Position Paper

Healing Hospitals: Patient and Healthcare Communities

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Healthcare Excellence Canada

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CHLNet
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Foreword

I am pleased to endorse the work done by Doran and his team to demonstrate the practical steps a leader can do to operationalize 'relationship-centered' leadership. As a former leader with the Emerging Health Leaders of Canada, as a member of the Canadian Health Leadership Network (where I had the privilege of working with him) Doran has worked hard to champion 'evidence-informed leadership' of which this study is an excellent example. While many of us talk about how to engage our workforce, few of us have changed our practice to achieve it. This study is an example of how the principles of relationship-centered leadership can be operationalized in a real work setting; and how when they are, it has a significant positive impact on the attitudes, beliefs, and commitment of clinicians and staff.

One of the most interesting conundrums that the study highlights is the dynamic associated with a team bringing those evidence-informed leadership practices (for example, the Engage Others domain of the LEADS framework) into an existing organizational context such as this case study describes. This dynamic includes having the research team modeling the behaviours associated with relationship-centered leadership, and the resulting challenge that exists—when the study comes to an end—for remaining leaders and staff to sustain beyond the study's timeframe. Similarly, it is important that readers of the study understand that its success is to a great extent context-specific; i.e., the specific dynamics that created improvements in work life experience and engagement may not be applicable to other different contexts. The described processes used to measure, engage and arrive at which dynamics are drivers of change may be more generalizable. Only the leader in the 'other' context can judge whether the conditions leading to success in this study are replicable in their own environment.

Regardless, it is exceptionally heartening to see that when a group of leaders deliberately set out to practice what the research tells us leaders need to do to engage their workforce, it works! As demonstrated in this study with valid and reliable evidence. Given that scenario, it also supports the research itself; and provides a real-life example of how it can be done. In today's world—with the fallout from COVID—with 'quiet' quitting, and people leaving the health workforce in droves, it is even more important that the ideas and practices highlighted in this paper become more the norm in healthcare rather than the exception. We owe it to the patients, families, and communities we serve, to be able to engaged by an energetic and motivated health care team. Relationship-centered leadership—as practiced in this study—shows that it can be done.

Yours sincerely

Graham Dickson
CEO, LEADS Global

Highlights

Key takeaways	Larger political forces and news/organization changes did not have a significant effect on staff feeling valued
	Negativity quickly erases positive gains
	Proactive inclusion in care i.e. what matters to you conversations and bedside shift reporting can dramatically impact patient experience

10-second Read

Integrated Leadership and Engagement: Relationship-centered leadership transforms patient and staff experiences. Leaders who actively cocreate with their teams foster a positive work environment, significantly boosting morale and care quality.

1-minute Read

Effective Interventions: Local context interventions co-created with patients and staff increased patients' sense of being heard and involved in their care, improving these metrics by 32% and 28%, respectively. Simultaneously, staff feelings of being valued by leadership saw a dramatic drop in negative sentiments from 40% to 2% over 3 months.

QI processes generalizability: Real-time analytics and continuous feedback loops ensure positive changes are responsive.

Actionable Strategies: Engaging in regular interactions through many open communication channels is crucial. These strategies ensure everyone feels heard and valued, driving continuous improvement in care quality and workplace satisfaction.

Context-Specific Success: Success depends on the specific organizational context and the leadership's ability to adapt evidence-based practices to local needs.

Collaborative Leadership: Engaging staff in decision-making processes enhances their sense of value and motivation.

Sustainability: Embed successful and evidence informed practices into standard operating procedures, provide ongoing professional development, and implement dynamic feedback systems for long-term success. Develop leaders with knowledge in data analytics, change management, quality improvement as well as clinical knowledge. These steps ensure continuous improvement in patient care and staff engagement, creating a thriving, supportive healthcare environment.

Executive Summary

Summary of Findings:

We were able to improve the patient experience of feeling listened to by 22% over three months and patients' feelings of being involved in their care by 47% over the same period. For staff feelings of being negatively valued by leadership, we saw a reduction of 38%, from 40% to 2%, over 12 weeks. Although starting from a fortuitous(?) high point, we also saw feelings of being negatively valued decrease from 40% to 3% over the same timeframe. Further analytics show that negative leadership appears to erase any positive gains, and the closer the leadership is to the frontline, the more significant the effect of this negativity can be.

Following our journey, we also posit that you cannot separate patient experience from staff experience, as each hospital, unit, program, and team are a community with symbiotic relationships between providers, patients, and families. Collaborative, co-creating, and inclusive leadership are key to increasing staff engagement. Larger political forces and news/organizational changes did not have as significant an effect on staff feeling valued compared to local leadership. Negative leadership and leadership decisions without engagement have a significant effect on staff feeling valued by leadership. Positively perceived leadership actions did not have a significant effect. Proactive inclusion in care, i.e., 'What Matters to You' conversations and bedside shift reporting, can dramatically impact the patient experience.

Key takeaways	Larger political forces and news/organization changes did not have a significant effect on staff feeling valued
	Negativity quickly erases positive gains
	Proactive inclusion in care i.e. what matters to you conversations and bedside shift reporting can dramatically impact patient experience

Most importantly, as close to real time as possible, analytics and a continuous quality improvement lens when implemented in conjunction with co-creation with staff can also lead to significant improvements in both patient experience and staff engagement.

Our journey is outlined below:

Pre-Implementation:

1. Look to what benchmarks are available for statistical analysis.
2. Map the patient experience.
3. Initiate detailed leadership rounding for provider and patient.
4. Analyze and understand experience drivers for both patient and provider.

Implementation:

5. Host initial townhalls to plan improvements collaboratively.
6. Monitor metrics in real-time across shifts.
7. Use varied communication methods for continuous feedback and adjustments.
8. Develop an analytics-based model using linear regression to identify key impacts on experiences.
9. Co-create a narrative of the journey with staff.
10. Use story and insights to begin next iteration.

Patient Experience:

1st Change Idea:

Daily "What Matters to You" conversations – Daily checkins to connect with patients and what matters to them.

2nd Change Idea:

Bedside Shift Report – Moving shift to shift healthcare professional reporting to be inclusive of the patient.

3rd Change Idea:

Release Time to Care - Staff driven initiative to decrease nursing workload with the purpose to free up time for quality patient care.

Staff Engagement:

1st Change Idea:

Co-designed ideas to reduce workload that are generated from staff ideas and facilitated by leadership for continuous quality improvement.

2nd Change Idea:

Implement a feeling valued by leadership metric across shifts.

3rd Change Idea:

Build community through staff selected events.

Current Scaling Highlights:

Alberta Health Services Medical Affairs, Community Engagement and Communications has featured our work in wide reaching communiques through AHS internal and external web pages as well as social media.

The Northern Alberta Chapter of the Canadian College of Health Leaders has developed a community of practice for C-suite and executives which is to be kicked off with a webinar based on this work for the topic of Healthcare Human Resources (HHR).

AHS Provincial Patient Safety and Quality Education filmed an 8-unit course on the importance of and how to implement QI into healthcare for managers. This course will be provided to all AHS managers and is based in large part on the work we're doing and has an aim of being a training course for all AHS managers.

The Glenrose Hospital is implementing this project iteratively unit by unit and sharing learnings from each scalable prototype forward to the next.

Canadian Health Leaders Network is distributing this paper out to its 40+ partners including the Canadian Institute for Health Information, Alberta Health Services, Vancouver Island Health Authority, Health Prince Edward Island, Health Canada, Canada Health Infoway, Canadian Medical Association, Canadian Nurses association among many others.

Introduction

With Covid 19 now endemic the previous faults in our healthcare systems have been exacerbated. Staff burnout, psychological safety and staff wellness have been stretched to unhealthy levels (Grimes et al., 2022) and patient experience has declined to the point where basic necessities such as hospital cleanliness and being heard are no longer taken for granted (Elliott et al., 2023).

This work aimed to find the intersection between patient experience and staff engagement and develop a process to improve and sustain both. Inspired by the IHI white paper 'Joy in the Workplace' (Perlo et al., 2017), the Canadian Health Leadership Network's (CHLNet) work on leadership during and post-COVID, and our 18-month Executive Fellowship with Healthcare Excellence Canada's EXTRA program, we sought to implement best-in-class leadership and quality improvement knowledge. Our goal was to develop a usable system that analyzes and enhances both patient experience and staff engagement.

What follows is a description of the process, an account of our journey, and the thoughts and ideas it has sparked. We hope this will inspire other local projects, encourage further discussion, and drive innovation in the most crucial areas of healthcare today: healing the healthcare provider and patient experience together. Now, more than ever, compassion is essential.

Process

> "If we can spark just a little bit of curiosity (no one has to change) but just a little bit of curiosity into how it is that we can deepen our relationships without compromising our values. That we can be in systems that are – we can see that they're not where we want them to be yet. We can see the power challenges, we can see the inequities, we can see the abuses, and we can be non-complacent. We can be strong and we can be absolutely fierce in the ways that we believe in certain ways forward and do so in a kind, gentle way that we lean on each other, where we need each other and where we practice non-violent resilience. So it's not about getting tougher and harder and closing that heart but we stay open and we bring our teachings about love one another, care one another and we encourage each other. "

Heather Atleo speaking on Compassionate Leadership Oct. 12 2022 BC Patient and Safety Quality summit Plenary

Pre-implementation: Leadership implemented 'Leader Rounding.' This involves management and senior leadership having day-to-day conversations with patients and staff about how to improve the unit, for six months prior. This leader rounding included a dashboard and record, which provided self-reflective leadership opportunities as well as information on how often the 'communication loop' was closed on issues. It also included accountability meetings for leaders within their reporting structure, as well as feedback to patients and staff on solutions to issues. It is a pre-step to co-creative and collaborative leadership.

