NURSING WORKLOAD
AND STAFFING PLAN PROCESSES

TOOLKIT
Resources for teams
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INTRODUCTION

Welcome! As part of a Memorandum of Agreement contained in the 2006-2010 Provincial Collective Agreement between the Health Employers Association of BC (HEABC) and the Nurses’ Bargaining Association (NBA), representatives of the Ministry of Health, the NBA, the Health Authorities and the HEABC joined together to implement workload and nurse staffing plan process projects at two acute care settings, two residential care settings, two community health care settings and two community mental health care settings within BC.

Purpose

The purpose of this project was to engage nurses (RNs, RPNs and LPNs) in discussions and decisions related to workload and safe and effective staffing plan processes within their specific practice environments. In some practice sites, other important care staff members, such as Care Aides or Support Workers, were included in these discussions and decisions. Project activities were conducted in collaboration with nursing management at each healthcare site. The year-long project consisted of three phases. The first phase involved project teams, staff, and management identifying and addressing practice environment issues related to workload. The second phase focused more exclusively on a specific nursing workload issue - staffing. A final phase of the project consisted of project team and staff focus groups to glean feedback on project successes and challenges. What we learned from these pilot projects helped develop this toolkit.

Background

The design of this project was based on the magnet/healthy work environment literature (Laschinger et al., 2003; Parsons, 2004; Parsons et al., 2004) and the empowerment literature. Effective workload management, including staffing/skill mix and care delivery model design, is one of the major work environment factors that contributes to magnet-like work environments. Magnet-like environments or healthy work environments are associated with improved nurse and patient/resident/client outcomes (Aiken et al., 2002; Havens & Aiken, 1999; Tourangeau et al., 2006; O'Brien-Pallas et al., 2003). Nurse job strain, burnout, and job dissatisfaction are associated with heavy nursing workloads (Baumann et al., 2001).

One way to address nursing workloads is to consider the context of nurses’ work—the work environment (Page, 2004). Phase 1 was designed to provide the project teams with the “bigger picture.” The teams were given tools and supports that enabled them to better understand and evaluate the context of their work. During Phase 1, the project teams were also taught how to engage in shared decision-making and participatory change management: project team-management processes that resulted in constructive solutions to workload issues. Shared decision-making/participatory change management are empowerment strategies that result in greater nurse satisfaction, organizational commitment, and nurses’ perceptions of improved quality care (Erickson et al., 2003; Laschinger, 2008). Shared decision-making and participatory management approaches have been successfully used to create healthy work environments (McGillis-Hall et al., 2008; Parsons, 2004; Parsons et al., 2004).
Once project teams were able to critically examine workload issues, we initiated Phase 2 with more in-depth evaluations of workload issues related to staffing. During Phase 2, project teams used a rating scale adapted from the synergy model (Curley, 2007) to identify workload associated with their patient/resident/client care needs. Based on staff characteristics, such as experience and scopes of practice, the project teams developed staffing plan processes with staffing decision rules to more systematically, objectively make staffing assignments. The premise of the synergy model is that a better fit between staff characteristics and patient/resident/client care needs will result in improved nurse and patient/resident/client outcomes.

Staffing plan processes in place in the United States have proven to be a successful way for nurses and nurse managers to identify the client/patient/resident needs of specific healthcare sectors and settings (DeVandry & Cooper, 2009). The research evidence shows that those who provide care are vital to staffing discussions. Nurses are knowledgeable about their own practice environment, and they know what is necessary to safely and effectively respond to their patients’ care needs (Canadian Health Services Research Foundation, 2006; Canadian Nurses Association, 2003). Staffing plan processes, developed by staff and management, provide a means for nurses to contextualize what they do for their clients/residents/patients in specific settings (DeVandry & Cooper, 2009).

This project was not intended to develop a nursing workload measurement system (WMS). Although progress has been made in refining WMSs currently in existence, these systems usually reflect only part of the actual work done (McGillis-Hall et al., 2006). Instead, this project was designed to enable front-line staff and management to address evidence-based factors that influence workload by: (Phase 1) participating in a broader examination of workload issues within their work environments, and (Phase 2) focusing specifically on workload issues related to staffing plan processes.

**This Work IS About...**

Empowerment: Building professional knowledge, skills, attitudes and judgments
- Asking insightful questions
- Looking at more than one way to deal with an issue
- Being flexible, creative
- Working collaboratively, building positive relationships
- Prevention: thinking ahead to the future
- Communicating, communicating, communicating: with each other and with key stakeholders, like management, the unions, other staff members

**This Work IS NOT About...**

Quick solutions: Getting in and out quickly
- Having all the answers
• Looking at one way to solve problems or issues
• Being an expert in everything (we’re all learners)
• Going it alone (That is why this is a project TEAM!)

**Toolkit Organization**

The following tools are organized according to the two PNWP project phases. We have provided you with the tools that worked for our project teams, with suggestions for how to adapt the tools to work for your setting. Sections 1-3 pertain to Phase 1, and Section 4 is based upon Phase 2 work with the synergy model and staffing plan processes. The Appendices contain other resources that were helpful to our project teams. For more information about PNWP outcomes and Phase 3 findings, please consult our final project report.
PHASE 1: Sections 1 - 3

Section 1 - Assessment of the Practice Environment

During phase 1 of the project, it is important for the project team to explore the strengths and challenges within their practice environments. Feedback from the entire staff can be gleaned through surveys such as the Quality Practice Environment Survey. After reviewing survey feedback, the team should brainstorm and identify priority practice environment challenges they can realistically tackle with the resources available to them. Once practice environment challenges have been identified and prioritized by the team (with input from staff and management), the team can begin developing action plans to address these challenges throughout the course of the project.

The tools below were used by project teams across BC as starting points for team discussions around workload. You have to begin with a critical analysis of the practice environment—it sets the stage for more in-depth workload discussions later on.

Quality Practice Environment Survey .................................................. 5

Strengths and Challenges of Your Site Brainstorming Exercise .................. 10
Quality Practice Environment Survey

Background Information

This survey is adapted from the College of Registered Nurses of British Columbia’s (CRNBC) Guidelines for a Quality Practice Environment. The CRNBC guidelines may be found at: https://www.crnbc.ca/downloads/409.pdf. A quality practice environment/healthy work environment/magnet-like environment is one of the values central to ethical nursing practice. The Canadian Nurses Association (2002) states that “nurses value and advocate for quality practice environments that have organizational structures and resources necessary to ensure safety, support and respect for all persons in a work setting” (p 17). The CRNBC Guidelines for a Quality Practice Environment are based on evidence from the literature and extensive consultation with nurses in all practice settings in urban, rural and remote regions of B.C. and other nursing organizations across Canada. These guidelines were developed by CRNBC for nurses and employers to use in evaluating and improving their practice environments.

We believe that our adapted survey contains some useful questions for care staff to consider with respect to their workloads. Some of the questions or wording of questions may not apply to you. Please note that throughout this survey, the term “nurse” or “nurses” is meant to include the entire direct care team. The term “patient/resident/client” is meant to include those under your care at your worksite. Minor adjustments in wording may be made to tailor the survey to each site. You might wish to add some questions of your own, if you have specific workload issues not addressed by this survey.

This survey should be used:

- to gather information about the direct care providers’ perceptions of their practice environments
- as a place to begin team discussions about your site’s practice environment issues

Distribution

We recommend that you give this survey to all direct care staff to complete. Set a deadline for staff to return their completed surveys.
### Control over Practice

**Nurses have authority, responsibility, and accountability for nursing practice.**

1. Nurses are supported to participate at appropriate levels regarding policies, practices and the work environment.

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<td>Strongly Agree</td>
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2. Appropriate resources are available to support evidence-based nursing care.

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3. Nurses and other health professionals work cooperatively and collaborate in decision-making.

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4. There are adequate supports in place to free nurses from doing non-nursing tasks.

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### Workload Management

**There are sufficient nurses to provide safe, competent, ethical care.**

5. The work environment enables nurses to develop a sufficient and rewarding relationship with their clients.

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6. Client admissions and services are based on nurses' ability to provide safe, competent, ethical care.

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7. Sufficient time is made available to discuss and plan client care with clients and colleagues.

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8. Nurses are involved in determining staff assignments.

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# Organizational Support

The organization's mission, values, policies and practices support and value nurses and the delivery of safe and appropriate nursing care.

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<tr>
<th></th>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
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<tbody>
<tr>
<td>12. Appropriate avenues are in place and accessible to resolve professional practice and ethical issues.</td>
<td>1 2 3 4 5 N/A</td>
<td>Strongly Agree Strongly Disagree</td>
</tr>
<tr>
<td>13. Nursing expertise is respected, excellence is recognized and nurses are valued.</td>
<td>1 2 3 4 5 N/A</td>
<td>Strongly Agree Strongly Disagree</td>
</tr>
<tr>
<td>14. Creative and innovative ideas and the pursuit of nursing knowledge are encouraged.</td>
<td>1 2 3 4 5 N/A</td>
<td>Strongly Agree Strongly Disagree</td>
</tr>
<tr>
<td>15. There are comprehensive health, wellness and safety programs.</td>
<td>1 2 3 4 5 N/A</td>
<td>Strongly Agree Strongly Disagree</td>
</tr>
<tr>
<td>16. There are measures to prevent and combat all forms of aggression, abuse and violence.</td>
<td>1 2 3 4 5 N/A</td>
<td>Strongly Agree Strongly Disagree</td>
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17. Continuous quality improvement programs are in place.

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Strongly Agree

18. The physical facility, equipment, supplies and services meet client and staff needs.

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Strongly Agree

19. Human resource policies consider nurses’ personal and family concerns.

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Strongly Agree

20. Information and communication systems are effective and integrated.

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Strongly Agree

21. Technology is used appropriately.

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Strongly Agree

22. Nurse leaders are supported in their roles which may include collaborators, communicators, mentors, risk takers, role models, visionaries and advocates for quality care.

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Strongly Agree

23. Nurse leaders have the authority to support safe nursing practice.

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Strongly Agree

24. A chief nursing officer reports at the senior executive leadership level in your health authority.

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<tr>
<td>Yes</td>
<td>No</td>
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Don't Know

25. When the primary focus of the unit or program is to provide nursing care, the first-line leader is a nurse.

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<td>Yes</td>
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Don't Know
26. The first-line leader is accessible and experienced.

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<td>Strongly Agree</td>
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<td>Strongly Disagree</td>
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</table>

27. Novice nurses are supported in practice by accessible, expert and experienced nurses.

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<td>Strongly Agree</td>
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<td>Strongly Disagree</td>
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### Professional Development

*The organization encourages a lifelong learning philosophy and promotes a learning environment*

28. Appropriate orientation is provided for all new positions and practice settings.

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<td>Strongly Agree</td>
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<td>Strongly Disagree</td>
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29. Staff have opportunities for in-service, continuing education and professional development.

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</table>

30. Staff have opportunities for debriefing and reflection on practice.

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<tbody>
<tr>
<td></td>
<td>Strongly Agree</td>
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<td>Strongly Disagree</td>
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</table>

31. Performance evaluation programs are in place.

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<td>Strongly Agree</td>
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<td>Strongly Disagree</td>
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</table>

### Other

Are there any other issues in relation to workload that you would like addressed?
Strengths & Challenges of Your Site Brainstorming Exercise

In order to decide where you want to go and how to get there, it’s helpful to know where you’re starting from. Brainstorm and create a list of the strengths and challenges in your work site. Think about what works well, and what could use some improvement. One recommendation is to give sticky notes to each member of the team. Use different colors for practice environment challenges and successes. Ask each member to generate as many ideas (successes and challenges) as possible - one idea per sticky note. Use flip charts or wall space for team members to display their sticky notes. Have a space for Successes and one for Challenges. Go through the notes and organize them into similar piles. This will give the team an idea of which successes and challenges garner the most attention of team members. “Priority” items should be revealed through this process—and serve as a point for more discussion and team consensus about key issues to tackle first. See the example on the next page.

You can develop action plans to help overcome some of the challenges you have identified, and to work towards realizing your hopes for the future of your site. Consider how your strengths can be used to help overcome the challenges. Be sure to acknowledge your successes!
<table>
<thead>
<tr>
<th>Strengths</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team supports each other well</td>
<td>A lot of sick calls</td>
</tr>
<tr>
<td>Good clerical staff support</td>
<td>Disorganized utility rooms</td>
</tr>
<tr>
<td>Our nurses are committed to providing good care for their patients</td>
<td>Physical layout of building</td>
</tr>
<tr>
<td>Team leader is open to hearing staff concerns</td>
<td>Staffing office not local – causes difficulty with filling shifts</td>
</tr>
<tr>
<td>Staff meetings are regular &amp; helpful</td>
<td>Vacant RN line</td>
</tr>
<tr>
<td>Consistent vision among staff re: patient care</td>
<td>Staff don't get restful and adequate breaks</td>
</tr>
<tr>
<td>Good educational resources on the unit</td>
<td>Unrealistic patient requests</td>
</tr>
<tr>
<td>New beds</td>
<td>A lot of call bells</td>
</tr>
<tr>
<td>Received an extra Dynamap</td>
<td>Lack of effective shift-to-shift communication</td>
</tr>
<tr>
<td>Good opportunities for professional education &amp; development</td>
<td>Interdisciplinary team communications sometimes strained</td>
</tr>
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</table>
Section 2 - Team Building

Highly effective teams are able to bring about positive change in their work environments. Effective teams typically consist of members who are ready to make a change and provide diverse perspectives and skills. It is important to take the time to build a team, and not a work group. The tools and documents provided in this section are intended to help you build a team which is based on respect and open communication, empowering you to make meaningful changes in your place of work.

Teamwork .............................................................................................................. 13

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Teamwork

In healthcare, effective teamwork is associated with nurses' increased job satisfaction, decreased turnover, and enhanced control over practice.

“Benefits to nurses occur in environments characterized by mutual respect, collegiality, and an exchange of knowledge and information.” (Dimeglio et al., 2005).

Respect, collegiality, communication, and accountability are some of the key characteristics of highly effective teams. Highly effective teams hold each other accountable for the quality of performance. Katzenbach & Smith (1993) identified a team as “a small number of people with complementary skills who are committed to a common purpose…for which they hold themselves mutually accountable” (p. 112). Accountability does not happen if team members are unable to communicate respectfully and openly with one another.

Teams Versus Groups

It’s important for the team to go through the list of characteristics of groups and teams below to ensure that members are committed to being a team—and not a group.

<table>
<thead>
<tr>
<th>Working Group</th>
<th>Team</th>
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<tbody>
<tr>
<td>Strong leader</td>
<td>Shared leadership</td>
</tr>
<tr>
<td>Individual accountability</td>
<td>Individual and team accountability</td>
</tr>
<tr>
<td>Work goals—getting the job done</td>
<td>Team goals—meeting goals through teamwork</td>
</tr>
<tr>
<td>Individual work outcomes</td>
<td>Teamwork outcomes</td>
</tr>
<tr>
<td>Occasional meetings to regroup</td>
<td>Regular meetings for open-ended discussion and active problem-solving</td>
</tr>
<tr>
<td>Measures of effectiveness: “Were the goals achieved?”</td>
<td>Measures of team effectiveness: “Did we achieve our goals?”</td>
</tr>
</tbody>
</table>

Adapted from Katzenbach & Smith, 1993
What are Some Ways to Build an Effective Team?
The nurse leader and team members have to work together. Sometimes an outside facilitator is needed to get the process started. The following are characteristics of highly effective teams:

- **Team Identity:** Members identify - Who are we?

