Box 1. 2013 Spotlight

1. Sustained highly satisfied rating in RN NDNQI job enjoyment and PES scale
2. Majority of NDNQI clinical indicators at or better than benchmark
3. Inpatient satisfaction sustained at the 99th percentile
4. ED satisfaction sustained at 95th percentile (50 K visits/year)
5. 19 advanced and 4 experts in total since opening
6. 63% BSN and 29% certified nurses (above the benchmark)
7. 95% National patient safety goals at top decile (3rd quarter at 100%)
8. Joint Commission Disease-Specific Certification in Heart Failure

ED, emergency department.

Advancement is discussed at time of hire, and the BHSF clinical ladder for professional nursing advancement is introduced to all nurses with education to resources and processes to advance. The journey to advancement generally starts during 1-on-1 nurse leader rounding meetings. At this time, professional development goals are discussed and an individual development plan created.

The program advances nurses from novice to proficient at 2 years of nursing experience, on to advanced and expert. Advanced nurses are expected to be enrolled in a BSN program, be certified in their specialty, and identify a clinical practice change using the CETEP model. Expert nurses are expected to have completed their BSN and an evidence-based project using the CETEP model. The structure of WKBH's collegially supportive model and a culture that values professional development, reduced barriers and fears with the advancement process, and strengthened staff personal commitment to nursing excellence. This includes library support services and a research specialist dedicated to promoting and teaching research and EBP. Thus, by the end of 2012, in less than 2 years, 12 nurses had been promoted to advanced nurse and 2 nurses had been promoted to expert nurse. Additionally, throughout WKBH, 60% of all nurses had a BSN, and 23% were nationally certified, which exceeded the NDNQI benchmark for like-sized hospitals.

Generating New Knowledge and Innovation

Building, supporting, and sustaining a culture of inquiry through shared governance stems from nurses' having opportunities to take part in EBP and research studies. Although utilizing the CETEP model is a requirement for advancement in the identification of clinical practice questions and the development of EBP projects, the decision to take part in and lead research projects is ignited by the passion of nurses to question and change clinical practice. Through the mentorship and guidance of the WKBH research specialist, nurses are supported from conception to dissemination of their research studies. Thus, WKBH has over 12 institution review board–approved research studies that are either developed by or include direct patient care nurses in the research team. One such example, in 2011, is one of our medical-surgical nurses who lead a small nursing team, with the support of the WKBH research specialist, through the development and dissemination of a study examining the impact medication cabinets in medical-surgical patients' rooms had on nurses' satisfaction with medication administration without altering medication charge accuracy and errors. Not only has this study been disseminated at local, national, and international conferences, but it is a step in an exemplar of transformational leadership. Since this initial research study, the lead nurse has moved on through the PNAP clinical ladder from advanced nurse to expert nurse and is now leading an interprofessional research team on a study funded by the Academy of Medical-Surgical Nurses.

CONCLUSION

As part of the executive planning, 4 guiding principles were established for the hospital: service, quality, diversity, knowledge. Knowledge was used to represent the learning organization culture WKBH was establishing. The evidence of WKBH living their principles can be seen in the coming together to open a new hospital; applying their orientation lessons in drills to assure safety; nursing's commitment to use of EBP and research in improving care; their enthusiasm for professional development (including the use of CETEP, and embracing the new family medicine medical students and residents from Florida International University. Furthermore, the results are self-evident in the high patient and family satisfaction, physician satisfaction, nurse satisfaction, core measures, and NDNQI bench marking. The outcomes validate the WKBH nursing mission and the journey takes us to our vision, Magnet designation. It is through the journey that we have seen our collaboration, communication, and celebration enhanced; our pride in practice increase; and most importantly, the delivery of exceptional care to our patients and families. This is reflected. not only in the mentioned results for 2012, but also the WKBH current 2013 accomplishments (*Box 1*).

On a final note, a lesson learned: it is easier to create a culture than to change a culture. Not to forget is that the exceptional culture and resources of Baptist Health South Florida was a natural springboard for launching the strategic vision of obtaining Magnet within 2 years.

