EP21: Describe and demonstrate the structures and processes that support shared leadership/participative decision-making and promote nursing autonomy.

Riverside Medical Center has supported shared leadership/participative decision-making and promoted autonomy in nursing practice. Through implementation, dissemination, and enculturation of our structures and processes, our nurses at all levels and in all departments have achieved a level of autonomy in the practice of professional nursing that is congruent with our policies and our state practice act.

Foundational Models

Our foundational Vigilance Professional Nursing Practice and Nursing Care Delivery Models serve as supporting structures for shared/participatory decision-making and nursing autonomy. The elements of the Vigilance models that support this source of evidence follow.

Vigilance Professional Nursing Practice Model Components

Organizational Vigilance: The continual observation, detection, interpretation, and communication of the changing needs and expectations of external and internal sources that result in creating purposeful change.

- **Shared Governance** - Organizational structures and processes that demonstrate a commitment to empower professional nursing staff’s and managers’ active engagement in policy- and decision-making. Nurses engaged in shared decision-making influence their professional practice environment and define, promote, and evaluate consistent nursing practice.

(Nursing Care) Vigilance: The primary abilities the nurse needs to have for vigilant nursing care within the work environment. The nurse’s watchful, continual oversight of the patient’s changing needs and responses resulting in effective clinical judgments, nursing actions, and intended outcomes.

- **Collaboration** -The ability to partner with others to achieve intended outcomes.

Professional Nursing Characteristics:

- **Evidence Based Decision-Making** - Systematic application of the best available evidence to evaluate options and make decisions in clinical situations.

- **Autonomy** – Recognition of the privilege to make decisions which are not subject to authoritative review by those outside a self-regulating professional body.

Vigilance Care Delivery Model Components
• **Transformational Leadership and Shared Decision-Making** - Consistently and appropriately effects change through engagement, involvement, and participation of peers and colleagues, leading others where they need to be rather than where they want to go.

**Illinois Nurse Practice Act**

The practice act for our state defines the levels of autonomy allowed for nurses at all levels – Advanced Practice Nurses (APNs), Registered Nurses (RNs), and Licensed Practical Nurses (LPNs). Every state differs in the levels of autonomy for nurses, especially for APNs. In the state of Illinois, APNs must have collaborative agreements. For more information or to view the Illinois State Practice Act, visit the website at [http://www.idfpr.com/dpr/WHO/nurs.asp](http://www.idfpr.com/dpr/WHO/nurs.asp)

In addition to the state practice act, nursing practice is governed by Riverside’s policies and procedures. Thousands of policies exist; those under the auspices of Patient Care Services outline, define, and clarify the role of the nurse and the scope of practice for each role (APN, RN, LPN). Few LPNs work in the hospital. In accordance with the state practice act, our policies delineate the scope of our practice, such as the types of procedures, skills, and decisions licensed nurses are allowed to make.

**Councils and Committees**

Several councils and committees serve as structures for promoting autonomous practice and participative/shared decision-making at Riverside Medical Center. One is the Patient Care Council (PCC), which has been described and mentioned in many of these sources of evidence. Following is an excerpt from SE1, which explains the structure, development, communication and reporting processes, of the PCC.

In the fall of 2006 as part of our organizational budgeting process, we chose to dedicate resources to support development of the Patient Care Council to drive clinical practice and nursing engagement within Riverside Medical Center. By October 2006, the process for populating the Councils with direct care staff nurses began as supported by Senior Management and our Board of Directors. Charters describing the Councils and requesting nursing representatives from all specialty areas were distributed to Nursing Leaders organizationally. Managers and Team Leaders personally shared the new Council purpose and structure with nurses, and in turn, nurses requested to join the Councils with approval determined by their nursing leader based upon being a role model of practice in good performance standing, and based upon being committed to the vision, time and active participation required as a Council member.

In January 2007, facilitated by the CNO, David Duda and Magnet Coordinator, Vicki Haag, the Patient Care Council launched their first-ever monthly meeting with 61 Council regular and ad hoc members not only from Nursing, but from Pharmacy, Respiratory, Radiology, Human Resources, Dietary, Education, Information Services, Laboratory, and Library Services, and other nursing departments across our health care
continuum (e.g. Home Care). The overall Patient Care Council is comprised of four individual Councils: Evidence Based Practice and Research Council, Professional Development Council, Quality and Safety Council, and Practice Council.

