



TL5 – Nurse leaders lead effectively through change.

Provide one example, with supporting evidence, of the strategies used by nurse leaders to successfully guide nurses through unplanned change.

And

Provide one example, with supporting evidence, of the strategies used by nurse leaders to successfully guide nurses through planned change.

Example 1 (Unplanned Change): Flooding affecting multiple units leads to evacuation and temporary unit relocation

Unplanned change:

On Sunday, August 25, 2013 at 1950, the nurses in two of our adult acute care units experienced one of the most exciting shifts of their careers. The excitement began when a nurse noticed water leaking from the ceiling into a patient's room on 6 West. This leak quickly grew into a steady flow of water down the walls, flooding this patient's room and flowing into the hallway and into other patient rooms. Within minutes, the water also began to flood 5 West, directly beneath. Other units experiencing water leakage, to a lesser degree, included the four ICUs adjacent to and beneath the sixth floor leak. These included the neuro ICU, surgical/trauma/burn ICU, TCV ICU and medical ICU.

A 1-inch pipe with full pressure had burst, producing huge amounts of water in a continuous flow. Nurses immediately began using available towels and linens in an attempt to limit the flow of water into other areas. The day and night shift managers on 6 West and 5 West immediately evacuated patients to ensure patient and staff safety. They quickly contacted the nursing supervisors and our Bed Coordination Center (BCC) for assistance. Nurses within the BCC helped communicate the very serious situation on the affected units. Other areas, including 6 East, 6 Central and the neuro ICU, sent staff to help move patients to safety. Fortunately, the north tower units, which had recently been completed, were empty. This provided a lateral evacuation option for many, but not all, of the affected patients. Remaining patients were moved to available beds on other units. A total of 56 patients were safely relocated within 50 minutes by on-duty nursing and support staff.



Clean-up underway for the flooding that affected multiple units leading to evacuation and relocation of patients and families.

Fortunately, there were two nursing supervisors on duty at the time. Mary Jane Willis, BSN, RN, and Michelle Robertson, BSN, RN, quickly activated the internal emergency response system, bringing leaders on site within 20 minutes. Staff from all over the hospital responded as well to help with the response. Those responding reported dismay as they exited the elevator to find water rushing toward them. In the 20 minutes before the nurse leaders arrived, Robertson and Willis quickly divided responsibilities and delegated to achieve the most urgent actions:

- Robertson maintained constant communication with responding hospital leaders, the bed coordination center and affected units, tracking which patients were going where.
- Willis coordinated receiving unit preparation and transport of immediate-need equipment to the relocation units: Workstations on Wheels, code carts, medications, etc.

Nurse leaders Chief Nursing Officer Lorna Facteau, DNSc, RN; Associate CNO Scott Croonquist, MSN, RN, NEA-BC; Administrator-on-Call Maggie Short, MSN, RN, NEA-BC; Director for Adult Medical-Surgical Care Joel Anderson, MSN, RN, CNL; 6 West Nurse Manager Susan Prather, MSN, RN, CNRN; and 5 West Nurse Manager Brian



Zwoyer, MSN, RN, sprang into action. When they entered 6 West, staff were moving patients through water that was halfway up their calves. Maggie made the immediate decision to open the Hospital Command Center. This resulted in the full activation of the Hospital Incident Command System (HICS), with an interprofessional team supporting efforts to mitigate the situation while simultaneously planning for recovery.