Note: WKBH submitted their application for Magnet Recognition in February 2014. NL

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Coach as Chief Correlator of Tasks to Results Through Delegation Skill and Teamwork Development

Ruth I. Hansten, RN, PhD, FACHE

Many are stubborn in pursuit of the path they have chosen, few in pursuit of the goal.[1]

—Friedrich Nietzsche

As leaders, we can effectively coach our point-of-care registered nurses (RNs) and practice councils by employing the most crucial of leadership skills: that of drawing a word picture line from the tasks and processes to be completed, to the patient's/family's intended results. As chief correlators, we use stories that link work to individualized outcomes to instill a sense of purpose and create a common language and understanding of the impact made by the team.

Illustrations of work-to-results association re-energize our coworker's sense of urgency and connection to each other in the processes of helping the patient achieve his or her goals. A patient/family outcomes orientation helps the RN think more effectively about the care processes that must occur in order for the patients to achieve their preferred results, and assists in development of critical thinking and clinical reasoning.[2]

Planning for best results means optimal staffing skill mix, and maximizing the efforts of all team members, including assistive personnel such as nurse's aides, technicians, unit clerks, nursing assistive personnel (NAPs) or unlicensed assistive personnel (UAPs). The complexity of today's patients requires all employees to exert their finest efforts all shift. Too often, technicians may await the time clock ticking, and some employees "Facebook" in the supply room while patient care needs go unmet. As nurse leaders, we leverage the brains and clinical expertise of all the RNs to guide and supervise NAPs effectively so that all engage fully in their healing work. Experienced workers and athletes alike can compare teams on which they've served and are able to identify the various factors that create synergy. When 4 efficient, industrious, trusted colleagues direct their energy toward their shared goals, more work is actually completed in a congenial and organized atmosphere than with 6 novice, unfamiliar, or lethargic colleagues that don't know the destination or how they'll get there.[3]

USING A SHARED MENTAL MODEL (SMM) AS A TEMPLATE FOR ACTION

A shared mental model (SMM) has been used effectively in healthcare and beyond to improve communication within complex circumstances, enhancing both explicit and implicit communication, and has been recommended for improving teamwork and decreasing care omissions.[4,5] A map, blueprint, or structure for work promotes a shared language and model by which actions are compared, and becomes a shorthand for work processes and eases complicated mentation. Using the concepts of the best delegation and supervision practices as a shared mental model for application-in-action, the nurse leader coach teaches while encouraging development of unit processes that will ultimately improve patient/family results and staff satisfaction.[6]

The National Council of State Boards of Nursing (NCSBN) and American Nurses Association (ANA) Joint Statement on Delegation and Supervision of assistive personnel structures the 5 Rights of Delegation. "The RN uses critical thinking and professional judgment when following The Five Rights of Delegation, to be sure that the delegation or assignment is:

1. The right task
2. Under the right circumstances
3. To the right person
4. With the right directions and communication; and
5. Under the right supervision and evaluation."[7(p.2),8(p.83)]

Nurses may be uncertain as to how to grasp these point-of-care leadership concepts, the definitions of "supervision" or "assignment," and make them come alive each day as a part of the care blueprint. RNs may not envision how to seize these ideas of matching the "right task under the right circumstances with the right person"[7] into their normal unit routines because they have become accustomed to sending off the NAPs to "just do their jobs" without individualized individual direction.

The 5 Rights become a useful mental device on which to center a discussion of the impact of point-of-care work processes. Comparing the shared mental model of the 5 Rights with actual action, with a leader's coaching, care team members can evaluate their daily work against these basic principles.

Step 1: Raising Awareness of the 5 Rights and Teamwork's Present State

The first step is raising awareness. As recommended in their Nurse Executive's Coaching Manual, McNally and Cunningham[9] observe that *awareness* leads to *insight* leads to *action*. Discussions during orientation, staff meetings, unit councils, or a yearly education update can be used to help RNs and NAPs review the facts of their state's Nurse Practice Act and the 5 Rights. Unfortunately, too often the knowledge remains disconnected from application to practice.

