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CONTENTS

Editorial
Moral Distress in Pediatric Intensive Care Nursing
Franco A. Carnevale, Canada

The Healthy Work Environment: Assessment, Initiatives and Outcomes in a Pediatric Intensive Care Unit
Dennis Doherty, Sandra Mott, Aimee Lyons, & Jean Connor
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Editorial

Moral Distress in Pediatric Intensive Care Nursing

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I have the privilege of travelling to many areas of the world to meet nurses caring for critically ill children across the globe. Although the challenges confronted by these nurses can vary widely, one phenomenon stands out as a common concern: *moral distress*. Moral distress is the discomfort that is experienced when a person is impeded or incapable of acting in a correct manner. In nursing, moral distress is more and more recognized as a problem in many practice settings.

In *general critical care*, nurses are reporting a significant degree of moral distress as resuscitative technologies are increasingly effective in sustaining life, although it is frequently unclear when life-prolongation is ethically right. Moral distress has been reported in *general pediatric nursing* because of the special problems involved in caring for a child who cannot assert her/his own best interests; where it is frequently unclear what is best for each individual child. *Pediatric critical care nursing* is therefore doubly challenging, where the difficulties of critical care nursing are amplified by the difficulties inherent in pediatric nursing.

Advances in our identification and understanding of moral distress in nursing have fostered an important shift in how we understand the difficulties confronted by many nurses. Traditionally, when nurses reported distress in their practice, this has been regarded as a personal succumbing to occupational challenges; as a form of psychological distress resulting from the demands of work that exceed one's personal capacities – a signal of one's limits. In some cases this has been referred to as *burnout*. In these situations, nurses have been frequently required to take some time off or seek psychological therapies to help them develop their capacities to cope with the stresses of their work.

Moral distress has helped highlight that, in many circumstances, nurses' distress is not a result of personal weakness but rather a consequence of conscientious and committed nurses practicing in adverse circumstances that impede them from practicing according to their personal and professional values; where they feel compelled to act unethically. Moral distress can help demonstrate nurses' moral strength, rather than psychological weakness.

I call on all our readers practicing in pediatric intensive care nursing to focus our attention on the difficulties we confront in our practice to help recognize moral distress that is being endured by our colleagues or even ourselves. Upon the recognition of moral distress, we can then help clarify situational or long-term precipitating sources that we can then address to help reconcile this distress.

For a more detailed discussion of moral distress in nursing, see an article that I was asked to write by the Brazilian Nurses' Association (article is available for free online, in English):
Carnevale, F.A. (2013). Confronting moral distress in nursing: recognizing nurses as moral agents. *Revista brasileira de enfermagem*, 66, Spec 33-38.
Available: http://www.scielo.br/scielo.php?pid=S0034-71672013000700004&script=sci_arttext

For information on a Canadian inter-professional study that we recently conducted on moral distress in pediatric intensive care, see:
University of Alberta [internet homepage]. The experience and resolution of moral distress in paediatric intensive care teams: a Canadian perspective [access July 4 2013].
Available: http://www.picumoraldistress.ualberta.ca/en/Background/MoralDistressinthePICU.aspx

The Healthy Work Environment: Assessment, Initiatives and Outcomes in a Pediatric Intensive Care Unit

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Abstract
Background: The Medical Surgical Intensive Care Unit (MSICU), a pediatric critical-care unit, participated in a project to appraise the current state of the unit's work environment. At the time of this project, the MSICU nursing staff faced multiple challenges including reduced staffing, high patient acuity, and emotionally challenging cases.
Methodology: A two phase quality improvement project was undertaken to better understand staff perceptions of the work environment. Phase one consisted of inviting staff to complete the AACN Healthy Work Environment Assessment Tool (HWEAT) to obtain general information about the health of the work environment. Phase two used focus groups to learn the why behind staff members' answers and their ideas about strengths and opportunities for improvement.
Results: Phase one survey response rate was 55% (89). The overall score for the MSICU was 3.78 indicating staff perceived the health of the work environment to be "Good". Scores for the individual standards were: Skilled Communication (3.85), True Collaboration (3.81), Meaningful Recognition (3.62), Effective Decision Making (3.98), Appropriate Staffing (3.61), and Authentic Leadership (3.82). Phase two data from the focus groups coalesced into three main categories: time off, efficient and effective communication from leadership, and appropriate number and skill of staff at bedside.
Conclusions: The healthy work environment project facilitated a better understanding of the work environment and supported a joint effort to work at improving the health of the work environment.

