Strengthening the Ambulatory Nurses’ Practice through the Implementation of Shared Governance

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Objectives
1. Describe steps and process required to complete an assessment of geography, specialty, roles, and staff readiness prior to creation of shared governance plan
2. Verbalize process to create shared governance structure in the ambulatory setting
3. Identify the tools to assist in implementation of shared governance and identify outcomes measures

We have no financial disclosures

Demographics

- Outpatient Visits (includes Home Health visits) 756,174
- Clinic Visits of Acquired Practices: 107,365
- # of Ambulatory Clinics: 74
- Ambulatory PCA/PCT: 108
- Ambulatory RN: 325
- Ambulatory LPN: 89

Shared Governance Background

- First introduced in the 1970s
- Christman (1976) viewed it as nurses and physicians operating on an equal footing in the decision making/operations of a hospital
- Cleland (1978) coined the phrase “shared governance”

What is Shared Governance?

- System of management that creates an environment of empowerment for staff nurses
- Nurses at every level of the organization play a role in the decisions that affect nursing activity
- Organizations must be transformed in a way that provides for participation and ownership
What is Shared Governance? continued

- Shared decision-making based on the principles of partnership, equity, accountability, and ownership at the point of service
- Conclusion: Those who are happy in their jobs take greater ownership of their decisions and are more vested in patient outcomes. Therefore, employees, patients, the organization, and the surrounding communities benefit from shared governance

American Nurses Credentialing Center (ANCC) and Magnet

- Magnet does not require shared governance to be in place, but they do require structure and processes that allow for shared decision-making across all levels of the organization
- Evidence/Empirical Outcomes related to shared decision-making are required

Key Take-Aways

- Professionals are different from employee work groups
- Shared governance reflects a professional expectation of the community

Benefits of Shared Governance

- Increases nurses':
  - Autonomy
  - Empowerment
  - Increased sense of control over practice and environment
  - Improved job satisfaction

Patient Benefits

- Improves patient outcomes
  - Lower infection rates
  - Lower fall rates
  - Fewer medication errors
  - Improves patient satisfaction

Tim Porter O’Grady

"shared governance is more than a new organizational chart or committee configuration; structures can be deceiving. The number, titles, and arrangements of committees are not as important as the people who make up the membership. Rather, their expertise and knowledge that guide their actions, what they have power to do, and their commitment to both their profession and the mission of their organization are more likely predictors of success. The meaning of success in terms of shared governance and patient care should be the control of practice leading to better patient outcomes"
Implementation

- Building the structure
- CNO supported implementation
- Inpatient areas first
- Task force created

Ambulatory SG Workgroup

- Kim Anger - Renal
- Adrienne Banavage - Cancer
- Alicia Boyd - Women’s and Children’s
- Veronica Brill - Ambulatory Operations/Cancer
- Jenny Dixon - Heart & Vascular (PNSO Pres-elect)
- Stan Hatcher - Fontaine
- Holly Hintz - Nursing Governance
- Cathy Kern - Northridge
- Tina Knicely - 2013 PNSO Pres
- Rhoda Miller - Peds
- Cherie Parks - Heart & Vascular (APC Chair)
- Linda Romeo - Digestive Health
- Benton Turner - Ambulatory Ops
- Cindy Westley - Patient Ed & Epic
- Jody Wiseman - Digestive Health
2014 Ambulatory Shared Governance Structure

Regional Structure

- **AMB GROUP 1:**
  - Diabetes Ed and Management program
  - Rheumatology
  - Endocrine
  - Physical Medicine & Rehab
  - Pain Management Center
- **AMB GROUP 2:**
  - DHC
  - Pulmonary
  - Dermatology-PCC
  - ID/Travelers
  - Kidney Center Clinic
- **AMB GROUP 3:**
  - Allergy
  - Piedmont Nephrology
  - Jefferson Area Board of Aging
  - Colonnades
- **AMB GROUP 4:**
  - Oral Surgery
  - Chronic Wound Care
  - Plastic Surgery
  - Surgery
  - Urology
  - Dentistry
  - Ophthalmology - Northridge
  - Ophthalmology - Old Med
- **AMB GROUP 5:**
  - Otolaryngology - Fontaine
  - Audiology/Contract Service
  - Spine Center
  - Sports - Ortho
  - Orthopaedics - Fontaine
  - UVA Hand Center
- **AMB GROUP 6:**
  - UPC
  - UMA - JPA
  - PCC - Family Medicine
- **AMB GROUP 7:**
  - Internal Medicine Orange
  - Western Albemarle Fam Med
  - Family Medicine
  - Crossroads
  - Family Medicine Stoney Creek

