

Final Closing Report - Foundation of Nursing Studies Project

**‘Knowing why we do what we do’ - Establishing a Unit Practice Council to
Improve Evidence Based Nursing Practice in Acute Medicine using
Appreciative Inquiry**

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Table of Contents

Executive summary	3
1.0 Background	4
1.1 Shared governance	5
1.2 Initial aim and objectives	5
1.3 Revised aims and objectives:	6
2.0 Methods and approaches	6
2.1.1 Appreciative Inquiry	6
2.1.2 Data collection and analysis	7
3.0 Establishing the Unit Practice Council	8
3.1 Invitation to join	8
3.2 First Meeting	8
3.3 Call for nominations to be the UPC Chair.	9
3.4 Developing UPC aims, objectives and communication strategy	9
3.5 Allocating roles and planning the UPC Launch	10
3.6 Unit Practice Council logo	10
3.7 UPC Launch event	11
3.8 Reflection on the process of Establishing a Unit Practice Council	12
4.0 Impact of the UPC	13
4.1 Trust Nursing and Midwifery Objectives:	13
4.2 Staff engagement	13
4.2.1 Transparency and communication.....	13
4.2.2 Improving staff morale.....	14
4.3 Patient Safety Initiative	14
4.4 Improving patient experience	15
4.5 Staff Development	16
5.0 Reflection	16
6.0 Destiny of the UPC	17
7.0 Conclusion	17
8.0 Acknowledgements	18
9.0 References	18
10.0 Appendices	20

Executive summary:

Nottingham University Hospitals NHS Trust (NUH) has undertaken extensive work identifying that one of the main concerns of newly qualified nurses, during their preceptorship period, was competence in caring for acutely ill ward patients, or those at risk of deterioration. In January 2012, the Trust's Medical Admissions Unit (MAU) had a complement of 90 whole time equivalent (WTE) registered nurses (16 of whom had been qualified for less than a year) and 20 non-registered nurses. This indicated a large number of newly qualified nurses in post with minimal experience of caring for acutely ill patients.

There was a keen desire within all levels of the nursing team on the MAU to take a leading role in decisions affecting nursing practice, including the development of all staff in order to enhance the care they provide for acutely ill patients. Supported by the Foundation of Nursing Studies, key stakeholders developed a Unit Practice Council to implement change using a shared governance approach. Shared governance is a style of nursing management which empowers frontline staff to be involved in the decisions made about their practice. It breaks from the traditions of hierarchical management models, and aims to involve the direct care-givers, who are experts in their area, and therefore in the best position to inform changes to practice.

Appreciative Inquiry was chosen as a guiding framework for the project as it provided a foundation on which to study, explore and actively search out, "the best and focussing on what is good, strong, already working and being achieved", rather than taking a traditional problem-solving approach (Carter, 2006). It has been described as transformative in its approach to facilitating change management.

The project identified how utilising the skills and knowledge of a group of frontline staff to implement and change practice at ward level through the development of a Unit Practice Council, can enhance the patient experience and be an effective way of developing and empowering frontline staff. It has been an invaluable learning experience for all involved, and will now form the basis of implementing shared governance throughout the whole Trust.

1.0 Background

Nottingham University Hospitals NHS Trust (NUH) is one of the largest acute teaching trusts in the country. It provides acute and specialist services to 2.5 million people within Nottingham and surrounding communities. The Trust is the principal provider of acute, general, specialist and tertiary hospital care to the population of Nottingham, receiving 98% of all elective and urgent referrals from primary care trusts in Nottinghamshire. It has one of the biggest and busiest Emergency Departments (ED) in Europe – providing unscheduled care for an average of 450 patients per day, with over 164,000 attendances per year.

The ward involved in the project 'B3' is a busy MAU, taking direct patient referrals from General Practitioners throughout the City and County of Nottingham, referrals from the Nottingham Treatment Centre and transfers from the ED. It has 47 beds, in addition to a nurse-led ambulatory care area. Each week an average 280 patients are discharged home from the ward, with others transferred to inpatient areas. Patients are triaged and transferred to specialist wards within 24-48 hours of arrival. Moore et al. (2006) identified that speciality triage in medical admission wards reduces mortality in the under 65 age group, and demonstrated a downward trend in length of stay.

The Royal College of Physicians report (2007) makes a number of recommendations about acute medical admission care, aimed at ensuring that the first assessment of acutely ill patients is made by competent clinical decision makers and supported, when necessary, by ready access to senior clinical decision makers. In January 2012, B3 had a complement of 90 whole time equivalent (WTE) registered nurses (16 of whom had been qualified for less than a year) and 20 non-registered nurses. This large number of newly qualified nurses in post with minimal experience of caring for acutely ill patients, resulted in a skill mix that increased the stress reported by staff, and had the potential to reduce the quality of care for the patients.

NUH had undertaken extensive work identifying that one of the main concerns of newly qualified nurses during their preceptorship period was competence and confidence in caring for acutely ill ward patients, or those at risk of deterioration. To support their development, a critical skills educator (AD) was appointed to identify key training needs, provide ward based clinical training and support, and devise focussed education programmes to enhance the competence and confidence of this important group of staff.

There was a keen desire within all of the nursing team on B3 to take a leading role in decisions affecting nursing practice, including the development of staff experience so that the care provided for acutely ill patients was the best possible. Improving patient safety and staff engagement were key objectives for the ward and Trust and therefore we viewed the Foundation of Nursing Studies project as an ideal opportunity to develop the skills, knowledge and confidence of staff through investment in training, and specifically, the piloting of a Unit Practice Council (UPC) based on the principles of shared governance.

1.1 Shared governance

Shared governance (SG) is a style of nursing management which empowers frontline staff to be involved in the decisions made about their practice. Hess (2013) suggests it breaks from the traditions of hierarchical management models. It aims to involve the direct care-givers who are experts in their area and therefore in the best position to inform changes to practice (Thrasher et al., 1992, Wessel, 2012).

Shared governance is a concept adapted from “participatory management” in the business sector, and first originated in American healthcare in the 1980s (Bronson-Gray, 2013, Hess, 2004, Swihart, 2006). At this time, the main drive for implementing shared governance was to improve patient outcome and respond to the challenges around the recruitment and retention of nurses. This is still of great relevance today in the United Kingdom (UK), with reduced numbers of national commissions to nurse training over previous years and now national and local nursing shortages (RCN, 2013). There is a critical need to attract, retain and develop student and newly qualified nurses.

In the years following implementation of SG, studies have focussed on this style of management. Although it is not without its challenges and constraints, its benefits are praised in the literature. The main advantages are increased frontline staff retention (Ribelin, 2003), improved outcomes of quality patient care (Becker et al., 2012), nurse job satisfaction and increased productivity (Anderson, 2011, Brody, 2011). Many organisations have SG structures, but they fail to reach their full potential, with success depending on clear responsibility for decision-making, manager support and regular meetings (Wessel, 2012).