- **Shared Vision:** Members establish common goals for the practice environment - What is our shared purpose?

- **Effective Communication:** Group members have to agree on a process for sharing information and resolving conflicts.

- **Mutual Trust:** Members understand each other’s roles and responsibilities and recognize how each team member contributes to the team.

- **Outcome Oriented:** Members commit to decisions and follow plan of action. Identify what actions to take, as a team, to improve the practice environment.

- **Accountability:** Members are accountable to each other, and for project outcomes

- Members focus on the **Collective Achievement** and identify with **Team Success**

"Teamwork is the ability to work together toward a common vision. It is the ability to direct individual accomplishments toward organizational objectives. It is the fuel that allows common people to attain uncommon results."

Andrew Carnegie
Project Team Roles & Responsibilities

It is helpful for those involved in a team to be aware of the roles and responsibilities of each member of the team. There might be negotiation of roles and responsibilities as needed. Decide who will take on the responsibilities and tasks necessary for your work. Some tasks/responsibilities to consider:

- Setting meeting agendas
- Leading team meetings
- Arranging for guests to come speak to, or collaborate with the team
- Drafting meeting minutes
- Drafting communications such as bulletins, memos, etc.
- Scheduling team hours for meetings & for between-meeting work
- Attending and participating in team meetings & activities
- Reviewing minutes and communications between meetings

It is important for the team to collectively identify and establish “Team Guidelines”; guidelines for behaviour to which all team members agree to adhere. Common team guidelines often address issues such as confidentiality and respectful communication. It is helpful to quickly review these guidelines at regular intervals and before each team meeting.

Example Team Guidelines

- Review minutes and other project documents before meetings, and come to each meeting prepared to work
- Be respectful of others’ opinions and create a safe environment for brainstorming
- No gossiping – don’t tell stories about people outside of the team and if a problem arises with the team, address it with the team
- Take responsibility for your own comfort and learning
Developing a Communication Plan

Effective communication is a vital part of quality practice environments. Communication failures are the leading cause of patient harm, such as medication errors (Miller, Riley, & Davis, 2009). Effective communication helps keep a project on track and prevents hiccups along the way. Developing a communication plan is a good way to keep others informed about your initiatives.

Formulate a plan to: a) communicate your team’s progress to your fellow staff members and management, and b) identify ways you will obtain ongoing feedback from your colleagues. Think of it as a two-way communication system (sending and receiving) to keep everyone “in the loop”. You should either: designate a “lead” team member to oversee project work communications, or designate more than one team member to manage different communication responsibilities (e.g., communicating with management, communicating with staff, getting staff input/feedback). Be sure to include communications as a part of each meeting’s agenda.

Examples of Communication Methods:

- **Team Minutes** – Cover the highlights of your meetings; record your successes and challenges; and document action items or “must dos” (a Minutes Template is on page 24). There is an “art” to taking Minutes, and you may want to rotate the responsibility among team members. Minutes may contain confidential information for team “eyes only,” and you need to respect Minutes confidentiality. Your team should decide on what Minutes/team meeting information you want to share with staff and management. The bullets below address communications with your other key stakeholders. Note: “Stakeholder” is a term used to describe those people or groups who are very important to you—they have a stake in what you’re doing.

- **Bulletins and Notices** – Make up “1 pagers” of key team actions, information, or announcements to post on notice boards or walls, or place in binders or in mailboxes. Bathroom stalls make handy places to post team information to staff! You may want a designated spot on a staff bulletin board to highlight team work.

- **Staff Meetings** – Appoint team members to attend staff meetings to give updates on the project. Let your nurse leader know that your team wants to have designated time during the staff meeting to give a project update. Allow some time for questions and answers.

- **Staff “Huddles”** – Each team member can do an impromptu 5 minute “huddle” with available staff to catch them up on project work. You can use the 5 minutes to give and receive information. It’s amazing what you can accomplish in just 5 minutes!

- **Email Distribution List** – Make separate lists for your team, staff, your leadership, etc. Double check your lists—don’t leave off anyone. You should consider to whom you forward information via email: Who needs to know what? Monthly e-mail updates to key stakeholder groups work well.
Things to Consider When Developing a Communication Plan:

1. **What do you want to say?** (What key messages do you want to convey?)
   - Consider your audience and decide what information you would like to share.
   - Some documents/matters are sensitive, and you will need to decide what message to convey.

2. **Who should receive the communication?** (To what key stakeholders do you want to convey the messages?)
   - Consider patients/residents/clients, staff members, support staff, management, etc.
   - Decide who needs to be involved at each stage of planning.
   - Decide who needs to be informed at each stage of planning.

3. **How do you want to say it?** (What's the best approach to reach each key stakeholder? One-on-one, e-mail, posted memo, staff meeting?)
   - Decide how to communicate with each stakeholder group.
   - Will your mode of communication reach all stakeholders?
   - Is a face-to-face meeting necessary?

4. **When do you want to say it?**
   - Decide the best time to share information.
   - What are the costs/benefits of waiting to share information?

5. Finally, **evaluate** the effectiveness of your communication. (How will you know your communication was effective?)
   - Elicit feedback from stakeholders.
   - Ensure there are avenues for two-way communication.
   - When you provide updates to staff, indicate who on the Project Team they can contact with questions or comments.

**Tips for success**

- **Situational Awareness**: maintain the ‘big picture’ about what is going on within the healthcare setting, the organization, the community.
- Make communication planning a routine discussion point at the end of each meeting.

**Effective communication is the best way to build a strong team and reduce unhealthy conflict.**
Conflict Management

Conflict typically occurs when people have different perspectives on an issue. Conflict often gets a bad reputation, but healthy conflict is a good way for people to share different ideas, opinions, and concerns about an issue. Healthy conflict can lead to a great resolution for a difficult problem. The outcome depends on the type of conflict and how conflict is managed (Simons & Peterson, 2000; Valentine, 2001). When emotional or interpersonal conflict occurs between individual team members, it should be managed outside the team by the individuals having conflict with each other. Task conflict is healthy, because it’s important for team members to discuss and debate how best to accomplish team goals.

There are 5 major strategies or styles for handling conflict: Avoiding, Compromising, Collaborating, Accommodation and Competing. You can take a simple test (pages 19-20) to see what styles you tend to use most often in conflict situations.

<table>
<thead>
<tr>
<th>Conflict Style</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoiding</td>
<td>You withdraw from the discussion or hide your true concerns.</td>
</tr>
<tr>
<td>Compromising</td>
<td>You give up something to ‘keep the peace.’</td>
</tr>
<tr>
<td>Collaborating</td>
<td>You work with others to find a solution that satisfies everybody. This is ‘healthy’ conflict: win-win situation.</td>
</tr>
<tr>
<td>Accommodating</td>
<td>You emphasize similarities and minimize differences between your perspective and others’ perspectives. This often masks the real issue.</td>
</tr>
<tr>
<td>Competing</td>
<td>You have to win.</td>
</tr>
</tbody>
</table>

Collaboration is the only effective conflict management strategy. Collaboration takes place when:

1. Basic communication ground rules are established, such as respectful consideration of everybody’s opinion.
2. All key stakeholders are included in the discussion. A speaker list can be a helpful way to ensure that everybody has a voice.
3. Common goals are identified. Unhealthy conflict happens when people take sides based on their own self-interests. A common goal, such as improved patient care delivery, connects people to a common vision and purpose that go beyond self-interests.

Did you know? A study was done on nurses’ preferred conflict management styles. The results are below:

#1 = avoiding
#2 = accommodating
#3 = compromising
#4 = collaborating
#5 = competing

The most effective style (collaborating) was the next-to-last approach used by nurses. Why? One explanation is that nurses are not trained in conflict management. Education and practice make a big difference in nurses’ ability to effectively manage conflict.
**Conflict Management Exercise**

**What is your primary conflict-handling intention?**
Indicate how often you rely on each of the following tactics by circling the number that you feel is most appropriate.

<table>
<thead>
<tr>
<th></th>
<th>Rarely</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) I argue my case with my co-workers to show the merits of my position.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>2) I negotiate with my co-workers so that a compromise can be reached.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>3) I try to satisfy the expectations of my co-workers.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>4) I try to investigate an issue with my co-workers to find a solution acceptable to us.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>5) I am firm in pursuing my side of the issue.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>6) I attempt to avoid being put on the spot and try to keep my conflict with my co-workers to myself</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>7) I hold on to my solution to a problem.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>8) I use give-and-take so that a compromise can be made.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>9) I exchange accurate information with my co-workers to solve a problem together.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>10) I avoid open discussion of my differences with my co-workers.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>11) I accommodate the wishes of my co-workers.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>12) I try to bring all our concerns out in the open so that the issues can be resolved in the best possible way</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>13) I propose a middle ground for breaking deadlocks.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>14) I go along with the suggestions of my co-workers.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>15) I try to keep my disagreements with my co-workers to myself in order to avoid hard feelings</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>
What is your primary conflict-handling intention?

To determine your primary conflict-handling intention, place the number 1 through 5 that represents your score for each statement next to the number for that statement. Then total up the columns.

<table>
<thead>
<tr>
<th>Competing</th>
<th>Collaborating</th>
<th>Avoiding</th>
<th>Accommodating</th>
<th>Compromising</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)_______</td>
<td>4)_______</td>
<td>6)_______</td>
<td>3)_______</td>
<td>2)_______</td>
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<tr>
<td>5)_______</td>
<td>9)_______</td>
<td>10)_______</td>
<td>11)_______</td>
<td>8)_______</td>
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<tr>
<td>7)_______</td>
<td>12)_______</td>
<td>15)_______</td>
<td>14)_______</td>
<td>13)_______</td>
</tr>
</tbody>
</table>

Totals:

_________  ___________  ___________  ___________  ___________

Your primary conflict-handling intention is the category with the highest total. Your fallback intention is the category with the second-highest total.

Reference:


How can I manage conflict more effectively?

- When managing conflict, try to remember that each party has their own needs, emotions and perceptions. Try putting yourself in the other party’s shoes and understanding where they are coming from.
- Don’t jump to conclusions about the other party’s intentions or goals – they might be more similar to your own than you think. Consider collaboratively writing a list of goals and then work backwards to find solutions. Be careful not to reject options proposed by the other party prematurely.
- Identify and openly discuss differences in perceptions.
- Begin from the most respectful interpretation of the other party’s actions and statements. Be careful not to place blame.
How to Run an Effective Meeting

Here are some tips to make the most effective use of time spent in meetings.

5 Steps to Running an Effective Meeting

- Make every meeting matter
- Establish an agenda and set goals for the meeting
- Take charge of your meeting
- Encourage input from everyone
- Leave with a plan

Step 1: Make Every Meeting Matter

Make sure a meeting is needed and that one is not being held just because it’s on the schedule. Once you have decided to have a meeting, only invite people who really need to be there. These are people who have something to contribute or who have something to gain from the meeting. This also includes individuals who have the power to move an action plan forward. You might want to invite some people to only a portion of a meeting. A good idea, for instance, is to set aside about 15-30 minutes at the end of each meeting to update your operations leader or director on how you’re progressing with your project work. What should they know? What might you need from them to move forward with your project? Operations leaders can often provide you with access to important information and resources.

Step 2: Establish an Agenda and Set Goals for the Meeting

Write an agenda and distribute it to attendees 1-2 days before your meeting (See page 23 for a Sample Meeting Agenda). This will ensure that everyone understands the objectives of the meeting, and it’s a good ‘refresher’ to get team members thinking about the upcoming meeting—it gets everyone on the same page. When you send out the agenda to attendees, ask them whether you’ve missed anything that needs to be added to the agenda: this facilitates more participation.

Step 3: Take Charge of Your Meeting

At the beginning of each meeting, set aside time up front to: a) Review the agenda and get an “OK” from team members; 2) Review your Team Guidelines or Ground Rules (page 15); and 3) Do a quick check-in to find out how everybody is doing. These simple meeting starts can set the stage for an open, engaged meeting.

Begin and end meetings on time! If someone is late to a meeting, catch them up during a break.

Stay on track. One way to do this is to have a meeting agenda with time allotted for each topic (i.e., Topic #1: Review staff feedback on project—15 minutes). If the topic begins to run off the rails, bring the conversation back to the topic at hand. Remind people of the topic time limit. If the new topic seems important to the group, you may need to revise your agenda. You can decide to build
in more discussion time for that item and eliminate other items of less importance, or add the item to the agenda for the next meeting. The group needs to determine the priority of agenda items. The process can be fluid and each meeting does not need to rigidly follow an agenda—this can shut down important conversation. It’s important, however, to maintain control of the meeting so that agreed-upon meeting goals/priority agenda items are covered during your allotted meeting time.

**Step 4: Encourage Input from Everyone**

Make sure everyone is heard. Nudge quiet types, curb the longwinded, reign in tangents, and control outbursts. Foster a respectful environment where everyone is heard and where one person does not dominate the conversation. Call on those who do not speak and gently remind those who speak too much. Shutting someone down or immediately saying ‘no’ might hinder brainstorming, so be respectful and encourage all participants. As mentioned before, you may need a Speaker’s List to indicate speaking order if there are many team members starting to talk at the same time.

**Step 5: Leave with a Plan**

At the end of a meeting, review action plans and ensure everyone knows what and when things are expected of them. This ensures action items are followed up and the project keeps moving forward. These action plan items are a commitment or “contract” among team members, and it’s important to get confirmation from individuals that they understand what they’re being asked to do before the next meeting.

**Jobs for Meeting Attendees**

Every meeting needs a Note (Minutes)-taker and a Facilitator. Rotating these responsibilities is a good idea—to give everyone practice with these important roles and ensure equitable workload among team members. It helps to have a consistent person in these roles for a few, consecutive meetings. A facilitator takes responsibility for steps 1-5 (all the important meeting steps). Note-takers do the Minutes, and they may assist with other team communications. We’ve found that it’s helpful to have the facilitator or another team member record key ideas or discussion themes on a flip chart or whiteboard. These visuals help everyone follow along.
Example Meeting Agenda

Provincial Nursing Workload Project
Project Team Meeting 10
August 21 2009, 8:00am – 3:30pm
Agenda

8:00am – 8:45am  Check-in & New Business
(a quick check on how everybody is doing &
discussion of new events/ issues since previous meeting)

8:45am – 9:00am  Short Break

9:00am – 11:30am  Action planning*
(Discussion of team’s action items)

11:30am – 12:30pm  Lunch

12:30pm – 2:30pm  Action planning

2:30pm – 3:00pm  Communications
(Agree on a communications plan for key stakeholders)

3:00pm – 3:15pm  Check out
(Quick round of how everybody feels about the meeting)

3:15pm – 3:30 pm  Wrap-up
(Review of key action items)

* Tools for action planning are in another section of the toolkit
# Meeting Minutes Template

**Team Meeting Minutes**

<table>
<thead>
<tr>
<th>MEETING DATE</th>
<th>MEETING TIME</th>
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</table>

<table>
<thead>
<tr>
<th>TYPE OF MEETING</th>
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<table>
<thead>
<tr>
<th>FACILITATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NOTE TAKER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>ATTENDEES</th>
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## Agenda topics

<table>
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<tr>
<th>TIME ALLOTTED</th>
<th>AGENDA TOPIC</th>
<th>PRESENTER</th>
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<tr>
<th>DISCUSSION</th>
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<table>
<thead>
<tr>
<th>CONCLUSIONS</th>
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<table>
<thead>
<tr>
<th>ACTION ITEMS</th>
<th>PERSON RESPONSIBLE</th>
<th>DEADLINE</th>
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<tbody>
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<table>
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<th>TIME ALLOTTED</th>
<th>AGENDA TOPIC</th>
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<th>PERSON RESPONSIBLE</th>
<th>DEADLINE</th>
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</table>
Section 3 – Creating Effective Change

There are changes going on all the time in healthcare—change can be daunting! Within healthcare, nurse leaders often get assigned to change management projects within their practice environments. Effective leaders work collaboratively with their nursing staff, because front-line nurses know their practice environments best. Although many change projects arise from higher levels within an organization, nurses and nurse leaders can also drive change. When something doesn’t work, nurses and nurse leaders should employ change management tools to create change that will enhance staff and patient outcomes. The following tools will help you create effective change!

