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Heart of Safety Coalition

Insights Huddle transcript

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Virtual nursing as a retention and wellbeing strategy

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Moderator: Liz Boehm, Executive Strategist, Heart of Safety Coalition

Liz: Welcome everyone and thank you for joining for today's insights Huddle. This is our heart of safety Insights Huddle focused on virtual nursing. So just a little bit of housekeeping before we begin. My name is Liz Boehm. For those who don't know me. I'm the Executive Strategist for the Heart of Safety Coalition, which is part of Stryker. We focus on three pillars of safety and wellbeing for team members, psychological and emotional safety, health justice and physical safety.

Insights Huddles are one of my favorite formats. The approach is to learn, connect and dig deeper into the learning. The first part of this conversation will be didactic, and we'll have our two speakers, Michelle and Tammy, share some amazing learnings. I'll give a little more context around virtual nursing during the didactic portion.

I ask if you do have questions put them into the chat, and I'll do my best to interject them. But once they've finished their presentation, we're going to stop recording and invite you all into a conversation with Michelle and Tammy. That gives you the opportunity to ask vulnerable questions or share stories, or say, this is what we're doing, whatever it is that you want to share. In that time, we will summarize all of this with notes, including notes of the conversation, but nothing you share will be attributed to you, and it'll be shared on HeartofSafetyCoalition.com. You can also go to that same website, and if you haven't already, you can attest to our Declaration of Principles around team member safety. And that brings you into this community and movement that is aimed at improving safety and wellbeing for healthcare team members all across the country.

I was first introduced to ChristianaCare's model in a session with the American Nursing Foundation. It was focused on virtual nursing. Lots of folks were sharing their approaches, but Dr. Tim Shiuh, who is an emergency medicine physician and the Chief Health Information Officer and VP of Digital Clinical Transformation of ChristianaCare was raving about the approach they've taken, which Tammy and Michelle have led at ChristianaCare because it's integrated and was creating this wonderful sense of teamwork and connection and opportunity for the nurses. And even the physicians were feeling the difference. It was so intriguing to hear a physician that was so enthusiastic about an approach, that I then reached out to Michelle and Tammy, who are now going to share their story about how ChristianaCare came to this approach, what's happening, how the expansion has gone, what they've learned in the process, and what the impact has been for nursing.

So, Michelle Collins is the Vice President of Nursing Excellence, and Tammy Brown is the Manager of the Virtual Acute Care Nurse Program at ChristianaCare. Michelle and Tammy, thank you so much for being here today.

Michelle: Thank you so much. I'll start us off if that's okay. Back in the late spring of 2022, our Chief Nurse Executive shared with me a project he wanted me to lead. He was like, "I want you to lead the work, establish a virtual nursing program for ChristianaCare." So, I pulled a steering committee together, including clinical nurses, to begin to formulate what it would it look like. What aims are we trying to achieve? How are we going to measure a difference? What technology are we going to use? And what two units want to sign up to be the first units that we pilot?"

So, our campus Chief Nursing Officers each identified a unit that from their respective campuses would be engaged. We added those leaders to the teams with their clinical nurses' intel. We began to look at similar programs that have a digital virtual program that we have with hospital care at home. We were able to leverage in our pilot work the technology that they were already using because they had surplus content technology. So, we pulled the team together. The nurses identified where they would optimize workflows. How we were going to eliminate the most burden for the nurses at the bedside. Part of my marching orders was that we were doing this with no new FTEs, and two years later we still have no new FTEs for this work. It's all been internal.

But back then, in September of 2022, we went live on a medical unit, and we went live on a surgical unit. We went in small increments. The medical unit was on the smaller side. They were live by November of 2022 with all 14 of their beds, and the surgical unit was live with all 35 of their beds by February of 2023. We began by looking at the workflow and asking, "what's the best value?" Many folks are doing virtual nursing now we realize that; but for us, in 2022 there weren't many hospitals doing this. At least not that we were aware of at the time.

