Nursing Excellence

2021 Magnet®-recognized and Pathway to Excellence®-designated Organizations Success Stories

Special Section

Navigating excellence during a pandemic: The Magnet® program director's role

Use the Magnet model components as a framework for meeting a crisis.

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In organizations across the country, the COVID-19 pandemic has disrupted patient care and hospital operations at every level, requiring rapid retooling of structures and processes to address the crisis. A New York City integrated academic healthcare delivery system, consisting of 10 campuses, is using the American Nurses Credentialing Center (ANCC) Magnet® model components (transformational leadership; structural empowerment; exemplary professional practice; and new knowledge, innovations, and improvements) as a guiding framework through the pandemic. The Magnet model drives organizations to describe and demonstrate empirical outcomes focused on these components.

With the pandemic imminent, Magnet program directors (MPDs) assessed risk to the Magnet culture and identified activities necessary to maintain it: clinical nurses having a voice and being involved in decision making, a healthy work environment, employee and patient safety, transformational leaders successfully guiding the team and advocating for resources, innovation, evidence-based practice, delivering culturally and socially sensitive care, and mentoring and succession planning.

The MPDs' role quickly shifted from leading the Magnet journey to supporting nursing teams. MPDs at each campus work alongside other nurse leaders to create an inclusive and engaging environment and reconfigure how the teamwork, courage, and resilience of nurses and the interprofessional team are recognized. In addition, MPDs have remained aware of the unfolding initiatives that can be used to describe and demonstrate Magnet narratives.

Transformational leadership

Our organization's culture, combined with the Magnet culture, is key to our success. Transformational leadership by the chief nurse executive, chief nursing officers (CNOs), and nurses at all levels is essential. As the organization began to experience unrelenting change

associated with the pandemic, nurse leaders embraced it, reprioritized goals, and focused on measures necessary to keep employees and patients safe. Professional governance shifted from formal meetings to robust pathways for nurses to advocate for needs and concerns. For example, we use direct messaging via specially created and staffed email accounts to expedite and escalate concerns about personal protective equipment (PPE), scrubs, parking, housing, and meals.

MPDs in action
Working alongside nurse leaders throughout the organization, MPDs rounded on clinical units to ensure nurses felt supported. During these rounds, MPDs were available to answer questions and report needs back to executive leaders. The MPDs advocated for clinical nurses, ensuring their needs were heard and their safety was a priority during the pandemic.

Structural empowerment

Nurse leaders cultivated resilience by embracing flexibility, providing support, and finding coping resources for the frontline nurses and teams. To build competencies and confidence for practicing in newly opened and repurposed practice settings, nurse leaders optimized staffing structures and strengthened cross-training and mentoring for nurses working in unfamiliar patient populations and specialty areas. Executive leaders streamed local, state, and national live news updates to communicate changes, statistics, education, and status reports. This robust communication sharing instilled calm, confidence, and pride by connecting nursing staff work to improving people's lives and recognizing the contributions and sacrifices among the healthcare system family.

MPDs in action
MPDs collaborate with staff in the nursing professional development department to provide input into cross-training redeployed nurses and influence curriculum and support. For example, MPDs contribute to hospital orientation for external agency nurses, working with educators to accelerate onboarding. In addition, MPDs infuse elements of the Magnet model and nursing excellence into the expedited orientations by promoting shared decision making and team building whenever possible.

Exemplary professional practice

In response to the extraordinary need for critical care beds, leaders swiftly activated alternative staffing plans and implemented contingency capacity strategies, which included suspending elective surgeries, procedures, and office visits and reassigning employees to areas with identified staffing shortages or to newly created COVID-specific units. Some system campuses temporarily closed selected services, such as pediatrics and psychiatry, to increase capacity for adult critical care patients. Through all these changes, guidelines for adult tracheostomy placement and care, aerosol-generating procedures, and patient proning protocols evolved. In the midst of challenging social distancing and restricted visitation policies, clinical nurses are steadfast and agile, implementing daily changes. In addition, nurse leaders work with clinical nurses to ensure competence as needed when enacting contingency staffing plans.

MPDs in action
MPDs serve as clinical advisors in a number of command centers throughout the organization. In collaboration with CNOs, MPDs advocate for nurses to be at the decision-making table during the crisis. They work in collaboration with interprofessional teams, provide insight through the nursing lens, and serve as active decision makers at critical huddles and meetings. For example, when a decision was made to expand critical care capabilities, the MPDs ensured that nurses at all levels of the organization were part of the planning so the teams could safely triple or quadruple the critical care capacity as needed.