The first subsection is on action research, because this approach was used with the PNWP projects. Action research acknowledges that nurses are the experts and know the most about their practice environments. Any successful change requires front line nursing input, and the action research approach is based on this premise. Information about empowerment is included, because successful change also requires empowered leaders and empowered nurses. Although it may seem like a cookbook approach, there are tried and true steps that you must follow in order to have successful outcomes. The change management subsection provides a table with the key steps you must address with any project. Innovation means “good change,” and there is an Innovation Theory that tells us how to ensure effective dissemination or spread of good ideas. The Plan-Do-Study-Act (PDSA) cycle helps us plan, test, evaluate and refine possible solutions. This cycle is a tool used by the Institute of Healthcare Improvement (IHI) to “chunk” out actions that project teams can carry out quickly (over a few weeks or months) to keep the change/innovation momentum going. Project plans/grids or action plans are visual displays of how to break down a problem into specific, manageable steps. They also serve as team blueprints for what has to happen (by whom, when, how). Effective communication with all your stakeholders is essential (See the Communication Plan on pages 16-17), and surveys are one way to gather feedback from stakeholder groups, such as your staff. Communicating the end of a project and project team successes is equally important—giving closure to work well done. Celebrate your successes!

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Change Management .................................................... 31
Innovation ................................................................. 33
Plan, Do, Study, Act (PDSA) ........................................ 35
Action Planning Worksheet ........................................... 37
How to Create a Survey  42
Celebrating Successes  45
Action Research

Action Research is a popular form of research in the healthcare professions, although it is commonly used by sociologists and psychologists, too. It has been used by nurses to improve their practice environments; it has been used by clients with problems, such as multiple sclerosis, to find better ways to manage their lifestyle needs; it has been used by families of patients with chronic illness to build communities of support and respite; it has been used by oncologists to find ways to incorporate alternate healing strategies into practice. It is not only a research tool, but an action tool - a way to bring about positive, significant change (Reason & Bradbury, 2001; Stringer & Genat, 2004)

How Does It Work?

Action Research is a “systematic, participatory approach to inquiry that enables people to extend their understanding of problems or issues and to formulate actions directed towards the resolution of those problems or issues” (Stringer & Genat, page 4). In other words, people who know their environment collaborate together to find the best ways of working and living together within that environment. They use tools, such as the Plan-Do-Study-Act (PDSA) cycle to systematically analyze their situation. In Action Research, the people within the environment are the experts. Facilitators, such as outside researchers, guide the experts through the process of figuring out what works well-and what needs some fine-tuning.

In addition to systematically analyzing the environment, Action Research means Action. Based on experts’ careful analysis of the environment, they make decisions to test out ways to improve the environment. Action Research has shown that there often are innovative ways of utilizing the resources at hand-innovative ways that can make significant, positive differences. The key components off Action Research are:

- Capturing experts’ experiences and perspectives. This can be done through surveys, focus groups, brainstorming sessions, and team meetings with lots of discussion.
- Identifying key features of importance. Experts sift through everything they’ve uncovered about their environment/situation and come up with some key issues they want to address. They believe they can competently address these issues with the information, supports, resources available to them.
- Communicating: Experts don’t operate in a vacuum. They often have the help of facilitators, such as trained researchers, but they also have internal supports, such as management, peers, colleagues, and patients/residents/clients. Action Research goes well when there are open lines of communication among the experts and between the experts and key stakeholders. Experts often have to go to a variety of key stakeholders, internal and external, to share ideas, gather feedback, and discuss possible courses of action.
- Creating solutions: Experts suggest possible courses of action to address changes they would like to make. There are tools, such as action plan worksheets, that systematically map out suggested courses of action. Remember that experts suggest courses of action after thoughtful analysis and consultation with key stakeholders. Getting buy-in beforehand from key stakeholders can reduce resistance to expert suggestions. In fact, when experts communicate closely with key stakeholders, such as management and peers, things go much more smoothly.
Piloting and testing: Even experts need to take small steps. It is important to take time to test out one small change at a time. If too many things are changed at one time, it is impossible to know what did or did not make a real difference. Experts have to identify what they expect to happen as a result of each suggested change. Researchers call these “outcomes indicators”. For instance, an expert project team decides to pilot hourly rounds on their unit. They agree to test this intervention over 2 weeks. They agree that if this intervention works, patients should not use their call lights as often. They design a special checklist to keep track of call light use during the 2-week pilot. They find that when nurses check with their patients on a regular, hourly basis, patients use their call lights significantly less frequently. Call light use is an outcomes indicator. It is important that outcomes indicators are: 1) obvious, direct outcomes or results of the pilot intervention, and 2) easy to measure.

Bottom Line
Action Research is a special form of research that can be done by anyone who really knows their environment/situation and cares about it. This form of research not only involves a close examination of a situation, but it also results in action - action that hopefully leads to improved outcomes.
Empowerment

Magnet hospitals are hospitals that do an excellent job of recruiting and retaining nurses. Magnet hospital research shows that nurses want to work in practice environments that empower them (Laschinger et al., 2003). Empowered nurses have lower rates of burnout and turnover and greater job satisfaction. Nurse empowerment is associated with high standards of professional practice and better patient care outcomes (Laschinger, 2008; Laschinger & Leiter, 2006). When healthcare institutions empower their nurse employees, there are better organizational outcomes: fewer patient complications and less money lost from recruiting and training new staff due to high turnover.

Overall, when nurses are empowered, there are better outcomes for nurses, patients and the organization.

What is Empowerment?
Nurse empowerment = having a voice in decision-making.

According to Dr. Heather Laschinger, a well-known nurse researcher:

“Nurses value work environments that provide opportunities to make decisions based on their expertise and professional judgment and to be involved in decisions that affect their working conditions... When nurses perceive their work environment to be empowering, they feel more supported to practice in a professional manner.” (2008, p. 328)

How Can Healthcare Organizations Empower Nurses?
The magnet hospital research has shown us what organizations need to do to empower nurses. A well-known business guru, Dr. Rosabeth Kanter (1977) from Harvard, says that empowered employees, such as empowered nurses, have access to information, leadership support, necessary resources to do the job, and opportunities to learn and to grow professionally. When these sources of power are unavailable in the organization, effective work is hampered or impossible to do.

Dr. Laschinger has done research in Canada that shows that empowered nurses work with management to make decisions about how to improve the practice environment. They also have a lot of autonomy about practice decisions related to their own patients, and they typically have good, professional relationships with physicians and other healthcare professionals.

Kanter’s view of empowerment is a very popular one, and a lot of research has been done on nursing empowerment using her model. There are other empowerment models that look at psychological empowerment, political empowerment, etc. Less is known about nursing empowerment from these other points of view. Another Canadian nurse researcher, Dr. Sonia Udod, published an article (2008) that uses a model of power based on the work of Michel Foucault, a French sociologist who studied power in a number of settings, including healthcare...
settings. According to Udod (and Foucault), empowered nurses “question the institutional and unit practices that are often taken for granted. In addition to using reflexivity within their own professional practice, nurses should also use it to discern how their practice is constituted and facilitated in their work environment. They can explore the conditions under which they act to govern their practice...This approach could create opportunities for nurses to structure their practice differently and improve their ability to ‘self’ rule.” (Udod, 2008, p.88)

**Bottom Line**
Regardless of the model of power/empowerment that you use, nursing empowerment means engagement: reflection, discussion, decision-making about nurses’ practice environments and care delivery. Organizations and leadership can promote nurse empowerment by providing access to information, resources, and opportunities to share in decision-making and change management projects, but nurses also have a professional responsibility to make it happen.
Change Management

Dr. John Kotter, a change management expert from Harvard University, has determined that there are eight key steps to follow (Kotter, 2007) when engaging in any change/innovation project. Successful change is more likely to occur if these steps are thoughtfully carried out. They are summarized below:

<table>
<thead>
<tr>
<th>Change Steps</th>
<th>Actions Needed</th>
</tr>
</thead>
</table>
| 1. Create a sense of urgency. People need to be convinced that a change is necessary. This is harder than it seems. People have to be emotionally convinced that change has to happen. What would it take to convince you? | a. Do a survey or needs assessment to find out what people are thinking. This is a good starting point - once you know what is important to people, you can make a better argument for change.  
  b. Besides a survey or needs assessment, collect other data or evidence to support the need for change. What’s convincing evidence? Patient satisfaction surveys, nurse and patient injuries, high nurse turnover?  
  c. Get management on board. Managers have the formal authority to make things happen - or they’re connected to sources of formal power. |
| 2. Form an effective team. Work gets done more effectively when committed people work together. | a. Identify people with a shared commitment to change - people who are willing to take some calculated risks, to try something new.  
  b. Get management on board. You need people with power on your side. |
| 3. Create a vision. Have a clear, succinct vision for your team: what you hope to accomplish. The vision is the headline or banner for your team’s change project. People easily get sidetracked and discouraged during change, because change is hard and it is frustrating. A simple, clear vision helps hold the team together, and it reminds everybody about the importance of the change project. | a. The vision should be short and easy to remember, like: “The purpose of this project is to empower nurses.”  
  b. Get team consensus on a team vision. |
| 4. **Communicate the vision.** It is also important to plan for how you will communicate the vision and vital information about the project. Who needs to know what? | a. Use a variety of communication methods to share the vision and information about the change project. E-mail, flyers, bulletin boards, communication books, staff meetings, informal chats, etc. When something is important to communicate with others, in-person communication is the best route for sharing and discussion.  
   b. Systematically plan for how you will communicate information about the change project to key stakeholders.  
      1. Identify your key stakeholders. A stakeholder is anyone who will be affected by the change.  
      2. How will you share information with them? When, where? |
| --- | --- |
| 5. **Empower others to act on the vision.** | a. Be positive about change. Role model enthusiasm and confidence.  
   b. Encourage risk-taking. Consider everybody’s ideas. |
| 6. **Plan for and create short-term wins.** Because change can be a slow, difficult process, it is important to have some quick successes to show people you mean business. | a. Identify some short-term changes you can make.  
   b. Carry them out in an expedient fashion.  
   c. Publicize your results! Let people know what you’re doing. Emphasize why they’re important to everybody. |
| 7. **Consolidate improvements and produce more change.** Keep change going by identifying more opportunities for improvement. | a. Use your short-term wins to get buy-in from more people - a snowball effect. |
| 8. **Institutionalize new approaches.** As more and more people buy in to change, the change will become the status quo. | a. Get management to help with this.  
   b. Management can help authorize policies, procedures, expectations to establish new norms or culture to accompany change. |
Innovation

There are many wonderful innovations in healthcare right now. The problem is, how do you get people to use them? Innovation, a good, evidence-based idea, needs to be combined with effective change management.

Dr. Donald Berwick is the founder of the Institute of Healthcare Improvement (IHI), a global, non-profit organization that seeks out evidence-based strategies to improve quality and safety in healthcare settings. Dr. Berwick advocates the use of Innovation Theory, a theory based on the work of sociologists, to identify the types of people you need on board to spread or diffuse innovation (2003). The innovation curve (page 34) demonstrates who needs to be on board for positive change to happen. The descriptions of the different types of people within the curve are described below.

Innovators are people who go out and find the innovations or the great ideas. These may be people who like to go to conferences. They have a knack for picking up great ideas.

The early adopters are leaders. They are people who recognize the importance of an innovation and are willing to champion it. They support the innovators and help to get others on board. They can explain the innovation and get others excited about it.

The early majority are interested in what the early adopters have to say. They will listen to the early adopters - they might even help pilot the innovation.

The late majority don’t like to take risks. They “watch and see.” If the early majority has success, they’ll follow along.

The laggards (non-traditionalists) really dislike risk. They are often the historians or the ones who have seen innovations come and go. They are distrustful of “another change.” Eventually, they’ll either leave or switch over to the innovation - usually when the innovation has become the new norm or status quo for everybody else.

Everybody plays a role and is important. For change to happen, 15 to 20% of the first part of the curve needs to be committed to the change: to try out the innovation. There needs to be leadership and an eager, willing early majority to test out the idea. Once momentum starts, it readily catches on.

Bottom Line

We often focus our energy on the people who are most resistant. This is a waste of energy, because they are so hard to get on board. We should focus our energy on identifying and supporting committed people who are willing to take some calculated risks.
Adopter Categorization on the Basis of Innovativeness

- Innovators: 2.5%
- Early Adopters: 13.5%
- Early Majority: 34%
- Late Majority: 34%
- Laggards: 16%

Time to Adoption (SDs From Mean)

The PDSA Cycle

Once a team has set an aim, established its membership, and developed measures to determine whether a change leads to an improvement, the next step is to test a change in the work setting. The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change – by planning it, trialing it, observing the results, and acting on what is learned. This is similar to the scientific method or the nursing process, and it is commonly used in action research.

Reasons to Test Changes

- To increase belief that the change will result in improvement
- To decide which of several proposed changes will lead to the desired improvement
- To evaluate how much improvement can be expected from the change
- To decide whether the proposed change will work in the actual environment of interest
- To evaluate costs, social impact, and side effects from a proposed change
- To minimize resistance upon implementation

Steps in the PDSA Cycle

1) PLAN: Plan the test or observation, including a plan for collecting data
   - State the objective of the test
   - Make predictions about what will happen and why
   - Develop a plan to test the change (Who? What? When? Where?)

2) DO: Try out the test on a small scale
   - Carry out the test
   - Document problems and unexpected observations
   - Begin analysis of the data/results

3) STUDY: Set aside time to analyze the data and study the results
   - Complete the analysis of the data, reflect on the information you’ve gathered
   - Compare the results to your predictions
   - Summarize and reflect on what was learned

4) ACT: Refine the change, based on what was learned from the test
   - Determine what modifications should be made
   - Prepare a plan for the next test
Retrieved & adapted from:
http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/testingchanges.htm
Action Planning Worksheet

The action plan worksheet is a tool we’ve designed to help you think through and plan for the actions you’ll need to carry out to accomplish desired outcomes. As you begin working on your project, you will need to revise the worksheet based on new information and the outcomes of your early steps. For example, if one of your first steps is denied approval, you will need to revise and update your plan. When collaborating with others, allow for more time and expect delays. The deadlines are to keep you on track and accountable, but timelines might need to be revised as you go forward with your plan. Note: You can “Google” action plans, project plans, project grids and find many other, wonderful tools. This is only one, suggested way of organizing your project work.
### Action Planning Worksheet

**Define:** What is the main issue or challenge that you want to tackle?

**Contributing factors:** What are the factors contributing to the issue/challenge?

**Goals:** What are your main goals? What do you want to accomplish?

**Missing information:** What do you need to know to start this project?

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<td>4</td>
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**Stakeholder analysis:** Who do you need to inform, involve, request approval from?