Introduction
Faced with mounting challenges of reduced staffing, increased patient acuity, and emotionally distressing situations, the nursing leadership of one pediatric intensive care unit wanted to learn more about how the work environment as appraised by the staff influenced staff satisfaction. The purpose of this article is to illustrate the appraisal process, strategy for using the findings, and the resulting outcomes.
The concept of a healthy work environment and its relationship to job satisfaction, recruitment and retention of staff, and improved patient safety has gained precedence in healthcare discussions. Thus it was important to learn more about the potential contribution of the working environment to quality patient/family centered care and staff satisfaction.

Review of the Literature
The first step in the process was to complete a literature review. Most of the articles retrieved focused on a single factor, such as communication or leadership and examined strategies for implementing characteristic behaviors. Although addressing a single factor in depth, comments were made to other factors indicating that there were additional interacting factors and behavior in one was reflected in the performance of others. The factors most frequently found related to interdisciplinary collaboration, leadership, communication, and adequate staffing.
Communication skills were found to be valued by employers and something they were willing to support by investing in related staff development programs. Studies noted that most of the issues associated with communication involved generational differences, cultural diversity, and lateral violence (1). Lewis & Malecha concluded that incivility amongst nursing staff led to

decreased productivity and lowered perception of the health of the work environment (2). In addition, communication of information between healthcare team members is essential to providing quality patient care and reducing errors (3).

Perhaps the outcome of skilled communication is that of true collaboration. When practitioners communicate skillfully the result is collaboration. Healthcare providers noted that the implementation of interdisciplinary team rounds is a measure that allows for integration of all input from stakeholders and improves quality of care (4).

Collaboration among intra and interdisciplinary team members is required in order to provide optimal patient/family centered care (5). Reports by the Institute of Medicine (IOM) and others highlight collaboration as essential to optimizing patient outcomes.

Many studies looked at appropriate staffing including associations between nurse staffing ratios and pediatric readmissions among children with medical or surgical conditions. When ratios were poor, discharge teaching suffered and readmissions increased (6). Furthermore, Pearson & Thomson found that staffing ratios affected both nurse productivity and satisfaction as increased patient numbers decreased job satisfaction and increased stress (7). Data also indicate that increased nursing workloads result in nurses missing important changes in patient condition plus contribute to initial covert and then overt behaviors indicative of nurse burnout (8).

Leadership skills were the most prevalent topic found in the literature. For a healthy work environment to exist the leaders must be engaged and embrace honesty, openness, and cooperation. They need to provide resources and incentives to both develop and maintain a positive work attitude, willingness to listen and act, and support change designed to improve patient/family centered care (9-10).

Healthy Work Environment

Framework

In 2005, the American Association of Critical Care Nurses introduced a framework that delineated the Healthy Work Environment (HWE) (11). A 2004 report from the Institute of Medicine (IOM) that linked excellence in patient care and patient safety to a stable satisfied nursing workforce served as the basis for development of the framework (12). In addition input from nursing staff members confirmed the importance and relevance of particular behaviors and their contribution to work satisfaction and consequent retention. The six standards that comprise the framework are: Skilled Communication, True Collaboration, Effective Decision Making, Appropriate Staffing, Meaningful Recognition, and Authentic Leadership (Figure 1) (11).

