CHAPTER 3

Professional Practice: A Prototype Linking Nursing in Interprofessional Teams

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LEARNING OBJECTIVES

1. Develop processes to lead and manage nursing and interprofessional teams.
2. Apply principles of management to reach desired organizational outcomes and a shared vision.
3. Design models that strengthen synergistic nursing and interprofessional effectiveness.

AONE KEY COMPETENCIES

I. Communication and relationship building
II. Knowledge of the healthcare environment
III. Leadership
IV. Professionalism
V. Business skills

AONE KEY COMPETENCIES DISCUSSED IN THIS CHAPTER

I. Communication and relationship building
II. Knowledge of the healthcare environment
III. Leadership
IV. Professionalism

I. **Communication and relationship building**
   - Effective communication
   - Relationship management
   - Influence of behaviors
   - Ability to work with diversity
   - Shared decision making
   - Community involvement
   - Medical staff relationships
   - Academic relationships

II. **Knowledge of the healthcare environment**
   - Clinical practice knowledge
   - Patient care delivery models and work design knowledge

- Healthcare economics knowledge
- Healthcare policy knowledge
- Understanding of governance
- Understanding of evidence-based practice
- Outcomes measurement
- Knowledge of, and dedication to, patient safety
- Understanding of utilization and case management
- Knowledge of quality improvement and metrics
- Knowledge of risk management

III. Leadership

- Foundational thinking skills
- Personal journey disciplines
- Ability to use systems thinking
- Succession planning
- Change management

IV. Professionalism

- Personal and professional accountability
- Career planning
- Ethics
- Evidence-based clinical and management practices
- Advocacy for the clinical enterprise and for nursing practice
- Active membership in professional organizations

FUTURE OF NURSING: FOUR KEY MESSAGES

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners with physicians and other health professionals in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and information infrastructure.

Introduction

Health care in the United States will face a number of irrefutable changes over the next decade. The United States will likely surpass the point where 20% of the nation's gross domestic product (GDP) is related to healthcare spending. As a society, we must decide whether we can afford to continue down this path or if we will find a way to improve the health of our population while reducing the per capita cost and improving the experience of those entering the healthcare arena. If we do not address these issues successfully, many believe there will be a tremendous negative impact on the standard of living in the United States.

What are the key drivers for the next decade? We know that in the United States we have an aging population to care for. Data from the U.S. Census Bureau clearly show a near doubling of the U.S. population aged 75 years and older, and aged 85 years and older, between 2010 and 2050 (Ortman, Velkoff, & Hogan, 2014). Other data show that historically there is a direct relationship between per capita spending on personal health care and age. Data from the Centers for Medicare

and Medicaid Services (CMS) clearly show the cost per capita basis rises dramatically at about age 75 years and jumps at age 85 years.

This is not the only phenomenon having an impact on the increase in per capita cost in the United States. Data from the Centers for Disease Control and Prevention (CDC) reveal that in 1990, no state had an obesity rate as high as 15%. The data reveal that by 2010, no state had an obesity rate under 20%, and some states had surpassed a 30% obesity rate. By 2016, fifteen (15) states and the Virgin Islands had surpassed 32% of adults being categorized as obese (CDC, 2016). Data from the Congressional Budget Office demonstrate the relationship between body weight and per capita healthcare cost (Congressional Budget Office, 2010; Volsky, 2010). The data reveal a dramatic change in both the proportion of obesity and its relationship to healthcare expenditures over a 20-year period, between 1987 and 2007, and reflect the change from being underweight to being overweight as the driver of cost.

It should not be surprising that the combination of an aging population, obesity, and progress in treating chronic diseases should lead to an increase in the average number of chronic conditions experienced by our population. In fact, data from CMS show that the percentage of Medicare fee-for-service beneficiaries having four or more chronic conditions exceeded 36% in 2015 (Centers for Medicare and Medicaid Services, 2015). With the increase in the number of chronic conditions comes an increase in cost, reflected by the percentage of spending for Medicare. In 2008, the 36% of the population with four or more chronic diseases was responsible for 76% of Medicare spending, according to CMS (2015).

