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Leadership and Quality Workforce Management Does Improve Patient Outcomes

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ABSTRACT

In October 2000 the Millennium year the author accepted the challenge to manage the delivery suite at RNSH and commission a birthing centre once the service was relocated.
Birthing Services RNSH comprises three models of care. High risk pregnancy management. Team midwifery care. Birth Centre midwifery care.

The past five years have seen Royal North Shore Birthing Services develop and effectively manage both increasing patient demand and workforce shortages. This result was achieved through rebuilding and relocating the service sound leadership and quality workforce management.

KEY WORDS

Communication Developing Feedback Outcomes Performance

INTRODUCTION

The paper will summarise strategies which have resulted in safe management of the 70% increase in patient numbers.
Demonstrated successful recruitment and retention of staff.
The paper will provide an example of an Improvement in patient outcomes following Normal Vaginal Delivery (A sustained reduction in Post partum Haemorrhage rates.)

Strategies

1. Workforce management reassessment of roles and responsibilities

2. Education training and Mentoring support for graduate midwives and resident medical staff

3. Introduction of evidence based practice and reduction in post partum haemorrhage

4. Workforce planning and effective rostering (addressing role and skill mix)

5. Redesign of workflow and reassessment of workloads

6. Physical relocation of Birthing Services

7. Information Technology

Leadership, and management knowledge and skills, are not necessarily a prerequisite for nurse registration or certification as a midwife.
I believe this knowledge and the ability to apply it is developed through further study and over time.

The role of midwife with woman requires listening to women and providing the support required for them and their families to experience a safe and fulfilling pregnancy.

Is it not reasonable then the role of Midwifery manager requires listening, supporting and the provision of a safe learning and working environment for staff?

Experience and observation in the mid to late 1980s identified what was known as ”The theory practice gap.” New Midwives and students recounted the theory studied in schools of midwifery failed to mirror practice in the hospital. This left them feeling unsupported and worried about their ability to provide safe care.

The challenge in the early 1990s as a Midwifery Educator lay in bringing the theory and practice together. The initial strategy required developing relationships with managers emphasising the value to all of the partnership. Time spent by the educator with the student in the clinical area provided support for both students and clinicians. The value of this shared role became clear as the students knowledge and competence accelerated. Clinicians and students enthused, the class room teaching began to reflect the practice.

Studies in Health service management provided the principles underpinning people and resources management. The recognition of the urgency to provide future midwifery and medical staff to care for women during pregnancy must also be a significant responsibility for midwifery managers.

The ability to manage a budget is important in these times of finite health dollars.
Leaders managing budgets appear to have little success without the support of the team. The challenge lay in making budget more relevant to clinicians than an obscure spreadsheet which was ultimately in their view the manager’s responsibility.

At RNSH the key to development of a successful team was effective dissemination of information to all staff.
This required a clear sense of the organisation’s vision, direction, value and purpose coupled with the ability to provide inspiration and motivation to work together.

Everyone who worked in the service needed to know the planned framework for developing positive working and learning environments. Effective information dissemination lay in its relevance to the recipients.

This strategy had in the past successfully maximised staff attendance at education sessions, planning days and achievement award nights.

1 WORKFORCE MANAGEMENT REASSESSMENT OF ROLES AND RESPONSIBILITIES

The first of what have been annual planning workshops was scheduled in early 2001
The questions posed were:

- Do you have an understanding of your place in the work environment?
- Do you ever feel an inability to work to your full potential affects your well being?

The aim of the workshop was to present information and discuss practical strategies to manage situations affecting us daily at work.

The workshop introduced information grouped under four headings. These four headings formed the permanent agenda items for regular unit meetings.

1.1. Budget

The concepts of staff establishments and the formula of nursing hours per patient day required to staff the unit were presented to the group.
We looked at the ability to positively affect our work environment and the budget bottom line through beneficial team behaviours such as:

- Improving professional relationships
- Rejecting bullying and harassment
- Utilising effective conflict management skills
- Fairness and equity in rostering, roster requests and allocation of annual leave.
- Adherence to the principles of equal employment opportunities and due process.