At the kickoff meeting, each Council member participated in training on meeting participation, group decision making guidelines, and dealing with group dynamics. Then, each Council separately met to get to know one another, review the individual Council charter and goals of their Council, and determined meeting ground rules for their team. Since 2007 through 2010, the Patient Care Councils have met each month jointly for start-up announcements and presentations, break out for individual council meetings, and then rejoin at the end of the Council Day for a collaborative report-off of work completed within all four Councils and describe plans for the next month to allow for communication sharing and report back to the departments/units they represent.

**Purpose and Structure of Patient Care Council's Four Sub-Councils:**

The purpose and structure of each Patient Care Council sub-Council is described below:

**Evidence-Based Practice/Research Council Key Tasks/Responsibilities:**
- Educate and inform Riverside staff of evidence-based practice (EBP) and research implementation
- Develop approval process and practices for implementing EBP and research projects
- Consult with departments and units to plan, develop, implement, evaluate, and incorporate EBP and research into practice.
- Partner with area schools to integrate EBP and research into collegial relationships.

**Practice Council Key Tasks/Responsibilities:**
- Establish, implement, and monitor exemplary communication processes related to shift-to-shift report, hand-off communications, medication reconciliation, etc.
- Develop and monitor interdisciplinary and peer practice review protocols.
- Implement nursing and ancillary case reviews.
- Review, pilot, and or implement new equipment, policies, and procedures, involving staff from nursing and ancillary areas.

**Professional Development Council Key Tasks/Responsibilities:**
- Promote a continuous learning environment at Riverside HealthCare
- Establish a process and structure for allocating monies for professional advancement (certifications, degree completion programs, etc.)
- Develop structures and processes for recognizing and rewarding professional advancement.
- Develop structures and processes for promoting the image of professional nursing, internally and externally.
Quality & Safety Council Key Tasks/Responsibilities:
- Review, plan, develop, and implement quality and safety practices
- Monitor, evaluate, and improve clinical processes and outcomes
- Promote ongoing performance improvement processes and practices
- Reduce errors through problem solving (i.e., medication errors, falls, restraints)
- Review Unusual Occurrences

Patient Care Council Membership Structure and Process

This Patient Care Council that launched in 2007, continues in meeting for one day per month, and as when the Council first started, it still has the same four sub-Councils. However, some of the names have changed although the areas of participation are generally the same as shown in the annual rosters as summarized below.

Evidence-Based Practice/Research Council Membership includes:
- RNs:
  - Direct Care
  - Ancillary Depts.
  - Team Leader
  - Clinical Resource Management
- ANCILLARY/OTHER:
  - Rehab Services Therapist
  - Librarian

Practice Council Membership includes:
- RNs:
  - Direct Care
  - Ancillary Depts.
  - CNS
  - Infection Control
  - Radiology
  - Cancer Center
  - Team Leader
- ANCILLARY/OTHER:
  - Ambulance EMT/Paramedic
  - Respiratory Therapist

Professional Development Council Membership includes:
- RNs:
  - Direct Care
  - Resolve Center
  - Home Health
- Educational Services
- Miller

**ANCILLARY/OTHER:**
- Dietitian - Ad hoc
- Director, Educational Services
- Vice President, Human Resources - Ad hoc
- Recruiter, Human Resources

**Quality & Safety Council Membership includes:**

**RNs:**
- Direct Care
- Ancillary Depts.
- Team Leader
- Quality Improvement

**ANCILLARY:**
- Pharmacist
- Radiology Tech
- Lab MT or MLT
- Respiratory Therapist

To share the developmental opportunity and perspective that being a member of these Councils provides, membership on a Council is expected to last for a minimum of a 12 month term, with a more experienced leader from the organization assigned as Facilitator of the Council, and a Chairperson and Co-Chairperson assigned who are in staff level roles to lead each of the four Councils. The Facilitator mentors the staff member Chairpersons in order to develop their leadership skills in running a meeting-including decision making and managing conflict/group dynamics. The Chairperson is responsible for running the meeting with assistance from the Facilitator and the Co-Chairperson. At the end of the 12 month term, Council members are asked if they wish to continue for another 12 month term, step off the Council to give someone else the developmental opportunity. In the case of the Chairperson, the Chairperson may transition off the Council or to a member role, with the Co-Chairperson then assuming primary meeting leadership duties for the Council, and a new Co-Chairperson appointed from existing Council members.

