ED Charge Nurse Course

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NEMOURS CHILDREN'S HEALTH

- Leadership – What is it?

Let’s Play a Game!


GOOD LEADER
inspiration
integrity
clear goals
good example
vision
clear communication
expects the best
support
encouragement
recognition
stimulating work
focus on team interests and needs

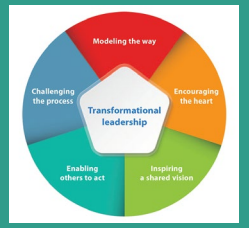
NEMOURS CHILDREN'S HEALTH

Servant

Coaching

Bureaucratic

Leadership Styles



Transformational

Laissez-Faire

Authoritative

(NOT authoritarian)

Autocratic

Democratic

Leadership style quiz and examples - Work Life by Atlassian

Leadership Styles

Transformational

- Creates shared vision
- Focuses on people: create unity & bonds
- Instills passion
- Emphasizes change and transformation
- Focuses on the future

Steve Jobs

The 6 Most Common Leadership Styles & How to Find Yours (imd.org)

Leadership Styles

Authoritative/Autocratic

- Visionary: provide overall direction to their team through guidance, feedback, and motivation
- Direct (NOT authoritarian)
- Emphasizes a “follow me” approach
- Mentor: Motivate and inspire staff
- Gets to know their team on a personal level so that they can provide personalized feedback and motivation
- Hands-On: may sometimes be over-bearing/micromanage

Bill Gates; John F. Kennedy; Martin Luther King Jr.

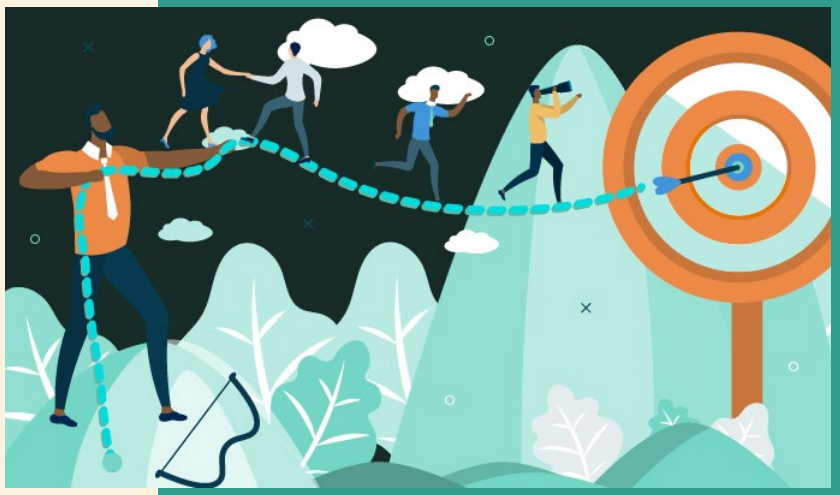
The 6 Most Common Leadership Styles & How to Find Yours (imd.org)

Leadership Styles

Servant

- Puts the needs of others first
- Focuses on creating strong relationships with those around you
- Focuses on enabling team to reach their full potential
- Focuses on ethical decision-making

Nelson Mandela; Mahatma Gandhi



The 6 Most Common Leadership Styles & How to Find Yours (imd.org)

Leadership Styles

Democratic

- Makes decisions based on team input
- Inclusive, collaborative, empowering
- Effective communicator
- Emotionally intelligent

Google; Dwight D. Eisenhower; Muhtar Kent

The 6 Most Common Leadership Styles & How to Find Yours (imd.org)

Leadership Styles

Bureaucratic

- Tight rules & regulations
- Strict, highly defined leadership structures
- Clear, non-biased, career focused

Winston Churchill; Collin Powell

The 6 Most Common Leadership Styles & How to Find Yours (imd.org)

Leadership Styles

Coaching

- Empowers the team
- Partnership & collaboration
- Intended to help colleagues achieve independent goals
- Excellent communication skills
- Motivate staff and allow them to operate autonomously

Oprah Winfrey; Richard Branson

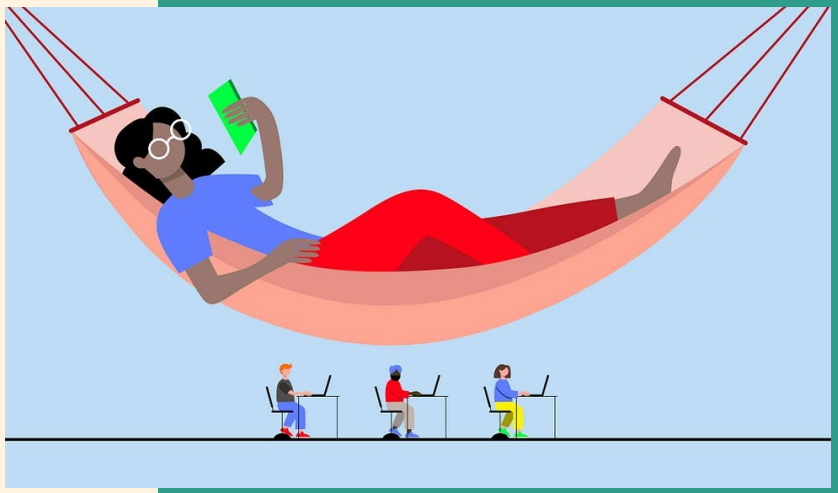
[The 6 Most Common Leadership Styles & How to Find Yours (imd.org)]

Leadership Styles

Laissez-Faire or Delegative

- Give nearly all authority to the team
- Limited guidance, direction, feedback
- Minimal interference & control
- High autonomy & freedom
- Empowerment & trust placed on team members

Warren Buffet; Mark Zuckerberg; Herbert Hoover



The 6 Most Common Leadership Styles & How to Find Yours (imd.org)

What's your leadership style?