So, the workflows consisted of several different buckets. There was a patient safety bucket. So, how are we utilizing national early warning system data to clue us in as to what patients should be prioritized on a unit for the virtual nurse to see admissions and discharges. That's an easy bucket taking patient phone calls because our technology has always been and remains one touch tablet. "Hello, I'm Michelle, your virtual nurse. How can I help you?" We were using all of that national early warning system data, including admissions and discharges and following up on consults, following up on labs, engaging providers for orders. And when we saw a problem with a transfer or an opportunity to correct discharge instructions, etc., our virtual nurses did all that work. They were highly engaged. By February both units were fully live, and we had a limited data set of clinical nurses functioning in this capacity, but they were really the ones helping to edit what they were doing, how they were doing it to improve the efficiency. And we began to look at what is the next evolution of our technology? And we were fortunate to get a grant whereby we co-developed the software platform that we use today. So, we began testing that platform as we were preparing for expansion.

But we wanted to transition the platform first so fast forward to between February and May. Our clinical nurses provided significant feedback on the platform that we had built and were able to help us drive the efficiencies of how quick the system would be and how fast and how many clicks and whatnot. Our two pilot units were the first to go live with it; and once it was live with them, we had already prepared for a very rapid expansion. So, in the entire Spring of 2023 we were meeting with leaders meeting with physicians meeting with the pharmacists, the respiratory therapists, the social workers of all the rest of the units that were going live. We went from two units being live to 20 units being live by June of 2023. It was a very scalable mass expansion. Today we're live with about 650 beds, over 20 units, and we continue to evaluate our nurse satisfaction.

In our pilot units our nurse satisfaction data said that of our responses, our virtual nurses had significant impact on the ability to prevent a nursing sense of indicator harm because they're doing follow up with patients. “Have you turned? Have you repositioned? What questions can I answer for you?” And they're using teach back. They significantly felt they were able to reduce burden for clinical nurses.

Now keep in mind at that time none of our virtual nurses did this work full time. They all rotated back to their clinical unit. Virtual nurses are trusted and valued experienced charge nurses. We asked the managers to select them, “Who's adept at wanting to learn technology and advance the innovation of nursing practice at ChristianaCare?” These were handpicked, interested folks who said, “Yes, I'd love to try this and do it.” But they rotated back to the bedside. And they loved that. We asked, “What do you like about virtual nursing?” They love the ability to have a different type of relationship established with patients. They felt like they got into nursing to be this kind of nurse that could ask additional questions and probe a little further and say, “How's this? How is this going to work for you at home? Is this reasonable to expect when you're home?”The other thing that our virtual nurses said, in addition to being able to impact the NSIs and decrease the clinical documentation burden just overall satisfaction in the engagement with the process. And it was a Yes across the board for all three of those things.

The other value that we've assessed is the patient satisfaction with the experience of having a virtual owner. ChristianaCare, for those of you who may not be familiar, is a 1,400-bed health system, and we're live with about half of our beds. And the focus in that expansion continued to be the rest of our medical surgical type units. We are not live. We have done EICU. We're not live in our ICUs to date. We're not live yet in hematology-oncology. We're not live yet in postpartum. But this has been a significant learning journey. September 14 was our two-year anniversary of being live.

Our patient experience has been very positive. Of our 35,000 patients at this point who have been exposed to virtual nursing in two years we've done three separate surveys, approximately 75 to 78% of our patients surveyed love it or like it. The reasons they love it or like it is the ability to quickly engage with a nurse. Being able to connect with a nurse in less than 30 seconds. A one-touch tap of their tablet. I come right up if I'm the nurse covering that unit. Hi, I'm Michelle. I'm your virtual nurse today. How can I help you? They love the ability for a virtual nurse to take time in explaining and re-explaining at discharge, or at any time during the course of their stay.

A family member can call the virtual nurse. A provider in the room can call the virtual nurse. A clinical nurse can call the virtual nurse. Anyone who walks in the room. We have no criteria for patient accessibility for this, and that's purposeful on our part, because it's not just meant for the patient. The providers, any caregivers that walk in the room can call the virtual nurse to clarify. Ask a question, review lab work or whatever it might be.

But patients love it because they're not on a call bell for 30 minutes. They're calling a virtual nurse and getting a response in 30 seconds to address the question. Because we have many patients who say, you know, cardiology came by at 5:30 this morning and explained my discharge plan. But it's 11:30 now, and I'm starving, and I don't remember what they said. But my son's here and wants to know the plan. Okay, fine. No problem. Let's go through it.