Step 2: Applying the 5 Rights to Point-of-Care Teamwork to Leadership Rounding: Promoting Insight

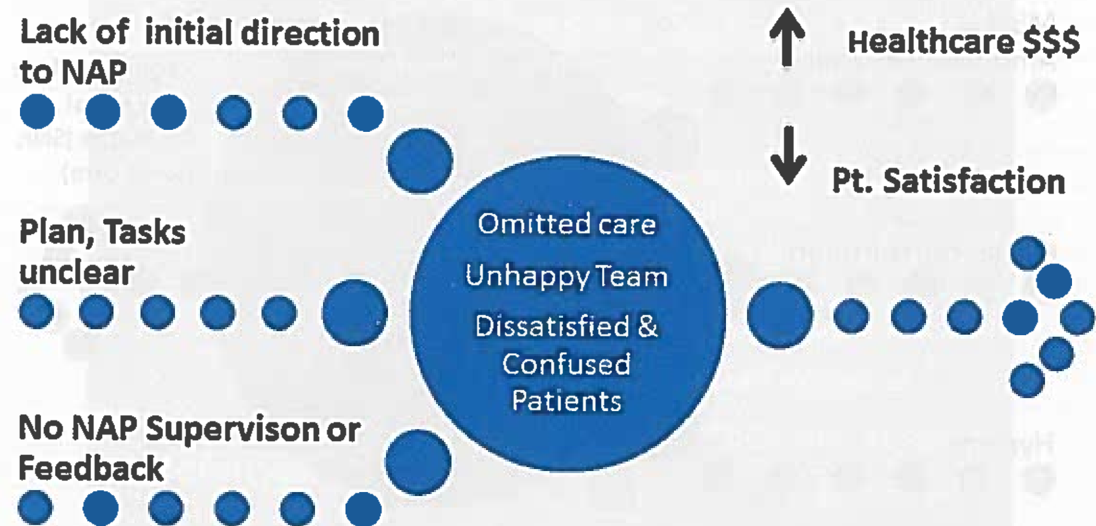
After a group or team has understood the basic concepts related to team accountability, a coach is ready to help the group forge facts and knowledge into awareness. In coaching, a leader often asks open-ended questions to help the employee or colleague correlate his own actions with personalized preferred results or goals, thus affirming the individual's ability to think through the situation and alter her practice. The individual nurse is the owner of her professional practice and can change in light of the team goals and what she can choose to do differently. Some coaching questions, designed to promote insight, whether used in unit councils or individually, may include such queries as these below:

"1. How would you rate the level of teamwork among point-of-care or bedside care providers recently?
- Excellent
- Good
- Fair
- Poor

Why? What is missing?

2. On this shift, how well do we use the 5 Rights of Delegation in our work? How would you rate our assignments matching the competencies of our workers?
3. To whom do you now delegate or assign tasks or care processes? Please list those roles (examples could be home health aides, unlicensed assistive personnel, licensed practical nurses, surgical technicians, nursing assistants, mental health assistants).
4. What processes do you routinely use to offer initial direction to team members that fulfill the above roles?
5. In what ways do you observe or evaluate whether or not tasks have been completed?

Figure 1. Delegation/Supervision Skills Correlated With Care Omissions



6. How do you now offer both positive and negative feedback to those to whom you assign care or work tasks?
7. How frequently do you and your team debrief and evaluate how well the care processes worked?"[10(p.2)]

Real-time coaching during leadership rounding will help each RN-led team to bridge awareness to insight to meaningful action. Review an example case of Mrs. Ryan, an 88-year-old admitted through the emergency department for syncope of unknown origin. The nurse leader learns that the RN did not have knowledge of orthostatic pressures or the patient's ability to ambulate and was unsure about the patient's current mentation due to lapses in the delegation/supervision routines and team communication. After listening to shift handover at the bedside together, the leader can discuss this patient's care outside the patient's hearing. "If we haven't asked Mrs. Ryan's daughter about her dizziness, mentation, and functioning prior to her admission, we won't know about whether or not she is ready to go home, with or without help, or to an assisted living setting. And if we don't have a current report on these issues from our team member Julie CNA, our discharge map is fuzzy and we are pretty lost. Mrs. Ryan could end up back here with a broken hip from a fall. Best case scenario would be that we could save everyone a ton of heartache and pain, and our health system quite a bit of money from avoiding that readmission. What are your thoughts about how we could best retrieve this kind of home/discharge information and use it?" Inclusion of assistive personnel in the conversation would be beneficial. "Julie, what did you notice about how well Mrs. Ryan sat on the bedside? How well did she ambulate to the toilet with help? How do you normally report these conditions and how is that working?" If the nursing assistant is not routinely offered initial direction during bedside shift reports, then this juncture could be used to ask "How and when do you (RN) find out about how well Mrs. Ryan ambulates and what her lying/sitting/standing pressures have been (from the NAP)? Did the NAP know she was supposed to report those values before Mrs. Ryan's daughter arrived? How is that feedback system of communication working for you as a team? What could be done differently to overcome those communication barriers?" Next steps would consist of linking that knowledge and communication with "How can we compare what's happening to the 5 Rights of Delegation: how well are we using the most effective and efficient processes to offer initial direction and gather feedback about our shared work?"