LEADERSHIP IS A SUBTLE ART
SO CHOOSE CAREFULLY
GOLD
RULES
PENWILL

What is a Charge Nurse?

Role

Duties

Function

Responsibilities

Attributes

NEMOURS CHILDREN'S HEALTH

STANDARDS OF BEHAVIOR

1. BE IN THE MOMENT

- Be punctual; respect others time and give your time to others.
- Remain open minded; respond and adapt to change.
- Maintain all expected Nemours and career specific certifications. Focus undivided attention on the current task or interaction.
- Listen actively to ensure understanding.
- Turn off 'autopilot' by pausing and choosing the appropriate response in situations.

2. BE AUTHENTIC AND HUMANISTIC

- Acknowledge and recognize the contributions of others in the work environment. Recognize and appreciate diversity.
- Demonstrate honesty and integrity with all people in all situations.
- Show sincere interest in people and their opinions, issues and/or concerns. Speak in a manner that maintains or enhances the self-esteem of others. Encourage 'balance' when it comes to work—and family-life issues.

3. VOLUNTEER DISCRETIONARY EFFORT CONSTANTLY

- Look for opportunities of improvement and make appropriate recommendations. Anticipate the needs of others, offer services before they are requested.
- Anticipate and resolve issues in a timely manner. Display initiative in all work activities.
- Take accountability for helping other individuals and departments be successful— ask yourself, "What more can I do to help or support you?"
- Routinely suggest creative ideas and solutions to help Nemours succeed.

4. MODEL HIGH PERFORMANCE— DESIRED BEHAVIORS THAT DRIVE DESIRED RESULTS

- Follow all policies and procedures regarding safety and quality.
- Be collaborative and supportive by working in a cooperative manner.
- Demonstrate individual leadership, ingenuity and initiative in doing the right thing by using AIDET: Acknowledge, Introduce Self, Duration, Explanation, Thank You.
- Proactively take action(s) to continuously improve yourself and the systems/processes with which you work.

5. RESPECT AND LEVERAGE SEPARATE REALITIES

- Apply the values of Nemours in everyday work.
- Be aware and respectful of the life situation of others and treat them with compassion, empathy and consideration.
- Be collaborative and supportive by working in a cooperative manner.
- Recognize that your 'reality' is not superior to others and that you can learn from them
- Compensate for potential personal 'blind spots' by soliciting diverse ideas and opinions.

6. BE CURIOUS VS. JUDGMENTAL

- Communicate with others in an open and appropriate manner. Listen and respond with empathy to all.
- Encourage analysis, inquiry, collaborations and innovation across disciplines.
- Ask questions to better understand the thoughts/beliefs and behaviors of others.
- Create a safe environment for people to say what they think and feel.

7. LOOK IN THE MIRROR FIRST— BE ACCOUNTABLE

- Know, accept and understand the responsibilities of your job. Accept responsibility for continued self-improvement.
- Meet deadlines and follow up on issues and requests.
- Behave with the mindset that 'I own Nemours, including its successes and opportunities for improvement'.
- Ask yourself, 'How am I contributing to what is or has happened? —take corrective action when necessary.
- Solicit feedback from others routinely and act on it when appropriate.

8. HAVE COURAGEOUS CONVERSATIONS

- Be conscious of budget impact of decisions; conserve resources when possible. Coach in private; commend in public.
- Communicate with others in an open and appropriate manner.
- Utilize all of these Standards when confronting difficult situations, people, or when you are going to express an unpopular idea or opinion.
- Address concerns or disagreements with the appropriate person in a timely manner—refrain from 'triangulation.'

9. PROVIDE TIMELY, CLEAR & SPECIFIC PERFORMANCE EXPECTATIONS & FEEDBACK

- Coach in private; commend in public.
- Encourage analysis, inquiry, collaborations and innovation across disciplines. Listen and respond with empathy to all.
- Utilize all of these Standards to communicate performance expectations and feedback in a timely manner.

10. TEACH, COACH & MENTOR— SPEND AT LEAST 1/2 OF YOUR TIME DEVELOPING OTHERS

- Strive to learn through educational opportunities provided by Nemours.
- Promote an environment in which personal growth and learning are encouraged. Focus on confidentiality when speaking about a patient and/or family.
- Utilize these Standards to be a high-performance role model for others.

The examples under each Standard are not all-inclusive, rather some example thought-starters.