As a result of this work, the AACN concluded that a healthy work environment is "imperative to ensure patient safety, enhance staff satisfaction and retention, and maintain an organization's financial viability" (11). The behaviors and interactions characteristic of each standard are delineated in Table 1. The health of the work environment has been linked to patient outcomes such as decreased frequency of hospital acquired infections (13). Although a laudable outcome, creating and maintaining a healthy work environment is difficult to achieve as it requires commitment and concentrated effort on the part of each staff member. According to one study, more than 50% of health care professionals have witnessed broken rules, mistakes, incompetence, poor teamwork, disrespect, absence of support, and micromanagement (14). Thus confirming the fact that maintaining a healthy work environment is not an automatic, it takes work on multiple levels by each and every staff member.

Assessment Tool

In 2009 the AACN introduced the Healthy Work Environment Assessment Tool (HWEAT) (15). It is a free-of-charge tool that is available electronically to institutions that are members of AACN. The tool enables small work groups, individual units, or entire organizations to gather information about the health of the work environment. The data that is provided can be used to guide strategies or interventions for improvement as well as trend progress in sustaining the health of the work environment over time. It does not specifically diagnose issues within a work environment, but rather offers an overall summation of that state of a particular unit.

The assessment survey tool consists of 18 general questions (3 per standard). The questions relate to all staff members and are based on the behaviors summarized in each standard. For instance in the Skilled Communication section there is a question about whether staff members keep each other well informed. Each question is answered anonymously using a 5-point Likert scale with 1 as strongly disagree and 5 strongly agree.

The report is generated by AACN and provides the response number and percentage for how each question was answered plus an aggregate score for the overall work environment, each of the six HWE standards, and each question within a standard. The HWEAT uses a 1-5 numeric scoring system that is divided into three categories, excellent (4-5), good (3-3.99), and needs improvement (1-2.99).

Preliminary psychometric testing of the HWEAT

has been completed (15). An expert panel selected by AACN, reviewed questions and content confirming face validity. The questions were then administered to two groups of 250 subjects each and internal consistency was determined with a Cronbach's Alpha scores of 0.80 or better. No further reliability or validity testing has been completed at this time.

Setting

Early in 2010 in a northeast freestanding, pediatric, urban teaching hospital the critical care and cardiovascular programs assessed the health of the work environment for each area. Among the critical care units was the 29-bed Medical Surgical Intensive Care Unit (MSICU). As noted, it was a time of multiple challenges. Nurse staffing for the unit had been decreased based on a bed occupancy assessment. Several staff members were on leave of absence resulting in many shifts being short staffed. Patient acuity levels were increasing plus there were a number of emotionally challenging cases on the unit. The atmosphere was one of obvious tension as workload was intense and nurses were strained to meet patient care demands.

The unit's multidisciplinary staff cares for over 2000 medical, surgical, and transplant patients, age range newborn to adult, each year. The nursing staff consists of over 130 novices to expert staff nurses whose experience ranges from 0 to ≥30 years. As the largest discipline in the MSICU, staff nurses are major stakeholders in terms of the health of the work environment. The MSICU nursing leadership council led by the nursing director and clinical coordinator and consisting of all level II (proficient) and level III (expert) staff nurses and two clinical nurse specialist expect excellence from the entire nursing staff providing care to patients and families. To facilitate this expectation, the MSICU nursing leaders support the work of the unit based council that addresses recruitment and retention issues relative to nursing staff.

Method

In an effort to learn more about how the staff perceived the health of the MSICU work environment, an improvement science project was launched. A two-phase approach was designed to 1) obtain general information using a standard tool and 2) learn more specifics of the work environment as perceived by the staff members.

Phase I - Survey Data Collection

The first phase gathered data about the current state of the MSICU work environment via the AACN Healthy Work Environment Assessment Tool (HWEAT). The nursing director of the unit registered with AACN.org as required for permission to use the tool. Registration included identifying the institution, the specific unit, and determining the time allowed for assessment. After registration was complete, the nurse director was given access to an electronic link to the HWEAT.

All members of the MSICU multidisciplinary staff were invited to complete the assessment tool during a designated two-week period. The invitation with the link to the tool was distributed to all members of the multidiscipline MSICU staff via email. While the link was open, email notifications that included the electronic assessment link were sent on day one, day seven, and days 13 and 14 of the survey period encouraging all staff to participate.