Structure of Regional Ambulatory Shared Governance

- Regional committees will focus on clinical practice, quality, professional development and research. Structure will be decided by regional areas.
- Meetings will occur every other month
- Minutes stored on the shared drive

Orientation

- For managers and committee chairs
  - In depth Nursing shared governance structure and process
  - Leadership expectations
  - Meeting management skills

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Manager Responsibility
- Manager and staff determine local committee structure
- Membership of committee
- Chair and co-chair of committee identified

Struggles
- Buy-in from staff
- Leadership
  - Not all RN leaders
  - Reporting structure
- Communication
- Work roles in ambulatory
- Perception of RN role in ambulatory
- DIVERSE PATIENT POPULATIONS
- GEOGRAPHY

Blood Draws from Central Lines
- Staff wanted CMAs to do it
- Leadership wanted to satisfy the providers and the patients
- Our campus is huge!
- Various types of access devices in various patient populations across the Health System

Scope of Projects
- Many, many stakeholders
- How to select projects that are valued but attainable
- What does success look like and how do we get there?
  - Short-term versus long-term

Implementation Success
- Vaccination task force
- Mock code sub-group
- Sterile Technique Summer Camp

Implementation Outcomes
- Vaccination task force
- Composed of inpatient, pharmacy, outpatient adult and pediatric nurses
- Developed flu and pneumococcal vaccination CBL
- Distributed pocket guides
- Direct link from EMR to updated CDC VIS

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu</td>
<td>39.71</td>
<td>47.63</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>26.12</td>
<td>34.79</td>
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</table>
Mock Code

- Training program to improve confidence, comfort level, resuscitation skills, and knowledge of staff by increasing exposure to adult resuscitation guidelines and equipment
- In coordination with Life Support Learning Center, trained local staff to become “super trainers”
- The sessions are brief - five minutes followed by a ten-minute discussion/debriefing session

Barriers and Solutions to the HVC Mock Code Training Program

- Staffing Issues → Offer sessions during scheduled clinic work hours
- Equipment → Utilize resources (LSCC manikin)
- Perception that mock codes are not a priority due to low volume → Staffing issues and lack of preparedness contribute to patient outcomes
- Resistance to change and the belief that experienced HCPs have nothing to learn from participating in mock codes → All HCPs can benefit from mock codes

This program has seen results, as evidenced by the improvement in nursing satisfaction with the survey question: “Active staff development or continuing education programs for nurses,” from 3.37 in 2012 to 3.44 in 2013

Graph provided by Katherine Couvillon, Data Analyst, Patient Care Services

Time and Cost

- What is the budget?
- What is the time allocation for direct care providers?

Categories of Work and Definitions

<table>
<thead>
<tr>
<th>SHARED GOVERNANCE</th>
<th>Professional Development</th>
<th>Administrative Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time designated for staff to work on shared governance projects related to nursing practice, quality, professional development and research.</td>
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</tbody>
</table>
| Time spent by staff in internal and external education activities such as:  
  - Conference attendance  
  - Staff delivering or receiving unit-based in-services  
  - Attendance at Evidence-Based Practice day  
  - Orientation/Preceptor  
  - Staff meeting/committee attendance and in the preceptor role. |
| Staff meetings, interviews, scheduling, Joint Commission prep, annual self evaluation, etc. |

