The positive impact of formalized charge nurse training

By Norma Teran, DNP, MBA, RN, and Paula J. Webb, DNP, RN, NEA-BC

Nurses play an important role in patient satisfaction, which impacts hospital reimbursement.[1] Value-Based Purchasing (VBP), a program designed by the Centers for Medicare and Medicaid Services (CMS), compensates hospitals with "incentive payments for the quality of care they provide to people with Medicare."[2] VBP has led to a focus on quality and patient satisfaction in acute care hospitals. One study demonstrated that a one-point increase in the nursing domain scores on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey can increase the odds of achieving a top-box patient satisfaction score by 4.9%.[3] The researchers concluded that hospitals can improve patient satisfaction and maximize Medicare compensation by focusing on nursing care.[3] A separate but important finding is how nurse turnover affects quality and patient satisfaction.[4] Stabilizing the workforce through retention ensures continuity of care and practice.[1]

Within our 530-bed health system in south Texas, with 100%+ capacity during the winter months, it isn't unusual for those nurses identified as highly skilled clinicians to be promoted to the charge nurse role with an expectation to excel—often with little or no training. The orientation provided to charge nurses at our health system is informal and frequently limited to unit routines, such as checking crash carts, collecting census, counting controlled substances, staffing for the oncoming shift, and contacting the house supervisor. On many of our units, after a brief orientation usually performed by an equally unprepared peer, the new charge nurse is left to manage the shifts without any further training. This lack of structured training leads to charge nurses who are unprepared to deal with the complexities of the shift. They're often unable to manage or prioritize a nurse unhappy with his or her assigned patients, a missing tray from dietary, or a family member requesting to speak with the charge nurse.

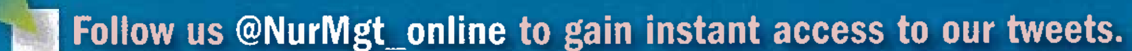
Charge nurses lead our units; focusing on their development through leadership training that emphasizes communication, mentoring, and coaching skills will result in charge nurses who have the authority to ensure assignments are based on patients' needs, delegate tasks successfully, supervise care, and provide assistance to those with less experience.[5,6] We describe how a formalized charge nurse training program can benefit the health system by improving patient satisfaction and nurse retention.

Decision support and unit selection

The concept for creating charge nurse leadership training was presented, discussed, and approved by our nurse executive council. With the support of the CEO, the training initiative was announced at all nursing meetings and at finance committee, medical executive committee, and governing board meetings as an educational opportunity and pilot project for charge nurses. A project aiming to increase patient satisfaction scores and nurse retention resonated with all parties, creating an excitement and willingness to make the project a reality.

The unit selected as the pilot for this project had HCAHPS scores that didn't meet benchmark

- It's often difficult to find time for web searching.
- Luckily, *Nursing Management* has a Twitter account where you can find links to our latest articles and online-only content.



- Check out "Think about it," *Nursing Management*'s blog, written by the journal's Editorial Board members.
- Review commentary on current topics that impact nurse managers and executives alike.
- We're also open to suggestions: Feel free to leave a comment and you may see your topic in the next blog post.

standards and nurse turnover rates higher than desired. This patient care unit is the closest to the surgical suites, has large patient rooms, and the nursing care is regularly declared by surgeons to be the best. It's made up of three floors with 16 beds each, for a total of 48 beds. Bariatric surgeries are cared for on the first floor, urology and orthopedic surgeries on the second floor, and longer-term surgical patients on the third floor. This unit was the first inpatient unit built after the original six physician investors created the ambulatory surgical center in 1997; care and outcomes across the health system often gets compared with this unit as an example.

When surgical patients are placed in other areas of the hospital due to capacity issues, the surgeons consistently voice their disapproval by contacting the patient intake center, house supervisor, and/or the biggest shareholder of the health system. With lower HCAHPS scores and higher nurse turnover than the rest of the health system, the physician perception of superior care didn't fit the picture. This conflict in perception made the unit a logical choice to serve as the charge nurse leadership training pilot.

A total of 11 charge nurses and 6 new clinical coordinators participated in this project. Emphasis was placed on defining and improving the four nursing domains of the HCAHPS survey: communication with nurses, responsiveness of hospital staff, pain management, and communication about medications.[7] Improvement in these areas has the biggest impact on patient satisfaction.[3]

Structure and nursing framework

The selected staff members completed 40 hours of classroom training divided into five 8-hour classes. The training occurred between May 30 and July 31, 2015. Classes included self-assessment and leadership, coaching skills, patient safety, beyond the bedside/nursing care, shared governance regulations and requirements, developing a charge nurse job description, and aggregating and implementing new knowledge. Team building, communication exercises, and discussions were incorporated into every session.