The first actions prioritized by nurse leaders in the command center included:

- Address relocation units' operational needs:
 - Staff badge access to the new care areas
 - Pneumatic tube system
 - Phones
 - Pyxis and related medication needs
 - Cardiac monitoring
 - Supplies
- Place the hospital on “transfer/hold” status to prevent additional admissions for a brief stabilization period
- Evaluate capacity
- Notify Infection Prevention and Control
- Direct initial cleanup and efforts to minimize additional damage

In the first 70 minutes the following key leadership actions/strategies were completed:

- Visited every displaced patient personally
- Personally thanked each RN involved with the evacuation
- Continued support and assistance in meeting needs as relocations occurred and new patient care settings were stabilized
- Allocated additional staff to the supplementary locations opened to accommodate patients

Prather and Zwoyer supported the 6 West and 5 West nursing teams and the affected patients, who were now on divided units. They communicated with staff, patients, families and the command center, and coordinated activities on both units in concert with night shift managers Ruth Clements, RN, CNRN, Clinician III, and Sarah Price, RN, CMSRN, Clinician III. They worked through the night settling everyone and focused patient care operations into meeting priority needs and beginning to plan for the morning. Prather and Zwoyer stationed themselves at the doors to the now-vacant flooded units to greet staff, physicians and other interdisciplinary team members as they arrived for the start of day shift to personally communicate and direct them to their assignments.



Additional services included rounds by our senior leadership to patients and visitors impacted by this major flooding event in an effort to apologize for the unforeseen interruption in service. To the staff's surprise, instead of complaints they received compliments. Families were very understanding of the situation and were impressed with the rapid, decisive actions of the staff caring for them.



A few of our Great Flood heroes: Katelyn Neal, RN; Beth Mehring, RN; Brian Zwoyer, MSN, RN; Susan Prather, MSN, RN, CNRN.

The Incident Command Center remained open until August 27 at 1800. Terri Haller, MSN, MBA, RN, NEA-BC, Administrator for Nursing Business Operations and Workforce Development and the administrator on call, assumed the role of incident commander on Monday morning, August 26. A big part of this role included coordinating communication throughout the organization. Emails were sent intermittently to all Medical Center employees informing them of the event and providing them with updates. Below are two examples of these emails:

(Exhibit TL5.a: [8/26/13 Emergency Unit Relocation Update #1](#))

(Exhibit TL5.b: [8/27/13 Emergency Unit Relocation Update #3](#))

Haller directed a full cadre of nursing leaders working with Physical Plant, Facilities, Environmental Services, Patient and Guest Services, Health System Computing, Pharmacy Services, Infection Control, Supply Chain, Clinical Engineering and others to continually assess, act and convene group “huddles” for the next 48 hours.



The command center in action with Terri Haller, BSN, MBA, RN, NEA-BC, Administrator for Nursing Business Operations and Workforce Development, on the far left leading the group's discussion.

This approach allowed us to continuously adapt to the changing conditions and demands. The huddle held at 0730 on Monday morning resulted in a systematic review of the operating room schedule to identify priority cases and lessen the impact of postsurgical cases on occupancy. Infection Control Nurses and Environmental Services continually monitored mold and moisture contents as facility workers attempted to beat the clock in demolition and drying efforts that were essential to limiting the potential unseen hazards of mold bloom. [Exhibit TL5.c](#) is the [After-Action Review Timeline](#) document completed by Emergency Management Services.

Participants:

TL5 Table 1. Participants, 6 West / 5 West Flood Response

Name	Discipline	Title	Department
Shelly Legg	Nursing	Shift Manager, Clinician III	5 West
Sarah Price	Nursing	Shift Manager, Clinician III	5 West
Ruth Clements	Nursing	Shift Manager, Clinician III	6 West
Melissa Pritchett	Nursing	Shift Manager, RN Clinician III	6 West
Mary Jane Willis	Nursing	Nursing Supervisor	Staffing Resource Office
Michelle Robertson	Nursing	Nursing Supervisor	Staffing Resource Office
Maggie Short	Nursing	Administrator	Patient Care Services
Terri Haller	Nursing	Administrator	Patient Care Services



Lorna Facteau	Nursing	Chief Nursing Officer	Patient Care Services
Scott Croonquist	Nursing	Associate Chief Nursing Officer	Patient Care Services
Brian Zwoyer	Nursing	Nurse Manager	5 West
Susan Prather	Nursing	Nurse Manager	6 West

It is events like this that reveal the leadership strength at every level. On this night, the nurses at the front line of the flood acted without hesitation, making difficult decisions to keep their patients safe.