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**Action Plan:** Plan out your actions step-by-step. Ensure that your plans are **SMART**: Specific, Measurable, Achievable, and that you have adequate Resources & Time. **Prioritize your first steps.** You’ll probably need to add more steps as you go along. Note: Be sure there is only one action item per step.

<table>
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<tr>
<th></th>
<th>Action</th>
<th>Lead</th>
<th>Key people</th>
<th>Resources</th>
<th>Deadline</th>
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**Evaluating your Outcomes:** How will you know if you’ve been successful? Create measurable outcomes with realistic deadlines. Evaluation is often left out of projects, but it is the most important part of what we do—it tells us whether or not we’ve met our goals.

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<thead>
<tr>
<th></th>
<th>Evaluation criterion</th>
<th>Deadline</th>
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<td>3</td>
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</table>
## Sample Completed Action Planning Worksheet

### Define: What is the main issue or challenge that you want to tackle?

Slings are disorganized, difficult to find, not being cleaned, incorrect slings are often used for residents.

### Contributing factors: What are the factors contributing to the issue/challenge.

- No one takes responsibility for organizing & cleaning the slings
- There’s no system in place
- The slings are kept far away from residents’ rooms
- Slings are kept in bins which are difficult to dig through

### Goals: What are your main goals? What do you want to accomplish?

- Would be able to find appropriate slings easily & quickly
- The right sling is being used for the right resident
- Slings are cleaned regularly
- Everyone knows the system for organizing & cleaning the slings

### Missing information: What do you need to know to start this project?

1. What are people doing now, and who is responsible for organizing & cleaning slings?

2. Do we have enough slings for the residents?

3. 

4. 
**Stakeholder analysis:** Who do you need to inform, involve, request approval from?

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Operations manager re:</strong> buying &amp; putting up sling hooks – need approval</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><strong>RCAs re:</strong> creating a schedule to wash &amp; change slings – need to involve</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td><strong>Physiotherapy re:</strong> education to ensure the correct slings are being used for each resident – need to involve</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td><strong>RNs re:</strong> what the new system will look like – need to inform</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Action Plan:** Plan out your actions step-by-step. Ensure that your plans are **SMART:** Specific, Measurable, Achievable, and that you have adequate Resources & Time. **Prioritize your first steps.** You'll probably need to add more steps as you go along. Note: Be sure there is only one action item per step.

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<th>Lead</th>
<th>Key people</th>
<th>Resources</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Draft a slings protocol (organization &amp; cleaning)</td>
<td>Carrie</td>
<td>Team</td>
<td>Time off unit</td>
<td>Apr 1</td>
</tr>
<tr>
<td>2</td>
<td>Meet with RCAs to discuss preliminary protocol</td>
<td>Moira</td>
<td>RCAs</td>
<td>Time off unit</td>
<td>Apr 8</td>
</tr>
<tr>
<td>3</td>
<td>Request approval from Ops Leader</td>
<td>Suzy</td>
<td>Team leader</td>
<td>None needed</td>
<td>Apr 15</td>
</tr>
<tr>
<td>4</td>
<td>Submit maintenance request for hooks</td>
<td>Patty</td>
<td>Ops leader Team</td>
<td>Available $ for hooks &amp; labor</td>
<td>Apr 22</td>
</tr>
<tr>
<td>5</td>
<td>Organize education sessions with RCAs</td>
<td>Sheri</td>
<td>Team leader RCAs Educator</td>
<td>Time off unit</td>
<td>May 15</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Evaluating your Outcomes:** How will you know if you've been successful? Create measurable outcomes with realistic deadlines. Evaluation is often left out of projects, but it is the most important part of what we do—it tells us whether or not we’ve met our goals.

<table>
<thead>
<tr>
<th></th>
<th>Evaluation criterion</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RCAs report less time searching for slings – discuss at staff meeting</td>
<td>May 30</td>
</tr>
<tr>
<td>2</td>
<td>The correct slings are being used for each resident – arrange audit with PT</td>
<td>May 30</td>
</tr>
<tr>
<td>3</td>
<td>Slings are being cleaned weekly – arrange audit with RCAs</td>
<td>May 30</td>
</tr>
</tbody>
</table>
How to Create a Survey

Change management projects often involve surveys of staff, patients/residents/clients, etc. Here are some tips to maximize your response rate and the value of the results if you need to prepare and apply a survey.

Surveying Your Staff or Patients/residents/clients

There are four steps in conducting a successful survey. They are:

- Define your objectives
- Determine who completes the survey
- Develop the content
- Analyze the results

Step 1: Define Your Objectives

What do you want to know from the survey? Your objectives will shape your survey questions.

If you don’t ask enough questions, or the right questions, you won’t get the information you need. If you try to include too much, the survey can get too long and people may disregard it because of its length. Or they may invest the time to complete it and tell you more than you can handle!

Step 2: Determine Who Completes the Survey

Identify those individuals whose opinions you want to measure. Is it everyone on staff? Do you want to survey all of them or a sub-group? Use the survey to reach people whom you would otherwise miss. For example, don’t just survey the handful of people you see most often. Distribute the questionnaire to people you tend not to interact with as frequently. They might have ideas or problems that you wouldn’t otherwise hear about.

Step 3: Develop the Content

The questions you ask flow from the objective you identified in Step 1. Resist the temptation to stray from the core issues to include topics you’re merely curious about. Follow these steps:

- Draft the questions. Make sure every question relates clearly to your objectives. Keep them simple and concise. Long questions force people to work too hard to understand what you want. Eliminate unnecessary words.

  Instead of: Does the clerk provide caring service all the time when you ask for their help?
  Ask: Does the clerk provide caring service? (Yes/No)

- Avoid ambiguous, vague and leading questions. For example, loading your question with positives can create “language bias” that influences how people respond.
Instead of: *Were you delighted with the changes to the kardex?*
*Ask: How would you rate the changes to the kardex?*

- Limit each question to one point. Otherwise, you may confuse someone who wants to respond positively to one part of the question and negatively to another.

Instead of: *Was the clerk pleasant and did she handle the request quickly?*
*Ask 2 separate questions: Was the clerk pleasant? Did the clerk handle the request quickly?*

- Put some thought into the order of the questions. Survey designers often warn about "order effect," or the sequence with which you ask questions. Where you place certain questions within the survey can influence what kind of answers you get. Ask specific questions first. End with "overall impression" questions. Specific questions will get people thinking, and you will get more honest, thoughtful impressions to general questions at the end of a survey.

- Choose a response format. There are two common options: a checklist and a Likert-type scale. Checklists have "yes" or "no" options. A Likert-type rating scale has a range of responses. Some examples of Likert-type scales:

<table>
<thead>
<tr>
<th>Rating</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example 1:</td>
<td>strongly disagree</td>
<td>disagree</td>
<td>neutral</td>
<td>agree</td>
<td>strongly agree</td>
</tr>
<tr>
<td>Example 2:</td>
<td>very dissatisfied</td>
<td>dissatisfied</td>
<td>indifferent</td>
<td>satisfied</td>
<td>very satisfied</td>
</tr>
<tr>
<td>Example 3:</td>
<td>very poor</td>
<td>poor</td>
<td>average</td>
<td>good</td>
<td>very good</td>
</tr>
</tbody>
</table>

The Likert-type scale allows people to express degrees of opinion and thus offers richer information than a two-option checklist. The utility of multiple response options levels off after five responses or choices. So while a five-point scale is better than just two options, ten is not necessarily better than five.

**Note:** Whichever response format you choose, you might want to add NR (not relevant), NA (not appropriate) and/or DR (decline response) options since there may be cases where the question is not relevant to the respondent, or cases where the material in question is sensitive and respondents might not feel comfortable answering certain questions.
- Use open-ended questions when you want some examples or explanations from respondents that go beyond Yes/No or Likert-type responses. However, use open-ended questions sparingly. They require more work to summarize.

- A combination of question formats is a good idea. Yes/No or Likert-type questions are great for easy comparisons, and open-ended questions provide detailed examples and explanations.

- Leave room for comments at the end of the survey. If a respondent has a specific problem or issue they want to share with you, that’s the place to describe it.

- Test the questions. Ask a “pilot group”, or small number of people, to complete the survey before you finalize it. They’ll help you flag any confusing or unnecessary questions.

- Keep it short. Long surveys reduce the number of responses you’ll get. And leave lots of white space so that the layout doesn’t intimidate or overwhelm respondents.

- Thank respondents for completing the survey.

**Step 4: Analyze the Results**

A computer spreadsheet program, like Excel, can make analysis easier to do. It is also possible to create a table with a Word document or by hand to sort the data into categories for easier comparison.

Celebrating successes

It is important to periodically take stock of what you’ve done and to celebrate the successes you’ve had along the way (Kotter, 2007). What have your group’s successes been? Consider successes such as improved communication and teamwork as well as more concrete and tangible successes. Some ways to celebrate:

- List your achievements on poster boards or a flip chart so you can see everything you’ve done
- Make a flyer, powerpoint presentation, or poster about your initiatives for the rest of the staff
- Have a potluck or include food while you discuss your project work – consider inviting other interested parties. You know how we all like food!
## Section 4 - Developing a Staffing Plan

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<td>49</td>
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<td>Adapting the Synergy Model for Use with Your Population</td>
<td>52</td>
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<td>Clarifying Terms &amp; Creating Markers</td>
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<td>Refining Your Adaptation of the Synergy Model</td>
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<td>Determining Inter-Rater Agreement</td>
<td>63</td>
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<td>Creating Guidelines for a Safe Staffing Assignment</td>
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<tr>
<td>Creating a Safe Staffing Assignment</td>
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<tr>
<td>Other Suggested Uses of the Adapted Synergy Model</td>
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The Synergy Model

During Phase 2 we looked at workload issues related to staffing. Safe, effective staffing depends on making a match or fit between patient/resident/client care needs and staff competencies. The environment, such as the physical layout of a unit/program, is another important staffing consideration. For the PNWP, we used the synergy model to systematically determine the care needs of patients/residents/clients. The synergy model was developed and validated by an expert panel of nurses (1990s-2000s) to describe the care needs of critical care, acute care, and sub-acute care neonatal, pediatric, and adult patients. This work was originally commissioned by the American Association of Critical-Care Nurses (AACN). Since then, the model has been used as a professional practice model in a number of US healthcare systems (Curley, 2007). It is currently being used in a Research to Action pilot project in Saskatoon, Saskatchewan (personal communication, Lynn Digney Davis, Chief Nursing Officer for Saskatchewan).

The synergy model is a “patient-centered care model” based on 8 universal characteristics of patients/residents/clients (stability, complexity, predictability, resiliency, vulnerability, participation in decision making, participation in care, and resource availability). The synergy model provides a means for care providers to articulate their patients/residents/clients’ characteristics, to consider the impact those characteristics have on workload, and to determine the professional healthcare provider best suited to meet their needs. According to the synergy model, a ‘fit’ between nurses’ competencies and patient/resident/client and family needs results in the best possible outcomes for the patient/resident/client, the family, and the healthcare system.

The PNWP project teams from different healthcare sectors agreed that the 8 characteristics of the synergy model captured what caregivers do to meet the needs of their patients/residents/clients. The characteristics reflect the holistic concerns of patients/residents/clients in a variety of healthcare settings. Feedback from the project teams confirmed the original validation work of the patient characteristics component of the synergy model (Curley, 2007).

The synergy model has a “nurse characteristics” component that was based on all-RN staff in the US (Curley, 2007). For the PNWP, we did not use this component of the model, because project team composition included a variety of direct care providers, including Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Registered Psychiatric Nurses (RPNs), Care Aides, Counsellors and Social Workers. Instead, we asked project teams to match staff characteristics to patient/resident/client needs based upon their scopes of practice, specialized skills, and experience with the population/site, following healthcare facility policies. We found that project teams were able to successfully create staffing rules for their patient/resident/client populations using this approach.

How does it work?

The patient characteristics component of the synergy model can be used as a patient/resident/client rating tool that yields individual “synergy scores” from 1-5 (1=most acute and 5=least acute). Each of the 8 characteristics is rated from 1-5, and it is possible to average the 8 scores to get a single synergy score. The 8 characteristics capture unique needs of each patient/resident/client to contextualize care delivery and ensure a better fit with staff characteristics.
The average synergy scores permit management to look at trends in acuity, care needs, and associated workload for the patient/resident/client population over shifts, months, quarters, etc. The average synergy scores have also been used to evaluate workload distribution among care providers. For example, in one PNWP acute care setting, average scores were used to ensure that new graduates received, on average, less acute patients during their orientation. While making assignments for new graduates, the clinical nurse leader used patients’ individual characteristic scores to identify patients with different care delivery needs who would provide a variety of learning experiences for the new graduates.

What can you do with the synergy model?

In the US, the synergy model has been successfully used as a professional practice model or framework to enhance nurses’ care delivery, resulting in increased clinical autonomy at point of care, increased nurse involvement in care delivery decisions, and improved inter-professional communications. It has served as a tool for: developing staffing plan processes, care planning, shift-to-shift reporting, rounding with other healthcare professionals, tracking performance trends at unit/program levels, performance appraisals/professional development, and nursing education (Curley, 2007; Kaplow & Reed, 2008; Kerfoot et al., 2006). The bulleted list below provides suggestions of how you can use the patient characteristics component from the synergy model to enhance your practice:

- **Communication**: The synergy model provides a common, standardized language that helps care providers communicate more effectively with each other. Use the rating tool as a ‘real-time’ communication tool during: hand-overs, shift-to-shift reports, Rounds, and care conferences.

- **Treatment/Care Planning**: Use the tool to capture patient/resident/client care needs on Kardexes and in practice notes. Use the 8 patient/resident/client characteristic scores to highlight areas of need.

- **Staffing Assignments**: Use the tool to determine who is best suited to care for an individual patient/resident/client. Staffing plan processes should be an inclusive process between staff and management. Consider your staff’s scope of practice, years of experience, experience with the population, and specialized skills. Develop staffing decision rules for making shift-shift staffing decisions.

- **Safe and Effective Workloads**: Use the tool to develop rules for making workload requests (i.e., requests for additional staff). Use the scores to ensure equitable workload distribution among staff.

- **Monitoring Patient/Resident/Client Trends**: Use the tool to monitor acuity and care needs over time. Monitoring will help you identify trends in patient/resident/client needs over shifts, days of the week, etc. More work needs to be done to tie synergy scores to patient/resident/client outcomes and nurse outcomes, but a systematic, objective scoring system is the place to start.

- **Empowerment**: Use the tool to engage staff and management in critical conversations about patient/resident/client care delivery. The PNWP project teams expressed a greater sense of ownership of their work environments by having the opportunity to have in-depth discussions about their patient/resident/client populations.
The Synergy Model’s Eight Patient/Resident/Client Characteristics

Adapted directly from Synergy: The Unique Relationship Between Nurses and Patients (Curley, 2007).

The following eight characteristics are based upon the original language/terminology used by RNs in critical care settings. You may need to adapt the terminology for your specific healthcare setting. For example, in a palliative care facility, high risk of death does not describe instability. Levels 1, 3, and 5 are used as illustrations along the 1-5 continuum for each characteristic.

