Re-Envisioning the Nurse Unit Manager Role

Transforming Managers into Leaders
Global Centre for Nursing Executives

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# Table of Contents

Advisors to Our Work ................................................................. 4

Executive Summary ................................................................. 7

Preamble: Transforming Managers into Leaders ............................... 9

Re-Envisioning the Nurse Unit Manager Role ................................. 29

Restructure the Role .................................................................. 31
  Imperative 1: Clarify Role Expectations .................................. 32
  Imperative 2: Revisit Span of Control .................................... 42

Ensure Strategic Prioritisation ...................................................... 65
  Imperative 3: Secure Daily Efficiency Gains. ............................ 66
  Imperative 4: Protect the Important from the Immediate ........... 103

Coda: The Executive’s Imperative ................................................. 129
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Executive Summary

Nurse Unit Managers Critical to Success in Today’s Transformative Times
Health care leaders today face a once-in-a-career period of upheaval. Organisations must meet higher expectations, provide care with more transparency, and assume greater accountability for both outcomes and costs—increasingly across the continuum of care. While leaders are rightfully focused on managing to these targets, many are underestimating the support that nurse unit managers need to deliver exceptional care on their units. Managers are stretched thin, expected to do more with less, support more complex patients, oversee a larger staff, and constantly elevate performance. Unit managers are at the very front of supporting change in hospitals, and yet their role has not changed with the times. This oversight puts patient outcomes, organisational performance, and staff engagement at risk.

Current Approaches Focus on Individual Improvement
Many organisations have looked to address challenges in the nurse unit manager role, but efforts have focused on improving the individual manager’s skills and competencies. Leadership training, hiring new staff, and addressing poor performance are necessary steps, but yet they still overlook a core challenge; the individuals in the role can be only as good as the role itself allows them to be. The highest performing unit managers achieve success at great personal cost, often investing significant time outside of business hours to complete work, for example developing plans, checking emails, and finishing performance reviews for staff members. Today’s nurse unit manager role has not kept up with the changes and challenges of the current environment, and as such average managers are not willing to put in the out-of-business hours and the best managers risk burnout.

A More Powerful Approach to Empowering Nurse Unit Managers
Effectively supporting nurse unit managers requires a shift in focus—away from the individual toward the role itself. The nurse unit manager role has not undergone significant revision, and as a result it is optimised for an outdated health care environment. Today, patients are sicker, budgets are tighter, and scrutiny on performance has intensified. While ensuring that the right person is in the role is important, the first step in empowering nurse unit managers has to be ensuring that the role is optimised. Leaders must determine what they want the unit manager role to look like, how they will support managers, and how managers should effectively prioritise their time.

Re-Envisioning the Nurse Unit Manager Role
The following study equips nurse leaders with a two-step strategy to re-envision the nurse unit manager role:

Restructure the Role
Ensure the nurse unit manager role is optimised to meet organisational priorities and operate at the top of license
• Establish the priorities of the role
• Identify what gaps need to be overcome to meet priorities
• Refocus unit manager role on priorities
• Provide additional support to unit managers

Ensure Strategic Prioritisation
Elevate manager focus by supporting them to prioritise high-level leadership activities and strategic priorities
• Delegate non-managerial work
• Formalise expert partnerships
• Enhance transparency on performance
• Structure managers’ days around strategic priorities
Road Map for Discussion

1. Preamble: Transforming Managers into Leaders

2. Re-Envisioning the Nurse Unit Manager Role

3. Coda: The Executive’s Imperative
The Goal of Nursing Leadership

Though this quote from Florence Nightingale is more than 150 years old, nothing sums up the contemporary challenge for nursing leaders better—to lead, not just to do.

Leaders must not only do the right thing themselves, but ensure that the right thing is always done by everyone. Not least because nurses and frontline staff today are struggling to do the right thing every time for every patient.

“Let whoever is in charge keep this simple question in her head (not, how can I always do this right thing myself, but) how can I provide for this right thing to be always done?”

Florence Nightingale
1860

The use of evidence-based practice has led to a much better understanding of what constitutes exemplary nursing care. However, multi-country research shows that critical nursing tasks are often left undone at the end of a shift.

The RN4Cast study included more than 30,000 nurses in 14 countries. These nurses reported they frequently did not have time to complete common, yet essential tasks that fall under nursing’s purview.

Frontline nurses are undeniably under pressure, with staffing shortages and increased complexity contributing to an already challenging environment. To better understand today’s nursing environment, in addition to measuring the frequency with which tasks were left undone by the end of the shift, the RN4Cast study sought to understand which factors in today’s environment allowed some organisations to get more evidence-based tasks done during each shift.

### Many Evidence-Based Nursing Tasks Not Completed by End of Shift

#### Percentage of Nursing Care Tasks Left Undone¹ in Hospitals

<table>
<thead>
<tr>
<th>Task</th>
<th>Canada</th>
<th>US</th>
<th>Europe²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparing Patients and Families for Discharge</td>
<td>13.7%</td>
<td>12.7%</td>
<td></td>
</tr>
<tr>
<td>Educating Patients and Families</td>
<td>22.4%</td>
<td>26.2%</td>
<td>27.9%</td>
</tr>
<tr>
<td>Comforting, Talking with Patients</td>
<td>40.6%</td>
<td>43.6%</td>
<td>39.5%</td>
</tr>
<tr>
<td>Developing, Updating Care Plans</td>
<td>52.6%</td>
<td>47.4%</td>
<td>40.9%</td>
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</table>

¹ The prevalence (mean percentage) of each nursing care task left undone is based on the proportion of nurses reporting leaving care need(s) undone. Possible range 0-13; activities left undone in most recent shift.

² Aggregate average sum for 12 European countries, including: England, Belgium, Switzerland, Germany, Spain, Finland, Greece, Ireland, Netherlands, Norway, Poland, Sweden. n=488 hospitals.

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**Nursing Care Often Left Incomplete Around the World**

“Nurses in countries with distinctly different health care systems report similar shortcomings in their work environments and the quality of hospital care...Resolving these issues...is essential to preserving patient safety and care of consistently high quality.”

Aiken LH, et al.

“Nurses’ Reports on Hospital Care in Five Countries”
The RN4Cast investigators conducted regression analyses with two types of independent variables—those associated with the nurses themselves and those attributable to the organisation—to understand why some nurses reported a greater ability to complete more tasks.

They found that simply adding more nurses did not lead to a dramatic improvement in more consistent completion of critical tasks.

Instead, nurses practicing in a positive work environment missed fewer critical activities. Critically, a positive nursing work environment has a stronger effect on nurses’ ability to complete work during their shifts than the effect of having more nursing staff.

In a positive work environment, even with staffing challenges, nurses are able to get more crucial work done. Creating a positive work environment requires daily attention and purposeful actions at the executive level all the way through the unit level.

The quality of the work environment had the strongest effect, suggesting that specific elements such as nurse manager ability, leadership, support of nurses, and collegial nurse-physician relations influence the way nurses organise and deliver necessary nursing care.

Ausserhofer D, et al. “Prevalence, Patterns and Predictors of Nursing Care Left Undone in European Hospitals”
Manager Key to Creating Positive Work Environment

Our research suggests that the relationship frontline staff have with their direct manager is the most important factor to create the type of work environment that engages staff.

Staff who perceive their manager as excellent are almost universally engaged, at 85%. Conversely, one in four people who report having a problematic manager are disengaged.

Managers who create a positive work environment actually help alleviate some of the pressures associated with staffing crises. Excellent managers have higher engagement, 36% lower turnover, and 57% lower absenteeism among their staff.

Evidence Seen in Engagement and Workforce Metrics

**Impact of Staff Perception of Manager Effectiveness on Engagement**

*Percentage of Respondents Engaged, Disengaged by Manager Effectiveness*

1. Based on multivariate regression of the impact of the drivers within the Manager Effectiveness Index on engagement score from Advisory Board’s Employee Engagement Initiative Division.
2. Average turnover per unit in the high performing group was 18% compared to 29% in the low performing group.
3. Average absenteeism per person in the high-performing unit manager group was 8 days per year, in the low-performing group 18 days per year.


People with excellent managers are five times more likely to be engaged, and virtually none are disengaged.

- **Problematic** managers are <1%
- **Fair** managers are 17%
- **Good** managers are 25%
- **Excellent** managers are 85%

Lower staff turnover achieved by high-performing unit managers

- **36%**

Reduction in staff absenteeism in units with high-performing managers

- **57%**
To understand what set high-performing nurse managers apart, the Global Centre for Nursing Executives spoke to high-performing nurse unit managers from around the world. These managers were recommended by executives and well regarded by their peers and staff.

Nearly every manager interviewed reported that they focused on a set of core activities, such as: supporting their staff, being visible on their unit, and ensuring nurses provided excellent care and met performance goals. These responsibilities are among the most critical to creating a positive work environment and alleviating staffing pressures.

**Looking for Answers**

**Effective Managers Prioritise Common Set of Activities**

Sample Activities on Which Best Managers Spend More Time, Energy

- Setting a clear unit vision
- Cultivating interprofessional relationships
- Staff coaching and professional development
- Managing toward goals
- Facilitating difficult conversations
- Rounding on staff and patients

**Prioritising Hands-On Mentorship**

“For me, it’s important to be available to the frontline staff for daily mentorship and the education that you have to provide...You get to learn who needs increased education, what are their skills and scope of practice, and who needs further development.”

Unit manager

Canadian public hospital

---

1) Unit managers were identified as high-performing across a variety of metrics, including: good clinical outcomes, high staff engagement, and good efficiency. The Global Centre also surveyed more than 200 unit managers around the world with online and written surveys to understand what constituted baseline performance.

In addition to interviewing excellent managers, the Global Centre polled managers from around the world to identify their top priorities.

The data revealed the average nurse unit manager focuses primarily on managing daily operations of the unit—ensuring safe staffing numbers, managing patient flow, and completing administrative paperwork.

The top operational priorities they reported are essential for effective and efficient unit operations. However, this list of priorities implies that average managers around the globe are often focusing on the most immediate tasks and letting strategic aspects of the role fall to the bottom of their to-do list.

### Managers Mired in the Details

#### Percentage of Unit Managers Ranking the Task Their Number One Priority

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<tr>
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<th>Percentage</th>
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<tbody>
<tr>
<td>Maintain safe staffing levels</td>
<td>56%</td>
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<tr>
<td>Manage patient flow</td>
<td>36%</td>
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<tr>
<td>Create a cohesive unit culture</td>
<td>15%</td>
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<tr>
<td>Build relationships with patients</td>
<td>14%</td>
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<tr>
<td>Track and monitor unit performance</td>
<td>10%</td>
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<tr>
<td>Develop staff professionally</td>
<td>10%</td>
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#### Sample Tasks Prioritised by Average Managers

- Updating staff rosters
- Filing patient complaint paperwork
- Tracking down data on unit performance
- Calling for agency nurse to cover shift
- Reviewing applications for RN vacancies
- Making copies of new policy guidelines

Managers not focusing on strategic functions, leadership activities of role

---

1) Responses to the question: *Please rank the top five overarching responsibilities of a unit-level manager’s position, by order of importance, with the most important as first.*

Source: Global Centre for Nursing Executives 2015 Survey of Organisational Nursing Structure and Frontline Leadership; Advisory Board interviews and analysis.
Ultimately, the ability to lead, not simply to manage, is what separates the best managers from the middle of the pack. Management and leadership are two distinct skill sets. While both are important, leadership is what creates a positive work environment and engages staff.

The Global Centre defines engaged staff as those who are inspired to do their best work. In turn, leadership is the act of inspiring others to action—not simply getting people to do things because of authority. Leadership is the input; engagement is the output.

Successful leaders need both leadership and management competencies. Management is creating the systems necessary to manage standards and ensure accountability for progress. Leadership is about having a vision for where you’re going and ensuring everyone is inspired to join on the journey. When choosing people to fill a leadership role, it is critical to ensure that they are able to carry out both aspects of the role.

### Not Effectively Balancing Leadership and Management Responsibilities

**Sample Competencies from Global Centre’s Leadership Competency Diagnostic**

- **Leading**
  - I believe in my hospital’s mission

- **Managing Relationships**
  - My manager stands up for the interests of my unit

- **Developing People**
  - I have experienced professional growth over the past year

### Two Sides of the Same Coin

“Leadership is different from management, but not for the reason most people think. Leadership isn’t mystical and mysterious. It has nothing to do with having ‘charisma’ or other exotic personality traits. It is not the province of a chosen few. Nor is leadership necessarily better than management or a replacement for it. Rather, leadership and management are two distinctive and complementary systems of action. Both are necessary for success in an increasingly complex and volatile environment.”

*Kotter J, “What Leaders Really Do”*

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To assist in ensuring leaders have a complete range of skills, the Advisory Board’s Leadership Competency Model defines a distinct set of competencies that can be measured when hiring and developing managers. In fact, this Leadership Competency Model powers the Global Centre’s Leadership Competency Diagnostic, a useful tool for assessing the competencies of current—and potential—managers.

**Key Leadership Competencies**

**Leading**
- Managing vision and purpose
- Taking initiative
- Motivating and influencing

**Managing Relationships**
- Building and strengthening relationships
- Upward management

**Developing People**
- Identifying and recruiting talent
- Developing and retaining talent

**Managing Standards and Accountability**
- Accountability
- Service orientation and patient focus

**Planning and Decision Making**
- Constructive thinking
- Financial acumen
- Process management
- Prioritising and delegating

**Communicating**
- Giving feedback
- Communicating effectively

For full leadership competency descriptions, access the online Leadership Competency Diagnostic tool, available at: advisory.com/international/gcne

Source: Advisory Board Talent Development Division; Advisory Board interviews and analysis.
Assessing leadership skills is a critical first step in identifying potential leaders. Training and development of those leaders must follow, to create a cadre of leaders who are well rounded and capable.

According to Global Centre research, hospitals and governments around the world recognise the importance of leadership training and have made substantive investments in programmes specifically designed to develop their leaders’ skills.

This type of leadership training is necessary, especially in light of the frequent practice to promote excellent clinicians to management positions. Frontline staff who exhibit strong clinical performance may not have the management skills necessary to direct a unit. Additional leadership training is therefore crucial for them to transition from a staff to a manager role.

### Organisations Investing Resources to Enhance Managers’ Capabilities

#### Investments Made Toward Improving Unit Leadership

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Of Canadian members</strong></td>
<td><strong>81%</strong></td>
<td>reported that their organisation had a leadership development programme</td>
</tr>
<tr>
<td><strong>£73.3M</strong></td>
<td></td>
<td>Annual Budget for the NHS Leadership Academy with £12M dedicated specifically to nursing and midwifery leadership programmes</td>
</tr>
<tr>
<td><strong>1,957</strong></td>
<td></td>
<td>N/MUMs Have Gone Through “Take the Lead,” a NSW government programme designed to allow N/MUMs to develop better leadership</td>
</tr>
<tr>
<td><strong>81%</strong></td>
<td></td>
<td>Of European members reported that their organisation had a leadership development programme</td>
</tr>
</tbody>
</table>

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**Leadership Skills Elementary**

“We are going back to basics. We...put a development programme into place that [focuses on] leadership development and whatever else is required to develop [managers] into leaders of their area.”

*Assistant Director of Nursing, English public hospital*

---

1) Responses to the question, “Does your organisation offer either internal or external leadership development programmes?” Answers included: Yes, No, and I don’t know. n=14.
2) Responses to the question, “Does your organisation offer either internal or external leadership development programmes?” Answers included: Yes, No, and I don’t know. n=22 out of 27 responses.
3) American Organization of Nurse Executives.

Yet Most Still Struggling

Yet, when members of the Global Centre were asked to choose only one topic of the four options shown here as part of setting the Centre’s research agenda for the year, the results were surprising. By nearly a two-to-one margin, nurse executives from around the world asked for Elevating Nursing Leadership. And within that topic, they specifically asked for help in better scoping and supporting the frontline unit manager role.

This interest indicated that despite efforts to improve leadership skills of frontline managers, hospitals around the world are still struggling to turn training into practice.

Part of this can be attributed to the inability to translate what is learned into practice. Managers simply lack the necessary time, support, and opportunity to employ the skills they learned as part of leadership training once they are back on their unit. One study in Australia found that nearly three out of four trainees failed to apply their learning to their work setting.

Current Efforts Falling Short

**Percent of Nurse Executives’ Choosing Topic as Number One Priority**

Global Centre’s 2015 Agenda Setting Topic Poll

<table>
<thead>
<tr>
<th>Topic</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross Continuum Care</td>
<td>16%</td>
</tr>
<tr>
<td>Workforce Development</td>
<td>18%</td>
</tr>
<tr>
<td>Cost-Efficient Nursing</td>
<td>24%</td>
</tr>
<tr>
<td>Elevating Nursing Leadership</td>
<td>42%</td>
</tr>
</tbody>
</table>

**Percentage of Trainees Who Fail to Transfer Learning to the Workplace After One Year**

- 70%

**Barriers That Inhibit Application of Learned Skills**

- No opportunity to deploy new skills
- No organisational commitment
- Unsupportive work environment
- Limited supervisory support
- Lack of practice, feedback, behavioural modelling


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advisory.com
Succeeding by Sheer Force of Will

Yet some managers are succeeding in spite of these barriers. Interviews with exemplar managers indicated a key ingredient in their success—intentionally making time for leadership.

Unfortunately, these same managers all struggled to complete everything in a normal work week. They had to put in extra hours, consistently going above and beyond on a regular basis in order to both manage and lead.

This is not a skill issue that can be resolved with more leadership training. Rather, unit managers need protected time and support so they may apply what they have learned in training to truly drive change on the unit. Working longer hours and investing extra personal time to complete leadership activities can lead to manager burnout, potentially undermining any investment in leadership training.

Top Managers Report Working at Unsustainable Levels to Get It All Done

Sample Unit Manager Daily Activities

<table>
<thead>
<tr>
<th>0700</th>
<th>Shift Handover</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit rounds</td>
<td>Patient complaint assessment</td>
</tr>
<tr>
<td>Budget review</td>
<td>Supply tracking</td>
</tr>
</tbody>
</table>

High-performing unit managers invest additional time on leadership activities

Beyond the Point of Saturation

“On the weekend, I’ve got all this work to do and my family goes ‘What are you doing?’ I ask myself that question all the time... but then when I get feedback from my staff, I am being effective... maybe it is just too big. I don’t think we’ve sat down and thought, ‘Where are we now?’ because we have the same nursing model of management that we had 15 years ago when we were a lot smaller.”

Nurse Unit Manager, Australian private hospital

Source: Advisory Board interviews and analysis.
The Risk of Inaction

If the best managers are doing their jobs at tremendous personal expense, they risk burnout and an early exit from the workforce. Given the rising tide of senior nurses set to retire in the next 10 years, many organisations will face (or are already facing) a shortage of critical manager talent.

At the same time, many organisations report struggling to interest young, high-performing bedside nurses to even consider taking on management roles.

Couple those two things together, and a succession management crisis looms in the future.

In Jeopardy of Burning Out Not Only This Generation, but Also the Next

Two Factors Contributing to Manager Recruitment Challenges

Nurses, Unit Managers Leaving Workforce
- Retention of nursing staff a problem in countries across the world
- Many managers approaching the age of retirement, or being promoted
- Lower numbers of qualified nurses reduce candidate pool

Negative Perception of Role
- Younger nurses see role as overly challenging with little reward
- Many nurses opt to pursue clinical specialisation over management
- Growth in complexity and scrutiny adds additional pressures to role

Ageing Manager Workforce

Unattractive Manager Role

“Nothing is more challenging than when you’re trying to help people but it’s a massive task. There is so much to do, I don’t know why anyone would ever think ‘when I grow up I’m going to go into frontline leadership’. It’s really hard.”

---

No Longer Aspiring to the Role

Looking into the Chasm

“I went into leadership because I thought I would be helping, but there is so much to do, I don’t know why anyone would ever think ‘when I grow up I’m going to go into frontline leadership’. It’s really hard.”

---

Chief Nursing Officer
English public hospital

“Looking at our Band 7s, most are over 40 years old. You kind of worry that once 55 hits them and they go, what is the future of leadership on the ward?”

---

Unit manager
Canadian public hospital

Recognising that change is necessary, many organisations have focused on fixing the individual in the role and enhancing individual skills for managers who are underperforming. However, this is only one part of the equation, and it is simply not enough to address the challenges of the position.

The other half of the equation is ensuring the role itself is structured correctly, and the organisation has the necessary supports around the role to set the manager up to succeed.