Building a representative steering committee inclusive of patient and Indigenous voices, as well as frontline staff and union representation we formed a group that due to the urgency of the initiative we named a task force. Out of the task force, two ad-hoc committees were formed to identify the drivers that would most improve patient experience and staff engagement.

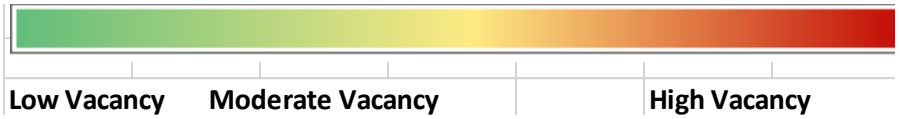
INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
The Glenrose	3D & 4C Team Patients UNA	Patient Experience Talent Development HR Volunteer Services Patients Family	Staff Champions Charge Nurses	Managers Directors

Implementation: Using patient experience surveys (Appendix A), patient journey maps (Appendix B), anonymous Gallup Poll survey results, and thematic analysis of the qualitative portion of a Gallup Poll, the patient committee and the staff committee designed diagrams identifying what they believed to be the most effective drivers to influence change. When we had this information, it was presented back to the respective populations, patients and staff, for feedback and any changes they recommended.

It was noted by the patient experience committee, that being listened to and having influence over care decisions were the main drivers of patient experience. The idea of 'What Matters to You' (Leitch, 2016) conversations and wrap-around bedside shift reporting for nurses were the respective solutions. Bedside shift reporting involved moving the shift handover report, which typically takes place in a side room on a nursing unit, and bringing the conversation into the patient's room, inclusive of the patient. It was decided that 15:00 handover was the best time for this conversation, as the other shift change times were either too early (07:00) or too late (23:00). Both the early morning and late evening times were declined by patients who would rather be asleep. Staff identified that they felt 15:00 would not be onerous or add too much to their workload if the report occurred once daily. It was important that we were accepting of influence from the staff for co-design and collaboration. During implementation, there was only one instance where this report went over 15 minutes. However, this unit had the same amount of staff and teams between their day shift and evening shift. On another unit that had attempted to implement bedside shift reporting, they had to adjust as they had asymmetrical amounts of staff on their teams from day to evening.

On the staff side building a sense of community or “Joy in the workplace”, maintaining staffing levels and workload were chosen as drivers to effect positive change in feeling valued. Leadership used a robust system of hiring we called continuous quality hiring that involved measuring targets and continuously working on hiring weekly if not daily. This was to ensure that vacancies were low and ensure that staffing levels were at baseline or higher for every shift. The following illustrates the lack of vacancies the year before the project up until the last month of the project Dec 2023.

3D	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
RN	2	2	2	1	1	0	0	0	1	3	2	0	0	1	0	0	1
LPN	1	0	2	1	1	1	0	0	0	1	1	1	1	0	0	1	0
HCA	0	0	1	1	1	0	0	0	0	0	0	0	0	0	1	1	0



As workload was deemed to be subjective, we decided to run weekly PDSA cycles in collaboration with nursing staff to address workload issues as they arose. The staff decided that community events *such as* staff-led potlucks (COVID rules had just changed enough to allow in-person events again) would provide a needed sense of community, and th*ree* were implemented.

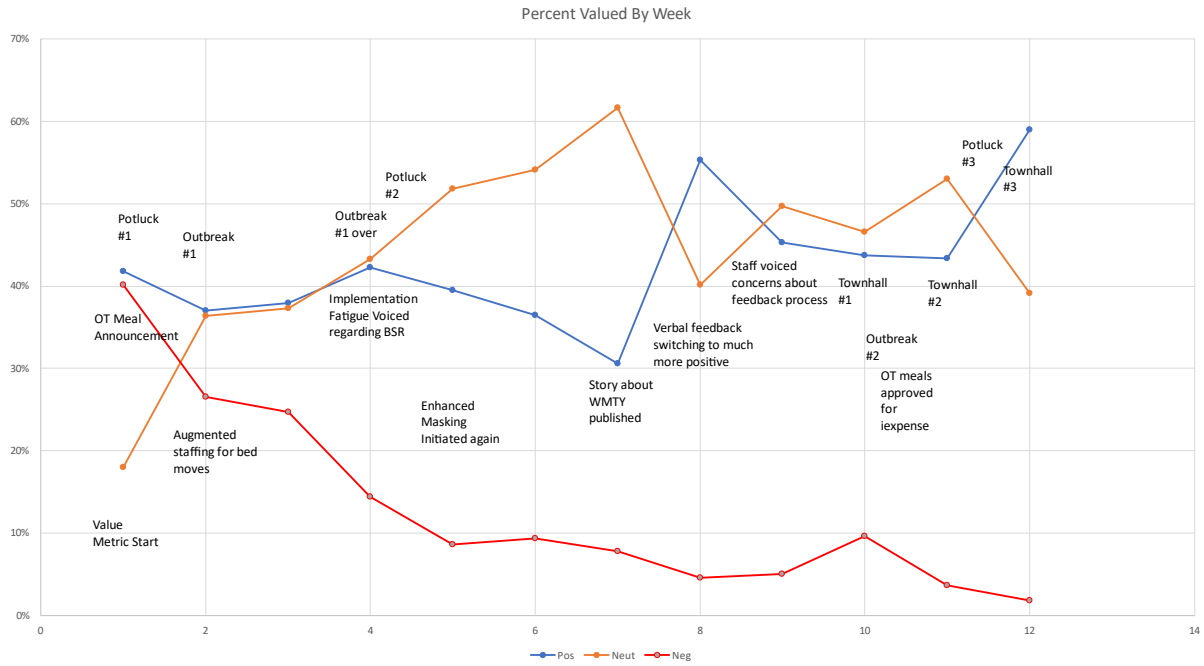
Measurements: We had implemented patient experience surveys (Appendix A). Using a 5-point Likert scale, much of our focus was on questions 1 and 2: 'Did you feel involved in decisions about your care?' and 'Do you feel listened to/heard by your healthcare team?' These are from a standard questionnaire implemented across much of Alberta Health Services and were selected as drivers because they had the lowest scores in our baseline data. However, this is also in keeping with Kemp et al.'s Alberta-specific research (2022), which states that patient experience is highly correlated with nurse communication, and Wong et al.'s work (2021), as it targets staff-patient communication.

For staff engagement, we turned to the Institute for Health Improvement's Framework for Improving Joy in the Workplace for suggestions (IHI, 2017). IHI states that they use a monthly pulse survey and recommend real-time measures for improving 'Joy.' Our baseline staff metric was a Gallup pulse survey that asked whether staff felt that leadership cared about their well-being on a 5-point Likert scale, which was then converted to a reading of 2.86. We had set an overarching goal of improving this by 1.0 to 3.86. For our real-time measure, we picked a 'feeling valued by leadership' metric (Appendix C). In memos sent to staff, we stated that leadership was representative of the patient care manager, who is the frontline manager. It had been brought up in staff meetings that it was difficult to interpret who 'leadership' represented in the Gallup poll, so we wanted to be clear. We picked 'feeling valued' as our metric because the committee felt it was a simpler representation of 'Do you feel leadership cares about your well-being?' Staff were very diligent, and we captured a positive, neutral, or negative value from all staff who wanted to participate across shifts. Initially, we had a happy/neutral/sad faces system (Appendix C), but there was feedback that staff felt it was not professional enough, so we switched to a checkmark system after 2 months. See the faces system in Appendix C. We ended up with 243 data points. We chose to include a neutral value because it was felt that polarizing only positive and negative would lead to too much of a binary choice and potentially foster toxic positivity expectations on the shift. We ended up with 243 data points, which we converted to percentages of the whole for each shift so we could compare shift to shift, as there are different staffing levels from days to evenings *to* nights.

Analytics and Discussion: Staff Engagement

Run Chart:

Overview: Within this work, as part of co-creation and to create meaningful, transparent data, we designed a run chart that tracked weekly percentage rates of each of the 'feeling valued' metric values. This was shared with the team to co-create a story together. While collecting the data, conversations with the unit, mainly through the charge nurse's voice, were captured for qualitative feedback and to tell the story of the experience. We also input key events that happened during this time. For validation, we presented this run chart, as well as the notes around it, to the staff and accepted any and all changes they suggested for the qualitative story.



Story:

Weeks 1-4: During the first week, we ran into our first hiccup with a change in practice around meals that are provided to staff when they stay more than 4 hours over an 8-hour shift, where they are to be provided with a meal according to union rules. A director of a different area had changed the process with no consultation with staff, and a memo was sent out that abruptly changed the meal process from having a reduced choice between the cafeteria and multiple food venues at another local hospital to having a selection of high sodium soup, chips, and frozen meals from a fridge in the admin suite. It did not help matters that many of the frozen meals were delayed in arriving, thus offering an even more restricted menu. Staff identified

that they felt very devalued by leadership through not being consulted and through the poor food options. We have developed a case study (Case Study 1) to further analyze this situation and share our learnings following the appendices.