*Stability* is the ability to maintain a steady state. Stability can be used to describe any vacillating phenomena that impact nursing care – physiological stability, psychological stability, emotional stability, and family or social stability.

- **Level 1** Minimally stable – Labile; unstable; unresponsive to therapies; high risk of death
- **Level 3** Moderately stable – Able to maintain steady state for limited period of time; some responsiveness to therapies
- **Level 5** Highly stable – Constant; responsive to therapies; low risk of death

*Complexity* is defined as the intricate entanglement of two or more systems. This characteristic includes multiple systems and/or therapies – body systems, family and social systems, and/or therapeutic interventions.

- **Level 1** Highly complex – Intricate; complex patient/resident/client/family dynamics; ambiguous/vague; atypical presentation
- **Level 3** Moderately complex – Moderately involved patient/resident/client/family dynamics
- **Level 5** Minimally complex – Straightforward; routine patient/resident/client/family dynamics; simple/clear cut; typical presentation
**Predictability** is the characteristic that allows one to expect a certain trajectory of illness. While most patients/residents/clients have a predictable course of illness, some individuals do not respond in the typical fashion. *When predictable, the patient/resident/client’s care can be managed using traditional practice guidelines; when unpredictable, practice guidelines are not helpful. When the diagnosis is unknown, one cannot anticipate the response to interventions or predict the trajectory of illness.*

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Not predictable – Uncertain; uncommon patient/resident/client population/illness; unusual or unexpected course; does not follow critical pathway, or no critical pathway developed</td>
</tr>
<tr>
<td>Level 3</td>
<td>Moderately predictable – Wavering; occasionally noted patient/resident/client population or illness</td>
</tr>
<tr>
<td>Level 5</td>
<td>Highly predictable – Certain; common patient/resident/client population/illness; usual and expected course; follows critical pathway</td>
</tr>
</tbody>
</table>

**Resiliency** is the capacity to return to a restorative level of functioning using compensatory and coping mechanisms (return to baseline). *How a nurse approaches and plans interventions that might challenge the patient/resident/client’s stability is based upon the individual’s capacity to restore homeostasis.*

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Minimally resilient – Unable to mount a response; failure of compensatory/coping mechanisms; minimal reserves; brittle</td>
</tr>
<tr>
<td>Level 3</td>
<td>Moderately resilient – Able to mount a moderate response; able to initiate some degree of compensation; moderate reserves</td>
</tr>
<tr>
<td>Level 5</td>
<td>Highly resilient – Able to mount and maintain a response; intact compensatory/coping mechanisms; strong reserves; endurance</td>
</tr>
</tbody>
</table>

**Vulnerability** is a susceptibility to stressors that may adversely affect patient/resident/client outcomes. Patient/resident/client vulnerability considers the patient/resident/client’s risk for adverse outcomes. For example, a patient/resident/client presenting with co-morbid conditions places him/her at high risk for adverse outcomes (e.g., smoking and heart disease). *Anticipatory assessment and management of associated risks impact the patient/resident/client’s nursing care and recovery.*

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Highly vulnerable – Susceptible; unprotected, fragile</td>
</tr>
<tr>
<td>Level 3</td>
<td>Moderately vulnerable – Somewhat susceptible; somewhat protected</td>
</tr>
<tr>
<td>Level 5</td>
<td>Minimally vulnerable – Safe; out of the woods; protected, not fragile</td>
</tr>
</tbody>
</table>
*Participation in decision making* describes the extent to which the patient/resident/client or family engages in decision-making (includes capacity, desire, and level of decision making). *The nurse might stand in for – or beside – a patient/resident/client and family to support them through a decision that will impact care and management.*

**Level 1**  
No participation – Patient/resident/client and family have no capacity for decision making; require surrogacy

**Level 3**  
Moderate level of participation – Patient/resident/client and family have limited capacity; seek input/advice from others in decision-making

**Level 5**  
Full participation – Patient/resident/client and family have capacity and make decisions for themselves

*Participation in care* describes the extent to which the patient/resident/client and family participate in care activities (includes capacity, desire, and level of participation). *The nurse either provides or helps the patient/resident/client and family give care.*

**Level 1**  
No participation – Patient/resident/client and family unable or unwilling to participate in care

**Level 3**  
Moderate level of participation – Patient/resident/client and family need assistance in care

**Level 5**  
Full participation – Patient/resident/client and family fully able to participate in care

*Resource availability* is the extent of resources the patient/resident/client, family, or community brings to the care situation (includes personal, physiological, social, technical, and financial resources). *Resource availability impacts the level of support nurses need to provide for patients/residents/clients and their families.*

**Level 1**  
Few resources – Necessary knowledge and skills not available; necessary financial support not available; minimal personal/psychological supportive resources; few social systems resources

**Level 3**  
Moderate resources – Limited knowledge and skills available; limited financial support available; limited personal/psychological supportive resources; limited social systems resources

**Level 5**  
Many resources – Extensive knowledge and skills available and accessible; financial resources readily available; strong personal/psychological supportive resources; strong social systems resources

*Impact on clinician care planning and workload.*
Adapting the Synergy Model for Use with Your Population

During the PNWP, project teams in different healthcare sectors were able to readily adapt the synergy model language to capture the unique needs of their patient/resident/client populations. The model can be used for considering patient/resident/client movement along a continuum of care—versus a static point on a scale. The project teams used the 8 characteristics to discuss current status as well as where clients/residents/patients were coming from and where they were going along an illness/recovery trajectory.

We will now take you through the steps for adapting the synergy model. We will elaborate on each step further in the toolkit.

Overview of Key Steps:

1) Read through each of the characteristics and familiarize yourself with the definitions, clarify terms. Discuss the patient/resident/client characteristic definitions and create “markers” (1-5) for each of the 8 characteristics based on your patient/resident/client population.

2) To refine the markers, score a selection of patient/clients/residents that represent a typical caseload. After scoring, discuss as a group. Obtain agreement for what 1-5 means for each marker with respect to your population. You may need to go through additional cases to ensure that your markers are truly representative of your population.

3) After you have consensus on what each marker (1-5) means, you will need to establish inter-rater agreement (see page 63). Independently score a selection of cases and compare with others to ensure that you have high (90%) agreement and that you’re using the synergy language/markers consistently.

4) Create staffing guidelines that provide a ‘fit’ between patients/residents/clients and care providers. Consider care provider characteristics such as scopes of practice, specialized skills, and years of experience with the population and healthcare facility. Although it is important to address the specific care needs for individual patients/clients/residents based on the 8 scores, for general staffing rules, use the average synergy scores.
Clarifying Terminology & Creating Markers

This is step 1 in our process of developing safe and effective staffing plan processes. You might need to return to this step further along in the process, as you become more familiar with the adapted synergy model.

1. Read through the original definitions in the “Synergy Model’s Eight Patient/Resident/Client Characteristics” document on page 49.

2. Change the terminology where necessary to better reflect the type of patients/residents/clients you care for, and the type of care you provide.

3. Think of your patient/resident/client population and develop a representative 1-5 marker for each of the 8 characteristics.
   a. For instance, how would you describe a 1 for complexity in your population? Think of the most complex patient/resident/client you’ve cared for.
   b. Be careful to stay away from listing tasks as markers – all of the markers should pertain to patient/resident/client characteristics.
   c. The creation of these 1-5 markers for each characteristic should generate a lot of conversation among you.

4. Compare your terminology and markers with the originals to be sure you haven’t lost the original meaning of the synergy model. The markers are meant to illustrate the patient/resident/client characteristics and ensure you are using the same language and are not meant to be used in isolation. See Appendix 2 for examples of markers created by PNWP demonstration site teams.
Refining your Adaptation of the Synergy Model

You’re now ready to move on to step 2, which involves refining your adapted version of the synergy model. To do this, you’ll need to rate your patients/residents/clients and compare and discuss scores with each other. There are a few approaches that you can use:

1) Choose a selection of patients/clients/residents that you believe are representative of your population. The following are examples of how this was done in the PNWP demonstration sites:
   - In acute care, you may obtain a roster/list of all your patients for a 24 hour period.
   - In residential care, this may be the entire resident population of your unit.
   - In home health, this may be the client assignment for a given day.
   - In community mental health, this may be one person’s caseload or a selection of clients from each team member’s caseload.

2) Do a comprehensive chart review so you are able to discuss these patients/residents/clients in detail with your colleagues. Make sure you have enough information about each individual to have an in-depth discussion about them.
   - You will need to have access to charts and Kardexes that you can use as references while you’re scoring and discussing these individuals.

3) Score the sample of your population.

4) Discuss the markers after scoring your population. Revise the markers as necessary.
Example Vignettes and Scoring

Vignette – Acute Care

Bed 2A:
Mrs. L is a 64 yr old with a radical resection of pelvic area to remove a malignant rectal tumor. Fresh post-op with significant blood loss. Her Hgb 1 hr ago was 70. She is now receiving blood. Orders are for her to have another Hgb drawn in 1 hr. She is hemodynamically unstable, with labile blood pressure and heart-rate. ICU is full. Has a double lumen central line catheter. Two IV lines and a PCA and orders for IV meds Q8H. Unable to communicate her needs. No family present. Unable to care for self. Requires close monitoring. Not sure of emotional status as is unconscious at times. Has a foley, large abdominal dressing with a JP, is on O2 4L NP, & has SCDs.
# Synergy Rating

Refer to your rating tool terminology and markers as you fill this out.

**Patient/resident/client:** Mrs. L  
**Date:** March 26 2010

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Definition</th>
<th>Rating</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| **Stability**     | Responsiveness to Therapy; Risk of death; Lability                        | Low 1  | Labile vital signs  
Recent blood loss  
Unconscious at times |
|                   |                                                                           | High 4 |                                                                           |
| **Complexity**    | Intricacy of care; Multiple systems involvement                           | High 2 | Receiving blood (therapy requiring increased knowledge, skill, and monitoring)  
Needs increased monitoring  
Caring for central line is an advanced skill |
|                   |                                                                           | Low 1  |                                                                           |
| **Predictability**| Adherence to expected pathway                                             | Low 1  | This is not a “typical” post op patient  
Complications of blood loss make her less predictable  
Diagnosis of CA – no post op report of success of surgery |
|                   |                                                                           | High 4 |                                                                           |
| **Resiliency**    | Ability to compensate; Ability to return to baseline functioning          | Low 1  | 64 yrs old  
No co-morbidities  
Diagnosis of CA |
|                   |                                                                           | High 4 |                                                                           |
| **Vulnerability** | Susceptibility; Safety concerns; Fragility; Risk for complications        | High 2 | Unable to communicate needs  
Foley, JP, Central line – risk for complications (e.g. infection) |
|                   |                                                                           | Low 1  |                                                                           |
| **Participation in Decision Making** | Capacity for decision making; Need for advocacy | Low 1  | Unable to communicate her wishes  
Family is not present |
|                   |                                                                           | High 4 |                                                                           |
| **Participation in Care** | Level of participation in care/ tx planning of patient and/or family | Low 1  | No participation in care |
|                   |                                                                           | High 4 |                                                                           |
| **Resource Availability** | Availability of skills, knowledge, finances and social resources | Low 1  | Largely unknown  
Family is not present |
|                   |                                                                           | High 4 |                                                                           |

**Mean Score** 1.5 /5.0*

*Score has been rounded
Vignette – Residential Care

Room 8B:
Mr. R is 84 yrs old, and has been living at the facility for 8 months. He has a history of coronary artery disease and diabetes, which has been unchanged since his admission. He was admitted because of his inability to care for himself. His daughter found him without heat, running water, and without food in his house: This prompted his admission 8 months ago. He was underweight on admission, but he currently has a normal BMI. Staff has been noticing increased confusion, forgetfulness, and belligerence over the last month. He was recently found wandering on the grounds near the highway.
# Synergy Rating

Refer to definitions and anchors as you fill this out.

**Patient/resident/client:** *Mr. R*

**Date:** *March 26 2010*

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Definition</th>
<th>Rating</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stability</td>
<td>Responsiveness to Therapy; Risk of death; Lability</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4 5</td>
<td>■ □ □ □ □</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Recent change in cognition</td>
</tr>
<tr>
<td>Complexity</td>
<td>Intricacy of care; Multiple systems involvement</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4 5</td>
<td>□ □ □ □ □</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Co-morbidities well managed</td>
</tr>
<tr>
<td>Predictability</td>
<td>Adherence to expected pathway</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4 5</td>
<td>■ □ □ □ □</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Recent change in level of consciousness -- no diagnosis yet</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>This change is common in this population and may be expected by staff</td>
</tr>
<tr>
<td>Resiliency</td>
<td>Ability to compensate; Ability to return to baseline functioning</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4 5</td>
<td>■ □ □ □ □</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Returned to normal BMI after admission to facility</td>
</tr>
<tr>
<td>Vulnerability</td>
<td>Susceptibility; Safety concerns; Fragility; Risk for complications</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4 5</td>
<td>□ □ □ □ □</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Recently found wandering by highway</td>
</tr>
<tr>
<td>Participation in Decision Making</td>
<td>Capacity for decision making; Need for advocacy</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4 5</td>
<td>□ □ □ □ □</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Daughter is involved</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cognitive functioning has recently decreased</td>
</tr>
<tr>
<td>Participation in Care</td>
<td>Level of participation in care/ tx planning of patient and/or family</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4 5</td>
<td>□ □ □ □ □</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Likely able to care for himself with reminders</td>
</tr>
<tr>
<td>Resource Availability</td>
<td>Availability of skills, knowledge, finances and social resources</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4 5</td>
<td>□ □ □ □ □</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Daughter is involved</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No concerns noted</td>
</tr>
</tbody>
</table>

**Mean Score 3.0 /5.0**
Vignette – Mental Health

Ms. H is 35 years old. Diagnosis of schizophrenia. Lives with her mother. Her mother runs a business out of her home, so there are many people coming and going. Recently had her meds changed from fluanxol to risperidone. Often resistant to treatment and can be very aggressive. PO meds were being crushed and smoked. Currently has a program assistant to check that she’s around and OK. Not linked with any other agencies. No social network. Paranoid of other people, and alienated from family. Does not participate in care, caregivers must go to her. Will not follow through with a treatment plan – very thought disordered. Is currently being seen q2wks for injections & 1x per week by program assistant. Has been introduced to other resources, but unable to follow through. Marijuana use. Physically healthy. Healthcare decisions are being made by care team.
Synergy Rating

Refer to definitions and anchors as you fill this out.