According to Global Centre research, many nurse executives have not proactively addressed the unit manager structure. In more than 250 interviews, only a small percentage of executives reported efforts to fix or re-envision the role itself.

Rather than depending on leadership skill-building efforts to optimise the performance of managers, hospital executives must re-envision this role to ensure that the manager role is doable and responsive to current organisational demands.

Out of 250+ interviews conducted in all regions, fewer than 25 organisations have done substantive work to redefine and better support the unit manager role.
Currently, the nurse unit manager role is out of balance. Unit managers are juggling many different responsibilities and tasks. The Global Centre categorised the three types of nurse unit manager work: leadership activities, managerial activities, and non-managerial work.

At the bottom of the pyramid is "non-managerial work." These are activities that do not require someone with the manager skill level to perform them, such as checking equipment, ordering supplies, and drafting reports. But this work consumes a lot of time and energy. It is work that is critical for unit success—but not critical for managers themselves to complete.

In the middle of the pyramid are "managerial tasks." These are the core operational processes and activities that ensure the unit can deliver on its vision: measuring performance, overseeing the budget, and ensuring safe staffing levels.

Leadership activities are at the top of the pyramid, as the unit manager’s most important functions. They are directly linked to creating and sustaining a positive work environment.
Unfortunately, at many organisations, too much time is spent on non-managerial tasks and too little time, if any, spent on leadership activities.

A closer inspection of the current state versus ideal state reveals this discrepancy. On this page, the width for these pyramids represents the amount of time and energy managers are spending on the activities. The height shows the importance of these activities to overall unit performance.

The goal of this research is to re-envision the unit manager role to help executives bring their managers’ work into proper balance.
To address this challenge, executives must first take a closer look at why the nurse manager role is out of balance today. Four main challenges surfaced during the course of the Global Centre’s research.

First, many executives have not been looking in depth at the unit manager role and what is required in today’s health care environment.

Secondly, nurse managers face often overwhelmingly large spans of control—making it difficult to spend personal attention with each nurse.

And while an overwhelmingly large span of control can certainly complicate things, managers are also not working efficiently. So even with a manageable span of control, managers can get bogged down with non-managerial work or spend too much time on complex managerial tasks such as budgeting and staffing.

Finally, frontline managers struggle to prioritise the activities that will deliver long-term results versus fighting the fires of the moment. Leadership activities can often be poorly defined, and they find it easier to focus on the here-and-now, short-term wins versus the long-term strategy.

Key Challenges Preventing Optimal Performance

1. Executives Not Addressing the Problem
   
   **Oversight Too Expansive**
   
   Unit managers not able to devote enough personal time to lead staff on their unit

   **Volume of Non-Managerial Work**
   
   Spending too much time doing work that can be delegated to non-managerial staff

   **Ill-Equipped to Perform Expert Managerial Work**
   
   Unit manager ineffective, inefficient at day-to-day managerial work

   **Attending to the Immediate**
   
   Immediate unit needs, lack of tools, guidance overshadow long term strategic focus from unit managers

2. Managers’ Span of Control Too Large

3. Managers Not Working Efficiently

4. Managers Not Prioritising Effectively

Source: Advisory Board interviews and analysis.
Re-Envisioning the Unit Manager Role

This page presents a strategic framework to address each of these challenges in turn.

First, every organisation needs to think critically about a feasible way to restructure the nurse manager role. Every organisation needs to assess its own priorities and design the role accordingly.

Next, in patient care services, executives need to revisit managers’ spans of control to enable managers to spend time truly leading individuals on their units. The Global Centre recommends thinking differently about span—re-scoping the role and taking careful stock of where existing resources might be leveraged to refocus the role on specific priorities.

Restructuring the role itself is not enough; executives must also ensure managers are focused on the highest-value activities. To do that, executives need to help managers spend less time on the things that they are spending too much time on today, thereby securing daily efficiency gains.

Managers also need accountability mechanisms to ensure they are using that extra time on the most important activities and protecting those activities from the more immediate concerns in their role.

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### Restructure the Role

1. **Clarify Role Expectations**
   - Establish the Priorities
     - Unit Manager Responsibility Prioritisation Exercise
   - Identify Gap to Goal
     - Unit Manager Time Audit

2. **Revisit Span of Control**
   - Refocus Current Role
     - Unit Microsystems
     - Unit Leader Dyads
   - Scale Additional Support
     - Data-Driven Needs Assessment

### Ensure Strategic Prioritisation

3. **Secure Daily Efficiency Gains**
   - Delegate Non-managerial Work
     - Supported Supervisory Status
     - Unit-Level Administrative Support
   - Formalise Expert Partnerships
     - Financial Problem-Solving Teams
     - Dedicated Human Resources Specialists
     - Unit-Based Clinical Leaders
   - Structure Day Around Priorities
     - Sustained Manager Rounding Time
     - Standard Management Work

4. **Protect the Important from the Immediate**
   - Enhance Real-Time Transparency
     - Staged Goal Tracking
     - Automated Unit-Level Dashboards

---

*Special Report*
- Interprofessional Unit Councils

Source: Advisory Board interviews and analysis.
Empower Managers to Focus on Leadership Activities

These pyramids help visualise how each step of this research helps managers focus more time and energy on the most important leadership activities. It is imperative to move from the role as it stands today on the left with too little time devoted to leadership activities, to the right with the most effective balance of leadership and management activities in the front-line unit manager role.

Division of Unit Manager Time

<table>
<thead>
<tr>
<th>Restructure the Role</th>
<th>Ensure Strategic Prioritisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarify Role Expectations</td>
<td>Secure Daily Efficiency Gains</td>
</tr>
<tr>
<td>Revisit Span of Control</td>
<td>Protect the Important from the Immediate</td>
</tr>
</tbody>
</table>

Source: Advisory Board interviews and analysis.
Road Map for Discussion

1. Preamble: Transforming Managers into Leaders
2. Re-Envisioning the Nurse Unit Manager Role
3. Coda: The Executive’s Imperative
Restructure the Role

• Clarify Role Expectations
• Revisit Span of Control
Two Imperatives for Restructuring the Role

The following section addresses two imperatives for restructuring the nurse unit manager role: first, clarifying role expectations and then revisiting span of control.

Many hospitals have not changed the nurse manager role very much across time, even though health care has changed dramatically. A unit manager’s role is defined by the size and scope of the unit—how many nurses and how many beds—rather than by the amount of work necessary to successfully lead that unit.

Therefore, the first step is to Clarify Role Expectations. Clear expectations allow the re-envisioning to start from a strong foundation. The following exercises help establish priorities and identify the gap to goal. Understanding the current reality and how far away is it from where the organisation needs to be is essential before moving forward.

1

Clarify Role Expectations
- Establish the Priorities
- Identify Gap to Goal

2

Revisit Span of Control
- Refocus Current Role
- Scale Additional Support

Source: Advisory Board interviews and analysis.
The health care landscape is changing and creating increased expectations for nurse unit managers. The increase in transparency of outcomes and scrutiny from accreditation bodies, governments, and payers means managers face more scrutiny for improvement and outcomes, even for those perennial nursing-sensitive indicators such as pressure ulcers and falls.

With these challenges, more and more tasks have been added to managers’ plates, often without removing anything.

“All these pressures, along with the demands of managing a budget, ward resources and a large team of nursing staff make the job almost impossible.”

Fenton K, “Developing Skills In Clinical Leadership for Ward Sisters”
Additionally, each task on nurse managers’ plates has become more complex.

Nurse unit managers were previously charged with delivering safe care to patients. Now they must structure opportunities for patient participation at the bedside, carefully monitor and report outcomes and errors, and manage care to reduce readmissions.

Unfortunately, hospitals cannot add more hours to the day to allow managers to complete all this work. Tight budgets also complicate efforts to improve the role, as many hospitals simply do not have the capacity to hire new managers and redesign unit operations to shift span of control.

To balance the new complexities in the role with the critical tasks that must be completed, something must change. Executives have a unique moment now to consider what is most critical for nurse unit managers to oversee, and how to ensure sustainability of the role for both current and future managers.

**Effect of Environmental Changes on Unit Manager Role**

- **Government-Regulated Quality and Safety Standards**
  - Increase and track patient satisfaction
  - Make patients aware of rights and responsibilities
  - Report patient outcomes

- **Rising Patient Acuity and Demands**
  - Build more complex rosters
  - Coordinate care with multiple providers

- **Increased Transparency**
  - Ensure staff revalidation
  - Track nursing hours per patient day

- **Staff Management**
  - Hit hospital LOS targets
  - Ensure morning discharges

- **Daily Unit Operations**
  - Greater focus on daily rounding
  - Reduce and monitor nurse-sensitive events

1) Length of stay

Source: Advisory Board interviews and analysis.
Organisations must ask if the current nurse unit manager job description is fit for purpose in this new reality.

The role of nurse unit managers has always been defined by their span of control—how many full-time equivalent staff and beds they manage. That is unlikely to change. However, given how unit management and care delivery has evolved, taking a step back and re-evaluating the scope of manager responsibilities is critical.

The pyramids on this page are currently blank. The Global Centre recognises that every organisation will have different priorities. The goal of this section is to help executives determine what their ideal state looks like, and then understand what their current state is—and what barriers prevent them from attaining their ideal state.

Clarify Role Expectations

Division of Unit Manager Time

1. Ideal State

Leadership Activities

Daily Managerial Work

Discussions: Establish the Priorities

2. Current State

Leadership Activities

Daily Managerial Work

Non-managerial Work

Tool: Identify Gap to Goal

Source: Advisory Board interviews and analysis.
What must unit managers be accountable for in their day-to-day role? What are they doing too much of? Not enough of?

The Global Centre asked all of these questions during the course of our research—via 549 completed surveys from executives and unit managers, more than 250 qualitative interviews, and extensive literature searches. All of these data revealed six core areas of accountability for the nurse unit manager role.

Each one of these represents an essential component of the role. Organisations may prioritise these responsibilities differently—but executives and managers in the same organisation must have a consistent vision of the managers’ priorities.

The Global Centre also found a wide array of tasks and responsibilities that a manager could own within each area. While nurse managers are still accountable for everything that happens on their units, they should not be personally responsible for every task.

Executives and managers need to come to a consensus—about what priorities are most critical for their organisation and which tasks managers should be responsible for.

### Six Key Areas of Accountability for Unit Managers

- **Patient Care Services**
- **Quality Improvement**
- **Business and Financial Operations**
- **Daily Unit Operations**
- **Staff Management and Development**
- **Service External to the Unit**

### Representative Unit Manager Responsibilities in Patient Care Services

- **Provide direct patient care**
- Lead discussions with doctors, nurses, and allied health staff regarding clinical care delivery
- **Establish a feedback process for patients and caregivers**
- **Review patient feedback, identify trends, and share with staff**
- **Coordinate discharge planning and processes**

Access these resources and more in-depth tools online at [advisory.com/unitmanagertoolkit](advisory.com/unitmanagertoolkit)

Source: Advisory Board interviews and analysis.
There may be some differences of opinion between managers and executives on what the priorities for the nurse manager role are—and what can be delegated. It is therefore important to work with the executive and managerial team before restructuring the role. Involve managers in any discussions, because they have valuable insights and opinions about the reality of the role.

It is also important to highlight the difference between accountability and responsibility. Managers remain accountable for everything that happens on the unit, but they do not need to be responsible for performing every single task within those areas of accountability.

Ultimately, the prioritisation exercise should drive actions on restructuring the role and ensure that the role is set up to deliver on the most important things.

### Fundamental Considerations for Aligning Priorities with Role

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Share Priorities and Obtain Buy-In from Stakeholders</td>
<td>Clarify priorities with managers; consider feedback when making strategic plan for role restructuring.</td>
</tr>
<tr>
<td>2</td>
<td>Differentiate Between Accountability and Responsibility</td>
<td>Ensure manager retains accountability for all six areas. Rethink the responsibilities and tasks within areas to maximise managers’ role.</td>
</tr>
<tr>
<td>3</td>
<td>Adjust Support to Reflect Your Priorities</td>
<td>Structure manager support to meet unit needs. Use priorities as a guide to selecting approach. Empower managers to delegate as needed.</td>
</tr>
<tr>
<td>4</td>
<td>Embed Structures to Instill Priorities in Day-to-Day Activities</td>
<td>Develop necessary infrastructure to facilitate manager focus on strategic priorities. Maximise existing structures and tools.</td>
</tr>
</tbody>
</table>

Source: Advisory Board interviews and analysis.
Team-Based Discussion Guides

To assist with critical conversations in setting priorities and determining areas of responsibility and accountability, the Global Centre has created an online suite of tools with discussion guides and templates.

In these online tools, the six areas of accountability are also broken down into tasks. This list is by no means exhaustive, it is simply a representative sample of the types of things unit managers do on a typical day.

These resources are designed to help executives and managers understand what tasks and responsibilities should truly fall under the unit manager, and what the ideal unit manager role looks like at their organisation.

These tools are available in greater detail on the Global Centre’s website.

Access these resources and more in-depth tools online at: advisory.com/unitmanagertoolkit

Source: Advisory Board interviews and analysis.
The Current Challenge

Audits Reveal Discrepancies Between Vision, Reality

Managers Spending Too Much Time on Day-to-Day Operations

Managers’ Actual Time Spent Versus Assistant Vice Presidents’ Ideal

Differences in Percentage of Time Spent (Manager Actual Percentage Minus AVP Ideal Percentage)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Manager Actual Percentage</th>
<th>AVP Ideal Percentage</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing/Scheduling</td>
<td>(10.8)</td>
<td>10.3</td>
<td>(7.3)</td>
</tr>
<tr>
<td>Maintenance of Unit</td>
<td>(9.8)</td>
<td>8.2</td>
<td>(1.6)</td>
</tr>
<tr>
<td>Office Functions</td>
<td>(7.3)</td>
<td>6.0</td>
<td>(1.3)</td>
</tr>
<tr>
<td>Meetings</td>
<td>4.4</td>
<td>4.0</td>
<td>(0.4)</td>
</tr>
<tr>
<td>Problem Follow-Up</td>
<td>5.7</td>
<td>5.0</td>
<td>(0.7)</td>
</tr>
</tbody>
</table>

Bars on the left: Managers spending less time than AVP ideal

Bars on the right: Managers spending more time than AVP ideal

Ensure Alignment of Priorities

“We found our [unit managers] were spending less than 40 percent of their time on clinical leadership... Add in audit and reporting and it becomes apparent that the role has become so vast that it is impossible to dedicate the clinical leadership time necessary to ensure consistency in patient care and experience.”

Fenton K, “Developing Skills in Clinical Leadership for Ward Sisters”

Case in Brief: Main Line Health

- Three-hospital, 1,500-bed system in Philadelphia, Pennsylvania, US; approximately 50 unit managers
- Nursing leadership recognised that unit managers were overwhelmed and unsure of their priorities
- Senior Vice President for Nursing asked the Assistant Vice Presidents to create a tool to quantify the gap between the leadership team’s expectations and actual unit manager performance

A Simple Tool to Measure Behaviours, Expectations

Using a time-audit tool can provide the concrete data required to identify the gap to goal during role restructuring.

The Global Centre has created a similar time audit tool to be used for just this purpose. The tool is divided into two sections. The first permits managers to fill out their time expenditures based on areas of accountability. The other is for executives to aggregate results and compare nurse managers’ actual time allocation with executives’ ideal allocation of time.

This exercise allows leaders to identify areas in which unit managers need extra support and where they need to clarify expectations with the managers.

Global Centre’s Time Audit Tool Suite

Contains tools for managers to measure how they spend their time based on discussion areas of accountability and responsibilities

Includes tools for nurse executives to compare manager actual time allocation to executive ideal time allocation and identify gaps

Includes automated Excel worksheets designed to streamline time audit process and ensure accurate results

For a full version of the Global Centre’s Time Audit Tool Suite, consult advisory.com/unitmanagertoolkit

Source: Advisory Board interviews and analysis.
Recognising that time audits are intensive, an organisation may need to assess their need for such an audit. The Global Centre created this self-assessment to help organisations evaluate if this would be a useful exercise. Organisations that feel they have a good sense of where challenge areas lie may find a time audit is not worth the effort.

However, the audit can be useful not only to analyse the results, but also to facilitate a conversation between managers and leaders about the priorities and involve managers in the process of role redesign.

**Member Self-Test**

<table>
<thead>
<tr>
<th>Level of Executive Understanding</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you familiar with how nurse managers spend their time on a day-to-day basis?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you know where bottlenecks typically exist in the unit manager’s job at your institution?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unit Manager Ability to Prioritise</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Do managers focus on areas that you consider top priorities?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Are managers clear as to what their primary responsibilities and desired outcomes are?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Do managers generally know where they spend their time and, for the most part, feel that they have accomplished something each day?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Do you feel that there is little or no disparity in the unit manager ranks as to understanding about senior nursing leaders’ priorities?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**General Applicability**

The primary benefit of a time audit is identifying gaps between nurse executive and unit manager understanding of manager priorities. A majority of “no” answers indicates a potential “fit” for time audit at your institution.

**Direct Indicators**

Members responding “no” to questions #1 and #3 should strongly consider conducting a time audit.
Certainly, the first step to restructure the nurse manager role is to gain clarity on unit management accountability and daily responsibilities.

However, another essential piece is taking a serious look at nurse unit manager span of control. Do the nurse unit managers currently have the bandwidth to meet, and even exceed, the organisation’s expectations?

Two Imperatives for Restructuring the Role

1. Clarify Role Expectations
   - Establish the Priorities
   - Identify Gap to Goal

2. Revisit Span of Control
   - Refocus Current Role
   - Scale Additional Support
Span of Control Overwhelming

Outside of health care—the average span of control for a frontline manager is nine direct reports, a number that is unrealistic for the health care industry, yet certainly illuminating.

Nurse unit managers are charged with overseeing large numbers of people. Even managers of the smallest units can oversee a staggering number. According to a survey conducted by Heather Laschinger and colleagues, the average Canadian unit manager’s span of control was 71, and our research in Canada has shown that the maximum number of reports can be over 200.

The Canadian example is not an anomaly. Based on survey results, members of the Global Centre shared, the average span of control for nurse unit managers across a number of countries is 45.

Managers Struggle to Provide One-on-One Interactions with All Staff

Representative Unit Manager Span of Control

Span of Control Data

| 9 | Average out-of-industry span of control¹ |
| 45 | Average unit manager span of control across four countries² |
| 148+ | Maximum unit manager span of control in countries studied² |


¹ According to Harvard Business Review article “How Many Direct Reports?”
² Average of data from Canada, the UK, Australia, and New Zealand. Canadian data according to Laschinger, et al. 2008, n=788 first-line managers, Australian and New Zealand data from responses to Global Centre for Nursing Executives 2015 Frontline Manager Survey question “How many people report to you?” n=145 Australia and New Zealand unit managers. UK data from responses to same survey, n=196.
Span of control is more than just the number of full-time equivalent positions a manager oversees. As James Fenush and colleagues wrote that sustaining nurse manager leadership is challenging, particularly because the complex nature of the role and high numbers of direct reports increase demands on nurse unit manager’s time.

Each unit is, after all, a unique environment. The number of beds, extent of coordination with other areas, staffing mix, services, throughput, and hours of operation are just a few items that can contribute to the complexity of a nurse manager’s span of control. To truly revisit span of control for nurse unit managers, these factors must be taken into consideration.

Span of Control More than Simply Number of Direct Reports

Additional Factors That Contribute to Manager Span of Control

More Than a Numbers Game

“Sustaining and supporting nurse manager leadership within healthcare organisations is challenging work. The nurse managers’ role in overseeing complex care and a diverse workforce adds to the demands…Number of direct reports is one of several factors that affect manager leadership. Bed number, unit operation hours, throughput complexity, primary service numbers, and education and skill mix of personnel are components…”

James Fenush, MS, RN, et. al
“Nurse Manager ‘Span of Control’: Is it Out of Control?”

Source: Fenush, James, PRN, MS, et al. “Nurse Manager ‘Span of Control’: Is It Out of Control?” Penn State Milton S. Hershey Medical Center.  https://scholarsphere.psu.edu/downloads/9880v585; Advisory Board interviews and analysis.
One detrimental effect of unwieldy spans of control is limited time of direct connection with staff. This can have a dramatic impact on unit operations. Turnover increases and staff engagement suffers with increased manager span of control, and managers report that large spans of control have a negative impact on communication with staff.