The staff this week selected to PDSA a solution to their main concern with workload, which was related to the overwhelming amounts of bed moves. They had faced a series of 6 bed moves in one shift and described feeling overwhelmed and that the shift felt chaotic. We discussed that if we know the previous day that 6 or more bed moves were going to occur, we would support with extra staff for half a shift. Shortly after these bed challenges, an outbreak of COVID occurred as it was the beginning of the COVID/Flu season. There were to be 24 bed moves in the following shift. We were able to find an extra staff to help with bed moves for 4 hours, and whereas staff previously described 6 bed moves as 'overwhelming' and 'chaotic,' this set of moves was described as 'old hat,' 'We work together well as a team,' and 'smooth.' It is interesting to note, and something else to explore in detail, that when appropriate labor resources are in place, there seems to be a positive effect on team engagement and possibly subsequent wellness that ends up being attributed to the team's mastery over their work. This situation is detailed in Case Study 2, following the appendices.

Week 4-8: Weeks 4-8 were characterized by staff-voiced implementation fatigue. During this time, leadership and the clinical nurse educator had to put in increased sustainment effort to keep the bedside shift report going. Leadership presence was significantly increased during this month, essentially trying to input the excess energy to carry the project through to the next month. Positive sentiment was slowly dropping, but negative sentiment was also dropping quite significantly. We had begun to receive some further attention for our work, and a story was published across the health authority featuring the work the team was doing. Following this story, it appears as if neutral sentiment turned to positive, and negative sentiment continued to decline.

Week 8-12: As we rounded out the second month and began the third month of our project, the voices that were more opposed to the project felt as if they were not heard and began to speak up, expressing this. Although our numbers were showing a dramatic shift in improving regard for leadership since the beginning of the project, I suspect that we were beginning to hear from the few percent who were still identifying as feeling negatively valued. We wanted to ensure that we were being as inclusive as possible to all points of view, so we started a series of three town halls over three weeks, where the main purpose was to listen and accept influence. During these town halls, we took down concerns and ideas and implemented as quickly as possible what was implementable.

It was identified by some team members during this time that they wanted a way to anonymously explain why they were identifying that they felt negatively valued by leadership. During this week, there were still occasional shifts where one or two negative sentiments were

recorded, but the number had reduced dramatically. We identified a way that we could capture the voices that did not have enough psychological safety to speak up as of yet. We repurposed an anonymous drop box whereby staff could choose to write the date and leave an anonymous note explaining why they had felt negatively valued or leave a suggestion or idea to be acted upon. For the final three weeks, we reduced the feeling negatively valued further, and our feeling positive stabilized and then increased, while neutral dropped as well. It appears we gained positive value both from the neutrals as well as from the negatives. It is also noteworthy that there appear to be different strategies needed to move the positive, negative, and/or neutral sentiments.

Discussion and Management Strategies from Run Chart Analysis:

Initial Challenges and Responses: The run chart analysis for the period under review highlights several critical incidents and management responses, beginning with a controversial change in meal provisions for staff. In the first four weeks, the sudden shift from diverse meal options to limited and unsatisfactory choices like high-sodium soup and frozen meals resulted in significant staff dissatisfaction. This scenario underscores the importance of leadership transparency and consultation with staff, especially regarding changes that directly affect their welfare. The negative impact on staff morale was palpable, as they felt devalued and overlooked by leadership, leading to the development of Case Study 1 to delve deeper into the mishandling and subsequent learnings.

Addressing Workload Concerns: Simultaneously, the staff faced an overwhelming workload due to excessive bed moves, which they initially described as chaotic. The decision to introduce extra staffing in anticipation of high bed move volumes during shifts proved effective, transforming the staff's experience from overwhelming to manageable and even smooth. This transition highlights the critical role of adequate staffing in managing workload and enhancing team dynamics and morale. The positive shift in the staff's descriptions of their work environment—from 'overwhelming' to phrases like 'old hat' and 'smooth'—suggests that appropriate labor resources not only improve operational efficiency but also foster a sense of teamwork and competency. We developed Case Study 2 to delve deeper into these learnings.

Sustaining Efforts and Overcoming Implementation Fatigue: Weeks 4-8 were marked by implementation fatigue among staff, a common challenge in prolonged projects. Leadership responded by enhancing their presence and support, attempting to inject the necessary energy to maintain momentum. This phase also saw public recognition of the team's efforts, which appeared to shift general sentiments from neutral or negative to more positive, illustrating the power of recognition and positive reinforcement in sustaining project engagement and morale.

Inclusivity and Addressing Negative Sentiments: As the project progressed into weeks 8-12, a minority of voices expressing dissatisfaction became more evident. Leadership took proactive

steps by organizing town halls focused on listening and integrating feedback, highlighting the importance of inclusivity in change management. The introduction of an anonymous feedback mechanism allowed those feeling undervalued a safe space to express their concerns, demonstrating a strategic approach to enhancing psychological safety and trust within the team.

Diversifying Engagement Strategies to Address Varied Staff Sentiments: The analysis further suggests that effectively managing staff sentiments and engagement requires a differentiated approach tailored to address positive, negative, and neutral attitudes distinctly. The initial blanket changes and subsequent adjustments revealed that a single strategy might not be universally effective across different emotional responses and individual experiences within the workforce. For instance, while increased leadership presence and recognition positively influenced neutral and slightly negative sentiments, more deeply rooted negative feelings required direct and safe channels for expression, such as the anonymous feedback mechanism.

This insight underscores the importance of a nuanced engagement strategy that recognizes and respects the spectrum of staff emotions and experiences. Implementing varied methods to specifically target different sentiment groups can lead to more effective management outcomes. For example, fostering positive sentiments might involve celebrating achievements and offering growth opportunities, while addressing negatives may require more focused interventions like enhanced communication channels or building trust that decisions will be collaborative with leadership rather than unilateral. Neutral sentiments could be engaged through regular check-ins and inclusion in decision-making processes to prevent potential disengagement.

Overall, this tailored approach can help in moving each group toward a more positive outlook, contributing to a more harmonious and productive workplace environment. Of note, when we turned towards voices of dissenting opinion rather than away, it appeared to significantly reduce the remaining negative sentiment and also appears to have flipped a significant amount of the negative sentiment to positive in the final week.

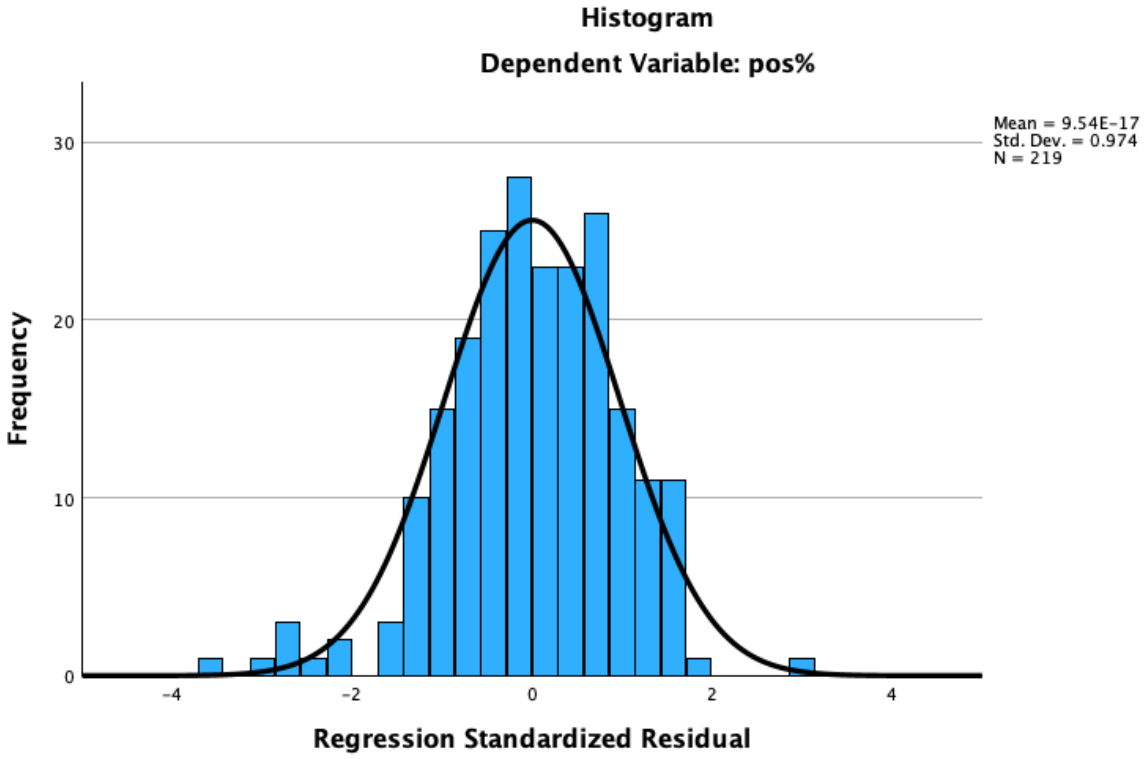
Key takeaways	
	Addressing workload concerns is the first step towards improving overall staff engagement
	For project sustainability leadership must increase energy until there is the opportunity for a project to be understood and viewed favorably
	Turn towards voices of dissent rather than away increase the demonstration of listening and integrating feedback to be dramatically visible and purposeful
	There needs to be nuanced approaches to diversified staff segments

Conclusion and Future Directions: The analysis of this period through the story and the run chart provides valuable insights into the dynamic interplay between staff engagement, management strategies, and project outcomes. It highlights the necessity of responsive and inclusive leadership practices that adapt to staff needs and changing circumstances. The positive outcomes from adjusted strategies suggest paths for future improvements, especially in fostering an environment where all team members feel heard and valued. Continuing to explore the impact of adequate staffing on team dynamics and the long-term effects of sustained management engagement could provide further valuable learnings for similar future initiatives.

