Building Nursing Unit Staff Champion Programs to Improve Clinical Outcomes

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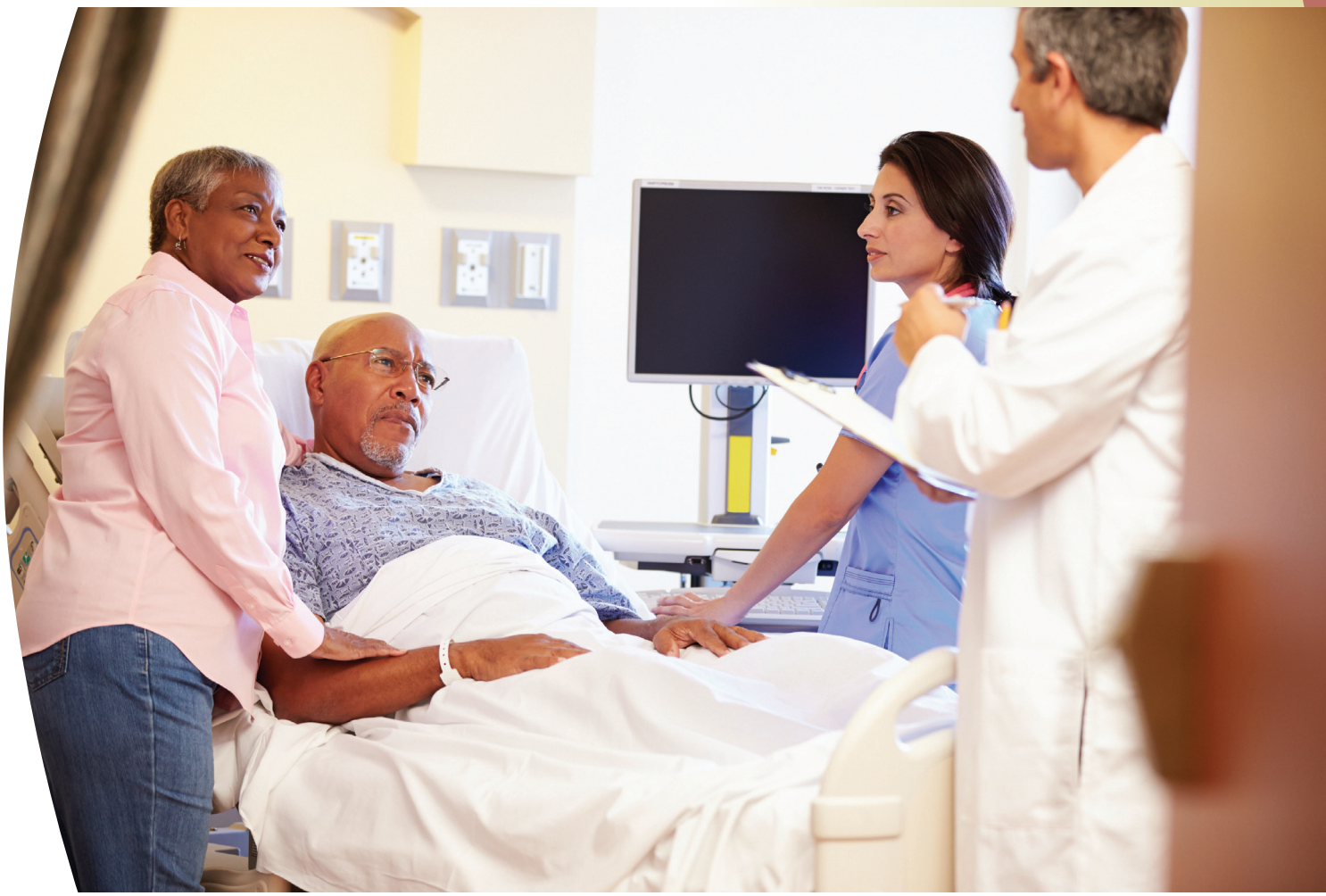

Building and mobilizing an overarching organizational strategy aimed to ensure positive patient outcomes in the midst of shrinking revenue and human resources is the challenge of healthcare leaders today. There is a palpable shift in care delivery as value replaces volume, quality trumps quantity, and safety pirouettes to the top of the "must have" list.[1] Quality outcomes and positive patient experiences are now demanded by consumers, required by payers, and transparently reported to the public. What is unchanged is the fact that these same constituents—quality outcomes, patient satisfaction, and safe care—have always been intrinsic to the core of nursing practice on every level.[2] A unified effort from nursing leadership and clinical nurses is required to meet today's healthcare demands.