Managers who oversee a large number of staff do not have capacity to promote staff needs and development. Additionally, limited clinical oversight can cause staff to feel unsupported in patient care, and patient experience is likely to suffer.

In these situations, leaders can lose focus. The Global Centre studied two organisations that regained their focus and alleviated span of control challenges by re-scoping the nurse manager role. These organisations identified priority areas of accountability for their unit managers that were falling short within their current infrastructures. They then figured out ways to repurpose existing resources to address the problem.

**Challenges Associated with Large Span of Control**

- Estimated **1.6% increase in turnover** for every additional 10 staff members in a manager’s span of control
- **27%** of hospital managers with a wide span of control reported a **negative impact on staff engagement**
- **40%** of hospital managers with wide span of control reported a **negative or very negative impact on communication with staff**

**Limited Focus on Professional Development**

Managers lack time to focus on individual needs of every staff member.

The first example is from Norton Audubon Hospital, a 432-bed facility in the United States. In the United States, strategic plans for hospitals are often visualised as a series of pillars, such as the Finance Pillar and the Quality Pillar. Norton Audubon recognised they had a problem in what they called their “People Pillar.”

Norton Audubon was interested in improving performance on human resource metrics such as RN vacancy rate and staff turnover. To achieve this goal, the hospital looked at how they might reorganise their nursing structure to better support their frontline nurses.

### Key Metrics Affected by Lack of Attention to Staff

- High Staff Nurse Turnover
- High Staff Nurse Vacancy
- Dissatisfaction with Communication

### Span of Control: The Root of the Problem

“We believed...that we needed to change the spans of control. We thought this would impact everything from our turnover to vacancies on units. We also set a goal of creating performance plans for every individual on an annual basis.”

Executive Norton Audubon Hospital

### Case in Brief: Norton Audubon Hospital

- 432-bed hospital located in Louisville, Kentucky, US
- Nursing leaders sought to improve performance on metrics comprising the “people pillar” in Norton’s strategic plan—including nurse turnover, vacancy, communication, and manager bench strength
- Nurse manager span of control identified as problem; nurse managers were unable to provide appropriate level of support for frontline staff, which impacted “people pillar” metrics for organisation
- Norton Audubon reorganised nursing organisational structure to deploy enhanced assistant nurse manager role, with goal of increasing interaction between management and frontline staff

Source: Norton Audubon Hospital, Louisville, Kentucky, US; Advisory Board interviews and analysis.
Norton Audubon began with a fairly typical nursing structure: their chief nursing executive oversaw patient care directors, who then oversaw unit managers who had shift-based charge nurses.

Under that structure, each manager was responsible for a minimum of 40 nurses. While a span of control of that size is fairly typical, Norton Audubon’s leadership team felt that those “people pillar” metrics, such as turnover, were suffering.

They decided to create a more permanent level in between the managers and the frontline staff. They elevated the charge nurses to be part of the unit leadership team—making them assistant nurse unit managers, or ANUMs. These ANUMs would formally oversee no more than 20 nurses each—essentially cutting the span of control in half on even the smallest units. The manager would directly oversee the ANUMs and maintain oversight of the staff. But the ANUMs could better support their smaller cadres of individual nurses on the front line.

New Assistant Nurse Managers Responsible for Small Subsets of Nurses

Nursing Department Structure Pre-redesign

Nursing Department Structure Post-redesign

1) Chief nursing officer.
2) At Norton Audubon Hospital the nurse manager role is equivalent to a unit manager.

Source: Norton Audubon Hospital, Louisville, Kentucky, US; Advisory Board interviews and analysis.
Trading a Patient Load for a Staff Load

In the US, charge nurses are typically more experienced staff nurses who are put in charge for a specific shift. They organise the operations for that shift, including patient assignments for the nurses, admissions and discharges, etc.

When Norton Audubon decided to elevate their charge nurses to ANUMs, they took away the responsibility of carrying a patient load. This allowed them to focus more on individual nurse needs, which in turn freed up the unit manager to provide general unit oversight as well as guidance for the ANUMs.

Additional manager oversight was important to improving key metrics at North Audubon. However, introducing new roles can be challenging, especially in times of strict budgets. Norton Audubon was able to introduce the new assistant nurse unit manager role across the organisation while adding only one FTE\(^1\) position in the process, as they focused on promoting existing staff and clarifying roles.

### Enabling More Direct Leadership with Only One Additional Full-Time Position

#### Key Changes in Norton Audubon’s Nursing Department Structure

<table>
<thead>
<tr>
<th></th>
<th>Before Redesign</th>
<th>After Redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title</strong></td>
<td>Charge Nurse</td>
<td>Assistant Nurse Unit Manager</td>
</tr>
<tr>
<td><strong>Number of FTEs(^1)</strong></td>
<td>44</td>
<td>45</td>
</tr>
<tr>
<td><strong>Source</strong></td>
<td>Preexisting roles</td>
<td>Promotion of charge nurses</td>
</tr>
<tr>
<td><strong>Hourly Differential</strong></td>
<td>+7% of RN base rate</td>
<td>+10% of RN base rate</td>
</tr>
<tr>
<td><strong>Shift Coverage</strong></td>
<td>24 hours, 7 days per week</td>
<td>24 hours, 5-6 days per week</td>
</tr>
</tbody>
</table>

\(^1\) Full time equivalent.

Source: Norton Audubon Hospital, Louisville, Kentucky, US; Advisory Board interviews and analysis.
A New Charge

Because Norton Audubon’s goal was to improve staff metrics, they focused the unit manager role on various elements of staff development. Time-consuming tasks such as scheduling became the responsibility of the ANUMs.

However, each ANUM was primarily responsible for one group of staff, not all staff on the unit. Not only were the ANUMs limited in what they looked after, but they were also limited in whom they looked after. This division into smaller groups allowed unit managers to devote more time to crucial tasks such as performance evaluations. By reducing the unit manager’s span of control and focusing on core responsibilities for supporting staff, the assistant nurse unit manager provides their team with the direct support they need, and remove some of the time-consuming people management tasks from the unit manager’s plate.

### Assistant Nurse Unit Managers Now focused on Elevating the “People Pillar”

**Core Responsibilities of Assistant Nurse Unit Managers at Norton Audubon**

<table>
<thead>
<tr>
<th>Core Responsibility</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete annual performance evaluations for assigned staff</td>
<td>Create, maintain unit schedule</td>
</tr>
<tr>
<td>Conduct monthly performance check-ins with assigned staff</td>
<td>Deliver in-the-moment coaching to all unit staff</td>
</tr>
<tr>
<td>Oversee discipline process for assigned staff</td>
<td>Assist manager with unit hiring</td>
</tr>
</tbody>
</table>

**Management Responsibilities Not Included in ANUM Role**

- Nurse manager develops and oversees unit budget
- Timekeeper tracks unit time and staff attendance
- Frontline nurses delivers direct patient care

Source: Norton Audubon Hospital, Louisville, Kentucky, US; Advisory Board interviews and analysis.
Standardised Staff Schedules Maintain Continuity

Not only did Norton Audubon elevate charge nurses to oversee nurses directly, they also rearranged the schedules to ensure consistency among team members.

Where possible, ANUMs were matched up with their cohort of nurses and worked shifts together. This consistency allows them to effectively provide coaching and guidance to staff, ensuring their continued development.

Additionally, while not applicable to all organisations, Norton Audubon did have a sizeable number of weekend-only nurses. They managed to accommodate this by having certain ANUMs who were also weekend-only, provide weekend nursing staff with the same consistency other staff had.

Without this scheduling adjustment, staff would work with a different assistant nurse unit manager each shift, undermining the original goal of the redesign.

For a copy of the assistant nurse unit manager job description and competency evaluation, please see advisory.com/unitmanagertoolkit

Source: Norton Audubon Hospital, Louisville, Kentucky, US; Advisory Board interviews and analysis.

1) Assistant nurse unit manager
Redesign Positively Impacts “People Pillar” Metrics

The ANUM role has had the desired effect: improvement on the key staff metrics in the “People Pillar”. In the first year after implementation, Norton Audubon saw no RN turnover and reduced the number of RN vacancies at the organisation to zero.

Unit managers no longer felt overstretched. They had assistants who were charged with very specific areas of responsibility. They were not jacks of all trades, but truly masters of one area. The ANUMs ensured that the units excelled in staff development. The unit managers were then better positioned to focus on the bigger picture.

This example shows how hospitals can reformat leadership structures to make a dent in the span of control problem without hiring new staff or significantly increasing costs—and see benefits for staff and unit performance.

Select Outcomes of Assistant Nurse Unit Manager Model in the Emergency Department

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN turnover in first year after implementation of ANUMs</td>
<td>0%</td>
</tr>
<tr>
<td>Number of open RN positions in first year after implementation of ANUMs</td>
<td>0</td>
</tr>
<tr>
<td>Wait list of prospective unit manager candidates</td>
<td></td>
</tr>
</tbody>
</table>

Extension of the Manager Role

“It has been helpful to me, with it being such a large department, to have another role to help with the communication with frontline staff. They are an extension of myself...”

Nurse Manager, Emergency Department, Norton Audubon Hospital

Managers Now Focus on Strategy

“...I can handle more of the global, management strategy for both of the units that I have. For instance, we are working on discharge process. I can rest assured that the staff issues are being handled [by the ANUMs], so I can devote time with the teams to develop discharge process improvements across the two units.”

Nurse Manager, Med/Surg Unit, Norton Audubon Hospital

1) According to Norton Audubon Hospital’s internal data collection and analysis.
Unquestionably, managers have broad accountability and oversight of their units—including both clinical and operational performance. And while improvement efforts are by necessity targeted across the full scope of a manager’s responsibility, there is often a tension between unit manager’s operational and clinical responsibilities. Many organisations feel this tension and reported that operational work can take priority because it is tangible, deadline-driven, and office-based, in contrast with clinical work’s amorphous, ongoing, unit-based nature.

When there is not enough focus on clinical leadership, clinical outcomes on the unit are at risk. Unit leaders are not responsible only for essential clinical tasks, but also for providing broader clinical oversight and leadership.

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**Operations Crowd Out Clinical Tasks and Clinical Leadership**

**Scope of the Unit Manager Role**

**Operational**

**Clinical**

**Tensions Between Operational and Clinical Work**

- **Tangible vs. Amorphous**
  Operations work includes specific tasks; clinical leadership not as measurable

- **Deadline-Driven vs. Ongoing**
  Operations work must be completed within specific short-term deadlines; clinical leadership not time-bound

- **In Office vs. On the Unit**
  Operations work often done away from staff on the units

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“Operations is a hungry bird that’s never satisfied. There’s always something you have to look at, all kinds of issues, funding, staffing, coverage, performance. It is endless.”

Rhonda Seidman-Carlson
Vice President Interprofessional Practice
Chief Nursing Executive
The Scarborough Hospital

Source: The Scarborough Hospital, Scarborough, Ontario, Canada; Advisory Board interviews and analysis.
This tension between operational and clinical work was what Rhonda Seidman-Carlson saw when she became the Chief Nursing Executive (CNE) at The Scarborough Hospital. Operations work on units was completed, but it was incredibly time-consuming for managers. Upon review, the CNE found an ineffective clinical structure that undermined the consistency of clinical leadership.

Patient care managers (the unit manager equivalent) at Scarborough oversaw both clinical and operational work. They had, however, recognized that frontline staff needed more clinical support and provided two types of clinical support roles: nurse clinicians and nurse educators.

These two nurse specialists, however, did not typically coordinate with each other, let alone with the managers, to provide clinical leadership for the unit as a whole. Instead, each role focused on its particular target group, resulting in a siloed approach. These roles did not sufficiently meet both patient and staff needs. Their physical time on a given unit was limited. When staff went to patient care managers for clinical support when the other clinical leaders were unavailable, they found their managers consumed with operations and unable to provide support.

Old Structure of Nursing Leadership Roles at The Scarborough Hospital

- **Patient Care Manager**
  - Responsibility for managerial and operational tasks, unit performance time-consuming
  - Also attempts to provide clinical oversight

- **Nurse Clinician**
  - Subject matter expert on specific patient populations within a program
  - Works with patients and families

- **Nurse Educator**
  - Broad-level expert
  - Works with staff on identifying knowledge gaps and education

Inefficient Use of Expertise

“When I arrived... the nurse clinicians didn’t work with the nurses, and the educators didn’t work with the patients. It seemed to be a very inefficient way to use expertise, and it tended to cause divisions... It’s all about applying knowledge and using it for best patient care.”

Rhonda Seidman-Carlson
Chief Nursing Executive and Vice President of Interprofessional Practice, The Scarborough Hospital

Case in Brief: The Scarborough Hospital

- 551-bed acute hospital located in Ontario, Canada
- Leaders wanted to increase staff accountability by changing their professional practice model
- To support new professional practice model and clarify confusion around clinical support roles, Clinical Resource Leader role was developed
- Clinical Resource Leader combined the Nurse Educator and Nurse Clinician roles in the old model and elevated the clinical support role to serve in a leader dyad with the Patient Care Manager

1) At The Scarborough Hospital, the patient care manager is equivalent to a unit manager.
Operational work and clinical work needed a dedicated leader at the unit level, so The Scarborough Hospital elevated existing managerial roles.

The Patient Care Manager was tasked with the more managerial aspects of running a unit. Essentially, the Patient Care Manager became the unit’s operational leader.

The Clinical Resource Leader is the person responsible for all aspects of education and clinical expertise on a specific unit. Scarborough redefined the nurse educator role and elevated those staff to a leadership position. The major difference now is that the role is dedicated to the unit and is charged with leading clinical activities, not simply educating the staff.

Scarborough thought carefully about how they could build an environment where this dyad worked as a cohesive team while maintaining accountability for overall performance. The CNE knew from looking through literature that there is a problem with separating operations and practice completely.

To overcome this, there is a 20% overlap between the Patient Care Manager and the Clinical Resource Leader. Each unit dyad negotiates what assistance they need from the other on their core responsibilities.

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**Partner Model Strengthens Clinical, Operations Focus**

**Overlap Creates Consistent Leadership on Multiple Fronts**

**Individual and Shared Responsibilities of New Dyad Leadership Model**

**Patient Care Manager**
- Payroll
- Scheduling
- Patient complaints
- Staff discipline

**Clinical Resource Leader**
- Staff certifications
- Staff education
- Onboarding
- Training programs

**20% Role Overlap**
- Incident reports
- Rounding
- Quality and safety projects
- Recruiting

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**Rethinking Unit Structures to Ensure Constant Clinical Presence**

“The decision was to combine [the nurse clinician and educator] roles and create a new role—the Clinical Resource Leader. But the literature talks about the problem of separating operations and practice. So we knew that we had to integrate practice by creating the partnership of the Clinical Resource Leader and the Patient Care Manager.”

Rhonda Seidman-Carlson
Chief Nursing Executive, Vice President of Interprofessional Practice
The Scarborough Hospital
Overlap Ensures Consistent Leadership on Unit

To ensure consistent leadership, the dyad works together in three key ways to develop a successful overlap.

First, both the patient care manager and the clinical resource leader know that, together, they are fully responsible for the unit leadership.

Secondly, they mutually decide on how the 20% overlap is going to play out on their unit on a day-to-day basis. They will decide which tasks they need help from their partner on, and at what times they might need coverage on the floor for example.

And finally, they have flexibility to change the definition of the overlap over time.

Key Strategies to Make Leadership Overlap Successful

- Mutually Responsible for Full Unit Leadership
  Together, the PCM and CRL have full responsibilities of the unit, ensuring reliance and trust between the leadership dyad.

- 20% Allocation Decided Together
  Each leadership dyad negotiates the responsibilities within 20% overlap as a team.

- Flexibility to Change 20% Over Time
  Structure allows flexibility to reevaluate and change responsibilities within 20% overlap over time.

A Negotiated Situation

“The 20% is a negotiated situation. [With this model, I] know that I have someone who has my back. I’m working with someone who I know, no matter what comes at us, we have a united front. If I’m pulled away from the unit for whatever reason, the unit is not unsupported.”

Clinical Resource Leader, The Scarborough Hospital

Source: The Scarborough Hospital, Scarborough, Ontario, Canada; Advisory Board interviews and analysis.
Having Each Others’ Backs

An example of this leadership dyad in action is provided here with an example from the emergency department (ED). Preparing payroll for the busy ED was a time-consuming task, one that required the Patient Care Manager to spend many hours on Mondays in her office, off of the unit floor. Because the Clinical Resource Leader is present on the floor and familiar with operational processes, the Patient Care Manager can process the payroll without worrying that her staff will not have someone to turn to for operational guidance.

Conversely, when the Clinical Resource Leader is pulled away for such tasks as developing new training initiatives, she knows that the Patient Care Manager will be available to provide clinical guidance and leadership to frontline nurses as needed.

The end result is that there is on-unit coverage 100% of the time, where leadership is always present with the staff.

Examples of Dyad Partners Covering for One Another

**Payroll**
Monday designated as payroll day for PCM; CRL spends full day rounding on staff and answering clinical, operational questions

**Special Project**
New initiative rolled out requires CRL to prepare training materials; PCM spends half-day on unit providing clinical supervision

Collaborating to Strive for Unit Excellence

“I think it really helped to standardise our approach and ensure we have collaboration of care. It helps us focus on patient care and strive for excellence.”

*Clinical Resource Leader, The Scarborough Hospital*

Source: The Scarborough Hospital, Scarborough, Ontario, Canada; Advisory Board interviews and analysis.
At Scarborough, frontline staff satisfaction scores have increased consistently since 2010, when the new leadership model was implemented. There was a 30% increase in employee engagement between 2010 and 2014.

Those involved in this kind of dyad model feel that they are better positioned to succeed in their respective roles, thanks to the more specialised nature of their work. They also point to the overlap between them and their leadership counterpart as being beneficial, increasing the support they feel in their work, knowing that they are not alone.

**Employee Engagement Scores**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>50.9%</td>
</tr>
<tr>
<td>2014</td>
<td>66.1%</td>
</tr>
</tbody>
</table>

*30% increase*

**Improving Quality Indicators**

“We have seen huge changes in our outcomes and indicators. Facility-acquired pressure ulcers are close to a never event. Our falls and medication errors have improved.

“And when there are problems they are dealt with right away because we have the professional practice model and clinical leadership resources in place.”

Rhonda Seidman-Carlson  
Chief Nursing Executive  
Vice President Interprofessional Practice  
The Scarborough Hospital

Source: The Scarborough Hospital, Scarborough, Ontario, Canada; Advisory Board interviews and analysis.
Unit managers around the world are struggling, and need additional support and a refined role to continue operating at the top of their license.

But there is an opportunity to evaluate the exact needs of a given unit more carefully, based on its own unique setup. To do this, however, robust data on manager span of control and purview complexity is necessary. This provides the needed information to see how different units measure up to each other in terms of supports and demands.

Hospitals Often Fail to Collect Sufficient Information to Support Role

Factors That Influence Span of Control
- Available budget
- Nursing leadership structure
- Hospital, unit size

Current Approach to Adjust Role and Support

Follow Past Precedent
- Use historical structures and support roles
- Continue with existing protocols with few changes

Take Partially Informed Action
- Review literature and peer work to assess need
- Informally speak with managers about desired support

Elements Necessary to Complete the Puzzle

Robust Data
- Limited unit-level data on manager span of control, role complexity
- Insufficient comparison data to determine cross-departmental needs and resource use

Strategic Integration
- Manager role assessment and additional support roles often separately developed from hospital priorities

Source: Advisory Board interviews and analysis.
In 1998, The Ottawa Hospital was going through a merger of three major sites: Riverside Hospital, Ottawa General Hospital, and Ottawa Civic Hospital. The merger brought together entirely different organisations that had different ways of operating, different models of care, and different cultures.

Salma Debs-Ivall, a project manager at The Ottawa Hospital (TOH), expressed it very well: “We were losing nurses, our vacancy and turnover were high, our patient satisfaction and nursing satisfaction plummeted, we had high sick leave, high overtime…we were in crisis…”

Staff were confused, and as a consequence patient care was suffering. Hospital leaders knew they needed to take action.