New knowledge, innovations, and improvements

Structures and processes that nurses relied on to accomplish their work have been interrupted during the pandemic, requiring ingenuity and innovation. Innovations to ensure safe patient care include alternate staffing models, specialized interprofessional teams (such as a proning team), temporary intensive care units on medical-surgical units and in operating rooms, a shift to team care delivery models, and PPE conservation measures. This is uncharted territory and nurse leaders rely on current evidence-based practice guidelines to make decisions affecting patient care.

MPDs in action
MPDs collaborate with nursing leadership to continue professional governance meetings and adjust to new ways of doing business by hosting meetings on a cloud-based platform for video, voice, content sharing, and chats. They worked with the information technology department to enhance desktop computers so nurse teams can attend professional governance and other meetings virtually. This gives nurses a sense of normalcy and reinforces the importance of shared decision making and communication.

In addition, MPDs focus on disseminating key strategies, redesigning workflows, and leveraging resources for team resilience. This includes sharing

Lessons for the future

The Magnet® program directors (MPDs) at a multi-campus healthcare system learned many lessons during the COVID-19 pandemic that will help guide them during future crises.

Lesson 1: Set priorities

- Stay calm and lead on.
- Determine Magnet-related "need to do" vs. "nice to do."
  - For organizations submitting their Magnet application in a year or less, the MPD should continue to focus on writing the Magnet document.
  - For organizations submitting their applications beyond 1 year, the MPD should shift priorities to current crisis needs, including staffing, managing inventory, and opening/expanding units.
- Manage facts, perceptions, and thoughts related to the crisis by ensuring accurate updates are shared with the team.
- Use tools at your disposal to provide critical updates, such as video chatting, secure text messaging, and other electronic forms of communication.
- As information changes during the crisis, use technology to ensure everyone on the team is current.

Lesson 2: Speak up

- Promote nurses at all levels to speak up early and often about opportunities and successes throughout the crisis.
- Leverage organization-wide use of a secure, cloud-based platform for video, voice, content sharing, and chats for robust communication.
- Empower clinical nurses and nurse leaders to propose innovative ideas for managing inventory, crafting staffing models, and fulfilling basic needs such as food, shelter, transportation, and childcare.

Lesson 3: Listen and observe

- Embrace change as constant during a crisis and accept that standard work may not exist.
- Listen and observe nurses' work to capture narratives for the Magnet document.
- Encourage questions during meetings, provide time for discussion, and observe teams when rounding on units.
- Disseminate knowledge gathered during observations and encourage teams to trial innovative initiatives.

Lesson 4: Practice self-care and reflection

- Provide opportunities for teams to discuss events during a crisis with pastoral care and psychiatric team members, including time for teams to decompress.
- Recognize teams' contributions during a crisis.
- Deliver basic necessities, such as meals, and establish recharge/respite areas for team members to take a break away from patient care.
- Acquire resources for at-home or off-site self-care and reflection, such as yoga, meditation, and exercise programs free of charge.
- Promote self-care by ensuring clinical team members have time for respite.

real-time best practices across the 10 campus locations and with external audiences. For example, workflow redesign was necessary to provide care for the surge of critically ill patients entering the healthcare system.

Lessons learned

The MPDs learned lessons—about setting priorities, speaking up, listening and observing, and practicing self-care and reflection—which will inform future decisions and plans for leading an organization to excellence during a crisis. As the COVID-19 pandemic rages on, MPDs remain focused on these skills to ensure their own resilience, as well as that of the entire nursing team. Leveraging the unique skill set of the MPDs has provided another level of leadership to help guide clinical nurses through this pandemic. (See *Lessons for the future.*)

Unwavering nursing excellence

Advancing nursing excellence is ongoing—not once every 4 years when the formal Magnet document is submitted—and it shouldn't be pushed aside during a pandemic or other crisis. Instead, the Magnet model components should be used as a framework for meeting the crisis. The COVID-19 pandemic has presented many new challenges, and nurse leaders have relied on the Magnet culture to navigate them. The MPDs' primary focus has changed during the pandemic, but it hasn't wavered from ensuring that nursing excellence is captured, described, and demonstrated. AN

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Pathway to Excellence® in long-term care organizations

This framework can help improve the practice environment for nurses.