That's what virtual nurses do. I think the other reasons that they like. It is just the pace. Unlike clinical bedside nursing. You provide virtual nursing care, one patient at a time. There's time for reiteration, and there's time for patience. There's time for teach back. There's not the same sense, potentially, that a clinical nurse may inadvertently give when they're trying to care for 5 or 6 patients, and they're orienting a novice nurse, and they're hanging blood. And there's a provider meeting happening with the family 3 doors down, and they're not. It's not that sense of. I hate to ask the nurse, because I don't want to be a bother. We if you're a nurse. You've heard that before. I don't want to be a bother. I know. I know how

busy you are, right with virtual nursing. They don't get that sense because the nurses work is not frenetic. It's happening one patient at a time.

That's a little bit about our program and how our virtual nurses work. I was thrilled when we were able to hire Tammy, an internal experienced leader within ChristianaCare, to lead this program and be directly present every day with the virtual nurses, because they're not on our hospital campus.

Tammy: Yes, what I would add to what you were saying is, I think patients love it a lot, too, because of the discharge instructions. And they can also call the nurse and say, "I'm ready to go home. Can you help me with my discharge?" Which they do. If you're a nurse on the floor, you try to get in there, and you may get in there and do a partial discharge, and then you get interrupted, and try to be back in 5 minutes. So, they really have the availability of the nurse, and then they can time their discharge. They can let us know when the rides coming. I hear that a lot as I'm doing my rounds. You know the patient is calling in and saying I'm ready to go.

I've been here for 9 months. I was hired in January prior to my coming on, nurse managers shared the responsibilities. A different nurse manager every day would come over. Nurse managers get pulled back, too. I think having the feeling of someone there supporting them every day is good. I'm not their manager, but I am the manager of the program, so I'm there for them. I have daily huddles with them. We've created a lot of good things since I came. I'm also a partner. I get calls almost weekly on how others can partner with us. We're going to partner with the ED and work on our boarding patients. And how virtual nursing can help that area.

I'm trying to partner with ChristianaCare Hospitalist Partners. See if we can get physicians to call the virtual nurse and ask their questions rather than walking around the unit and poking their head in different rooms, saying, "Are you the nurse for so and so?" I am also partnering with our Advanced Practice Physicians to do some consults virtually with our virtual nurses. So, all kinds of good stuff. And just this morning I was contacted by speech therapy to see how we can partner with them to utilize virtual nursing. It's growing. I've seen it grow a lot since I came, and I'm hoping to grow it more in the next year.

Michelle: Tammy has also established a Virtual Acute Care Nursing Practice Council. So, we have clinical nurses helping to drive the decision making who know about the program and their workflows. As I mentioned before, we would remain FTE neutral. Our virtual nurses work in a ChristianaCare building across the street from our main campus in Newark, Delaware. They are cohorted together. They are multiscreen, headsetted and Tammy helps to align assignments for bed coverage. We still try to make sure we align that it's a known nurse who is facilitating the virtual care delivery for the clinical units.

But we've adopted a new model. You're going to get it hot off the presses. One of the models that we have adopted is asking our nurse managers for an FTE. You want consistent, virtual, acute care, nursing support on your unit because you know how valuable it is. You know its impact. Your patient experience scores are going up. You know that your nurses love it. You know that your novice nurses love having a phone-a-friend or a nurse coach in your pocket. It's like "I'm going to call the virtual nurse while I'm in the room doing my assessment because I've got a question about hanging blood. Or "I've got a question. Something doesn't seem right. I'm not sure where this patient's bleeding from, but their hemoglobin is low. I need to have you talk me through what you would assess as a more experienced nurse. Because I feel like I'm missing something."

Tammy has been very successful. When we started she had no direct report. She now has 5 direct reports that are nurses that are now fully full time. They are virtual acute care nurses, and they are within our cost center. So, that's a piece of this program that we certainly want to help grow. Those positions are posted like any other, you know, opportunity for people to apply, but folks are very interested because of

that difference in connectivity. They're still working 12-hour shifts. They're Monday through Friday, eight hours. I know other programs have their virtual nurses working at home. For us the decision has been made to keep them cohorted because we rely on them to be able to cross cover one another. You can't miss a call because you're emptying the dishwasher. Working at home has its benefit, but it also has challenges. We want to make sure our patients know that. Know we're here. We're committed. We're available to you. At one point in our program, we were live with weekends and holidays.