Decision-making using an SG framework is a strong indicator of excellence. This excellence in professional practice can only be gained and sustained if frontline nurses have significant influence in the decision-making process (Porter-O’Grady, 1987 in Swihart, 2006). SG provides an internal infrastructure for communication and decision-making that is a foundation for a good professional practice environment (Swihart, 2006). SG can be used in different ways – the most common being the councillor, congressional and administrative models (Porter-O’Grady, 1987). SG is commonly implemented using a formal council structure promoting shared leadership (Wessel, 2012) and research evidence supports that UPCs enable staff to identify solutions to clinical problems and then allow them to work with their teams to drive and implement meaningful change on behalf of their patients. These outcomes are both qualitative and quantitative, with Wessel (2012) reporting improved perceptual experience for the patient and improved clinical standards and patient safety.

The Director of Nursing and senior nurses at the Trust were keen to support the project using the SG approach in order to utilise it as a pilot project in advance of extending SG to enable transformational change in the whole organisation.

1.2 Initial aim and objectives

At the outset, the project's initial aim was to employ the principles of Appreciative Inquiry (AI) (Bushe, 2001) to establish and evaluate a UPC in order to:

1. Enable frontline staff and managers to work together to improve the quality of patient care, safety and experience on B3..
2. Evaluate the impact of a pilot intervention of training in quality improvement and evidence-based practice skills, in addition to focused coaching and mentorship.
3. Focussing on a mission-critical issue to the Trust, the UPC were to be trained and supported through a programme of improvement in the care of acutely ill and/or deteriorating patient outside a critical care environment.
4. Support the development of UPC skills, capacity and capability to lead and self-govern actions relating to this important issue.
5. Move the focus from reactive nursing practice and a sense of a lack of control over decision-making, to an active direction of priority areas for continually improving patient care.
6. Use this project as a pilot ward on which to base a wider Trust implementation of UPCs and SG.

1.3 Revised aims and objectives:

Within the first month of the project it became evident that the initial aims had been too ambitious, not only in terms of the timescale, but in the essential role of allowing UPC members to understand the principles of SG and how their UPC might want to function. Following discussions with the FoNS facilitator, our main aim was revised to focus on the formation and development of the UPC, exploring the key elements required for its successful development and sustainability. The revised objectives therefore set out to:

1. Establish the UPC using the principles of Appreciative Inquiry and co-production with UPC members.
2. Create a forum to enable frontline staff and managers to work together to improve the quality of patient care, safety and experience on B3.
3. Identify key UPC roles and responsibilities, Terms of Reference and meeting structure.
4. Ensure clear understanding of the UPC within members and the wider multidisciplinary team, including a launch event.
5. Conduct a baseline measurement of staff wellbeing and sense of involvement in work.
6. Use this project as a pilot ward on which to base a wider Trust implementation of UPCs and SG.

2.0 Methods and approaches

2.1.1 Appreciative Inquiry

Appreciative Inquiry was chosen as a guiding framework for the project as it provided a foundation on which we could study, explore and actively search out, "the best and focussing on what is good, strong, already working and being achieved" on the ward area, rather than taking a traditional problem-solving approach (Carter, 2006). It has been described as transformative in its approach to facilitating change management and is based on a four-phase cycle applied throughout the course of this project:

1. Discovery (the best of what is or has been).
2. Dreaming (what might be).
3. Designing (what should be).
4. Destiny (what will be).

This was a new approach to AD and JC, and therefore we were grateful to have the support of Kate Sanders, FoNS facilitator in its application to the development of the UPC.

2.1.2 Data collection and analysis

At the outset of the project we had anticipated using a mixed methods approach, integrating quantitative and qualitative data. We wished to analyse data of patient care outcomes (for example, identifying patient deterioration using an Early Warning Scoring Tool and whether appropriate care and escalation had taken place in a timely way). We also planned to hold qualitative focus groups identifying the experience of staff when being a member of a UPC.

However, due to the project's developmental nature and time pressures we finally undertook a more service development approach. Data was collected primarily from notes taken during attendance at the UPC meetings by project leads and UPC minutes, supplemented by photographic records of the UPC's development.

A baseline survey reviewing staff engagement with the ward was conducted by the UPC vice-chair (RD) at the start of the project. This survey was believed to be important because of an identified high level of staff turnover and perception of low morale with staff. Twelve questions were developed with the Trust's Learning and Organisational Development Team based on a tool used by the Gallup Organisation (Forbringer, 2002). In order to find a correlation between the development of a shared governance approach and improved satisfaction with the workplace, this survey was undertaken during the first three months with the intention of repeating it after 6 months to a year. Unfortunately the second survey was never completed.

Staff, from all pay bands (n=63) had the opportunity to evaluate their perceived level of agreement with several statements in different categories that would reflect how staff were feeling about their workplace, their colleagues and whether they were being developed. The key findings from this survey were that there was a difference in opinion, not just between the different roles and grades but within grades as well. Full results can be found in Appendix One.

Key findings:

- When asked whether B3 was a good place to work, staff reported dissatisfaction with several aspects of working life, including lack of engagement in personal development, particularly with band 5 registered nurses.
- 55.6% said that their work hadn't been recognised or praised in the last seven days.
- 55.6% of staff felt that they were cared about as a person, despite 60.3% feeling their opinion at work wasn't listened to.
- 65.1% of staff felt they didn't have the materials or equipment to perform their job.

There appeared to be a clear need to invest in staff personal growth, and it was anticipated that by developing a UPC for different grades and professions in the team improvements in morale and engagement would be reported

3.0 Establishing the Unit Practice Council

3.1 Invitation to join

Raising awareness of and engaging support for the UPC was our first priority. During March 2012, AD placed flyers in key areas around the ward and sent an email to all registered nurses, non-registered nurses, ward receptionists and clinical support workers to raise awareness about the project and invite interested parties to attend a workshop to discuss the development of the UPC.

3.2 First meeting

Ten staff members from bands 3-7 volunteered and attended the first meeting on May 29th 2012 which was facilitated by Kate Sanders from the Foundation of Nursing Studies, AD and JC (Figure 1).



Figure 1

The meeting focused on :

- Establishing ways of working/ground rules
- Setting the context:
 - Background to project
 - Developing an understanding of shared governance
 - Presenting different models of UPCs
- Introducing AI and using three elements of the AI cycle:
 - Discovering: Appreciating the best of shared decision-making
 - Dreaming: Creating a vision for the B3 UPC
 - Designing: Considering terms of reference, identifying stakeholders who can support and influence UPC, creating a communication plan to facilitate the engagement of stakeholders

Outcomes of the meeting:

After the initial meeting, and as requested by the UPC, observations of care were conducted by JC and AD on B3. These were designed to gain an objective overview of issues/positive influences when working on the ward.