Multiple Linear Regression:

Overview: In our pursuit to better understand the dynamics of positive workplace sentiment, we embarked on constructing a multiple linear regression model. This was particularly relevant for analyzing what was statistically significant, as the project occurred during a period of significant announced changes within the health authority, which included the segmentation of a unified health authority into four distinct subsections (GOA, 2023). Additionally, the context was further complicated by two COVID-19 outbreaks on the unit, a policy reintroduction mandating masks in all hospital areas for staff, and other wellness markers such as sick time and/or overtime use on the unit. These developments presented a unique opportunity to examine a plethora of influencing factors. Our model succeeded in explaining approximately 40% of the observed variance in sentiment and, perhaps more importantly, elucidated some counterintuitive knowledge that we will outline below.

Dataset: The dataset for this study comprised 243 data points, collected over three different shifts. Given the variability in staff numbers across these shifts, we adjusted the data representation to percentage representations of positive, neutral, and negative sentiments for comparative purposes. This standardization facilitated the alignment of our data with the assumptions of normality required for effective multiple linear regression analysis.



Not Significant: When designing the model we tried many different methods to account for the larger political announcements around organizational change but were unable to find statistical significance for the announcements when they occurred. Of note there was no qualitative feedback around this news during this time period either. Also of note the positive community events that we had developed did not show statistical significance and nor did the amount of staff working overtime or the amount of daily sick time per shift. This was our first counterintuitive surprise. We wanted to use these values as place holders for units that have larger staffing issues as one area to note on this unit is they never operate with less than baseline nursing. There was only one shift where the unit ran short for a few hours due to a late sick call during the 3 month project period.

Significant: As noted above, the community-building events and other events qualitatively described as positive were not statistically significant. However, the negative effects of locally perceived events and the negative impact that local leadership can have were statistically

significant. It appeared, when looking across weeks, that there was variability from week to week depending on the rotating frontline leadership. These values had been anonymized from an ethical standpoint, so we weren't examining individuals but rather whether leadership in general had a positive or negative statistical effect. It was assumed to be a positive effect, but, as with the events, it was not positively statistically significant; rather, it was negatively statistically significant. Of note, only 40% of frontline leadership had a statistically significant effect in either direction. Local unit COVID-19 outbreaks had a statistically significant negative effect, and night shifts had a statistically significant positive effect. Qualitatively and intuitively, night shifts tend to be better resourced with staff. In total, with an adjusted R-square, this model explains 40% of the variability we observe in feeling valued. Our model summary, ANOVA, and coefficient significance are presented below for those who want to dig into the numbers.

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics			
					R Square Change	F Change	df1	df2
1	.652[a]	.426	.395	.23701147 6745477	.426	13.945	11	207

Model	Change Statistics	Selection Criteria			
	Sig. F Change	Akaike Information Criterion	Amemiya Prediction Criterion	Mallows' Prediction Criterion	Schwarz Bayesian Criterion
1	<.001	-618.907	.641	12.000	-578.238

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	8.617	11	.783	13.945	<.001[b]
	Residual	11.628	207	.056		
	Total	20.245	218			

a. Dependent Variable: pos%

b. Predictors: (Constant), Neg events, CN9, CN3, CN5, CN16, CN7, CN13, CN15, Outbreak, CN12, Night

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			Correlations		
		B	Std. Error	Beta	t	Sig.	Zero-order	Partial	Part
1	(Constant)	.583	.034		17.344	<.001			
	Night	.234	.038	.357	6.192	<.001	.430	.395	.326
	CN3	-.435	.110	-.214	-3.968	<.001	-.183	-.266	-.209
	CN5	-.314	.075	-.235	-4.156	<.001	-.173	-.278	-.219
	CN7	-.266	.063	-.234	-4.214	<.001	-.055	-.281	-.222
	CN9	-.298	.121	-.131	-2.459	.015	-.074	-.168	-.130
	CN12	-.132	.052	-.140	-2.534	.012	.014	-.173	-.133
	CN13	-.201	.066	-.167	-3.038	.003	-.087	-.207	-.160
	CN15	-.373	.067	-.310	-5.568	<.001	-.268	-.361	-.293
	CN16	-.231	.070	-.179	-3.277	.001	-.133	-.222	-.173
	Outbreak	-.085	.034	-.138	-2.492	.014	-.075	-.171	-.131
	Neg events	-.178	.039	-.244	-4.546	<.001	-.163	-.301	-.239

Discussion and Management Strategies from Multiple Linear Regression:

1. *Large Political Events have little effect on local engagement:* Contrary to initial hypotheses, major political announcements, community-building events, and markers of staff workload (overtime and sick time) did not significantly impact positive sentiment of feeling valued by leadership. This was an unexpected finding as such factors are typically presumed to be strong influencers of workplace sentiment. The absence of statistical significance and qualitative feedback suggests that employees might have been more resilient or indifferent to these factors than anticipated.

2. *Negativity quickly erases positive gains:* Positive sentiment was negatively impacted in a statistically significant way by negatively perceived leadership decisions. Interestingly, though leadership has a positive effect overall as shown by the project, leadership's effect was assumed to be positively significant but turned out to be negatively significant. This indicates that poor leadership practices might be more impactful than good ones. This points to a possible negativity bias or a disproportionate effect from negatively perceived information as compared to positively perceived information (Vaish et al. 2008). This might be best managed through a defensive management strategy avoiding negatively perceived interventions as they may erase any positive sentiment gained. It also may be best managed through deeper levels of empowerment and transformational leadership as posited by Avey et. al's work which describes the value of positive psychological capital (hope, efficacy, resilience and optimism) and cynicism (2008). This may explain some of the positive results we saw as leadership cocreated change with staff to have more decision making over their own unit.

3. *Compassion:* Additionally, COVID-19 outbreaks and night shifts were significant predictors. The outbreaks understandably had a negative impact on staff feeling valued, highlighting the stress and uncertainty associated with health crises. Conversely, night shifts had a positive effect on sentiment, potentially due to better staffing ratios or more stable working conditions during these hours. It also could potentially be due to less leadership oversight with a lack of a direct manager on site although this would be true for evening shifts as well and there wasn't the noted effect.

4. *Unknown factors:* With an adjusted R-square of 0.395, the model is robust enough to serve as a reliable basis for understanding key factors but also indicates considerable unexplained variance. This suggests that while we have identified several critical influencers, other unknown factors may also play a significant role in shaping workplace sentiment.

Key takeaways	
	Enhance Frontline Leadership Training: Given the significant impact of leadership styles, investing in leadership development could enhance positive sentiment and mitigate negative impacts
	Negativity bias quickly erases positive gains
	Targeted Support During Outbreaks: Implementing more compassionate leadership styles during could help mitigate their negative impacts on staff.
	When workload is reduced it likely has a statistically significant positive effect

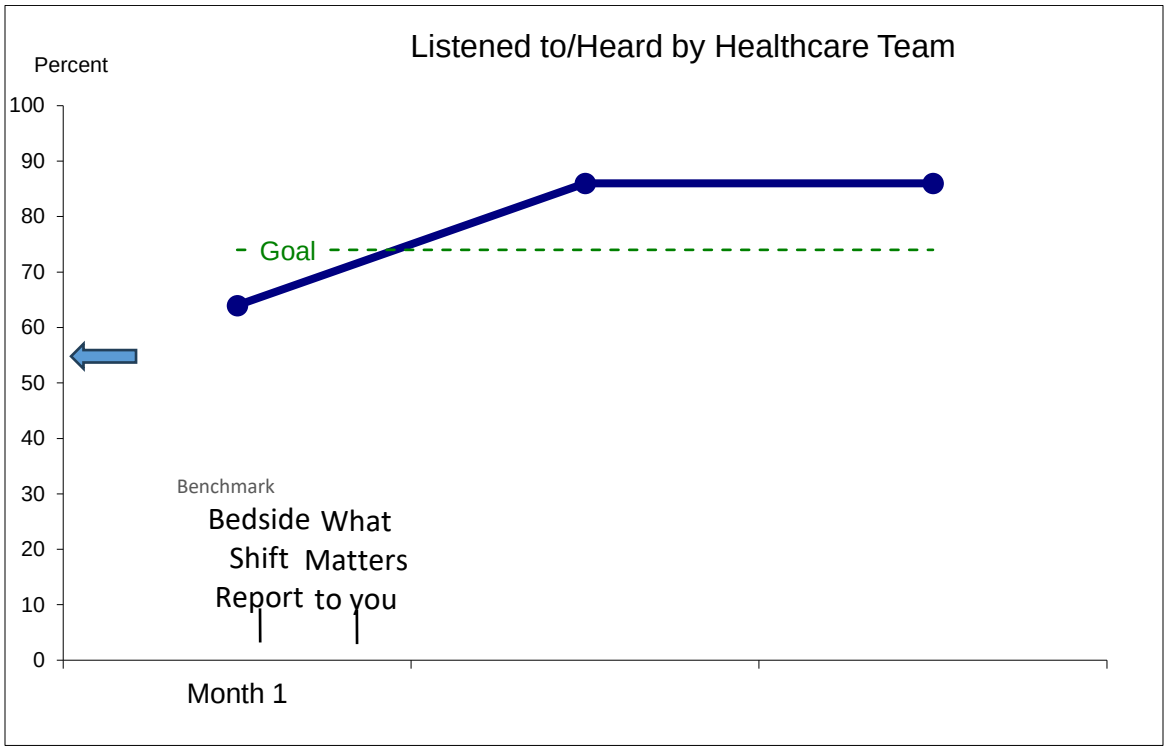
Conclusion and future direction: This analysis underscores the intricate interplay between diverse factors and employee sentiment, shedding light on the key drivers of workplace valuation. By strategically addressing local negatively perceived leadership actions and enhancing support during increased workloads, such as outbreaks, we can mitigate negative sentiment and cultivate a more supportive and positive organizational culture. Moving forward, focusing on these areas will be crucial in truly valuing and uplifting our staff.