Participants anonymously completed the assessment tool online. No demographic information was collected to assure anonymity. At the completion of the predetermined assessment period the nurse director accessed the results through a password protected site and downloaded the report. This report contained the total number who answered the question as well as a breakdown in terms of numbers and percent of how they answered each question thus providing an overall aggregate score as well as scores for each standard and each question.

While the HWEAT provided a numeric score that collectively reflected staff appraisal of the health of the work environment, it did not provide insight into how or why staff members answered each question. In order to better understand their thinking, a deeper dive into the data generated from the HWEAT was required. The second phase of this project was designed to encourage staff to share their perceptions of the environment via a series of focus groups.

Phase II – Focus Group Data

Qualitative inquiry informs the understanding of a phenomenon by learning from the participants about the experience of interest (16). It was important to hear from the staff their thoughts and concerns about the state of the unit. To gather this data the nurse director identified a staff member to work with the program's nurse scientist and organize the focus groups. All staff members involved with this project thought that the focus group format would be least threatening and most informative.

A single nurse scientist served as moderator for the focus groups. This individual had no supervisory responsibilities to the MSICU staff. Flyers were posted in the staff lounge and in staff restrooms plus electronic communication was sent to all MSICU staff announcing the focus group sessions with dates, times, and locations. Focus groups were held during day shifts and one during a night shift until saturation of data

was attained. In order to facilitate participation by as many staff members as possible, two sessions were held back to back to enable staff to cover each other's patient assignment. Focus groups were held in an on-site MSICU conference room. In addition, project team members were approved to work in order to provide quality care for patients during focus group sessions. Each session lasted approximately 30 minutes. In no way was patient and family care interrupted or compromised during data collection.

Using the HWEAT scores as a guide the nurse scientist asked the focus group participants open-ended questions to illicit discussion about their perception of specific aspects of the work environment. Probing questions were asked when appropriate to gain a better understanding of the feedback. All focus groups sessions were audio taped, transcribed verbatim, and had all identifiers removed. Transcripts were checked for completeness and accuracy. The de-identified transcripts were read and analyzed by the nurse scientist using conventional content analysis. Data that informed the health of the work environment and/or offered suggestions for improvement were identified and extracted as first level codes using the words of the participants. After this was done for all of the transcripts, these data were clustered into common categories thus making the number more manageable and given a more comprehensive label. Upon further analysis of the categories, it was noted that each of them were aligned and could be situated in one of the healthy work environment standards. Most of our categories were concentrated in Skilled Communication, Meaningful Recognition, or Appropriate Staffing. While a few categories were aligned with the other 3 standards, it was decided that appropriate initiatives were obvious and could be implemented easily; therefore, they were given little attention at this time. The HWEAT scores and focus group data were reported to nursing leadership and MSICU recruitment and retention council.

Results

Of the 163 multidisciplinary staff members invited to participate in answering the questions in the HWEAT, 89 (55%) completed it. The overall score of the MSICU was 3.78, indicating that the staff perceived the work environment to be "good." Six focus groups were held and attendance varied related to patient census and acuity. On average 6-10 staff members attended each group. Table 2 provides a summary of Phase I and Phase II findings. The aggregate score was lower in three of the standards and these coincided with the areas staff identified as needing improvement. The majority of staff members' concerns related to behaviors in the standards skilled communication, appropriate staffing, and meaningful recognition. In the standard of skilled communication staff perceived electronic communication to be too frequent and negative. Nurse to nurse real time communication of patient care was viewed as an opportunity for improvement. Leadership's approach to appropriate staffing was viewed as confusing with budget cuts necessitating staffing reductions yet there were constant calls for overtime. Staff perceived variability in the formal recognition programs and noted that the ability to have time off was a form of meaningful recognition for their dedication to patient care.

Outcomes

The leadership team requested the MSICU Council on Recruitment and Retention to suggest initiatives that would address staff concerns. The council organized working groups to explore options and suggest initiatives for creative solutions to improve the perception of the unit's performance in these three standards. In the fall of 2010 the working groups and nursing leadership collaborated to implement these initiatives and suggested actions for achieving a healthier work environment.