Our virtual nurses do a phenomenal job with discharges. Tammy can talk about what a wonderful job they do and the ROI that we're seeing in the fact that they're engaged with discharges. One of the opportunities for us is getting back as staffing equilibrates to the inclusion of weekends and holidays so we have consistent virtual nurse support.

Tammy: Yes, with discharge instructions they take their time. They are one-to-one. No interruptions. So, because of the time factor and the attention that they can give to one patient, we feel like that has really made a difference in the discharge instructions that we've been recognized now across the organization. I've been added to committees because of this. So, I think it's a really strong part of the virtual nurse program. As far as staffing, in my previous leadership position, I was the contact for light duty nurses. When I came here, I asked for a couple. Because of that I am now the new contact for light duty nurses. So, if there's a light duty nurse, they will contact me first to see if I can give that nurse a position. It will help me, but it also will help her not to use her PTO. She doesn't have to lose time out of her work years. She will come over to work, and I will train her on the virtual nurse program until she's able to go back.

Michelle: That’s Awesome. I'm excited.

Tammy: Yes, isn't it? Today, I had five light duty nurses. So, that's five nurses that are not using their PTO, and and they are helping the organization while they can still work. But they wouldn't be able to go on the floor and work because of various injuries or whatnot.

Michelle: I often get asked, “How did that impact the units?” We had units that had to go from 1 to 4 to 1 to 5 ratios. We had units that went from 1 to 5 to 1 to 6, but our stance has been and remains that the value is strong enough that we see it in our patient experience data. We see it in length of stay. We see it readmission rates. We are continuing that course. Some folks may have a tendency to only see it as a takeaway. But we're evolving to the place where if a virtual nurse is doing your entire admission that could be 30 minutes given back to the unit. So, now you've got your meal break. If your virtual nurse is doing every discharge on the floor that day, and some of our surgical units like yours may turn over half of your unit every day.

If the virtual nurse is able to do that comprehensive discharge and do that full assessment that has enabled us as an organization to put in place some additional safety measures from a performance improvement perspective. That's great. That's giving you minimally another half hour back because the virtual nurses are doing your discharges as well. I think with Tammy there consistently as a nurse leader, I also think we have fluidity of the virtual nurses. They work together as a team. At this point many of them know each other. We've been doing this work now for two years. It's another added benefit.

Liz: Before you move off the the question of ratios. I imagine that there was a lot of skepticism and concern about the shift in ratio as the the program was getting off the ground. How does that look and feel for nurses now, of the floor nurses, particularly? Are they comfortable with the the ratios? Is there push back? I mean, I've rarely gone into a nursing unit where people didn't say we could use more staff right. So, what has the response and reaction to that been?

Michelle: As you can imagine, any nurse leader on the call you can imagine, when we first started doing the work and the ratios were being altered, it was like, “Oh, no, we need a body back.” It was not, “I need a registered nurse back.” It was, “I need a body back.”

Ok, so we asked, “What is it that you need the body to do? What do you need the person to do. And we were told, “We need a person to turn a patient and toilet and feed, and none of this was RN required, licensed nurse work. So, we had to work with the nurse managers and ask them. “How are you using your techs differently to have that happen?” We explained a value was getting meal breaks now.

We happened to be doing a site visit we had guests coming from another organization who wanted to see our command center and wanted to tour on the unit. And so we took them to our pilot surgical unit. And it just so happened that one of our virtual nurses was working that day as a clinical bedside nurse. And so that team was asking her, “Well, what do you think?” And she said, “I would rather have a 1 to 6 surgical patient assignment than to ever not work with a virtual nurse again because I'm so much less stressed when I'm in with my patients. Our virtual nurses also can document head to toe assessment. So, the clinical nurse calls the virtual nurse on the tablet. They know the flow of the documentation. So, the virtual nurse will document the head-to-toe assessment, and then the clinical nurse has the final sign off when they go into our HER. The clinical nurse can sign it off or make edits if there's anything the virtual nurse didn't get correct.

Tammy: And also as the virtual nurses is doing her assessment if they come across something that is needed, for instance the IV is not working, the virtual nurse, while she's still assessing and the bedside nurse is still in the room, the virtual nurses can request the IV team. She can put the order in for the IV team. She can put the consult out for a doctor to come up and see the patient if they find something else going on.