Patient/resident/client: **Ms. H**
Date: **March 26 2010**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Definition</th>
<th>Rating</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stability</td>
<td>Responsiveness to Therapy; Risk to self or others; Lability*</td>
<td>Low 1</td>
<td>High 4 5</td>
</tr>
<tr>
<td>Complexity</td>
<td>Intricacy of care; Presentation; Multiple diagnosis</td>
<td>High 1</td>
<td>Low 2 3 4 5</td>
</tr>
<tr>
<td>Predictability</td>
<td>Adherence to expected pathway</td>
<td>Low 1</td>
<td>High 2 3 4 5</td>
</tr>
<tr>
<td>Resiliency</td>
<td>Ability to compensate; Ability to return to baseline functioning</td>
<td>Low 1</td>
<td>High 2 3 4 5</td>
</tr>
<tr>
<td>Vulnerability</td>
<td>Susceptibility; Safety concerns; Fragility; Risk for complications</td>
<td>High 1</td>
<td>Low 2 3 4 5</td>
</tr>
<tr>
<td>Participation in</td>
<td>Capacity for decision making; Need for advocacy</td>
<td>Low 1</td>
<td>High 2 3 4 5</td>
</tr>
<tr>
<td>Decision Making</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in</td>
<td>Level of participation in care/ tx planning of patient and/or family</td>
<td>Low 1</td>
<td>High 2 3 4 5</td>
</tr>
<tr>
<td>Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource Availability</td>
<td>Availability of skills, knowledge, finances and social resources</td>
<td>Low 1</td>
<td>High 2 3 4 5</td>
</tr>
</tbody>
</table>

**Mean Score 1.5 /5.0**

*Note wording change for mental health clients.*
Vignette – Home Health

Mrs. Y is 55 years old. She has been referred to home health for post op care of a double mastectomy. According to hospital, she was discharged on schedule with no complications. She has a history of high cholesterol, which is medically managed. She lives in an affluent neighbourhood. Her husband was able to take 1 week off work to care for her at home. She also has two teenaged children who live at home and go to the local highschool.
## Synergy Rating

Refer to definitions and anchors as you fill this out.

**Patient/resident/client:** Mrs. Y  
**Date:** March 26 2010

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Definition</th>
<th>Rating</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stability</td>
<td>Responsiveness to Therapy; Risk of death; Lability</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4 5</td>
<td>Recovering from surgery as expected</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ □ □ ■ □</td>
<td></td>
</tr>
<tr>
<td>Complexity</td>
<td>Intricacy of care; Multiple systems involvement</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4 5</td>
<td>Specialized knowledge necessary for post-op wound care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ □ □ ■ □</td>
<td>No other systems involvement</td>
</tr>
<tr>
<td>Predictability</td>
<td>Adherence to expected pathway</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4 5</td>
<td>Discharged on schedule with no complications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ □ □ □ □</td>
<td>Recovering as expected</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ □ □ □ □</td>
<td>Dx is familiar and practiced</td>
</tr>
<tr>
<td>Resiliency</td>
<td>Ability to compensate; Ability to return to baseline functioning</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4 5</td>
<td>CA prognosis is unknown</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ □ □ □ □</td>
<td>Generally healthy otherwise</td>
</tr>
<tr>
<td>Vulnerability</td>
<td>Susceptibility; Safety concerns; Fragility; Risk for complications</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4 5</td>
<td>At risk for post op complications (e.g. infection)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ □ □ □ □</td>
<td>Emotionally vulnerable – unknown prognosis, body image considerations</td>
</tr>
<tr>
<td>Participation in</td>
<td>Capacity for decision making; Need for advocacy</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Decision Making</td>
<td></td>
<td>1 2 3 4 5</td>
<td>Able to make own decisions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ □ □ □ □</td>
<td>Family present to help with decision making</td>
</tr>
<tr>
<td>Participation in Care</td>
<td>Level of participation in care/ tx planning of patient and/or family</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4 5</td>
<td>Able to participate in care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ □ □ □ □</td>
<td>Family present to help with client care</td>
</tr>
<tr>
<td>Resource Availability</td>
<td>Availability of skills, knowledge, finances and social resources</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4 5</td>
<td>Lives in an affluent neighbourhood</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ □ □ □ □</td>
<td>Husband is available to help with care</td>
</tr>
</tbody>
</table>

**Mean Score 4.0 /5.0**

*Score has been rounded.
Determining Inter-Rater Agreement

After you've agreed to the terminology and markers you're using, it's time for Step 3: Determining agreement. You want high (90%) agreement.

There are two ways that we've determined inter-rater agreement.

1. Consider your team to be the scoring experts. Once your team has scoring consensus, use the team scores as the gold standard. Train your staff or a portion of your staff to use the tool and compare their scores to the team's scores (gold standard). Use a selection of cases that will score along the continuum (low, medium, and high). You may need to go through additional cases to ensure that you have good agreement.

2. Denote one of you as the most senior, experienced care provider in your team. This individual's scores are the gold standard, and you compare everyone else's scores to this individual's scores.

To calculate inter-rater agreement set up a table (see below). Each column space should represent one caregiver's score for a given patient/resident/client.

Whenever possible, we recommend using whole numbers. Some raters will want to assign half scores (e.g., 2.5, 3.5) or transition scores (e.g., 2-3, 3-4), and this is permissible. Our PNWP teams have appreciated this type of flexibility with the tool: another opportunity for more discussion. Just make sure there is agreement over how you use half scores/transition scores.

<table>
<thead>
<tr>
<th>Patient/resident/client</th>
<th>Gold Standard (team)</th>
<th>Caregiver #1</th>
<th>Caregiver #2</th>
<th>Caregiver #3</th>
<th>Caregiver #4</th>
<th>Caregiver #5</th>
</tr>
</thead>
<tbody>
<tr>
<td>401</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>402</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>403</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>404</td>
<td>3</td>
<td>2.5</td>
<td>3.5</td>
<td>4</td>
<td>2</td>
<td>2.5</td>
</tr>
</tbody>
</table>

1. Agreement rules: Determine agreement/disagreement for each characteristic on the synergy model. The following is how you determine agreement/disagreement.
   - Agreement:
     i. When raters have the same score.
     ii. When raters' scores are within one point of each other and they are able to choose a score quickly after some discussion.
   - Disagreement:
     i. When raters' scores are two or more points apart.
     ii. When raters' scores are within one point of each other and they are not able to come to consensus after discussion.

If you disagree, consider whether you need to revise your markers or provide more staff education.
In the Table, there is one disagreement (Caregiver #4) with the gold standard for 401 and there is one disagreement for 403. There are 20 ratings to compare with the gold standard. The formula (# disagreements/ total # possible scores) yields 18/20 = 90% inter-rater agreement. Note: Whenever possible, discuss your scores to make sure you are using the terminology and markers appropriately: Be sure you really agree and/or disagree on the same things!
Creating Guidelines for a Safe Staffing Assignment

**Step 4** is the creation of staffing guidelines based on a fit between the adapted synergy model scores and key staff characteristics, including scopes of practice, specialized skills, and experience with your population and facility. This is a thoughtful process that should involve staff and management.

**Determine how the scores inform safe, effective assignment of each patient/resident/client**
- Can a patient/resident/client with a score of 1 (…2 ...3 ...4 ...5) be assigned to any member of the care team?
- Are there elements of care that can be, or should be, provided by a team member other than the primary caregiver for a patient/resident/client with a score of 1 (…2 ...3 ...4 ...5)?
- What caregiver attributes are needed to effectively care for a client with a score of 1 (…2 ...3 ...4 ...5)?

**Sample Staffing Guidelines**

*(Residential Care)* If a resident has a score of 1, the RN directs all aspects of care and may delegate care as appropriate to the LPN and/or RCA.

*(Acute Care)* If a patient has a score of 1, the primary assigned nurse needs to be an experienced RN.

*(Residential Care)* If a resident has a score of 4, the RCA may provide assigned care independently, informing the LPN or RN of any changes in resident status.

*(Home Health)* If a client has a score of 3, no extra time needs to be allotted for the home visit.

*(Community Mental Health)* If a client has a score of 5, a program assistant can see the client independently, informing the case manager of any changes in client status.

**Determine how many patients/residents/clients are appropriate for a safe staffing assignment.**
- How many patients/residents/clients with a score of 1 (…2 ...3 ...4 ...5) can a caregiver safely provide care? Consider each member of your team (case manager, RN, LPN, RCA, social worker etc.)
- How many patients/residents/clients can the unit/program as a whole safely manage given patient/resident/client scores?
Example Staffing Assignment Guidelines

(Acute Care) An RN cannot care for more than two patients with a score of 1.

(Residential Care) An RN cannot have more than 10 residents with a score of 1 in their assignment.

(Public Health) An LPN doing immunizations for a school with a score below 3 must have additional supports in place.

(Home Health) An RN cannot have more than one patient per day with a score of 1.

(Community Mental Health) With an average caseload score of 2, the clinician cannot have over 20 assigned clients.
Creating a Safe Staffing Assignment

Use the synergy scores to make a staffing assignment for your unit. The scores should be used in addition to unit protocol and your professional judgment.

1) Score patients/residents/clients in a regular and systematic way. This will help inform “next visit” or “next shift” decision making and care planning. The following are ways the PNWP teams have set this up:
   1) Acute care: Consider scoring patients at the end of every shift.
   2) Complex or long term care: Consider scoring residents every 3 months or as acuity changes.
   3) Home health: Consider scoring clients after each home visit.
   4) Community mental health: Consider having each case manager score their own caseload. Clients can be scored every time the case manager sees a client or a minimum of every 3 months, and on admission to the service.

2) Assign patients/residents/clients to the most appropriate caregiver using the staffing guidelines you have developed. Take into consideration each caregiver’s level of experience, expertise with the population, and specialized skills.

3) If there are not enough caregivers to safely care for the patients/residents on the unit, discuss with your supervisor or manager. Case assignments may need to be re-distributed or you may need to request “workload” to safely care for everyone.

---

Things to consider when making a staffing assignment

- Should allow for general unit “busyness” (admits/discharges/transfers, doctors’ orders, phone calls)
- Should allow for appropriate surge capacity (to cope with changes in acuity & workload)
Other Suggested Uses of the Adapted Synergy Model

The following suggestions for use of the synergy model came out of discussions with the PNWP teams. The teams found different uses for the adapted synergy model, depending on their healthcare settings. Some of the teams have implemented the rating tool in the following three ways:

- **Orientation:** The teams identified that the rating tool highlighted patient/resident/client characteristics that are important to care providers. Several teams suggested incorporating the tool into their regular new staff orientation as a part of holistic care.

- **Treatment Planning:** During the process of scoring their populations, several teams found that the rating tool helped them focus on the specific patient/resident/client needs requiring intervention, helping to direct care planning. Furthermore, the teams found that discussing the patients/residents/clients’ synergy scores helped with brainstorming better ways to meet the patients/residents/clients’ needs. This was of particular use during case conferencing and/or grand rounds.

- **Determining Appropriateness of Services:** Further to treatment planning, the teams found that the rating tool helped in assessing the level of intervention necessary to care for an individual. While this was mostly discussed in the community mental health context, it can be applied to other settings such as determining what unit in a hospital is most appropriate for a new admission, or what care facility is most appropriate for a new referral to long term care. In community mental health, the tool aided in determining frequency of client visits, assessing the need to close case files, and moving clients between services (teams, group therapy, and/or clinicians).

The PNWP public health site that piloted the adapted synergy model did not use it to create staffing assignments. Due to the nature of their work, they determined that the rating tool was not useful in determining the day to day staffing needs of their unit. Often the public health nurses are seeing a client during a 5-minute immunization appointment, or during mass immunization. This does not allow for an in-depth assessment of the client. However, they did suggest that the tool could be used in a variety of other ways in public health:

- **Identifying populations at risk:** the team discussed scoring entire populations (e.g., downtown clientele vs. suburb clientele) with the tool.

- **Programs involving ongoing care and follow up:** (e.g., prenatal registration, sexually transmitted infections clinic, breastfeeding clinics) the team discussed using the tool to identify at-risk clients who attend these programs and might need more follow up.

- **School nursing:** the team discussed using the tool to identify schools which are likely to take more time and resources during immunizations and would benefit from extra staffing.
APPENDICES

Appendix 1: Example Phase 1 Deliverables from the PNWP Demonstration Sites 70
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## Appendix 1: Example Phase 1 Deliverables from the PNWP Demonstration Sites

The table below lists some examples of initiatives undertaken by the Provincial Nursing Workload Project demonstration sites.

<table>
<thead>
<tr>
<th>Site Type</th>
<th>Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>• Call light intervention study &amp; hourly rounds protocol</td>
</tr>
<tr>
<td>Acute</td>
<td>• Revision and roll-out of a 24-hour charting document</td>
</tr>
<tr>
<td>Long Term</td>
<td>• Collaboration with regional lean initiative to reorganize clean and dirty utility rooms and to address medication delivery</td>
</tr>
<tr>
<td>Long Term</td>
<td>• Implementation of a revised shift-to-shift report with communication procedures</td>
</tr>
<tr>
<td>Mental Health</td>
<td>• Grand Rounds implementation</td>
</tr>
<tr>
<td></td>
<td>• Identification and implementation of additional staff training</td>
</tr>
<tr>
<td></td>
<td>• Roll-out of new protocols for residential and short-stay sites</td>
</tr>
<tr>
<td></td>
<td>• Roll-out of synergy model tools to the entire team</td>
</tr>
<tr>
<td>Mental Health</td>
<td>• On-site care delivery model changes</td>
</tr>
<tr>
<td></td>
<td>• Review of workplace safety measures, including “Working Alone”</td>
</tr>
<tr>
<td>Community Health</td>
<td>• Revision of existing report procedures</td>
</tr>
<tr>
<td></td>
<td>• Incorporating synergy model tools into current workload assessment system</td>
</tr>
<tr>
<td>Community Health</td>
<td>• Revision of clinic schedule</td>
</tr>
<tr>
<td></td>
<td>• Streamlined school immunization procedures</td>
</tr>
</tbody>
</table>
Appendix 2: Example Patient/Resident/Client Rating Scale
Terminology & Markers

From acute care:

1) Stability: the ability to maintain a steady state. Stability can be used to describe any vacillating phenomena that impact nursing care – physiological stability, psychological stability, emotional stability, and family or social stability.

Level 1 – Minimally stable – Labile; unstable; unresponsive to therapies; high risk of death.
For example:
- Needs emergent intervention(s)
- Needs constant/very close monitoring
- Recent, significant systems deterioration or change (neurological, respiratory, GI, GU, etc)
- Not responding to treatment; condition is deteriorating despite treatment
- Labile and/or deteriorating vital signs

Level 3 – Moderately stable – Able to maintain steady state for limited period of time; some responsiveness to therapies.
For example:
- Needs urgent intervention(s)
- Needs increased monitoring
- Subtle systems change (neurological, respiratory, GI, GU, etc)
- Some response to treatment
- Wavering vital signs

Level 5 – Highly stable – Constant; responsive to therapies; low risk of death
For example:
- Needs non-urgent intervention(s)
- Low monitoring needs
- Improvement in systems functioning or no systems change
- Responding to treatment as expected
- Stable vital signs
2) Complexity: the intricate entanglement of two or more systems. This characteristic includes multiple systems and/or therapies – body systems, family and social systems, and/or therapeutic interventions.

Level 1 – Highly complex – Intricate; complex patient/family dynamics; ambiguous/vague; atypical presentation
For example:
- Multiple systems involvement and/or failure
- Multiple co-morbidities requiring complex monitoring and treatment
- Interventions require increased monitoring, advanced knowledge, and skill
- Interventions are new, unpracticed, and/or unfamiliar

Level 3 – Moderately complex; Moderately involved patient/family dynamics
- Some systems involvement
- Some co-morbidities
- Interventions require intermediate monitoring, knowledge, and skill
- Interventions are unfamiliar and/or unpracticed

Level 5 – Minimally complex – Straightforward; routine patient/family dynamics; simple/clear cut; typical presentation
- No systems involvement
- No or few well-controlled co-morbidities; generally healthy
- Interventions require basic monitoring, knowledge, and skill
- Interventions are familiar and practiced

3) Predictability: the characteristic that allows one to expect a certain trajectory of illness. While most patients/residents/clients have a predictable course of illness, some individuals do not respond in the typical fashion.