Communication

- Staff
- Provider
- Family
- Interdisciplinary (PFS, other charges, RT, SW, CL, etc.)
- Escalation

What are some communication tools that can be used when communicating?

NEMOURS CHILDREN'S HEALTH

Remember…You've Got This!

You set the tone for the department…the staff look to you and are influenced by your state of emotion (panic, calm, anxiety, etc.).

“

Leaders instill in their people a hope for success and a belief in themselves. Positive leaders empower people to accomplish their goals.

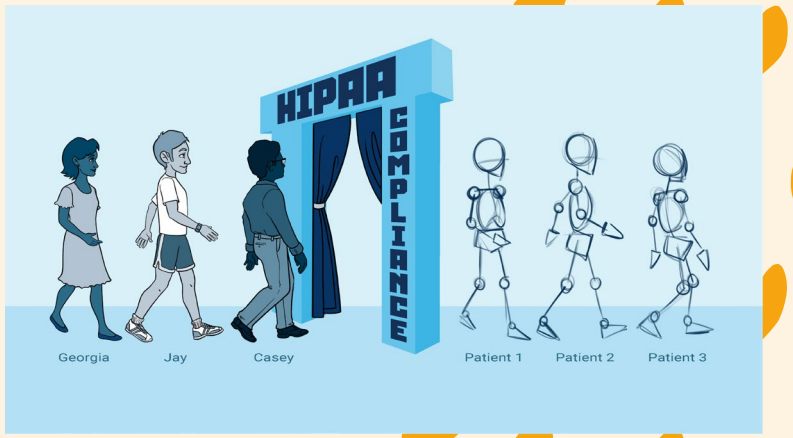
- Unknown -

”

- The Essentials -

HIPAA – Health Insurance & Accountability Act

- Federal law; National standards to protect private patient health information from being shared without patient consent
- PHI: protected health information



At NCH:

- Right patient – Right paperwork
- Release of Documents: law enforcement, DCF, family, etc.
- ➢ Medical Records
- Logout of computer screens (at desk and in rooms)
- Patient Information Stickers

Health Insurance Portability and Accountability Act of 1996 (HIPAA) | CDC

Consent

- Consent for treatment

Scenarios/Special Cases…What do we do?

- Unaccompanied minor
- Grandparent (or other non-parent guardian) presents with child
- What if we are unable to obtain consent for the entire stay….what process should be done?

What would you do?

- A 13-year-old patient arrives to ED seeking treatment. They are unaccompanied?
  - Can you see them/sign them into the ED?
  - Can you obtain consent? How? From whom?

- …Same patient, but now they state they are staying in Florida with a sponsor host family who are on a plane back to Florida from Italy. Registration is unable to reach them or obtain consent. The patient refuses to answer further questions about guardians.

- …Same patient, now the patient tells you that he is from California and give his mother's number. You obtain consent to treat, but no have no adult to discharge patient to?

HIPAA

National standards that protect sensitive patient health information (PHI) from being disclosed without patient consent

Examples of PHI in the Department:

- Computer screens left open
- Patient identification stickers left on workstations and in patient rooms
- Giving incorrect paperwork to a patient/family

- *Other examples?*

What would you do?

- A parent calls and asks about information on patient in the ED?
- DCF arrives and wants to see patient?
- Police officer arrives to the department and asks to see patient?

EMTALA: Emergency Medical Treatment & Labor Act

- Federal Law
- Ensures emergency care for all patients regardless of insurance status or ability to pay
- Large fines for those who violate

What does this mean for the emergency department?

Three Responsibilities for Participating Hospitals

Medical Screening Exam (MSE)

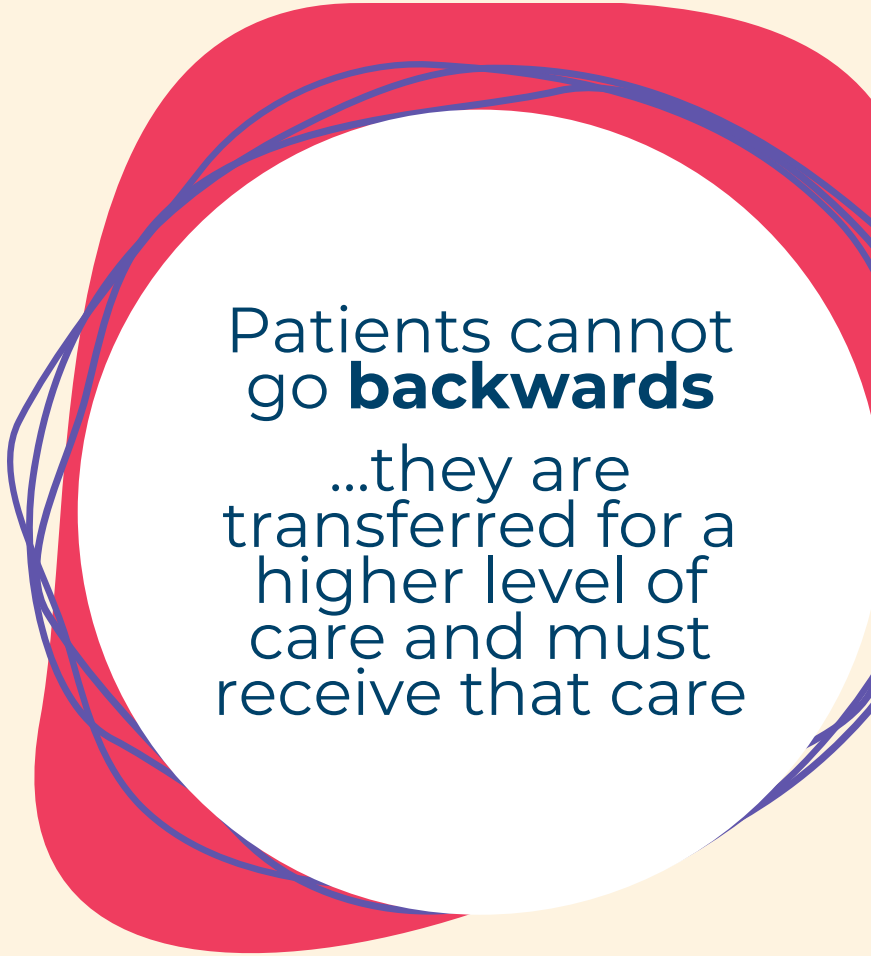
- ALL patients regardless of insurance status, nation of origin, race, religion, etc. are entitled to MSE if they are on “hospital campus” (within 250 yards of hospital building)
- What does this mean for NCH?
- What are our parameters? (Bus stop? Parking lot? Data center?)