It is our joint responsibility, both nurse executives and clinical nurses, to improve care. Regardless of this symbiotic relationship, clinical nurses often feel that they are unable to influence organizational change. Tackling quality issues and nurturing a commitment to change can occur when nurse leaders teach, mentor, and empower frontline nurses to fix inefficacies and failures by application of quality improvement processes and research findings.[3] Infusing these leadership concepts into unit-based nurses creates a fundamental framework for successful shared governance.[4] Virginia Commonwealth University (VCU) Medical Center, a Magnet-designated academic medical center in Richmond, Virginia, has instituted a shared governance structure and unit-based clinical champions as a winning combination to improve nurse-sensitive outcomes.

SHARED GOVERNANCE

According to the seminal work of Porter-O'Grady,[5] shared governance is an organizational commitment intended to empower clinicians through decision-making control over individual clinical practice, based on the principles of partnership, equity, accountability, and ownership. Shared governance is currently characterized by open communication, explicit value on point-of-care staff, change driven from the bottom up, significant increase in knowledge transfer and spread of innovation, high expectations of staff, knowledge-based decision making, and systems of appreciation.[6] Authentic shared governance asserts a culture of accountability for outcomes and ownership of one's work[7]; it is where clinical expertise coincides with decision-making authority.[8]

Shared governance as we know it today mirrors the earlier work of Drucker and Odiorne,[10] called management by objectives (MBO). This model outlines a process whereby common goals are identified and the individual's major areas of responsibility and expectations are defined, thus guiding the operation of the unit. The model links unit goals to those of the enterprise, thereby allowing individual clinical nurses to know and actively participate in organizational goals. The MBO process spells out the goals in relationships among units, emphasizes teamwork, and encourages clinical nurses to be responsible contributors toward meeting unit goals.

UNIT-BASED CHAMPIONS

Unit-based clinical champions are clinical nurses with demonstrated interest—and knowledge beyond their peers'—in a specific clinical topic. With novice nurses, the unit manager may identify the nurses' aptitude and ability to contribute to unit improvement and assign them to a champion role; more experienced nurses may simply disclose their area of interest. There is formal recognition that these nurses are the unit's designated expert. Effective champions show leadership characteristics and have a sense of empowerment to improve clinical outcomes. A shared governance model provides the structure for unit-based champions to influence peers and ameliorate care. An example of unit-based champions supported in a shared governance model at VCU is the Champions of Skin Integrity team (CSI team) charged with reducing hospital-acquired pressure ulcers (HAPU).

PRESSURE ULCERS: AN ORGANIZATIONAL ISSUE

Pressure ulcers are a nurse-sensitive indicator and, for the most part, are avoidable with the application of evidence-based guidelines. However, the science of pressure ulcer etiology continues to unfold through research, which is uncovering the complex pathophysiology of this global age-old healthcare issue. The search to find ways to prevent this complex issue continues. Because current published guidelines are several years behind emerging science, evidence-based nursing interventions provided in the guidelines, even when implemented appropriately, may yield suboptimal results.

Pressure ulcers incur both physical and psychological burden on patients, and not only increase mortality and morbidity, but significantly reduce quality of life for the individual and caregivers. Pressure ulcers are costly, increase length of stay, and as a primary diagnosis, may be responsible for readmissions. The mean cost to treat per episode is estimated at $1606 for a Stage I/II pressure ulcer and $71,503 for a Stage III/IV injury. In a retrospective secondary analysis of the national Medicare Patient Safety Monitoring System database, the incidence of pressure ulcers in patients discharged between January 1, 2006 and December 31, 2007 was 4.5%.[12] The average length of stay for all patients was 4.8 days and 11.2 days for those who developed a pressure ulcer.[14] This same study reported that HAPU patients were significantly more likely to be readmitted within 30 days (odds ratio [OR] = 1.33, CI = 1.23-1.45) and were more likely to die in the hospital (OR = 2.81, 95% CI = 2.44-3.23).[14]

Centers for Medicare & Medicaid Services identified HAPUs as a nonreimbursable diagnosis-related group effective October 2008. The financial impact of this regulatory change grabbed the attention of hospital's senior leaders. Sustainable reduction in HAPU rates requires an organizational approach, with nursing admittedly being the largest contributor.[15] Because pressure ulcer prevention is an organizational responsibility and occurs at the point of care (bedside), a dilemma exists, posing the question, "How does a skilled, expert nurse consultant team (the wound, ostomy, and continence [WOC] team) transfer knowledge, skills, and accountability across the organization and specifically to the bedside nurse?" One primary way to improve and influence behavior at the bedside is to develop unit-based peer skin champions. The collective synergistic support of senior leadership, clinical experts, unit leadership, and unit-based skin champions are important organizational components framing VCU's comprehensive pressure ulcer prevention program.

SENIOR LEADERSHIP SUPPORT

Successful HAPU prevention programs must have the support of senior leadership at the highest level; specifically, the chief nursing officer (CNO). This point is well supported in the literature and validated in published national guidelines.[16,17] Transformational leadership characteristics specifically underpin an organization's success in reducing