The format for training included presentations and lectures, online video resources, teamwork exercises, reading assignments, individual nurse presentations, and group discussions. Nurses were paid for time spent in training and meals were provided. Continuing-education credits were given to participants upon completion of each 8-hour day (See *Table 1*.)

Patricia Benner's novice-to-expert theory became the ideal design for the charge nurse leadership training.[8] Nurses develop knowledge through clinical experience, which then assists them with ethical judgments. Benner's theory proposes that clinical and ethical judgments are "inseparable."[7] We aimed to transition these charge nurses from novice/advanced beginner to competent/proficient during the 6-month posttraining period. After the multifaceted training, the charge nurses' competencies were assessed through observation and return demonstration with real-life

Table 1: Topics for leadership charge nurse training (40 hours)

Topic	Time	Focus	Tools
Self-assessment	4 hours	Personality test	16Personalities test
Leadership	4 hours	Leadership	Leadership styles; manager vs. leader
Coaching	8 hours	Communication	InsideOut Coaching
Patient safety	6 hours	Patient	Environment of care assessment
Beyond the bedside/ nursing care	2 hours	Nursing care issues	Patient throughput and interdisciplinary teams
Shared governance	4 hours	Empowerment	Magnet® journey
Regulations and requirements	4 hours	Compliance	CMS, The Joint Commission, and Texas Department of State Health Services guidelines and requirements
Charge nurse job description	6 hours	Autonomy and responsibility	Current job description vs. actual responsibilities
Aggregating and implementing new knowledge	2 hours	Lessons learned	Lessons learned and program evaluation

Lack of structured training leads to charge nurses who are unprepared to deal with the complexities of the shift.

situations. These charge nurses had 1:1 nurse leader coaching availability and support throughout the assessment period to ascertain their transition to competent/proficient status.

Evaluating outcomes

Two tools were used to measure outcomes. Health system patient satisfaction data are collected through the HCAHPS survey.[8] Press-Ganey is the third party administering the surveys and providing reports to the hospital. The survey results provided the necessary data to analyze patient satisfaction before and after the charge nurse leadership training. To evaluate nurse turnover, the human resources department provided validated nurse turnover rates for the pilot unit.

A retrospective descriptive design was utilized to assess the effectiveness of charge nurse leadership training on HCAHPS scores and nurse retention. The project timeline included information for a total of 12 months beginning December 2014 and ending March 2016; scores obtained during the training phase were excluded. Patient satisfaction scores and nurse retention rates were evaluated for 6 months posttraining and compared with scores and retention rates for the 6 months before the beginning of the training. The effectiveness of charge nurse training was evaluated for statistical significance via the use of descriptive statistics visualized through control charts. The pre- and posttraining scores were compared using a paired z-test analyzed using statistical software. (See *Table 2*.)

Team building learned during the training gave charge nurses the confidence required for professional development.

Strategies discussed during the training to address nurse retention included self-reflection and feedback. During the 5 days of training, strengths and challenges emerged for individual charge nurses. The challenges were addressed with additional reading assignments, the shadowing of interdisciplinary team members, and discussions with members of the nurse executive council. Crucial debate and self-discovery centered on lateral violence, with deficiencies identified and confronted. Unfortunately, this resulted in the demotion of one charge nurse to clinical nurse, where she's continuing to develop her customer service skills. When evaluating the efficacy of the training program in addressing nurse retention, there was a 2% decrease in nurse turnover posttraining. (See *Figure 1*.)

Although not statistically significant, three of the four nursing domain scores improved after charge nurse leadership training: "communication with nurses" increased from 78.9% to 79.7%; "pain management" had the most improvement from 72.6% to 75.3%; and "communication about medications" had a two-point jump from 67.8% to 69.8%. A disappointing finding requiring further investigation was a significant decrease in the "response of hospital staff" domain, with a pretraining score of 67.1% dropping to 60.2% posttraining. (See *Figure 2*.)