In after-action review, while opportunities for growth were identified, there was overwhelming consensus that the shift managers and informal nurse leaders at the bedside acted heroically. In addition to those evacuating patients were those receiving patients. The careful handoff of unfamiliar patients between clinicians to ensure uninterrupted care was virtually flawless. Our formal nursing leaders acted quickly to initiate the support systems needed to sustain safe care delivery and support operations until everyone could return to their home units.



Repairs to 6 West took 4 weeks to complete.

6 West sustained the most extensive damage of the several areas affected by the flood. Altogether the 6 West team was out of their unit and in two separate locations for four weeks. Prather implemented a daily morning huddle on 6 North, at which all incoming staff participated in the day's update, assignment discussion and assignment making by unit. Given the high acuity of 6 West's patient population (neurosurgery, neuro intermediate care and ENT surgery), staff competencies and patient continuity were considered. Prather credits this daily planning huddle with inspiring a sense of strong team spirit and clear direction within the staff on how to handle each day. The team was



very proud of how they performed in this crisis, and morale continued to be high as they took on the various challenges of life in two units.

Prather toured the closed home unit daily, meeting with facilities and infection control leaders to guide the rebuilding process. Every day as decisions on construction details arose she would grab staff on duty to come over and participate in that day's decisions. In this way she wove on-the-spot staff feedback into key parts of the unit's reconstruction.

Prather recognized the opportunity to achieve several unit goals during the reconstruction period and was supported by nursing and facilities leaders to incorporate these changes into the unit while it was vacant. These included:

- Wall-mounted PCs in all semiprivate rooms to facilitate Workstation On Wheels (WOW) retirement
- Removal of alcove work surfaces and implementation of designated patient care equipment storage
- Installation of EMR electronic whiteboards in the team station
- Team station "beautification" and reorganization to improve workflow

5 West returned to its home unit on September 15 and 6 West on September 30. With the support of nurse leaders and with exemplary teamwork, clinical nurses successfully navigated this dramatic unplanned change.

Example 2: Planned Change: Acute Care Pediatrics expansion and closure of Kluge Children's Rehabilitation Center (KCRC)

Background:

The UVA Children's Hospital is a "free-leaning" children's hospital. It is integrated within the Health System, but it has its own identity and brand. The seventh floor of the Medical Center contains the acute care units, the pediatric ICU and the neonatal ICU. There is a separate but connected space in our emergency department for pediatric patients, and children are seen in a variety of outpatient settings. In 2012, the UVA Children's Hospital still included the Kluge Children's Rehabilitation Hospital (KCRC). KCRC was composed of 10 inpatient rehabilitation and nine acute-care beds as well as outpatient clinics.

Strategic goals were established in 2011 that shifted the programmatic direction of pediatric services. These included:

- Construction of the Battle Building to house pediatric outpatient services and outpatient surgical services for all patients



- Shift to outpatient-only rehab services and closure of the inpatient KCRC beds due to the decline in demand for inpatient needs and the cost-prohibitive renovations required to update the aging KCRC building
- Expansion of inpatient acute-care beds into the new north tower

These plans represented a considerable change for the staff members working in those areas. Nurse leaders facilitated the changes through direct leadership, delegation and communication.

Planned Change Part 1: Acute Care Pediatrics Expansion and Refurbishment

Acute care pediatrics was composed of two physical units prior to the expansion: 7 Central and 7 West. These units are staffed by a single group of nurses, PCA/PCTs, and HUCs who work together as a team and worked in both units. The beds in these units are not designated by specialty or age, which facilitates bed availability and patient flow. The nurses of acute care pediatrics care for every specialty and age served in the Children's Hospital and have truly comprehensive skills.