While utilization, as reflected by increased chronic diseases per capita and increased healthcare spending per capita, continues to climb at an alarming rate, we find ourselves in a growing misdistribution and shortage of clinicians in key areas. Data from the Association of American Medical Colleges (AAMC) project that the shortage of primary care physicians may be as high as 91,500 physicians by 2020 (AAMC, 2010). We already know there are tremendous shortages of primary care physicians and Obstetrics and Gynecology positions in parts of the country (Cunningham, 2011; Richards, Albright, & Rayburn, 2011). We continue to face a shortage of nurses that is greater than the shortage of physicians by at least a factor of 10. Similarly, according to the American Association of Colleges of Nursing (AACN), there is a substantial nursing misdistribution within the United States (AACN, 2014b). As the population ages, the current workforce continues to age in place. In 1985, physicians aged 65 years and older represented 9.4% of the physician workforce. By 2011, physicians aged 65 years and older grew to represent 15.1% of the physician workforce (AAMC, 2011). Similarly, the age distribution of nurses reveals progression from 1980 through 2020 (AACN, 2014b; Buerhaus, 2008). There is some reason to hope for a modest correction of the aging trend in nursing; the number of full-time equivalent registered nurses, ages 23 to 26, rose by 62% between 2002 and 2009 (Auerbach et al., 2011).

In addition to aging, we are now realizing the impacts of burnout on the healthcare workforce. Reports indicate that nearly half of physicians struggle with burnout, which affects their ability to relate to patients and focus on work in a way that avoids medical error (Shanafelt et al., 2012). Similar burnout rates are reported for registered nurses (Erickson & Grove, 2007; Todaro-Franceschi, 2013).

Yet clearly clinicians are not the only ones within the healthcare system to experience substantial stress. Patients are experiencing economic stress as they navigate the healthcare system. In addition to the personal stress of illness, substantial economic stress results. Himmelstein, Thorne, Warren, and Woolhandler (2009) studied bankruptcies that were filed in 2007 in the United States. They found that 62% of all bankruptcies filed that year related to medical expenses. Of those who filed for bankruptcy that year, nearly 80% had health insurance. Himmelstein and colleagues (2009) said the findings of this study show that middle-class families "frequently collapse under the strain of the healthcare system that treats physical wounds but inflicts fiscal ones" (p. 746).

Where do these revelations lead us? We have evidence that the U.S. population will continue to utilize healthcare resources at an ever-increasing pace. We have clear evidence that there is an existing misdistribution and shortage of clinical professionals. We have a system to pay for health care that puts the middle class at risk for bankruptcy and arguably prevents the poorest and most vulnerable from being able to access health care where and how they need it. We have a growing distance between what the United States and other countries, with whom we compete economically on a global scale, pay for health care (Kaiser Family Foundation, 2011). The authors believe that to meet this challenge, clinical professionals must come to the table with a different mind-set and a different skill set if we are to avert potential healthcare shortages or prevent the cost of caring for the current population to be borne by many future generations. In this chapter we share some thoughts and insight about how we can manage this Herculean task. If not us, then who? If not now, when?

THE CALL FOR A DIFFERENT APPROACH

No individual discipline—medicine, nursing, pharmacy, social work, physical therapy, or others—can meet the needs of U.S. citizens alone. Many of the structures and processes we currently enjoy were created within disciplinary siloes. But our current system is fragmented, contains costly redundancies, and is not achieving necessary outcomes. We have to create a different health system that absorbs fewer resources and yields better outcomes. We have to find a way to fully leverage the strengths and perspective of each discipline and co-create the future system. The best system will be created by consumers, nurses, medical doctors, dieticians, physical and occupational therapists, pharmacists, mental health clinicians, community agents, and the faith community all coming together to develop a shared vision, required outcomes, and the processes and structures necessary to achieve these outcomes. Through shared perspectives, knowledge, and experience we will find the best answers to the challenges we face as a nation.