Analytics and Discussion: Patient Experience

What Matters to you/Listening*:*

Overview: To accurately measure and improve patient experience, a detailed survey was administered to patients at the time of discharge, utilizing a 5-point Likert scale ranging from "always" to "rarely" (Appendix A). This survey enabled the collection of comprehensive feedback on various aspects of patient care. Specifically, the survey sought to gauge how often patients felt listened to and involved in their care decisions. Through analysis conducted by the patient experience committee, it was identified that the scores for being listened to were among the lowest, establishing it as one of the two main drivers for targeted improvements. The committee decided to focus on the "always" responses for this metric, as these represent the highest standard of care perceived by the patients and are indicative of consistent and

exemplary communication practices. This approach ensures that the interventions aim to elevate patient experiences to the highest possible standard, reflecting a true and sustained improvement in care quality. What follows is a graph and analysis of our results. We are also including a set of themes of topics that were brought up by patients during “What Matters to You” conversations.



Initial Context and Intervention: The initial intervention, "Bedside Shift Report" implemented in Month 1, may have set the groundwork by slightly elevating patient experience from the benchmark of 54%. This intervention involved more direct engagement with patients during shift changes but seemed to have a moderate impact on the overall feeling of being heard.

Main Driver - What Matters to You: The major surge in patient experience scores occurred in Month 2 with the introduction of "What Matters to You" conversations. This approach centers on engaging patients directly to discuss what is most important to them in their care, thereby personalizing the interaction and potentially increasing their trust and satisfaction with their healthcare providers.

The graph shows a sharp rise to 86% in Month 2, significantly surpassing the set goal of 74%. This indicates that patients responded extremely well to having their specific needs and concerns directly addressed by healthcare staff.

Sustained Success: In Month 3, the percentage of patients reporting that they felt listened to remained steady at 86%, indicating that the positive effects of the "What Matters to You" conversations were sustained. This stability suggests that once patient care is aligned more closely with individual patient preferences and concerns, the perceived quality of communication and attentiveness is maintained.

Thematic Qualitative Analysis of "What Matters": Desire for Mobility and Discharge: A significant number of patients expressed a desire to improve their mobility ("being able to walk," "getting out of bed") or mentioned a wish to go home. This is likely to be expected from a rehabilitation unit, however, this theme underscores the importance of physical progress and autonomy to patients, as well as their eagerness to return to normal life, reflecting common goals in patient recovery trajectories.

Comfort and Immediate Needs: Requests such as needing a warm blanket at night, wanting bed made, and needing more ice water point to the basic comfort needs that patients prioritize during their stay. These aspects of care are crucial as they directly affect the patient's comfort and satisfaction with the healthcare service.

Health Management: Many entries focus on specific health management issues such as pain management ("control pain," "leg pain"), managing symptoms of specific conditions (e.g., "manage incontinence," "manage covid symptoms"), and medication management ("eye drops on time"). Addressing these medical needs promptly and effectively is vital for patient care quality and comfort.

Personal Autonomy and Privacy Concerns: Several patients voiced the need for more personal autonomy in their care ("wants to be independent," "manage own care") and concerns about privacy ("no privacy, crowded room"). These concerns highlight the psychological aspects of patient care, where maintaining dignity and respect for personal space significantly affects the overall patient experience.

Communication and Information Needs: Patients also expressed needs related to information and communication, such as wanting to have discussions about their care plans or updates on their condition ("dentist, hair," "discussion about room change"). Effective communication is essential in healthcare as it helps in managing patient expectations and enhances their involvement in the care process.

Social and Emotional Support: Entries like "family visited" or the use of an interpreter indicate the importance of social and emotional support to patients. Family involvement and language services are crucial for patient comfort and can significantly impact their emotional well-being during hospital stays.

Discussion and Management Strategies from What Matters to You/Listening:

Implementation and Impact: The transformative change occurring in Month 2 with the implementation of "What Matters to You" conversations, significantly personalizing the interaction between patients and healthcare providers. This method proved exceptionally effective, with patient experience scores soaring to approximately 80%, well above the target of 74%. The sustained success into Month 3, maintaining steady scores around 80%, confirmed the lasting positive effects of these personalized discussions.

Thematic Qualitative Analysis: The thematic analysis of "What Matters to You" conversations identified several critical areas of patient concern, highlighting diverse needs that impact their healthcare experience. Key themes included the desire for improved mobility or discharge, emphasizing the need for physical progress and autonomy, particularly in rehabilitation settings. Patients also expressed significant needs for basic comforts, such as warm blankets, timely bed making, and access to ice water, which directly influence their satisfaction and perception of care. Health management concerns were also prevalent, with an emphasis on effective pain control and management of symptoms. Issues surrounding personal autonomy and privacy, especially in crowded rooms, were noted as significant to maintaining patient dignity. Additionally, the importance of effective communication was underscored by patients' desires to be kept informed about their care plans and any changes to their health condition, reflecting the necessity of clear and ongoing dialogue between patients and healthcare providers. The role of social and emotional support was also emphasized through patient appreciation for family visits and the need for language services, which play substantial roles in their comfort and emotional well-being during hospital stays.

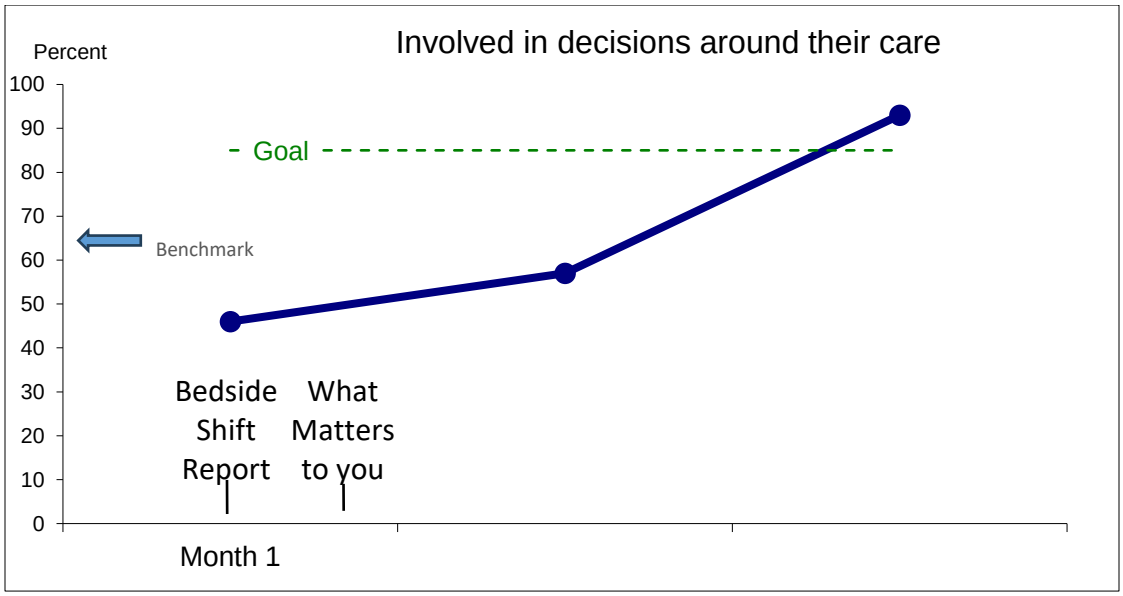
Key takeaways	
	Expand and Standardize Personalized Conversations such as "What matters to you"
	Strengthen Feedback Mechanisms through developing stronger, more effective feedback systems that can capture real-time patient experiences and adjust care practices accordingly
	Increase social and emotional support through increasing family inclusion and communication access

Conclusion and Future Directions: The "What Matters to You" initiative has not only improved how patients feel listened to but has also shifted patient care towards a more personalized and patient-centered approach. For future directions, it is essential to expand and standardize the "What Matters to You" framework across the healthcare system to ensure that all patients benefit from this level of personalized engagement. Additionally, ongoing training and resource enhancement for healthcare providers are critical for the effective implementation of these practices. Investing in infrastructure to improve facility design and privacy and strengthening feedback mechanisms are also recommended to better accommodate patient needs and capture real-time experiences. These measures are aimed at not just meeting but exceeding patient expectations, thereby fostering an environment of excellence in healthcare delivery.

Bedside shift report:

Overview: The other main driver from our patient experience survey was patients feeling involved in decisions about the care. Represented by question one from the survey in Appendix A. The patient experience committee using the patient journey mapping as well as our benchmark results felt that bedside shift report would be a driver to effectively get patient's involved in decisions about their care in a visible way. The committee still focused on responses indicating the highest standard of care—those categorized as "always"—to elevate patient experiences to an exemplary level.

The implementation of "Bedside Shift Report" in the first month marked a strategic effort to boost patient experience from an initial benchmark of 65%. This intervention involved more direct engagement with patients during shift changes, aiming to enhance transparency and patient involvement in immediate care processes.



Graph Analysis and Results: The subsequent analysis reveals a notable improvement in patient experience scores, which reached 93% by the third month, significantly surpassing the initial goal of 85%. This marked improvement highlights the effectiveness of the bedside shift reports in making patients feel more involved in their care, contributing to higher satisfaction and perceived quality of communication.

