Redefining "charge nurse" within the front line

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Under The Patient Protection and Affordable Care Act of 2010, the Hospital Value-Based Purchasing Program provides monetary incentives to hospitals for exceeding expectations on various domains, one of which is the patient experience of care domain.[1] The focus on this patient experience domain is now being addressed by the national media. In 2013, $964 million in Medicare funding was tied to patient satisfaction.[2] Charge nurses may have a greater impact on patient, physician, and staff satisfaction than any other nurse leaders.[3] Charge nurses, frontline leaders who perform complex duties, are untapped resources who can be groomed for future leadership positions. They desire leadership development and mentoring.[4] Charge nurses with little or no preparation are often "thrown" into frontline leadership positions that are highly complex, stressful, and critical to the success of a unit.[2] Investing in structured leadership training for charge nurses is essential in the current complex healthcare environment.[5] The purposes of this quality improvement project were to redefine the charge nurse role using leadership competencies, implement a formal charge nurse leadership program on two medical-surgical units, assess the program's effect on patient satisfaction with nurse communication, and assess whether the program improves nurse retention.

Education at the forefront

There has been little published about charge nurse development programs. However, literature supports the need to invest in charge nurse development. The American Organization of Nurse Executives (AONE) competencies provide structure and metrics for leadership development of charge nurses based on a novice to expert scale.[6] Key elements of AONE competencies include communication, knowledge, leadership, professionalism, and business skills.[6]

When comparing leadership skill with other nursing leaders (such as managers or supervisors), several study authors believe charge nurses require additional leadership competencies, including effective communication skills, knowledge of the complex healthcare environment, human resource management skills, professionalism, and clinical operation skills.[6,7] A positive impact on patient outcomes and patient satisfaction has been attributed to charge nurses. Literature suggests a positive relationship between nursing leadership and improved patient

outcomes (increased patient satisfaction and reduced patient adverse events and complications).[3,8-18] Lack of investment in charge nurse leadership skills may put healthcare organizations at risk for underperforming in a highly competitive healthcare environment.[16]

Developing the leaders

The Plan-Do-Study-Act quality improvement model was used to develop a formal leadership training program for charge nurses at a 137-bed community hospital located in a rural area of Texas.[9]

Plan

An informal focus group of 22 charge nurses and 5 nursing directors was convened by the CNO in October 2012. As an outcome of the discussion, the need to redesign the charge nurse role was identified along with a need for leadership training. The CNO formed a redesign team of nurse educators, charge nurses, and the medical-surgical nursing director; the team was assigned to redesign the charge nurse role and develop a charge nurse leadership program. The long-term goal of this project was to develop, implement, and evaluate an evidence-based program at our hospital that could be used system-wide.

Do

The redesign team evaluated the current charge nurse orientation competencies based on clinical experience and input from charge nurses, listed the strengths of the current method of training, and identified opportunities for improvement. From this, the new vision of elevating the charge nurse role to perform as an influential frontline leader was proposed. (See *Table 1*.) This role expansion was a significant organizational change and discussions led to a decision to have current charge nurses reapply for their positions based on new competencies.

To explain the new vision and outline plans for the charge nurse leadership program, the nursing directors, the redesign team, and the CNO conducted an open forum meeting with current charge nurses. The CNO also conducted face-to-face, hospital-wide, nursing staff informational sessions to solicit feedback regarding the charge nurse role and to provide the opportunity for staff engagement.

The redesign team identified the need for a new charge nurse job description. After evaluating the various existing charge nurse job descriptions used within our 14-hospital healthcare system, the redesign team developed a new charge nurse job description. The team incorporated the best of each existing job description, integrated charge nurse expectations, and developed the Charge Nurse Commitment letter and Charge Nurse Expectations document. (See *Charge nurse expectations* and supplemental content on the *Nursing Management* iPad app.) Each new charge nurse is required to agree to and sign the commitment letter before starting the leadership program.