Table 2: Pre- and posttraining statistical results

	Before training				After training			
	n	%	Lower 95% limit	Upper 95% limit	n	%	Lower 95% limit	Upper 95% limit
Nurse turnover rate	44	9.0%	0.5%	17.5%	44	7.0%	-0.5%	14.5%
Customer satisfaction (HCAHPS scores: Nursing domains)								
Communication with nurses	196	78.9%	73.2%	84.6%	131	79.7%	72.8%	86.6%
Response of hospital staff	190	67.1%	60.4%	73.8%	123	60.2%	51.5%	68.9%
Pain management	189	72.6%	66.2%	79.0%	125	75.3%	67.7%	82.9%
Communication about medications	186	67.8%	61.1%	74.5%	107	69.8%	61.1%	78.5%

These findings are based on the inclusion of a small group of charge nurses, which limits generalizability of the results. The decrease in the domain of "response of hospital staff" needs further exploration. One of the action plans to assist with this domain on the pilot unit is updating the current antiquated call light system, which lacks the functionality found across the health system. The nurses on the unit were also participating in auditing for compliance with newly set documentation guidelines, followed immediately by more documentation training, which competed with the importance of the charge nurse training.

Figure 1: Pre- and posttraining nurse turnover rate

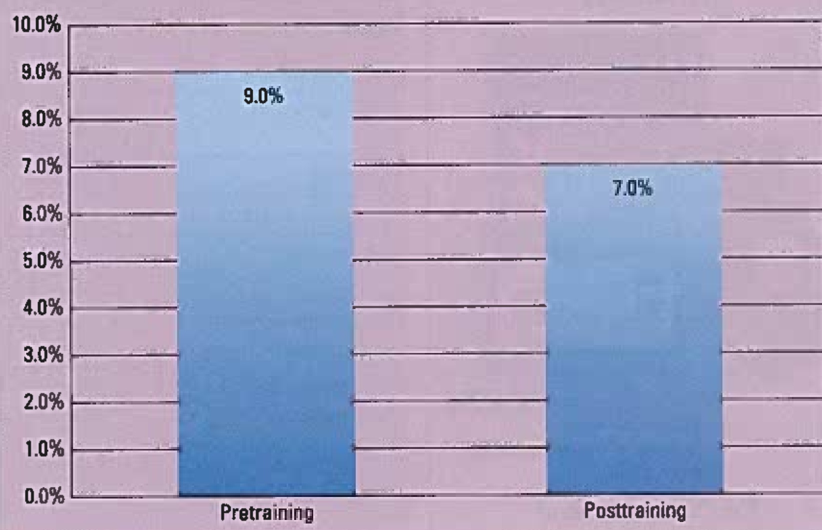
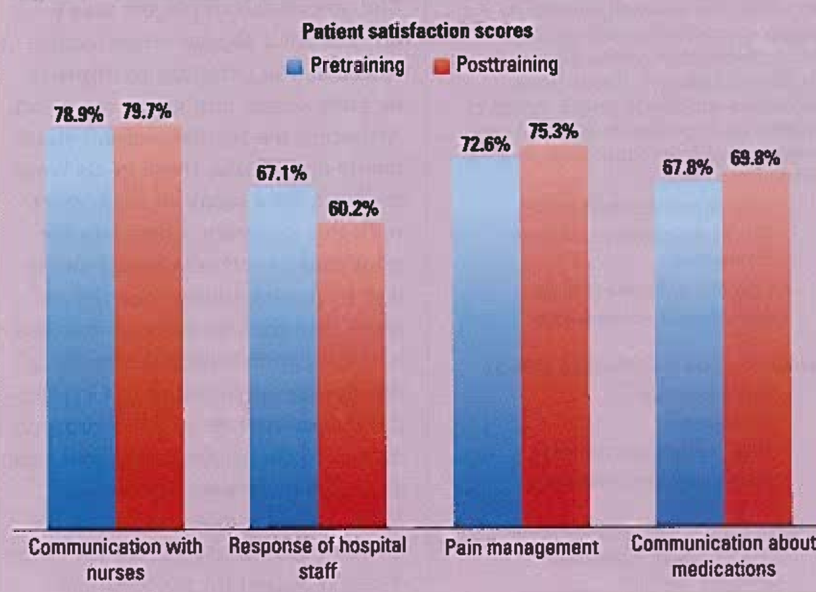


Figure 2: Pre- and posttraining nursing domain HCAHPS scores



Lessons learned

We had significant challenges backfilling a unit with charge nurses for an entire shift—thorough planning is a must. With the exception of women's services, June, July, and August are historically the months with a lower census across the health system. During planning, we anticipated summer vacations and holidays; however, unplanned absences made it difficult to take all charge nurses off the schedule for training. The charge nurse who was regularly scheduled to work received a call from the unit at least once during every training session. On two occasions, we had to release a charge nurse from training to work on the unit.