Discussion and Management Strategies for Bedside Shift *Report:*

The analysis suggests that bedside shift report can be a valuable tool in fostering a sense of involvement in their care from patients. These reports provide a platform for open two way communication, allowing patients to understand and participate in their care actively.

To build on the success of bedside shift reports, standardizing this practice across all hospital units is essential. This ensures that every patient receives consistent and personalized care information, which is crucial for maintaining a uniform quality of care throughout the facility. Enhancing training programs for staff on the effective delivery of these reports is also recommended to deepen their skills in communication, patient engagement, and sensitivity to patient needs, thereby improving the interaction quality and patient satisfaction. Establishing robust feedback systems is critical for gathering patient and staff perceptions on the effectiveness of bedside shift reports, allowing for iterative improvements and adjustments based on real-time data, which can significantly refine care processes and outcomes. Furthermore, integrating technology, such as visual aids or digital summaries that can be reviewed with patients, enhances the clarity and retention of care information. Leveraging the standardized Electronic Medical Record (EMR) system to “turn the monitor towards the patient” when requested can make these interactions more transparent and engaging, empowering patients and fostering a greater sense of involvement in their own care.

Key takeaways	
	Proactive inclusion in care i.e. what matters to you conversations and bedside shift reporting can dramatically impact patient experience
	Transparency with EMR and charting may improve feeling involved in care

Conclusion and Future Directions: The "Bedside Shift Report" has significantly contributed to improving patient involvement in care, as evidenced by the positive surge in patient experience scores. This initiative underscores the shift towards a more patient-centered care model, where patients are active participants in their health management. Moving forward, the focus should be on enhancing the scope and quality of these interactions through standardized practices, staff training, and the integration of innovative tools to support communication. Such strategic enhancements are expected to not only meet but exceed patient expectations, fostering an exemplary environment of healthcare delivery.

Limitations

Despite the promising outcomes of this project, several limitations must be acknowledged, which could impact the interpretation and generalizability of the findings. Firstly, the study design may have introduced selection biases. The voluntary nature of participation for both patients and staff may have skewed the sample toward individuals more inclined to engage with the project, thus potentially influencing the results.

Another potential limitation of this study is the possibility that participants altered their behavior because they knew they were being observed. The increased attention from leadership and the introduction of new initiatives might have temporarily boosted both patient and staff engagement metrics. Consequently, this could result in an overestimation of the interventions' effectiveness, as improvements may partly stem from participants' heightened performance under observation.

Additionally, the reliance on self-reported data for assessing both patient experience and staff engagement introduces the risk of social desirability bias. Participants may have provided responses that reflect perceived expectations rather than their genuine experiences and perceptions, thus affecting the validity of the data.

The scope of the project's implementation was limited to specific units within a single healthcare facility. This limits the generalizability of the findings to similar settings, and the leaders' belief that the settings are likewise enough to assure him/her of comparability of results. Moreover, the relatively short duration of the study, particularly the three-month period for assessing changes in patient experience and staff engagement, may not adequately capture the long-term sustainability and impact of the interventions.

A notable limitation is the potential self-selection bias among the leaders running this project. Those who chose to participate likely had a predisposition towards, and greater competency in, collaborative, empowering, and co-creative leadership practices. This could mean that the

positive outcomes observed may not be easily replicable in contexts where leaders do not possess similar skills or passions for these approaches. Managers and leaders who do not have the same inclination or ability for these leadership practices might not achieve comparable results, thereby limiting the generalizability of the findings.

Whether we were able to find statistical significance it is likely that concurrent external political and organizational changes influenced staff sentiment and patient experiences, complicating the attribution of observed changes solely to the interventions implemented. We do know that local political events such as the multiple linear regression model used in the analysis explained only 40% of the variance in staff feelings of being valued, indicating that other unexamined factors likely play a significant role in shaping these sentiments.

Future research should aim to address these limitations by employing a more robust, longitudinal design that extends the evaluation period to better understand the long-term effects of the interventions. Expanding the study to multiple sites with diverse organizational contexts would enhance the generalizability of the findings. Additionally, incorporating mixed methods approaches, including qualitative data, could provide deeper insights into the underlying factors influencing patient and staff experiences, thereby enriching the overall understanding of the interventions' impact.

Sustainment and Call to Action

Relationship Between Patient Experience and Staff Engagement: Our comprehensive analysis shows that it is possible to improve patient experience and staff engagement and that it's possible at the same time. Initially with the project we discussed having one versus two committees for patient experience and staff engagement and whether they were separate projects. We finally settled on the fact that two committees were important so that each topic could be focused on but we also landed on the fact that both experiences are connected. We also noted within the journey mapping that both clients we interviewed had explained many of the same challenges on the unit that nursing had, they also highlighted workload as a reason that there was less time for nurses to connect with them. In our analytics we see that when the work of the nurses on the patient side was highlighted positive sentiment to leadership and likely engagement at work significantly increased. This all highlights a profound interconnectedness between patient experience and staff engagement within healthcare settings. Enhanced patient experience often results directly from highly engaged staff who feel empowered and valued in their roles. For instance, initiatives such as "Bedside Shift Reports" and "What Matters to You" conversations not only improve patient satisfaction by fostering

inclusivity and respect but also enhance staff morale by affirming their impact on patient care. This dynamic relationship was observed to contribute to a more harmonious and effective healthcare environment, where engaged staff deliver patient-centric care that aligns with both clinical outcomes and emotional well-being. This would posit that for healthcare workforce or patient quality improvement projects that there is significant benefit to viewing the whole as a community.

Robust Sustainment Plan: To ensure the long-term sustainability of our initiatives we discussed, as a task force, ideas around sustainment. The following multi-faceted approach is proposed and has begun being implemented:

Institutionalization of Best Practices: Embed effective communication and patient engagement strategies into the standard operating procedures of healthcare institutions. This includes regular updates to training modules and procedural guidelines to reflect the latest best practices and research findings.

Advanced Training Programs: Establish continuous professional development opportunities that focus on advanced communication techniques, empathy training, and leadership skills for all levels of staff. These programs should be designed to adapt to the changing dynamics of healthcare needs and staff feedback. The work that has been done has been embedded within quality improvement training courses as an exemplar unit.

Dynamic Feedback Systems: Implement adaptive, real-time communication mechanisms for both staff and patients to provide feedback to leadership. This system should utilize appropriate technologies to provide continuous analytics on patient care outcomes and staff satisfaction levels, allowing for timely adjustments and interventions.

Cultural Reinforcement: Foster a culture of recognition by regularly acknowledging staff contributions to patient care improvements. This should be complemented by a supportive management structure that prioritizes staff well-being and patient care equally.

Scalability and Adaptation: Develop a clear roadmap for scaling successful practices across different units and settings, including a framework for adapting interventions to meet local needs without compromising the core objectives of patient and staff engagement. As we reach a critical mass of frontline leaders who have lead teams through this process they will retain the tools they learned through this work and be able to apply them to further day to day operations.

Conclusion and Vision for the Future:

Our journey through enhancing both patient experience and staff engagement within our healthcare system has yielded substantial improvements in care quality and workplace satisfaction. By closely integrating the efforts of staff engagement with patient care

enhancements, we have established a model to improve healthcare delivery's most vulnerable populations and most valuable resource: Patients and Staff.

The evidence from our initiatives suggests that the future of healthcare lies in the continued fostering of a collaborative community within healthcare settings—a community where staff, leadership, and patients actively collaborate and support one another. Moving forward, it is imperative that healthcare systems embrace this model of collaborative community to further the dual goals of enhancing patient experience and enabling staff to feel psychologically safe and able to fulfill their true professional desire and purpose of caring for their patient.

Our vision for the future is rooted in a commitment to these collaborative practices and through using real time continuous quality improvement practices as we've described in this paper to organically develop collaborative and codesign leadership practices. We advocate for an ongoing dialogue between all members of the healthcare community, supported by robust systems that enable such interactions. We aim to create a healthcare environment that is not only responsive but also resilient to the challenges ahead.

In conclusion, the path forward requires a steadfast dedication to the principles of community, compassion, and honest introspection in healthcare practices. By adhering to these principles, we can ensure that our healthcare systems not only meet the current demands but are also well-prepared to adapt to future challenges, ultimately leading to a more humane and effective healthcare system for all.

Conclusion

The "Healing Hospitals: Patient and Healthcare Communities" initiative has demonstrated the transformative potential of integrating Quality Improvement (QI) processes with co-design and collaborative leadership. By leveraging real-time analytics and QI theory, we established a framework that dramatically enhances patient experience and staff engagement.

Our approach combined staff engagement with patient care improvements, highlighting their interconnectedness. Each ward, wing, hospital, and health authority functions as a community of professionals and patients. Interventions like "Bedside Shift Reports" and "What Matters to You" conversations illustrate the efficacy of co-designed, relationship-centered leadership, significantly elevating patient satisfaction and boosting staff morale through inclusive decision-making.

Near real-time analytics were crucial, enabling continuous monitoring, assessment, and refinement of our interventions. This adaptive methodology ensured sustained improvements, fostering a culture of evidence-based practice and iterative enhancement. QI theory provided a robust framework for testing changes, evaluating outcomes, and refining strategies based on empirical evidence, cultivating a culture of continuous learning and empowering staff to drive change.

Scaling this project across multiple sites will provide insights into the generalizability of our findings. Comparative analyses across different organizational contexts will help discern universally applicable elements and context-specific nuances. This approach will deepen our understanding of implementing QI processes and collaborative leadership practices in diverse healthcare environments.