Different Ways of Working Yield Cultural, Quality Challenges

Impact of Ottawa Hospital System Merger

Overcome by Change

“We are talking about organisations that were competitors that had different cultures and completely different models of care, different ways of doing business...[after the merger] we were losing nurses, our vacancy and turnover were high, our patient satisfaction and nursing satisfaction plummeted, we had high sick leave, high overtime…we were in crisis…”

Salma Debs-Ivall
Project Manager
The Ottawa Hospital

Case in Brief: The Ottawa Hospital

• 1,117-bed hospital located across three sites, Civic Campus, Riverside Campus, and General Campus; located in Ontario, Canada
• In 1998, the three sites merged which created confusion about model of practice, as a result, leadership revised the professional practice model
• Unit managers led the unit changes and their role was seen as critical to successful implementation

Source: The Ottawa Hospital, Ottawa, Ontario, Canada, Advisory Board interviews and analysis.
TOH felt the most essential first step in integration was to adopt a new model of professional practice. TOH’s leaders worked with staff and patients to decide on values and goals of their model. Then they unified the entire organisation around a set of guiding principles centred on creating patient-focused care.

To ensure the new model was successfully embedded, TOH chose to roll it out unit by unit. Work groups on each unit, called “Advance Teams,” reviewed a unit’s situation and thought through changes necessary to better embody the guiding principles. All staff then helped identify improvement opportunities and action plans.

Unit managers led the charge. Their role was, rightfully, identified as essential to successful rollout of this new model. But TOH quickly realised that the current unit manager role was not sufficiently defined. They needed to revisit and re-envision the role to ensure success at the unit level.

A major realisation by TOH leadership was that the managers themselves needed new kinds of supports. But needs were not the same across all units, and money was tight. So leadership wanted to do a careful assessment of exactly what supports would help the units meet their goals.
Span-of-Control Analysis Reveals Support Gaps

To get an accurate picture, executives developed a comprehensive span-of-control assessment. It measured span of control in terms of FTEs, but that was just the beginning. The assessment accounts for unit-by-unit complexity on a whole range of factors.

Indicators in the assessment tool fell into three main categories: unit focused, staff focused, and program focused. Executives used the tool to assess what contributed to complexity and what the severity of the complexity was in each area.

When the severity ratings were all collected, unit managers each met with their specific director to discuss the evaluation appropriate next steps. Simply having the conversation did not automatically mean a support role was added onto the unit the next day. But it did allow the managers and their supervisors to create plans for how to find resources that matched their needs and how to advocate for that support. Managers were not left to feel their needs were forgotten.

TOH found this process to be about having a conversation and determining next steps. Additional supports do not need to be added immediately, but managers should be actively involved in any conversations to ensure the needs of both parties are met.

Evaluation Helps Align Support Roles with Manager Needs

Decision-Making Tool for Span of Control

<table>
<thead>
<tr>
<th>Unit-Focused Indicators</th>
<th>Complexity</th>
<th>Material Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>High</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff-Focused Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volume of Staff</td>
</tr>
<tr>
<td>Low</td>
</tr>
<tr>
<td>Medium</td>
</tr>
<tr>
<td>High</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Program-Focused Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversity</td>
</tr>
<tr>
<td>Low</td>
</tr>
<tr>
<td>Medium</td>
</tr>
<tr>
<td>High</td>
</tr>
</tbody>
</table>

How to use this tool:
1. Reflect on the reality of your unit/service for the last 12 months.
2. Circle a value of high, medium or low for each indicator, based on the corresponding definitions. Then multiply the point for that value times the weight to provide a total. Then add up all of the tools for each indicator and place your grand total on page 5.
3. Example: for hours of operation, if a unit is open 24/7 then you would circle high and multiply 3 points times a weighting of 2 for a total of 6. If a manager has 2 units and one is 24/7 and one is weekdays only, you would choose the higher rating.
4. Discuss the score with your Director to validate scoring range and its implications.

Ensure Uniform Support

“It has given me and the unit everything we need to actually function. Before the model, there were some units without ward clerks. That was ridiculous because you had some nurses doing non-nursing duties, and that doesn’t make sense. It gives you the ward clerk, the orderlies, the resources and the ability to work within those resources to provide the best care for patients.”

Clinical Manager
The Ottawa Hospital

Source: The Ottawa Hospital, Ottawa, Ontario, Canada: Advisory Board interviews and analysis.
Now there are the various layers of support within TOH. Unit-level supports focus on the needs of direct care providers and alleviate pressure on clinical managers (the term for unit managers at TOH) by directly supporting nurses.

Management supports activate additional unit-based specialty roles. For instance, the care manager and charge nurses (who report to the clinical manager) oversee the unit during weekend shifts, which provides on-unit presence during that time, and allows the clinical manager a much needed break.

And organisational support roles exist on a more centralised level to improve clinical managers’ efficiency on critical tasks like budget management and hiring.

Every level of support is seen as ultimately contributing to improving patient care and patient experience.

Source: The Ottawa Hospital, Ottawa, Ontario, Canada; Advisory Board interviews and analysis.
The entire structure at TOH offers mechanisms to move toward high-quality, patient-centred care. In addition to helping clinical managers by offering unit-specific and centralised support, TOH also facilitates their managers’ ability to maintain visibility, conduct routine analysis, and establish goals on their units. TOH protects time for managers to round on their units daily, provides managers with timely and relevant data to inform performance improvement, helps managers to create 90-day plans, and encourages them to share these with unit staff. All of these circle back to the strategic priority of patient care services.

**Practices Supporting Leadership’s Focus on Quality Patient Care**

- **Visibility**
  - Protected time for clinical managers to round on units

- **Analysis**
  - Clinical managers provided with relevant, timely data to aid in performance improvement

- **Setting Goals**
  - Clinical managers encouraged to share 90-day plan with unit staff

**Putting the Patient First**

“We really believe that a clinical manager’s role is really about knowing and supporting the nurses and patients in their programme. This model helps bring them back to the unit, to make them accessible, available, and accountable.”

Salma Debs-Ivall, Project Manager
The Ottawa Hospital

Source: The Ottawa Hospital, Ottawa, Ontario, Canada; Advisory Board interviews and analysis.
Supportive Infrastructure Yields Improvements

Not only has TOH consistently met their goals for patient-centred care, they are also seeing impact on HR indicators and staff satisfaction. More remarkably, since 2011, the clinical manager turnover rate has dropped from 4.8% to 0%. This speaks to the ability of a model like this to support managers in a very meaningful way.

Source: The Ottawa Hospital, Ottawa, Ontario, Canada; Advisory Board interviews and analysis.

1) Based on The Ottawa Hospital’s internal analysis.

Change in Performance Metrics After Implementation

Manager Turnover Rate

<table>
<thead>
<tr>
<th>Year</th>
<th>Pre-Implementation</th>
<th>Post-Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>4.8%</td>
<td>0%</td>
</tr>
</tbody>
</table>

14% Increase in nurse satisfaction over three-year initial implementation period

Turnover Rate

<table>
<thead>
<tr>
<th>Before Implementation</th>
<th>After Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>10.0%</td>
</tr>
<tr>
<td>2015</td>
<td>7.0%</td>
</tr>
</tbody>
</table>

Vacancy Rate

<table>
<thead>
<tr>
<th>Before Implementation</th>
<th>After Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>13.0%</td>
</tr>
<tr>
<td>2015</td>
<td>2.9%</td>
</tr>
</tbody>
</table>
Ensure Strategic Prioritisation

- Secure Daily Efficiency Gains
- Protect the Important from the Immediate
Unit managers are beset by a number of competing responsibilities and are expected to prioritise them efficiently. However, a limited amount of available time and the sheer number of tasks can overwhelm even the best laid plans.

Thus it is necessary to focus on strategies to ensure strategic prioritisation. The way to do that is first to secure daily efficiency gains. The, once manager time is freed up, they will have more time to focus on the most critical elements of their role.

But even with more time, many unit managers struggle to fill that free time with the most important tasks. Managers often prioritise the here and now—or tasks they are good at or enjoy. So to ensure strategic prioritisation, executives must also help unit managers protect the important from the immediate.

### Two Imperatives for Ensuring Strategic Prioritisation

<table>
<thead>
<tr>
<th>3</th>
<th>Secure Daily Efficiency Gains</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Delegate Non-managerial Work</td>
<td></td>
</tr>
<tr>
<td>• Formalise Expert Partnerships</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4</th>
<th>Protect the Important from the Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Enhance Real-Time Transparency</td>
<td></td>
</tr>
<tr>
<td>• Structure Day Around Priorities</td>
<td></td>
</tr>
</tbody>
</table>

Source: Advisory Board interviews and analysis.
Most unit managers are spending too much time on activities where they, in their role and with their expertise, are not a “value-add.” Instead, they should be dedicated to “top-of-role” activities. Efforts to secure daily efficiency gains help free up time for managers to focus on what really matters—more time for critical leadership activities that often get lost in the shuffle.

To do this, non-managerial work must be eliminated first. Then, agreed upon managerial work must become more efficient through support structures. These two steps give managers time back into their days to focus on oversight and leadership of the unit.
Unit managers are often mired in the details of day-to-day unit operations, or peripheral tasks.

The challenge is that when too much time is spent on these tasks—things like report writing, data collection, payroll management—there is a trade-off with other potentially higher-value tasks. These types of activities often keep managers in their offices and off their unit, away from staff and patients.

This means there is less time and opportunity for leadership activities such as coaching and mentoring staff. In effect, these peripheral tasks are squeezing out the high-value responsibilities of the re-envisioned unit manager role.

Time Spent on Peripheral Tasks Diverts Unit Manager Attention

Source: Advisory Board interviews and analysis.
Separating the Wheat from the Chaff

Ultimately, high-value responsibilities are those that cannot be shared or delegated to anyone else but the unit manager. There are two options to protect time for those types of high-value responsibilities.

First, remove non-managerial work from the manager’s plate. Managers are often performing tasks that do not need their level of expertise to perform. This is not to say the tasks are not critical for the successful operations of the unit; they just are not high-value tasks for the unit manager to do.

Next, make the agreed-upon managerial work even more efficient. Teams or support personnel can help ensure that work gets done better and faster.

Secure Unit Support to Ensure Managers Maintain Appropriate Focus

Two Methods to Seek Efficiency Gains

Doing Non-managerial Work

42% Of unit managers report that they spend “too much time” performing administrative office duties

Remove Work

• Ensure that unit managers are not expected to do work that is not value-adding, beyond the scope of their role
• Clarify who is responsible for completing administrative work

Doing Inefficient Managerial Work

1 in 3 Unit managers report that they spend “too little time” tracking quality on their units

Improve Support

• Identify experts throughout the hospital who can assist unit managers with complex or specialised work
• Develop teams on units to provide additional clinical oversight, guidance

1) Responses to the question: “In your opinion, how much time do you spend on these day-to-day tasks? Performing administrative office duties.” Possible responses were “Too much time,” “Just enough time,” “Too little time,” or “No time.” n=339 unit managers.

2) Responses to the question: “In your opinion, how much time do you spend on these day-to-day tasks? Quality tracking.” Possible responses were “Too much time,” “Just enough time,” “Too little time,” or “No time.” n=329 unit managers.

Source: Global Centre for Nursing Executives 2015 Frontline Manager Survey; Advisory Board interviews and analysis.
A Structural Difference in the Role

The Global Centre believes that direct clinical care and carrying a patient load should be considered “non-managerial work.” Nurse unit managers should be supervisory to practice. They need to be in charge of ensuring high-quality patient care, but not delivering it themselves. Managers should be “supernumerary” to practice and not counted in nurse-to-patient ratios, and thus be solely dedicated to supervising their units.

This is no longer an area of concern for some countries. However, in others, namely the UK and parts of Australia, there has been resistance to removing ward managers from direct patient care in many settings.

It seems straightforward that managers should oversee, rather than provide, patient care. But in environments where this is the long-standing norm, many nurse managers are still providing direct patient care—and despite the best intentions, there are barriers inhibiting change.

Supervisory Status Signifies Whether Managers “Counted in the Numbers”

Two Different Options for Nurse Manager Role

Non-supervisory (non-supernumerary) nurse managers carry a direct patient load, and are “counted in the numbers” when calculating nurse-patient ratios

Supervisory (supernumerary) nurse managers do not carry a direct patient load; they are not “counted in the numbers” and are dedicated to leadership and management activities

Government Mandates Recommending Supervisory Nurse Manager Role

Francis Inquiry (2013) published in England, stressing the importance of supervisory ward sisters to ensure high-quality care is provided by ward staff

Garling Report (2008) published in NSW, highlighting the need to redesign NUM role to enable them to focus on clinical leadership, supervision of patients and staff

Even in organisations where managers said they were supervisory, they still reported taking on patient assignments. In fact 98% of managers who self-identified as having supervisory status still reported taking on a patient load.

Sometimes, unit managers see it as their duty to pitch in and help. Other organisations report staffing challenges that prevent managers from completely removing themselves from patient care, especially as patients become increasingly complex. Tight budgets also make it more challenging for hospitals to hire sufficient staff to support a supervisory management structure.

In addition to budgetary constraints, there may also be a cultural resistance to change from both managers and executives. There is a hesitation by some to move toward 100% supervisory status because of the concern that supervisory unit managers will lose their clinical credibility. As a result, many organisations provide managers with a few days of supervisory time, with the other time spent on direct patient care.

### Potential Root Causes for Why Unit Managers Are Pulled into Patient Care

- Manager willingly filling in for staff
- Failure to appropriately plan for staffing gaps
- Increased care complexity
- Cultural resistance to change
- Frontline staffing shortage
- Financial constraints to making managers supervisory

### Filling in the Gaps

“Any good ward leader, if they are supernumerary but they have gaps in their rosters, will become clinical and become an extra pair of hands working on the floor looking after their patients. This ends up negating any benefit you get from giving them supernumerary status.”

*Deputy Director of Nursing, English public hospital*
Supported Supervisory Status

In Australia, Melbourne Health provided their nurse unit managers with some supervisory time. However, increasing expectations of the role led Melbourne leaders to re-evaluate their supervisory status.

Melbourne Health faced external pressures, including recent policy changes and government mandates calling for stronger, more visible clinical leadership on wards. In addition, they were very aware of recommendations made in the Francis Report following serious care lapses in the UK.

Melbourne Health’s nurse unit managers also raised concerns about the time constraints they faced. Because they had only two days of protected managerial time, managers were not able to complete the strategic aspects of their role. They were worried about clinical performance as a result. Even more pressing, the organisation as a whole was facing significant quality concerns.

Having reached their tipping point, Melbourne Health leaders decided to move forward with removing direct patient care responsibilities from their nurse unit managers and making them 100% supervisory.

Key Factors Prompting Leaders to Revisit Supervisory Nurse Unit Manager Role at Melbourne Health

- **External pressures and policy changes** influenced thinking at Melbourne Health, looking at the Garling Report and the Francis Inquiry.
- **Managers raised concerns about time constraints** and limitations on their ability to complete everything they were expected to with only two days of management time each week.
- **Quality concerns** prompted executive team focus on leadership; poor performance on falls and pressure ulcers necessitated action.

**Increasing Expectations for Strong Visible Clinical Leadership**

“We were conscious of the increasing expectations of the NUM role heightened through the introduction of the National Standards and the comparison of the Australian health system with that of that in the UK (Mid Staffs Inquiry). The lessons from the UK Mid Staffs Inquiry and NSW Garling Report highlighted the need for us to evaluate the NUM role description and position them with time to be strong visible clinical leaders.”

Kristie Mackenzie
Director of Nursing Workforce and Professional Practice
Melbourne Health

**Case in Brief: Melbourne Health**

- Health service located in Melbourne, Victoria, Australia; The Royal Melbourne Hospital is a 571-bed, acute, public hospital.
- Executives focused on the nurse unit manager role because nurse unit managers reported insufficient time to deliver on key elements of the role.
- National reports and quality concerns in other health systems, particularly the UK, also drove executives to review nurse unit manager position and structure.
- Melbourne Health invested in staffing to allow nurse unit managers to be completely supervisory, enabling them to reduce reliance on agency nurses, improve quality performance.

1) Nurse unit manager.

Source: Melbourne Health, Melbourne, Victoria, Australia; Advisory Board interviews and analysis.
Not a Small Request

Making nurse managers supervisory is certainly not a small request. It requires an up-front investment in additional nurses and thoughtful preparation for redesigning the manager’s role expectations and goals.

Melbourne Health’s nursing leaders took five key steps to determine what the new role would look like, how much investment would be needed, and ultimately how they proposed the case for 100% supervisory NUMs to their hospital board.

They followed broadly the steps necessary to make any project successful, which required gathering data, time spent making the case for the role, and even some revisions of the plan itself. Ultimately, these steps were critical to ensure that the new proposal was aligned with organisational needs and designed to most effectively support managers.

Thoughtful Approach to Ensuring Executive Buy-In

Key Steps for Proposing the Need for Supervisory Managers at Melbourne Health

1. **Identify Challenges with Current Role**
   - Melbourne leaders led focus groups with NUMs1 to discuss challenges with their role; reviewed external literature, policy

2. **Determine Key Attributes of New, Supervisory Role**
   - Clearly defined key attributes of supervisory NUMs, with guidance from published Royal College of Nursing recommendations

3. **Forecast New Staff Requirements**
   - Determined number of additional FTEs2 required for supervisory changes to occur; estimated total cost

4. **Develop Business Case to Secure Funding**
   - Created business case to be presented by CEO to hospital board, requesting investments for supervisory change

5. **Roll Out New Supervisory Manager Role**
   - Developed clear expectations for supervisory NUMs, provided training and resources aligned with new responsibilities

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1) Nurse unit managers.
2) Full-time equivalents.

Source: Melbourne Health, Melbourne, Victoria, Australia; Advisory Board interviews and analysis.
Melbourne Health’s executives knew it was important was to prevent unit managers from sliding back into delivering patient care.

First, the leaders developed very clear expectations for the NUM role. They looked to the literature and spoke with nurse managers before defining the expectations of for the role.

Leaders then communicated these expectations not only with the nurse managers, but also with all staff.

Executives found that it was important not only to develop policies and procedures that provided clear direction for unit managers in their new role, but also to stress the importance of communicating those new expectations with staff working with managers.

Finally, leaders at Melbourne Health provided their NUMs with a number of tools and training opportunities to support them in their new role. These included a Masterclass aligned with the new attributes of the role and a user-friendly NUMview dashboard to help NUMs track and analyse key metrics on their ward.

### Support Mechanisms Sustain Supervisory Status

#### Develop Clear Manager Expectations
Five attributes clearly outlined in the job description; attributes reflected both new realities of the role and expectations for performance.

#### Communicate Expectations with All Staff
Nursing leaders communicated expectations, new policies with directors of nursing, managers, assistant nurse managers, and frontline staff.

#### Provide Appropriate Tools and Resources
NUMs attended Masterclass training on new role; leaders developed resources to support NUMs in dedicating their time to ward leadership, strategic planning.

### Five Critical Attributes of Supervisory Managers

1. **Being visible and accessible** in the clinical area to the clinical team, patients, and service users
2. **Working alongside the team** in different ways, for example, by coaching
3. **Monitoring and evaluating standards of care** provided by the clinical team
4. **Providing regular feedback** to the clinical team on standards of nursing care, analysing and using patient survey results as drivers of change
5. **Creating a culture for learning and development** that will sustain person-centred, safe, and effective care

Source: Royal College of Nursing, “Breaking Down Barriers, Driving Up Standards. The Role Of The Ward Sister And Charge Nurse,” RCN, 2009; Melbourne Health, Melbourne, Victoria, Australia; Advisory Board interviews and analysis.

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1) Melbourne Health leaders utilised supervisory nurse unit manager attributes recommended by the Royal College of Nursing’s “Breaking Down Barriers, Driving Up Standards” publication when developing their expectations for supervisory nurse unit managers at their organisation.

2) Nurse unit managers.
One of the key steps in Melbourne Health’s process was gaining executive support. Executives, including the Executive Director of Nursing and the Chief Executive Officer, developed and presented the business case to the hospital board.

Tenacity on the part of the Executive Director of Nursing was instrumental to this business case finally being successful. Denise Heinjus, the Executive Director of Nursing Services and Allied Health, was absolutely determined that this was the right answer, and one “no” didn’t stifle her drive to eventually see this project come to fruition.

Thorough Business Case Convinced Board to Green Light Investment

Key Elements Included in Melbourne Business Case

- External literature, policies supporting argument
- Cost estimates for additional staff, proposed value in clinical outcomes
- Clear implementation plan, methods for evaluation

Demonstrating Value of Investing in Managers

“If you have a very vigilant, budget-conscious CEO, then you have to demonstrate the value...Using data to demonstrate that the investment in leadership equals improvement in patient and staff outcomes is important.”