Level 1 – Not predictable – Uncertain; uncommon patient population/illness; unusual or unexpected course; does not follow critical pathway, or no critical pathway developed
- Is not following/has veered significantly from expected illness trajectory or pathway
- Is experiencing serious complications
- Diagnosis is unfamiliar or unknown

Level 3 – Moderately predictable – Wavering; occasionally noted patient population or illness
- Some deviation from illness trajectory or pathway
- May experience some complications
- Diagnosis is not routine

Level 5 – Highly predictable – Certain; common patient population/illness; usual and expected course; follows critical pathway
- Is following expected illness trajectory or pathway
- No complications
- Diagnosis is routine and familiar
4) **Resiliency:** the capacity to return to a restorative level of functioning using compensatory and coping mechanisms (return to baseline).

Level 1 – Minimally resilient – Unable to mount a response; failure of compensatory/coping mechanisms; minimal reserves; brittle
- Unlikely to return to baseline health and/or functioning; unlikely to make a full recovery
- Is immunocompromised, malnourished, etc
- Inadequate or no social support or personal coping mechanisms

Level 3 – Moderately resilient – Able to mount a moderate response; able to initiate some degree of compensation; moderate reserves
- May be able to return to baseline health and/or functioning over time
- May be somewhat immunocompromised, undernourished, etc
- May have some social support or personal coping mechanisms

Level 5 – Highly resilient – Able to mount and maintain a response; intact compensatory/coping mechanisms; strong reserves; endurance
- Is likely to return to baseline health and/or functioning; generally healthy
- Has a strong immune system, is adequately nourished
- Has strong social support and personal coping mechanisms

5) **Vulnerability:** a susceptibility to stressors that may adversely affect patient/resident/client outcomes. Patient/resident/client vulnerability considers the patient/resident/client’s risk for adverse outcomes. For example, a patient/resident/client presenting with co-morbid conditions places him/her at high risk for adverse outcomes (e.g., smoking and heart disease).

Level 1 – Highly vulnerable – Susceptible; unprotected, fragile
- Generally at risk; several safety concerns
- High risk for complications
- Is isolated with little or no support systems

Level 3 – Moderately vulnerable – Somewhat susceptible; somewhat protected
- Some safety concerns
- Moderate risk for complications
- Has some social connection; can access support systems with some difficulty

Level 5 – Minimally vulnerable – Safe; out of the woods; protected, not fragile
- No safety concerns
- Little or no risk for complications
- Is socially well connected
- Is able to “take care of self”
6) **Participation in decision making:** the extent to which the patient/resident/client or family engages in decision-making (includes capacity, desire, and level of decision making).

Level 1 – No participation – Patient and family have no capacity for decision making; require surrogacy
- Decision making is left to healthcare professionals

Level 3 – Moderate level of participation – Patient and family have limited capacity; seek input/advice from others in decision-making
- Needs much encouragement and explanation with decision making
- Rely on healthcare professionals to direct decision making

Level 5 – Full participation – Patient and family have capacity and make decisions for themselves
- Able to make decisions with minimal input from healthcare professionals

7) **Participation in care:** the extent to which the patient/resident/client and family participate in care activities (includes capacity, desire, and level of participation).

Level 1 – No participation – Patient and family unable or unwilling to participate in care
- Full assist with activities of daily living (“total care”)
- Family is absent or unwilling to help with care
- Needs extensive coaching, teaching, & support to participate in care
- Needs extensive discharge planning

Level 3 – Moderate level of participation – Patient and family need assistance in care
- Partial assist with activities of daily living
- Needs some coaching, teaching, and support to participate in care
- Needs some discharge planning

Level 5 – Full participation – Patient and family fully able to participate in care
- Independent with activities of daily living
- Family is available and willing to assist with care
- Needs minimal coaching, teaching, and support to participate in care
- Needs minimal discharge planning
8) **Resource availability:** the extent of resources the patient/resident/client, family, or community brings to the care situation (includes personal, physiological, social, technical, and financial resources).

*Resource availability impacts the level of support nurses need to provide for patients/residents/clients and their families.*

Level 1 – Few resources – Necessary knowledge and skills not available; necessary financial support not available; minimal personal/psychological supportive resources; few social systems resources

Level 3 – Moderate resources – Limited knowledge and skills available; limited financial support available; limited personal/psychological supportive resources; limited social systems resources

Level 5 – Many resources – Extensive knowledge and skills available and accessible; financial resources readily available; strong personal/psychological supportive resources; strong social systems resources
From a community mental health site:

1. **STABILITY**: the ability to maintain a steady state. Stability can be used to describe any vacillating phenomena that impact care – physiological stability, psychological stability, emotional stability, and family or social stability.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood</td>
<td>Erratic</td>
<td>Severe Labiality</td>
<td>Labile</td>
<td>Moderately Labile</td>
<td>Euthymic</td>
</tr>
<tr>
<td>Suicidality</td>
<td>Highly Suicidal/Homicidal – Plan and intent present</td>
<td>Suicidal/Homicidal-Plan with little intent or an inability to care plan out</td>
<td>Frequent Suicidal/Homicidal ideation – No intent</td>
<td>Passive Suicidal/Homicidal ideation</td>
<td>Little or no thoughts of harm to self or others</td>
</tr>
<tr>
<td>Intervention</td>
<td>Emergent</td>
<td>Crisis</td>
<td>Urgent</td>
<td>Involved</td>
<td>Non-urgent</td>
</tr>
<tr>
<td>Mental Status Exam</td>
<td>Decompensating Major change (i.e. appearance, thought process and communication)</td>
<td>Significant Change</td>
<td>Subtle Change</td>
<td>Limited or no change</td>
<td>Stable</td>
</tr>
<tr>
<td>Treatment</td>
<td>No engagement and no response to treatment</td>
<td>Difficulty engaging in treatment or little response to treatment</td>
<td>Engaging in treatment with some difficulties</td>
<td>Some response to treatment</td>
<td>Responding to treatment as expected.</td>
</tr>
</tbody>
</table>
2. **COMPLEXITY**: the intricate entanglement of two or more systems. This characteristic includes multiple systems and/or therapies – body systems, family and social systems, and/or therapeutic interventions.

<table>
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<tr>
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<th>1</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>a) Co-Morbidities</strong></td>
<td>Many</td>
<td>Several</td>
<td>Some</td>
<td>Few</td>
<td>None</td>
</tr>
<tr>
<td><strong>b) Complexity</strong></td>
<td>Highly complex – Intricate ambiguous/vague</td>
<td>Increased complexity – Family dynamics are at odds, multiple diagnosis</td>
<td>Moderate complex – Presentation is mixed</td>
<td>Somewhat complex</td>
<td>Minimally complex and straightforward</td>
</tr>
<tr>
<td>i.e. diagnoses, family involvement, presentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>c) Agency involvement</strong></td>
<td>Many (AAC, Out-Patients, Probation, MCFD)</td>
<td>Several</td>
<td>Some</td>
<td>Few</td>
<td>No other agency involved</td>
</tr>
<tr>
<td><strong>d) Interventions</strong></td>
<td>Increased monitoring, advanced knowledge, New and unpracticed/unfamiliar.</td>
<td>Frequent monitoring, advanced skill, Interventions are new.</td>
<td>Intermediate monitoring and skill, unfamiliar and/or unpracticed.</td>
<td>Intermittent monitoring, Somewhat routine.</td>
<td>Basic Monitoring, familiar and practiced.</td>
</tr>
</tbody>
</table>
3. **Predictability**: allows one to expect a certain trajectory of illness. While most clients have a predictable course of illness, some individuals do not respond in the typical fashion. When predictable, the client’s care can be managed using traditional practice guidelines; when unpredictable, practice guidelines are not helpful. When the diagnosis is unknown, one cannot anticipate the response to interventions or predict the trajectory of illness.

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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a) Diagnosis</strong></td>
<td>Unusual presentation or illness, unknown diagnosis (e.g. Folie à Deux)</td>
<td>Uncommon presentation, illness or diagnosis (e.g. dissociative illness)</td>
<td>Occasionally noted presentation or diagnosis (e.g. Schizoaffective)</td>
<td>Common presentation, illness or diagnosis (e.g. Schizophrenia)</td>
</tr>
<tr>
<td><strong>b) Therapy</strong></td>
<td>Unknown or unusual course</td>
<td>Uncommon course</td>
<td>Limited familiarity of course</td>
<td>Familiar course</td>
</tr>
<tr>
<td><strong>c) Treatment Outcome</strong></td>
<td>Patient not following treatment</td>
<td>Patient has difficulty following treatment</td>
<td>Patient attempts to follow treatment with moderate difficulty</td>
<td>Patient is managing to follow treatment with some support</td>
</tr>
</tbody>
</table>
4. **RESILIENCY**: the capacity to return to a restorative level of functioning using compensatory and coping mechanisms (return to baseline). How a caregiver approaches and plans interventions that might challenge the client’s stability is based upon the individual’s capacity to restore homeostasis.

<table>
<thead>
<tr>
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<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Response</td>
<td>Unable to initiate, fragile</td>
<td>Rarely able to initiate, few reserves</td>
<td>Some response, moderate reserves</td>
<td>Able to initiate a response,</td>
<td>Able to initiate and maintain response, shows endurance</td>
</tr>
<tr>
<td>b) Baseline</td>
<td>Improbable return to baseline</td>
<td>Increased difficulty returning to Baseline</td>
<td>Some difficulty returning to baseline</td>
<td>Likely to return to baseline</td>
<td>Will return to baseline</td>
</tr>
<tr>
<td>c) Coping</td>
<td>Failure to Engage</td>
<td>Difficulty engaging coping</td>
<td>Few Coping Mechanisms</td>
<td>Utilizing coping with some challenge</td>
<td>Intact coping</td>
</tr>
<tr>
<td>Mechanisms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. **VULNERABILITY:** susceptibility to stressors that may adversely affect client outcomes. Client vulnerability considers risk of adverse outcomes. For example, a client presenting with co-morbid conditions places him/her at high risk for adverse outcomes (e.g., smoking and heart disease). Anticipatory assessment and management of associated risks impact the client/patient/resident’s nursing care and recovery.

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<tr>
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<th>2</th>
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</tr>
</thead>
<tbody>
<tr>
<td>a) Safety</td>
<td>At high risk, multiple safety concerns</td>
<td>At risk with several safety concerns</td>
<td>Moderate risk with few safety concerns</td>
<td>Little risk or safety concerns</td>
<td>Safe and protected</td>
</tr>
<tr>
<td>b) Social Supports</td>
<td>Isolated</td>
<td>Little to no social network</td>
<td>Some or infrequent social support</td>
<td>Regular support</td>
<td>Well socially connected</td>
</tr>
<tr>
<td>c) Risk of Complications</td>
<td>Very high</td>
<td>Likely</td>
<td>Probable</td>
<td>Unlikely</td>
<td>Little or no risk</td>
</tr>
</tbody>
</table>

6. **PARTICIPATION IN DECISION MAKING:** the extent to which the client or family engages in decision-making (includes capacity, desire, and level of decision making). The caregiver might stand in for – or beside – a client and family to support them through a decision that will impact care and management.

<table>
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<tr>
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<th>2</th>
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<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Decision Making</td>
<td>Pt/ Family has no capacity</td>
<td>Pt/Family has diminished capacity</td>
<td>Pt/Family has limited capacity</td>
<td>Pt/Family has some capacity</td>
<td>Pt/Family has full capacity and is able to make decision for themselves</td>
</tr>
<tr>
<td></td>
<td>Decision making is made by others</td>
<td>Decision making is needed by others</td>
<td>Input and direction is sought out</td>
<td>Input is sought out but pt/family is directly involved</td>
<td></td>
</tr>
</tbody>
</table>
7. **PARTICIPATION IN CARE/TREATMENT PLANNING**: the extent to which the client and family participate in care activities (includes capacity, desire, and level of participation). The caregiver either provides or helps the client and family give care.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Level of Participation</td>
<td>Pt/Family is unwilling or unable to participate</td>
<td>Pt/Family has difficulty to participate</td>
<td>Pt/Family is participating with assistance</td>
<td>Pt/Family is participating with limited assistance</td>
<td>Pt/Family is participating</td>
</tr>
<tr>
<td>b) Family Presence</td>
<td>Family is absent or unwilling to help with care</td>
<td>Family has a diminished interest in care</td>
<td>Family has some involvement in care</td>
<td>Family is offering care</td>
<td>Family is involved and will to offer care</td>
</tr>
<tr>
<td>c) Discharge Planning</td>
<td>Extensive planning</td>
<td>Detailed planning</td>
<td>Some planning</td>
<td>Little planning</td>
<td>Minimal to no planning</td>
</tr>
</tbody>
</table>

8. **RESOURCE AVAILABILITY**: the extent of resources the client, family, or community brings to the care situation (includes personal, physiological, social, technical, and financial resources). Resource availability impacts the level of support caregivers need to provide for clients and their families.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Knowledge of resources available</td>
<td>No awareness</td>
<td>Diminished awareness</td>
<td>Little awareness</td>
<td>Moderately aware</td>
<td>Fully Aware</td>
</tr>
<tr>
<td>b) Resources</td>
<td>No resources</td>
<td>Some resources</td>
<td>Limited resources</td>
<td>Sufficient resources</td>
<td>Wide range of resources</td>
</tr>
</tbody>
</table>
Appendix 3 – Example Staffing Guidelines

In the early stages of the project, we separated the synergy model into 2 sub-scores: acuity and capability. Acuity included stability, complexity, predictability, and resiliency. Capability included vulnerability, participation in decision making, participation in care and resource availability. At the end of the pilot, the teams determined that valuable information was lost when the model was divided in this way. However, when the acute and residential care site developed their staffing guidelines, we were still using the acuity/capability version of the model. The following are examples of how the guidelines can be developed; however, the teams ultimately agreed that an average of the 8 characteristics should be considered for staffing purposes.