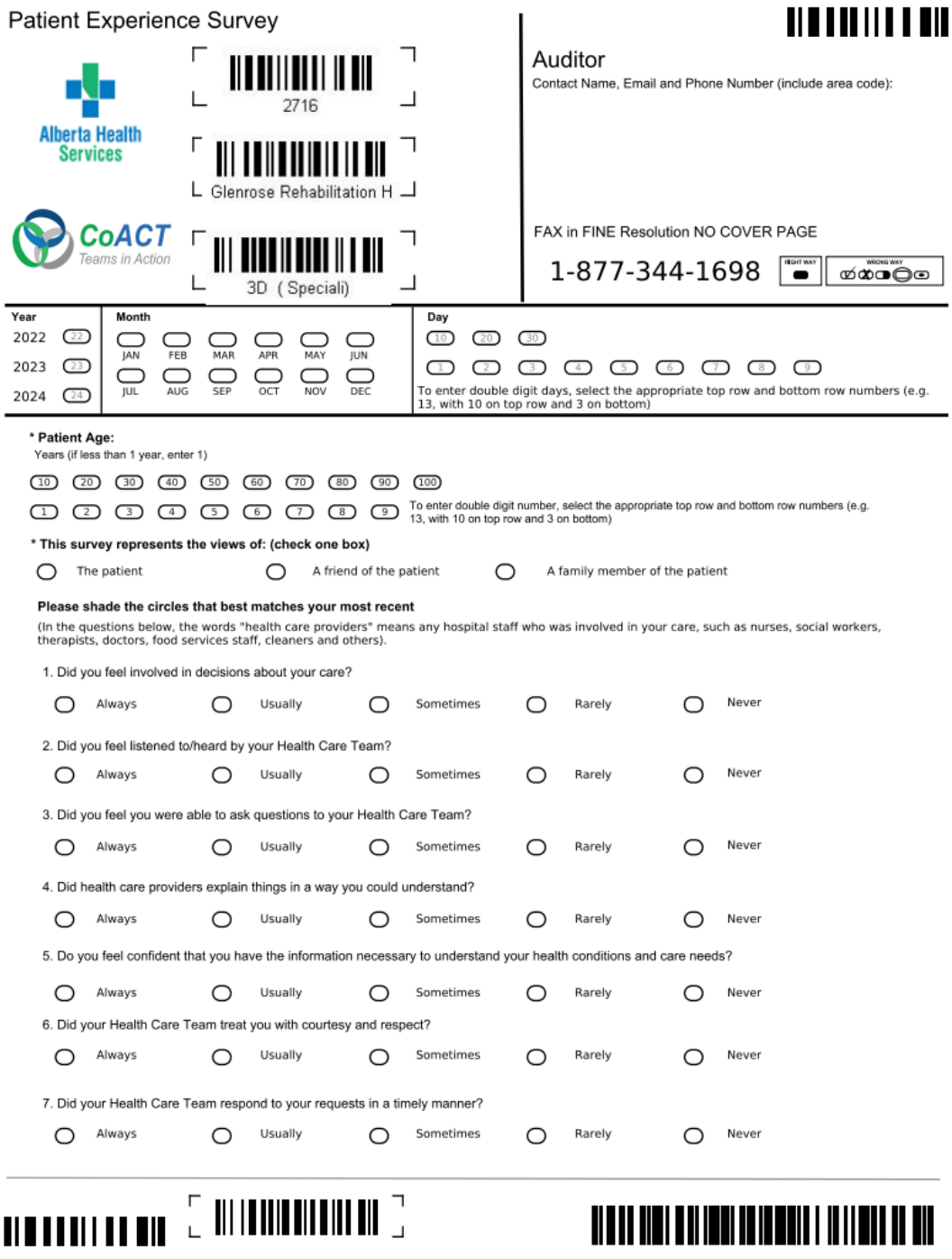
Key takeaways, such as the impact of negativity bias and the importance of compassion during increased workloads, may be generalizable. Listening to patients and involving them in care decisions are likely common themes across healthcare. Our process, combined with relational and engaging leaders, will adapt to local contexts, improving healthcare communities across Canada.

To ensure long-term sustainability, our plan involves institutionalizing best practices through advanced QI techniques, comprehensive data analytics, and co-design methodologies. Continuous professional development will equip healthcare leaders and staff with skills to perpetuate and expand improvements. Dynamic feedback systems will ensure ongoing staff and patient input, central to evolving healthcare practices.

Our vision for the future is a collaborative healthcare community where co-designed leadership and strategic QI processes are integral to daily operations. By prioritizing these principles, we aim to cultivate a resilient healthcare system that meets current demands and navigates future challenges, creating a more effective and compassionate environment for patients and staff.

In conclusion, the trajectory forward necessitates a steadfast commitment to implementing collaborative principles, co-designed leadership, and continuous analytics on experience and engagement. We need leaders who skilled in fostering and developing relationships with their teams in order to engage them and patients. By adhering to these foundational tenets, we can ensure that our healthcare systems not only improve but excel, fostering a culture of excellence and empathy that profoundly enhances the experiences of both patients and healthcare providers.

Appendix A



Patient Experience Survey

Alberta Health Services

CoACT Teams in Action

2716

Glenrose Rehabilitation H

3D (Speciali)

Auditor

Contact Name, Email and Phone Number (include area code):

FAX in FINE Resolution NO COVER PAGE

1-877-344-1698

RIGHT WAY WRONG WAY

Year: 2022 (22) 2023 (23) 2024 (24)

Month: JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

Day: 10 20 30 1 2 3 4 5 6 7 8 9

To enter double digit days, select the appropriate top row and bottom row numbers (e.g. 13, with 10 on top row and 3 on bottom)

*** Patient Age:**

Years (if less than 1 year, enter 1)

10 20 30 40 50 60 70 80 90 100

1 2 3 4 5 6 7 8 9

To enter double digit number, select the appropriate top row and bottom row numbers (e.g. 13, with 10 on top row and 3 on bottom)

*** This survey represents the views of: (check one box)**

○ The patient ○ A friend of the patient ○ A family member of the patient

Please shade the circles that best matches your most recent

(In the questions below, the words "health care providers" means any hospital staff who was involved in your care, such as nurses, social workers, therapists, doctors, food services staff, cleaners and others).

1. Did you feel involved in decisions about your care?

○ Always ○ Usually ○ Sometimes ○ Rarely ○ Never

2. Did you feel listened to/heard by your Health Care Team?

○ Always ○ Usually ○ Sometimes ○ Rarely ○ Never

3. Did you feel you were able to ask questions to your Health Care Team?

○ Always ○ Usually ○ Sometimes ○ Rarely ○ Never

4. Did health care providers explain things in a way you could understand?

○ Always ○ Usually ○ Sometimes ○ Rarely ○ Never

5. Do you feel confident that you have the information necessary to understand your health conditions and care needs?

○ Always ○ Usually ○ Sometimes ○ Rarely ○ Never

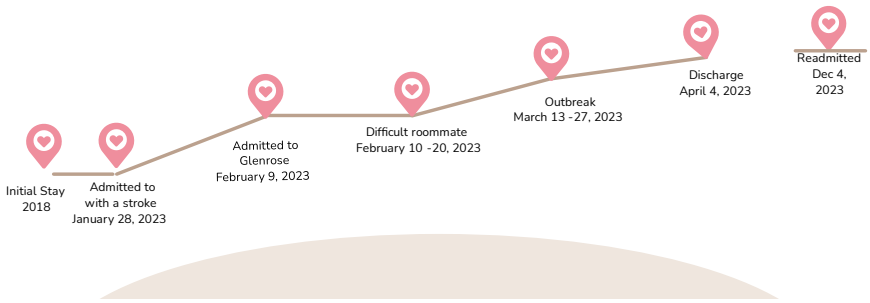
6. Did your Health Care Team treat you with courtesy and respect?

