**EP3: The structure(s) and process(es) that include direct care nurse involvement in tracking and analyzing nurse satisfaction or engagement data.**

Riverside Medical Center nurse leaders and nursing staff use several structures and processes to track and analyze nurse satisfaction or engagement data. Structures and processes have developed over time. Dissemination of nurse satisfaction results throughout all levels of nursing – nurse executives, directors and managers, and direct-care staff – have improved since we started tracking RN satisfaction using a valid and reliable survey tool. Improved structures and processes for analyzing RN satisfaction survey data and forming action plans have resulted in hospital-wide enculturation of the importance of using RN satisfaction data to improve the practice environment.

Structures include RN survey tools and a guide for interpreting results, nurse councils or committees, and additional structures such as a dedicated budget for labor, materials, and survey incentives; state-mandated regulations; job descriptions; and performance appraisals. Processes include our selection of a survey tool, selection and appointment process for forming Unit-based councils (UBCs), our organization-wide performance improvement process, communication processes and other processes related to state-mandated regulations and our performance appraisal process. Outcomes from the establishment of these structures and processes will be addressed. Specific outcomes of our RN satisfaction surveys over the past three years will be explored and explained in EP3EO.

**RN Satisfaction Survey Tool – Development, Dissemination, and Enculturation of Structures, Processes, and Outcomes**

Since the middle 1990s, Riverside Medical Center has conducted a number of employee surveys to assess and measure employee satisfaction and organizational culture. Surveys from a variety of vendors and have been used, including the Organizational Culture Inventory® and surveys by Morehead Associates, Great Places to Work, the VHA Collaborative, the Agency for Healthcare Research and Quality (AHRQ), and Press-Ganey. In 2006, Riverside Medical Center’s nursing leaders began to explore methods to assess and monitor nursing-specific satisfaction in the hospital. RN recruitment and retention strategies had been initiated in 2004 and leaders wanted to conduct a nurse survey to evaluate our progress and to support our pursuit of Magnet Recognition from the ANCC.

**Structure.** In 2007, Riverside Medical Center chose the National Database of Nursing Quality Indicators (NDNQI) RN Survey as the key structure for measuring RN satisfaction and job enjoyment. Riverside selected the NDNQI RN survey for many reasons. Primarily, we were interested in measuring RN-specific satisfaction at the unit and organizational levels - NDNQI provides both unit-specific and aggregate results. Less than 10 LPNs work in the hospital in direct care, so choosing an RN survey was felt to yield the most information on nurse satisfaction within the hospital. NDNQI provides a detailed guide for interpreting data. We also wanted to select a survey that high performing hospitals use so we could compare Riverside to the "best of the best."
In addition to comparisons with all hospitals in the database, NDNQI allows comparisons in several categories: staffed bed size, hospital type (such as non-teaching, teaching, and academic centers), and Magnet status. There is no additional fee for the RN survey for hospitals that also report nursing quality indicator data. Finally, the NDNQI survey is reliable and valid. We have participated in the survey annually since 2007 and plan to participate again in October of 2010, which will be our fourth year of participation.

The NDNQI RN satisfaction survey is a database of the American Nurses Association (ANA, 2009). The University of Kansas School of Nursing manages the NDNQI database for the ANA (ANA). The database includes information on nursing quality indicators and RN satisfaction. The RN survey is optional for hospitals reporting quarterly nursing sensitive information. NDNQI offers three survey options: RN Survey with Practice Environment Scale (PES), RN Survey with Job Satisfaction Scales, and RN Survey with Job Satisfaction Scales-Short Form. Riverside has used the RN Survey with PES for all three years since we started tracking RN satisfaction and job enjoyment. We opted to use the PES for several reasons:

- The PES has been endorsed by the National Quality Forum (NQF), a private, non-profit organization devoted to developing and implementing a national strategy for measuring and reporting quality in healthcare (NQF, 2004)
- The PES has a specific category for measuring RN participation in hospital affairs, an indicator of shared governance or decision-making
- The approximate length of completing the survey is 15-20 minutes, a time frame that is acceptable to our staff nurses because it does not take the nurse away from the patient's bedside for an inordinate amount of time.