This discovery phase identified positive aspects of the ward culture that were fed back to the new UPC to give them ideas about how to engage with the ward team:

- Showing all roles are valued (interrupting clinical work only if essential, acknowledging importance of everyone's role and expertise)
- Increasing awareness and understanding of 'compassionate care on B3'
 - Creating a sense of 'time' for patients and each other
 - Not conveyor belt
 - Acknowledging each other/patients
 - Waving at/seeing/connecting
 - Peer support
 - Confidentiality

3.3 Call for nominations to be the UPC Chair.

Following the first meeting, all UPC members were invited to self-nominate by email their desire to be the first UPC Chair. They were asked to write 300 words about why they would be suitable for the role and what qualities they could bring to the group. There was only one volunteer (KT), an enthusiastic, newly qualified nurse (6 months since registration) who accepted the position. In order to provide more senior guidance and support, a Band 6 nurse was approached by AD to take the position of Vice-chair and she accepted the role.

3.4 Developing UPC aims, objectives and communication strategy

A second meeting was held on August 9th 2012 where the key council members were appointed formally. The meeting was co-facilitated by KT and the FoNS Facilitator KS. JC presented feedback on Observations of Care undertaken on the ward during July. These focussed on examples of clinical decision-making with recommendations for further improvement provided by ward team members to JC as noted before.

It was essential to ensure good channels of communication between ward staff and the UPC council members. Each member of the UPC was allocated a mixed group of staff of varying grades, and it was their responsibility to ensure that any feedback and minutes from meetings was delivered to those individuals in a manner they preferred. eg email, verbal, letter. This clear link also allowed the staff on the ward to feedback any ideas or concerns that they wished the UPC to consider at the council meetings.

The UPC members were keen to establish aims and objectives, to allocate roles and responsibilities and write UPC Terms of Reference. The project leads felt it was essential to allow this to develop rapidly in order to maintain interest and relevance for the team. Much time was allocated to

developing a UPC strapline and summary message and resulted in the “Listen, Act, Improve” three point message:

B3 Unit Practice Council is here to:

LISTEN: We will ask for your ideas and views. Your Voice matters – share it.

ACT: To speak on behalf of patients and staff. Lead the way as a team and share innovation.

IMPROVE: Leading improvement from the bottom up. To focus on unique and meaningful ideas for B3.

3.5 Allocating roles and planning the UPC launch

On September 7th 2012, meeting 3 was chaired by the new Chairman, and roles and responsibilities for the group were allocated. The main focus of the meeting was on developing workstreams in support of the UPC launch event planned for October 2012. Members formulated a plan of how to communicate their work with a cross-section of hospital staff, including the Trust Board, ward managers, staff on B3 and practice development staff.

One sub-group wrote terms of reference and job descriptions, with another focussing on allocation of staff members into communication groups. The UPC discussed the benefits of reflecting the corporate image of the Trust and that a UPC logo would help to communicate its role as a corporate entity.

3.6 Unit Practice Council logo

In collaboration with the Trust Communication team, the UPC developed their own logo and tag line (Figure 2). This tree logo was initially developed to symbolise the change of seasons as part of evolution and personal growth and development, with the three core elements of the UPC, Listen, Act and Improve at the root. This was adopted by the UPC for its launch, and has since been made more generic so that it can be used as a symbol for all Trust directorates and ward councils who are beginning their SG journey.



Figure 2

3.7 UPC launch event

A major launch event of the UPC was held in October 2012. Using email, verbal invitation and formal letters of invitation, the UPC invited members of Trust management (including the Trust Executive and Board), B3 staff members and practice development staff to the event to raise awareness about the role of the UPC, the potential benefits of SG and to provide an opportunity for visitors to share their views on developing B3.

Members of the council asked each visitor to comment on the following three questions:

- Listen - What do you think is good about B3 (what works well)?
- Act - What do you think we could do to make B3 better?
- Improve - What do you think could be improved on B3?

There was a huge amount of positivity on the day. Appendix Two identifies the full details of feedback from staff, but the key themes were as follows:

- Staff identified that the ward team was friendly, with supportive managers and good educational support for student nurses
- The staff were positive about delivering high standards of patient care
- Staff felt that patient care could still be improved, along with difficulties with doctors allocation
- Communication issues were identified with documentation and handover
- Reference was made to insufficient staffing levels
- According to staff, improvements should be made in patient care, training for the team, particularly new members of staff, and communication
- The ward team also wanted greater understanding from other nurses and members of the multi-professional team in the Trust about the work done on B3



Ward managers speaking to members of the UPC



Peter Homa (Chief Executive) and Kerry Taylor (UPC Chair)



Feedback board

The event was extremely successful, with many executive and non-executive members of the Trust Board attending. All showed great support for the idea of SG, and reported being 'impressed' with the UPC's enthusiasm and drive for change.

3.8 Reflections on the process of establishing the UPC

What went well?

The Appreciative Inquiry methodology was new to all the project leads and it was found to generate a really positive ethos for the project. The second meeting lapsed slightly, with council members lacking positivity at times, focussing on ward issues and problems rather than using the AI approach. At the third meeting all present were reminded about the importance of AI, and it then generated a supportive, focussed culture of working which continued throughout the period of the project.

- The UPC and SG model was well supported by the ward managers, matrons, clinical leads and Director of Nursing.
- The more senior members of the ward team embraced the SG ideology, allowing more junior members of the team to lead on key decision-making.
- Most members of the UPC were enthusiastic about the project, and worked hard to ensure deadlines were met and jobs completed.
- The Chair of the council was really committed to the project, and began developing leadership skills, and learning how to approach senior members of hospital staff and motivate the team.
- Kate Sanders from FoNS was an invaluable source of support and advice for key stakeholders. Using an expert to guide the project ensures continued support for the project leads and develops confidence.

What didn't go so well?

- As mentioned previously, it became evident that the initial aims of the project were overly ambitious. We amended the primary focus towards the development of the UPC only using an Appreciative Inquiry approach, rather than starting to address outcomes the UPC may have on patient safety and clinical issues.
- When liaising with the Trust communication team, the chair (a more junior member of staff) was told that they did not support projects like this. A project lead who is a senior nurse in the trust had to speak to the communications team in order to get them to support the project, which they now do extensively.
- Despite support from the senior clinical team in the directorate, council members had difficulty attending the meetings due to unforeseen clinical commitments and off-duty changes. This was continuously reviewed, as protected time for monthly meetings/office time for council members was agreed at the beginning of the project. After the UPC had been embedded over a period of a few months, and the ward managers appeared to develop an understanding of the UPC role, this became less problematic.

4.0 Impact of the UPC

Having prioritised the development of the UPC as the project's main aim, an encouraging number of positive outcomes for staff and patients can be reported 18 months after the start of the project.