<table>
<thead>
<tr>
<th>Central</th>
<th>Unit-based</th>
<th>Research</th>
</tr>
</thead>
</table>
| Examples include:  
  - PNSO Career Ladder  
  - PNSO Central Professional Development Committee  
  - PNSO Nursing Cabinet  
  - Other organization-wide meetings |
| Examples include:  
  - Unit-based shared governance meetings  
  - Unit-based employee engagement action-planning sessions |
| Unit research committee  
  - Research mentor work  
  - Manuscript preparation |

Data Collection Tool

After the Heart and Vascular Center’s shared governance model refresh in March 2013, eighteen cardiology nurses collected data over seven months. Four of the eighteen consistently documented non-direct patient care activities.
Sterile Technique Summer Camp

- Cancer Center staff identified a sudden “bubble” in the number of infected implanted vascular access devices
- Next steps? A united effort
  - Small group of infusion nurses came together with nurse educator to discuss the results, formulate a plan for improvement, and implement the plan

Findings

- Approximately 40% of the infections occurred within 48 hours of implantation
- 30% occurred between 48 hours and 2 weeks
- 30% occurred 2 weeks after implantation or more

Questions Asked

- Do we have the right equipment?
- Are the right people doing this job?
- Do these people have the right training?

Interventions

- More structured data collection
  - QR for each occurrence
  - Notification of nurse educator
  - Added a description of the VAD site each time the VAD was accessed

Non-Patient Care Time - Estimated Cost 2013

<table>
<thead>
<tr>
<th>Month</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
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<tbody>
<tr>
<td>Cost</td>
<td>$5,989</td>
<td>$5,570</td>
<td>$5,768</td>
<td>$4,305</td>
<td>$4,114</td>
<td>$3,183</td>
<td>$1,905</td>
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Total Hours Worked

<table>
<thead>
<tr>
<th>Month</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours</td>
<td>6,000</td>
<td>6,500</td>
<td>6,600</td>
<td>6,600</td>
<td>6,400</td>
<td>6,300</td>
<td>6,200</td>
</tr>
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American Academy of Ambulatory Care Nursing (AAACN) 39th Annual Conference (2014)

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Education

- Two-part education
- Definition of CLABSI and review of literature around this
- Demonstration of correct technique for port access
- Demonstration of “trouble-shooting” interventions for common problems

Results

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Pre-implementation</th>
<th>Post-implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 second CHG scrub</td>
<td>86%</td>
<td>93%</td>
</tr>
<tr>
<td>Application of sterile dressing prior to additional actions</td>
<td>76%</td>
<td>100%</td>
</tr>
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Outcomes

- Increased awareness in importance of sterile technique
- Decrease in number of infected ports identified

Take Aways

- Priorities can be set by all stakeholders
- Everyone needs to have a voice - but not all at the same time
- Projects often need to be “budget neutral”
- It may not look the way you thought it was going to look

Bylaws Proposal

- **PNSO Ambulatory Nurse Committee**
  - **Charge:** The Ambulatory Nurse Committee is accountable to PNSO Cabinet for guiding the development, implementation, and evaluation of ambulatory evidence-based practice, quality, and professional development.
  - **Membership:** Members of the Ambulatory Nurse Committee are appointed by the Cabinet, serve for two-year terms. Exceptions to this are for standing members. The Immediate Past-Chair will be an ex officio member for one additional year as a resource to the ANC.
  - **Duties:** The Ambulatory Nurse Committee shall:
    a) Promote evidence-based clinical practice through discovery, education and dissemination of information and research.
    b) Review and define professional nursing practice and documentation to promote consistency across ambulatory settings.
    c) Provide guidance and recommendation for annual ambulatory competencies and CBLS.
    d) Provide a forum for the discussion of ambulatory practice changes and related problem solving.
    e) Collaborate with Nursing Quality Committee in the review of nurse sensitive indicators and future recommendations.
    f) Collaborate with ambulatory leadership and nursing, quality committee to biannually review patient satisfaction results and provide recommendations for action plans.
    g) Report to Cabinet quarterly, providing a summary of activities and recommendations for future initiatives.
References

- Structural Empowerment and the Nursing Practice Environment in Magnet Organizations by Joanne Clavelle and Tim Porter O’Grady delivered in March 2014 at AONE