The goal each year of all four Councils making up Patient Care Council has been to have about 50% turnover of members to provide for that development each year. What we discovered in many Councils is it takes 12 months to move the Councils to a norming stage of team development because of meeting frequency, and the volume of work and knowledge required for assignments being completed each month. As a result, we do not force turnover each year but allow each Council with their Facilitator and Chairpersons to evaluate progress and encourage turnover by inquiring if staff want to transition off the Council to give someone else an opportunity. As our Councils have
matured—it has been increasingly challenging to have turnover as the staff are engaged and enjoying the opportunity to make a difference.

**Structure of Patient Care Council Day and Communicating Results**

Each month, Patient Care Council Day begins at 8AM with all four Councils convening in Johnson Lecture Hall at the Medical Center. The first hour of the meeting includes updates on a variety of topics ranging from national conference updates presented by the staff nurses Riverside sent to the ANCC National Conference, to hearing the Nursing Strategic Plan from our VP of Nursing Services, to an update and Question and Answer time on organizational and economic concerns from our COO/CNO, to updates on online clinical databases and voting/giving recommendations as Councils regarding which one to purchase (for example, Nursing@Ovid was selected by the Councils in 2009 for 2010 implementation). Then, the Councils break out individually to work on their Council agenda items. Typically, the final 30 minutes of the meeting all four Councils along with Nursing Leadership reconvene back in Johnson Lecture Hall together, and each Council has one staff RN report off on their accomplishments for the day and key messages for all Council members to take back to their units/departments. From there, the key points are shared at unit meetings/huddles, shared with nursing leaders at Patient Care Forum, and submitted to the Nursing Newsletter in a Magnet Update. Finally, each year, each Council prepares a posterboard highlighting their role and that year’s accomplishments and staffs a booth at the annual Nursing Excellence Poster Fair so employees, leaders, local nursing schools, physicians and community members may be informed about our progress.

In addition, each Council prepares an annual report with the Council members then present an update to the Senior Executive Team in the Board Room which is well-received each year as evidenced by applause from the senior executives following the presentation and financial support each year approved to fund the continued efforts of these Council members in support of meetings.

**Recognition of Patient Care Council Participation**

Patient Care Council participation brings many rewards—a chance to make a difference and improve care and processes for staff and our patients, a chance to build relationships with other professionals on our interdisciplinary team—developmental opportunities by virtue of working in this team. Finally, participants who attended 80% or more of each year’s Council Days earns an invitation to the annual Nursing Celebration where a dinner is held in their honor, the CEO, COO/CNO, VP of Nursing Services, and Magnet Coordinator, Vicki Haag, individually recognize them for being part of our journey by awarding a journey pin and recognizing publicly by reading their name.

**Unit-Based Councils**

In the fall of 2006, Riverside also chose to approve resources to support paid time for direct care staff to meet in clinical areas in Unit-Based Councils to support collegial
shared decision making. These Councils (also known as UBCs), are smaller than Patient Care Councils and were developed to gain staff input and foster decisions to improve care, practice and the work environment by meeting monthly. These UBCs meet in a centralized meeting day and location (Johnson Lecture Hall) each month for two hours following the Patient Care Council meeting.

Part of each UBC meeting is global announcements and updates provided to all the UBCs, followed by breakout meetings for each UBC individually, with a final 30 minute report-off with all UBCs re-convened together in Johnson Lecture Hall to share what each area is working on, foster collaboration across units, and provide for communication takeaways to share at unit meetings.