It was agreed focusing on these issues and including them in the service culture was important to all staff. Indicators would be a decrease in sick leave rates and improved retention and recruitment.

1.2. Occupational Health and Work place safety

The focus was practical revisiting responsibilities and actions for personal safety and the safety of work colleagues. We identified the tools to be reviewed updated and developed. e g. Safe working practices, Material safety data sheets and Infection control guidelines for practice.

1.3. Evaluation Quality Improvement Program

We reviewed The Australian Council of Health Care Standards accreditation guide. The Guidelines for Maternal and Infant Care Services (1998) would provide the framework for updating clinical practice and clinical practice guidelines.

- The Continuum of Care
- Leadership and Management
- Human Resources Management
- Information Management
- Safe Practice and Environment

- Improving Performance.

The Divisional intranet site was to be developed utilising the guidelines as its framework.

1.4. Staff Development and Education

We discussed accessibility and equitable support for professional development for all staff.
The group acknowledged new practitioners and clinicians focused on the development and enhancement of clinical skills. There was overwhelming consensus a positive learning environment enhanced their opportunity to achieve their maximum potential.
Inspiration for the work ahead was provided by Henry Brooks Adams ”A teacher affects eternity he can never tell where his influence stops.” Leadership by all in the sense of support for staff would be the key to successful recruitment and retention.

2 EDUCATION TRAINING AND MENTORING SUPPORT FOR GRADUATE MIDWIVES AND RESIDENT MEDICAL STAFF

In the year 2000 Royal North Shore had not been exempt from the world wide shortage of midwives.
The staffing full time equivalent employed in the Delivery suite was only 50% of the number required to provide adequate staffing for the new facility.
The number of deliveries at The Royal North Shore Hospital had declined following the collocation of a private facility on the campus.
The planned relocation and upgrade for RNSH remained in the planning stages.

The future was dependent in the first instance on retaining and supporting the staff base. In the absence of successful recruitment, retention and development of our students and new graduate midwives was essential.
The NSW Framework for Maternity Services 2000 had identified the need for” flexible work practises developing new skills associated with new models of care and accessing refresher courses and ongoing educational opportunities that may assist in retaining certified midwives in maternity services.” (Page 14) [1]

A planned experience program for all graduate midwives with a rotation to all clinical midwifery areas and models was formalised.
The aim of the graduate year was to encourage and support the transition from student to newly certified midwife.
Graduates from the area health service attended study days together. This allowed further skill development and provided important peer support.

Experienced clinicians worked with the maternity educator and unit managers to identify their educational needs.
Staff were supported with conference and study leave. Numerous birthing services staff have successfully completed their Masters of Midwifery studies in the past five years.

The effective and collaborative relationships between medical specialist obstetricians, registrars and midwives continue to enhance the quality of patient care.

3 INTRODUCTION OF EVIDENCE BASED PRACTICE

Systematic review of clinical practice guidelines became ongoing. Management of maternity emergencies has been a priority. In early 2002 a multidisciplinary team began to analyse data related to the service's post partum haemorrhage rate. The team looked at management techniques, drugs utilised in the management of the third stage, staff present at delivery and post partum care.

The review resulted in the development of an algorithm to guide clinicians. The algorithm presents possible risk factors for PPH to be considered before and during labour. It states the preferred timing and drug management for the third stage if risk factors are/not present. It states the observations to be attended in the hour following delivery of the placenta and the time frame for summoning medical assistance and the treatment to be initiated if there is a PPH.

RNSH has the ability to separate Post partum haemorrhage data by mode of delivery i.e. caesarean section, instrumental delivery and normal vaginal delivery. This allows monitoring review and evaluation.

