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Nurse Managers New Zealand Newsletter

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Chairperson's Report

Hello everyone.

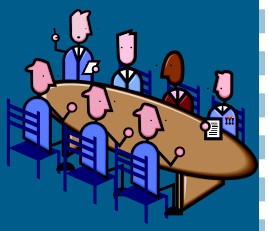
The new committee gathered in Dunedin in March. It was great to meet face to face and we set out a pathway for succession planning within the committee to ensure the smooth transition at the completion of committee member terms of office. Roles within the committee are now more evenly distributed and are listed below:

Chairperson – Raewyn Hughes
Vice Chair – Sarah Tweedale
Secretary – Monique Toes-Rouse
Assistant Secretary – Maria Armstrong
Treasurer – Itayi Mapanda
Newsletter Coordinator – Sarah Tweedale
Membership Coordinator – Janeen Holmes
Website Coordinator – Sue Stevenson

We were fortunate to meet briefly with Jane MacGeorge (Manager Nursing and Professional Services – NZNO). Jane explained her brief to us – she leads the NZNO legal team, research team, library and professional nurse advisor team. Jane briefly described NZNO's next challenge to become more strategic and looks forward to "peeling back the layers" of NZNO to review its direction.

The committee have also started to develop guidelines and a process to provide funds to assist section members with study and professional development costs. This is a work in progress and you will be informed of the progress. Planning is in its infancy and we would welcome any suggestions regarding this. Please email the section on dcnmsection@gmail.com if you would like to contribute to the development of this.

Sarah Tweedale organised a well attended education forum on the Wednesday evening held at Dunedin Hospital. Please read Sarah's report within this newsletter. The committee were given a quick insight into the issues and concerns that are facing the southern area. It was good to network with section members.



Chairperson's Report

Plans are afoot to hold the 2016 Nurse Managers conference on Thursday 3rd and Friday 4th November 2016. Just a heads up to keep those dates free. More to come on this shortly.

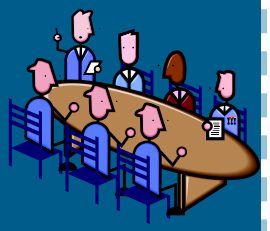
International Midwives Day is to celebrated on May 5th with the theme 'Women and Newborns – The Heart of Midwifery' and May 12th is International Nurses Day with the theme 'A force for change – Improving health systems resilience'. Are you organising something in your workplace to celebrate this? I am sure you will agree with me that nurses are truly deserving of a celebration of the skills, compassion and worthiness. Feel free to let us know what you have done to celebrate this day by sending us photos and maybe a brief story on your work area. We will happily publish this in our newsletter.

I would just like to leave you with this thought that Jane Wilson used during her presentation at the education forum "…. the standard you walk past is the standard you accept".