The working group focused on what they deemed the most significant areas of concern based on the frequency and intensity of comments. They did not attempt to create an initiative for each concern verbalized. The plan was to begin the process and then involve others and eventually have the entire staff involved in the effort of improving the health of the work environment. Table 3 highlights the initiatives and corresponding suggested activities.

Discussion

After administering the HWEAT MSICU leadership learned that the MSICU work environment was "good". However they did not know exactly what was meant by good or how to make it better. As a unit the MSICU expects excellence in the care provided to patients and families and therefore must strive for excellence in the work environment.

Using focus groups as a forum the MSICU leadership were able to gain greater insight into the staff members' perceptions of the MSICU work environment. Staff members were able to contribute their ideas in a safe forum and willingly offered their suggestions to the improvement process.

One overriding observation evident in the staff members' comments was the central role of skilled communication. All of the other standards seem to some degree dependent on open, honest communication. As noted in the literature, this standard appears universally acknowledged

as critical to high level functioning of any group. In multiple ways, patient outcomes depend on the thorough, timely, accurate, and effective communication exchange (3).

Perhaps the most individually significant of these standards is meaningful recognition. The morale boost that is given when someone is recognized, rather than being taken for granted, for providing exceptional patient care vibrates throughout the unit and inspires others. A sense of pride in working together to accomplish positive outcomes is equated with staff satisfaction and improved retention, both indicators of a healthy work environment. Nationally the Daisy Foundation, a not-for-profit organization, has brought a forum to recognize the contributions nursing makes to over 1,300 institutions worldwide. This recognition empowers nurses to celebrate the impact their care has on patients, families, and patient outcomes (17-18). Employee of the month programs, staff recognition socials, and programs aimed at brightening a colleague's day are important at the institutional and unit levels.

The effects of staffing on morbidity and mortality numbers and readmission statistics have been well documented as noted in the literature review. However, staffing involves more than numbers, it is also a mix of skill and experience that contributes to providing quality care that ensure excellent patient/family centered care (19).

The smaller working groups configured to develop initiatives aimed at addressing the feedback from staff recognized both the value of the feedback and the capability of staff to formulate solutions and create a plan. In collaboration with the MSICU nursing leadership these initiatives were validated and implemented over the course of several months.

The health of the work environment score, although "good" revealed a number of opportunities for improvement. The method used provided a forum for staff to participate and generate detailed information to facilitate improvement. As in any high acuity area, pressure and stress are part of the job description. This healthy work environment project facilitated communication between MSICU staff and nursing leadership. This project served as a forum allowing MSICU staff to be heard safely and anonymously. The MSICU staff was able to contribute to the improvement process by offering creative ideas and suggestions. The primary investigator, nursing director, and MSICU recruitment and retention council members collaborated on developing targeted initiatives to address focus group data and implement it over the course of several months.

Limitations

There are limitations to this quality improvement project. Currently the AACN HWEAT does not have the ability to ensure that participants do not complete the assessment tool multiple times. In spite of best efforts to recruit focus group participants from all disciplines in the MSICU there was no participation from the unit's physician colleagues in any of the focus groups; however, some of them did complete the assessment tool. While the focus group session is described as a "safe place" for participants to share their perceptions and/or experiences, there is the potential for retaliation from other participants in the focus group. Also some participants may feel intimidated by other personnel present especially if they had problems in the past. Finally, some staff may not want to share based on their personal preference.

Conclusion

Assessing the health of the work environment provided an opportunity to explore what was good and what needed to be improved. As this project came to an end with the development of initiatives aimed at addressing concerns brought forward by the MSICU staff, it was evident that this was not the terminal point of the project. Improvement is an ongoing effort and periodic reassessment is necessary to evaluate effectiveness of this project. Moving forward a plan was set in place to reassess the health of the work environment every two years using the HWEAT. The two years period provides sufficient time for initiatives to be fully implemented and to demonstrate whether or not they are sustainable.

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NB: See the following page for Tables and Figure.