4.1 Trust Nursing and Midwifery Objectives:

The chair represented the UPC at a senior nurse meeting, where 2013/14 Nursing and Midwifery aims and objectives were being set. She discussed her role, and that of SG with the Director of Nursing, Clinical Leads and Matrons. The response from the senior team was generally supportive, and after a debate about junior nurses being empowered by this new way of working, one clinical lead said:

"So basically what you're saying is, I just need to stop being a blocker and start being an enabler.."
(Clinical Lead)

Kerry Taylor's reflection after the launch:

"It is important to realise that this project is not going to work overnight. It has already been difficult to sustain just one UPC and will take years to put in place throughout such a large trust. I feel the next steps are about sustainability of the UPC that is already running and to look at one other area with enthusiastic nurses."

There is now a project lead for SG in the Trust (LH), who is conducting extensive work rolling out SG and developing UPCs in Oncology and Maternity services. The aim is to continue to develop a Trust wide SG strategic approach to nursing leadership.

A Leadership Council has been in place for over 12 months, which the B3 chair has attended to represent the ward, but also to feed back about the pilot project. As part of the Leadership Council it is her responsibility is to:

- Attend the meeting on a monthly basis
- Present a monthly report on what the UPC has achieved that month, are working on that month or any issues that have arisen
- To be open and voice opinion on matters raised
- To disseminate information back to the UPC
- To ask for UPC opinion on matters raised and bring this back to the Leadership Council
- To use research and EBP to present ideas and/or findings to the UPC

4.2 Staff engagement

4.2.1 Transparency and communication

Following the recent report about the Mid Staffordshire Trust (Francis, 2013), transparency and communication are currently top of the UPC's agenda. Following advice from the Advisory Board at a senior nurse time out day, a performance board was created based on "the ward's current agenda", "the ward's current positives" and the dashboard results. The UPC worked together with the ward management team to create a larger performance board to include compliments and complaints,

dashboard results, B3's agenda and UPC's agenda. Information is changed and kept up to date monthly.

4.2.2 Improving staff morale

The UPC reviewed the literature and highlighted that happier staff means a happier patient experience (Taylor, 2012). It was identified that staff were not taking breaks, and it was noted the staff room was not a pleasant environment in which to relax. The UPC applied for funding from the hospital charity to make this place more welcoming and uplifting. The plans aimed to create a separate safe place where every team member had a personal locker and space to leave their belongings, allowing the staff room to be a clutter free space where they can enjoy breaks and socialise with colleagues, thereby promoting a healthy work life balance. This was achieved by the UPC by fund-raising.

It was evident from the findings of the baseline survey that the ward team felt development opportunities were not sufficiently available. With this in mind the UPC secured funding to create a resource and development room. The resource room would be easily accessible, and have two sets of desks and computers, shelves for technical books and dossiers with latest guidelines/protocols, a lockable cupboard for confidential information and a message board where information about study days or conferences can be displayed. This place would be for all staff to complete any packages they want to do, any coursework for extra modules or to do any reading and research.

4.3 Patient Safety Initiatives

Medicines management:

The UPC consulted with registered nurses on the ward, and identified that pharmacy stock was running out on a weekly basis, which was felt to compromise patient care. Medication such as intravenous antibiotics or analgesia was running out at the end of every week, sometimes days before the weekly pharmaceutical delivery. The UPC liaised with the lead pharmacist and the medicine management project team, after which stock levels were checked and reviewed. This action resulted in stock being increased, in some instances nearly doubled. Medication is now available for patients to receive their treatment promptly.

Acknowledging patient's comments and complaints gathered by the medicine management project team it was identified that the nursing team needed training regarding care and management of diabetic patients. The UPC linked with the ward management team and arranged for protected time for registered nurses to complete their online diabetes modules.

Patient safety awareness training:

As part of the UPC staff development plan they are developing a *Monthly Awareness* campaign where they plan to focus on a subject related to patient care each month - liaising with link nurses to provide updates in their area. The UPC also plan to provide in house training for interested staff by liaising with specialist nurses and medical team colleagues. With these initiatives they aim to improve patient safety outcomes in the longer term.

4.4 Improving patient experience

Patient leaflet:

The UPC identified that medical admissions wards are unique areas, and that with such a large demand for the service and high patient turnover communication is sometimes difficult. A single patient leaflet was written in conjunction with the medical teams that now focuses on informing patients about their journey. It provides information needed for admission to the MAU.

Recognising that most of the patients that are admitted to B3 are transferred from the ED, the UPC is developing another leaflet to give advanced information about the ward. ED staff will be advised to give this to patients who are being admitted.

Visiting times:

The UPC has worked with ward staff to create new posters for visiting times. They are now more visible both at the entrance of the ward as well as in all the bays. They have implemented a standardised approach by all ward staff when it comes to allowing visitors on the wards, particularly out of hours or challenging visitors. They are considering a system to highlight the end of visiting time.

Noise at night:

After collecting feedback from patients, and reviewing the latest evidence about noise at night, the UPC arranged for Trust engineers to cost the amount of funding required to change the sound boxes for patient and emergency buzzers to allow volume adjustment. The UPC contacted the ED and transfer teams to change the practice of moving beds and trolleys across the ward. They now use the door at the end of the ward when transferring a male patient or patient to and from side rooms. This has reduced the noise for the female bays but also provides more privacy for all patients. Ear plugs were purchased by the UPC, and are offered to all patients during the 10pm drug round to try to reduce their perception of the inevitable noise of an admissions ward. The UPC work with ward staff to reinforce the need to challenge people who do not comply with reducing noise at night by speaking loudly or wearing hard sole shoes.

Reduction in patient complaints:

As noted above, the UPC has worked actively with patients in order to try and improve their experience. This has been extremely successful with patient complaints reducing from 38 in 2011, to 18 in 2013 (Figure 3).

Year	Number of patient complaints
2011	38
2012	34
2013	18
2014 to date	5

Figure 3

Charity fundraising:

The UPC has been involved with charity fundraising by organising different events. To date (May 2014) they have raised over £1200 by holding a car boot sale, a sponsored weight loss campaign and Christmas raffle. The UPC organised an Acute Medicine Spring Ball which 150 members of hospital staff attended, raising a further £1200 for the NUH hospital charity and the British Red Cross Society. This has improved the patient experience as money raised has been used to buy equipment which facilitates prompt discharge to the patients home (Figure 4).



Figure 4

4.5 Staff development

Staff interviews:

As part of the UPC's personal development and to implement the SG approach to leadership, UPC members have had the opportunity to join the interview panel for the Band 7 ward manager and Band 6 interviews. More recently the chair of the UPC was on the interview panel for the new Director of Nursing at the Trust. After recent discussion with the management team it was suggested that these opportunities should be available for every member of staff in the future.