For nursing to participate fully in this interprofessional effort, individual nurses need to first fully understand their own practice. What do nurses uniquely bring to the table in helping the population maintain health or in helping those patients with illness regain health or find optimal functioning with their disease? Too often nurses have a hard time defining for others what nursing is and what the discipline brings to patient care (Parse, 2013). Competencies of nursing, such as skill in modifying the patient's environment to maintain or regain a state of health, are just not salient to many nurses today. When joining an interprofessional team, nurses can be reticent contributors, unsure about what they can bring to the planning of patient care. Without clarity about nursing's contributions, nurses will not be good partners in creating the health system of the future (Engel & Prentice, 2013; Haskins, 2008).

Nurses also need to be clear about their accountability to the public. Nurses are issued a license by their state governmental agency. This license gives the nurse a right to care for people, have access to sensitive patient information, perform critical assessments and treatments, have the privilege of teaching patients and families, and make decisions about the right course of nursing interventions to bring about a return to a level of health. In return, nurses accept accountability to always do what is in the best interest of the patient; maintain currency in the best nursing practice; protect patient rights and personal information; advocate for patients, families, and communities; and practice with the highest ethical behavior (American Nurses Association [ANA], 2010a, 2010b).

The Institute of Medicine (IOM, 2010) report *The Future of Nursing: Leading Change, Advancing Health* also provides clear guidance that nurses need to expand their knowledge and skills through formal education and practice to the full extent of their license. Then nurses need to be willing to engage and collaborate with physicians and other healthcare professionals in redesigning health care in the United States. Those in positions to affect the nursing educational system have the additional responsibility of advocating for seamless academic progression and

improved data collection structures to create more effective workforce planning and public health policy. Now is not the time for nurses to be hesitant or wait for someone else to come forward to do the job.

Personal Accountability for Competency

Nurses and other members of the healthcare team need to bring their very best selves to the collaborative effort to be good partners in creating the health system of the future. Team members need to learn skills beyond expert knowledge of their own discipline. It is essential for team members to understand the complex nature of systems, particularly the healthcare system that currently exists in the United States. And they need an understanding of the outcomes and resource consumption that will be required of systems in the future. Team members will need to be critical thinkers who can evaluate ideas and reflect on them in light of the required outcomes, constrained resources, and available assets.

There is a set of skills that is perhaps even more important. These include listening skills, emotional intelligence, change leadership, and personal journey disciplines. Exquisite listening skills are required of each team member. Each member brings a unique set of knowledge, skills, and experiences to the table. There are differences in language that must be understood through listening and clarification. Some team members may be called on to serve as translators, verbalizing what they understand and helping other teammates comprehend meanings. Through listening, clarifying, and translating for others, members of the collaborative team can share their perspectives and ideas and pool them with the perspectives and ideas of their teammates, and thus create the broadest set of options for consideration in designing the health system (Bridges, Davidson, Odegard, Maki, & Tomkowiak, 2011; Interprofessional Education Collaborative Expert Panel, 2011).

Emotional intelligence is a set of skills that contribute to accurate assessment and expression of emotion in oneself and in others (Salovey & Mayer, 1989). Goleman (2006) went on to explain that, without emotional intelligence, humans cannot be fully successful in relationships, work, and even physical well-being. Goleman explains that emotional literacy can be enhanced, yielding the ideal combination of both mental and emotional intelligence. Members of the collaborative healthcare team need to individually develop their emotional intelligence to accurately assess and express emotion as a component of idea exchange and understanding, and to use emotional intelligence skills in interpersonal negotiations.