In December 2012, charge nurse positions were posted for each nursing unit so that all clinical nurses had

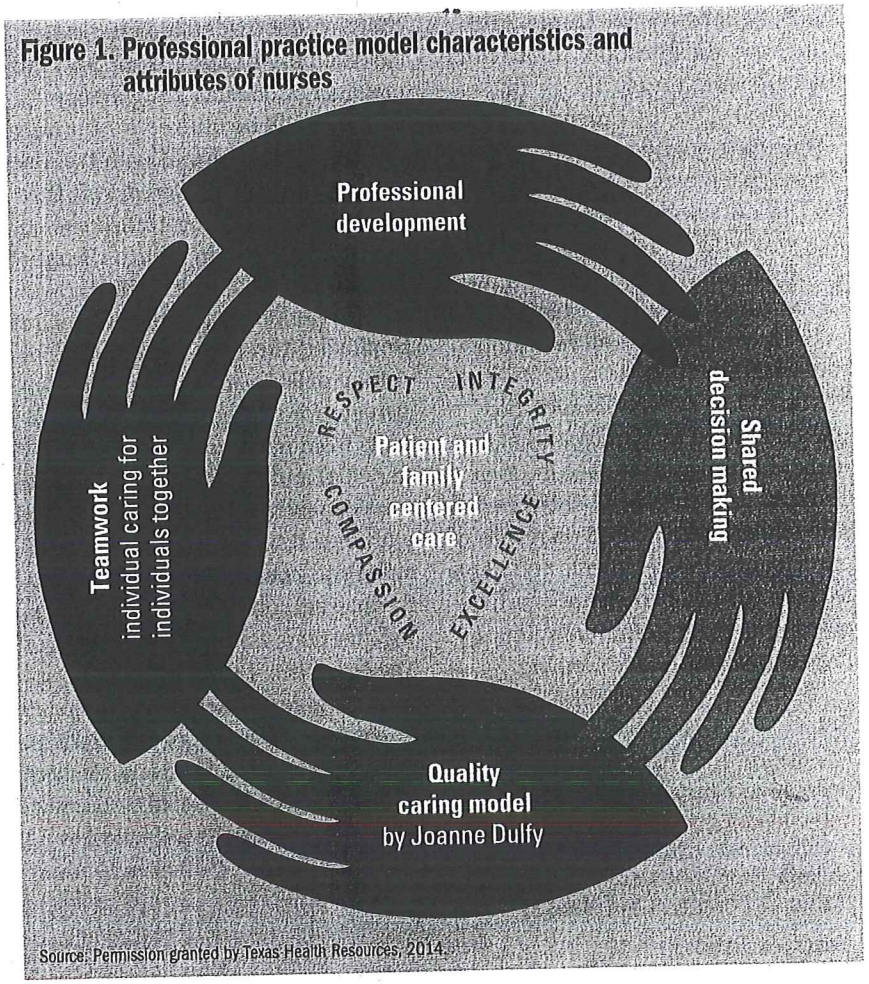
Table 1: Charge nurse program before and after criteria

Criteria for charge nurse	Before 2013	After 2013
Job description	No	Yes
Apply for position	No	Yes
Commitment letter	No	Yes
Expectations formally outlined	No	Yes; both helped to motivate the charge nurses toward professional development and feel supported in their efforts.
Structured training	Yes; one 8-hour day.	Yes; every quarter with the entire charge nurse group. Content based on AONE competencies.
Evidence-based competencies	No; charge nurse competencies were identified and based on the entity-specific performance outcomes.	Yes; based on AONE Nurse Executive competencies.
Structured quarterly charge nurse meetings	No; annual update only.	Yes; • emphasis on patient outcomes and entity communication/networking • leadership component • CNO leads meetings.

the opportunity to apply. Current charge nurses were required to reapply for their positions. The hiring process utilized panel interviews with nursing directors and frontline staff. Candidates were selected by the end of December 2012, and the new charge nurse leadership program began with an orientation in January 2013.