New starters package:

Newly qualified staff nurses fed back to UPC members that they didn't always feel prepared for certain acute situations on a busy ward. The UPC worked with them to develop a "*starter pack*". Two newly qualified nurses attended the UPC meetings to work on this project, completing their research and compiling the information with help and input from one of the UPC representatives. The compilation of all the information highlighted by both junior and senior staff is now finished and being revised. It will shortly be introduced to the ward. The UPC have been liaising with the Trust Preceptorship Team to offer assistance with their strategic guidelines and projects.

5.0 Reflection

It is clear that many aspects of this project have been a huge success, and in many ways exceeded the team's expectations of the impact the UPC had on staff involvement and decision-making. However on reflection, the authors acknowledge that are factors which should have been addressed at the start of the project rather than halfway through. These issues were due to the leads lacking knowledge about setting up UPCs as this had never been done before in the Trust.

It would have been useful for the UPC to have been supported by nurses who had a wider experience of SG. Despite support from FoNS, many aspects of the implementation of the project were undertaken by novices, with the inevitable consequences of learning by our mistakes.

Input and expertise was required from the FoNS team to enable and facilitate the slower growth of the project. Due to the enthusiasm of all taking part, there was a great desire to rush on with developing the UPC and taking on too many projects. Having key, objective support enabled the project leads to refocus on what was important, and to gain a real understanding of what the key aims and objectives were. This was crucial to enable our success.

We soon realised that we needed to prepare our ward leaders properly about the difference in leadership style that would be required when using a SG approach. Rather than doing it as we went along, we should have actively engaged them before the UPC started. It must be recognised that the senior nursing team were extremely supportive throughout, but at times lacked clarity of their leadership role due to poor understanding of the concept of SG. As we take SG forward in the Trust, detailed work is being done to support and engage with ward leaders and senior nurses from the beginning.

While AI was a suitable framework, at times it was difficult to approach problems with the positivity that was required. Inherently the UPC focussed on problems, rather than what is strong on the ward and what could be achieved. However as the months progressed, there was a clear change in attitude, with the UPC embracing the framework, and it can be seen in action now at meetings. Bushe (2010) suggests that collectively focussing on what you want more of, and inquiring into the best of what people know and care about will always make things better, and “problems” will get solved.

It is important to consider succession planning for key roles such as Chair and Vice-chair, as the staff who initially took on these roles are moving to other clinical roles to develop their careers. Leadership training is important in order to give future Chairs, regardless of their job or grade, the support to develop the necessary skills required to undertake this role.

6.0 Destiny of the UPC

The UPC on B3 is now working independently to develop further projects to improve patient care, and is acting in a leadership capacity to support the roll out of SG throughout the rest of the Trust.

7.0 Conclusion

This project has been an invaluable learning experience for all involved, and forms the foundation for implementing SG throughout the whole Trust. It has identified how utilising a group of frontline staff to implement and change practice at ward level through a UPC can enhance the patient experience and be a really effective way of developing and empowering frontline staff.

8.0 Acknowledgements

Huge thanks must go to Kate Sanders and the team at FoNS for their constant support and unerring advice throughout the course of the project.

Greatest thanks to Ms Jenny Leggott, Director of Nursing and Midwifery, Deputy Chief Executive. Her vision for developing shared governance throughout the whole trust is truly innovative and empowering.

Congratulations to KT, who was shortlisted for the Nursing Times Emerging Leaders Award 2013 as a result of her work as UPC Chair.

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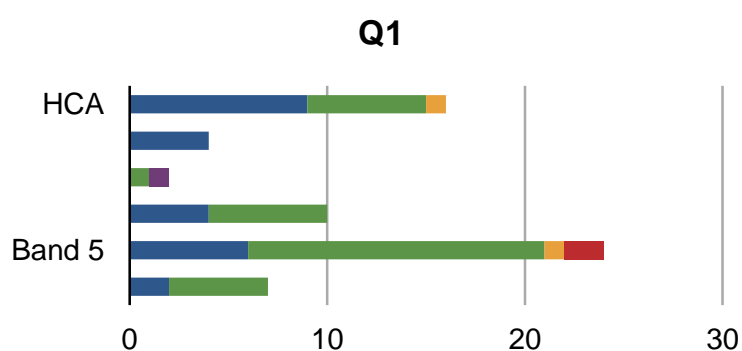
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10.0 Appendices:

Appendix One:

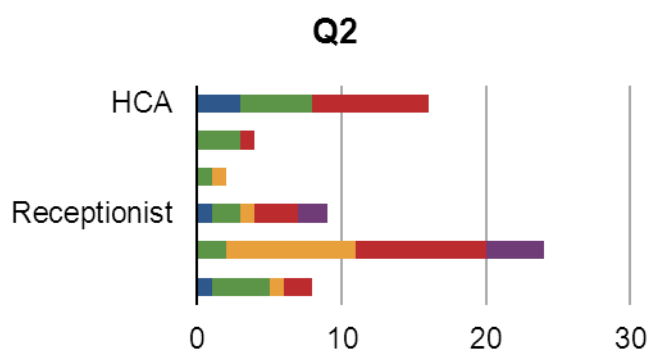
Question 1. I know what is expected me at work

Question 1	Strongly Agree	Agree	Neither	Disagree	Strongly disagree
HCA	9	6	1	0	0
CSW	4	0	0	0	0
Progress Chaser	0	1	0	0	1
Receptionist	4	6	0	0	0
Band 5	6	15	1	2	0
Band 6 / 7	2	5	0	0	0



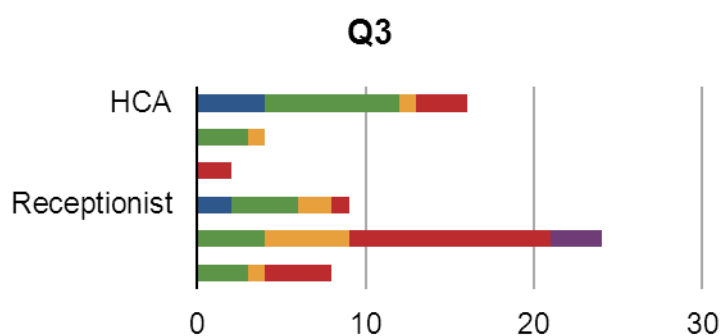
Question 2: I have the materials and equipment I need to do my work right:

Question 2	Strongly Agree	Agree	Neither	Disagree	Strongly disagree
HCA	3	5	0	8	0
CSW	0	3	0	1	0
Progress Chaser	0	1	1	0	0
Receptionist	1	2	1	3	2
Band 5	0	2	9	9	4
Band 6 / 7	1	4	1	2	0