Denise Heinjus
Executive Director of Nursing Services and Allied Health
Melbourne Health

Source: Melbourne Health, Melbourne, Victoria, Australia; Advisory Board interviews and analysis.
Already Seeing Positive Return on Investment

As noted before, changing the unit manager role was not a small feat, and it required a thoughtful approach along with some significant investment by the hospital board. However, Melbourne Health has seen improvement in a number of important areas; a significant reduction in reliance on agency nurses, a 50% reduction in falls across the hospital, and a huge increase in compliance with flu vaccination.

But beyond just these metrics, nurse managers at Melbourne Health also expressed increased satisfaction with their new supervisory status, leading to increased retention.

By removing direct patient care from managers’ workload, they have more time to devote to managerial and leadership work, and can positively impact patient care and quality.

Expanded “Time to Lead” Improving Quality, Reducing Costs

<table>
<thead>
<tr>
<th>Investments Made by Melbourne Health</th>
<th>Selected Improvement Results Since Supervisory Change Implemented in July 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$796,704</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Reduction in agency nurses to cover staff vacancies</td>
</tr>
<tr>
<td>Investment made by hospital board for elevating NUMs&lt;sup&gt;2&lt;/sup&gt;</td>
<td><strong>7.2%</strong></td>
</tr>
<tr>
<td><strong>12.26 FTE</strong>&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Total reduction in reported falls over the past 8 months</td>
</tr>
<tr>
<td>Number of additional employees needed to elevate NUMs to supervisory status</td>
<td><strong>50%</strong></td>
</tr>
<tr>
<td></td>
<td>Compliance with flu vaccination protocols, improved from 45% over two years</td>
</tr>
<tr>
<td></td>
<td><strong>94.1%</strong></td>
</tr>
</tbody>
</table>

Now Feeling Capable of Achieving Success

“A lot of the feedback we get is, ‘Thank goodness we got this supervisory role, because we couldn’t have achieved our responsibilities for the national standards without this extra time.’ They don’t know how they would have done what they needed to without this new structure.”

Kristie Mackenzie
Director of Nursing Workforce and Professional Practice
Melbourne Health

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1) Australian dollars.
2) Nurse unit managers.
3) Full-time equivalent.

Source: Melbourne Health, Melbourne, Victoria, Australia; Advisory Board interviews and analysis.
Of course, it is not simply caring for patients that pulls unit managers away from leadership activities. Administrative tasks consume a disproportionate amount of a unit manager’s time.

Unfortunately, as the quote at the top points out, the administrative assistant role is quickly on the chopping block when looking to save money in the short term. The problem with cutting the role is that the work doesn’t disappear. All too often, it gets shifted back onto the manager’s plates.

The effect of this is that managers spend far too much time on administrative tasks, something that is far below their top of role work. Twenty percent of time effectively boils down to one day in a five day work week. The level of administrative work has ballooned as reporting requirements increase and budgetary pressures mount, and these new realities are partially to blame for diverting time from leadership activities.

Administrative Work Detracts from Leadership Responsibilities

“While the role of Nurse/Midwifery Unit Managers was originally intended to provide clinical leadership, increasing expectations to undertake administrative tasks has detracted from this important role.”


Administrative Work Pulls Unit Managers Away from Core Tasks

“So much time is taken away for administrative work, which pulls the ward sisters away from bigger tasks.”

Matron

English public hospital

Costly Impact of Cutting Support Staff

“Some [administrators] take drastic action [in cutting costs] by reducing head count, starting with administrative support personnel… But disproportionately cutting support staff can be shortsighted when it lowers clinicians’ productivity and raises the cost of treating patients’ conditions.”

Kaplan RS, Haas DA

“How Not to Cut Health Care Costs”

1) Based on a study conducted by the University College London Hospitals Foundation Trust in 2011 to determine the daily activities of their ward sisters and how much time was dedicated to each task.

Hindering Ability to Recruit Managers

At University Hospital Southampton in Hampshire, England, unit managers expressed concerns about the growing amount of clerical work that was leaving little to no time for clinical leadership on their units. Becoming disenchanted with the role, they felt stretched too thin, were burning out, and ultimately leaving the position prematurely.

This troubled leaders at Southampton greatly. They wanted to provide the necessary support to ensure managers spent their time leading their units, not sitting in their offices overburdened with never-ending clerical work.

Southampton Endeavours to Ensure Leaders Use Time Appropriately

Key Factors Leading to Unit Manager Recruitment Challenges for Southampton

Ward Managers Burning Out
Managers\(^1\) expressed concerns with abundance of clerical work leaving little to no time for clinical leadership

Frontline Staff Disinterested
Frontline staff see role as burdensome, not interested in applying for existing vacancies

Not the Most Appropriate Use of Managers’ Time
“Our priority for ward leaders was around supervising and leading others, and spending the majority of their time on administrative work was not the most appropriate use of their time. We made an assumption that...a ward secretary would be worthwhile.”

Rosemary Chable, Associate Director of Nursing
University Hospital Southampton NHS Foundation Trust

Case in Brief: University Hospital Southampton NHS Foundation Trust

- 1,100-bed teaching hospital located in Hampshire, England
- Nursing leaders sought to support ward managers by providing an administrative support role that would alleviate clerical tasks consuming ward managers’ time
- Six full-time ward secretaries (Band 3) were employed to work across the hospital; each secretary covered two wards from Monday to Friday, providing administrative support to two ward managers within a directorate
- General tasks carried out by ward secretaries include: general secretarial duties, audit and project work, budget reviews, booking staff training and appraisal, managing annual and sick leave, managing schedule requests and rostering, gathering data for unit managers
- Costs in 2014 for Band 3 were £19K without “on costs,” £32K with “on costs”; costs in 2014 for Band 7 (ward sister/manager) were £40K without “on costs,” £68K with “on costs”

\(^1\) At Southampton NHS Foundation Trust ward managers are equivalent to unit managers.

Source: University Hospital Southampton NHS Foundation Trust, Hampshire, England; Advisory Board interviews and analysis.
Nursing leaders calculated the costs of having ward sisters (their unit managers) spend time on administrative tasks. Then they compared this to the salary of an administrative assistant. They conducted this cost analysis using the time the ward sisters were spending on administrative tasks and their (much higher) salaries.

Once given the green light on investment, the organisation hired full-time ward secretaries to work across the hospital. Each ward secretary covered two wards from Monday to Friday, providing administrative support to two ward sisters.

But all didn’t go smoothly—and Southampton learned some important lessons along the way.

Key Components of Introduction of Ward Secretary Role at Southampton

1. Analyse Existing Clerical Support Models
   Reviewed support roles in outside industries, such as teaching; found that even small input of administrative assistance had significant impact on workload

2. Calculate Costs Needed to Support Investment
   Calculated cost of having ward managers spend time on administrative tasks compared to salary of ward secretary

3. Develop Clear Job Description, Induction Training
   Leaders created a finalised job description with clear expectations for the role, as well as a development programme for the induction of new ward secretaries

4. Involve Ward Managers in Hiring Process
   Ward managers were involved in selection of ward secretaries throughout hiring process; each ward secretary shared across two wards, by two ward managers

For more details about Southampton’s ward secretary role, see advisory.com/unitmanagertoolkit

Source: University Hospital Southampton NHS Foundation Trust, Hampshire, England; Advisory Board interviews and analysis
Evolving to Overcome Barriers, Ensure Efficiency

At first, ward managers struggled to understand what type of administrative work to delegate to ward secretaries. The managers needed some delegation skill training to help them ascertain the tasks they could delegate to their ward secretaries.

Trust-building between the secretaries and the managers was also an issue. Even if managers had the skills to delegate work to their secretaries, a lack of trust in their secretary’s ability resulted in an unwillingness to delegate work. Leaders facilitated group discussions to help foster an environment of trust.

Due to limited work space on the wards, ward secretaries struggled to find space to complete clerical work. As a result, leaders provided all ward secretaries with laptops to encourage mobility when space was limited.

Overcoming these barriers ultimately allowed the new ward secretary position to be sustainable long term.

### Unexpected Barriers

- Ward managers lacked delegation skills, struggled to understand what administrative work to delegate to ward secretaries
- Ward managers needed to build trust in ward secretaries’ abilities in order to willingly delegate tasks
- Ward secretaries struggled with limited work space to complete clerical work on desktop computers

### Sustainable Solutions

- Leaders provided delegation skill training for ward managers; now include delegation skills in new clinical leadership programme
- Leaders facilitated group discussions, team-building exercises to build trust; involved ward managers in hiring; provided extensive training for new ward secretaries
- All ward secretaries were provided with laptops, encouraging mobility when space is limited

Source: University Hospital Southampton NHS Foundation Trust, Hampshire, England; Advisory Board interviews and analysis.
Southampton has seen significant improvements. The ward secretaries have been in place for seven years, and even in the austere environment of the NHS there are no plans to cut funding for the programme.

Having ward secretaries has saved each ward manager at their hospital an average of 26 days per year that they would have previously spent solely on administrative work. The institution has also experienced significant improvements on key performance indicators such as falls reduction. In addition there have been improvements in ward manager retention and the appeal of the role to the younger generation.

Adding administrative support can have a financial consideration. But by sharing secretaries across wards, Southampton believes they have paid for the investment based on the time savings and improvements on ward performance.

**Ward Secretary Saves Manager Time, Alleviates Recruitment Challenge**

26

Days each ward manager saved per year; equivalent to one office day every two weeks

**Improvements in Performance, Recruitment**

"In wards where they have a ward secretary and the ward leader is supervisory, we have seen real improvements in their key performance indicators in terms of reduced falls, improved appraisal rates and improved staff training rates.

"...We don't have an issue with succession planning into our Band 7 [manager] post now at all."

Rosemary Chable
Associate Director of Nursing
University Hospital Southampton NHS Foundation Trust

Source: University Hospital Southampton NHS Foundation Trust, Hampshire, England; Advisory Board interviews and analysis.
Southampton chose to share secretaries, but organisations and units have a number of options for providing administrative support. While there are a range of choices, the Global Centre recommends shared administrative assistants as the most cost-effective option for most institutions.

Unit managers are now responsible for a large variety of more challenging and complex work, and they must constantly switch between several different types of tasks. Some operational tasks actually do require the oversight and involvement of managers. However, the problem with these higher-level managerial tasks is that even they are taking up too much time and preventing managers from hands-on strategic leadership. Administrative responsibilities are just one example of this, and other tasks may also require targeted support.

A Range of Solutions for Administrative Support

<table>
<thead>
<tr>
<th>Type of Support</th>
<th>Additional Cost</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedicated Unit Secretary</td>
<td>Potentially high</td>
<td>• Provides full-time commitment, greatest potential to off-load clerical tasks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added cost may be prohibitive for many institutions</td>
</tr>
<tr>
<td>Shared Secretary</td>
<td>Moderate</td>
<td>• Provides part-time commitment, opportunity to off-load many clerical tasks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Possesses knowledge of nursing department needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Moderate cost, high benefits</td>
</tr>
<tr>
<td>Director’s Secretary</td>
<td>Low to none</td>
<td>• Secretary relatively uncommitted to manager’s projects, but provides accountability through personal relationship</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Some knowledge of nursing needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Very low incremental cost</td>
</tr>
<tr>
<td>Unit Clerk</td>
<td>Low to none</td>
<td>• Very little time available for assisting with even basic clerical tasks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Personal accountability, knowledge of unit needs, and convenience of location a plus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Very low incremental cost</td>
</tr>
</tbody>
</table>

Source: Advisory Board interviews and analysis.
Unit managers often spend too much time on non-managerial tasks that they should not be responsible for. However, even the tasks for which they should be responsible can be complex, resulting in inefficient work and ineffective outcomes.

One such area of concern is managing unit finances. For example, hospital leaders were asked to rate managers in a host of different domains. Unfortunately, many were not convinced that unit managers had the financial savvy to successfully manage the business operations of their units.

In some ways, this is understandable. Managers are promoted into these roles due to their clinical—not their financial—expertise.

But as the quote at right notes, it is more important than ever before that our managers be equipped to deal with the complexity of unit finances. Ministries of health are constantly asking hospitals to do more with less, and unit finances have a huge impact on organisational finances.

The right answer is not to outsource this completely to someone with more expertise and experience. But if managers are not set up for success in this critical area, they will be at a significant disadvantage.

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**Unit Managers Key to Meeting Financial Targets**

“...[H]ealthcare is constantly challenged to do more with less, to increase output with decreased financial input and to deliver better-quality care to increasing numbers of people. Nursing managers, a large proportion of the healthcare organisation's management team, must be equipped to face these changing and growing demands and to develop the knowledge necessary to ensure that the services and team they oversee meet the established goals.”

*Chubbs K, “Business Acumen in Nursing Management”*
Banner Health, a 23-facility system headquartered in Phoenix, Arizona, US, was experiencing a loss of 8% to 10% for Medicare, the government health payment system for those over the age of 65 in the United States. In essence, Banner was losing money on every patient over the age of 65. Their goal was to turn this around—with an ambitious aim to reach 5% profit by 2014.

Banner’s leadership realised that to meet this goal they would need to reduce labour spending, increase productivity, and create a more fluid workforce across all facilities.

For Banner, this would involve hundreds of managers who did not have the training or expertise to turn these goals into realities. The system would have to set up training programs, which would eat into time that managers were already spending doing other important tasks.

Many Managers Lack Business Training to Address New Targets

Medicare Margin Targets for Banner Health

<table>
<thead>
<tr>
<th>Actual Margin in 2011</th>
<th>Margin Goal for 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>-8% to -10%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Input Required

- Organisation must reduce labour spending across all 23 facilities
- All facilities must increase productivity based on external benchmarks
- Fluid workforce (part-time and seasonal staff) introduced to decrease percentage of full-time staff

Training and tools must be provided to hundreds of managers across the organisation, many with limited business training

Case in Brief: Banner Health

- 23-facility health system headquartered in Phoenix, Arizona, US
- To help line managers achieve their budgets, created two internal consulting teams to provide solutions for productivity problems
- Financial teamseams identify underperforming units, create software solutions to assist managers in monitoring real-time costs and productivity, work directly with units to overcome barriers to achieving productivity targets

Source: Banner Health, Phoenix, Arizona, US; Advisory Board interviews and analysis.
To better equip their managers for success, Banner created two financial teams to help the units that have the worst financial performance.

Banner was intent on capitalising on the system’s centralised expertise so they could meet their aggressive financial goal. They felt this was the best use of resources given their pressures.

The first centralised team is a group of seven Labor Management Engineers (LMEs). They are the data experts and tool developers.

The second team is a group of Clinical Operations Consultants (COCs). These are eight full-time clinicians embedded in the finance department. They work closely with department and unit leadership—in the trenches, so to speak—to identify the core problems. Because they are also clinicians, they understand the clinical environment and are trusted when they come to partner with the unit managers.

**Two Centralised Financial Support Teams at Banner Health**

<table>
<thead>
<tr>
<th>Labour Management Engineers</th>
<th>Clinical Operations Consultants</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Seven FTEs with data analytics expertise</td>
<td>• Eight full-time clinicians embedded in finance department¹</td>
</tr>
<tr>
<td>• Analyse all departments’ and units’ performance against external productivity benchmarks</td>
<td>• Work with leadership in all departments or units identified by the Labour Management Engineers</td>
</tr>
<tr>
<td>• Focus attention on underperforming departments, units</td>
<td>• Analyse root causes of productivity issues in underperforming departments, units</td>
</tr>
<tr>
<td>• Create custom tools to assist department leaders, unit managers with improving productivity</td>
<td>• Help department leaders and unit managers solve productivity issues</td>
</tr>
</tbody>
</table>

¹) At Banner these clinicians are registered nurses.

Source: Banner Health, Phoenix, Arizona, US; Advisory Board interviews and analysis.
The two centralised problem resolution teams at Banner Health work together to support struggling departments.

In the example shown here, the LMEs identified one department as performing below benchmark targets. The COC team was then deployed to work with the units in this department. They discovered that ineffective scheduling was the root of the productivity problem.

The COC and LME teams then worked together to build an electronic staffing tool that would address the productivity issue. The COC team also worked to help coach unit managers and department leaders on how to make best use of the tool.

Once the tool was in place and unit management and department leadership were trained in using it, the department began meeting their established targets.

Identifying Root Causes, Creating Effective Tools

Problem Resolution Teams Collaborate with Managers to Find Solutions

Representative Process for Supporting Unit Managers

1. Unit performing below benchmarking targets
2. Reasons for underperformance not readily identified
3. COCs uncover ineffective scheduling as root cause of poor productivity
4. Unit manager utilises staffing tool to alter scheduling process on unit

1) Automated, labour analytics software that provides analysis of key data such as labour costs and workforce productivity.

Source: Banner Health, Phoenix, Arizona, US; Advisory Board interviews and analysis.
Although small-scale improvements are always welcome, this practice has created large-scale impact as well. Banner Health has been able to save $150 million dollars.

Banner executives believe in the value of this strategy, and realised “A lot of the reason that managers weren’t able to schedule and staff effectively, is because they lacked tools...If they are able to better schedule people, they are better able to manage to their targets. Those that don’t have the [necessary support] are ineffective at building those schedules and are always over their targets. What we are trying to do is make sure they have the right tools to do their job.”

At Banner, the purpose of this practice was tied to an organisational financial target. In fact, this practice clearly helped the organisation as a whole, in addition to unit managers.

$150M
Decrease in Banner Health’s labour spend between 2011 and 2014

Helping Managers Meet Their Targets
“A lot of the reason that managers weren’t able to schedule and staff effectively, is because they lacked tools...If they are able to better schedule people, they are better able to manage to their targets. Those that don’t have the [necessary support] are ineffective at building those schedules and are always over their targets. What we are trying to do is make sure they have the right tools to do their job.”

Source: Banner Health, Phoenix, Arizona, US; Advisory Board interviews and analysis.
Finance clearly impacts the whole organisation, but there is another unit manager responsibility that has an equally large impact on institutions. The Global Centre coined the term “Chief Retention Officers” for unit managers in the early 2000s, and the title remains just as relevant today.

Unit managers have a clear human resource responsibility, engaging and retaining their staff, and ensuring that new recruits have the skills, training, and behaviours to succeed.

Unfortunately, nurse turnover remains a constant struggle. And not only does this reiterate the importance of unit managers’ involvement in human resources—it also means there is a lot of work for them to recruit new talent when someone leaves.

One study in the Journal of Advanced Nursing estimated that it costs between £13,000 and £41,000 for every nurse that turns over.

High Turnover Rates Require Investment of Unit Manager Time, Focus

Cost of Nurse Turnover Globally

$19K-$62K

Cost of replacing a nurse

Nurse Turnover in Australia

15%

Quarterly Turnover of Qualified Nurses

According to the Royal College of Nursing

6,000+ STAFF MEMBERS

2014 Net Loss of Regulated Nurses in Canada

According to Canadian Institute for Health Information

2,360 STAFF MEMBERS

St. Vincent’s Private Hospital in Sydney, Australia, was facing significant nurse turnover of around 15%, unsustainably high agency use, and high nurse vacancies, about 15 to 30 at any given time.

Essentially, St Vincent’s was in a reactive state when it came to turnover, agency use, and vacancies, with nurse unit managers and HR personnel always troubleshooting after problems occurred. Consequently, the unit manager’s time was being taken up by inefficient hiring processes. St. Vincent’s decided it was time for a change.

Originally, unit managers were responsible for almost the entire recruitment process. They wrote the position description, filtered through applications, conducted interviews, checked references, and took care of all the logistics of making the offer and coordinating onboarding paperwork. The full process took up to 10 hours for each staff nurse hired onto the ward. Put simply, it was an inefficient and ineffective way for unit managers to spend their time.

Estimated NUM Hours Spent to Recruit One New Nurse

- High Turnover: 15% staff nurse turnover
- High Agency Use: Agency use on units unsustainable
- High Vacancies: 15-30 vacancies at any given time

Realised old HR role too limited; unable to solve key nursing problems

Dedicated HR Specialists

Managers Burdened by HR Functions

Case in Brief: St. Vincent’s Private Hospital Sydney

- 270-bed, Magnet® designated hospital located in Sydney, Australia
- Found previous HR support role to be insufficient in supporting nursing, wanted to improve turnover, practice environment, and work toward Magnet® status
- In 2010, redesigned HR role to focus specifically on developing strategies to support nurse unit managers with workforce planning and development
- New role assists nurse unit managers and other nursing staff with hiring, performance management, staffing, professional development, industrial agreements, and succession planning
- Organisation has reduced vacancies to zero over the past five years after role restructuring
Notably, at the time, St. Vincent’s Private Hospital Sydney had someone in HR who in theory could help unit managers through this process. However, in practice, the person was a generalist who worked with the nursing team only in a limited capacity.