Michelle: Literally, the virtual nurse can take care of the clinical nurse's to-do list. “Oh, I've got to get cardiology called. I've got to find out why is the MRI not done yet? Oh, the IV blew.” Literally, before the the clinical nurse leaves the room, the virtual nurse has paged the IV team. The IV team is in the room. The new line is getting put in, and she's like, “You can't replace my stress level. “It’s great having all of that taken care of on my first round with the unit and then knowing that when I go to chart six hours later, I don't have to worry about remembering all six patients’ head-to-toe assessments with 100% accuracy because it's already been documented for me.”

We've been able to stem the tide. Do we still have outliers? Absolutely. I haven't seen the latest data, but we did do another clinical nurse assessment of the virtual acute care nursing program. So, we look forward to the iterations because we have additional units to go live that we will be planning for because we are going into some niche areas, some specialty areas that we can learn and evolve our program as to what they may need and how virtual nursing can best support them.

Liz: Makes sense. I want to ask another question, possibly two, before we move into the open conversation. When I first learned about the model, you hadn't moved to this approach where there are some full-time virtual nurses. And one of the benefits, as I understood it was twofold. One is that because these were nurses who were also bedside nurses on those same units, their peers knew them, their colleagues knew them. They could say with confidence, “Your virtual nurse today is going to be X, or these couple of folks. They're amazing.” It was a sense of camaraderie and connection because one might be virtual today and bedside tomorrow. So, they're all in it together. That was one thing. And then, similarly, for some patients on some units. If they are there over an extended time, they might have the same nurse virtually that they had bedside and that creates that feeling of “Oh, I understand who this is, and it sort of gives a continuity feeling.” I'm interested to learn how, if at all, that has shifted as you've moved to some full-time folks, as well as what the rationale is for having them go full time in the virtual space. Was it so people can learn from that?

Michelle: I'll start, and then I'll hand off to Tammy. I think, ultimately, we want to keep our own nurses because they're not agency nurses. They're not nurses from a technology company. They are ChristianiaCare nurses, and they are experienced nurses. So, having the full-time virtual nurse option is a retention grabber. It exends the likelihood that a nurse will stay in a hospital system versus seeking employment in a different type setting. For us that was very attractive. It also helps to establish stability of our program and the consistency with which we can provide it. If our virtual nurses are getting pulled back into staffing because they belong to a clinical unit that impacts our care delivery and the volume of patients each virtual nurse is covering. By having some of our own full-time positions we are able to minimize some of that instability. We can make sure we have greater stability within the virtual nurse program because they're not getting pulled out of our cost center that's not associated with a unit budget.

Tammy: I would also add that we are having the nurses who are going to float around per se that are full time nurses they communicate every day. They're in charge over in the virtual nurse arena. So, they get to know those nurses. They help them. So, when they are going to take over that unit that nurse already knows them, and that nurse hands off to them. And when she goes back to her unit she will say, you know, “Diane is your nurse today. I've worked with her.” That's one of the models.

The other models for the nurses that were given to us by the units. That's just starting. We have one starting in two weeks. She's going to go over and spend two days on the unit getting to know the nurses. She's going to be with the charge nurse all day long, and then she's going to come over and work with that unit's virtual nurses for the rest of the week. She will have a full week of getting to know all of those nurses and vice versa. Those nurses will get to know her. The trust issue is definitely something that we were concerned about, but we're working with that. So, the two ways we're doing it is to have them go to those units or have the charge nurse get to know every virtual nurse that's coming. We're integrating it slowly to earn the trust.

Liz: I think that's so important because that sense of connection to the unit. You don't want to start having what feels like different classes of nurses - some doing some kind of work and some doing others.

Thank you so much, Michelle and Tammy for sharing. The insights you've shared are just incredible. The work you're doing is amazing. I love the connections you've made both to maintaining workflow, but to looking at what is the experience for nurses? What is the experience for patients? How you've managed to do this in a neutral way, but to evolve the model also so beautifully over time with nurses involved in that decision, making process. So, thank you so much to both of you.

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The Heart of Safety Coalition places care team member safety and wellbeing at the heart of healthcare. This national community of leaders, learners and advocates ensures that voices are heard, connections are made, and standards are raised to inspire systematic and individual change. The Coalition works to advance the Heart of Safety Declaration of Principles, which intersects health justice, physical safety, and psychological and emotional wellbeing to accelerate transformation. Driven by its mission to make healthcare better, Stryker supports and manages the Coalition.

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