The PES has the following components (NDNQI, 2009):

- Nurse Participation in Hospital Affairs
- Nursing Foundations for Quality of Care
- Nurse Manager Ability, Leadership, and Support of Nurses
- Staffing and Resource Adequacy
- Collegial Nurse-Physician Relations

All survey options include the job enjoyment scale, which is a measure of the degree to which nurses like their work. Work context and RN characteristics are also in all surveys. RN characteristics are reported at the organization level only to protect the identity of RNs.

Process. NDNQI has a detailed process for preparing hospitals to participate in the survey. A hospital-employed RN, Vicki Haag, RN, MS, Magnet Coordinator, is the Riverside survey coordinator. She ensures only eligible units and RNs are included. Specific criteria are defined in NDNQI materials. Eligible RNs must perform direct care activities (as specified in NDNQI definitions of direct care nursing), be employed on the unit for a minimum of 3 months, and must not be employed directly by the hospital rather than an agency. Nursing directors and managers are involved in evaluating RN
eligibility – these leaders ensure that eligibility criteria are met for participating RNs. Letters of invitation from NDNQI and the hospital are sent to eligible RNs. Testing of computers, which RNs will use to complete the survey, is done. The survey can also be completed by RNs from their homes – web addresses for home use and a link to the survey form Riverside’s intranet site (called Rivernet) are established with the assistance of the hospital’s Information Technology departments. The hospital letter includes incentives for completion of the survey while supporting RN anonymity. For example, one of the incentives for all three surveys was a special prize for all eligible RNs in units with a participation rate of 90% or higher. Since we do not know which RNs complete a survey, all eligible RNs received an incentive prize: stethoscope lights in 2007, umbrellas in 2008, and computer flash drives with the RMC logo in 2009.

The survey period lasts for three weeks. During this time, the survey coordinator sends emailed and paper reminders and flyers encouraging RNs’ participation. RNs can print 2-part certificates of participation when they finish the survey. The RN retains one half of the certificates, which include a code number for each RN. The RN returns the other half to the survey coordinator, who draws code numbers for awarding incentive prizes to individual RNs at the completion of the survey period. Every RN who completes a survey and returns a certificate half to the survey coordinator receives a $2 gift certificate to the hospitals gourmet coffee shop. Incentive prizes are also awarded to all eligible RNs in units that have greater than a 90% average participation rate. These prizes have included stethoscope lights (2007 survey), compact umbrellas (2008 survey), and computer flash drives imprinted with the Riverside logo. (Participation rates by year will be provided in EP3EO.)

NDNQI sends the survey results to the survey coordinator approximately one month after the close of the survey period. The results are cumulative; if a hospital conducts their survey in one of the early survey periods in the year, results from all hospitals include previous months’ survey results. Riverside’s first survey in 2007 was during April. Riverside leaders decided to change the month to an autumn month after 2007 so results would include the comparison data from the entire calendar year. In addition, changing the survey period to September or October was more likely to include new graduates who generally started their jobs in July, and would therefore have completed their three month orientation and be eligible to take the survey.

The next step in the process involves communication of results. The survey coordinator receives email notification that results are available via the NDNQI website. The survey coordinator accesses the report and sends the report to executive nursing leaders, directors, and managers. Executive leaders share the results with the entire 10-member senior management team (of which five are RNS!) and the hospital Board of Directors. The survey coordinator also writes about the results in the bi-monthly nursing newsletter, which is emailed to all hospital unit leaders. Nursing directors and managers post reports on their units and share results with their staff in various formats (email, unit rounding, department meetings). Results are also shared specifically with UBC members, who track and analyze the reports along with their unit managers and
directors. Riverside’s UBC format is another structure that supports tracking and analysis of RN satisfaction and survey results.