Stabilize Patient with an Emergency Condition

- Must stabilize patient (reasonably sure that patient can be discharged or transferred without clinical deterioration)

Transfer or Accept Appropriate Patients

- “Appropriate transfer” to a higher level of care if patient’s condition requires
- What does higher level of care mean?
- What if a patient comes via NCH transport and requires ED for temporary hold? What should we do?
- What if inpatient patient requires surgical procedure, surgeon calls PEM and request sedation in ED d/t limited OR space?



All About EMTALA: The Law That Runs the ED EMRA

Diversion

Regulatory Requirements (CMS and AHCA)

- Regulations require acceptance of transfers, especially by specialty hospitals and services
- Regulations are by service available (capability) and with capacity, not by ED bed space or hospital bed space

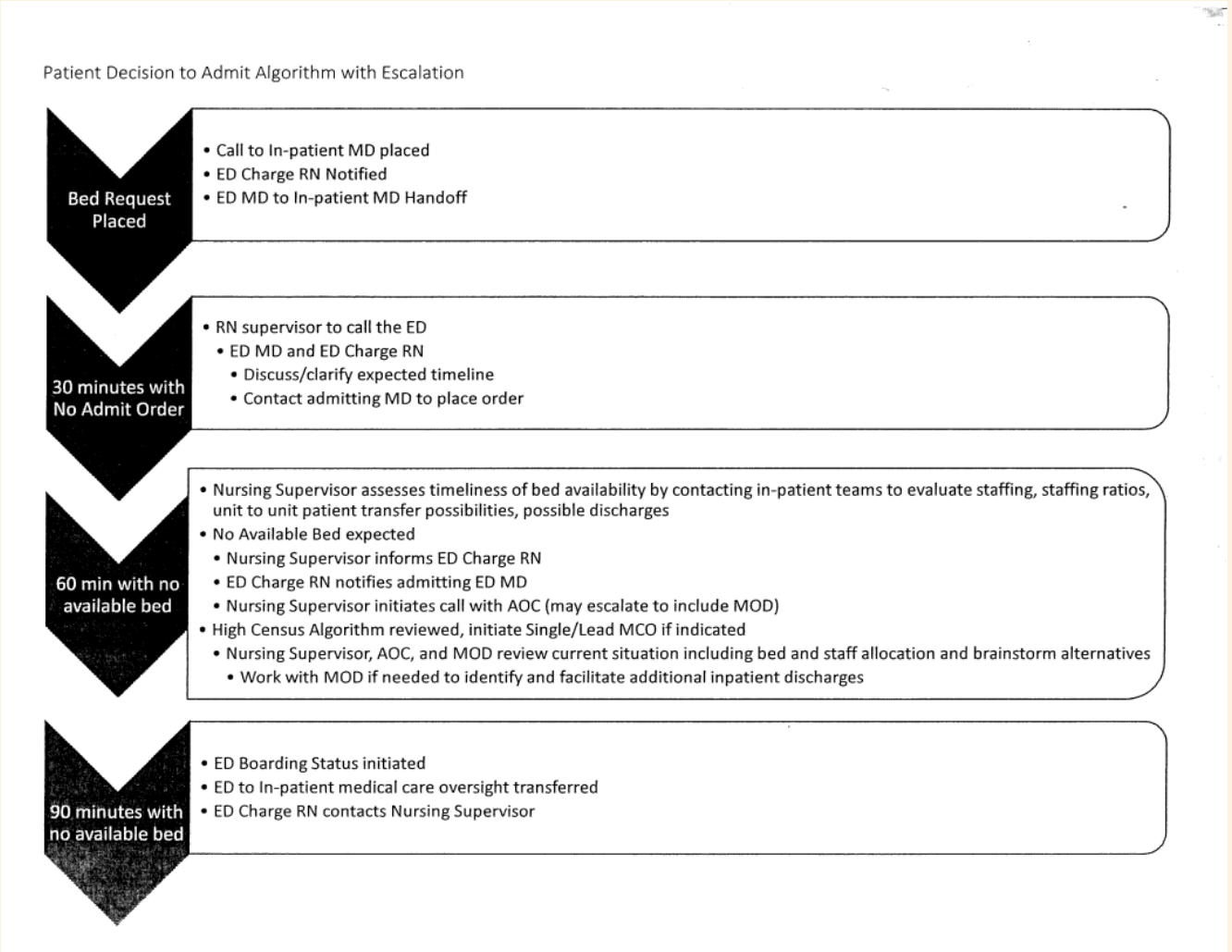
Nemours Mission

- Refusing patients is contrary to our mission to ensure access to the highest quality of care to all patients
- Refusing patients will/has damaged our partnership relationships and growth

Bed Delays

What is the process?

Bed Delay Algorithm



Bed Delay Algorithm

Boarding

- Boarding is associated with “poor healthcare & outcome” (Nouri et al., 2020)
- Several throughput projects to decrease boarding in the ED

When boarding:

- Place appropriate BOARDED order-60 min past ED Request order
- Ensure that bedside RN staff understand boarding process/procedure
- Check inpatient orders
- Boarding checklist x1 needs to be completed
- Accepting provider responsible for all orders, etc.

Points to Consider when Boarding

- Patient placement within the department
- Oncoming shift's staffing
- If rooms are being used for boarded patients, then PEM/other ED providers can see patients elsewhere as they are not responsible for boarded patient's care (admitting team is responsible for these patients)

Consider: Creative thinking…where else can PEM see ED patients that are waiting – How can I maintain throughput?

Escalation

- Charge Nurse
- Manager/Supervisor present in department
- Nursing Supervisor
- AOC for Department
- AOC for Hospital
- MOC

Behavioral Issues in the ED

According to the International Association of Healthcare Safety & Security healthcare workers are 5x more likely to be victims of workplace violence than those in other occupations.

- The rise in threatening behavior has risen exponentially in ERs nation-wide as wait times increase
- The Bureau of Labor Statistics reports that the rate of injuries from violent attacks against medical professionals grew by 63% from 2011-2018

