Exemplary Professional Practice

St. Joseph Hospital
Exemplary Professional Practice

Professional Practice Model

EP1
Clinical nurses are involved in the development, implementation and evaluation of the professional practice model.

Redesignation

Provide a description with supporting evidence of the ongoing evaluation of the nursing professional practice model and how clinical nurses are involved.

The SJO Professional Practice Model (PPM) was originally developed and implemented in 2003 by a cross-section of nurse leaders, advanced practice nurses, clinical educators and clinical staff nurses. The goal of the PPM is to achieve optimal patient outcomes through accountability, responsibility, collaboration, professional growth and development of each registered nurse.

EP1 Figure 1
Professional Practice Model

The PPM is based on the four core values of the organization with the patient, family, community and healthcare team at the center of all we do. The PPM also supports the three domains of professional nursing practice, which are fundamental in the delivery of patient care:

- **Culture/Caring** is a central theme to recognize the caring relationship that exists between the patient, family, the nurse and the whole healthcare team. Caring practices are activities that are responsive to the uniqueness of the patient/family and create a compassionate, therapeutic environment. Culture is a collection of traditions, beliefs, values and behaviors that make up the context of how care is delivered.
• **Clinical Practice** defines how the RN is accountable to recognize the health and quality-of-life needs of patients, family and community and to collaborate with them to achieve mutually agreed upon goals. The RN utilizes his/her specialized skills and scientific knowledge to design collaborative and integrated care that binds together all resources in a goal-oriented movement toward health.

• **Collaboration** is the process whereby members of the healthcare team plan and practice together as colleagues working interdependently within the boundaries of their scopes of practice. The team uses shared values and mutual respect for each other’s contribution to care for individuals, their families and the communities.

The four supporting structures - Shared Governance, Care Delivery Model, Leadership Development and Clinical Development - provide structure to the three domains of nursing practice. These structures further define our autonomous nursing practice environment.

• **Shared Governance** reflects the structures and processes by which nurses participate in decision making that affects their practice environment. Shared Governance incorporates nursing and Unit-Based Councils, workgroups and nursing policies and procedures.

• **Leadership Development** prepares nurses at all levels to assume professional roles in practice, leadership, education and research through a variety of onsite courses and educational support for tuition reimbursement and attendance at outside conferences.

• **Clinical Development** provides the structure for nurses to achieve professional growth, development and recognition through advancement on the clinical ladder.

• **Care Delivery Model** describes how nursing care is delivered from state-mandated staffing guidelines, staff competency for patient assignment, and the delivery of patient- and family-centered compassionate care incorporating our nursing theorist Jean Watson’s Theory of Human Caring.

The core tenets of the PPM – our values and domains of nursing practice (collaboration, clinical practice and culture/caring) – remain strong and continue to serve as the foundation of our nursing practice. The support structures of the PPM that mobilize and connect nursing practice at SJO have evolved and continue to be evaluated by clinical nurses.

In support of our PPM SJO nurses are also guided by Jean Watson’s Theory of Human Caring. We were fortunate that Jean Watson visited SJO in the past. We are currently guided by two of Jean’s Caritas Coaches who are full-time nurses at SJO. Much work
has been done to integrate the Theory of Human Caring into our daily nursing practice and documentation.

**Ongoing evaluation**
In August 2012 we conducted an overall review and evaluation of our nursing Shared Governance supporting structure to ensure our council work was aligned with the strategic goals of the organization. Our goal was to ensure that we were maximizing the effectiveness of our council members’ time, input and knowledge, and that our councils were focused on the most important, highest priority goals of nursing and the organization. As part of the evaluation process council members, workgroup members and frontline staff were asked the following three questions:

- What is working well with our Shared Governance model/structure?
- What is not working within the Shared Governance model/structure?
- What outcome data is being reported to each of the councils and acted on?

A cross-section of frontline nursing staff, nursing leaders, educators and quality leaders were tasked with soliciting this information and bringing it forward for review. This input was instrumental in helping us plan the next stage of our evaluation of our PPM. In August 2012, a three-day evaluation and planning event was held to fully review current councils, goals, membership and gaps.

