TL2
Nurse leaders and clinical nurses advocate for resources to support nursing unit and organizational goals.

> Provide one example, with supporting evidence, of a nurse leader's advocacy that resulted in the allocation of resources to support an organizational goal.
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Example #1
Nurse Leader Advocacy: Patient Placement Coordinator for Operations Hub

One process improvement initiative outlined in the Nursing Strategic Plan is Strategy 1, which states: "Provide excellent, compassionate, patient and family-centered care that promotes healing of mind, body and spirit." Objective 3 under this strategy states: "Partner with other departments to improve the patient experience, patient flow and nursing workflow."

Admission and placement current state
In July 2012 the SJO nursing team recognized an opportunity to improve the flow of patients throughout the hospital. Capacity management and patient flow are keys to decreased cost of care, improved patient outcomes and improved patient satisfaction. Bottlenecks in care were reported through clinical staff, physician and patient interactions. The patient entry points of the Emergency Care Center (ECC), the surgical suites, physician offices and the community were all competing for the same attention and timely bed placement.

Nurse leaders' advocacy
Kathleen Penzes, DNP, RNC, NEA-BC, Executive Director of Women's Services and Nursing Administration, and Pat Brydges, MBA, BSN, ACM, Executive Director of Admitting, Case Management and Social Services, each managed departments that "owned" steps in the admission and placement process.

Pat managed the Bed Reservations Department, which was staffed with non-clinical personnel who served as the point of contact for a patient admission/ bed request. This team reviewed the open bed options in-house and assigned the location for patient placement. This information was only relayed to the nursing supervisor (in Kathleen's department) if the team needed assistance with clinical placement questions.

The Staffing Office/Nursing Support Department housed the nursing supervisors and the staffing coordinators who matched staffing needs to volume and acuity. The nursing supervisor role was handled by rotating inpatient nurse managers for the day shift 7 a.m. to 3 p.m. and staffed with a dedicated nursing supervisor from 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m. Although the nursing supervisor role expectation included knowledge of house-wide operational barriers and staffing needs, there was minimal

communication between the two departments and no assigned individual who managed the “big picture” for optimal efficiency.

SJO nurse leaders have been trained in St. Joseph Way methodology with many achieving green belt status. In August 2012 Pat and Kathleen utilized their St. Joseph Way training to address this organizational challenge. They were supported by CNO Katie Skelton, MBA, RN, NEA-BC, who served as the executive sponsor to drive identified strategies to improve processes. Pat and Kathleen scheduled a Rapid Improvement Event (RIE) in September 2012. The purpose of the RIE was to explore options that would address the current flow challenge. The following stakeholders participated in the RIE: Cheryl Welp, BSN, RN, CNML, Observation Unit Manager; Kathy Yezarski, BSN, RN, ACM, Nurse Manager Case Management; Robert Garcia, MSN, RN, CMSRN, Emergency Care Center Nursing Manager; and Amir Ghiassi, MD, Critical Care Intensivist. The RIE team was facilitated by Tammy Alvarez, MSN, RN, CCRN.

Using the A3 process, the stakeholders created an Accelerated Improvement Method statement: “To establish a predictability model that improves patient flow, eliminates barriers to the timely placement of patients by addressing staffing, bed availability, and the timely discharge of patients, thereby creating an optimal patient experience.” The current state and the ideal state were listed and discussed. The concept map outlines the objectives and strategies outlined in the context of the environmental analysis. The patient placement challenge was not isolated to surgical and emergency room patients alone .The team also reviewed the current tasks and functions required to admit patients from various areas including direct admits and out-of-network patients.

TL2.1.1 Strategy Concept Map

Pat and Kathleen, along with the team, reviewed the current physical structure that existed to manage patient flow, which consisted of two separate departments that were managed and staffed by two separate managers. The Beds Department received the requests for admission and attempted to manage bed assignments with a card system that provided an outline of available space. This non-clinical group was often challenged by diagnostic information that was essential for appropriate placement. Across the hall, the Staffing Office and nursing supervisors channeled the bed requests and attempted to match staffing needs to accommodate the flow. It was recognized through analysis that the siloed structures led to communication gaps and delays in serving patient needs for timely admission and discharge. The existing patient placement steps were fragmented, and not coordinated for optimal efficiency.

To support flow improvement the team recommended creating physical space to serve as the operations hub or “command central.” The hub would combine Pat and Kathleen’s two departments. To operate the hub, the team recommended expanding the hours of coverage and the role of the nursing supervisor to include dynamic patient placement and flow coordination. This new role would be supported by combined and

cross trained Bed Reservation and Staffing Office personnel to create a clerical support network in the hub.

Allocation of resources
Utilizing the foundational principles of "Structure, Process, Outcome," Pat and Kathleen met with representatives from Plant Operations and Construction and Design to brainstorm space planning options. Drawings were constructed for expanded shared space and functionality. In May 2013 Pat and Kathleen submitted a Capital Expenditure Request and advocated for $177,333 in capital dollars to construct the operations hub. This programmatic re-design also included training expense to ensure that staff was up to date on all requirements of the discharge process. They also advocated for an additional $62,906 educating and training departmental staff.