Disruptive Visitor Policy

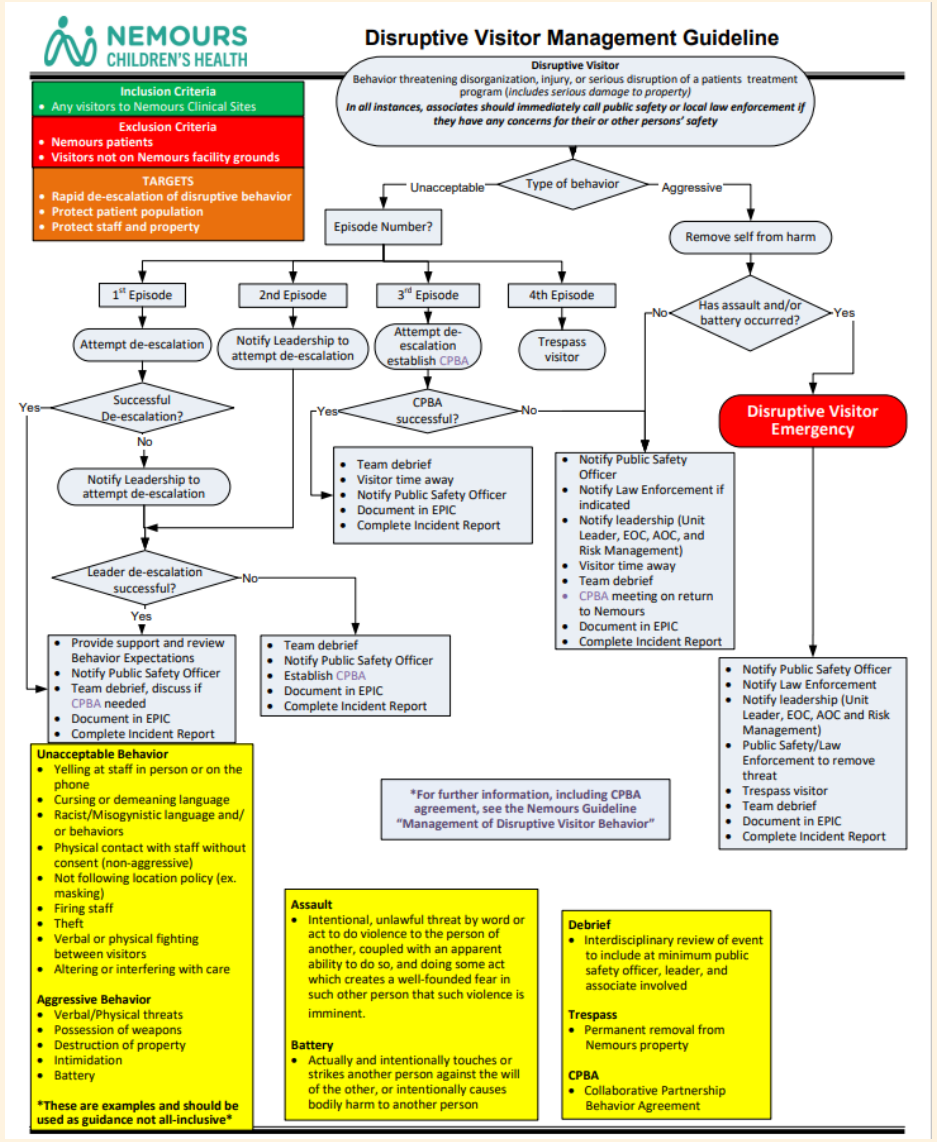
Unacceptable

- Yelling at staff in person or on the phone
- Cursing or demeaning language
- Racist/Misogynistic language and/or behaviors
- Physical contact with staff without consent (non-aggressive)
- Not following location policy (ex. masking)
- Firing staff
- Theft
- Verbal or physical fighting between visitors
- Altering or interfering with care

Aggressive

- Verbal/Physical threats of harm
- Destruction of property
- Intimidation
- Assault
- Battery

Disruptive Visitor Algorithm



Placing/Utilizing Behavioral Flags in Epic

- Use the Disruptive Visitor Algorithm to determine is behavior is unacceptable OR aggressive
- Document all behavioral issues in Epic using the FLAG function of Epic
- Make sure to use .behavioralhuddle dot-phrase
- Always place an RL as well

Just Culture & RLs

What is Just Culture?

What is the purpose of an RL?

What information should an RL contain?

Objective vs Subjective data

How do we report RLs?

Within what time frame should RLs be completed?

Baker Acts

- Prepare room → Room 5 (any room other than 1-4 temporarily)
- SW, physician, or police to enact BA
- Sitter 1:1 after BA initiated
- Keep all original paperwork together as this must go with patient to receiving facility
- Once medically cleared → Transfer Center to send packet
- Original paperwork to go with patient when they depart

- *What forms are needed?*
- *What are mandatory items to medically clear patient?*
- *What can charge RN do if parents "refuse" BA?*
- *What if a potential BA leaves LWOT*

Narc Waste & Discrepancies

- Check each pyxis at end of shift
- Ensure staff is using practice guidelines which will help decrease frequency & frequency & number of discrepancies (i.e., pulling meds per order for sedation)
- Staff to waste meds when they are pulled & it is witnessed by another RN
- Remedy all discrepancies in the moment or prior to leaving
- Forms are in charge binder & can also be received from pharmacy
- Send form to pharmacy → Make a copy for your (and bedside RN's records)
- All staff found to have discrepancies will be asked to come back to rectify
    - → If they fail to report there may be corrective action
    - → Regulations are mandated by law

Death Packet

- SharePoint → search “Death Packet”
- All forms found in SharePoint
- Follow Expired Patient Checklist → PFS can help with the required steps
- *Procedures at Time of Death* Policy
- *Expired Patient* binder in Fish-Bowl

How long do we let family stay with the patient?

Under what circumstances do we remove or leave all tubes, lines, etc. in place on the patient?

Expired Patient | Checklist

Task	Yes	No	N/A	Comments
MD to pronounce death and note the time of death in the EMR Pronouncing MD Date Time	☐	☐	☐	