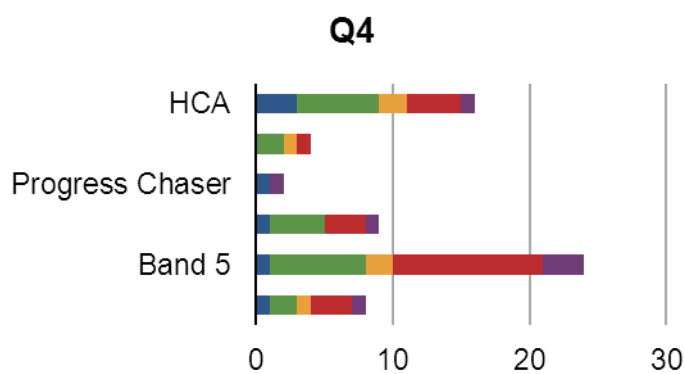
Question 3: At work I have the opportunity to do what I do best every day:

Question 3	Strongly Agree	Agree	Neither	Disagree	Strongly disagree
HCA	4	8	1	3	0
CSW	0	3	1	0	0
Progress Chaser	0	0	0	2	0
Receptionist	2	4	2	1	0
Band 5	0	4	5	12	3
Band 6 / 7	0	3	1	4	0



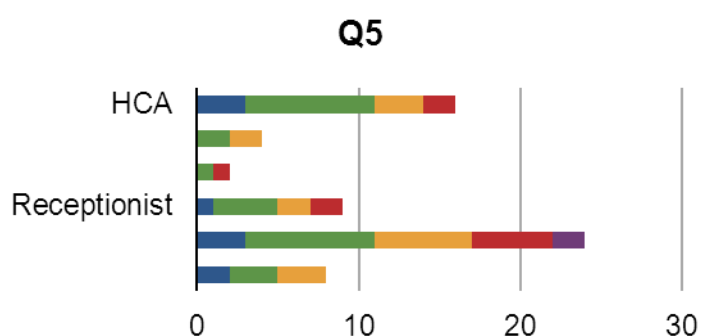
Question 4: In the last 7 days I have received recognition or praise for doing good work

Question 4	Strongly Agree	Agree	Neither	Disagree	Strongly disagree
HCA	3	6	2	4	1
CSW	0	2	1	1	0
Progress Chaser	1	0	0	0	1
Receptionist	1	4	0	3	1
Band 5	1	7	2	11	3
Band 6 / 7	1	2	1	3	1



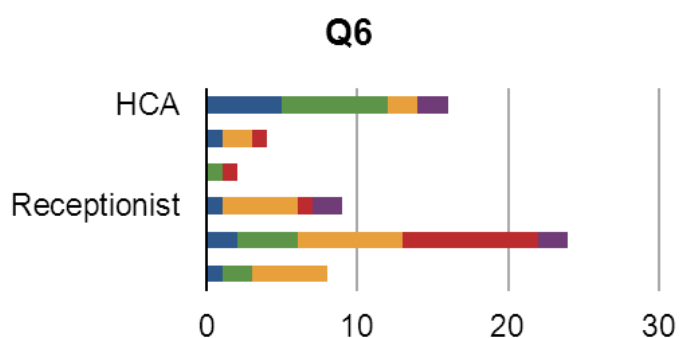
Question 5: My supervisor, or someone at work seems to care about me as a person

Question 5	Strongly Agree	Agree	Neither	Disagree	Strongly disagree
HCA	3	8	3	2	0
CSW	0	2	2	0	0
Progress Chaser	0	1	0	1	0
Receptionist	1	4	2	2	0
Band 5	3	8	6	5	2
Band 6 / 7	2	3	3	0	0



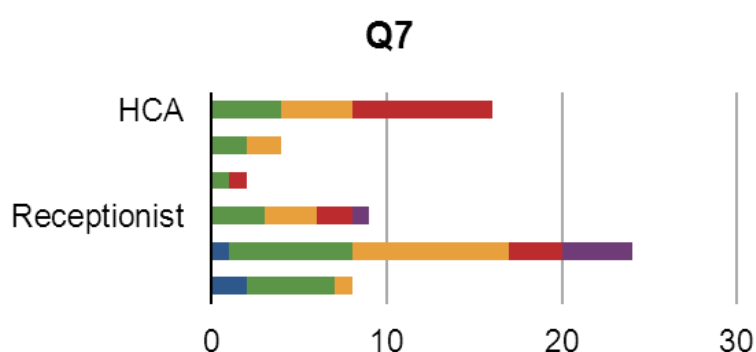
Question 6: There is someone at work who encourages my development

Question 6	Strongly Agree	Agree	Neither	Disagree	Strongly disagree
HCA	5	7	2	0	2
CSW	1	0	2	1	0
Progress Chaser	0	1	0	1	0
Receptionist	1	0	5	1	2
Band 5	2	4	7	9	2
Band 6 / 7	1	2	5	0	0



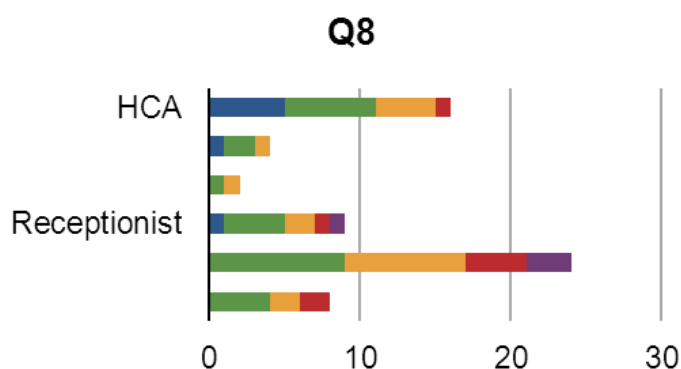
Question 7: At work my opinion seems to count

Question 7	Strongly Agree	Agree	Neither	Disagree	Strongly disagree
HCA	0	4	4	8	0
CSW	0	2	2	0	0
Progress Chaser	0	1	0	1	0
Receptionist	0	3	3	2	1
Band 5	1	7	9	3	4
Band 6 / 7	2	5	1	0	0



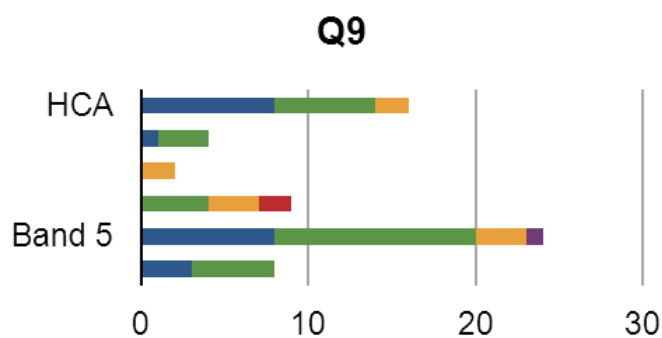
Question 8: I see my job reflected on the NUH mission *"To deliver excellent, caring and thoughtful healthcare for Nottinghamshire and the East Midlands"*