Rather than hire an additional HR support worker, St. Vincent’s Private decided to redesign this generalist HR role into a specialist role specifically dedicated to helping unit managers. The specialist is herself a former unit manager, and while that was not the intention when filling the role, it adds an extra layer of understanding.

The key is specialisation—taking advantage of one individual’s focus—but then finding ways to ensure that their expertise is deployed effectively to the people who need it when they need it. To ensure that the focus is effectively deployed across the nursing organisation, the HR specialist reports directly to the Director of Nursing (with a dotted line to HR). The director ensures that their work aligns to the nursing department’s priorities.

### Elements of Role Prior to Redesign

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reactive Workforce Planning</td>
<td>Worked to fill vacancies after they occurred</td>
</tr>
<tr>
<td>Generalist</td>
<td>HR role previously worked with nursing staff in a limited capacity</td>
</tr>
<tr>
<td>Distant Crisis Management</td>
<td>HR role interacted with staff minimally, as problems arose</td>
</tr>
</tbody>
</table>

### Elements of Role Following Redesign

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proactive Workforce Planning</td>
<td>Works with managers to plan for future vacancies, requirements</td>
</tr>
<tr>
<td>Nursing HR Specialist</td>
<td>Understands manager challenges, was previously a unit manager</td>
</tr>
<tr>
<td>Regular Visible Support</td>
<td>Consistent resource to all nursing staff on any topic related to HR</td>
</tr>
</tbody>
</table>

### Key Elements of Specialisation

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>New role reports directly to the chief nursing officer</td>
<td>Able to align support for managers to nursing department priorities</td>
</tr>
<tr>
<td>Require person in new role to understand nursing context</td>
<td>Knowing key priorities and time sinks for managers essential to supporting them</td>
</tr>
<tr>
<td>New role functions align to Magnet® designation goals</td>
<td>Proactive HR planning and support build a positive atmosphere for nursing staff</td>
</tr>
</tbody>
</table>

Source: St. Vincent’s Private Hospital, Sydney, New South Wales, Australia; Advisory Board interviews and analysis.
Collaborative Partnership Streamlines Manager Work

In line with nursing priorities, hiring a new nurse for a unit is now a joint effort at St. Vincent’s Private Hospital.

Unit managers remain accountable for reviewing resumes, conducting interviews, and selecting the best candidate.

Now, however, the dedicated HR specialist takes over the detailed aspects of the hiring process. She meets with unit managers to identify gaps proactively, posts position descriptions, collects the applications, and addresses all hiring aspects such as finalising paperwork, setting up pay and benefits, and coordinating the new hire’s start date.

This new process allows unit managers to focus on the aspects of the hiring process where their role is critical, such as assessing cultural fit and clinical skills. The dedicated HR specialist gives valuable time back to the unit managers enabling them to focus on leading units, engaging, and retaining staff.

Providing Space for Managers to Be on the Unit

“I support the managers with all of these human resources issues so they can be clinical managers on their units.”

Sarah Coleman, Workforce Planning and Development Manager, St. Vincent’s Private Hospital Sydney

Source: St. Vincent’s Private Hospital, Sydney, New South Wales, Australia; Advisory Board interviews and analysis.
In the five years since redesigning the HR role, St. Vincent’s Private Hospital Sydney has been able to bring their staff turnover down to 3%. Plus have had no vacancies over the past five years—the proactive planning has really paid off.

Additionally, by reducing turnover and cutting lag time between new positions, the cost of hiring a new nurse onto a unit is likely significantly lower than it otherwise would have been.

Being an Available HR Resource for Nursing

“Now staff come up to me and ask questions because they know me. I’ve become more available to staff and my predecessor had never done that.”

Sarah Coleman, Workforce Planning and Development Manager
St. Vincent’s Private Hospital Sydney

Source: St. Vincent’s Private Hospital, Sydney, New South Wales, Australia, Advisory Board interviews and analysis.
Financial and HR activities are core unit manager tasks, and manager oversight is irreplaceable. However, unit managers are ultimately leaders of clinical units, and overseeing the performance and quality of those units must be prioritised.

All too often, quality improvement projects fail or succeed by the level of oversight and attention the unit manager gives them. And when there’s an ever higher bar on quality improvement, that puts even more pressure on the manager.

Hospitals demand a great deal from nurse unit managers in terms of quality outcomes for their units, but institutions often fall short of truly supporting managers to do excellent work. Managers at University of Pennsylvania Health System, or UPenn, felt this. Executives at UPenn also thought too much of that pressure was lying squarely on the unit manager’s shoulders.

And one unfortunate incident prompted UPenn to take action.

### Quality Improvement Falling on Manager’s Shoulders

"[Unit managers] are the heart of the organisation – in terms of supervising quality, identifying when things go wrong and implementing improvement plans. We should be supporting them...But they’re not feeling like we’re supporting them in that job.”

Chief nursing executive, Canadian public hospital

### Representative Unit Manager Responsibilities Under Global Improvement Frameworks

- **Pressure Injury Prevention**
  - Track injuries, create evidence-based systems to prevent pressure injuries

- **Patient Falls Prevention**
  - Track patient falls; implement systems to prevent avoidable falls from occurring

- **Infection Prevention**
  - Track hospital-acquired infections; prevent them

### National Standards Overwhelming for Nurse Managers

“The demands from the new standards are overwhelming…I think there’s too much emphasis on meeting these standards…It doesn’t matter how organised you are, how many years you put into planning…it is very overwhelming.”

Nurse manager, Australian hospital

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2) Ontario Quality Improvement Plan requirement “Falls”, Australian NSQHS Standards, Standard number 10: Preventing falls and harm from fall.


At UPenn 23 nurses resigned from a single OR unit in one year. There were quality shortfalls, and when executives looked into the situation they found what they called a toxic environment.

Using 22 focus groups to learn more, executives found that there was a lack of accountability for quality improvement. Projects would start and stall, and interprofessional teams blamed each other for the lack of progress and poor quality.

The issue was not isolated to this unit alone. Unit managers across the hospital were trying to push forward quality improvement projects on their own. However, they lacked buy-in from their interprofessional colleagues, and as a result, they lost the resolve to implement initiatives on their own teams.

The leaders at UPenn knew they couldn’t afford to let negative and siloed professional relationships get in the way of quality patient care and hinder the work of their unit managers.

Lack of Cooperation Stymies Progress, Frustrates Staff

Root Cause for OR Nurse Resignation and Quality Issues OR Manager Faced

Finding the Root of Negative Environment and Quality Problem

“We had 23 nurses resign in the OR and we realised we had a toxic environment. So, we conducted 22 focus groups across the organisation and found that lack of professionalism in action was at the heart of this. So, we created our blueprint for quality; the foundation of this was unit accountability and the tactic for that was these unit-based clinical leadership teams.”

Dr. Patrick Brennan, Chief Medical Officer
University of Pennsylvania Health System

Case in Brief: University of Pennsylvania Health System

- Five-hospital health system located in Philadelphia, Pennsylvania, US
- System uses unit-based clinical leadership (UBCL) teams to develop unit-specific initiatives aligned to UPenn’s Blueprint for Quality and Patient Safety, a document outlining yearly system clinical imperatives
- Each team has a doctor, the unit’s nurse manager, a quality project manager, and additional unit relevant staff
- Stipends allotted to cover 20 hours per month for doctors dedicated to the doctor leader role
- Team members meet formally to develop unit-based initiatives; leaders charged with relaying information to members of their profession working on the unit
- UBCLs have implemented numerous successful quality improvement projects, and managers report that the teams are increasingly effective across time

Source: University of Pennsylvania Health System, Philadelphia, Pennsylvania, US; Advisory Board interviews and analysis

1) Operating room.
Building Unit Teams to Drive Quality Improvement

UPenn created an infrastructure of shared responsibility for unit-based quality improvement projects through a team they call their Unit-Based Clinical Leaders—or UBCLs for short. At its core, the UBCL is an interprofessional team of three leaders: one each from nursing, medicine, and quality improvement.

Each team has a quality leader from the centralised quality improvement department who facilitates the work of the UBCL. These leaders are quality representatives on several UBCLs across the organisation, usually within a specialty, or a department. They have a birds-eye view of what might be applicable across similar units and the ability to create cross-collaboration.

Each UBCL also includes the unit manager who provides the day-to-day perspective for the unit. The team is rounded out with a doctor who has a specific interest in the unit’s patient population.

To secure doctor participation created a small stipend to “protect” the doctor’s time dedicated to UBCL work. To earn the stipend, doctor leaders on the UBCL commit 20 hours per month to the team. On complex units, there is often more than one doctor on the UBCL.

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**University of Pennsylvania’s Core Unit-Based Clinical Leaders Team**

- **Nurse Leader**
  - Nurse manager on unit automatically serves as unit-based nurse leader

- **Quality Leader**
  - Central quality staff who serves as quality leader on multiple units, facilitates work of UBCL

- **Doctor Leader**
  - Doctor with patients on unit and interest in unit population

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**Unit-Dependent UBCL Membership**

- **Pharmacist**
  - Pharmacist added to UBCLs on units requiring high level of pharmacy input

- **Other**
  - Additional staff (APRN5, anesthetists, etc.) according to unit needs

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**Finding Doctor Time**

UPenn involved doctors by:
- Dedicating 20 hours per month to doctor leader role
- Allocating additional funds for person in the role
- Allowing two doctors to co-lead on complex units

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1) Unit-based clinical leaders.
2) Advanced practice registered nurses.
The UBCL team works collaboratively to find resolutions to a given quality issue. As an example, in the surgical intensive care unit (SICU) the UBCL found an unacceptable rate of readmissions.

The SICU team analysed their data and noticed a trend with respiratory patients. Whenever the patients were moved to the step-down unit, mistakes were happening, putting the patients at risk for aspiration pneumonia. The interprofessional UBCL team designed a checklist for respiratory patients who were entering or leaving the step-down unit.

Because doctors, nurses, and respiratory therapists had representation on the UBCL, the implementation process went smoothly. Each professional representative helped communicate the plan to their colleagues.

**UBCL’s Process to Address SICU Readmission Challenge: Green Sheet Project**

1. **Choose Focus**
   - High readmissions identified as key problem for UBCL to address

2. **Discuss with Partners**
   - Data showed high readmission rates among patients with respiratory complications

3. **Create Plan**
   - RRT\(^2\) included in discussion; team created new form; RRT/nurse sign form pre-/post-discharge to step-down unit

4. **Implement and Advocate**
   - RRT, nurse manager, doctor communicated and reinforced new protocol with their teams

5. **Assess**
   - Evaluation of readmissions rates revealed improvement

---

**Interdisciplinary UBCL Projects Enable Better Solutions**

“Our UBCL became a huge interdisciplinary operation…silos could not work on our unit with the types of patients we see.”

*Nurse Manager, University of Pennsylvania Health System*
Aligning Unit-Based Initiatives with System Goals

UBCLs create action plans specific to their unit needs. But there is a structure in place to ensure that these initiatives align with overall organisational priorities.

Annually, all UBCL teams are given a “Blueprint for Quality and Patient Safety,” a primer on the organisation’s strategic priorities for the performance year—which the quality lead reviews and brings to the UBCL team meeting.

Using this as a guide, the quality head leads a discussion on unit priorities—sharing unit-specific data with the group. The UBCL team homes in on a specific project and then collaborates with unit staff to create an implementation plan. And they repeat the process for other projects they have in mind.

Unit-Based Clinical Leaders’ Process for Goal Alignment

- **Start with Organisational Goals**
  - Quality lead reviews health system’s “Blueprint for Quality and Patient Safety”

- **Analyse Unit-Specific Data**
  - Team identifies greatest unit-specific opportunities for improvement

- **Align Unit Initiatives with System Goals**
  - Team selects unit-based initiatives that advance both organisational goals and unit needs

- **Create Unit Action Plan**
  - Team collaborates with unit staff to plan and implement targeted initiatives

Upenn’s blueprint guides overall strategy both for the institution as a whole and for the individual UBCLs. Leaders have created a series of structures to ensure there is both accountability for UBCLs’ individual performance and robust sharing of best practices. To accomplish this, there are monthly executive check-ins and Quarterly Grand Rounds. These structures embed a certain level of accountability within the teams to the organisation. They also provide specific times when others can learn what each UBCL is working on—and potentially apply a similar project to their own environment.

Formalising Collaboration Across the System

UBCL Meeting Structure Promotes Collaboration On and Off the Unit

Weekly Unit Meetings
Quality member facilitates weekly UBCL meetings; brings relevant data, information; all members contribute expertise

Monthly Executive Check-Ins
Monthly meetings with system executives allow UBCL teams to provide status updates, request advice, make case for additional resources

Quarterly Grand Rounds
UBCL teams come together across units quarterly for “grand rounds” to share lessons learned

Aligning Improvement Across the System

“The blueprint is a very important framework for the work that goes on in the organisation to ensure that there is some alignment across the organisation. It has gone through iterations as things have changed in the health care context, and UBCLs use the blueprint as their framework as they line up their projects.”

Regina Cunningham, Chief Nursing Officer, University of Pennsylvania Health System

Quality Teams Help Drive Results

Each unit can point to a number of improvements as a result of UBCLs. For example, UPenn has seen a 14% reduction in readmissions rates within their SICU, readmissions that would no longer be paid for under the new US rules.

Additionally, unit managers no longer have to drive quality improvement projects on their own. They now have interprofessional colleagues who can serve as project advocates. The unit managers also know who they can go to with quality concerns among the different professions.

Beyond their great results, the UBCL teams are engaged and excited about their projects, and they have strong interprofessional working relationships.

Part of the success of this practice lies in its enfranchisement of others around the unit manager to be leaders. Therefore, not everything falls on the manager, and the leadership work that leads to better outcomes gets prioritised.

Creating Quantitative Results and Building Efficiency for Managers

![Graph showing Central Line-Associated Bloodstream Infections](image)

**Central Line-Associated Bloodstream Infections**

**Nine-Month Period**

- **Units Without UBCLs**
- **Units With UBCLs**

33 fewer central line-associated bloodstream infections

**Quality Improvement Efficiencies UBCLs Provide to Nurse Managers**

- No longer driving quality projects alone
- Interprofessional colleagues serve as advocates among their peer groups
- “Go-to” colleagues available for specific interprofessional questions
- Quality problem delegation to interprofessional team members now possible

**UBCLs More Effective Over Time**

“I do see the UBCL evolve, and I do see the ways it makes my life better and better as time goes on. The UBCL is more and more effective as it becomes more enculturated.”

*Nurse Manager, University of Pennsylvania Health System*

1) According to SICU internal data collection and analysis.

In our research, we encountered another system that maximises and fully utilises those people who surround the unit manager on a daily basis. Shared-governance unit councils use the expertise of the frontline staff to positively impact the practice environment.

In *Energising the Nursing Workforce*, the Global Centre reviewed the details of shared governance structures as a way to engage frontline nurses in decision making. A core element of shared governance is unit councils.

In organisations with shared governance structures that include unit councils, the unit managers have a resource in plain sight. These unit-level councils can take ownership of improvement projects. The manager becomes an “advisor” or “facilitator” rather than the person leading the charge.

**Practice Environment Initiatives**
- Improve training around occupational hazards
- Develop new way to handle leave requests around holidays
- Create forum for staff dealing with stress and burnout
- Determine strategy to recognise staff for displaying organisational values

**Additional Resources from the Global Centre**
For more information, see our Tools for establishing a formal shared governance structure and our studies, *Energising the Nursing Workforce* and *Towards Staff-Driven Decision Making: Assessing, Building, and Sustaining Shared Governance* on advisory.com/international/gcne

Illustration of One Structure

*Source: Advisory Board interviews and analysis.*
UPenn also has a shared governance structure with very active unit councils. Most of the councils’ work focuses on improving the nursing practice environment.

Sometimes operations of the unit councils and the UBCLs overlap and they coordinate on work. But most time, the unit council does its own work separately.

One manager expressed the magnitude of the impact the unit council has on the unit manager role, “Having a shared governance structure takes a lot of responsibility related to staff-led projects away from the manager and puts it into the hands of the staff, which actually improves the work environment and staff engagement.”

Unit Councils Serve Distinct Purpose

Staff Experts in the Professional Practice Environment

Unit Responsibility Framework

- Unit Manager
  - Strategic unit leadership
- Unit Council
  - Practice environment improvements
- UBCL
  - Quality improvement initiatives

Example Unit Council Projects

- Improving staff shift handover communication
- Creating uniform color code so patients can easily identify various caregivers
- Improving staff documentation on the unit
- Changing location of supply storage on the unit

Unit Councils Relieve Managers of Different Pressures

“There may be other ways that managers need to be supported that UBCLs can’t help with…Having a shared governance structure takes a lot of responsibility related to staff-led projects away from the manager and puts it into the hands of the staff, which actually improves the work environment and staff engagement.”

Nurse Manager, University of Pennsylvania Health System

Coaching Managers to Work with Unit Councils

For the relationship between the unit councils and the manager to flourish, the staff need to feel empowered to make change. For that to happen, the manager has to understand how to work with staff in this framework.

Managers need to learn to release some authority. The command-and-control approach doesn’t work at all in this kind of environment. Managers must facilitate a sense of ownership among their staff. When staff truly own the improvements in their practice environment and are empowered to create changes, the unit will see improvements and some work can be removed from the unit manager’s plate.

In the unit council structure, staff are the leaders, managers serve as advisors, the practice environment is the focus. And, this last point is key: the more authority managers are able to give staff, the more that staff are empowered to make change—and support the manager in this way.

Key Pieces for Manager to Remember About Unit Councils:

- **Staff as Leaders**
  Unit council meetings, work, and decisions are staff-led

- **Managers as Advisors**
  Managers provide additional information in an advisory role

- **Practice Environment Is the Focus**
  Meetings and work are focused on unit practice environment

- **Managers Give Staff Authority**
  The more authority managers give staff, the more staff can help them

Questions to Ask When Triaging Project Ownership

- Is this something that requires manager authority to implement?
- Is the answer to the problem best determined by those who are affected by it daily?
- Does this work require a high level of staff activation?
- Is this related to the unit practice environment?
- Is this something staff feel strongly about and will want to be involved in?

Thus far, the steps for re-envisioning the role have focused on clarifying expectations, as well as providing time and support for managers. However, the simple fact is that just freeing up time is not sufficient on its own.

The role of nurse unit manager is ultimately to be the first line of leadership in the organisation. Managers must focus on the most critical tasks to ensure that they, and their staff, are consistently doing the right thing.

To truly ensure strategic prioritisation, organisations must also develop structures that help managers protect the important from the immediate.

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**Two Imperatives for Ensuring Strategic Prioritisation**

1. **Secure Daily Efficiency Gains**
   - Delegate Non-managerial Work
   - Formalise Expert Partnerships

2. **Protect the Important from the Immediate**
   - Enhance Real-Time Transparency
   - Structure Day Around Priorities

Source: Advisory Board interviews and analysis.
If hospitals want unit managers to prioritise strategic oversight of their units, they cannot assume it will automatically happen simply by freeing up managers’ time. An infrastructure that helps them focus and see the bigger picture is critical, as are structures that help build in accountability on a daily basis.

**Division of Unit Manager Time**

- **Leadership Activities**
- **Daily Managerial Work**
- **Freed Up Time**

**Protect the Important from the Immediate**

- Enhance Real-Time Transparency
- Structure Day Around Priorities

**Source:** Advisory Board interviews and analysis.
While freeing up time will theoretically allow managers to spend more time on those high-value leadership activities, the benefits will follow only if managers actually spend that extra time on that high-value work. That is not an assumption executives can afford to make.

The Global Centre team surveyed nurse executives and managers and asked them to rank their top responsibilities. While executives clearly ranked leadership activities, such as creating a unit-based culture, as the number one priority, managers focused on operational responsibilities, such as ensuring safe staffing levels and managing patient flow.