The CNO and redesign team determined that the AONE Novice to Expert Leadership Training Curriculum provided entry-level leadership education that was ideal for a novice charge nurse program.[5] Because many of our experienced charge nurses lacked formal education in the role, we also believed they needed the education. The redesign team then identified the leadership characteristics and attributes required for charge nurses based on the system's professional practice model, feedback from the charge nurse focus group, and literature published about the charge nurse role. (See *Figure 1.*)

Figure 1. Professional practice model characteristics and attributes of nurses



Source: Permission granted by Texas Health Resources, 2014.

Charge nurse expectations

- Certification in advanced cardiac life support
- Round on all patients
- Conduct quality and safety rounds
- Ensure core measures are met
- Round with physicians, as needed
- Attend 3:00 staffing briefing
- Conduct beginning-of-shift briefings
- Ensure 100% bedside reporting
- Conduct survey readiness rounds
- Model the promise behaviors
- Provide input on performance evaluations
- Attend daily case management briefing (N/A for surgical services)
- Ensure appropriate staffing per grid
- Board certification
- Maintain Nursing Career Advancement Program level IV or higher (after achieving board certification)
- Champion Team STEPPS
- Accountable for physician, patient, and staff satisfaction

Changes incorporated into the redesign included classes in frontline leadership, career development, service excellence, professionalism, clinical operations, communication, and human resource management. *Table* 2 lists the schedule of classes offered in the program.

In partnership with the healthcare system's Center for Learning and Career Development, a formalized, year-long, classroom-based, instructor-led nurse leadership program for charge nurses was developed. Classes were held for 6 to 8 hours on one day beginning in January 2013. Two classes were held in February, and classes were then held every other month through October 2013. Program instructors were selected from the system's Center for Learning and Career Development staff based on their areas of expertise with curriculum topics. Classes were designed to be interactive and required pre- and posthomework assignments.

Study

Two medical-surgical units were evaluated because the majority of the participants in the leadership program came from those two units. The leadership program effectiveness was evaluated by comparing patient satisfaction survey scores on three nurse communication questions and the human resources department measuring nurse retention rates for

the last quarters of 2012 and 2013. Three specific questions about nursing care were measured for this project: (1) Did the nurses treat you with courtesy and respect?; (2) Did nurses listen carefully to you?; and (3) Did nurses explain everything in a way you understand? Nurse retention rates were measured by comparing the overall retention rate in 2012 with the overall retention rate in 2013.

The AONE self-assessment tool was completed by participants at the end of the program to describe their perceptions of improvement in leadership effectiveness.[6] Based on results of participant self-assessments and nurse leader feedback, participant effectiveness improved in communication, professionalism, and leadership.

Act

To support the change, program classes were taped for future charge nurse leadership trainees. Online charge nurse leadership classes based on the AONE's certified nurse manager and leader competency program will be utilized for future training and consistent with the formal on-site classes offered in 2013.[5] This will allow for continued sustainability of training for this front-line leader role.

Deploying the trainees

A total of 944 patient satisfaction surveys for the medical-surgical units from fourth quarter 2012 (n = 404) and the fourth quarter 2013 (n = 540) were returned and analyzed with statistical software. Cronbach's alpha was conducted to determine the internal consistency reliability of the questions asked on the survey. The Cronbach's alpha was 0.716, indicating good internal consistency.

The three survey questions from the Centers for Medicare and Medicaid Services (CMS) related to nursing communication were analyzed for the two medical-surgical units using data from the fourth quarter of 2012 (before the program began) and the fourth quarter of 2013 (after program completion). The response options to these questions are on an ordinal scale where higher order indicates a more logical positive response to the question. Group outcome data were analyzed using a Mann-Whitney U (Wilcoxon Rank-Sum) test. (See *Table 3.*)

We also evaluated nurse retention on the two medical-surgical units. The human resources department tracks nurse retention data for the entity at the unit level. The 2012 RN retention rate for clinical nurses on the medical-surgical unit was 70.52%. The retention rate for 2013 improved to 76.21%, an 8.1% increase.