Step 3: Tracing Work Tasks and Processes to Patient Results: Creating a Mandate for Action

When a nursing department has functioned without major errors for a few months, and if nurse-sensitive indicators such as falls, pressure ulcers, failures to rescue, and patient satisfaction percentiles aren't appalling, then some may not perceive a compelling case for improving the care team's processes. However, as chief correlator, the leader/coach would be able to tell the story of what can (and does) go wrong each day in healthcare organizations. The following figures illustrate the associations.

When delegation/supervision/assignment processes are not working well as a part of the daily routine, then NAPs work without sufficient understanding of the patient and his or her intended results, and may either not complete their tasks or perform the wrong task with the wrong patient. Confusion among team members allows for communication errors and omissions. Chaos reigns, and the patient's/family's anxiety rises along with pain levels. Because no regular plan or interval for feedback occurs, nurses and technicians alike can hold grudges and begin to withhold their assistance. People don't learn from the malfunctions in their work processes. Reflection (important for developing critical thinking) is not reinforced. Those individuals that are not doing their jobs are not noticed and/or the necessary counseling steps are not taken for them to either improve or be encouraged toward a new challenge (*Figure 1*).

The repercussions of the occasional missed care task may not seem as unsafe or persuasive when the first 1 or 2 ambulations or

Figure 2. NAP Task Omissions Correlated With Negative Clinical Impact

repositionings are missed. "After all, we were short today."

Nurses and assistive personnel in delegation workshops often state that most frequently omitted care on their units include mouth care, hygiene or baths, and ambulation or turning, and recount horror scenarios about when they learned of a problem too late. But the slippery slope of missed basic patient care must be linked with all shifts' care processes so that clear accountability can be understood. Figure 2 shows some potential results of care omissions. Using the MISSCARE Survey, Dr. Bea Kalisch and colleagues have reported on evidence related to rates of basic care omissions as a result of labor and material resources and communication.[4] Two studies inclusive of 3 hospitals (N = 459) and 10 hospitals (N = 4288) were summarized in 2010.[11] Frequently missed care elements included ambulation (84% in 2009, 76% in 2011), assessing effectiveness of medication (83% in 2009), turning (82% in 2009, 58% in 2010), mouth care (82% in 2009, 64% in 2010), patient teaching (80% in 2009), timely administration of PRN meds (80% in 2009).[11(p233-234)] Gravlin and Bittner[12] identified ineffective delegation and critical thinking, interpersonal tension, role confusion, and ineffective delivery models (2009) as root causes of omissions. Kalish and Lee[11] reported in 2010 that teamwork alone accounted for about 11% of missed care. Additionally, although NAP reporting gaps were not depicted as a potential care task omission in Figure 2, the crucial processes of missed recognition and/or reporting of vital signs, blood glucose, mentation, or urinary output could result in a failure to rescue (FTR) and patient demise.

Step 4: Proactive Action: Point-of-Care Knowledge and Processes as Defense to Avoid Negative Consequences

With the knowledge that care is being missed, at least partially because of improper delegation, teamwork, and ineffective care delivery processes, and there are deleterious results to patients and the health of our communities, what then should be done? If our intent as nurse leaders is to improve delegation and supervision, critical thinking, problem solving, and shared decision making within our teams, then we can use coaching processes to help them choose to change their unit processes to apply new knowledge, awareness, and insight. Figure 3 adapts James Reason's ubiquitous Swiss Cheese Model to specific patient safety defenses related to RN/NAP teamwork.[13] This model illustrates delegation processes as a method to avoid healthcare acquired conditions, errors, or missed care. A graphic such as this can initiate discussions related to the point-of-care processes used in each department for teamwork accountability and patient safety.