By Edna Cadmus, PhD, RN, NEA-BC, FAAN, and John R Mastrocola, BS

The COVID-19 pandemic has prompted nurses to examine the long-term care environment and some of the ongoing issues that plague these facilities. Gaps and disparities highlight the need to focus on these settings and provide strategies, such as the Pathway to Excellence in Long Term Care® Program (PTE-LTC) to address concerns aggravated by the pandemic. The PTE-LTC designation, created by the American Nurses Credentialing Center, recognizes organizations that create a positive work environment to empower and engage staff. Applying PTE-LTC's standards (leadership, shared decision making, safety, quality, well-being, and professional development) builds engagement and resilience of staff (both nurses and unlicensed assistive personnel such as certified nurse assistants), resulting in improvements in quality and safety for residents.

Leadership

Leadership buy-in is key to a successful PTE-LTC journey—a journey well worth committing to. By creating a positive work environment, PTE-LTC's framework helps improve staff recruitment and retention and—ultimately—care quality. Leadership plays a part in that environment by supporting shared governance and facilitating collaborative decision making.

Directors of nursing in long-term care need to be supported in their leadership work, especially during the pandemic. As one director of nursing for a small facility described, "I'm … feeling the weight of the world on my shoulders now. Our nursing home has nursing assistants and housekeepers who work two and three jobs to pay their bills." The director adds that many staff are afraid to come to work and frequently express their anxiety. Many nurse leaders are under similar

stress to maintain care quality and reassure staff; PTE-LTC can help them address issues brought to the forefront as a result of the pandemic.

Administrators and owners of long-term care facilities should understand that PTE-LTC designation provides the return on investment facility administrators and owners may be looking for. The return on investment calculator can be downloaded at nursingworld.org/organizational-programs/pathway/apply/fees/fee-calculator-form.

Shared decision making

Shared governance gives everyone a voice in their practice. It builds on nurses' and certified nursing assistants' strengths and brings them together to provide input into their work environment. Unfortunately, few long-term care facilities have a shared governance structure. The director of nursing and other organization leaders can support staff by facilitating networking, collaboration, and idea sharing and by creating a structure that fits the organization's size and focus.

Safety

This standard includes resident and staff safety and a workplace free of incivility, bullying, and violence. Safety also relates to protection of staff from infection. Infections are one of the leading causes of morbidity and mortality among nursing home residents and are frequently attributed to low staffing levels and inadequate resources. These issues have been exacerbated during the pandemic, when lack of resources limited facilities' ability to contain the virus. Most long-term care facilities are unprepared for the threat of a widespread infection, and they don't have a full-time nurse who serves as an infection control preventionist to ensure all staff are using proper infection control techniques. It's important for nurse leaders to ensure access to personal protective equipment (PPE) and realignment of resident rooms to prevent infections.

Quality

All long-term care should be person-centered and evidence-based, and quality care indicators should show continual improvement. Castle and colleagues examined deficiency citations for infection control in nursing homes and found that staffing levels for all caregivers were associated with deficiency citations. This finding also may be applied to nursing homes that enforce consistent staffing and refrain from rotating staff through multiple facilities, which may have better outcomes with regard to reducing COVID-19 spread among residents and employees.

Director of nursing and staff turnover increases costs and decreases care quality. Evidence supports that a healthy work environment can improve care quality and staff retention. An integrative review by Rajamohan and colleagues suggests that job satisfaction increases nursing home care quality and residents' quality of life. The researchers also found that organization leadership support and person-centered care correlates with improved care quality, staff satisfaction, and staff retention. Therefore, workforce skill mix and engagement should be considered.

Steps to excellence

Self-assessment: Start your Pathway to Excellence in Long Term Care® (PTE-LTC) journey with a workplace culture self-assessment to identify gaps between your organization's actual and desired state. Engage staff and leaders in this process and create a roadmap to build on the organization's strengths and discover strategies for improving the work environment. Appoint a PTE-LTC program director to ensure timelines are followed and stories are collected.

Documentation and standards: Register for a PTE-LTC application. This starts the clock for document submission.

Validation: After you've submitted the documentation, a survey is administered to organization nurses (RNs, advanced practice RNs, and licensed practical nurses) and certified nursing assistants to validate the enculturation of the standards into the work environment.

Many resources—including workshops, webinars, a pre-intent program, a learning community, an annual conference, and a dedicated staff—are available to guide organizations through this journey. Learn more about PTE-LTC at nursingworld.org/organizational-programs/pathway/overview/pathway-to-excellence-in-long-term-care/.

