Visibility, Accessibility and Communication

TL8
The CNO uses various methods to communicate, be visible, and be accessible to nurses throughout the organization.

Provide one example with supporting evidence of communication between the clinical nurse(s) and the CNO that led to a change in the nurse practice environment.

Provide one example with supporting evidence of communication between the clinical nurse(s) and the CNO that led to a change in the patient experience.

In her 17 years at SJO, CNO Katie Skelton, MBA, RN, NEA-BC, has provided a stable foundation for strong nursing relationships. Katie enables staff at all levels to communicate directly with her and to participate in the decision-making process. As an executive leader, Katie’s visibility and accessibility are strategically and formally designed through the line reporting structure and the matrix outline that connects her to areas that may directly report to another member of the Executive Management Team (EMT). This structure has the full support of executive leadership.

With a direct connection to all of nursing, Katie is able to address issues and ideas as well as provide feedback on nursing practice and information. This structure serves as a catalyst in successfully implementing change.

Katie is a leader who is able to make difficult decisions, focus on people, and is an honest and direct communicator. Katie routinely rounds in all patient areas, allowing time to check in with patients, families and staff members. Every Monday, Wednesday and Friday she attends Nurse Executive Rounds, along with other nursing directors. During rounds she reviews the census in each area, surgical volume and Emergency Care Center census, and assists in problem solving any barriers that are presented.

Recognizing that communication is the key to organizational success, Katie works diligently to keep the staff up to date on internal and external healthcare changes and opportunities.

TL8 Figure 1
Description of CNO communication methods

<table>
<thead>
<tr>
<th>Method</th>
<th>Description of CNO Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Forums</td>
<td>Leads hospital-wide communication sessions to update staff and field questions or address concerns.</td>
</tr>
<tr>
<td>Nursing Annual Report</td>
<td>Annual update of Nursing accomplishments and status on metrics.</td>
</tr>
<tr>
<td>Nurse Executive Huddles</td>
<td>Three times each week, the CNO participates in a huddle to review staffing and patient volume to</td>
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</table>
Katie maintains a relationship with key nursing stakeholders at the health system and local level and is highly visible, as evidenced by the following:

**TL8 Figure 2**
Description of CNO visibility

<table>
<thead>
<tr>
<th>Group</th>
<th>Description of CNO Visibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>SJH Leadership</td>
<td>CNO has chaired the SJH CNO group since 2005. This team meets three times per year to review progress on strategic goals and share best practices. She coordinates bi-monthly conference calls for the CNOs within SJH. She participates in the SJH Ministry Leadership Council, which meets two to three times per year. At these meetings the CEOs, COOs, CFOs and CNOs of SJH hospitals review and plan strategic priorities. Katie co-chaired the October 2014 meeting with the SJH CEO.</td>
</tr>
<tr>
<td>SJO Board of Trustees</td>
<td>Attends all meetings, along with the CEO and COO, to formalize strategy and organizational priorities.</td>
</tr>
<tr>
<td>Executive Management Team</td>
<td>Serving as the official nursing leader, assists the other members of the management team in discerning practice issues and advocates for clinical resources (including ongoing review of equipment needs).</td>
</tr>
<tr>
<td>Nursing Executive Council</td>
<td>Chairs this council of nursing leaders to establish organizational priorities and manage for optimal outcomes, utilizing the talents of the team.</td>
</tr>
<tr>
<td>Nursing Leadership Team</td>
<td>Chairs this broad assembly (inpatient and outpatient) of nursing leaders to translate goals into practice. This team meets bi-weekly.</td>
</tr>
<tr>
<td>Nursing Advisory Council</td>
<td>Facilitates this formal two-way communication vehicle that addresses issues such as benefits, workflows, dress code, communication regarding organizational changes and quality of work life issues. Katie forwards issues beyond the scope of</td>
</tr>
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Transformational Leadership

<table>
<thead>
<tr>
<th>Group</th>
<th>Description of CNO Visibility</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>this group to the appropriate department or personnel to facilitate resolution and shares the subsequent outcomes.</td>
</tr>
<tr>
<td>All Nursing Staff</td>
<td>As a servant leader, is visible in the organization. Regularly participates, along with other members of EMT, in the employee forums. These meetings, scheduled on varying shifts, serve to update employees about all aspects of our organizational operations and performance. The employee forums include time for questions and any suggestions from staff on improvement opportunities. “Breakfast with the CNO” is scheduled intermittently so staff can have direct access to the CNO during period of great change. Katie welcomes all RNs at the opening of Nursing new hire orientation. Katie recorded a podcast for all staff to review on the re-design of the nursing shared governance structure.</td>
</tr>
</tbody>
</table>

SJO supports the servant leadership model, which promotes availability and accessibility of all organizational leaders to work directly with staff.