The length and content of training also needed to be refined. We were expecting continuous interaction, but 8-hour classes proved to be too long for our charge nurses to keep engaged. Moving forward, we're keeping the time commitment to 20 hours for the entire charge nurse training. Classes will be broken up into dynamic 4-hour sessions, with didactic time kept to 55 minutes and 5-minute breaks between modules. The coaching module will be an initial 2 hours, with scenarios and coaching opportunities provided during every 4-hour session. There's no longer a need to develop the charge nurse job description and our "lessons learned" will be integrated into every session. (See *Table 3*.)

To help improve attendance and access, we're offering weekend classes when the census tends to drop. In addition, plans include the promotion of teamwork and communication across all units by combining charge nurses from multiple departments into the classes. These steps will assist the program to gain momentum and make a significant impact on patient satisfaction and nurse retention.

Professional Case Management

One Subscription
Multiple ways
to Access

Editor-in-Chief:
Suzanne K. Powell, RN, MBA, CCM, CPHQ

The Official Journal of the Case Management Society of America (CMSA)

Professional Case Management is a bimonthly, peer-reviewed journal that crosses all case management settings. Articles focus on the coordination of services, management of payer issues, population- and disease-specific aspects of patient care, improving the quality of care/patient safety, data and outcomes analysis, and patient advocacy.

- Original peer-reviewed articles
- Patient and outcomes-oriented information
- Clinically-applicable material
- Earn CE credits in every issue.

Features Available on the iPad® Edition
- Read the full text
- Share articles
- Easily manage your content
- Receive new issue notifications

Link to professionalcasemanagementjournal.com
- Browse journal archives and save your searches
- View topical article collections
- Read published ahead-of-print articles

To Subscribe visit professionalcasemanagementjournal.com or call toll free 1-800-638-3030

Wolters Kluwer

4-K356

Table 3: Topics for leadership charge nurse training (20 hours)—revised

Topic	Time	Focus	Tools
Self-assessment	4 hours	Personality test	16Personalities test
Leadership	4 hours	Leadership	Leadership styles; manager vs. leader
Coaching	2 hours	Communication	InsideOut Coaching
Shared governance	2 hours	Empowerment	Magnet® journey
Patient safety	4 hours	Patient	Environment of care assessment
Beyond the bedside/ nursing care	2 hours	Nursing care issues	Patient throughput and interdisciplinary teams
Regulations and requirements	2 hours	Compliance	CMS, The Joint Commission, and Texas Department of State Health Services guidelines and requirements

Success as a team

The aim of this of project was to implement a charge nurse leadership training program to improve HCAHPS scores and nurse retention. Although the results weren't statistically significant, these goals were realized. As a result of their work with this program, nurses on the pilot unit have verbalized motivation to pursue higher nursing degrees. Another result is an increase in certification within 6 months of the charge nurse training. Certifications demonstrate a career commitment and dedication to patient care, both of which benefit patients.[9] Team building learned during the training gave these nurses the confidence required for professional development. NM

REFERENCES

1. Hines PA, Yu KM. The changing reimbursement landscape: nurses' role in quality and operational excellence. *Nurs Econ.* 2009;27(1):7-13.
2. Centers for Medicare & Medicaid Services. Hospital value-based purchasing. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf.
3. Wolosin R, Ayala L, Fulton BR. Nursing care, inpatient satisfaction, and value-based purchasing: vital connections. *J Nurs Adm.* 2012;42(6):321-325.
4. Kovner CT, Brewer CS, Fatehi F, Jun J. Nurse turnover: the revolving door in nursing. www.medscape.com/viewarticle/836577.
5. Cintron LA. Helping charge nurses understand their leadership role. www.strategiesfornursemanagers.com/ce_detail/244933.cfm#.
6. Kennedy B, Craig JB, Wetsel M, Reimels E, Wright J. Three nursing interventions' impact on HCAHPS scores. *J Nurs Care Qual.* 2013;28(4):327-334.
7. Sherman RO, Schwarzkopf R, Kiger AJ. Charge nurse perspectives on frontline leadership in acute care environments. http://dx.doi.org/10.5402/2011/164052.
8. Alligood MR, Tomey AM. *Nursing Theorists and Their Work.* 7th ed. Maryland Heights, MO: Mosby Elsevier; 2010.
9. American Association of Critical-Care Nurses. Nurse certification benefits patients, employers and nurses. www.aacn.org/wd/certifications/content/benefitstoptempnrs.pcms.

Norma Teran is the CNO of Doctors Hospital at Renaissance in Edinburg, Tex. Paula J. Webb is an associate professor at Texas Tech University Health Sciences Center in Lubbock, Tex.

The authors have disclosed no financial relationships related to this article.

DOI-10.1097/01.NUMA.0000502810.52671.aa