**Outcomes.** The structures and processes surrounding the NDNQI RN satisfaction survey have been beneficial for disseminating survey results and for encouraging improvements to the practice environment as an essential nursing activity at all nursing levels in the hospital. The NDNQI RN survey has become an annual event, and one that is considered a valid indicator of nurse engagement and satisfaction at Riverside.

From a perusal of results from the 2008 NDNQI RN Survey, nurse managers from each unit wrote and implemented plans to improve outcomes. One goal was to increase the unit response rate for each area. We saw our overall response rates fall from 2007 to 2008. Managers believed they had not promoted the survey as much as they could have. In 2009, managers increased communication about the survey. For example, Eileen Krach, 2nd Medical/Surgical manager, made face-to-face contact with RNs on all shifts, asking them to participate in the 2009 survey. The 2nd Med/Surg unit response rate increased from 40% in 2008 to 62% in 2009. The graph below shows the average response rate for the 3-year period.

The 2010 NDNQI RN Survey is scheduled for October. One goal for the 2010 survey is to achieve an overall response rate of 80%. The 2010 plan includes asking direct care nurses for ideas on increasing participation rates.

In the spirit of Riverside’s quest for continuous practice improvements, a new step in the RN survey dissemination process will be implemented in the spring of 2010. Based on feedback from nursing leaders and staff, the survey coordinator will host and facilitate a quarterly NDNQI Data Forum for nursing leaders and UBC members. An open invitation to the forum for any other direct care RN who wishes to attend will also be extended. Riverside leaders believe this quarterly meeting will enhance communication of survey
results among nursing unit leaders and direct care staff, minimize duplication of nurse satisfaction efforts, and promote sharing of information and action plans.

Specific satisfaction data and hospital-wide action plans from Riverside’s 2007, 2008, and 2009 NDNQI RN survey results will be described in EP3EO. The integral role of Riverside’s UBC format follows.

**Unit-Based Councils - Development, Dissemination, and Enculturation of Structures, Processes, and Outcomes**

**Structure.** Another structure supporting direct care nurses’ involvement in tracking and analyzing nurse satisfaction data is our unit-based councilor structure. Begun in the fall of 2007, unit-based councils (UBCs) are comprised of three to five RNs. Ancillary staff and/or CNAs serve as regular or ad hoc members of the UBC, depending upon the project the UBC is working on. The UBC structure has evolved over the past three years.

In 2007, 14 UBCs were formed to represent hospital nursing areas. Some UBCs were comprised of RNs from individual units and some were combined from several units or service areas. The single-unit UBCs were 2nd Med/Surg, 2ICU, 3rd Ortho/Neuro, 3rd Med/Tele, 4th Med/Peds, 4th Rehab, 5 Tele, 5ICU, and Emergency Services. Service-related UBCs were Mental Health Unit (included child to adult inpatient mental health and the Girls Specialty Mental Health Unit), Cardiopulmonary Diagnostics (EKG/EEG/EMG, Cardiac Rehabilitation, and Cardiac Cath Lab) OB (Post Partum/Gynecology, Nursery, and Labor & Delivery), and Perioperative Services (Operating Room [OR], Cardiovascular Operating Room [CVOR], Post Anesthesia Care Unit [PACU], Outpatient Surgery [OPS], and Special Procedures Lab [SPL]). When we first formed UBCs, we also asked non-hospital nursing areas if they wanted to form a council and attend the initial 2-hour training session. Our Home Health Care department opted to form a UBC and their group included RNs and a Physical Therapist.