Regards

Raewyn Hughes
Chairperson

Membership Report



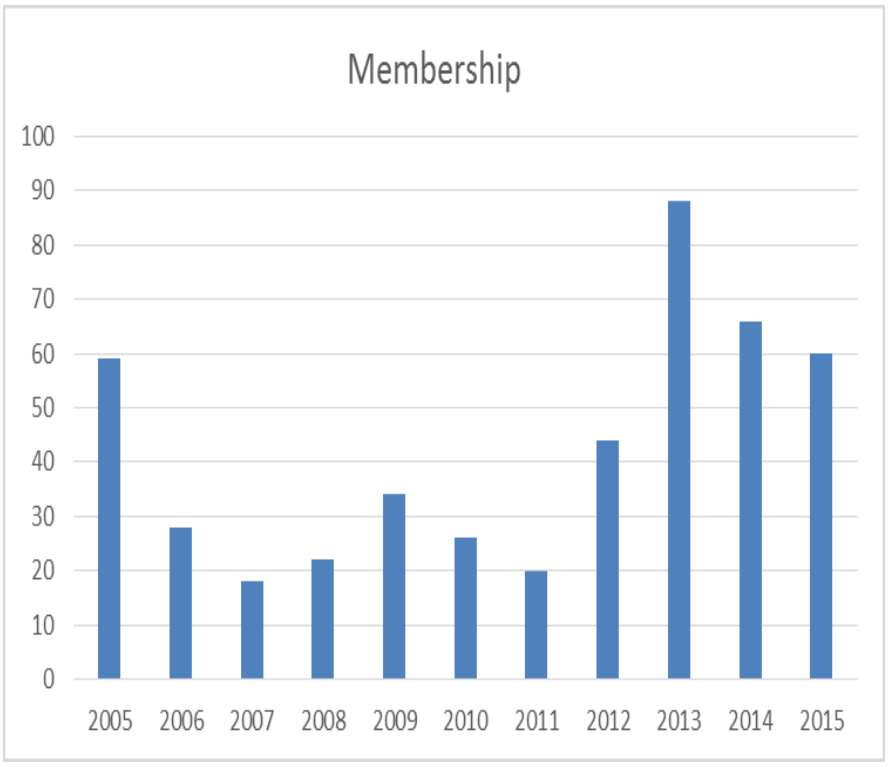
Itayi Mapanda

Welcome to the first 2016 membership update. Wow! Yet another year has passed us by. They seem to be flying past faster and faster. Just this year we have hopped over January, stepped over February and looked past March and here we are in April already. As of 31st March the section membership stood at a total of 472. Seven new members have so far joined the section since January 2016 to March 31st.

Let us look back since the commencement of the section in 2005 to 2015 (using calendar year) and analyse the trend of our membership numbers increment by each year. If you look at the bar graph below you will see the varied increment of members year by year. The year 2013 had an increase of 88 members and this is the highest increase so far for the section. The Second-best year was 2014 with 66 members.

From 2005 to 2013 we can see a fluctuation of more members one year and less the next. The peak in 2013 has been followed by a steady decline in the years 2014 and 2015. The average increment from 2005 to 2015 is 42 members per year, meaning the decline in the last two years is still above the trend average.

The NZNO Nurse Manager section is an amazing group to be involved with as we offer so much support as well as professional education and networking. Together let us market the section and encourage other Nurse Managers to get involved so that we are all benefitting. Our vision is to see membership growing well above average each year.



Education Forum Summary

On the 16th March we had a great turnout for our professional forum here in Dunedin; our two guests for the evening were Dr Tim Kerruish FACEM ED SMO and Jane Wilson one of our Nurse Directors who is currently seconded into the commissioner's office. They spoke brilliantly to our diverse audience of 50 from across primary and secondary care, education, public and mental health, acute and rehabilitation settings.

The focus was how as nurse leaders we are a pivotal part of improvement and engagement. While Tim presented he acknowledged it's sometimes hard to translate the well-known but not always well understood Toyota Way into real and tangible improvements in our workplace. Fundamental requirements to avoid failure being the commitment of senior management to trust and support the frontline staff to do this. Tim went on to discuss why this is necessary to bring about system changes, rather than settling for what is often seen as lip service and lack of desire to commit or invest long term to improvements. One trap that Tim believes organisations fall into, often due to lack of understanding is just picking and choosing parts of the Toyota principle and not fully committing. He recommended a book called '"The Score Takes Care of Itself" by Bill Walsh, reflecting if the right systems and processes are in place the desired outcomes will be self-evident. By stopping focusing on the finances rather get our models and systems right, match the workforce with the workload and eliminate waste; the financial score will take care of itself.

Jane followed on from this, presenting to us a great insight into what she experienced on her trip to IHI 27th Annual Forum in Orlando late last year. Her family visited Disney world while she attended forums! What commitment! Jane focused on the ones addressing workplace culture and engagement for improvement, sharing with us some proven strategies, ways of working, communicating and role modelling to bring about positive culture change. It was great that this presentation dovetailed so well into the SDHB's 'Our Future' work that we down here at Southern are working through at present. The other takeaway from Jane was to get a twitter account and 'follow' some great health improvement twitterers (is that a real word?) also organisations offering leadership courses for free! I can testify since I opened my account there are great sound bites, links to pod casts and YouTube presentations and much more. It's also great to see internationally what health care is up to and up against.