Question 8	Strongly Agree	Agree	Neither	Disagree	Strongly disagree
HCA	5	6	4	1	0
CSW	1	2	1	0	0
Progress Chaser	0	1	1	0	0
Receptionist	1	4	2	1	1
Band 5	0	9	8	4	3
Band 6 / 7	0	4	2	2	0



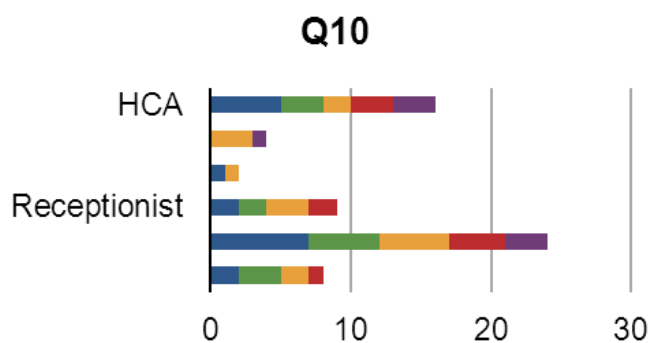
Question 9: My work colleagues are committed to doing quality work

Question 9	Strongly Agree	Agree	Neither	Disagree	Strongly disagree
HCA	8	6	2	0	0
CSW	1	3	0	0	0
Progress Chaser	0	0	2	0	0
Receptionist	0	4	3	2	0
Band 5	8	12	3	0	1
Band 6 / 7	3	5	0	0	0



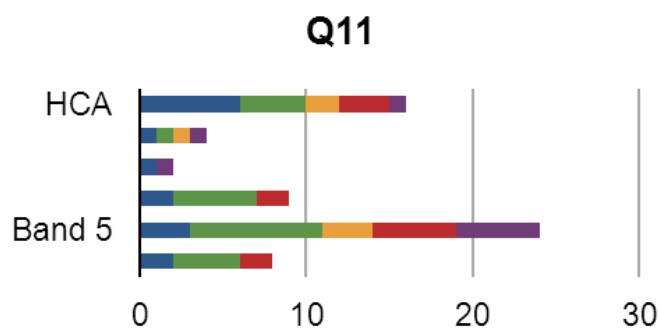
Question 10: I have a best friend at work

Question 10	Strongly Agree	Agree	Neither	Disagree	Strongly disagree
HCA	5	3	2	3	3
CSW	0	0	3	0	1
Progress Chaser	1	0	1	0	0
Receptionist	2	2	3	2	0
Band 5	7	5	5	4	3
Band 6 / 7	2	3	2	1	0



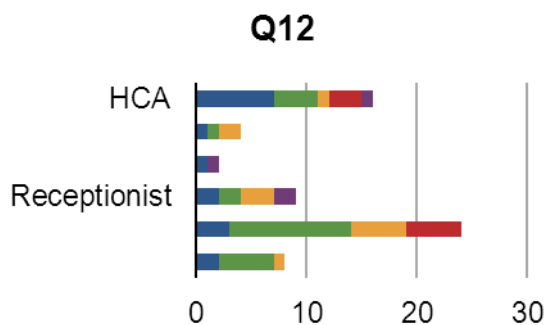
Question 11: In the last six months, someone at work has talked to me about my progress

Question 11	Strongly Agree	Agree	Neither	Disagree	Strongly disagree
HCA	6	4	2	3	1
CSW	1	1	1	0	1
Progress Chaser	1	0	0	0	1
Receptionist	2	5	0	2	0
Band 5	3	8	3	5	5
Band 6 / 7	2	4	0	2	0



Question 12: This last year I have had opportunities to grow:

Question 12	Strongly Agree	Agree	Neither	Disagree	Strongly disagree
HCA	7	4	1	3	1
CSW	1	1	2	0	0
Progress Chaser	1	0	0	0	1
Receptionist	2	2	3	0	2
Band 5	3	11	5	5	0
Band 6 / 7	2	5	1	0	0



Appendix Two:

Feedback from Launch Day: Listen - what is good on B3

Team

- Lovely team
- Well motivated staff
- Team work
- Friendly, supportive, approachable team
- Team work
- Staff will help each other when struggling
- Teamwork and support from colleagues
- Coming together when really needed
- Team work!
- We have a fantastic team who always work together without fail!
- Great team!
- Everyone works well together!
- Everyone who works on the ward gets asked to be involved in everything
- Staff nurses, reception staff team work and support coordination working
- Very friendly
- The brilliant staff
- Good team work
- Staff team work
- Night receptionist friendly and approachable
- Great team
- Team spirit
- Team work
- Team work :)
- Team work
- Friendly team
- Team work
- Team wonderful to work with

Managers

- Managers have done great deal to improve B3
- Management supportive!

Education

- Good bed-side teaching
- Good learning opportunities
- Very good learning experiences to develop skills
- Staff always eager to educate
- Well educated
- Really good introduction to the ward
- The student room is a really good area
- Supportive staff to students on the ward
- Medical students really enjoy their time on B3
- Very positive learning environment
- Good learning place for students
- Very good learning experiences to develop skills

Care and environment

- Manage well under very difficult circumstances (i.e. large volume of patients in 1 shift)
- Flexibility
- Patients go home on the same day after lots of assessment, treatment, investigations and consultant review
- Staff are very good at taking and acting upon “shabby” handovers from ED

- Everyone works to the best of their ability to provide the best possible care given the difficulties we face
- We are starting to see patient feedback
- It is never boring!
- Variety
- Safe
- Hardworking staff try to give best possible care in often difficult busy circumstances
- Hard work great work
- Nurses on ward rounds
- Always manage no matter how hard it gets - Although it should be acknowledged that this then mean people do not always give the help that is needed

Others

- Lots of food when everyone is leaving
- Clinic enjoy working there

Feedback from Launch Day - Act

Patient Care

- Clinic: all Doctors nurses to write on board where patients and moves are all the times
- Look to prioritize beds for elderly patients even if it means getting proper hospital beds in the clinic
- Please remember to clean the legs/footrest of the patient bedside tables. We often forget to get down low and clean and they are often dusty/stained
- Re think about how clinic woks (trolley/bed spaces, streaming process...)
- Minimum bed wait for patients in clinic. "target time"
- 4h wait time in clinic
- Just reduce pressure slightly to discharge patients - need to ensure all is done and chased before getting them home
- Staff work very hard to keep patients moving through the ward to free up bed space
- Quality of experience for patients linking to doctors
- Not having enough time for elderly patients and go home feeling I haven't cared for the patient properly
- Better organized - doing the little things well every day
- Reception - treating patients and relatives with respect and courtesy
- Speak up and challenge
- How long elderly patients spend on trolley's in ambulatory clinic
- Buzzer noise at night
- B3 rules - staff don't always apply to them - results in failure of compliance
- Better consultant care in clinic
- Better food facilities for clinic! Some patients have sandwiches for lunch and tea. Can we give hot meal at lunch?
- Providing food for clinic patients
- Think! is it a chore or is it a safety barrier?