○ Always ○ Usually ○ Sometimes ○ Rarely ○ Never

7. Did your Health Care Team respond to your requests in a timely manner?

○ Always ○ Usually ○ Sometimes ○ Rarely ○ Never

Appendix B



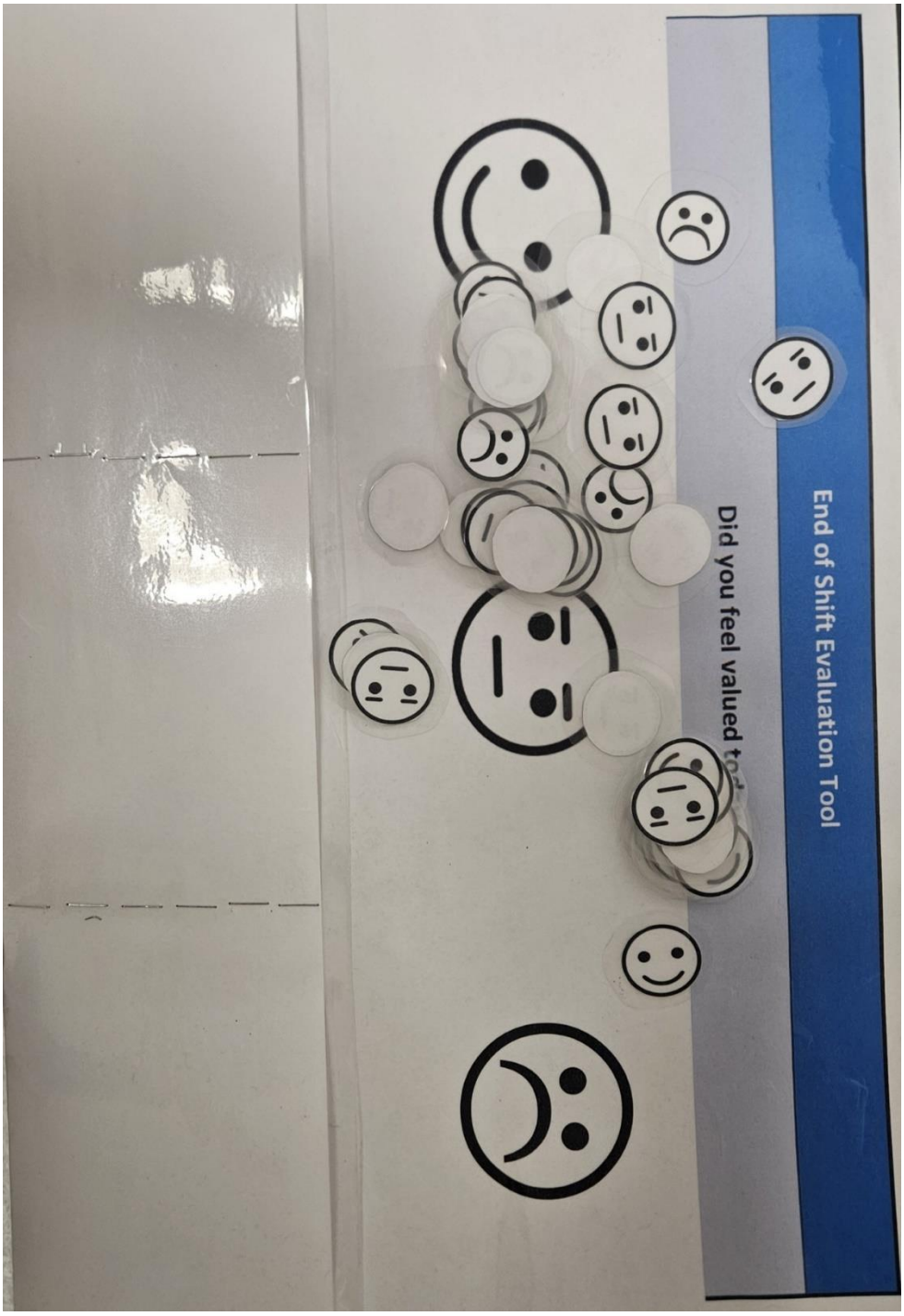
Major Themes Identified by Stay:

Initial Stay 2018:
Had time to speak to nurses and felt that the Glenrose stays were perfect.
Beds were made everyday.
Rooms were clean.
Nurses visited for 30 minutes 3 times per shift.

February 2023:
Nurses do not have time to spend with patients
Computer usage is taking away from time with patients
Rooms were not cleanly/organized
Dec 2023:

Bedside Shift report noticed. Stated that she felt “Really cared for”. “I am able to ask questions”
The rooms were noted to be much cleaner
What matters to you - “I think so. They’re really good. Especially the older nurses. They take the time to listen”
Highlighted that there were differences in consistency and quality of BSR and communication depending on which team she was under
Of note talked about workload for nurses and double shifts

Appendix C



Case Study #1

Case Study: Organizational Change Management and Employee Welfare - The Meal Policy Shift

Background A hospital in an urban area operated under a union agreement stipulating that staff members who work four hours overtime after an eight-hour shift are entitled to a meal provided by the employer. Traditionally, staff had the flexibility to choose their meals from the hospital cafeteria or several food venues at a nearby hospital, offering them a variety of options to suit different dietary preferences and needs.

The Challenge In a surprising move, the Director of another department decided to overhaul the existing meal provision system without prior consultation with the staff or the union. The new policy, communicated through a memo, abruptly restricted the meal choices to pre-packaged options like canned soup, ramen, and frozen meals available from a fridge in the administrative suite. This change came under the guise of fiduciary responsibility and preventing fraud of using meal tickets during subsequent days rather than the shift in which the OT accumulated. At the same time research into whether staff were feeling valued was about to take place and during the first week of measurement there was to occur a staff appreciation event at the same time as metrics for measuring whether staff feel valued by leadership were to begin being collected.

Reaction The staff reaction was overwhelmingly negative. Employees felt devalued and disrespected, not just because of the degraded quality of the meals provided but also due to the lack of involvement in the decision-making process. The project started with over 40% of staff stating that they felt negatively valued by leadership. The sentiment was that leadership had failed to consider the impact of such changes on staff morale and well-being, which was especially critical given the demanding nature of their work. The frustration was compounded by the operational hiccup of delayed meal deliveries, which left staff with even fewer choices than promised.

Analysis The decision by the Director highlighted several key failures:

- **Lack of Stakeholder Engagement**: Implementing changes without consulting the people directly affected by them can lead to resistance and dissatisfaction. In this case, involving staff and possibly the union could have provided valuable insights and fostered a more acceptable compromise.
- **Poor Communication**: The change was communicated through a memo, a method that seemed impersonal under the circumstances. Better communication could have prepared the staff for the change and potentially softened the backlash.

- **Inadequate Implementation**: The failure to ensure the availability of the new meal options before implementing the change exacerbated the situation, highlighting poor planning and execution.

Outcome The negative response from the staff prompted the senior leadership team to revisit the decision. As there were metrics, feedback and reporting from the project to the Senior Operating Officer of the hospital as they were the project sponsor the issue was clearly communicated in real time. With mounting pressure from the union and the staff, a series of meetings were scheduled to discuss the meal policy. These discussions opened up a dialogue about the importance of staff welfare and the practical aspects of meal provision for overtime shifts.

Lessons Learned

- **Engagement is Critical**: Changes, especially those that directly affect employee welfare, should always involve stakeholder engagement. This approach not only helps in making more informed decisions but also ensures that the staff feel valued and respected.
- **Effective Communication**: Change management requires transparent, clear, and empathetic communication. Understanding and addressing concerns at the outset can prevent misunderstandings and build trust.
- **Robust Implementation Planning**: Effective change implementation involves thorough planning and preparation. Ensuring all elements are in place before rolling out changes is crucial to avoid operational failures.

Moving Forward The Senior Operating Officer of the Hospital and the Director directly responsible for this area now aware of the importance of collaborative decision-making, committed to a participatory approach for future changes. The hospital began exploring more flexible meal provision options, including a receipt submission process that allowed staff to pick any restaurant or delivery service to get their meals from. This potentially reintroducing some elements of choice while maintaining fiduciary responsibility through redundant checks that naturally occur during expense submission processes to ensure the meals were being used appropriately. This case serves as a valuable lesson in the importance of empathy, engagement, and effective communication in leadership.

Case Study #2

Case Study: Effective Staffing Strategies for Enhancing Operational Efficiency in Healthcare

Introduction In the dynamic environment of healthcare, managing the operational challenges such as bed moves can significantly impact staff workload and patient care quality. This case study explores a specific incident at a healthcare facility where staff faced significant challenges due to an overwhelming number of bed moves. The study examines the problem-solving approach adopted, the implementation of a Plan-Do-Study-Act (PDSA) cycle, and the outcomes of these strategic interventions.

Background A typical shift at the healthcare facility involved managing several patient bed moves, which are critical for accommodating incoming patients, discharges, and transfers within the hospital. During one particular shift, the staff had to manage six bed moves, leading to feelings of being overwhelmed and chaotic operations. Recognizing the stress and inefficiency this caused, the team decided to proactively manage such situations through strategic staffing and planning.

Challenge The main challenge was the sudden increase in bed moves during shifts, exacerbated by seasonal peaks in patient admissions due to the flu season and a concurrent COVID-19 outbreak. The specific incident involved a forecast of 24 bed moves in an upcoming shift, significantly higher than usual, which could potentially lead to operational chaos and decreased quality of patient care.

Solution Implementation The staff, using the PDSA cycle, decided to address this challenge by:

1. **Plan**: Anticipating the high volume of bed moves, the team planned to augment staffing levels to handle the increased workload efficiently. This involved scheduling additional staff for the specific shift where the surge in bed moves was expected.
2. **Do**: On the day of the shift, extra staff members were deployed strategically to assist with the bed moves. These personnel were briefed on their roles and the importance of smooth coordination during the shift.
3. **Study**: Post-implementation, the team monitored several parameters, including the time taken for each bed move, the impact on staff stress levels, and overall shift efficiency.
4. **Act**: Insights gained from this intervention were documented to refine future strategies for managing similar situations. This included adjustments in the scheduling of extra staff and improvements in communication during shift changes.

Outcomes The intervention led to remarkable improvements in the operational dynamics of the shift:

- The shift that anticipated 24 bed moves went from being potentially overwhelming to being described as "Old hat," with comments from the staff like "We work together well as a team" and "smooth."
- The additional staffing not only alleviated the physical workload but also contributed to a more positive emotional and psychological climate among the team.
- Team engagement appeared to improve, with staff feeling more supported and less stressed, suggesting a direct correlation between adequate staffing and job satisfaction.

Discussion This case highlights the critical role of adaptive staffing strategies in managing operational challenges in healthcare settings. By effectively anticipating the needs of the staff and proactively planning resources, healthcare administrators can ensure both high-quality patient care and a positive work environment. Moreover, this scenario underscores the importance of agile management practices in responding to fluctuating demands in healthcare facilities.

Conclusion The successful management of bed moves through strategic staffing adjustments provided valuable lessons in operational efficiency and staff welfare. This case study serves as a model for other healthcare facilities facing similar challenges, emphasizing the importance of flexibility, proactive planning, and the well-being of staff in achieving operational excellence. Future directions include leveraging technology to predict and plan for variable staffing needs and further integrating staff feedback into operational planning processes.

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