Well-being

The well-being standard, which supports staff physical and mental health, is one of the defining hallmarks of PTE-LTC. Staff working in long-term care facilities endure difficult situations and accompanying stress, making strategies to improve their well-being essential. A thematic analysis of databases by Embregts and colleagues identified the potential impact of infection outbreaks on the psychological state of long-term care staff. The researchers identified three themes: emotional responses (fears and concerns, tension, stress, confusion, and no additional challenges), ethical dilemmas, and reflections on work attendance. Identified suggestions to support and protect staff include education, information, housing, equipment, and infection control policies and guidelines. Organizations can use these suggestions to build a sense of well-being in their facilities and a positive work environment during the pandemic and beyond.

Professional development

Leaders must ensure that nursing staff are competent and provided with education beyond mandatory state or federal requirements. For example, many nurses felt unprepared at the beginning of the pandemic, so emergency preparedness should be incorporated into all long-term care facilities' professional development pro-

grams. Another advantage of education as a tool for professional development is that it enhances staff engagement. (See *Steps to excellence*.)

Why now more than ever?

Nurses voices can help shape the future of long-term care. The care inequity experienced by residents in these facilities during the pandemic must never happen again. System facilitators and barriers must be addressed to ensure this vulnerable population's healthcare needs are met. Directors of nursing can lead this initiative and gain buy-in from facility owners and administrators. Too frequently, however, directors of nursing don't have a strong voice in shaping the organization, so top leadership must make a commitment to change.

We applaud the nurses and staff working in long-term care during this pandemic, but we can't accept what happened and go back to business as usual. Investing in long-term care staff is a powerful way to change the course of healthcare and improve patient outcomes. Now is the time to make revolutionary changes and take the PTE-LTC journey. AN

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Professional governance and staff engagement

A new medical unit establishes an engaged nursing workforce.

By Teresa Costley, APRN, MSN, ACNS-BC, and Diaz Clark, APRN, MSN

Establishing a new medical unit in a large academic hospital presents opportunities and challenges. At Emory University Hospital in Atlanta, an unbudgeted new unit, led by experienced nurse leaders (unit director, clinical nurse specialist [CNS], and clinical nurse/charge nurse), surmounted its first challenge (staffing) by starting primarily with contract staff. However, in just over a year, they filled all positions, eliminating the need for contract nurses. From the beginning, unit leaders acknowledged an opportunity to create a culture grounded in teamwork, shared governance, and accountability for patient outcomes. The challenge then became: How to effectively establish this culture within a diverse team?

Building a professional governance culture

The unit's nurse leaders understood Tuckman's stages of team formation—forming, storming, norming, and performing. (See *4 stages of team formation*.) During this process, several themes emerged, including teamwork, professional (shared) governance, accountability, and ownership of patient outcomes. Porter-O'Grady's description of empowered work environments, where those accountable for outcomes make decisions about the work, resonated with the leaders. Professional governance empowers nurses to own the outcomes of their practice and advocate for the resources necessary to improve patient care and the work environment.

4 stages of team formation

Tuckman identified four stages of team formation.

Stage 1—Forming: The team comes together and gets acquainted. Relationships are formal, and leaders within the group are emerging.

Stage 2—Storming: This stage is characterized by conflict, pushing boundaries, and competition as individual personalities become more apparent. Staff performance may decrease as a result of energy spent on nonproductive activities, leaving leaders discouraged.

Stage 3—Norming: Conflicts are resolved, and agreement is reached on common goals.

Stage 4—Performing: The team works together without friction to achieve its goals.

To develop this culture and engage nurses in making practice decisions and advocating for resources to improve the environment and care outcomes, the nurse leaders established a unit practice council (UPC).

Creating a UPC

The unit leaders identified nurses and nurse technicians on both shifts who displayed enthusiasm and creativity to serve on the UPC. The clinical nurse leader, a bedside nurse with experience leading clinical initiatives, serves as the UPC chair. The CNS is a non-voting member who serves as an internal clinical expert, connects the UPC to other resources within the organization or the healthcare system, presents outcome data, collaborates with the council members to establish priorities, and mentors them to identify the best decision-making evidence. The unit director is an ad hoc member the UPC can turn to for help finding resources and setting the scope of the UPC's work.

