**Transformational Leadership: Visibility, Accessibility and Communication**

**TL8:** The CNO uses various methods to communicate, be visible, and be accessible to nurses throughout the organization. (Choose two of the three examples to provide).

**TL8a:** Provide one example, with supporting evidence, of communication between the clinical nurse(s) and the CNO that led to a change in the nurse practice environment.

**Communicating with the Chief Nurse**

The role description for the Chief Nurse Officer (CNO) and Senior Vice President for Patient Care at Massachusetts General Hospital (MGH) states that the individual directs the activities of all sections of the institution responsible for direct patient care. For over twenty years, clinical nurses at MGH have known and trusted Jeanette Ives Erickson, RN, DNP, NEA-BC, FAAN, Senior Vice President for Patient Care and Chief Nurse to create structures, processes and associated resources to support the delivery of high-quality, safe and effective patient- and family-centered care. Ives Erickson has done this through her skill, strategic vision, and collaborative nature which has allowed her to create a world class nursing service.

Ives Erickson has long recognized that to deliver high-quality care, clinical nurses need to practice in an environment which gives them the tools and resources to deliver that care. There are many ways a CNO can come to understand what is needed in the practice environment to allow clinical nurses to care for patients including the review of staffing and budgeting reports, census reports, safety reports and quality data, patient population and demographics, and feedback from nurse leaders. Ives Erickson also creates opportunities to communicate directly with nurses on whether the practice environment supports the care of their patients.

In addition to email communication, clinical nurses have direct contact with Ives Erickson through bi-weekly town hall meetings, unit-based rounds, and an “open door” policy. Ives Erickson also chairs the monthly Collaborative Governance (CG) Staff Nurse Advisory (SNA) meeting. SNA (attachment TL 8a.a) is comprised of clinical nurses from across all practice settings, who bring practice and quality of work-life issues and concerns to the meeting. The minutes from the meeting are shared not just with SNA members but are also disseminated widely throughout Nursing & Patient Care Services (N&PCS) via email using key distribution lists. Updates of all committees are presented to the CG Committee Leaders meeting which includes the staff co-chairs of all CG committees. All CG champions (members) also have access to the minutes of every committee through a Sharepoint site. The SNA meeting has both a formal component, where presenters from within N&PCS or MGH come to present and ask for feedback followed by an open forum where clinical nurses raise issues regarding their practice and nurse practice environment.
Ives Erickson is joined at this meeting by Associate Chief Nurses, the Executive Director for Nursing and Patient Care Operations, the Director of PCS Informatics, the Executive Director for the Institute for Patient Care, the Director of Patient Care Services Quality and Safety, and the Director of Clinical Support Systems. She strategically includes them so that issues raised by clinical nurses regarding the practice environment can either be addressed by the accountable leader during the meeting or a plan can be developed to address the issue. On December 3, 2013, a clinical nurse raised an issue in the practice environment which was affecting the quality and safety of patient care and also had a budgetary impact due to wasted supplies. The following story describes how a clinical nurse’s communication with the CNO led to a change in the practice environment.

**Lack of Equipment Impacts the Nurse Practice Environment**

The rapidly changing healthcare environment is visible everyday on the patient care units and departments at MGH. Clinical nurses and their colleagues work to ensure that care is compassionately delivered in a safe, effective and efficient manner. Clinical nurses recognize that delays in treatment impact not only the patient they are caring for, but other patients as well. The availability of stretchers and beds can lead to such delays that have an impact on patient care.

At the December 3, 2013 SNA meeting (attachment TL8.a.b), a clinical nurse raised the issue that delays in finding stretchers was impacting patient flow. SNA members agreed with her opinion and described cluttered hallways which contributed to a lack of control over the nurse practice environment. Hearing their concerns, Ives Erickson charged Kevin Whitney, RN, DNP, NEA-BC, Associate Chief Nurse, Surgical, Orthopaedic, and Neuroscience Nursing Services, to work with George Reardon, MBA, Director of Clinical Support Services to develop and implement a plan to address the clinical nurses concerns related to stretcher availability and report back to SNA.