**UBC Membership**

In order to launch the UBCs, Directors, Managers and Team Leaders personally shared the new Council purpose and structure with nurses, unit secretaries, and techs in their units, and in turn, staff requested to join the Councils with approval determined by their nursing leader based upon being a role model of practice in good performance standing, and based upon being committed to the vision, time and active participation required as a Council member. More specifically, the commitment and purpose of each UBC requires:

- Develop and support a unit/department culture that incorporates shared decision-making in all aspects of patient care
- Continue improving your unit/department’s provision and outcomes of quality and safe patient care
- Investigate, evaluate, and implement evidence-based practices at the unit/department level
- Promote a continuous learning environment in your unit/department
- Assess, identify, plan, implement, and evaluate current and new practices and policies for patient care at the unit/department level
- Promote a positive practice environment in your unit/department.

When our UBCs first launched, they met separately and individually on units. In 2007, we found that in some cases, UBCs met infrequently and yet, were working on similar projects. The synergy achieved by the Patient Care Council we decided to replicate starting in January 2009 by having all UBCs meet together following the Patient Care Council meeting—and by having a joint report-off/update time to share information across areas.

UBCs actively meet from the following units.

1. Emergency Department
2. 2ICU
3. 3Tele
4. Miller Rehabilitation@Sojourn (formerly known as Miller Center)
5. Home Health
6. Cardiac Services
7. 4Rehab
8. 2Med-Surg
9. 5ICU
10. 5Tele
11. 4Med-Peds
12. OPS (Outpatient Surgery)/PACU
13. OB
14. Special Procedures Lab
15. Mental Health Unit (MHU)/Girls Specialty Unit (GSU)
16. 3Ortho-Neuro

In the fall of 2007, when UBCs were launched, and through 2009, we had 14 UBCs. Some were grouped according to service rather than unit because they had similar goals and patient populations. For example, the Perioperative UBC included RNs from the OR, CVOR, Special Procedures Lab (SPL), Outpatient Surgery, and PACU. An example of one of their first projects, which applied to all of these areas, was the development of a hyperthermia cart. In 2010, the SPL nurses and their manager decided to form their own UBC, knowing they could, at any time, tap into their peers if projects benefited from having a unified UBC.

Also at the end of 2009, Miller Rehab Miller Rehabilitation@Sojourn (formerly known as Miller Center) asked to send a representative group of nurses as their own UBC to the regularly held meetings. Although not part of the hospital, this was seen by nurses at all levels as a positive development because, like Home Health, the Miller nurses represented another point in the care continuum.

**Riverside 1st Annual EPB/Research Poster Fair:**
**UBCs Show Off Results of Shared Decision-Making and Autonomous Practice**

Numerous posters outlining common problems, explored solutions, and clinical outcomes lined the walls. Enthusiastic representatives described the outcomes of their findings. Incognito judges asked probing questions. Striving to find clinical solutions to common problems, UBCs cooperated in a fun loving competition. Each of the individual posters listed UBCs’ participants names with the unit, i.e. second medical-surgical, as well as an explanation of the explored problem. Background information regarding the problems importance highlighted the need for a solution. Posters described the intervention and outcomes.

The Magnet group *Evidence-Based Practice and Research Council (EBP/Research)* planned the poster fair as a showcase of the *Unit Based Council (UBC)* work, and the exploration into EBP/Research. With initial roots in a summer of 2007 brainstorm between Vicki Haag, RN, MSN - Magnet Coordinator- and Janet Jensen –Director of Education Services- the poster fair combined the *Nursing Excellence Celebration* with the previously celebrated *Nurse Preceptor Dinner*. Placed into the 2008 budget by Vicki and Janet, Riverside Medical Center (RMC) approved the budget for the project as *Magnet and Education*. The budgetary approval gave the EBP/Research Council in
cooperation with the UBCs the summer of 2008, the ability to proceed by coordinating and planning the entire event. Plans featured Riverside’s 2008 UBC projects via poster presentations. In conjunction with a subsequent Nursing Excellence Celebration; the posters highlighted Quality Improvement, Evidence Based Practice, or Research projects that UBCs had been working on all year.