During a kick-off meeting, council members established initial goals and priorities and created a purpose outlined in the UPC charter. The charter (based on a model charter available from a system-supplied toolkit) includes the council's mission, vision, and values as well as its operating procedures, including officer elections and meeting frequency. The UPC then brainstormed key issues related to patient care and safety, including teamwork, communication between the nurses and nurse technicians, unit involvement in strategic quality initiatives, and improving the existing bedside shift report structure.

After finalizing the charter, shared goals, and strategic initiatives, council members created a clear communication structure using ISBAR (**I**dentification, **S**ituation, **B**ackground, **A**ssessment, **R**ecommenda-

(continued on page 44)

Staying accountable

The accountability spreadsheet serves as a visual aid on the unit to ensure that committee members and other initiative champions submit reports outlining progress toward identified goals. The assigned unit champions enter the check marks after they've attended the monthly meeting; champions also submit a report to the unit practice council (UPC). After verifying attendance and receipt of the report, the UPC chair changes the check mark to a blue dot. A red dot indicates the unit champion didn't attend the meeting; in this case the CNS follows up with the champion.

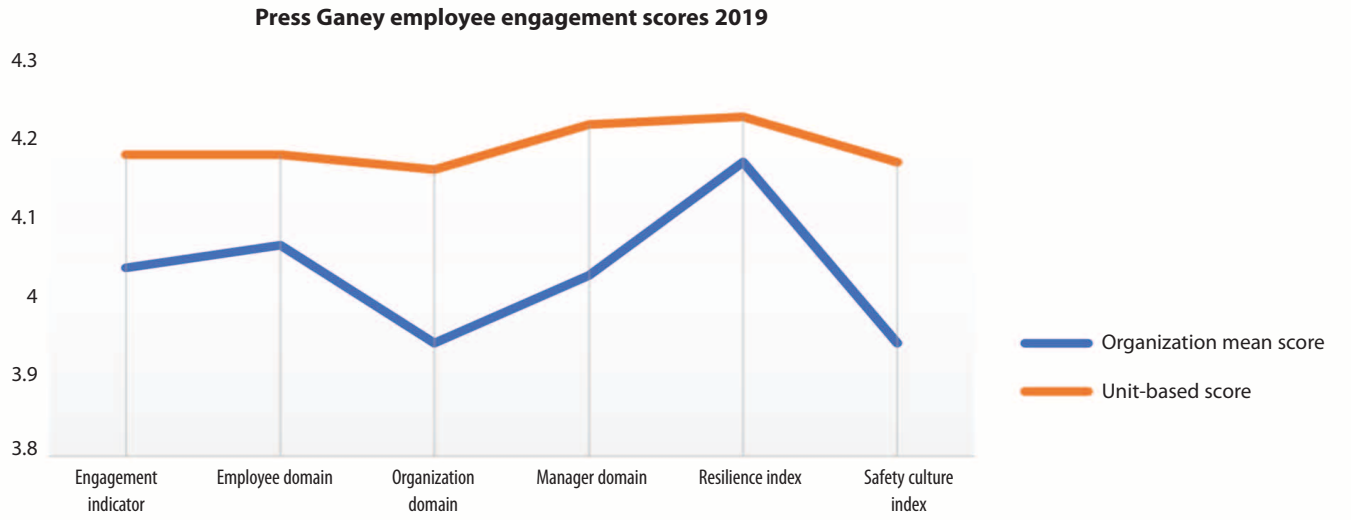
Committee accountability spreadsheet

Committees	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
CAUTI	●	●	●	●	●	●	●	●	●	✓		
Code MET	●	●	●	●	●	●	●	●	●	✓		
Diabetes	●	●	●	●	●	●	●	●	●	✓		
EOC/safety	●	●	●	●	●	●	●	●	●	✓		
Exemplary professional practice	●	●	●	●	●	●	●	●	●	✓		
Falls prevention	●	●	●	●	●	●	●	●	●	✓		
Infection prevention	●	●	●	●	●	●	●	●	●	✓		
Magnet	●	●	●	●	●	●	●	●	●	✓		
PLAN	●	●	●	●	●	●	●	●	●	✓		
Professional development council	●	●	●	●	●	●	●	●	●	✓		
Restraints	●	●	●	●	●	●	●	●	●	✓		
Skin integrity	●	●	●	●	●	●	●	●	●	✓		
Staffing	●	●	●	●	●	●	●	●	●	n/a		

EOC = environment of care, MET = medical emergency team, PLAN = professional lattice for advancement in nursing

Engaged workforce

Based on results for six key areas (each ranked on a scale of 0 to 5), employee engagement scores indicate that the new unit operates above the organization mean.



tion). This format allows nurses to identify an issue, describe the situation that caused the issue, provide background information, assess the issue, and make recommendations for improvement.