MD to notify Medical Examiner (ME) if reportable case (407-836-9400 or 407-836-9499)	☐	☐	☐	
MD to order the ME Order set (if ME case)	☐	☐	☐	
MD to notify Organ Procurement Organization (1-800-458-7570)	☐	☐	☐	
MD to notify Eye Tissue Back (1-800-458-7570)	☐	☐	☐	
MD to fill out Organ and Tissue Donation Referral form	☐	☐	☐	
MD to discuss the option of autopsy with the parents or next of kin (if NOT and ME case)	☐	☐	☐	
If consent is given for an Autopsy, MD and parents or next of kin completely fill out and sign the autopsy consent form • The consent form must be completely filled out to be a valid consent; no fields or questions must be left unanswered • The original copy of the signed consent remains with the deceased • A copy of the signed consent is given to the Nursing Supervisor	☐	☐	☐	
If an Autopsy consent is signed, Nursing Supervisor notifies the on-call pathologist via phone call	☐	☐	☐	
Nursing Supervisor e-mails the consent to the (NCH) Autopsy distribution group	☐	☐	☐	
Nursing Supervisor calls the contracted Transportation Service at 407-385-9738	☐	☐	☐	
MD to notify patient's primary care provider	☐	☐	☐	
Nursing to complete disposition of body form	☐	☐	☐	
MD to sign disposition of body form, regardless of funeral home information being available. MD to complete Autopsy Service Information Worksheet	☐	☐	☐	
Nursing to perform COVID testing, if positive, Autopsy will **NOT** be performed	☐	☐	☐	
Nursing staff to call Nursing Supervisor	☐	☐	☐	
Nursing staff to notify Risk Manager in unexpected death and / or risk related circumstances	☐	☐	☐	
• Were restraints in place 48 hrs before death?	☐	☐	☐	
Nursing staff to notify social work, chaplain or child life as needed	☐	☐	☐	
Nursing staff to collaborate with social work and notify DCF and or law enforcement (if needed)	☐	☐	☐	
Nursing staff to remove Tot Guard band from patient	☐	☐	☐	
Nursing staff to ensure that patient's identification bracelet is intact	☐	☐	☐	
Nursing staff to give family # to call Nursing Supervisor (407-567-4420) with funeral home information and notify Nursing Supervisor with Family's best contact number (if no funeral home info at this time)	☐	☐	☐	Family Contact #: _____
Nursing Supervisor to send notification to (NCH) Expired Patient distribution list	☐	☐	☐	
Nursing Supervisor to call Security for escort to the morgue (Retain completed original Disposition of body form)	☐	☐	☐	
Nursing Supervisor and Security to perform double verification of the identity of the body and log the body into the morgue	☐	☐	☐	
Nursing Supervisor to complete My Tech ticket once body has been released to ME or funeral home. **Escalate any delays in disposition of body ≥ 3 days**	☐	☐	☐	
Nursing Supervisor to deposit disposition of body form to HIM bin after body has been released to ME or funeral home (Be sure all info is filled out on Disposition of Body form including funeral home)	☐	☐	☐	