Previously, an annual Preceptor Appreciation Dinner hosted by Educational Services’ LeAnn McCormick, RN, BSN, Onboarding Coordinator recognized peer mentoring or preceptor nurses who had peer mentored the previous year’s newly hired nurses. Beginning in 2003, the Nurse Preceptor celebration highlighted and recognized the achievement of nurse preceptors. The program developed to provide nurse retention, career development, and patient care advocacy.

“Dig into EBP/Research” served as the title for the planned Indiana Jones themed fair and competition. Brown scrolled compass paper invitations requested UBCs participation. The artistic invitations showed the relationship between of the theme to the “Dig into EBP/Research.” Contest criteria developed by the EBP/Research council combined the qualities of desired qualities. Three categories were chosen (Best Overall Project, Best Collaboration, and Best Outcome.)

At the event, EBP/Research Council members displayed membership and support by wearing khaki pants and a Riverside shirt. Two senior executives, Vice Presidents Deena Layton and Allen Kelly and Director of Patient Safety Employee Health served as undercover judges. Without revealing their status as judges, they circulated the room and interviewed staff presenters and project participants. Approximately one-hundred people attended the November 14, 2008 Nursing Excellence Celebration.

Based upon the previously established criteria developed by the EBP/Research council, project ratings were tallied and discussed by the judges. In collaboration, they selected the final winners. Awards were announced in the Hospital Lobby (where the poster fair was held) with Framed certificates and certificates of appreciation for all other entries.

Fifth Telemetry UBC received the award for the Best Clinical Outcome. By recording fall trends with a fall assessment pilot, the Fifth Telemetry UBC developed a pilot which found eventual application throughout the entire hospital. The identified problem—falls—found a solution in a pair of red socks. By issuing red socks to patients identified as at risk for falls, the UBC effectively maximized communication and reduced falls.

In collaboration with respiratory therapy, Second Intensive Care Unit (2-ICU) UBC’s project led to an implementation of their solution in Fifth ICU. The project received the award for Best Unit Collaboration due to this interdisciplinary collaboration.

The Emergency Department’s UBC restocking process change project, not only won Best Overall Project, but also found implementation throughout RMC.
After the poster fair, the posters continue to share the spirit of cooperation, problem solving, and Evidence-Based Practice. On a weekly basis, the posters traveled throughout the organization. For fourteen weeks, the showcase of the UBCs labor were displayed in units throughout the hospital.

In numerous ways, the poster fair demonstrated the autonomy of nurses. Individual clinical nurses shared ideas to improve outcomes. Nurses explained the perceived problems identified by unit peers. By making decisions and promoting leadership, the UBCs sought solutions to patient care and practice environment issues. After identifying the problems and possible solutions, the UBCs implemented the solutions.

Documentation of the background of the issue or problem demonstrated the importance of the problem. Methodical explanation of the explored solution and its execution allowed onlookers to understand and reproduce their interventions. Comparison of data from before implementation of the proposed solution to data after implementation allowed units to use documented information to track the results of their labor. Thus, the UBCs applyied the very essence of evidence based practice to the practicality of clinical practice.

Furthermore, by sharing the results of their practical clinical solutions, the individual units further demonstrated the spirit of evidence based practice. Through shared outcomes, the UBCs were given the opportunity to utilize initially tested resolutions to problems other nurses might also encounter. Promoting not only the autonomously designed solutions, but also the nursing leadership needed to implement relevant solutions, the tracking of identified clinical problems and their solutions combined with the communication of the results put evidenced based practice in relevant and practical use.

The success of the 1st Annual Poster Fair set the stage for the 2nd Annual Poster Fair in November of 2009. More posters and more units were represented. The hospital lobby was once again filled with nurses, physicians, senior leaders, Riverside employees, and hospital visitors. The Highlights of the 2009 UBC projects are described in the attached booklet, which was developed by Vicki Haag and the EBP/R Council.