The first meeting included a two-hour training session to introduce UBC members to the UBC structure and to reinforce our quality improvement, evidence-based practice (EBP), and research processes. Emphasis for 2007 was on quality improvement and using best practice evidence to affect change. We repeated the training in January of 2009 and 2010 to introduce the UBC concept to new members and to reinforce training for incumbent members. Training also includes:

- the roles of executive nursing leaders, directors, managers, and direct-care staff in the UBC structure;
- differentiation among quality or performance improvement, EBP, and research projects;
- how to charge their time to the correct cost center; how to address conflict and decision-making within UBCs;
- integration of the Magnet model (transformational leadership; structural empowerment; exemplary professional practice; new knowledge, innovations, and improvement; and empirical outcomes) into the UBC structure.
• identification of various Riverside resources for UBC work; and expectations for communication among UBC members and between UBC members and their nurse manager.

In 2008, we added the expectation that all UBCs enter a poster depicting one of their projects in our annual Poster Fair, which is sponsored by the Riverside EBP/Research Council.

UBC members involve a variety of staff when UBC projects warrant it. For example, RNs on 3rd Ortho/Neuro worked with their CNAs to develop and implement a CNA recognition project. The 3rd Ortho/Neuro nurses put together bags of treats and thank you notes to show CNAs how much nurses appreciate the care CNAs provide. The 2nd Medical/Surgical UBC added a CNA to their UBC in 2008. Nurses on the 5th Telemetry UBC involved their CNAs in a multi-year project to decrease falls rates on their unit. The OB UBC, which was the first nursing-related UBC in the hospital, is comprised of RNs and OB techs from the three areas that make up the hospital OB area. The Cardiopulmonary Diagnostics UBC, includes a registered echocardiogram technician.

UBCs meet monthly (or more often, if needed for time-sensitive projects), usually on Riverside’s Council Day, which is the 2nd Tuesday of the month, when several other councils meet. In 2007, UBCs were budgeted to meet for two hours every two weeks to help seed the new structure. The two-week schedule was for budgetary purposes – hours were allocated according to our organization’s pay period schedule. (The budgetary structure for UBCs will be discussed in an upcoming section of this source of evidence.)

From 2008 forward, UBC meetings decreased to two hours per month – this change was due to reallocation of funding to support construction of a new addition to the hospital and remodeling of the existing building. UBC members also desired the decrease in meeting times and frequencies due to family and other personal commitments and because the groups had matured to a point where shorter meetings became more productive. In 2009 and 2010, the two-hour, monthly meetings remained, in spite of organizational concerns for the worsening economy. Our UBC structure is recognized as an essential component of nursing practice in the hospital.

One UBC process involved the selection/appointment process. The selection/appointment process for UBCs was and continues to be voluntary – RNs contact their managers toward the end of the calendar year, asking to join the UBC. Newly hired RNs also receive information about our councilor structures during orientation. They are encouraged to contact their managers or RN preceptors during department orientation to learn more about the work of their UBC and to communicate their interest in joining a UBC.

UBC members’ term of service on their UBC is usually one year; however, some UBC members have continued to participate for a two-year or three-year period, citing it can take up to a year to form meaningful and effective team dynamics. Members who stay on UBCs for longer than a one-year term have served as mentors to new members,
teaching them the work and processes involved in UBCs and making the transition from year to year more seamless. The UBC RN “veterans” have become resources and recognized peer leaders on their units. For these reasons, we still do not mandate a specific turnover percentage from year to year. We have found that new members join the UBCs because they wish to become more involved in UBC initiatives. During performance evaluations, managers and RNs discuss the RN’s participation in unit activities, such as the UBC. UBCs have proven extremely valuable as structures for supporting the tracking and monitoring of RN satisfaction, as described previously in the process for dissemination and communication of NDNQI RN survey results.

When we first started formal UBC meetings in the summer of 2007, members determined their own meetings times and dates, and met off their units on a day when they were not scheduled to work. We tracked each UBC’s compliance with meeting every month by requiring the UBC members to complete a short meeting/minutes form. Nursing leaders set a target for 100% of UBCs to meet monthly. We found that attendance was not optimal during the first year of UBC existence. Since RNs on UBCs worked different shifts – generally 12-hour days, nights, or weekends – the RNs were challenged to select a meeting time when all UBC members could attend. Additionally, personal commitments such as children’s schedules made it difficult for UBC members to establish a regular meeting time. Another challenge was ineffective communication among members, among the various UBC groups, and between the UBCs and their managers.