Leading up to the changes planned for the Children's Hospital, nurse leader Karin League, MSN, RN, NEA-BC, Associate Chief for Children's Hospital and Women's Services, kept the group informed through live meetings and email communications. As they anticipated the September opening of the new north tower unit, 7 North, an opportunity to refurbish 7 Central and 7 West presented itself. Facility updates were needed, including ceiling tile replacement and painting of the entire 7 West and 7 Central units. League advocated for the opportunity to make the units more visually appealing to staff, patients and families. This necessitated relocation of the patients and staff through several units over the course of several months. The opening of 7 North also provided the needed bed expansion to incorporate the acute care patients that would be displaced when KCRC closed.

Although expanding into a new space is exciting, it presented considerable logistical challenges:

- **Rotating units** – 7 Acute rotated through four different physical locations during the refurbishments: 8 North, 7 Central, 7 West and 7 North
 - September 24: 7 West closes; patients relocated to 7C/7N/8N
 - October 17: 7 West reopens / 7 Central closes; patients relocated to 7W/7N/8N
 - November 12: final moves; patients relocated to 7C/7W/7N
- **Scheduling and staffing** – Staff, including RNs, PCAs and HUCs, covered three physical locations
- **Shift manager roles** – Two shift managers covered three locations and had to determine how to divide the work areas to be sure they were available for staff and



for RN/MD rounding. Focused communication to this important group of nurses kept them informed of the project's progression. The dynamic planning included multiple logistical concerns as to Nurse Manager Linda McGhee, BSN, RN, and Assistant Nurse Manager Amber Tyson, BSN, RN, worked with the planning teams. Plans and timelines sometimes changed as unanticipated delays occurred. They worked to respond to concerns and offer ideas on how to address those concerns and always sought input from frequent unit shift managers. Because of varying schedules, it was not possible to meet face to face with everyone as frequently as would have been ideal. They relied on electronic means to ensure timely and nimble communication. [Exhibit TL5.d](#) is an email from Linda to the shift managers sharing updates and seeking feedback. ([Exhibit TL5.d: 090712 Email McGhee to Shift Managers-Upcoming Changes](#))

- **Multiple locations** – At times during this process, the 7 Acute team operated on two separate floors and three physical locations
- **Security** – 8 North was not set up for infant security. Coordination between security, facilities and systems engineers was required in order to have the infant security system installed in 8 North.
- **Equipment** – 8 North supplies and equipment did not meet the needs of pediatric patients. Equipment was divided between two floors, and the clean supply room was restocked with the needed pediatric supplies. For the expansion, new equipment was ordered, and some was brought over from KCRC to meet the demand of six additional beds.
- **Storage displacement** – Facilities worked with nursing to identify storage locations for furniture, equipment, supply carts and toys that were displaced during the refurbishment.
- **Budgeting** – Going from operating two units to operating three units required learning how to budget appropriately to have the right number of FTEs available. In addition, managing three locations from one operating budget, and learning how to reorganize the daily operations routine to meet the needs of three physical locations was challenging.
- **Communication** with patients and families.

Rather than directly oversee the refurbishment, League decided to empower McGhee and Tyson, to fully oversee the logistics of the unit moves during the refurbishment. McGhee and Tyson worked closely with Rebecca Lewis, MSN, RN, NE-BC, Administrator, Clinical Logistics and Planning for Facilities Integration, and Cavell Kopetzky, Director, Facilities Planning, to plan the multiple relocations.



Immediately prior to move days, McGhee and Tyson spoke with each nurse to gain an understanding of the patients who would be moved the next day. Using the information they received from the clinical nurses, they mapped out which patients would go where so everyone would be clear on move day. [Exhibit TL5.e](#) is one of the logs they used to plan patient moves. ([Exhibit TL5.e: Peds Patient Move Log, Redacted](#))