From a PNWP Residential Care Site:

Acuity
- Acuity of 1-2, the RN directs all aspects of resident care and may delegate care as appropriate to the LPN and/or RCA
- Acuity of 3-5, the LPN assesses residents, recognizes changes, collaborates and participates with the RN to plan care and may delegate care as appropriate to the RCA

Capability
- Capability of 1-2, the RN directs all aspects of resident care and may delegate as appropriate to the LPN and/or RCA
- Capability of 1-2, the assigned RCA has the appropriate skill set and/or have specialized training for the population (if an appropriate RCA cannot be assigned, an RCA with the necessary skill-set needs to be available as a resource person or mentor)
- Capability of 3-5, LPN assesses residents, recognizes changes, collaborates and participates with the RN to plan care and may designate care as appropriate to the RCA

Students
- RCA students need supervision by an RN when they are assigned to a resident with an acuity or capability score of 1-2

Experience
- If an inexperienced RN has a resident assignment with residents who rate 1-2 on acuity or capability, there needs to be an experienced RN available for consultation
- An inexperienced LPN should also have an experienced RN or LPN available for consultation

Experienced = increased understanding of the resident population, deep understanding of gentle care philosophy and successful integration of the philosophy in practice
From a PNWP Acute Care Site:

1) High acuity patients (synergy score 1-2) should be cared for by an experienced RN at a ratio of 1:2
2) Moderate to low acuity patients can be cared for by any RN at a ratio of 1:4
3) Experienced LPNs or newly graduated RNs:
   - Should be paired with an experienced RN for fresh post-ops
   - Should have low to moderate acuity (synergy score 3-5)
4) If capability score is less than 3, require an experienced LPN or an RN on team
5) Each RN/LPN team should have a maximum of 7 high acuity patients under their care (ideally no more than 6)
6) Each RN/LPN team should have a maximum of 8 low to moderate acuity patients under their care
7) Pediatric patients should be cared for by an experienced RN at a ratio of 1:4 maximum

From a PNWP Community Mental Health Site (guidelines to assess appropriateness for a service):

<table>
<thead>
<tr>
<th>Synergy Level</th>
<th>Impact on Workload</th>
<th>Assess appropriateness for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>High</td>
<td>Assertive case management</td>
</tr>
<tr>
<td>2</td>
<td>High to Moderate</td>
<td>Primarily 1:1; some groups</td>
</tr>
<tr>
<td>3</td>
<td>Moderate</td>
<td>Some groups; some 1:1</td>
</tr>
<tr>
<td>4</td>
<td>Moderate to Minimal</td>
<td>Primarily groups; minimal 1:1</td>
</tr>
<tr>
<td>5</td>
<td>Minimal</td>
<td>Primarily groups, may require some 1:1;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Actively working towards discharge</td>
</tr>
</tbody>
</table>
Appendix 4: References


Available at www.chsrf.ca


Appendix 5: Additional Resources


Appendix 6: Stories for Safety

Stories for **SAFETY**
Sharing the evidence about nursing and patient safety

**STAFFING PLANS: RESPONDING TO VARIATION**

Until quite recently, “nurse staffing plan” would have been just another name for the schedule that showed who was working when. But extreme acuity, complex treatments, changing technology, and sub-specialization mean a simple rota pinned to a bulletin board is a thing of the past. In today’s world of nursing, constructing nursing teams with the best mix of staff to look after patients is a must, because the evidence shows poor staff mix equals poor patient outcomes.

The goal of nurse staffing plans is to provide high-quality care to patients while making the workplace safe and rewarding. They are being promoted as an alternative to nurse-patient ratios, which are set by law in many parts of the U.S. but which critics call blunt instruments, since they don’t take the context of the patient population into account. An overview of research on nurse staffing and patient safety, *Staffing for Safety*, published by the Canadian Health Services Research Foundation, says every organization should have effective, formal nurse staffing plans.

Acceptance of this new approach is spreading, but getting it put into practice is slow going. Staffing plans are just coming into being in the U.S. In this country, they don’t really exist, but in spring 2006, the British Columbia Nurses Union and the provincial government signed a contract that included an agreement to study nurse workload as a first step to developing staffing plans for acute and residential care. By 2010, staffing plans — based on patient mix, with plans to manage vacancies and surges in demand — will be tested in several pilot projects in the province.

**Mandatory ratios can’t be fine-tuned**

Nurse staffing plans consider the type of unit and the needs of its constantly changing patients, the experience levels of nurses and other staff who work there, and which other professionals and support services the organization can provide.

In contrast, nurse-patient ratios assign staff based on how many beds are occupied. They don’t allow for important variations that affect care, workloads, and safety, such as how sick the patients are, what other health professionals are on the care team, or what support there is, whether it’s technological or human resources, for that unit’s work in the organization overall.

**Both an art and a science**

Creating a nurse staffing plan requires hard evidence — the science — such as data on the types of patients the unit treats, their outcomes, and how the unit ranks on standard measures of quality, such as infections, bed sores, and readmissions. Nurse staffing plans should also draw on both the experience of front-line nurses and the expertise of administrators — the art of drawing out peoples’ knowledge.

Sharon Gale, executive director of the Massachusetts Organization of Nurse Executives, led the committee that developed a template for nurse staffing plans for the hospitals in the state. The Massachusetts Hospital Association wanted to avoid legislated nurse-patient ratios, which it felt would not serve its mix of academic health centres, community and rural hospitals, and elder-care centres.

“We knew that one-size-fits-all wasn’t going to work with the mix of acuity, nursing education, and experience and other variants,” says Ms. Gale.
The project is still in its early stages, but hospitals have developed staffing plans (available on the web at www.patientsfirstma.org). They list units’ average number of patients, types of caregivers (registered nurse, licensed practical nurse, mental-health counsellor, unlicensed caregiver) and how many work in any shift. A separate chart lists “additional care team members,” from clinical nurse specialists to intravenous therapy teams, pharmacists, and students.

The charts posted now are projections, showing anticipated patient needs. The next step is to compare them with real staffing over one year and analyze differences: were patients sicker than anticipated? Was there a shortage of RNs, so more practical nurses were hired? The results will be used to modify future plans. Factors that affect a plan include whether the unit has surgical or medical patients; whether there are specialist teams for respiratory, intravenous, and rehabilitation care; and what percentage of work is done by licensed practical nurses. While these are not ideal staffing plans, they are a great first step.

It’s generally agreed a staffing plan should include ways of managing staff shortages or other problems. If a patient goes into cardiac arrest, for example, the anticipated amount of nursing needed on the unit quickly becomes irrelevant. Is back-up available to care for other patients when that happens? Staffing plans should include options for when there are not enough staff on shift, which can include giving floor staff the authority to refuse new admissions, call in nurses on overtime, or use an agency or a permanent staff “floater,” assigned day-by-day or week-by-week to units as needed. Staffing plans are very promising as an idea; better uptake and more examples are needed to make that promise a reality.
Appendix 7: CRNBC Guidelines for a Quality Practice Environment

Guidelines for a Quality Practice Environment for Nurses in British Columbia

COLLEGE OF REGISTERED NURSES OF BRITISH COLUMBIA

CRNBC
Our mission is safe and appropriate registered nursing practice, regulated by registered nurses in the public interest, and achieved by promoting good practice, preventing poor practice, and intervening when practice is unacceptable.

For information about the Guidelines for a Quality Practice Environment, contact CRNBC’s Practice Support Service at 604.736.7331 (ext. 332) or 1.800.565.6505.

CRNBC resources are also available from the College’s website www.crnbc.ca
CRNBC GUIDELINES FOR A QUALITY PRACTICE ENVIRONMENT

Introduction

CRNBC’s Guidelines for a Quality Practice Environment establish benchmarks for nurses and their employers to use in creating quality practice environments in their organizations.

Under the Health Professions Act, the mandate of the College of Registered Nurses in British Columbia is to protect the public through the regulation of registered nurses and nurse practitioners. This is achieved by promoting good practice, preventing poor practice and intervening when practice is unacceptable.

Nurses comprise the single largest group of health care providers in the province. British Columbia, like much of the world, is in the midst of a shortage of nurses. Nurse human resource concerns have been largely ignored during periods of downsizing and restructuring of the health care system. Nurses are increasingly unwilling to work in organizations with practice environments that put clients at risk. The shortage of nurses in the health care system has become a serious public safety issue.

This document, Guidelines for a Quality Practice Environment for Nurses in British Columbia, has been developed to support CRNBC’s mandate to protect the public. There is a direct correlation between the quality of nurses’ practice environments and job satisfaction, productivity, recruitment, retention and, most importantly, the quality of client care and client outcomes.

Unlike CRNBC’s Standards of Practice, these guidelines are voluntary. While CRNBC has no jurisdiction over nursing practice environments in organizations, research shows that the environment has a significant impact on a nurse’s ability to meet practice standards. These Guidelines for a Quality Practice Environment have been developed for nurses and employers to use in evaluating and improving practice environments in all practice settings in B.C.

What is a guideline?

A guideline is a systematically developed, evidence-based statement which assists in decision-making about appropriate practices with the assumption quality of care will improve. Guidelines for a quality practice environment are statements about what health care organizations need to have in place to enable nurses to practise professionally and provide safe and appropriate care for clients.

The beliefs underlying the Guidelines for a Quality Practice Environment are:

• Governments, employers and nursing organizations – including regulatory bodies, unions and schools of nursing – are jointly responsible for creating nursing practice environments necessary for safe and appropriate care.

• Nurses have a responsibility to participate in creating and maintaining practice environments that promote safe care.

• Certain key elements must be in place in an organization to attract and retain nurses, to support nurses to meet practice standards and to promote safe care.
What forms the basis of the Guidelines for a Quality Practice Environment?

"Quality practice environments" is one of the values central to ethical nursing practice. The Canadian Nurses Association’s Code of Ethics for Registered Nurses states this value as “Nurses value and advocate for quality practice environments that have the organizational structures and resources necessary to ensure safety, support and respect for all persons in the work setting” (page 17). The CRNBC Guidelines for a Quality Practice Environment reinforce the importance of this value.

The Guidelines for a Quality Practice Environment are based on evidence from the literature and extensive consultation with nurses in all practice settings in urban, rural and remote regions of B.C. and other nursing organizations across Canada. Nurses were consulted through focus groups, individual interviews and via the College’s website. These guidelines are essential preconditions for nurses to provide quality care to clients. CRNBC believes organizations that create quality practice environments for nurses also provide a quality work environment for other members of the health care team and ultimately contribute to improved client outcomes.

Who has responsibility for creating a quality practice environment?

Creating quality practice environments is a shared responsibility of governments, employers and nursing organizations. Nurses have a responsibility to participate in creating and maintaining practice environments that promote safe care. It is the responsibility of individual nurses to act professionally and be accountable for their own practice. However, at times, nurses are unable to meet CRNBC’s Standards of Practice for reasons that are related to their practice environment and are beyond their control. In particular, unmanageable workloads, the loss of nursing leadership positions and few opportunities for continuing education make it difficult for nurses to consistently meet CRNBC Standards of Practice in some organizations. While nurse leaders have a responsibility to advocate for quality practice environments, it is ultimately the employer who controls many elements of the environments in which nurses practise. Employers who are interested in attracting and retaining nurses, creating a highly functioning, healthy staff and improving client outcomes will use these guidelines to do so.
What are the Guidelines for a Quality Practice Environment?

The five guidelines for a quality practice environment are broad in nature and applicable to the varied settings, roles and locations in which nurses practice. The guidelines are:

1. **Workload Management**: There are sufficient nurses to provide safe, competent, ethical care.

2. **Nursing Leadership**: There are competent and well prepared nurse leaders at all levels in the organization.

3. **Control over Practice**: Nurses have responsibility, authority and accountability for nursing practice.

4. **Professional Development**: The organization supports and encourages a lifelong learning philosophy and promotes a learning environment.

5. **Organizational Support**: The organization’s mission, values, policies and practices support and value nurses and the delivery of safe and appropriate nursing care.

Leaders are essential in getting others towards a common goal or vision. They have influence and/or power through their knowledge, experience or position. Leaders work with people to enhance their growth, potential and accomplishment.

What are the indicators?

Each guideline has a corresponding series of indicators. These indicators are examples of how the guideline can be met. Indicators provide criteria against which an organization can measure itself, or others can measure the organization. The indicators are not written in order of importance, nor are they intended to be an exhaustive list of criteria related to the guideline. Some terms such as “sufficient” and “appropriate” are intentionally non-specific. It is expected nurses and their employers will discuss what these terms mean in their environment and develop ways of measuring them. Nurses can also expand upon the indicators to address the specific circumstances of their organizations.
Suggestions for using the CRNBC Guidelines for a Quality Practice Environment for Nurses in British Columbia.

This document provides nurses and their organizations with a framework that has a variety of uses. Here are some suggestions on how individuals or groups can use these guidelines to enhance a quality practice environment and improve client outcomes:

- Read the document thoroughly and keep as a ready reference.
- Share the guidelines with other health professionals and the organization’s leaders to enlist their understanding and support to assess your organization’s environment.
- Develop additional indicators that would be relevant to your organization.
- Assess how your organization compares against each of the five guidelines and the related indicators.
- Identify organizational strengths and plan to reinforce and celebrate them.
- Identify areas for improvement within your organization and make plans to address them.
- List resources required to address the areas for improvement and plan to obtain those resources.
- Call CRNBC’s Practice Support Service for more information.
Guideline 1

Workload Management:

There are sufficient nurses to provide safe, competent, ethical care.

Indicators:
1. Care delivery systems enable nurses to develop a sufficient, continuous and rewarding relationship with their clients.
2. Client admissions and services are based on nurses’ ability to provide safe, competent, ethical care.
3. Sufficient time is made available to discuss and plan client care with clients and colleagues.
4. Nurses are involved in determining the staff mix and client/nurse ratios.
5. Nurses are involved in resource allocation and utilization decisions.
6. Overtime is infrequent and not mandatory.
7. Work scheduling is flexible and innovative.

3 "Nurse" refers to the following CRNBC registrants: registered nurses, nurse practitioners licensed graduate nurses, student nurses.

Guideline 2

Nursing Leadership:

There are competent and well-prepared nurse leaders at all levels in the organization.

Indicators:
1. Nurse leaders are supported in their roles as collaborators, communicators, mentors, risk takers, role models, visionaries and advocates for quality care.
2. Nurse leaders have the authority to support safe nursing practice.
3. A chief executive nurse reports at the level of other executive leaders in the organization.
4. When the primary focus of the unit or program is to provide nursing care, the first-line manager is a nurse.
5. Nurses are supported in practice by accessible, expert and experienced nurses.

4 Leaders are committed to guiding others towards a common goal or vision. They have influence and/or power through their knowledge, experience or position. Leaders work with people to enhance their growth, potential and accomplishment.
5 Authority is the right to exercise control or influence.
Guideline 3
Control over Practice:

*Nurses have authority, responsibility, and accountability for nursing practice.*

**Indicators:**
1. Decision-making is participatory at appropriate levels regarding policies, practices and the work environment.
2. Appropriate resources are available to support evidence-based nursing care.
3. Nurses and other health professionals work cooperatively and collaborate in decision-making.
4. Nurses determine the competencies required for nursing practice in the work setting.
5. Adequate supports free nurses from doing non-nursing tasks.

Guideline 4
Professional Development:

*The organization encourages a lifelong learning philosophy and promotes a learning environment.*

**Indicators:**
1. Appropriate orientation is provided for all new positions and practice settings.
2. Preceptoring and mentoring programs are available.
3. Staff have opportunities for inservice, continuing education and professional development.
4. Staff have opportunities for debriefing and reflection on practice.
5. Performance evaluation programs are in place.
Guideline 5

Organizational Support:

The organization’s mission, values, policies and practices support and value nurses and the delivery of safe and appropriate nursing care.

Indicators:
1. Appropriate forums are accessible to resolve professional practice and ethical issues.
2. Nursing expertise is respected, excellence is recognized and nurses are valued.
3. Creative and innovative ideas and the pursuit of nursing knowledge are encouraged.
4. There are comprehensive health, wellness and safety programs.
5. There are measures to prevent and combat all forms of aggression, abuse and violence.
6. Compensation is commensurate with skill, experience and responsibility.
7. Continuous quality improvement programs are in place.
8. The physical facility, equipment, supplies and services meet client and staff needs.
9. Human resource policies consider nurses’ personal and family concerns.
10. Information and communication systems are effective and integrated.
11. Technology is used appropriately.
Bibliography


College of Registered Nurses of British Columbia. (2004). *Nursing practice environments for safe and appropriate care (policy statement)*. *Vancouver: Author*.