Closer inspection

Although we didn't find a statistically significant difference, we believe our results are clinically significant. The system's inpatient satisfaction composite score increased by 24% from 51% in 2012 to 63% in 2013. Additional improvements were experienced in the organization that may be a result of implementing the charge nurse leadership program. Nurse-physician collaboration was identified in the survey results as a key strength, and each year physicians are invited to participate in a physician satisfaction survey. In 2012, 56% of physicians responded; 57% participated in 2013. Physician satisfaction improved

Table 2: Charge nurse classes

Education classes	Schedule
Nurse leader orientation	January 2013
Service excellence	February 2013
Communication	February 2013
Knowledge of the healthcare environment	April 2013
Leadership	June 2013
Professionalism	August 2013
Business skills	October 2013

Table 3: Mann-Whitney U (Wilcoxon Rank-Sum) test statistics

HCAHPS question	Preintervention mean rank (n)	Postintervention mean rank (n)	*P* (MW*)
Nurses treat with courtesy/respect	475.33 (n = 404)	470.38 (n = 540)	$p = 0.611$
Nurses listen carefully to you	479.98 (n = 405)	466.88 (n = 539)	$p = 0.288$
Nurses explain in a way that you understand	478.90 (n = 403)	465.97 (n = 539)	$p = 0.325$

*MW, Mann-Whitney U test (Wilcoxon Rank-Sum test)

Significant difference defined as ($p < .05$) between mean ranks before and after intervention.

from the 41st percentile in 2012 to the 88th percentile in 2013.

Nurse leaders and physicians have provided positive feedback related to charge nurse leadership effectiveness and increased collaboration and coordination of care. Nurses in the program provided reflective comments about their experience and indicated increased leadership development and effectiveness, interprofessional collaboration, and confidence in their roles.

The next recruits

Although we experienced positive anecdotal results, we didn't experience the significant improvement in the patient satisfaction scores we hoped to attain. We may have evaluated these metrics too early in the change process to see significant change. Projects such as this may require several years to demonstrate significant improvement.[17] Therefore, continuing this program and reevaluating the results in the future is critical to evaluating the success of the frontline leadership program and improved patient satisfaction in the organization.

In analyzing our results further, we recognized there were several external variations that weren't controlled for, which may have influenced our results. A major construction project was in progress on the second floor medical-surgical unit for 5 months in 2013. And, unfortunately, noise can be a factor that negatively influences patient satisfaction scores.[18] In addition to the construction project, we experienced unexpected leadership, staff, and charge nurse turnover on the two medical-surgical units that were the focus of our project. The reasons for the turnover were multifactorial. A sudden unexpected departure of a director over both units, charge nurses who chose not to participate in the leadership education (and were going to leave their charge nurse status), and life-events affecting some nurses were believed to be some of the causes of the turnover.

Nurse retention is essential for staff satisfaction, quality healthcare, and patient satisfaction.[15] We believe that through rebuilding the team, aligning the organization, and increasing stability in leadership, continued monitoring will show further improvement in our patient satisfaction, retention of nurses, and charge nurse leadership effectiveness.

Roll out to other organizations

We found that we were able to implement this program effectively within our institution with minimal assistance from the larger healthcare system. Developing highly competent frontline leaders and the use of CMS data in nursing care may provide a significant contribution to knowledge about patients' views of their hospital experience. Nonparametric statistical methods can appropriately be used for this type of analysis and allow for a thorough evaluation of data. We believe that this quality improvement project can be successfully replicated in other settings, and should be because charge nurses are the first on the frontline to improve patient and staff satisfaction and health. NM

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