**TL8 Figure 3**

Description of CNO accessibility

<table>
<thead>
<tr>
<th>Method</th>
<th>Description of CNO Accessibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast with Katie</td>
<td>Accessible to all staff for updates on hospital operations</td>
</tr>
<tr>
<td>Leadership Rounds</td>
<td>Informal unit visits to check in with staff.</td>
</tr>
<tr>
<td>1:1 appointments</td>
<td>One-on-one appointments are available per request.</td>
</tr>
<tr>
<td>E-mail, text, phone</td>
<td>24-hour responsibility; always available for consultation.</td>
</tr>
</tbody>
</table>

**Example #1**

Change in Nurse Practice Environment: EMR Nursing and Pharmacy Work Flow

The Nursing Advisory Council provides a mechanism for direct, effective communication between frontline staff from each nursing department and the CNO to discuss nurse retention, nurse satisfaction, work environment, recognition efforts, current challenges and workplace issues in an environment of mutual respect. This council meets monthly.

**Communication between clinical nurses and CNO**

In January 2013, Katie organized an “open” Nursing Advisory Council meeting with the goal of discussing, “What are we doing well and what are our challenges?” in hopes of
uncovering barriers that were interfering with our patients’ perceptions of care and their experience. Traditionally, the Nurse Advisory Council is comprised of each department’s Unit-Based Council representatives. Katie sent an open invitation to any clinical nurses who were interested in attending and encouraged them to also solicit and bring feedback from their peers regarding barriers that prevented them from providing exceptional care to our patients.

TL8.1.1 Nurse Advisory Council Meeting Minutes – January 2013

During the meeting, Katie reviewed our HCAHPS scores, and shared that our patients were telling us that their experience was not what they wanted it to be and that we sometimes “missed the mark” in communicating and responding to our patients. During the meeting it became apparent that several of the barriers had to do with our recent electronic medical record (EMR) implementation and nurse pharmacy workflow issues that were contributing to breakdowns in communication, efficiency, nursing and patient satisfaction.

After the meeting, Katie reviewed and organized the feedback and comments so she could address the issues that the nursing staff brought to her attention. The main themes identified included: workload barriers (including admissions and discharges), patient placement, ancillary support, adequate staffing levels and the overall level of change within the organization. After reviewing the gap analysis, and the number of pharmacy workflow issues cited, it was determined that a nurse/pharmacy team needed to be developed to address identified problems. The RN/Pharmacy Workgroup was formed.

The RN/Pharmacy Workgroup was comprised of representatives from Pharmacy, Pharmacy leadership, clinical nurses, nursing leadership and staff from the Clinical Information Services (CIS) department. This workgroup was established to review and address issues/problems that resulted from the inauguration of electronic record keeping. Sixty-three issues were identified during the open Nursing Advisory Council. These were grouped into seven major categories: 1) Prescribing, 2) Transcribing, 3) Dispensing, 4) Distribution, 5) Administration, 6) Education, and 7) Monitoring and Use.

TL8.1.2 Medication System Issues Working Toward Resolution

To ensure that the Nursing Advisory Council and staff were updated on the RN/Pharmacy Workgroup’s progress, Katie focused the February 19, 2013 Council meeting on reviewing issue resolutions so council members could communicate back to staff. The workgroup also issued a series of FAQs to each manager to place in reference binders on the unit. Upon completion of the issues list, a self-learning module (SLM) was developed and placed on the Learning Management System, which included all the FAQs as well as a post-test on the information presented. All inpatient nursing staff completed the SLM.
Change in nurse practice environment
Changes in nurse practice environment that resulted from communication between clinical nurses and the CNO include:

- The nurse’s ability to co-sign student charting.
- A streamlined documentation of independent double check for high-risk medications.
- A change in the standard morning medication time assigned, moving from 9 a.m. to 10 a.m. to improve workflow.

Katie is a visible and accessible CNO who is respected by nursing for her honesty, integrity, and dedication to the nurse practice environment. In 2013 the NDNQI Nurse Satisfaction survey results demonstrate SJO nurses’ respect for their chief nursing officer. On the survey, 61.14% of SJO nurses indicated that they were “satisfied with the hospital chief nurse executive.” These results exceeded the NDNQI mean of 59.93% demonstrating SJO nursing’s satisfaction with their CNO.

As a result of the communication between clinical nurses and the CNO, a team of clinical nurses, pharmacy and clinical informatics staff was developed to address the pharmacy workflow issues. Clinical nurses identified issues and assisted in providing solutions for the EMR to improve workflow and avoid patient safety issues. This resulted in an improved nurse practice environment.

Example #2
Change in Patient Experience: Quiet Hospital Environment:

During the first quarter of FY 2013 the “Quietness of the Hospital” section of HCAHPS was identified as a low-scoring item throughout the hospital. To seek clinical nurse input on barriers and solutions to achieving a quiet, healing environment, CNO Katie Skelton suggested that this topic be added to the Nursing Advisory Council agenda on August 20, 2013 for discussion.