**Ensuring that Nurses Practice in an Environment Which Supports Patient Care**

On March 4, 2014, Whitney and Reardon returned to SNA (attachment TL8a.c) to report on the work that had been accomplished regarding clinical nurses concerns on bed and stretcher availability and storage issues (i.e. “Bed Flow Management’). Whitney and his team had created three workgroups to address these issues:

**Inpatient Bed Management Team:**

**Issue:** Beds and stretchers are cluttering the practice environment.
**Charge:** Create designated storage space for clean beds and stretchers.
**Update:** Pilot designated parking locations for clean beds and stretchers on units, bridges and elevator lobbies. These areas will be designated by green tape on the floor as well as “no parking” signage. Pilot on Orthopedics Unit (White 6) and Orthopedics Unit (Ellison 6) will begin in April 2014.
Issue: Patients admitted/transferred to the unit on a bed causes the units to discard bed linen causing a waste of effort and resources.

Charge: To identify system to prevent waste of effort and resources.

Update: Piloting of plastic bed covers will begin on General Surgery (White 7), General Surgery (Ellison 7), Orthopedics Unit (White 6) and Orthopedics Unit (Ellison 6) in April 2014.

OR/PACU Bed Management Team

Issue: Lack of beds for first cases in the morning.

Charge: Identify a system to ensure easy access to beds.

Update: Night OR Aides/Environmental Services are delivering beds to Post Anesthesia Care Unit (Lunder 3, 4) implemented in March 2014.

Proactively identify which patients require a bed based on their clinical needs. Issue will be brought to the Post Anesthesia Care Unit Committee in April for discussion and approval. Whitney will update SNA on this issue at a future meeting.

Coordinate timing of OR bed requests to match when bed is needed; implemented in March 2014.

Post Anesthesia to Inpatient Unit Communication team

Issue: Patients who were transferred to the OR on a stretcher and now require a bed.

Charge: Identify a communication/system method to ensure availability of beds for patient post-op.

Update: All patients on Orthopedics Unit (White 6) and Orthopedics Unit (Ellison 6) will be transported to the OR on their beds. This intervention was implemented in March 2014.

Clinical nurses approved of the work groups’ recommendations and gave feedback on issues of broken stretchers. Reardon responded that there is a system for identifying broken equipment through the use of a yellow tag; he will communicate the need to re-invigorate this program and will follow up with unit based leadership, his staff and encouraged SNA members to also communicate this to their colleagues.

A clinical nurse raised the issue that patients who are transferred to the unit on a Lunder bed, had to transfer to a new bed, so that the Lunder bed could be returned causing more work and lost linen. Ives Erickson clarified that there is no difference in beds and that the nurses should keep the patient in the bed they were transferred on to avoid these issues. Ives Erickson thanked Whitney and Reardon and their teams and asked them to return to update the clinical nurses on these important changes to their practice environment.
On August 5, 2014, Whitney and Reardon returned to the SNA meeting (attachment TL8a.d) to update the members on a number of interventions which have improved the practice environment including:

**Inpatient Bed Management Team:**

**Issue:** Beds and stretchers are cluttering the practice environment.

**Charge:** Create designated storage space for clean beds and stretchers.

**Update:** The pilot on Orthopedics Unit (White 6) and Orthopedics Unit (Ellison 6) was successful, though issues were identified on the need for clearer signage and the need to add food trucks to the spaces. The plan is to implement the change hospital wide in September 2014.

In addition, the team also has the Unit Service Associate round on the unit to identify broken equipment or beds which need to be removed.

**Issue:** Patients admitted/transferred to the unit on a bed causes the units to discard bed linen causing a waste of effort and resources.

**Charge:** To identify system to prevent waste of effort and resources.

**Update:** The pilot on General Surgery (White 7), General Surgery (Ellison 7), Orthopedics Unit (White 6) and Orthopedics Unit (Ellison 6) has been very effective and we are currently working on a cost analysis to expand to other units.

**OR/PACU Bed Management Team**

**Issue:** Lack of beds for first cases in the morning.

**Charge:** Identify system to ensure easy access to beds.

**Update:** Post Anesthesia Care Unit Committee approved the proposed guidelines on proactively identifying patients at their April 2014 meeting. The guidelines are in effect.

In their comments, SNA members recognized what a challenging issue this is but also recognized that the team’s efforts have aided in implementing changes that have resulted in a less chaotic, more efficient and safer nurse practice environment. The workgroup has made great strides in resolving a complex and long-standing issue. The ability of clinical nurses to communicate with the CNO on this issue ensured that the nurse practice environment will support safe and efficient care of patients and a safe environment for staff.