Table 1: The Standards

AACN Evidence-Based Standards that define the Health of the Work Environment
Skilled Communication: "Nurses [and their care-giving partners] must be as proficient in communication skills as they are in clinical skills" (11).
True Collaboration: "Nurses [and their care-giving partners] must be relentless in pursuing and fostering true collaboration" (11).
Effective Decision Making: "Nurses [and their care-giving partners] must be valued and committed partners in making policy, directing and evaluating clinical care and leading organizational operations" (11).
Appropriate Staffing: "Staffing must ensure the effective match between patient needs and nurse competencies" (11).
Meaningful Recognition: "Nurses must be recognized and must recognize others for the value each brings to the work of the organization" (11).
Authentic Leadership: "Nurse Leaders must fully embrace the imperative of a healthy work environment, authentically live it and engage others in its achievement" (11).

AACN Standards for Establishing and Maintaining a Healthy Work Environment (11).

Table 2: HWE Standard Specific Scores and Common Themes/Current Experience

HWE Standard	First level codes
Skilled Communication Communication that is professional, effective, and efficient Aggregate score: 3.85	Email communication was considered to be used too frequently, and was found to be difficult to interpret. The content often was perceived to be negative. Weekly electronic updates often look "the same". Staff members mentioned that it was difficult to identify new or important information. Verbal communication among nursing staff related to real-time patient care issues could improve. Staff members perceived limited regular use of SBAR, assertion, and closed-loop techniques. Some staff members were not sure if these techniques would improve communication.
True Collaboration Collaboration within discipline and with other disciplines Aggregate score: 3.81	Overall, staff members felt collaboration among the health care team was very healthy and respectful. Staff members verbalized occasions where collaboration was attending-driven. Staff members working on the night shift verbalized that frequently collaboration among the nursing staff was dependent on the individuals working.

Effective Decision Making Team members share accountability for effective decision making Aggregate score: 3.98	Overall, staff members felt the decision making in the MSICU was very good. Staff verbalized the need for more contact with leadership and less electronic communication. This was especially true for the night staff.
Appropriate Staffing Team members should be aligned with patient needs Aggregate score: 3.61	Overall, staff members perceive a great deal of confusion regarding adequate staffing. The issue of budget cuts to staffing is very stressful to staff. Staff members feel that there have been mixed messages sent, with constant requests for overtime despite the need to reduce staffing numbers. Staff members are very conflicted and aware of the high sick call rate for the unit. Vacation time is felt to be a major issue on unit. Many staff members have been denied vacation or time off requests in this last year.
Meaningful Recognition Consistent recognition of the value of team members Aggregate score: 3.62	Staff members interpreted recognition in many ways. This included the need for time off, the need for support of certification, and the need for leadership to recognize the stress of caring for the patient population. Staff members noted formal recognition seems variable. The issue of certification regarding recognition was perceived to be very stressful to staff. Staff focused on the issue of vacation requests as an example of inadequate recognition. Staff also commented on the limited motivation of achieving clinical recognition through the staff I, II, and III ladder system. This was based on the required time commitment for level II and III and reduced financial differential.
Authentic Leadership Leadership that embraces the imperatives of the healthy work environment and engages others in its achievement Aggregate score: 3.82	The overall leadership was perceived by staff to be very good. The staff verbalized the need for more contact with leadership and less electronic communication. This was especially true for the night staff.

Table 3. Initiatives and Actions to Address Staff Concerns about the Health of the Work Environment