Change leadership is a hot topic in health care. Healthcare leaders, including those engaged in designing the health system of the future, need a solid understanding of change and the skills to plan for change, communicate to people about the needed change and the steps that need to be taken, and ultimately lead people through change. If change is to be successful and sustainable over time, it needs to be understood on multiple levels. In his model of change, Kotter (2002) describes the need to create urgency or a compelling case for not staying in the present state. Without a compelling reason to change, people will not expend the energy to leave their current behaviors and thinking. Schein (2004) describes change on four organizational levels. For change to be successful, leaders need not only to address technical and process changes but also to deal with what people need to know and the skills they need to possess, and they need to address the beliefs, attitudes, and behaviors of those going through the desired change. Change can be sustained only if the effort reaches into this last cultural level and takes hold. The healthcare team members need to recognize that resistance can be a positive sign of initial engagement that needs to be embraced and nurtured rather than avoided or fought. Without basic change leadership knowledge and skills, the collaborative team members will be limited in their ability to plan for the implementation of change and sustain it.

In an arena like health care, which is complex and rapidly changing, keeping up with what one needs to know about external influences, changing clinical knowledge, and personal growth

requires more than traditional learning. Personal journey disciplines are key practices that help individuals learn from every experience, every encounter, and every potential source of learning. These disciplines are not a book that can be read or a lecture that can be attended. Personal journey disciplines involve practices such as action learning and reflective practice (American Organization of Nurse Executives, 2005).

Professional Accountability

Members of the collaborative team, including nurses, need to fully understand what professional accountability requires of them. Guanci (2007) notes that a combination of various tenets makes up a profession, including (1) a well-defined body of knowledge, (2) depth of education, (3) control over practice and the practice environment, (4) self-regulation, (5) use of evidence-based practice and nursing research, (6) peer review, (7) the ability to practice autonomously, (8) affiliation with professional organizations, (9) a system of values, and (10) the development of a unique relationship with patients. We will take a closer look at just a few of these.

Values guide the creation of any organization or structure. Outcomes that are the target of the initial design express the values of the individuals or sponsoring body that forms an organization. These values may be implicit or explicit, but they are always there. Ethics is closely related to a system of values. Ethical behavior and ethical practice, both of which serve to help protect the public, are absolutely essential. Ethics are used to guide how the work of the organization or system is accomplished, and each professional needs to understand his or her discipline's standards of ethical behavior (ANA, 2009, 2010a, 2010b; Engel & Prentice, 2013).

Professional practice is based on the best evidence. In creating the health system of the future, the best evidence will be required, both for clinical practice in each of the involved disciplines and for leadership. Too often, evidence-based practice is applied only to the clinical realm. Leadership and management require the use of the best knowledge available, and old methods that no longer serve to accomplish the desired outcomes should be discarded. In designing health care for the future, the best clinical and leadership evidence needs to be used. Borrowing from Sackett and his colleagues (2000), this evidence needs to include not only the best research evidence but also the experience of expert clinicians and the values and priorities of the people that will be served. Yet how do we manage the explosion of information and evidence? Clinical professionals across disciplines need to employ a different approach if they are to cope effectively with the amount of information that appears annually in an increasing number of publications. Clinical leaders need to develop new systems through which information on the best evidence can be supplied to clinicians in the trenches where and when it is most needed. Expecting that clinicians will continue to personally read all the available literature, make critical decisions on the value of the literature, and implement that knowledge effectively and rapidly may be unrealistic. In the future—perhaps already—individual clinicians will need to trust teams of subject matter experts who will review evidence and particular topics and put together recommendations and supportive rationales that they will be able to access, accept, and follow.

INTERPROFESSIONAL COLLABORATION

The authors perceive that, in this context, interprofessional teams will work in collaboration to review evidence and deliver recommendations for team-based approaches to deliver the highest quality and lowest cost evidence-based care that also maximizes the patient experience. As such, we see that the leadership challenge is in the willingness, and ability, to work in teams representing different disciplines and potentially different cultures. In fact, the historically different cultures that affect how clinical professionals train, work, think, and behave should not be underestimated as a potential impediment to future interprofessional collaboration. We believe that when open discussion among clinical professionals in interprofessional teams addresses cultural differences

and creates similar mental models of the future of healthcare design, the stage will be set for effective collaboration leading to rule clarification, professional respect, and trust. These elements are essential to the effectiveness of both clinical leaders and clinical professionals at the bedside.