During the meeting Kathleen Penzes, DNP, RN, RNC-NEA-BC, Executive Director of Women’s Services, shared SJO’s quietness scores by unit and contrasted them with the top performing hospitals in the nation. Noise has long been recognized as a deterrent to healing and appears to be a force that can be mitigated by our practices. Kathleen noted the alignment of this focus on noise with the Caritas processes of SJO’s nursing theorist Jean Watson and the historical comments recorded by Florence Nightingale, who dedicated an entire chapter of her book to noise: “…unnecessary noise then is the most cruel absence of care which can be inflicted on sick or well…Such unnecessary noise has undoubtedly induced or aggravated delirium in many cases.”
Kathleen then presented a PowerPoint entitled, “Creating a Quiet Hospital Environment,” which was created in partnership with Julie Hernandez, Director of Risk Management, Patient Relations and Quality Management. Kathleen and Julie are both members of SJO’s Patient Experience Core Team. The team was focused on improving “Quietness of Hospital” HCAHPS scores. The PowerPoint provided a recap of patient and staff feedback obtained on August 14 and 15, 2013 when all inpatients were rounded on and asked “Were there any noises that disturbed your sleep last night?” Patient responses fell into five categories: staff voices, beeping IVs, visitors, hallway noise, and air conditioner noise that had not previously been reported to Plant Operations.

During this same time, staff was asked the question, “What’s keeping us from having a quieter environment?” Staff responded with: the 5 a.m. generator check, floor cleaning schedule with the buffer machine, tube systems in the units, fire alarm testing and food carts. When asked what they could do to create a quieter environment, staff offered the following solutions:

- Managing expectations of the patients: discuss the plan for the night with the patient; group care interventions.
- Dim the lights; close the doors to the patient rooms.
- Continue the overhead announcement reminder to visitors that it is rest time (end of visiting hours). Explore the practice used at a sister ministry of having a good night blessing overhead, read by one of the Sisters.
- Manage our own staff behavior to support the quiet environment.

**TL8.2.1 Creating a Quiet Hospital Environment**

**Communication between clinical nurses and the CNO**

After the presentation, Katie engaged the Nurse Advisory Council to respond to the same question the Patient Experience Team asked staff on August 14 and 15: “What is keeping us from having a quieter environment in the hospital?” Clinical nurses agreed with the list of sources outlined in Kathleen’s PowerPoint. They augmented the list, adding: alarms on the call system are noisy and overhead paging is loud,

Katie then asked Nurse Advisory Council for solutions to the noises mentioned by patients, front line staff and council members. In addition to the solutions offered by staff, the clinical nurses also added:

- Staff should be constantly reminded about noise levels; post signage to remind people.
- As a signal, staff should flip the dim light switch when noise levels increase.
- Phones and beepers on vibrate.

**TL8.2.2 Nurse Advisory Council Meeting Minutes - August 2013**

The suggestions from front frontline staff and Nurse Advisory Council were summarized and shared with the Nursing Leadership Team in October 2013. Each manager was
asked to take this topic and presentation to their Unit-Based Councils (UBC) for discussion and department-specific action steps.

TL8.2.3 FY 2014 Unit Based Council Members: Mother Baby Unit

Change that occurred in the patient experience
The Mother-Baby Unit (MBU) is a 60-bed unit that spans two floors of the hospital to care for SJO’s delivery volume. Julie Gonzales-Morton, AD, RN, CN II, from the MBU was present at the Nurse Advisory Council meeting August 20, 2013. She shared the discussion with the UBC about the initiative to create a quite hospital environment.

In November 2013 the UBC and Terry Zeilinger, MSN, RNC-OB, MBU, nurse manager, discussed the quietness challenge on MBU and its impact on new families. As a Baby-Friendly designated hospital, MBU supports practices for early infant attachment and 100% rooming in. MBU also receives the highest volume of excited visitors in the hospital.

To help reduce noise on the unit, the UBC proposed “Quiet Time” between 2-4 p.m. each day to promote rest and healing for our families. In January 2014, the team reached out to Cathy Semar, Director of Marketing and Communications, to request signage for the unit’s main entry and for each patient room to notify family and visitors about “Quite Time.” Standard work was developed by the UBC that included the following steps:

1. At 2 p.m. each day, the secretary will notify each nursing station to dim the lights in the station areas.
2. The nursing assistants will dim the hall lights and close patient room doors.
3. All staff will refrain from performing clinical tasks in the patient rooms and encourage those in the hallways to use quiet voices.
4. Visitors will be directed to the waiting areas to allow rest time for mother, partner and infant.

TL8.2.4 Standard Work Mother Baby Unit: Quiet Time

In February 2014 this standard work was fully implemented in MBU and shared with physician colleagues, ancillary departments, and published in our public educational classes, web site and print collateral.

Since implementation, Quite Time has received support from our patients and families and serves as a daily reminder to our staff of the role they play in restful healing. Under Hospital Environment, the unit’s HCAHPS scores related to quietness have demonstrated improved performance.

TL8.2.5 Mother Baby Unit HCAHPS Quiet Scores

During the August 20, 2013 Nurse Advisory Council, discussion focused on the patient experience. As an outcome of this communication between clinical nurses and the
CNO, work began with the UBCs to develop strategies to improve the patient experience. One UBC that developed and implemented positive change was MBU. Their scores reflect the work they did to improve quietness for their post-partum families.