### Unit Manager Focus Not Necessarily Aligned with Executive

#### Unit Managers Ranking Their Top Responsibilities

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain safe staffing levels</td>
<td>56%</td>
</tr>
<tr>
<td>Manage patient flow</td>
<td>36%</td>
</tr>
<tr>
<td>Create a cohesive unit culture</td>
<td>15%</td>
</tr>
<tr>
<td>Build relationships with patients</td>
<td>14%</td>
</tr>
<tr>
<td>Track and monitor unit performance</td>
<td>10%</td>
</tr>
<tr>
<td>Develop staff professionally</td>
<td>10%</td>
</tr>
</tbody>
</table>

#### Nurse Executive Ranking Top Unit Manager Responsibilities

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create a cohesive unit culture</td>
<td>38%</td>
</tr>
<tr>
<td>Maintain safe staffing levels</td>
<td>31%</td>
</tr>
<tr>
<td>Manage patient flow</td>
<td>21%</td>
</tr>
<tr>
<td>Build relationships with patients</td>
<td>19%</td>
</tr>
<tr>
<td>Develop staff professionally</td>
<td>15%</td>
</tr>
<tr>
<td>Track and monitor unit performance</td>
<td>10%</td>
</tr>
</tbody>
</table>

1) Responses to the question: "Please rank the top five overarching responsibilities of a unit-level manager’s position, by order of importance, with the most important as ‘First.’"
All too often, frontline managers lose sight of the bigger picture. Not just because they have so much work to do, but because this is the work they know—this is the work they prioritise. Managers are caught up in the immediate with relatively simple and concrete responsibilities that they know they can complete. This focus crowds out more long-term projects—projects that drive unit success.

Managers Often Consumed with Solving Immediate Problems

Organisation’s Strategic Priorities

Excel in providing high-quality clinical service
Provide cost-effective care
Improve patient safety

Unit Goals

Patient satisfaction
Staff development
Unit budget

Immediate Unit Needs

Low med supply
Equipment malfunction
Nurse calls out sick

Unit Manager

Source: Advisory Board interviews and analysis.
Of the unit managers surveyed from around the world, 46% reported that they spend too little time on performance improvement for their units.

Why is that?

One answer kept coming up: unit managers are constantly putting out fires.

Managers often, they get caught up in immediate needs that pop up unexpectedly. They have the least amount of time to do the most important things—to pull themselves out of the trenches and really take a look at what is happening on their units.

If organisations want to see improvements in quality and safety metrics that they are being held accountable for, unit managers need time to go beyond the daily work and see the bigger picture. After all, accomplishing goals without someone on the unit actually prioritising the strategic planning and goal setting for their unit performance is nearly impossible.

Unit Managers Struggle to Focus on Unit-Level Strategic Planning

Percentage of Unit Managers Indicating They Spend “Too Little Time” on Performance Improvement for Their Units

Struggling to Prioritise Leadership

“It’s like it is so complicated and they [unit managers] have so many papers on their desk, they are just lost in the day-to-day things that are asked of them: They can’t look back and say my unit is not the way it should be and here is how I’m going to lead the change and here is who I’m going to call for help and here is how we are going to work together. They are just not doing that.”

Associate Director of Nursing
Canadian public hospital

Constantly Putting Out Fires

“I was a ward sister for nine years and I loved the role...but you firefight and very seldom have time to stop and think: ‘What am I going to do with this team?’”

Matron
English public hospital

1) Responses to the question “In your opinion, how much time do you spend on these day-to-day tasks? Performance improvement and performance improvement initiatives.” Possible responses were “Too much time,” “Just enough time,” “To little time,” or “No time.” N=372 global unit managers.

Source: Global Centre for Nursing Executives 2015 Frontline Manager Survey: Advisory Board interviews and analysis.
When King Faisal started their magnet journey six years ago, they had a vision about how unit managers would work. They wanted managers to have clear goals, time to assess unit performance, and the opportunity to think strategically.

They envisioned head nurses using goals to help prioritise their work. They would break them into actionable tasks that made big goals seem manageable. They would prioritise daily work with these unit goals in mind. And they would use data to assess progress, and readjust where necessary.

But as is often the case—their vision was not immediately realised. Their goals were too vague, head nurses were still fighting fires, and they were not using data as a tool to drive performance.

Sometimes the structures are not entirely in place to apply rigor and ensure sustainability for implementation. King Faisal’s infrastructure, and the lessons they learned, help managers actually structure their days around these goals.

### Staged Goal Tracking

#### Unit Managers focused on Immediate Tasks

<table>
<thead>
<tr>
<th>King Faisal’s Ambition</th>
<th>King Faisal’s Reality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit goals are broken into actionable tasks and evenly distributed between head nurse¹, unit staff</td>
<td>Unit goals across King Faisal are broad, unclear and head nurse takes on majority of work</td>
</tr>
<tr>
<td>Head nurse structures work day with unit goals in mind</td>
<td>Head nurse’s day focused on immediate tasks, putting out fires</td>
</tr>
<tr>
<td>Head nurse creates data-driven goals, held accountable for unit performance</td>
<td>King Faisal staff not held accountable for using data to drive performance</td>
</tr>
</tbody>
</table>

### Often Blind to Important, Long-Term Unit Goals

#### Case in Brief: King Faisal Specialist Hospital & Research Centre (KFSH&RC) - Jeddah

- Three campuses located in Riyadh and Jeddah, Saudi Arabia: KFSH&RC¹ (General Organisation) – Riyadh; King Khalid Children’s Cancer Centre; KFSH&RC (General Organisation) – Jeddah
- KFSH&RC - Jeddah has over 3,200 personnel including 1,100 nursing staff with staff from 25 countries
- JCI² accredited since 2002, first hospital in Saudi Arabia, sixth internationally to achieve Magnet® Designation
- Unit-level goals have been in place for approximately six years, with increased formalisation of process of goal setting and reporting
- Each unit must set goals to support Magnet® outcome requirements in following areas: Patient Quality, Patient Satisfaction, Professional Development, and RN satisfaction

¹ At King Faisal Specialist Hospital and Research Centre, the head nurse is equivalent to a unit manager.

² Source: King Faisal Specialist Hospital and Research Centre, Jeddah, Saudi Arabia. Advisory Board interviews and analysis.
Helping Managers Develop, Track Unit Goals

King Faisal Specialist Hospital has put three key structures in place that allow goals to be cascaded from the executive level to unit level.

First, they have an annual nurse strategy day. In the morning, executive leaders present the organisation’s annual strategic goals to the head nurses. Then the nurse executive explains how those organisational goals translate into priorities for the nursing department. Managers then have a clear understanding of how their department and unit fit into the overall strategic objectives of the health system.

In the second half of the day, unit managers create unit goals and action plans for the coming year. They hear a presentation on how to create realistic and attainable unit goals, which King Faisal calls “smart goals.”

To ensure that managers and unit staff stay on track with their unit goals, the head nurses have quarterly check-ins with supervisors to discuss their progress on each goal.

Finally, dashboards help to ensure staff members prioritise the right metrics and track their performance throughout the year.

Key Structures to Enable Unit Goal Creation at King Faisal

Nurse Strategy Day
Annual nurse strategy day dedicated to presenting nursing department goals and working with head nurses to create unit goals, action plans for the upcoming year

Quarterly Progress Goals
Head nurses have quarterly check-ins with supervisors to discuss progress on goals

Dashboards
Dashboards ensure staff prioritise the right metrics, track performance throughout the year

Starting the Year with Annual Strategy Day
“We have an annual strategic planning day where they hear what is happening [across the organisation]... We then have an additional goal setting day where we work with the head nurses and unit council chairs to help set their goals for the upcoming year. So, we put a lot of structure around the process.”

Sandy Lovering, Executive Director of Nursing Affairs
King Faisal Specialist Hospital & Research Centre - Jeddah

Source: King Faisal Specialist Hospital and Research Centre, Jeddah, Saudi Arabia. Advisory Board interviews and analysis.
Drawing Focus to the Most Important Tasks

To help keep head nurses on track with unit goals, King Faisal employs two key strategies.

First, leaders at King Faisal help break down unit goals into smaller, quarterly targets. For example, at the end of the first quarter unit managers are expected to reach 25% of their final goal, and sustain additional improvements across each successive quarter.

This process helps make each goal feel more attainable. It also keeps managers and staff on track by providing specific targets to ultimately get them to 100% of their goal.

The second key component of the unit-level goals at King Faisal is the targeted action plan that head nurses create for each goal. Part of creating “smart” goals is to make them action-oriented and specific, so these managers work with unit council chairs and their staff to outline the crucial steps needed to achieve success.

Quarterly Check-Ins, Action Plans Keep Managers on Track

Percentage of Unit Goal Attained by Quarterly Check-Ins

<table>
<thead>
<tr>
<th>Quarterly Check-In</th>
<th>Percentage of Goal Attained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>25%</td>
</tr>
<tr>
<td>Q2</td>
<td>50%</td>
</tr>
<tr>
<td>Q3</td>
<td>75%</td>
</tr>
<tr>
<td>Q4</td>
<td>100%</td>
</tr>
</tbody>
</table>

Sample Unit Goal Action Plan

Unit Goal: Improve central line bloodstream infection rate to less than 4.3/10001 by December 2015

Action Steps
- Awareness of central line bundle through weekly in-services after morning hand-over
- Conduction spot-check hand-hygiene of 80% SN1, SN2, SN3 by August 2014
- Update privilege in CVC2 maintenance of 90% of current staff by June 2014
- Nurse Clinician and Primary Nurse to do daily rounding before 10:00 a.m. on CVC maintenance

For a copy of KFSH&RC – Jeddah’s Unit Goals Progress Report template, please see advisory.com/unitmanagertoolkit

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1) Per 1,000 device days. According to KFSH&RX – Jeddah internal data collection and analysis.
2) Central venous catheter or central line.

Source: King Faisal Specialist Hospital and Research Centre, Jeddah, Saudi Arabia. Advisory Board interviews and analysis.
In addition to helping head nurses prioritise the right work, King Faisal’s unit-level goals also empower these managers to say “no” to work that isn’t aligned to their goals.

While this seems simple, it is a challenge for many managers. They often say “yes” to any request they receive from staff, doctors, other managers, or their leaders. Then they feel overwhelmed.

To keep managers focused on value-added work, it’s important to empower them to delegate requests to others—or even question whether the request is actually necessary.

Creating, Communicating Goals with Unit Staff Clarifies Work

Requests Filtered to Appropriate Staff Member

<table>
<thead>
<tr>
<th>Request</th>
<th>Unit Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department leaders require units to implement central line compliance checklist</td>
<td>Reduce central line bloodstream infections</td>
</tr>
<tr>
<td>Daily rounding with unit staff to review CVC maintenance</td>
<td>Reduce central line bloodstream infections</td>
</tr>
</tbody>
</table>

Head nurse leads discussion with unit council, tracks progress with council

Head nurse passes request to clinical nurse specialist

Learning How to Say “No”

“One thing that I learned through the process is that I need to say ‘no’ sometimes. In the beginning, I would say ‘okay I will do it’ to everything. At the end I would feel that I loaded myself with a lot of things that are not in my job description, and it would be on top of everything I had to do.

“I reached a point through this process where I realised that I needed to say ‘this is my job and my responsibility, and this is not’ in a professional way. If we are in a meeting and the responsibility should belong to someone else or should be shared, we can talk openly about that.”

Head Nurse
KFSH&RC - Jeddah

For additional information about unit councils, see advisory.com/international/gcne/sharedgovernance

Source: King Faisal Specialist Hospital and Research Centre, Jeddah, Saudi Arabia. Advisory Board interviews and analysis.
Unit Achievements Drive Organisational Success

Since implementing this program, King Faisal has seen a 21% increase in the number of units across the organisation that have outperformed on all NDNQI measurements between 2010 and 2013. The NDNQI is a nursing indicators database often used by Magnet® hospitals to benchmark their performance.

More specifically, last year there were zero cases of ventilator-associated pneumonia in the cardiac surgery ICU, along with a steady decrease in number of patient falls and falls with injury. The CNO credits their overall process of creating unit-level actionable goals with these positive results on their key strategic priorities.

King Faisal’s leaders understand that the performance of the organisation is ultimately dependent on the work happening at the unit level.

As Sandy Lovering, Executive Director of Nursing Affairs, points out, unit goals help keep their staff focused on what the organisation is trying to achieve.

**Selected Results from King Faisal**

- **21%**
  - Increase in number of units outperforming on all NDNQI measurements from 2010 to 2013

- **0**
  - Cases of ventilator-associated pneumonia in cardiac surgery ICU (adults & pediatrics) for 2014

- **Decrease in patient falls and falls with injury from 2010 to 2013**
  - Decrease sustained in 2014

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*Focusing on Long-Term Goals*

“We found that by being goal-driven and having aligned goals, you can actually drive your results. Through these unit goals, we have been able to achieve really great outcomes around our quality indicators, our RN satisfaction, and our patient satisfaction. It keeps everyone really focused on what we are trying to achieve as an organisation this year.”

_Sandy Lovering, Executive Director of Nursing Affairs_  
_**King Faisal Specialist Hospital & Research Centre** - Jeddah_

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1) Results based on King Faisal Specialist Hospital and Research Centre’s RN Satisfaction  
T-Scores from Press Ganey National Database of Nursing Quality Indicators-Nurse Work Index RN survey.

2) Improvements resulted in hospital achieving 6/8 quarters better score than Magnet™ mean for ventilator-associated pneumonia rates.

3) Improvements resulted in hospital achieving 6/8 quarters better score than Magnet™ mean for total fall rate.

4) In neuroscience.

Source: King Faisal Specialist Hospital and Research Centre, Jeddah, Saudi Arabia. Advisory Board interviews and analysis.
To make better prioritisation decisions, not only do managers need to understand their goals, but they also need better data to assess their performance and progress against these goals. In the past few years, organisations have made great progress creating unit-level dashboards and giving unit-level performance data to managers. In fact, on the Global Centre’s annual survey, 72% of unit managers globally indicated they have access to data.

However, many managers still feel the data sets they have available are not easily accessible. The data is often difficult to find, and managers must spend time sifting through various databases or spreadsheets to find the necessary information.

Even when the right data is available, many unit managers do not have the time to analyse it, identify significant trends, and develop a plan of action for improving areas of weakness. To enhance performance transparency for unit managers, data should be easier to access.

### Majority of Unit Managers Do Not Appropriately Use Data

#### Percentage of Unit Managers Indicating They Have Access to Performance Data for Their Unit\(^1\)

- **72%**

#### Data at a Snail’s Pace

“We used to put all of the key performance indicator audits every month into a system. It was sent to our safety department. [The department] would collate all of the data and we would get a report back. It was quite slow—it would sometimes take three to four months to get back to me. I wouldn’t be able to see how we were doing... during that time.”

*Ward Sister*  
*Northern Ireland public hospital*

#### Data Is Hard to Digest

“We give them tons of data, but how do they have the chance to digest it and use it with their staff?”

*Nursing executive*  
*Canadian public hospital*

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\(^1\) Responses to the question: “Do you have a manager dashboard or other means of easily accessing performance data and information relevant to your unit?” Possible responses were: “Yes,” “No,” and “Unsure.” n=385 global unit managers.
Melbourne Health in Victoria, Australia, realised that their Nurse Unit Managers (NUMs) did not have easy access to data. Their NUMs struggled to consistently track performance data for their units.

Managers raised concerns with the database Melbourne Health had in the past:

- Key metrics were very difficult to access; they were often dispersed among different databases or spreadsheets.
- The process for collecting and entering data was manual and slow. Therefore, key information and incident reports could fall through the cracks.
- Finally, the process for generating trended reports was very manual and thus time consuming.

Melbourne Health realised the inefficient data collection process was impeding progress on key indicators. They decided to make this process more seamless.

**Managers Struggle to Consistently Track Data to Impact Performance**

**Key Problems Associated with Melbourne Health’s Past Database**

- **Inaccessible**: Key metrics difficult to access, dispersed among different databases
- **Limited Usability**: Manual process for entering and collecting critical data, incident reports
- **Inefficient**: Time-consuming process for generating trended data reports

**Starting from Scratch**

“There was nothing in place when I came four years ago into this role. Getting data was a very manual job and doing reports was a lengthy process. [Managers] needed something that was easy to understand.”

*Nurse Unit Manager
Melbourne Health*

**Case in Brief: Melbourne Health**

- Health service located in Melbourne, Victoria, Australia; The Royal Melbourne Hospital is a 571-bed acute care, public hospital
- Hospital-wide focus on quality improvement and better data performance was a mandate from the new CEO
- Existing data was difficult for many nurse unit managers to access, not intuitive, and reports were often only available monthly, making it challenging to respond to safety and quality concerns in a timely manner
- As part of hospital-wide dashboard development, institution invested in nurse unit manager-specific dashboard to track quality, financial, and staffing indicators at unit level
- Improved access to data supported falls reduction campaign which saw 20% average reduction in injurious falls each month

Source: Melbourne Health, Melbourne, Victoria, Australia; Advisory Board interviews and analysis
Building a More User-Friendly Platform

The overhaul of the data collection process started with Melbourne Health’s Business Intelligence team consolidating existing data from across the organisation into a common location. The group worked with leaders to identify which metrics would be most important to track.

While this was an organisation-wide initiative, Melbourne Health wanted to ensure NUMs, in particular, had access to the right data. Based on feedback from NUM focus groups, the Business Intelligence team created a NUM dashboard. Called NUMview, the dashboard is user-friendly and consolidates, tracks, and visualises data on a daily basis.

While quick and easy access to the online dashboard helps NUMs track progress, training was also essential to enable managers to use the dashboard to improve outcomes. The initial training was followed up by visits to the teams and also individual sessions on request.

Melbourne Health leaders have found that people are now declining some of the training sessions—not because they are disinterested but because they find the tool self-explanatory and easy to understand.

Melbourne Provides Clear, Easily Accessible Metrics Through NUMview

Process for Developing NUMview Platform at Melbourne Health

1. **Consolidate Data**
   Relevant data from various internal, external sources consolidated into one “warehouse”

2. **Decide on Metrics**
   Focus groups determine most important data needed to focus on 12 top KPIs

3. **Build Platform**
   Qlikview visualization tool enables display of current, actionable information

4. **Provide Training**
   Live demos held with managers, with opportunities for Q&A

5. **Roll Out Across Org**
   All managers have access to NUMView following training

6. **Follow Up with Managers**
   Managers have regular check-ins on usability; regular masterclasses planned

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1) Key performance indicators.
2) QlikView is a business data visualisation and analytics tool from the Qlik software company, which is based in the United States and provides online business intelligence and visualisation software platforms and programs.

Source: Melbourne Health, Melbourne, Victoria, Australia; Advisory Board interviews and analysis.
NUMView is an easy-to-read, scannable page. NUMs can open the application as soon as they come in for their shift and check incidents from the previous shift. Monthly reports are clearly shown on the top of the page, and they allow NUMs to quickly identify trends and analyze common factors such as time of day, day of week, or even the age of the patient.

Each NUM meets monthly with their Divisional Director of Nursing and Operations to review unit-level key performance indicators. In the meeting, they discuss any variances and check on action plans that have been developed to address specific areas of variance.

Additionally, NUMview has drastically cut the time to generate reports and therefore allows managers to use data to reduce patient harm.

To illustrate one example, NUMs can use the falls page to gather information on trends and isolate the important factors that could be contributing to the incidence of patient falls. For example, there may be more falls occurring at 10am, which is morning tea time and there are less staff on the ward to supervise patients.
Since the NUMview dashboard was introduced in November of 2014, Melbourne Health has seen remarkable improvements in their rate of inpatient falls resulting in fracture, with the average falling below their target just a few months after implementing the tool.

As Denise Heinjus notes “Giving managers information to make good decisions is vital for improving timely patient care.”

Giving NUMs access to better, more timely data, and teaching them how to use it, can help them prioritise the activities that will drive better performance. And it can help them in their efforts to instill accountability on the unit.

**Reported Inpatient Falls Resulting in Fracture**

2013-2015

Target = 0.099

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Nov</td>
<td>0.257</td>
<td>0.082</td>
</tr>
<tr>
<td>Dec</td>
<td>0.257</td>
<td>0.082</td>
</tr>
<tr>
<td>Jan</td>
<td>0.257</td>
<td>0.082</td>
</tr>
<tr>
<td>Feb</td>
<td>0.257</td>
<td>0.082</td>
</tr>
<tr>
<td>Mar</td>
<td>0.257</td>
<td>0.082</td>
</tr>
</tbody>
</table>

**Driving Decisions with Improved Data**

“We have gone from spread-sheeting to finding things at the click of a button. This saves a lot of time, and as a manager you always want to build efficiency. Giving managers information to make good decisions is vital for improving timely patient care.”

Denise Heinjus
Executive Director of Nursing and Allied Health
Melbourne Health

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1) Per 1,000 bed days. According to Melbourne Health internal data collection and analysis.
2) NUMview tool rolled out across hospital in November 2014.