Communication, Relationship-Building Competence, and the Care of a Partnership

Many books have been written about the need for clear communication within teams and building foundational relationships. Teams also need to have a common purpose. This provides motivation for expending energy to form relationships. We all know that some relationships give us energy and stoke our creativity, while others seem to drain us. Members of the best interprofessional teams bring their best selves to the work, but they don't focus on recognition. Instead, team members take deliberate steps to understand other members. They commend input that is offered by another. They use "we" language and focus on the goals of the team. They draw attention to the perspectives and contributions of others. Taking team relationships a step further, collaborative relationships are careful to set aside personal interests and focus on cooperative efforts with no sense of vanquishing or beating others (World Health Organization, 2010). Power and authority are shared in collaboration, and efforts are focused on understanding the unique contributions of collaborators (Kagan, 2004). As discussed earlier, there are multiple disciplines in health care, each with unique education and differing perspectives and areas of focus. Team members must understand and respect one another's unique contributions to the common purpose and goals.

It is important to note that collaborators within healthcare design teams are likely to include nontraditional participants. Competitors might have to collaborate to serve a population. A single former competitor might be a competitor in one situation and serve as a collaborator and full member of the team for a different service. New collaborators are emerging as drugstores, grocery stores, and others enter the urgent care and health maintenance arena. Still other collaborative partners are likely to be insurance companies who are funding the care of patients by clinicians. Teams will have to collaborate not only across disciplines but also across entirely different organizations with differing objectives and experiences. All stakeholders need to be at the table to design systems that meet the needs of a given population.

Relationships require care, attention, and feeding. Collaborators can begin to misunderstand motives and misinterpret behaviors if ongoing communication and relationship building are not embedded in the process. Time must be set aside not only for planning itself but also for team members to continually communicate, seek clarity, and ensure that the relationship is strong and functional.

Best Management Science of Interprofessional Teams

Interprofessional teams need to base their design work on the best evidence from clinical and leadership literature, expert opinions, and patient values and preferences. This evidence needs to be drawn from multiple disciplines and vetted by team members. The days of nurses working on teams but focusing most of their efforts on isolating nursing and creating protective walls to guard nursing are long past. This isolationist behavior was in response to perceived threats, but it was counterproductive and sometimes led to nurses' voices not being heard. Nurses need to be strong and know their assets, but these qualities need to be in service of better caring for the population.

INTERPROFESSIONAL PRACTICE PARTNERSHIPS

Several landmark reports have catapulted interprofessional learning and partnerships to the forefront. While patients, lawyers, and each discipline recognized the strengths and shortcomings

of their work, relatively little effort was put forward prior to 2000 to address common concerns around patient safety and quality of care.

The first report was the IOM's (1999) *To Err Is Human: Building a Safer Health System*, followed by the IOM Committee on Quality of Health Care in America report *Crossing the Quality Chasm: A New Health System for the 21st Century* (IOM, 2001), which recognized that healthcare professionals working in interprofessional teams can communicate and address the complex needs of patients and families most effectively. This was followed by an IOM (2003) report on interprofessional education, *Health Professions Education: A Bridge to Quality*, which was recently updated in *Interprofessional Education for Collaboration: Learning How to Improve Health from Interprofessional Models across the Continuum of Education to Practice* (IOM, 2013). Last, the *Future of Nursing: Leading Change, Advancing Health* (IOM, 2010) report stressed the need for nurses to become equal partners in health policy, decision making, and practice. Common to each of these reports is the recognition that collaboration, effective communication, shared learning, and building teams are neither intuitive nor commonplace, yet they are essential in the provision of high-quality, safe patient care.