Standard	Concerns	Initiatives	Action
Skilled Communication	Less electronic communication – too many emails, important ones get lost	Online MSICU Website	New online MSICU website available outside of the hospital
	ecommunication difficult to interpret – perceived as negative	MSICU Guidelines around scheduling, vacations, sick calls	Documented guidelines on the MSICU website for all to reference
	Weekly updates all look the same, difficult to detect new ones	MSICU Top 5 weekly updates	New weekly update, top 5 items, short and concise
	Description of recognition varied widely among staff from tangible to intangible acknowledgement	Social outing to recognize everyone's contribution to caring for complex, acutely ill patients	Staff social - Harbor Cruise
Meaningful Recognition	Formal recognition seemed variable	Poster with Daisy, Employee of the Month and ECES award information displayed on unit	Regular encouragement of staff to use hospital recognition system and give prominent display of those who received awards
	Overall stress about adequacy of staffing and use of personnel	Quarterly communications from nurse director regarding staffing issues	Nurse Director address staffing on a quarterly basis with communication to staff
Appropriate Staffing Appropriate Staffing Continued	Perceived mixed messages between staff and leadership with constant requests for overtime despite budget cuts and messaging the need to reduce staffing numbers	Over Time Incentive	Staff who agreed to work x number of shifts in defined time will receive cash bonus
	Staff conflicted about high sick call rate and its use to obtain time off	No Sick Call Incentive	Staff who do not call out sick for a defined 6 month period will be able to use 12 hours ETS in the next 6 month period as sacred day, this is in addition to scheduled vacation time

	Confusion regarding adequate staffing and its relation to budget cuts	Traveler Nurses	Travelers have been hired to help staffing leaves of absence and vacations
	Staffing mix and acuity of patient care needs	Reinforce Chain of Command and notification of nurse Director for difficult assignments	Nurse Director will communicate to staff to use CRN, Charge RN as well as notify Nurse Director either by phone, page, or email so that she can review assignment and situation in real time or as soon as possible

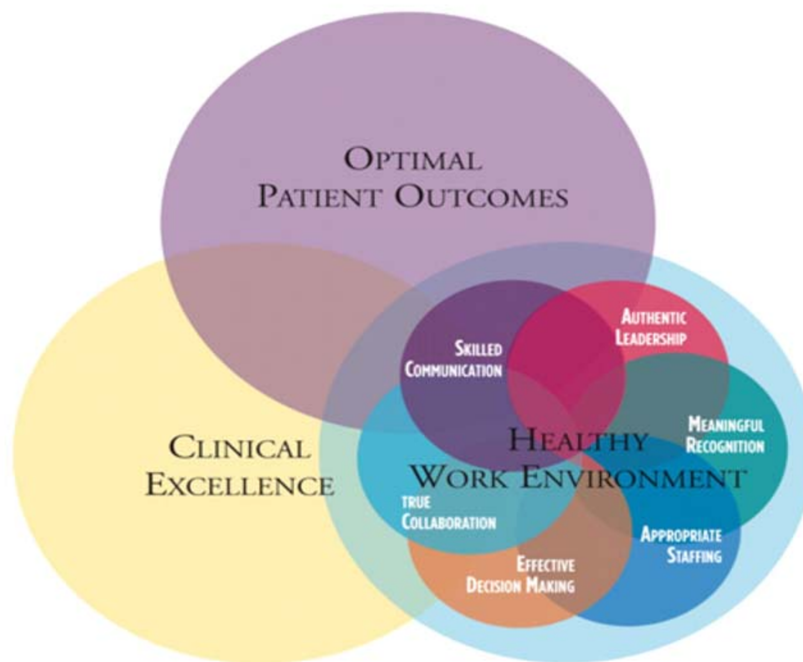

Figure 1. AACN's Interdependence of healthy work environment, clinical excellence, and optimal patient outcomes (11).

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or contact Franco Carnevale (moderator) at
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Instructions for Authors

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Pediatric Intensive Care Nursing is an international journal which promotes excellence in clinical practice, research, education and management, and provides a forum for the exchange of knowledge and ideas. The editors welcome articles on any topic of interest to pediatric or neonatal intensive and critical care nurses.

Manuscripts submitted to *Pediatric Intensive Care Nursing* must not have been published previously (except in the form of an abstract or as part of a published lecture or academic thesis), and must not be concurrently under consideration by any other journal. Once accepted for publication, manuscripts become copyright to *Pediatric Intensive Care Nursing* and may not be reproduced without permission from the editors.