**EP1 PARTICIPANTS:**

<table>
<thead>
<tr>
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<th>Title</th>
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<tbody>
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<td>Oncology</td>
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The evaluation concluded that there was redundancy in some of the workgroups and that there was an opportunity to better align nursing’s work with the organization’s strategic plan. As a result, the nursing Shared Governance model was revised. This new model refocused the resources onto our most important, high priority work. It also eliminated workgroups that were either redundant or not aligned optimally with the strategic plan.

The evaluation showed that some of our most important nursing work, our infection prevention work, was currently being performed outside our nursing Shared Governance council structure. Communication flow was poor and the work was made more difficult because it wasn’t integrated well within the Division of Nursing. Nurse leader Susan Parke, DNP, NP, FNP-BC, CPHQ, CIC, was invited into the Nursing Executive Council. The four active subgroups working on infection prevention, each with clinical nurses actively on them (Surgical Care Improvement Project Team, Device Associated Infection Prevention Team, the Environment Associated Infection Prevention Team, and the Surgical Site Infection Team) were linked to our nursing council structure as well as Medical Staff structure. This vastly improved communication, problem solving and overall workflow for all involved.

The evaluation also showed that much of our work related to patient safety and harm resided outside the structures of our nursing Shared Governance councils. In order to change that, we again expanded our Nurse Executive Council to include the Director of Risk Management. We created a new council focused on Patient Safety and Medication Safety. Workgroups were realigned and developed to report into this council. They include the Patient Safety, Falls, Pain, Skin, Medication Event and Perinatal Safety workgroups.

Other changes in our Shared Governance council structure resulting from the three-day evaluation and planning event included the development of a Staffing and Productivity workgroup. This group’s purpose was to develop pro-active staffing solutions and have healthy dialogue around staffing and productivity challenges. A continuum of care workgroup was developed to help create seamless transitions between inpatient and outpatient services and programs and to examine readmission cases to improve care. Our Critical Illness and Core Measure Teams have been in place for many years at SJO. These teams are co-chaired by nurses and physicians. Through this evaluation it was determined that these groups would be incorporated under the Clinical Practice Council to ensure the flow of information was effective. The team felt that the three-day evaluation and planning event was very successful. The new PPM aligned our work, goals, values, priorities, structures and resources within an integrated framework.

EP1.1 Nursing Shared Governance Structures, Metrics, Outcomes
EP1.2 Updated Nursing Shared Governance Structure – October 2012
In an effort to engage all clinical nurses CNO Katie Skelton, MBA, RN, NEA-BC, recorded a podcast explaining the updated Shared Governance structure and the development of new councils and workgroups. She asked clinical nurses to review and evaluate the council and workgroup descriptions and determine what area of interest they had. She also sent a letter to each nurse’s home detailing the excellence achieved from our Shared Governance work related to nursing outcomes. She asked that they review the council descriptions and complete an attached ballot and return it within a designated timeframe. Posters and ballot boxes were placed on nursing units. More than 225 nurses responded to the call for action. Many nurses requested to participate in more than one council or workgroup. Every effort was made to assign each nurse to the first council of their choice. The new council structure was fully implemented in January 2013.

EP1.3 Nursing Call to Action Letter from Katie - September 2012

In December 2014, council chairs identified a challenge in obtaining consistent attendance at council and workgroup meetings. Many nurses travel long distances to work at SJO and freeway congestion makes the commute even more difficult. Staff also identified that it was challenging to get release time from busy nursing units. Two suggestions/questions emerged from staff:

- Would it be possible to have council meetings all on the same day each month?
- Is it possible to allow staff to participate via conference call?

These were popular options. A plan was developed for eight councils and workgroups to pilot this innovation. During the next few months guidelines were developed for the chair and co-chair for online meeting preparation and facilitation. Guidelines for the participant were also created. On May 6, 2015 with 140 nurses in attendance Gemma Seidl, MSN, RN, presented the pilot which is being conducted from July 2015 through December 2015. Based on clinical nurse feedback and results achieved, a full plan will be implemented for CY2016 in an effort to ensure robust council and workgroup meeting attendance.

Leadership development
SJO offers ongoing leadership development courses for nurses currently in a leadership role as well as for those who are interested in becoming a nurse leader. At the end of each course participants are asked to complete a course evaluation form. Based on nurse leader formal and informal feedback a variety of courses were added to meet the expressed needs.