In 2008, we changed the meeting structure so all 14 UBCs met on the same day at the same time. This proved advantageous because we could make announcements or present brief educational programs at a time when all members were present. Our executive nursing leaders could also make comments to the entire group; this increased executive staff visibility and demonstrated executive leader support of the councils and their work. We also implemented the 60-Second Summary, which is the last 15 minutes of the two-hour meetings when all UBC members gather in a large meeting room and have 60 seconds per UBC to report on their projects, progress made on the project, and next steps. Nursing leaders were invited to attend the 60-Second Summary so they could hear about all UBC projects. At least one representative of our hospital’s executive nursing staff – Vice President of Nursing, Vice President of Perioperative and Procedural Services, or CNO – also attend the 60-Second Summary every month. The 60-Second Summary has encouraged UBCs to collaborate on similar projects. Shared ideas for addressing unit-based issues and initiatives have helped build cohesiveness across units.

Outcomes. In 2008, we also began posting our UBC meeting percentage to a common electronic dashboard. Our dashboard item was the percentage of UBCs who submitted monthly reports to the UBC facilitator, Vicki Haag, RN, MSN. This was also a measure of the percentage of UBC meetings held per month; if the UBC did not send meeting minutes to Vicki, we knew the UBC did not meet. The change in format accommodated some UBC members who could not always meet at the established time and date. We
also included this metric in Magnet Office monthly reports to senior leaders. We saw our measure reach a high of 73% for 2 of the last 6 months of 2008. (See graph below.)

This structure remained in effect throughout 2009. Again, we struggled with our measure (percentage of monthly reports submitted) due to family and personal commitments. In addition, approximately 40 RNs, many of which were UBC members, joined one of three BSN degree completion cohorts that began in 2009, which decreased the amount of time they could serve on UBCs. Some RNs left the UBCs and were replaced by other members. Nursing leaders and the UBC facilitator supported these changes – we wanted to provide all the support we could for RNs seeking advanced nursing degrees. When UBCs could not meet at the appointed time due to family commitments and staffing patterns, their manager attended the 60-Second Summary or asked the UBC facilitator, Vicki Haag, RN, MSN to share their 60-second summary report.

The percentage of UBCs submitting monthly reports fluctuated between 71 and 100% throughout 2009 (see graph below). (We did not hold UBC meetings in July of 2009 in accordance with our annual summer plan, when we decrease labor use during times of low hospital census, which usually occurs during the summer months.) The improvement in UBC meetings held/monthly reports returned was significant. Our target remains at 100%
The UBC structure changed again for 2010 when we asked the service-based teams if they wanted to divide into their own unit-based groups. The Periop UBC, which formed in 2007, divided into three separate UBCs: a Special Procedures Lab (SPL) UBC, an Operating Room and Cardiovascular Operating Room (OR/CVOR) UBC, and a Post Anesthesia Care Unit/Outpatient Surgery (PACU/OPS) UBC. The Mental Health UBC and Cardiovascular UBCs wished to stay together. A non-hospital based nursing area asked to join the UBC structure. Senior Living Services formed an RN-based UBC and began meeting in January of 2010. Senior Living Services is a separate entity from the hospital and nursing practice in that area is not overseen by our CNO. Outcomes related to their inclusion in the UBC structure, however, will be monitored. Their inclusion has the potential of improving intra-system communications, system-wide nurse collegiality, and patient hand-off processes, which may contribute to nursing satisfaction and engagement and improve the overall continuum of care in our community.