Team work

- Think ahead! We're in it together: restock drugs before they run out and don't leave for next shift
- Need to be fully informed by co-ordinator or progress chaser of all moves. Its not good when relatives have been sent down the ward and then patient has been moved or indeed passed away and they didn't know
- Teamwork see it - do it, don't leave it for someone else
- Staff nurses to help auxiliaries more with admissions
- More staff nurses to help when admitting patients - some nurses don't help with them
- "It's not my job"

Staff / Rota issues

- Empower staff
- More staff on to help give care
- Look at allocations on a regular basis and understand we don't have to work in same are ALL the time
- Workforce re-design sharing of teams
- Fairer rota for all
- prepare staffing ahead - put out to bank earlier
- check weekly staffing
- More staff - it's amazing having 6 patients
- Bed coordinators jobs need re evaluating
- Define job roles properly
- Receptionists need to keep a consistent level of politeness and how to speak to patients
- Not enough rest days between shifts (nights, sleep day then LD)
- Closing clinic on time
- Link staff need protected hours put on the rota every month
- Fairness in rota, needs sorting!
- Rotas and staffing are a big issue on B3. Staff are mentally and physically drained after shift
- Auxiliaries could be allocated different bays more!
- Allocation to be looked at more!
- Requesting annual leave/days off rejected several times as others off. need to use up annual leave and not able to
- Staff being off sick or changing of shifts. We should try self rostering.
- More experienced staff to improve patient/staff ration daily
- Even out shifts: too many one week, not many the next
- being told you owe hours is very annoying, when its investigated works out they owe you - different system?
- Consistent number of staff
- Need more CSW, please
- E-roster: all staff to be taught how it works
- Ratio of nurses to patients
- Staffing 1:6
- Members of staff being treated the same. Certain staff have annual leave and carers leave others are refused
- Always 1 nurse to 6 patients

Communication

- Why documentation wasn't filled in properly
- Too much paperwork leads to it being incorrectly or incompletely filled
- Bring back the transfer slips when moving patients
- Check and challenge the Drs. they are often wrong (occasionally, "often" perhaps a little harsh)
- Communication between staff and reception - have a message pop up icon on homepage to message reception. click send as then pops up at reception
- Clearly, legible, properly communicated drug charts
- More cross-professional communications to keep processes working and reduce errors and omissions
- Been thoughtful of other staff ensure all documents are ready and full verbal hand over
- Ensure GPs give the right info to patients before they come to clinic so that they have realistic expectations
- Handover missing some basic information (allergies, diabetes etc) which could cause health issues
- Too many "trust" words like TTO's, patients look worried as don't know what they mean
- Be friendly and approachable to all members of staff that enter the ward. Agency etc, also
- A better handover when receiving patients from ED or clinic e.g. sometimes patients from clinic come with no notes

- All staff need handover regardless of what time they start their shift
- To ensure that is always 1:6 and CSW on the ward

Training

- More training for band 5's e.g. EDIS more support in finishing packages and having them signed off
- Training program for nurse by the NP, on its way
- More training for nurses, B3 team, NP
- Make clear every member job role and responsibilities
- Meaningful education challenging pts dementia
- New staff induction
- Reduce canceling study days

Equipment and layout

- Better placement for patients
- Different design see male assessment lay out
- Female assessment has a dangerous and impossible layout design: especially for full care, cardiac arrest and ill patients
- Spare primo mattress available on ward
- Proper bed spaces in female assessment get rid of 4+9
- Get reliable dishwasher in the kitchen
- More hoists working
- Weight bridge coming into clinic to weight all patients
- Need new dressings as we have very limited supply of basic dressings
- Reduce number of thing left in the corridors (cages, wheelchairs, beds, computers...) they are safety hazard!
- Layout of female and male needs improving
- Arrest buzzer can't hear at either end of ward
- Better layout of ambulatory
- Layout in female assessment and clinic
- Getting weights for patients who are bed bound is very difficult as weight hoist rarely works
- Equipment could be improved
- Staff allocation, area rotation
- Rota to be improved to make it fair
- Need management time to carry out link roles
- More staff during the day
- Improved facilities, i.e equipment. Someone needs to regular check and stock equipment
- Clerical equipment in clinic to save waiting for labels/wristbands

Recognition

- Other wards/managers need to know more about workload on B3 as difficult for them to always understand
- Greater team engagement/leadership
- Areas outside B3 need to appreciate the roles and workload of staff on B3 and their skills
- Recognition, thank you's

Others

- More team-building exercises
- Families, visitors etc strolling around the ward - make it hard to move around! strict visiting times
- Something to entertain patients
- Somewhere for patients to go to "chill out" i.e. if there is a disruptive patient in the same bay

Feedback from Launch Day - Improve

Patient Care

- Better food facilities for clinic! Some patients have sandwiches for lunch and tea. Can we give hot meal at lunch?
- Lease with FSA to put proper plan in action for feeding clinic patients

Doctors allocation

- Same doctors on each bay for at least one week - continuity
- Junior doctors 2 months B3 then 2 months D57 rather than alternating all the time
- Keeping junior doctors on the ward longer so we feel part of the team

Staff

- Have extra staff on in the day shift so that they can float to help with admissions or washes etc.
- Have our own transfer team
- Define job roles properly
- Employ staff to do rotas only
- Two CSW in clinic on pm shift
- Progress chaser in clinic to free up co-ordinator
- Full time meeter and greeter in clinic please

Rota

- Good rota, balancing to equal same amount of staff per shift
- More juniors and senior doctors cover at night
- Staff being off sick or changing of shifts. We should try self rostering.
- Set rotas e.g. 3 months rotation
- Off duty: maybe part self rostering would work

Communication

- Have better communication via time out days etc
- A way in which communication is better in clinic to let patients what they are waiting for and why
- Pop up icons on computers saying where patients have moved to
- Communication sheet from Dr with plan on given to the nurses so they know the plan and then this is given to the patient so they are then aware of what they are waiting for
- Sign saying predicted times in clinic to reduce complains
- Speak to the ward volunteers for their ideas and input

Training

- Creating an induction program for all staff new staff, including documentation, training and good practice. This would ensure all staff are aware of best practice and potentially reduce incidents
- Tissue viability nurses to attend study days and bring back ideas to ward and appropriate or new dressings
- Giving the agency nurses a better induction as to how B3 works

Recognition

- Staff on other wards should have a short secondment so they can see what pressure B3 get

Others

- Day room for patients and relatives
- Tv room/read room as patient get bored
- Radio's TV's in the bays or day room
- Christmas carols by locals guides etc