On the day of each move, McGhee and Tyson arrived at 0600 to help night shift staff prepare the patients for transport and helped facilitate timely report to oncoming day shift staff. As each day shift nurse completed the report process, McGhee and/or Tyson directed them to their new unit and arranged for a PCA/PCT or other staff member to assist in transporting that nurse's patients to their new unit. Tyson and McGhee tracked all patients and staff movement to be sure everyone was accounted for and safely in their new location. After the final patient was moved, Tyson and McGhee shut down and secured the vacated unit. Their presence allowed frontline nursing staff, including the shift managers, to focus on patient needs and daily unit operations. By providing information and offering presence, leadership and cheerleading, McGhee and Tyson supported the team through a challenging time. [Exhibit TL5.f](#) is another email communication reflecting these efforts. ([Exhibit TL5.f: Tyson Email - Moving Again!](#))

League served as a resource as needs arose, but felt confident in the 7 Acute leaders' ability to guide the 7 acute team through the day-to-day changes and operational challenges. This allowed time for League to serve as a more active leader in the closure of KCRC.

Planned Change Part 2: Closure of KCRC

Kluge Children's Rehabilitation Hospital (KCRC) opened its doors to inpatient pediatric rehab and chronic acute care patients in 1957. The highly skilled and committed KCRC team members took great pride in the specialized rehabilitation services provided to pediatric patients from near and far. Their outcomes were outstanding, and patients and families were highly satisfied. The closure was a difficult decision, but it was necessary in order to accommodate the new construction and programmatic changes. Closing KCRC presented logistical and emotional challenges as the transition occurred. League decided to bring an experienced 7 Acute nurse leader into the KCRC team. Susan Steck, BSN, RN, CPN, Clinician III, served as the interim Assistant Nurse Manager to provide consistent leadership presence, facilitate the closure of KCRC and help staff make the difficult transition.

One complicating factor was the uncertainty of the timeline. Many issues created challenges in predicting the actual closing date of the inpatient services, and this caused understandable stress among the KCRC team members.

Nurse leaders relied heavily on active communication as a strategy to support the team through the transition. This communication occurred in two primary venues:



- Visits by League to the KCRC facility. [Exhibit TL5.g](#) is an email exchange between Steck and League coordinating one of her visits early in the process. ([Exhibit TL5.g: League Steck Emails-Planning Visit to KCRC](#))
- Weekly communication between Karin and Susan.

There was understandable angst related to continued employment. League worked with the human resources department to make sure positions on 7 Acute were available to nurses who wished to join that team. Some nurses chose to transfer to different settings within the organization, and some opted to discontinue their employment. The exit of some of these nurses occurred prior to the closing of the facility and created staffing challenges. League approved incentive bonuses to those who agreed to stay as long as the KCRC unit remained open. [Exhibit TL5.h](#) is an email communication regarding incentive pay, including the guidelines for receiving it. ([Exhibit TL5.h: Children's and Women's Services Voluntary On-Call Guideline may 2012](#))

To further mitigate this staffing transition, League coordinated with the leaders in each setting to share/float nursing and PCA/PCT staff from 7 Acute to KCRC. This allowed time for nurses to get to know each other. During this time frame, overtime pay was approved by League.

Participants:

TL5 Table 2. Participants, KCRC / Acute Pediatrics Transition

Name	Discipline	Title	Department
Karin League	Nursing	Associate Chief	Children's Hospital and Women's Services
Linda McGhee	Nursing	Nurse Manager	7 Acute
Amber Tyson	Nursing	Assistant Nurse Manager	7 Acute
Susan Steck	Nursing	RN Clinician III (Acute Care Pediatrics); Interim Assistant Manager (KCRC)	7 Acute



Rebecca Lewis	Nursing	Administrator, Clinical Logistics and Planning	Patient Care Services
Cavell Kopetzky	Facilities Planning	Director, Facilities Planning	Facilities Management

On Aug. 31, 2012, the KCRC inpatient unit closed its doors for good. The dedicated KCRC staff experienced a sense of loss and understandable grief. The transition of the KCRC nurses into the acute care pediatrics team has been very successful. They required very little training; the seven nurses were oriented and taking assignments independently after one week of orientation, ending September 7. The KCRC nurses have successfully assimilated into the 7 Acute team, bringing with them the strengths of unique rehab skills to share.