LWOT

- Metric will be tracked by CMS
- Presents safety issue for patients
- Patient/Family dissatisfier
- Charge RN to be notified of anyone wanting to leave as LWOT

What scripting can be used/effective when speaking with parents/families while trying to avoid them leaving?

What can we do to prevent LWOT -- What are some methods that have been effective for you in the past?

NRC

- Measures patient experience
- Focuses on “Human Understanding”
- VOC, Hand Hygiene, Respect & Courtesy of Staff, Patient/Family Understanding, etc.
- These scores are completed weekly → every patient through the ED & SS are contacted
- These scores are shared, viewed, & monitored by leadership on many levels
- Incorporated into Magnet journey

Productivity

- Bi-Weekly reports that coincide with pay periods
- Metrics used to determine appropriate staffing to patient census

  → Considerations as CN
- Used to determine workload; Department staffing levels

Productivity Ranges

→**0-95%**

→**95-98%**

→**98-105%**

→**Above 105%**

Goal: GREEN

Throughput/Strategy

Opening other spaces

- Annex/Radiology
- Room 1
- Treatment Room

Assign Roles: Assign a specific person to o lunch coverage, Reassessment RN, Triage 1, Triage 2

Be specific in role assignment. *Example: reassessment RN VS, re-assessment, PO challenge, downgrade carestream if able, etc.*

What are other ways to increase throughput?

Physician and Charge nurse will have a discussion on where to see patients til boarded get roomed. See patients in treatment rooms or bring provider to triage with the nurse.

Charge nurse to brainstorm and formulate new plan for pt flow.

- Use room ready team.
- Move one provider forward to triage area to get things started on patients.
- If ST heavy maybe CN can see few pt's turn and burn out of any available room.

- Assess needs: Is it a provider issue, nursing or other factors. Contact admin as needed.

Less than 4 super track patients in the waiting room. Increased number of diagnostics in waiting room. Turn rooms 14-15-16 into soft diagnostics.

Charge nurses to run the board every 2 hours with physician:

- Longest length of stay
- Disposition of patients: Admit? Or discharge?
- Any delays: labs, radiology, bed availability.
- What are we waiting on to make disposition?
- Look at the waiting room, anything we can order on these patients?

Be flexible…

You not only lead the team, but also are a member of it.

If you need help in an area, then you can fill the gap.

Staffing Assignments

- Know & consider competencies &/experience of staff
- New Grads & new hires w/o experience should be in “bed” assignment for at least 6 months – No triage
- New hires w/experience should not be in triage until at least 6 months
- Have a plan for lunches (triage should always be running)
- Is PFS placement of patient appropriate?
- What questions should be asked/considered when assessing proper placement of the patient for ED & SS?

→Respiratory status

→PEWS

Rounding

Charge RN should round on patients in the department.

This promotes:

- Best Practice – EBP
- Patient safety
- Patient satisfaction

“

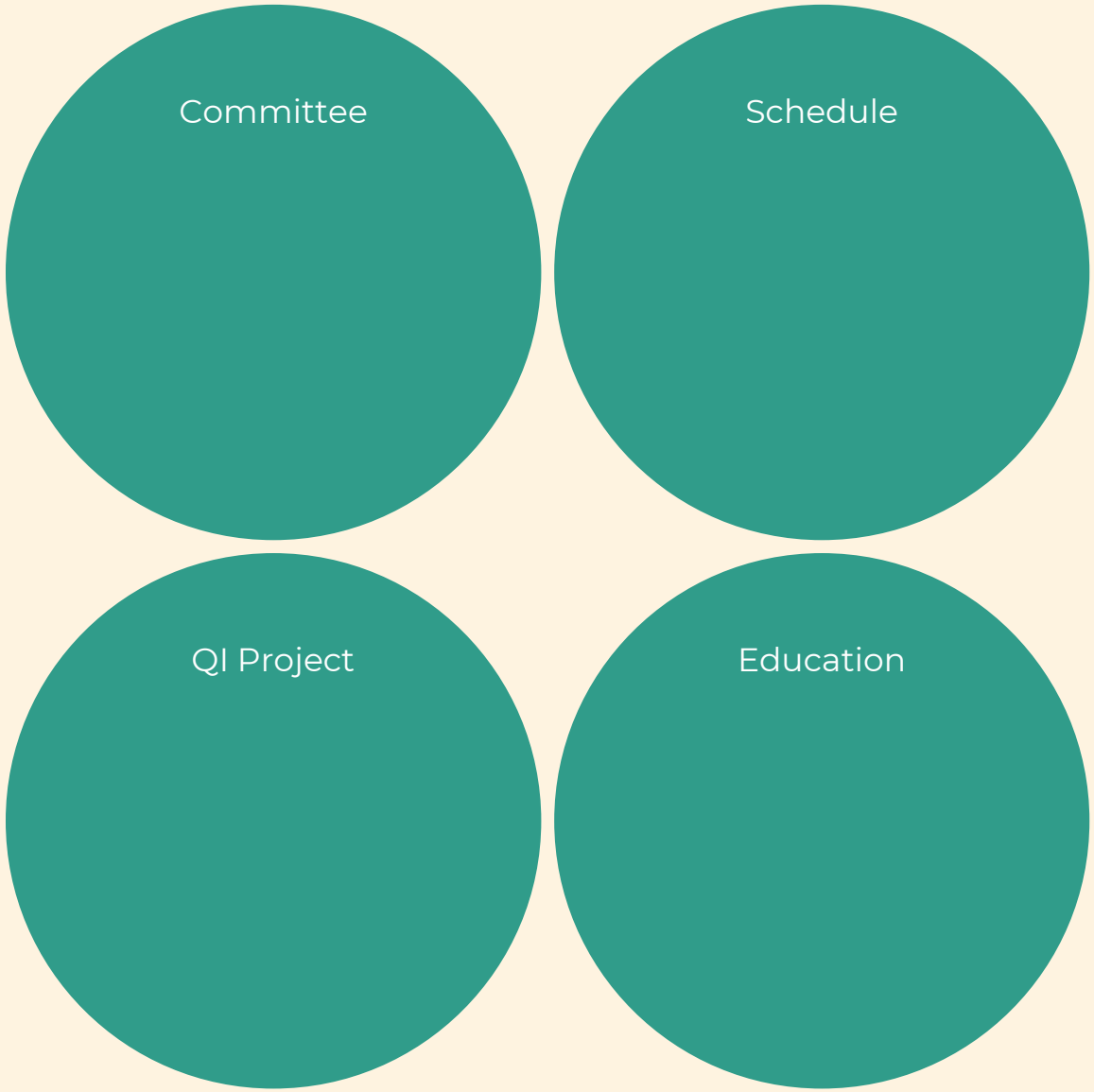
The pessimist complains about the wind. The optimist expects it to change. The leader adjusts the sails.

-John Maxwell-

”

Discretionary Effort

As Charge Nurse…you set the example for the department.



Scenarios

...Yes, these have all happened in our department

NEMOURS
CHILDREN'S HEALTH

Scenarios – What would you do?

- Patient in the department assaults guardian – OPD notified. OPD wants to arrest patient in the ED
- Positive ingestion & potential sexual assault. Inpatient team refuses admission because patient needs SANE exam, but patient is not medically cleared for discharge and requires inpatient observation stay?
- Suspected physical or sexual abuse, social work states “no DCF involvement required”
- Aggressive parent of Baker Act patient states that he refuses for his son “to be transferred to another facility and just wants to take him home”
- Unaccompanied minor presents with c/o sore throat. Unable to provide guardian’s information to obtain consent
- EMS arrives with patient and no parent. Parent does not arrive to the ED.
- Patient family member states that they want to harm themselves
- Transport team brings a PICU patient into the ED to “hold” in TR1. They give report to ED RN & leave patient. Patient has insulin drip infusing and is in DKA.
- Trespassed parent arrives to the ED with their child
- Patient just discharged from surgery has packing “fall out” while getting in vehicle to leave NCH. Security brings patient to the ED

Questions?

Thank you for all that you do for our department every day!

- What Is the Coaching Leadership Style? (positivepsychology.com)
- https://positivepsychology.com/coaching-leadership-style/
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) | CDC
- All About EMTALA: The Law That Runs the ED EMRA
- https://www.dech.org/2023/01/25/aggressive-behavior-in-healthcare/#:~:text=According%20to%20the%20International%20Association,wait%20times%20for%20treatment%20grow.
- Nouri, Y., Gholipour, C., Aghazadeh, J., Khanahmadi, S., Beygzadeh, T., Nouri, D., Nahaei, M., Karimi, R., & Hosseinalipour, E. (2020). Evaluation of the risk factors associated with emergency department boarding: A retrospective cross-sectional study. Chinese Journal of Traumatology, 23(6), 346–350. https://doi.org/10.1016/j.cjtee.2020.09.002
- https://nrchealth.com/about-nrc-health/
- NCH Policies