Source: Melbourne Health, Melbourne, Victoria, Australia; Advisory Board interviews and analysis.
It is not sufficient for managers to just have access to data. They need to use it to motivate staff to take action on the weak areas pinpointed through data analysis.

Data can be crucial to help managers and staff focus on the most important priorities, but executives need to make sure data is used effectively to transform performance.

In the recent study *Instilling Frontline Accountability*, the Global Centre identified three key steps to illuminate individual impact and make dashboards meaningful reports on current performance and improvement opportunities.

Manager-Led Strategies for Instilling Accountability with Dashboards

- **Highlight Key Priorities on a Continual Basis**
  Manager pulls key priorities from unit dashboard data, uses data to create and regularly update clear list of priorities for unit staff.

- **Translate Rates Into Lives and Lives Lost**
  Manager selects rates from unit dashboard to translate into patient impact metrics, communicates patient impact through supplemental charts with graphics showing number of patient cases.

- **Share Caregiver-Level Data with Staff**
  Manager includes select individual caregiver data on dashboard, recognises top performers, and links individual compliance to larger outcomes for the unit.

For more information, see our study *Instilling Frontline Accountability* and our Nursing Dashboard Metric Selection Tool at: advisory.com/international/gcne

Source: Advisory Board interviews and analysis.
Clear goals and accessible data can help unit managers prioritise big-picture goals. However, managers still struggle to consistently carve out appropriate time for priority activities.

For example, when managers are present and visible on the unit, staff are more engaged and outcomes improved. And yet many managers do not prioritise the time to build this positive culture every day.

To enable managers to have quality time with their staff and their patients, and to use that time effectively, many organisations have implemented manager rounding. The basics of the process are simple: the manager sets aside time to observe unit service delivery and talk with staff and patients about specific challenges. Unit managers are visibly present on the unit and can see firsthand what is going well and what needs improvement.

But while many institutions are actually going so far as to require manager rounding, globally more than 56% of managers who try to round do not do so consistently.

The Current Challenge

Managers Distracted by In-the-Moment Tasks

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But while many institutions are actually going so far as to require manager rounding, globally more than 56% of managers who try to round do not do so consistently.

Struggling to Protect Time to Focus on Important Responsibilities

The Importance of Being on the Unit

"Leadership’s role…is about being out on the floor, working with the staff, and experiencing the care that is required rather than doing it from behind the desk. It is about doing clinical leadership, decision making, understanding the patients in your care, and the staff’s strength and weaknesses in providing that care, capitalising on strengths and developing weaknesses, and quality communication."

Chief Nurse
Australian public hospital

Percentage of Unit Managers Indicating Whether They Protect Time on a Daily Basis to Round on Patients, Staff1

- Yes, every day: 55%
- No, I do not routinely protect time: 23%
- Sometimes, but I often get caught up in other work: 22%
- Sometimes, but I do not routinely protect time: 5%

Too Many Priorities Too Little Time

"The days are long. There are always competing priorities, and there never feels to be enough time."

Nurse manager
Canadian public hospital

1) Responses to the question: “Do you protect time on a daily basis to round on patients and staff and provide in-the-moment coaching and feedback?” Possible responses included: "Yes, every day,” “Sometimes, but I often get caught up in other work,” “No, I do not routinely protect time.” n=401 unit managers.

Source: Global Centre for Nursing Executives 2015 Frontline Manager Survey; Advisory Board interviews and analysis.
Rounding often can be seen as a nice-to-have activity when another project or priority comes up. This was the case at Winant Hospital, a pseudonymed organisation in the United States.

Winant introduced daily unit manager rounding across the organisation to improve patient satisfaction. When they began, their patient satisfaction score was at the 58th percentile. Unit manager rounding soon had a noticeable impact, moving their score up to the 87th percentile.

But introduction of an electronic medical record system interrupted their progress. Managers often found themselves pulled away from rounding, and satisfaction scores dropped to the 76th percentile.

EMR\(^1\) Implementation Distracts Unit Managers from Rounding

Unit Manager Rounding Initiative at Winant Hospital\(^2\)

<table>
<thead>
<tr>
<th>Unit manager rounding introduced on all units as part of service excellence initiative; initial patient satisfaction 58th percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital decides to implement EMR on all units, requiring unit managers to stop rounding to concentrate on implementation process</td>
</tr>
<tr>
<td>Rounding has noticeable impact on performance across hospital and patient satisfaction; scores rise to 87th percentile</td>
</tr>
<tr>
<td>Untrained charge nurses(^3) take over rounding from managers; patient satisfaction scores fall to 76th percentile within three months</td>
</tr>
</tbody>
</table>

Case in Brief: Winant Hospital

- 400-bed hospital located in the United States
- Hospital began to focus on service excellence; leadership rounding introduced to support this effort
- Unit manager time protected daily from 7:00am-9:00am to facilitate rounding

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1) Electronic medical record.
2) Pseudonym.
3) At Winant Hospital, a charge nurse is a senior staff nurse designated as the go-to resource for unit staff on certain shifts.

Source: Advisory Board interviews and analysis.
New Structures Help Managers Prioritise Rounding

Executives knew that unless they signalled that rounding was a priority, managers would often deprioritise the activity. They created a structure to ensure rounding happened every day.

First, they blocked off the time between 7am and 9am each morning for rounding. During this time, no meetings requiring unit managers could be scheduled. The timing of the block allowed the unit managers to touch base with the night shift before they left, and to see what needed addressing during the day. This was clearly conveyed across the organisation to all the professions.

Secondly, they had unit managers create weekly rounding reports for the Chief Nursing Officer. These reports reinforced rounding completion, since unit managers now had to report on their results. But more importantly, it created a structured way for managers to reflect on notes from the week and identify unit needs and strategic priorities.

Protected Time, Weekly Reporting Make an Amorphous Activity Tangible

### Core Components of New Rounding Practice

<table>
<thead>
<tr>
<th><strong>Consistent Time Block</strong></th>
<th><strong>Weekly Rounding Report to CNO</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily meeting-free block allows managers to prioritise rounding every morning between 7am and 9am</td>
<td>Weekly report submission prompts manager to reflect on unit needs/strategy and informs CNO on unit performance</td>
</tr>
</tbody>
</table>

### Example of How Daily Rounding Notes Inform Unit Strategy

<table>
<thead>
<tr>
<th><strong>Wednesday</strong></th>
<th><strong>Thursday</strong></th>
<th><strong>Friday</strong></th>
<th><strong>Weekly Summary</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Daughter of patient 501 complains that the purpose of new tests was not explained</td>
<td>Patient 512 notifies manager that nurse Lee didn’t explain why his medication changed</td>
<td>Patient 519 complains that an aide drew blood without explaining why</td>
<td>Manager decides to set up staff training on explaining procedures to patients</td>
</tr>
</tbody>
</table>

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1) Chief nursing officer.

Source: Advisory Board interviews and analysis.
Leading to Sustained Patient Satisfaction

Not only did the protected time for manager rounding improve clinical outcomes, but it also affected patient satisfaction. After introducing protected time and CNO reporting, Winant’s patient satisfaction score rose to the 99th percentile.

Through the creation of structures of protected time and weekly reporting, Winant was able to ensure that managers continually advanced clinical outcomes and patient satisfaction even when other more immediate issues arose.

**Helping Managers Prioritise Improved Patient Satisfaction**

“It takes a lot of dedication and a lot of vigilance on the part of the nurse managers to get the kind of satisfaction results we have been getting, and it isn’t always easy in our busy, hurry-up world…to stay on top of that service component. A positive patient experience is the goal of our work, and we have built in accountability systems to make sure that happens.”

*Chief Nursing Officer, Winant Hospital*

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1) Pseudonym.

Winant Hospital’s Press Ganey Percentile Ranking After Rounding Restarted

*Overall Patient Experience*

Source: Advisory Board interviews and analysis.
The Need for Change

Protecting time in the manager’s schedule for daily rounding had significant results at Winant. Similar tactics have also worked elsewhere.

ThedaCare, a seven-hospital, US-based health system world-renowned for their work on lean management, also found that embedding structures in managers’ day-to-day work enables them to prioritise the right activities more consistently. But ThedaCare has been more prescriptive and has created Standard Manager Work—a daily template for managers to use to design their days.

In fact, ThedaCare credits their work to standardise manager work as a “breakthrough” in their journey. They realised that to achieve their goals in an ever-changing environment, they needed to adapt not only their processes, but also the way they managed their people.

We achieved a breakthrough…managers stated that ‘the ultimate arrogance is to change the way people work without changing the way we manage them.’ We realized then … [our] expectations of our people had changed, but the way we supported them had not.”

*Barnas K, “ThedaCare’s Business Performance System”*
ThedaCare started working with lean principles in 2003 with great success for five years—but in their improvement plateaued and a new ambitious goal was put in front of them.

A project team tasked with identifying the root cause of the plateau found that managers themselves weren’t well supported to support their teams in the lean way of working.

In focus groups, managers reported they suddenly felt responsible for things they had not been responsible for until now. For example, no one had explained to them how to sustain improvement or ensure that new tools and processes were truly embedded in their units. In the beginning, they worked with lean facilitators to implement new processes and resolve issues. Once the facilitators left, however, managers floundered.

ThedaCare had what they call a “breakthrough” moment. It is not enough to change the processes and expectations of the front line. They needed to think how their managers could support that work—and how the organisation in turn could support them.

Looking for Solutions as Improvement Stagnates

Timeline of Improvement at ThedaCare

In the beginning,

Continuous Daily Improvement

Lean methodology and goals introduced

Improvement plateaus when facilitators leave units

Time

10%

Annual Improvement
New productivity goal for ThedaCare announced in 2008

Failing to Keep Up with Initiatives

“We had... [lean] facilitators... [who] would help us with improvement and tools on the units... But once they left, the manager didn’t know how to pick that up. All of the sudden, they were back in the work and didn’t have someone helping to coach and push them. They became firefighters again... They were no longer organised around their problem solving.”

Jamie Dunham, Vice President of Operations, Appleton Medical Center, ThedaCare

Case in Brief: ThedaCare

• Seven-hospital system headquartered in Appleton, Wisconsin, US
• From 2003-2008, ThedaCare achieved significant improvements in quality and elimination of waste through a new improvement system called lean
• However, to meet its goal of continuous daily improvement, ThedaCare needed to change the way its managers and leaders conducted daily work
• Leaders developed their Business Performance System™ to achieve, sustain continuous daily improvement

ThedaCare began to develop their Business Performance System, a set of structures and tools to help managers at all levels organise their days, keep institutional priorities in mind, and identify and solve problems.

The cornerstone of this program is a concept ThedaCare adapted known as “Manager Standard Work”—very simply, a set of tools and guidance to allow managers to structure their day.

One example of standard work is that managers protect the first two hours of each day to fill out a stat sheet to identify any potential incidents from the previous shift, then huddle with staff and discuss findings. They then spend time on the unit, in the work space, interacting with their team as work is being done.

Very importantly, as part of their own standard work, VPs and other supervisors must also come to the units at least once a week and meet with managers to understand their struggles. Essentially the goal is to “stand in the work” and see where the issues might be, and what’s surrounding those issues.

For an excerpt of ThedaCare’s Manager Standard Work, please see advisory.com/unitmanagertoolkit

Using Standard Work to Achieve Quality Goals

For example, a manager from a medical/surgical unit starts her day filling out her stat sheet. In one case, she identified an increase in patient falls during the previous shift.

Per manager standard work guidance, the next step was to discuss the issue with her team. At this point, the manager also gathered volunteers from the front line to help identify root causes and put an improvement plan in place.

The team then spent time on the unit, observing and trying to understand why the falls were happening. They completed a root cause analysis that enabled them to identify that falls occurred while patients were in the bathroom. Through a standard approach to manager work and problem solving, ThedaCare leaders were able to identify potential challenges earlier and deliver on their ambitious goals of continuous improvement.

Case Study of Manager Application of Standard Work in a Medical/Surgical Unit

Manager reviews stat sheet to determine what risks to quality and safety took place during previous shift, identifies increase in patient falls

Manager establishes a plan with team to observe in the work (go see) for objective understanding of why patient falls are happening

Team determines falls are occurring while patients are in the bathroom; team implements new standard work for patients at high risk for falls

Manager leads daily huddle with staff and reports on findings; containment plan created

Manager pulls cross-unit team together for A3 1 work; team gathers data and drills down on root cause

Process and results audited and tracked for six months; patient falls in the bathroom diminish, driver removed from unit’s tracking board

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1) A3 is a structured problem-solving and continuous-improvement approach, first employed at Toyota and typically used by lean manufacturing practitioners.

Source: ThedaCare, Appleton, Wisconsin, US; Advisory Board interviews and analysis.
Standard work is so much more than just a schedule for the day. It gives managers the structures they need to push forward on organisational objectives. It allows them to feel continuously supported by involving their supervisors and the entire executive team.

Some may ask if there is a risk that standardisation comes at the expense of creativity.

Jamie Dunham, Vice President of Operations, believes that standard work at ThedaCare has actually promoted creativity by allowing people to focus on the things that truly matter, and giving them the opportunity to proactively identify problems and improvement areas.

### Key Component | Outcomes
---|---
Maps daily routines and strategies to organisation-wide goals | Managers have **clarity on their work within organisational priorities**
Serves as a guide to leading unit and interacting with staff | Managers are a **consistent, focused presence** on unit
Gives structure and tools for problem identification and action planning | Managers guide progress on continuous daily improvement
Creates **structured interactions** with multiple levels of management | Managers feel **supported and have consistent executive guidance**

Given that ThedaCare’s goal was to engender continuous improvement, they measured the number of improvements achieved by the pilot groups in 2010. Their objective was to introduce at least 300 improvements per unit during the year. They met that goal with over 3,600 improvements across the 18 participating units in the BPS program.

Additionally, by giving clear guidance, structure, and support, they have also been able to bring their managers into the fold and sustain 100% manager engagement two years in a row.

All Levels of Management See Benefits from Standard Work

“It works for the managers to be organised and have a system where they can problem solve and engage staff in problem-solving. [They] feel like they really have something concrete that they can go to daily and they’re not just firefighting... But it also helps me because I have a regular cadence. So... I have a VP standard work... [Now] I’m more engaged in the business.”

Jamie Dunham, Vice President of Operations, Appleton Medical Center, ThedaCare

Unit Improvements Documented in 2010

Number of Unit Improvements

100%
Percentage of manager engagement two years in a row
Road Map for Discussion

1. Preamble: Transforming Managers into Leaders
2. Re-Envisioning the Nurse Unit Manager Role
3. Coda: The Executive’s Imperative
Unit Managers, the Linchpins for Hospital Performance

Nurse unit managers are at the centre of any organisation. Their role is critical to engage staff, ensure quality care, and improve patient experience. As one nurse executive said, they may be more integral to daily operations than any other staff member.

“I could take out the nursing directors for a week and we would still function. I could even take out all of our executives and we would still be able to look after patients. But if I took out the nurse unit managers, we would have complete chaos within a day or two.”

Executive Director of Nursing & Midwifery
Australian public hospital

Source: Advisory Board interviews and analysis.
And yet, unit managers are at risk of burnout and turnover given the complexity and challenge of today's work environment.

To perhaps add insult to injury, the ageing nursing workforce is approaching a critical mass all around the world. Many unit managers are set to retire in the next few years. For example, in one US study more than 50% of nurse unit managers reported that they intended to leave their current position in the next five years. Certainly some of those nurses will move up to higher leadership positions, but many of them will leave nursing altogether, either due to burnout or retirement.

Many executives are starting to think critically about their succession-planning infrastructure—but we think these efforts may be underserved without a close look first at the unit manager role itself.

### Tackling Succession Planning

“We know that all of us baby boomers are going to be retiring in the next 5 to 10 years, so there is so much talk about succession planning, I think there’s a gazillion pieces of literature out there about succession planning…but how do you exactly do that?”

Director of professional practice
Canadian hospital

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1) US unit managers.

As Go Managers, So Go Staff

During the course of this research, the Global Centre heard repeatedly that the nurse unit manager role is seen as undesirable to many younger nurses. A number of Chief Nursing Officers said that even they would not want the job as it stands right now.

This is challenging for our current managers, but it also has a direct impact on our ability to recruit the next generation. Many nurse unit managers reported that they are in the role because they had an excellent manager who inspired them to apply for the position.

Not only do younger managers need only aspire to want the role, but they also need to be engaged by their own managers to be inspired to take the next step.

Managers Impact Engagement, Succession Planning

Correlation Between Leader Engagement and Staff Engagement

“Already Facing Struggle to Recruit

“We have struggled to recruit [for manager positions] because people don’t want to step up. They have the skills and would be fantastic managers, but they don’t want to take on the stress.”

Deputy Chief Nursing Officer
English public hospital

“Impact of Positive Role Modelling

“To find someone that is even willing to cover the NUMs' annual leave can be difficult on some units. However, on other units it’s not a problem at all. What it really comes down to is how the NUM portrays the role...”

Director of Nursing
Australian public hospital

Engaging Managers, So They Can Engage Their Teams

Organisations therefore need to think critically about whether unit managers' themselves are engaged.

Engagement has long been a focus of research for the Global Centre. Staff engagement is a priority for many organizations. However, in addressing frontline staff engagement, unit managers have been overlooked. Unit managers are expected to work to engage staff, when they themselves may be disengaged.

The Global Centre has done regression analyses on the drivers of manager engagement and has found that managers, not surprisingly, share many engagement drivers with all staff.

However, many organisations focus engagement efforts on frontline staff, neglecting the person in the role most critical to successful staff engagement efforts.

Study after study has shown that engaged managers are more likely to have engaged staff. And most organisations already have the necessary tools to support efforts to improve manager engagement, it is simply a matter of shifting focus.

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Engagement’s Ripple Effect

“There’s strong correlation between staff nurses’ positive relationship with their nurse manager and their engagement and longevity.

Ultimately, if you want to get the staff manager and staff nurse to stay, then you want to cultivate an engaged manager—the manager is the key to staff nurse engagement.”

Mackoff B and Triolo PK
“How to Keep Great Nurse Managers”

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Top Drivers of Manager Engagement with Opportunity for Improvement

1. Executive actions reflect mission and values
2. Training and development helps me improve
3. Interested in promotion opportunities
4. Executives respect contribution of department
5. Manager has helpful discussions with me about my career
6. Kept informed of organisation’s plans
7. Organisation recognises employees
8. My ideas and suggestions are valued
9. Organisation helps me deal with stress and burnout
10. Performance review helps me improve
11. I have a manageable workload

Executives need to think strategically about manager engagement. Even if the drivers are the same, a one-size-fits-all approach to manager engagement will not succeed. There are three steps to improve engagement, and the different drivers in each step map to different strategies to engage managers.

The first crucial step is to focus first on the unit manager role. Ensure it is sustainable for all managers. This will help managers feel they are in a role where there is potential to succeed.

Second, after re-envisioning the role, ensure that managers feel that they are set up to succeed.

And third, build a stronger connection between managers and executives to help them truly engage with the role and the organisation.

### Skill Development, Executive Leadership Crucial to Fully Engage Managers

#### Categorising Key Drivers of Manager Engagement

<table>
<thead>
<tr>
<th>Poor Organisation of the Work → Role Redesign</th>
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<tbody>
<tr>
<td><strong>Related Drivers</strong></td>
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<tr>
<td>• Organisation helps me deal with stress and burnout</td>
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<td>• I have a manageable workload</td>
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<tr>
<th>Limited Capabilities of Managers → Leadership Training &amp; Skill Development</th>
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<tr>
<td><strong>Related Drivers</strong></td>
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<tr>
<td>• Training and development helps me improve</td>
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<td>• I am interested in promotion opportunities</td>
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<td>• My performance review helps me improve</td>
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<th>Disconnection Between Managers and Executives → Executive Leadership</th>
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Source: Advisory Board Survey Solutions Employee Engagement National Database; Advisory Board interviews and analysis.
Better leadership starts with a better role. Right now unit managers are not leading—not necessarily because they lack the skills or ability, but because they don’t have the time or structure to enable them to effectively lead.

Without addressing the unit manager role itself, investments in leadership development will not pay off as expected. But this is not an either/or conversation. Leadership development efforts should not be stopped, because they become even more effective as the role is redefined and properly supported.

Nurse executives need to re-envision the unit manager role and provide leadership development, but they should also role model leadership behaviours and engage current (and future!) unit managers, so they too will engage their staff.