The AACN has established two notable partnerships in support of interprofessional team development and collaboration. First were formal academic–practice partnerships, established in 2003, to support the transition of nurse graduates, irrespective of educational program, in becoming practice organization leaders. The task force members, comprising nurse leaders spanning practice and academe, joined together to establish parameters and criteria in support of effective and meaningful transitions from the school setting to practice. The task force generated a white paper that became the foundation to a decade of long work to bridge the worlds of practice and academe for effective entry into the profession. The white paper was the impetus for several academic–practice collaborations regarding professional development, interprofessional learning, and curricular expectations for bachelor's, master's, and doctoral education of nurses (AACN, 2003).

Most recently, the AACN joined the American Association of Colleges of Osteopathic Medicine, the American Association of Colleges of Pharmacy, the American Dental Education Association, the Association of American Medical Colleges, and the Association of Schools and Programs of Public Health to establish an expert panel that generated *Core Competencies for Interprofessional Collaborative Practice* (Interprofessional Education Collaborative Expert Panel, 2011) as a product of the Interprofessional Education Collaborative. Inspired by a shared vision of interprofessional practice forming the foundation for safe, high-quality, accessible, patient-centered care, a commitment to develop interprofessional competencies with health profession students was seen as key to preparing the future workforce. While each profession builds from distinct disciplinary learning, each member of the collaborative agreed that the need to move beyond discipline-specific education by engaging students in interactions with other disciplines would be fundamental to interprofessional learning, team building, and ultimately becoming an effective team member in the workplace (Interprofessional Education Collaborative Expert Panel, 2011).

The AACN and the American Organization of Nurse Executives (AONE) joined together to form a task force on academic–practice partnerships to initiate a national dialogue, recognizing that, although nurse leaders who are responsible for education and operations would need to partner, this would be insufficient. As such, they established an expectation that academic–practice partnerships should include other health disciplines; leverage evidence and best practices; and make recommendations based on definitions, expectations, qualities, and products of academic–practice partnerships (AACN, 2015). As an outcome of this work, eight guiding principles for academic–practice partnerships were established (AACN, 2012), and a tool kit that supports ongoing education was created (AACN, 2014a).

Practice leaders also stepped forward to create expectations and structures for interprofessional collaboration and learning within the practice environment. Supported by the Agency for Healthcare Research and Quality and based on work developed in the U.S. Department of Defense, Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS)

established a teamwork system to improve safety that is predicated on improved communication and teamwork skills within practice organizations across the continuum of care (Agency for Healthcare Research and Quality, 2011). TeamSTEPPS is an evidence-based, systematic approach to improve and sustain a culture of safety by providing an interdisciplinary curriculum, readiness assessments, and consultations to organizations that commit to implementation. Shared learning within and among disciplines is emphasized and supported by leadership engagement, coaching, feedback, and skill building across disciplines throughout the organization.

As the nation moves into an era of population health, accountable care, and healthcare reform, additional partnerships will enter the landscape. They will include community partners that are not commonly considered members of a healthcare team, such as business entities, wellness disciplines, health educators, navigators, technology-based industry members, and policy makers. Their shared goal will be to improve the health of our country through innovative practice models that embrace partnering to improve care outcomes.

The role of individual patients in the planning for health care must continue to shift. Patients have historically been the recipients of a plan of care developed by their physician provider, or at best their healthcare team. Newer concepts like co-production (Batalden et al., 2015) highlight the fact that, in the end, healthcare decisions are the patient's decisions alone. The healthcare team may develop a plan and the patient has the full agency to decide that she or he will not follow a plan that is not in alignment her or his priorities and goals. Batalden argues that health outcomes are a consequence of both patients' and professionals 'capacity and behaviors in co-producing a plan of care/health promotion.

SUMMARY

The United States is headed in the wrong direction in terms of the costs of health care, health-harming personal behaviors, and outcomes. Change is not just inevitable; it is essential to future success. We have to turn around the current trends and create a health system that will yield a higher degree of health at a lower cost.