Thanks Tim and Jane for your time; there was some really positive feedback from the evening.

Sarah Tweedale

CCDM Overview

CCDM from the Charge Nurse Perspective

By Caroline Dodsworth, Charge Nurse, Palmerston North Hospital

In 2012 I was Charge Nurse Manager of an acute 32 bed medical ward. TrendCare was well-embedded in the organization at this time and activity and acuity for the ward showed a consistent negative variance, often between 20 and 30 hours negative over the 24 hour period. Rostering practices were entrenched and did not recognise peaks and troughs in workload or care rationing and missed nursing care were invisible. The opportunity to become the first ward to undertake work analysis and data collection to inform Care Capacity Demand Management (CCDM) programme was floated and our application was successful. We had two NZNO delegates working on the ward, both of whom were active in change management processes and quality improvement initiatives. Completion of forward prediction and Inter Rater Reliability (IRR) testing was routinely 100%. The ward had recently demonstrated a positive change management culture through implementation of a room for actively caring for patients with delirium, trial and implementation of new smoking cessation forms, trial and implementation of new care plan format and implementation of Microster (a new electronic rostering and payroll system). The ward had robust nursing governance in place with a very dynamic Leadership and Management Action Group, and Education and Research Group. We also had vigorous but very efficient “word of mouth” communication processes through “what’s on top” discussions at every shift hand over. This helped to overcome potential barriers to implementation of CCDM through negativity created by high acuity and workload.

Initial interest in the CCDM process was gauged through conversations with the nursing team (including union delegates), allied health, operational and clinical leaders - all key stakeholders demonstrated positive responses to the idea. My perception of my role in the work analysis data collection and any subsequent changes to the model of care was that of supportive oversight ensuring 100% compliance with the requirements of the process. The data collection process was as difficult and hard work as I had anticipated - ironing out teething problems, ensuring everyone was on the same page, encouraging the negative staff and the fence-sitters, keeping the momentum going when enthusiasm flagged. However by the end of the two weeks the staff had become quite attached to their diaries and appreciated the fact that they were able to clearly articulate care rationing - especially the missed nursing care that had become “business as usual” because they never had time. Then there came a period of stasis while the data was analysed. Because the analysis took a period of time, staff began wondering if their hard work had all been for nothing.

During this time we implemented releasing time to care which helped keep a sense of momentum for change although staff remained very interested in anticipating the outcome of the data analysis.

However as soon as the results were confirmed we swung into action and developed a new model of care based on input from the entire nursing team - we used butchers paper and models, felt pens and timetables, arranging and rearranging the FTE and the roster to meet the peaks and troughs of work over the entire 24 four hour day and seven day week. The team divided up the available FTE into the most efficient and effective spread of qualified and non-qualified staff, thinking outside the square and breaking down traditional shift times barriers. The new model of care implemented a new role of "admission and discharge nurse" who straddled the AM and PM shift without a patient load, but focused on timely discharges and active "pulling" of patients from MAPU and ED. The model of care in the delirium room also changed - instead of being staffed by a ward RN and a bureau Health Care Assistant (HCA) we had our own ward HCA who knew the patients and provided continuity of care for them.

The difference to staff morale and motivation as a result of CCDM was immense. While the ward remained very busy it operated efficiently and effectively. Complaints, incidents, falls and medication errors reduced, staff turnover was practically zero and productivity improved. The ward also managed to implement Releasing Time to Care (RTC) at the same time as CCDM which was an amazing achievement. We found that the two programmes supported and enhanced each other.

The natural progression from Mix and Match (now known as Staffing Methodology) was the development of the Variance Response Management (VRM) process. While implementation of Mix & Match across other acute wards has been challenging, the push to develop the VRM tools were given maximum exposure and used an organization wide collaborative approach in partnership with NZNO. It has replaced a problematic and cumbersome safe staffing process and is progressing towards a more visible and user friendly process. It still cannot produce nurses out of thin air, but it raises awareness of areas under pressure to all the right people and allows an Organization-wide approach to pooling resources to provide support where it is needed. Everyone is talking the same language, and much like the Early Warning System to detect the deteriorating patient, VRM triggers a response at the top of the cliff instead of the bottom.