The UPC chair then developed communication tools and protocols, including an ISBAR form, bulletin board,

and monthly meetings and committee reports. In addition, UPC members developed a committees accountability spreadsheet.

ISBAR form

When nurses want to communicate with the UPC about an issue, they complete an ISBAR form, which the council uses to analyze the concern, create an action plan, measure the impact of the solution, and follow up with staff. (To view an ISBAR form, visit myamericannurse.com/?p=70137). To ensure individual nurse anonymity, ISBAR forms are submitted via a locked UPC box.

Bulletin board

The UPC uses a bulletin board to communicate with the unit about council members and initiatives, new ideas, and current projects. A section of the bulletin board titled "Your Voice—We Listened!" shares action plan follow-up and decisions that impact patient care.

Monthly meetings and committee reports

At each monthly UPC meeting, an agenda guides the items for discussion, although members may raise other items of high importance. Nurses and nurse technicians who participate in quality initiatives and committees submit a monthly committee report to update the UPC and other team members about what's happening across the organization. (To view a monthly committee report form, visit myamericannurse.com/?p=70137.)

Accountability spreadsheet

The committee accountability spreadsheet is used to ensure that council members and other initiative champions submit reports outlining progress toward identified goals. It also serves as a visual reminder for the staff to attend meetings, so information is brought back to the UPC for dissemination. (See *Staying accountable.*)

UPC projects

Examples of current UPC projects include tools in patient rooms for nurses and nurse technicians to communicate with patients and each other, a standard bedside shift report process used by nurses and nurse technicians, and a buddy system for staff breaks. The UPC also monitors quality outcomes on the unit, such as catheter-associated urinary tract infection (CAUTI) and hospital-acquired pressure injury (HAPI) prevention.

Outcomes

Engaging staff using the UPC model and creating a supportive practice environment has resulted in nurse-sensitive outcome and patient and staff experience measures that outperformed the benchmarks for most of the preceding six quarters (four before the UPC was implemented and two after). During the new unit's first year, no CAUTIs were reported. Team members identified one HAPI during quarterly prevalence rounds. Eradicating HAPI on the unit became a strategic goal. The action plan included education, reviewing risk re-

duction strategies, and performing "it takes two" assessments (two sets of eyes to assess the skin when patients are admitted).

On organizational staff engagement surveys, this unit outperformed the mean—they're engaged and less likely to express an intention to leave, and they perceive their work as high quality and that they have control over unit decisions. These high engagement scores illustrate that the unit has progressed from the storming to the norming phase of team formation. (See *Engaged workforce.*)

Supported and trusted

High nurse and nurse technician engagement on this new unit facilitated top performance in the care transition domain of the Hospital Consumer Assessment of Healthcare Providers and Systems survey. Scores averaged in the 95th percentile within two quarters of opening the unit. Patient experience scores have ranked in the top 25th percentile for the past 6 out of 7 months and have ranked in the top 10th percentile for the past 4 out of 7 months.

Although the unit expanded from 14 beds to a maximum capacity of 23 beds within a year, the UPC developed an innovative model to engage newly hired staff members in creating a practice environment that supports quality outcomes and promotes a safer environment. Clinical nurses at the bedside drive improved practice, and the professional governance structure conveys a message that nurses are supported and trusted to make critical decisions that impact patient care. AN

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Jefferson Health

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Jefferson Health, home of Sidney Kimmel Medical College, is reimagining health care in the greater Philadelphia region and southern New Jersey. Jefferson's dedicated team of doctors, nurses, health professionals and staff provides a range of primary to highly-specialized care through 14 hospitals (seven are Magnet®-designated by the ANCC for nursing excellence), more than 40 outpatient and urgent care locations, the NCI-designated Sidney Kimmel Cancer Center, Magee Rehabilitation and the JeffConnect® telemedicine program. For 2020-2021, Thomas Jefferson University Hospitals is ranked among the nation's best hospitals in nine specialities by *U.S. News & World Report*. Jefferson Health's mission is to improve the lives of patients in the communities it is privileged to serve through safe, effective, equitable, compassionate care.

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