
  o Complex Care Meetings T-Th

• Provide **tools** for staff.
  o CareGraph
• An evaluation and documentation tool that describes clinical progression in incremental steps on scales from 0-4.

• The clinical progressions are organized by system and were developed by representatives from various disciplines.

• Each patient’s score is an itemized synthesis of assessments. Patients care be rated each shift or daily.

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### IMMUNOLOGICAL/INFECTION:

(Identify focus__________________________________)  

<table>
<thead>
<tr>
<th>0 - Has absence of any signs/symptoms of infection</th>
<th>Admit Date</th>
<th>Baseline Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Temperature declining or is afebrile or responding to prescribed therapy or resolving neutropenia or immunosuppressed.</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>2 – Is febrile or has signs/symptoms of infection and is immunosuppressed.</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3 – Has sepsis with or without + blood culture, no signs/symptoms of shock, with or without neutropenia.</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>4 – Multi-system failure or absolute neutrophil count &lt;1500 cells/mm³</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

### FLUID BALANCE/GU:

(Identify focus__________________________________)  

<table>
<thead>
<tr>
<th>0 - Has balanced Intake &amp; Output</th>
<th>Admit Date</th>
<th>Baseline Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Has &gt;240ml urinary output in 8 hours or fluid restriction or weaning IV intake</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2 – Has &lt;240ml urinary output in 8 hours or weight gain &gt;2 lbs in 24 hours or requires total IV intake &lt;150ml/hour</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3 – Has &lt;120ml urinary output in 8 hours or requires total IV intake = or &gt;150ml/hour</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>4 – Has absence of urinary output or continuous bladder irrigation/toomey or requires IV fluid bolus</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

### MOBILITY/FUNCTIONAL MOVEMENT:

(Identify focus__________________________________)  

<table>
<thead>
<tr>
<th>0 – Motivated and moves independently and communicates clearly.</th>
<th>Admit Date</th>
<th>Baseline Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Minimum assistance for transfer/ADLs/communication or needs motivation/encouragement/assistive device for communication.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2 – Moderate assistance for transfer/ADLs/communication.</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3 – Maximum dependence on staff to transfer/ADLs or unclear speech, inability to follow verbal instructions</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>4 – Is unable/refuses to move without assistance or bedfast or unable to communicate verbally or non-verbally.</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

### NUTRITION/GI:

(Identify focus__________________________________)  

<table>
<thead>
<tr>
<th>0 – Is eating adequately and fully functional GI tract</th>
<th>Admit Date</th>
<th>Baseline Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Is tolerating food &amp; fluids or needs nutritional supplementation/dietary monitoring or passing flatus</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2 – Is dependent on Tube Feeding or taking sips with advancement of diet or active bowel sounds with no flatus</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3 – Is dependent on TPN or NPO or tube feeding with large residuals or hypo/hyper bowel sounds</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>4 – Is unable to take P.O. nutrition and not on nutritional support or absence of bowel sounds</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
Example of Clinical Integrations Outcomes After One Year

- Length of Stay went from 4.24 to 3.37 days.
- Cost per admission from $6723.00 to $5919.00.
Collaboration as Outcome Measure
Using Nurse-Physician Collaboration Instruments

Collaboration and Satisfaction with Care Decisions (CSACD)

Psychometric Article

Use
Measures nurse-physician collaboration and satisfaction with care decisions in intensive care units (ICUs)
Collaboration as Outcome Measure
Using Nurse-Physician Collaboration Instruments

The Jefferson Scale of Attitudes toward Physician Nurse Collaboration

Psychometric Article:

Use:
Measures physician and nurse attitudes toward authority, autonomy, responsibility for patient monitoring, collaborative decision making, role expectations and collaborative education.
Collaboration as Outcome Measure
Using Nurse-Physician Collaboration Instruments

ICU Nurse-Physician Questionnaire

Psychometric Article:

Use:
Measures organizational climate, with a focus on unit culture, leadership, communication, coordination, problem solving/conflict management, cohesiveness and perceived effectiveness.
Summary

• Collaboration is conceptually difficult to understand but is becoming a necessity in healthcare today. Collaboration can improve patient outcomes and patient satisfaction as well as health care provider’s job satisfaction. (Knaus, Draper and Zimmerman, 1986, Manojlovich & Antonalkos, 2008, Mitchell, Armstrong, Simpson & Lentz, 1989).

• Barriers to collaboration can be overcome by dedicated, innovative leaders.
References


References