The graph depicting the first quarter of 2010 follows. No UBCs met on the designated date in February due to a snowstorm. Managers of several UBCs asked if their members could meet at a different time anyway due to the need to work on pending projects that could not wait until March. Vicki Haag approved these meetings but we did not track UBC meetings since Council Day was cancelled. Vicki noted the dedication and involvement of these managers and UBC members to meet outside of the regular meeting time in order to move forward with their projects marked an important milestone in the evolution and maturity of the UBC structure and process at RMC. Another important milestone was the overall individual attendance at the January and March 2010 meetings: individual attendance in March was at 92%, the highest individual rate we have achieved in our 2.5-year history. The only UBC that did not meet in January

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<th>Month</th>
<th>Percentage of UBC Meetings Held</th>
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was our Emergency Department team. They were changing members and working on their staffing schedules to accommodate attendance during the regular meeting time. They will start attending the regular meetings in April and were excused from attending in March. In addition to the E.D. UBC, the Senior Living Services team was also excused from attending in March due to commitments. The OR/CVOR team was the only team that was not excused and did not meet outside of the regular meeting time. Julianne Post, RN, OR Manager, specifically followed up with each member to stress the expectation for attendance.

The UBC members at Riverside Medical Center work with their peers and nursing leaders on a variety of projects. One process they use frequently is our quality improvement process.

**Process.** UBC members, other direct care RNs, and their managers use Riverside’s quality/performance improvement process of PDCA (Plan, Do, Check, and Act) in tracking and analyzing nurse satisfaction and engagement data. UBC members, direct care RNs, and their leaders study results from NDNQI RN and Employee Opinion surveys to determine priorities for action plans (Plan). Managers then send their action plans to their nursing directors and vice presidents. Plans are implemented (Do). Since the NDNQI RN survey and Employee Opinion surveys are done annually, managers and direct care RNs discuss progress toward achieving action plan goals throughout the year (Check). Plans continue or are modified or revised as needed (Act).

One example to demonstrate this process is from the 2nd Medical/Surgical Unit’s plan, developed from examination of results from their 2008 NDNQI RN Survey. Survey results indicated a need to improve overall scores on the Practice Environment Scale (PES) with attention on improving 2 Med/Surg scores on the PES components, Nursing Participation in Hospital Affairs and Staffing Resource and Adequacy. Eileen Krach, RN, BSN, Nurse Manager, worked with direct care staff and the 2nd Med/Surg UBC to develop the following plan:
- Improve staff recognition by creating a unit-specific recognition program
- Examine the staffing plan for Palliative, Hospice, and Chemotherapy patients.
- Involve more nurses in councils and committees

For the “Do” component of PDCA, Eileen handed out 189 Thank You notes and 62 Connection Cards. Connection cards are part of the hospital’s reward and recognition program. In the fall of 2009, the unit started an RN and CNA of the Month award. These awards are posted in the unit hallway. In the break room, the staff redesigned the communication boards to show patient satisfaction scores with patient comments. The board also shows other unit measures such as Length of Stay, Call Light Answering percentages, and an idea board. The UBC developed a “High Five” board in the hallway. This board allows staff members to recognize each other on a job well done.

To address staffing, nursing staff examined staffing ratios for Palliative, Hospice, and Chemotherapy patients. They decided to place these patients in a lower staff to patient ratio.

During 2008-2009 performance appraisal meetings, Eileen encouraged staff to take a more active role in unit decision-making. They reassigned nurses to the UBC and changed nurse membership for the hospital’s acuity committee. For the first time, Eileen had more staff volunteer for these groups than she had places on these committees.

For the “Check” portion of PDCA, results from the 2009 NDNQI RN survey demonstrated improvement in the unit’s overall PES score as seen in the graph below, . . .