EP1 Figure 2
CY2014 and CY2015 leadership courses

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<thead>
<tr>
<th>CY2014 Leadership Courses</th>
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<tr>
<td>7 Habits for Managers</td>
<td>Essentials of Interviewing and Onboarding</td>
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<tr>
<td>Coaching and Mentoring</td>
<td>HR Policies &amp; Procedures Essentials</td>
</tr>
<tr>
<td>Conducting Effective Performance</td>
<td>7 Habits of Highly Effective People</td>
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Care delivery model: patient-family centered compassionate care

Our care delivery model is patient-family centered care incorporating Jean Watson’s Theory of Human Caring as our nurse theorist. Kim Rossillo, BSN, RN, PCCN, and Vivian Norman, MSN, RN, CCRN, are caritas coaches trained at the Jean Watson Caring Science Institute. Feedback from some staff during the years has been that nursing theory is very “theoretical” rather than practical. Our two caritas coaches took this feedback and developed many practical applications of the theory so it could become more alive and real to all staff.

Kim and Vivian have been instrumental in integrating Jean Watson’s Theory into practice during the past several years. In 2013, they held educational sessions for clinical nurses that included self-care with experiential learning projects such as painting lotus, finger labyrinths and sharing Sacred Encounters. During these educational sessions Kim and Vivian distributed laminated pocket cards to all RNs. One side of the card outlined Jean Watson’s caritas processes; the reverse side of the card listed a three-part touchstone meditation.

In 2014 Kim and Vivian developed end-of life-education for nurse assistants, which included caring content based on Watson’s theory. They also held classes for the Emergency Care Center with emphasis on the patient experience, Sacred Encounters and Jean Watson’s Theory of Presence and Awareness and Being the Healing Environment. In 2015 they held caritas exercises on Authentic Presence and Self-awareness for general surgery nurses.

Kim and Vivian have also integrated Jean Watson’s Theory of Human Caring into the annual Blessing of the Hands during SJO Nurse Week celebrations. They focus on the five core principles of Watson’s theory and ask five nurses to read passages during the ceremony and light five candles.
Further integration of Jean Watson’s theory includes highlighting one of the caritas processes in each issue of the bi-monthly publication, Clinical Education Update, which also includes a clinical narrative that reflects on the caritas processes. During the May Magnet Meeting in 2015 they presented caritas exercises on identifying caring behaviors in nurse stories.

Direct care nurses provide input into the evaluation of the care delivery model through their participation in the council structure. When a nurse finds a practice concern or an opportunity for change, he/she can take this to the appropriate council for a discussion among nursing peers. After review of evidence-based research, a protocol may be revised and a team organized to implement a research initiative or a trial process. Because this system is structured around nurses helping nurses, the communication flows freely with everyone wanting to be a part of the process. An example of this involves the Clinical Policy and Procedure workgroup. Nurses are having an impact on care delivery by contributing to the review, development and updating of policies and procedures and practice guidelines that address the specific needs of the populations they serve.


Clinical development
SJO initiated a self-review process in 2007. Based on staff evaluation of the tool, the process has undergone several revisions since its introduction. The latest revision occurred in October 2014 after the Clinical Development Council heard comments from clinical nurses that the current process took too long to complete. Council members reached out to the clinical nurses, clinical coordinators and nurse managers and asked them to evaluate the current tool: What was working? What was not working?

Clinical nurses and clinical coordinators requested a shorter self-review tool. Clinical nurse IIs requested a shorter Score 2 tool where the only option for evaluating performance was “on target.” A new three-page, Score 2 tool was developed for clinical nurse IIs. The shorter tool maintained the integrity of the evaluation allowing staff to show evidence that they were performing to the standard of their role. This new self-evaluation tool is being implemented with the 2015 performance evaluations.

Clinical nurse IIs and IVs were invited to attend separate meetings to provide feedback and recommendations to revise their tools. Based on feedback received changes were made and presented to clinical nurses in the following summary.

EP1.5 Summary of Changes to Self-Review Tool – October 2014

Ongoing evaluation of our PPM by seeking feedback from clinical nurses ensures that nursing practice evolves as healthcare practices and organizational needs change. Recent changes in the PPMs have resulted in nursing practice that is better aligned and integrated with the organization’s strategic plan and top priorities.
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