With the 2nd Annual Poster Fair, UBC participants are expanding the practice of nursing beyond Riverside. Four of our UBC poster abstracts were submitted for consideration of inclusion at the 17th National Evidence-Based Practice Conference at the University of Iowa School of Nursing. The Iowa selection process included a blind review in which the names of units and hospitals were removed. The abstracts were for the posters from the following UBCs: MHU, Home Health, 2 Med/Surg and 5ICU. On December 14th, we learned that all 4 of the posters were accepted! The four posters were converted into professional quality posters and some of our UBC members attended the conference and presented their posters in Iowa City, Iowa on April 22rd and 23rd, 2010. In addition, we received notice in February 2010, that our Emergency Department’s UBC poster was accepted for the 16th Annual Evidence-Based Practice Research Symposium at Memorial Medical Center in Springfield, IL to be held later this year.
Recognition of UBC Participation

The final component of UBC’s structure is recognizing contributions of all UBC members. UBC members who attended 80% or more of each year’s Council Days earn an invitation to the annual Nursing Celebration where a dinner is held in their honor, the CEO, COO/CNO, VP of Nursing Services, and Magnet Coordinator individually recognize them for being part of our nursing excellence journey by awarding a Discovery pin and recognizing them publicly by reading their name.

Additional Committees and Taskforces

Direct care RNs and Leader RNs also serve or lead numerous Riverside Medical Center committees as requested. Time to participate is supported and funded by our organization in order to create a culture of ownership and engagement. A few of these committees are listed here:

- Environment of Care Committee (focuses on TJC compliance for safety)
- Patient Safety/Medications Committee (focuses on Medical Safety of IV/Med Admin Processes including our electronic technology/barcoding)
- Bedflow Committee (looks at how patients are admitted and beds freed up across units including ED to support patient flow and be placement and remove bottlenecks)
- Disaster Preparedness Committee (chaired by an RN, this team assures compliance with TJC emergency preparedness, and plans and conducts disaster drills up to and including utilization of our surge hospital)
- Ethics Committee
- Palliative Care Committee
- Program and Education Committee (plans for medical residents and CME events)
- Restraint/Falls Committee
- Employee Safety Committee (examines employee injuries and looks at how to reduce injuries)
- Minimal Lift Committee (conducted peer review of minimal lift equipment in 2009 and also chaired by an RN)
- Culture and Communication Committee (works on assuring assertive communication between all staff and the medical staff)
- Infection Control Committee
- Quality Improvement Committee (looks at quality data and shares it with the Board and Medical Staff)
- Patient Care Forum (clinical leaders meet monthly to focus on a team on clinical care topics)
- Nurse Recruitment and Retention Committee
- Senior Management Meeting—we have five vice presidents/senior presidents who are RNs in our facility (includes our COO/CNO). This meeting drives the
organization’s strategic direction and our CNO/COO is a regular participant at our Board of Directors’ meeting.

- Advanced Practice Nurse Committee – led by LaRee Shule, APN, this committee meets monthly and is open to both Riverside-employed and community-based APNs to support their nursing practice and drive research.

- CHNN (Community Health Network Nurse) Committee - We are also expanding meetings to support nursing practice discussions beyond the acute care. Specifically, in 2009, we launched the CHNN (Community Health Network Nurse) meeting. This meeting pulls together our COO/CNO, Regional Directors, and RNs from our physician practices to connect them to our system. This team is newly formed, and conducted elections for nurses to lead this team with election results announced in 12/2009 as follows: Robin Major, Chair and Lisa Waskosky, Co-Chair. To promote connectedness to hospital structures for nursing practice and to shift to a systemic look at the care environment, the CHNN Co-Chair began serving on the Patient Care Council in January 2010 – specifically on the Practice Council.

- Patient Satisfaction Committee is chaired by our VP of Nursing Services and looks at Inpatient and ED Patient Satisfaction Data with an interdisciplinary team of nurses and ancillary staff from all surveyed areas working to improve results… And many others!

Summary

Like many organizations, we historically have had many teams, committees, councils and taskforces with primarily managers and leaders in these groups—but not direct care-level RNs. Since 2006, we have committed significant support and resources to add the Patient Care and UBC Council structures to provide for more engaged staff through shared decision making, with Councils made up of leaders and direct care nurses and ancillary staff working together.

Autonomous practice has heightened: direct care nurses are seeking more opportunities to participate in decision-making in all aspects of their practice. They have embraced the Vigilance model definition, and have recognized their privilege in making decisions to improve patient care and promote nursing practice.