Format
Manuscripts must be written in English; either American or British spelling may be used but must be consistent throughout. Manuscripts should be typed double-spaced, using Arial or Times New Roman font in at least 11-point, with margins of at least 2 cm or 1 inch. Number pages consecutively beginning with the title page. The preferred length for research, clinical and review papers is 1000-2500 words, excluding references. Submissions to Spotlight on PICU should not exceed 1500 words. The sections of the manuscript should be in the following order.

Title page
- Title should be concise and informative, and typed in bold capitals.
- Names (first name, initial(s) and family names) of authors in the order in which they are to appear. Include a maximum of 4 qualifications for each author
- Institutional affiliation(s) of each author
- Address, telephone and fax numbers and email address of corresponding author

Abstract
An abstract not exceeding 250 words is required for all submissions except those for Spotlight on PICU. For research studies, the abstract should be structured under the following headings: Background, Methodology, Results (or Findings), Conclusions.

Body of text
Use headings to structure the paper. The type of paper will determine the headings, eg for research papers the main headings will be Introduction, Background, Methodology/Methods, Results/Findings, Discussion, Conclusion. Up to 2 levels of headings may be used. Papers reporting research conducted in humans or animals should include a statement that the study was approved by the relevant body or bodies.

References
The list of references should only include works that are cited in the text and that have been published or accepted for publication. References such as “personal communications” or “unpublished data” cannot be included in the reference list, but can be mentioned in the text in parentheses.

References should start on a separate page following the text. They must be numbered in the order in which they appear in the text and listed in numerical order. In the text, designate reference numbers on the line (i.e., in normal text, not superscript) in parentheses. If using Endnote or Reference Manager, references should be formatted using the style *Intensive Care Medicine*.

Examples

Journal article: Tan AM, Gomez JM, Mathews J, Williams M, Paratz J, Rajadurai VS (2005) Closed versus partially ventilated endotracheal suction in extremely preterm neonates: physiologic consequences. Intensive and Critical Care Nursing 21:234-242

Journal article published on-line ahead of print: Duff JP, Rosychuk RJ, Joffe AR (2007) The safety and efficacy of sustained inflations as a lung recruitment maneuver in pediatric intensive care unit patients. Intensive Care Medicine 10.1007/s00134-007-0764-2

Book: McHaffie H (2001) Crucial decisions at the beginning of life: parents' experiences of treatment withdrawal from infants Radcliffe Medical Press, Abingdon

Book chapter: Cordery C (1995) Doing more with less: nursing and the politics of economic rationalism in the 1990s. In: Gray G, Pratt, R. (ed) Issues in Australian Nursing 4. Churchill Livingstone, Melbourne, p 355-374

Conference paper: Copnell B, Tingay DG, Kiraly NJ, Sourial M, Gordon MJ, Mills JF, Morley CJ, Dargaville PA Comparison of the effectiveness of open and closed endotracheal suction. Procedings of the Pediatric Academic Societies' Annual Meeting, San Francisco, May 2006. E-PAS2006:2059:5560.2342.

Electronic source: National Institutes of Health (2004) Program announcement: Improving care for dying children and their families. http://grants1.nih.gov/grants/guide/pa-files/PA-04-057.html Accessed: July 20, 2004

Figures and Tables

All figures (graphs, photographs, diagrams) and tables should be numbered consecutively and cited in the text. Each figure and table should be on a separate page at the end of the manuscript. Tables should have a title above and, if needed, a legend at the bottom explaining any abbreviations used.

Figure legends should be typed on a separate page. They should be concise but self-sufficient explanations of the illustrations.

Illustrations should be supplied in electronic format.

Written permission must be obtained to reproduce illustrations and tables that have appeared elsewhere, even if the work of the author(s). Borrowed material should be acknowledged in the legends. Identifiable clinical photographs must be accompanied by written permission from the persons in the photograph, or parent or guardian for children.

Manuscript submission

Electronic submission is required. Manuscripts should be saved as a Word document and emailed to the editor Franco Carnevale (franco.carnevale@mcgill.ca).

Submissions to Spotlight on PICU can be emailed directly to the column editor, Dr Bev Copnell, at Beverley.Copnell@med.monash.edu.au