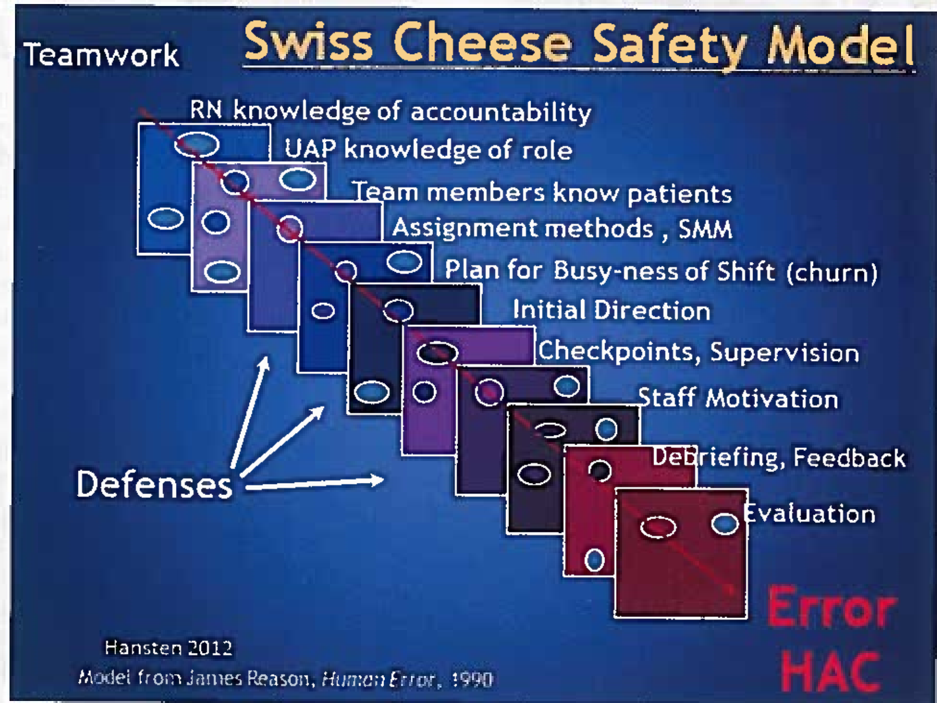
REVIEW NEXT STEPS AS CHIEF CORRELATOR AND COACH

1. Use facts and knowledge and a shared mental model to create awareness. Nurse Practice Act regulations and the shared mental model of the 5 Rights will raise *awareness* of RN/NAP responsibility. Nurses are often surprised to see, in writing, that they are expected by their state practice board to offer initial direction, feedback, supervision, and evaluation, and that each person is accountable for fulfilling their own roles.[14(p52)]

2. Contrast the 5 Rights with actual department routines. Use coaching questions to further raise *awareness* of actual practice contrasted to standards. Discuss what you have learned about department satisfaction with teamwork processes. During change of shift handover or during rounding, specific patient situations can be highlighted in terms of RN/NAP teamwork and reciprocal reporting and feedback.

3. Coach toward insight as patient care implications are realized. Compare the impact of completed care with the consequences of care missed. The chief correlator coach promotes professionals to gain *insight* as research evidence related to care omissions is revealed. When coupled with patient scenarios and the actual impact of care that has been (or could have been) missed within each shift, a burning platform for action is identified. The potential cost to our patients in healthcare acquired conditions (HACs) supersedes any reticence to take on the mantle of leadership at the point of care.

Figure 3. Swiss Cheese Safety Model



4. Help the team move from awareness, to insight, to action.[9] Unit councils, staff workgroups, and professional practice committees can toil together to create shared mental models as maps for working together seamlessly. At the very least, these blueprints should reflect the 5 Rights of Delegation-in-action to become team shift plans. Include shift-by-shift work routines to allow for best assignment, initial and individualized direction for patient care with parameters for reporting, clear lines of RN/NAP accountability, checkpoints before and after breaks and meals, and time to debrief processes and offer personalized feedback.

As chief correlator, the nurse leader will be able to highlight the outcomes of successful model implementation with patient metric improvements through better delegation and teamwork. Coaching processes used to promote teamwork will also influence RN critical thinking from task-based to results-oriented, ownership of professional practice, and point-of-care leadership. Fewer care omissions will be manifested in improved nurse-sensitive indicators such as patient satisfaction and avoided errors. The nurse leader as coach connects the dots and tells the stories of completed care and ensuing health outcomes: fewer falls with injury, improved skin care, happier patients and families, satisfied nurses and NAPs, and saved lives. NL

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Ruth I. Hansten, RN, PhD, FACHE, is principal consultant for Hansten Healthcare PLLC, in Port Ludlow, Washington. She can be reached at Ruth@Hansten.com.

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