![2 Med/Surg NDNQI PES Scores for All 5 Indicators](image-url)

in the 2 Med/Surg Unit’s indicator for nurse participation, as seen in the following graph:
and in the 2 Med/Surg Unit's indicator for staffing adequacy as evidenced in the graph below:
Our current UBC structure and processes have developed over time to become essential parts of our hospital nursing structure. As previously stated, UBCs are part of the process for dissemination of NDNQI RN survey data and action plan formation. The outcomes of direct nurse involvement – though UBC membership and involvement of nursing staff – have resulted in improvements on NDNQI PES scores from 2008 to 2009 for units such as 2 Medical/Surgical and for the entire hospital. Scores in all five areas of the PES exceeded the national mean as did our aggregate PES score. These improvements were due, in part, to additional structures and processes used by Riverside to support direct care nurse involvement in tracking and analyzing nurse satisfaction and engagement data.

Additional Structures and Processes to Support Direct Care Nurse Involvement

A third structure to support direct care nurse involvement in tracking and monitoring nurse satisfaction is a dedicated budget to support the NDNQI RN survey and UBCs. In 2006, executive nursing leaders of Riverside Medical Center decided to establish a dedicated cost center to support, track, and analyze nursing excellence initiatives such as nurse satisfaction. The annual fee for NDNQI Membership and costs for NDNQI RN survey incentives are allocated to this hospital cost center. UBC work is considered a part of direct care RN’s regular work schedule, but labor is paid from the dedicated budget (rather than unit budgets) to better enable us to track our costs associated with nursing excellence initiatives such nurse satisfaction and engagement activities.

A state regulatory structure that has provided indirect support for staff nurse tracking and analysis of nurse satisfaction is an amendment that was added to the Illinois State Hospital Licensing Act. The goal of the mandate was to promote quality care and improve the delivery of healthcare services through “an organizational climate that values registered nurses’ input in meeting the health care needs of the hospital patients” (Illinois General Assembly, 2008, ¶ 1 – 3). The amendment was signed in August of 2007, and went into effect on January 1, 2008. Public Act 095-0401 requires hospitals to include direct care nurses in the development and evaluation of a nurse-to-patient
staffing plan based on patient acuity and “complexity of [RN] clinical professional judgment” (Illinois General Assembly, 2008, ¶13). The mandate requires hospitals to form committees, comprised of a minimum of 50% direct care RNs, to establish acuity models. Patient acuity structures may contribute to direct care RN satisfaction with the practice environment. Mandating hospitals to use shared governance structures and processes supports creation of a practice environment that is more satisfying for nurses.

Revised RN job descriptions and performance appraisal processes were implemented in 2009. These structures and processes support direct-care RN involvement in unit-based projects and decision-making, which includes tracking and analysis of RN satisfaction and engagement data. Additional information on this newer structure and process can be found in EP20. This structure and process is proving more effective in supporting open communications between nursing staff and their managers.

Summary

Riverside Medical Center is a member of NDNQI and participates in the annual RN satisfaction survey to continually assess and improve the nursing work environment. Riverside nurses analyze and track NDNQI RN survey data to develop strategies that enhance shared decision-making, teamwork, and a climate of care and trust. Survey results are shared across all levels of Riverside nursing. Together, nursing staff and leaders create and implement action plans to enhance the RN work environment and positively affect NDNQI survey outcomes.

The evolution of Riverside’s UBC structures and processes remains open to change. The slow but steady development of the UBCs at Riverside Medical Center has enhanced dissemination, tracking, analysis, and formation of action plans from the NDNQI RN satisfaction survey results. UBC structures and processes have become part of the nursing “DNA” of Riverside Medical Center.

State regulatory requirements, such as the 2008 amendment to the Hospital Licensing Act, and revisions to Riverside’s RN job descriptions and performance evaluations are additional structures and processes, which have been implemented to support direct care RN involvement in tracking and analyzing RN satisfaction and engagement. The results of our NDNQI RN surveys in 2007, 2008, and 2009, which will be described in EP3EO, will demonstrate Riverside’s progress in building a practice environment that promotes RN satisfaction.

References