The solution will come through the collaboration of interprofessional teams that will include nurses, physicians, other clinical disciplines, patients, insurers, and many new providers of urgent care and health maintenance. Nurses need to prepare themselves educationally and mentally to participate as members of these teams and work to design the health system of the future. They need to understand their own practice and unique contributions. In addition, nurses must be prepared to fulfill their contract to serve the public good and behave with the highest degree of ethical behavior and integrity. They need to gain knowledge of the best available evidence and hone their skills in relationship building, teamwork, change leadership, and how to best participate as a full collaborative member of an interprofessional team. As nurses bring their best selves to this work, they will cast a strong leadership shadow and positively contribute to the work of the whole team.

The United States needs courageous nurses to prepare for and take their seat at the redesign table. When nurses, physicians, and members of the healthcare team come to the table fully prepared, the design of the new health system will take off.

REFLECTIVE QUESTIONS

1. Describe an experience you have had while working with an interprofessional team. What frameworks (lenses) did you use to understand and work with processes in managing the team's goals?
2. Considering your work with an interprofessional team, how would an emotionally intelligent leader use specific skills to effect positive outcomes?

3. How would you design models that strengthen synergistic nursing and interprofessional effectiveness?
4. Supported by the Agency for Healthcare Research and Quality and based on work developed in the U.S. Department of Defense, TeamSTEPPS provides an evidence-based teamwork system to improve safety that is predicated on improved communication and teamwork skills within practice organizations across the continuum of care. Describe two strategies from this evidence-based practice that could improve hand-off communication in your practice.

CASE STUDY 3-1 Academic–Clinical Partnership and Team Cohesion

Lori Lioce and Kristen Herrin

Natalie Busby was recently hired as a department nurse manager by a regional nonprofit healthcare system. She has master's degree preparation in nursing administration. Natalie served as a nurse manager at a small private hospital for 2 years after graduation.

Natalie just completed new employee orientation. Last week she had her first meeting with the chief nursing officer, who addressed department goals. During the meeting, Natalie became aware of several concerns in the department. Historically, the department had run smoothly and efficiently and was one of the premier departments within the organization. During the past 6 months, some of the nurses began requesting transfers to other departments, and some left to seek employment outside the organization. The chief nursing officer is concerned and would like Natalie to make this her first priority as the new department head.

In Natalie's first department manager meeting, the unit nurse managers voiced concerns about the increase in the number of nursing students on the floor at one time and nursing instructors sitting in the break room while relying on floor nurses to guide the students' clinical experience. Some nurses are refusing to take students or are calling in sick when students are expected on the floor, resulting in short staffing and incivility among staff members.

The department has 152 full- and part-time employees, consisting of 88 registered nurses (RNs), 40 licensed practical nurses (LPNs), and 24 nursing assistants. Each unit has a staffing mix of 22 RNs, 10 LPNs, and 6 nursing assistants. In the past, the staff members have worked well together. The recent increase in turnover has resulted in additional stress among the staff members, creating a negative and distrusting culture. The unit nurse managers said that, because many seasoned nurses are leaving and new nurses are coming on board, staff members feel overburdened with training new nurses and dealing with nursing students. In addition, staff members feel like the patients may not be getting the proper care.

Case Study Questions

1. What additional coaching would be beneficial for Natalie?
2. How should Natalie address the nurse managers' concerns?
3. What strategies can Natalie employ internally with the following groups:
   Nurse managers
   Staff nurses (LPNs and RNs)
   Nursing assistants
4. What strategies can Natalie employ externally with the following groups:
   Schools of nursing
   Nursing instructors
5. Which leadership style or styles should Natalie use to create a positive work environment?
6. What change theory or theories could be used in this situation?
7. Why is there a culture of incivility? How can this be addressed? How can Natalie involve staff to change the culture?
8. Natalie asks for current patient outcome data for her department. The catheter-associated urinary tract infection (CAUTI) rates are reported as the second highest in the hospital. How can Natalie use this data when working with her team? What strategies would be effective in improving patient outcomes?

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