TL2.1.2 Construction Floor Plan
TL2.1.3 Approved Capital Expenditure Request for Construction

In addition to the physical environment, the job descriptions, scheduling and competencies of the clerical and clinical positions were reviewed and re-designed to promote efficiency with a focus on patient flow. The current compliment of staff included seven full-time, one part-time and four per diem clerical staff and four full-time, two part time and five per diem clinical staff members. Kathleen reviewed the proposed changes and needs to redesign the skill mix, resulting in 6.2 full-time equivalents (FTEs) cross-trained clerical and 4.2 FTEs of clinical staff to oversee the operations hub. The hours and functions of the nursing supervisor position were expanded to create the new role of patient placement coordinator. This 24/7 position serves as the point person for the operations hub, coordinating patient flow from the ECC, Post-Anesthesia Care Unit and direct admits. The coordinator also maintains a focus on placement of SJO medical group patients who have been admitted to other local hospitals and who await transfer to SJO.

TL2.1.4 Approved and Filled Requisition for Patient Placement Coordinator

The patient placement coordinator also ensures that staffing needs are proactively matched to volume and activity. This newly redesigned role is responsible for managing the bed huddles, which are held three times a day. Charge nurses from across all units attend and report in to the patient placement coordinator. The meetings provide an opportunity to share information across the organization related to staffing, discharge status, patients ready for admission from the ECC, and barriers to patient flow.

TL2.1.5 Patient Placement Coordinator Standard Work

The patient placement coordinator remains in constant communication with a newly formed Admit Discharge team. This team of clinical nurses takes direction from the patient placement coordinator, whose real-time patient flow information focuses the team and maximizes patient movement. The Admit Discharge team provides a solid foundation for patients at admission and a comprehensive, non-interrupted teaching

opportunity for the patient and family at time of discharge, which contributes to improved patient outcomes and satisfaction.]The Admit Discharge team also allows more time for the clinical nurses to provide care for their other patients.

After substantial review of the flow process, nurse leaders successfully advocated for resources to restructure the physical environment and change nursing roles. As well as additional resources to have a patient placement coordinator in place 24 hours a day, 7 days a week. This has resulted in improved patient flow, which supports the process improvement initiative outlined in the Nursing Strategic Plan.

Example #2
Clinical Nurse Advocacy: Centralized Monitoring System for Emergency Clinical Decision Unit

The Nursing Strategic Plan provides a framework for continuous improvement. The plan outlines goals and tactics that nursing leadership has identified as ways to achieve desired outcomes. One of the goals in the strategic plan is to improve patient throughput in the Emergency Care Center (ECC). To achieve this outcome Glenn Raup, PhD, RN, CEN, Executive Director of the ECC, developed a plan to re-use space vacated by the Post Anesthesia Care Unit (PACU). This redesigned space, located in close proximity to the ECC, would accommodate ECC patients awaiting bed placement or further diagnostic testing. This would give the ECC additional beds for those patients requiring longer lengths of stay and would help support rapid turnover of other ECC beds.

TL2.2.1 Nursing Strategic Plan

TL2.2.2 Glenn Performance Goal for Patient Throughput

Redesign work began in January 2014. Since the space was originally designed as a PACU, the beds in the new Emergency Clinical Decision Unit (ECDU) featured bedside monitors for physiological monitoring (EKG, blood pressure, heart rate and pulse oximetry).

The new, 14-bed ECDU opened on February 1, 2014. The new unit was staffed with experienced ECC clinical nurses who were encouraged to provide feedback on the ECDU's physical environment. Glenn asked Robert Garcia, MSN, RN, CMSRN, Emergency Care Center Manager, to set up scribe sheets in the unit to capture staff feedback and suggestions. Robert then compiled all the ideas listed on the scribe sheets into one document entitled ECDU Suggestion Items/Tracking List and provided the entire list, along with follow-up and status on each item, to Glenn and ECDU staff on a daily or weekly basis depending on the issue or supplies staff requested.

TL2.2.3 ECC Power Minute Requesting Staff Suggestions – February 2014

Clinical nurse advocacy
ECDU clinical nurse Leonor Burris, BSN, RN, CN II, recognized the need for a centralized monitoring system. Since a majority of the patient population was admitted to the unit for chest pain observation, nurses had to continually round on these patients to monitor cardiac rhythm and vital signs. In addition, ECDU nurses identified an issue with the bedside monitors, which continually alarmed for benign rhythms in patients. The constant alarming resulted in nurses continually leaving other patients or the nurses' station to check on patient beside alarms. Since the ECC had a centralized monitoring system, Leonor understood the benefit. She was also familiar with the RN Guide to the Nursing Strategic Plan and understood the importance of making her manager aware of issues that could contribute to patient problems. She also held herself accountable for finding a solution and advocated for the installation of a centralized system in the ECDU.

TL2.2.4 ECDU Signed Staff Suggestions and Action Plan

Leonor's advocacy for the centralized monitoring system was key to improving the efficiency and effectiveness of the expanded care area. It allowed nurses in the ECDU to monitor patients without having a high number of false alarms. Nurses were able to focus on care and avoid alarm fatigue. It gave the nurses the ability to recognize true abnormal physiological changes in a timely manner. This newly expanded space supported the ECC goal of improving patient flow. It opened up beds quicker for other patients who were waiting.

Allocation of resources
Glenn also understood the value of a centralized system. He requested that Biomedical Engineering evaluate existing computer hardware that was not being utilized in another department. Biomedical Engineering determined the hardware would be sufficient if upgraded. Glenn successfully advocated for resources to purchase cabling and cable adapters to upgrade the hardware, and to purchase wall mounts to install a system that would enable nurses to monitor patients continually in the ECDU.

TL2.2.5 Invoice for Central Monitoring System Refurbishment

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