I have included some comments from the nursing staff involved in the CCDM process to give a non-biased view of the process. But the comment I found made the most impression on me, and the thing that I think CCDM stands for above all else for nurses was:

Since CCDM it feels like I've actually met the patients, & I don't go home with that horrible feeling that I've missed something".

As the Charge Nurse for that ward I can take some pride in the fact that I was responsible for making that happen. We need Senior Managers to influence change at the executive table, but the Charge Nurse is responsible for driving change at ward level with enthusiasm and passion, leading from the front and never giving up.

Comments about CCDM

Process

There was excellent communication during the process; ward staff were included and actively involved. The process was a great example of working in partnership with close collaboration between Charge Nurse, NZNO and ward staff. Ward staff were given every opportunity to express their concerns and listened to in a non-judgmental manner. Data sharing facts and figures were explained to staff and they were given time to digest and seek clarification if unsure. Unfamiliar data was explained in language that could be understood by all. Charge Nurse, Associate Charge Nurses, Management and NZNO delegates were professional and supportive, and assisted with propelling the process forward- staff joined in at “grass roots level”.

Data Gathering

There was initial fear, anger and distrust at the process. It was generally seen as a “lip-service” situation and “what was going to happen with the data?” Many staff thought it was another data gathering exercise with no tangible benefit to the patient or staff. But as the process developed it was an eye opener to be able to quantify the many interruptions during the shift. It also highlighted and reinforced what nurses already knew due to many interruptions - less time was being spent in patient care. They also gained further insight into peaks and troughs of ward work. The process of reporting back the data seemed to take a long time. This resulted in a slight drop in momentum. However it was a good example of “joining in”. On the feedback days many staff came in on their days off to participate- there was ownership of the ward and the staff.

Improvements
The constant drive of bed occupancy and staffing in medical wards is a continuous balance. For staff to be involved in determining how FTE is used across shifts is momentous. They felt listened to. Everyone had a voice and an opportunity to be heard in this valuable process - from HCA, hospital aides, Enrolled nurses, Registered nurses, Allied health staff and doctors. It was great to have a process that came from concern for staff and patient safety. Staff are now more aware of how the process works and what can be done if things are not working. Patients were mainly positive about the process as they understood it was about safety and more direct patient care. Additional staff has been a tangible benefit - it has shown staff that the process is not finished and never will be; they are still part of continuous improvement. The ward started RTC at the same time as CCDM and this was a lot of work. Although I think we should have started with CCDM and then RTC, they are both very positive processes. RTC was a very positive process but it got a bit lost in CCDM and was a bit overwhelming.

Staffing
To have our own HCA in the cohort room is amazing. The benefits to the patient outcomes, and working relationships between the team are invaluable. The staffing numbers across all three shifts are well thought out. Patient safety has improved significantly with an extra Registered nurse at night. The introduction of the admission/discharge nurse means that patients feel more informed. New admissions are seen and assessed early without waiting for a busy nurse to be able to see them.

Admission/Discharge Nurse role
There is less pressure on the qualified staff, especially on the morning shift. Discharges happen in a timelier manner, and the discharge of complex patients requiring a lot Registered nurse time is now smoother.

If you would like to know more about CCDM please talk with your local NZNO Delegate or Organiser, or visit http://www.nzno.org.nz/get_involved/campaigns/care_point or http://centraltas.co.nz/strategic-workforce-services/safe-staffing-health-workplace/

Membership Application Form

Post to:
NZNO Nurse Managers New Zealand Administrator
NZ Nurses Organisation
P O Box 2128
Wellington 6140

OR **Email to**: heathers@nzno.org.nz

Full Name _____

Workplace _____

Role / Position _____

Email _____

Home Phone _____

Mobile _____

Address _____

_____

Postcode _____

NZNO Membership # _____

NZNO queries Ph: 0800 28 38 48

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Are you currently a member of another NZNO section?

YES / NO

If YES what section?.....