Although the algorithm guidelines were implemented the overall average PPH rate for vaginal delivery remained unchanged. Six months after the move to the new unit in March 2004 we began a clinical practice improvement activity. Each month the records of women having a normal vaginal delivery and a PPH were audited. The patient information was de identified and feedback related to the algorithm was provided to staff. Over the next six months the rate began to drop and staff interest rose. Each month staff eagerly awaited the monthly statistics. The rate has been consistently below 10% for 17 consecutive months.

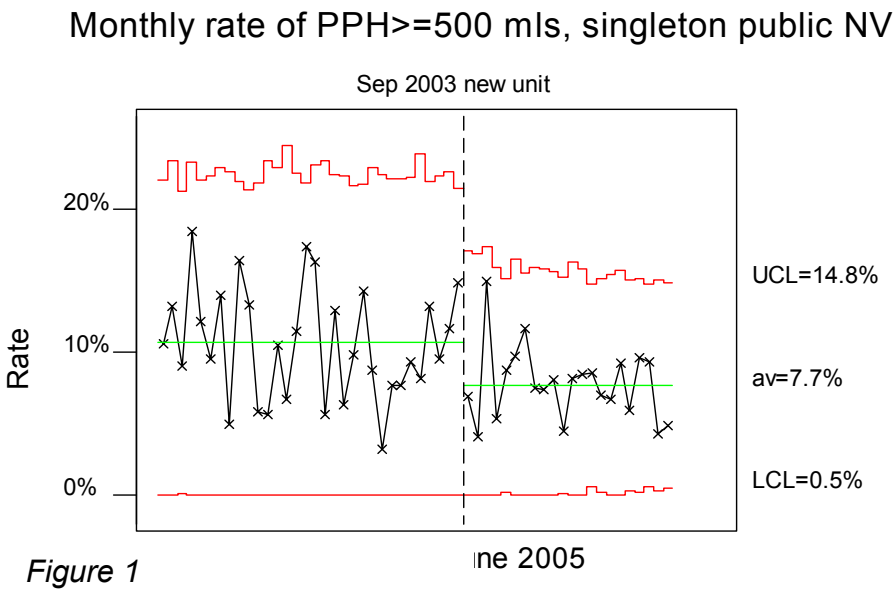

Figure 1

4 WORKFORCE PLANNING AND EFFECTIVE ROSTERING (ADDRESSING ROLE AND SKILL MIX)

The successful retention of many graduate midwives from 2000 increased the staff establishment in the delivery suite. A minimum allocation of experienced staff on each shift provided essential support for less experienced staff.

The introduction of an activity and 24 hour dependency tool provided staff and patient data for analysis by all staff.
Mentoring provided a support person for graduates and an opportunity to debrief with staff who knew and worked with them.

In early 2002 the staff of the Team Midwifery Model joined with the delivery suite staff as part of the developing RNSH birthing services.
The Team was established in 1998 and delivered a safe and much sought after model of care for women and babies at RNSH.

The unit roster was a significant addition to the unit meeting agenda. Family friendly rosters needed to encompass all staff. Equitable allocation of requests and preferences are balanced with staff who have infrequent requests.

5 REDESIGN OF WORKFLOW AND REASSESSMENT OF WORKLOADS

The increasing staff retention and skill mix in the delivery suite and team provided encouragement to staff. How we carried out our work was achieving results. The new facility was under construction, the planned change was a tangible reality. Anxieties and tensions were addressed with the project coordinators. Dealing with identified problems constructively led staff to look to the job ahead.

RNSH as a tertiary referral centre for Obstetrics and Neonatology expected a rise in transfers and bookings which required reassessment of workflows. The delivery suite and birth centre had less delivery rooms. The Newborn intensive care unit would have increased cots.
The anticipated delivery numbers were expected to rise over time to approximately 2400 per annum or 200 per month.
Patient flow was reviewed and staff brainstormed suggested change management strategies.
Staff were successfully recruited to prepare for commissioning the new Birth centre.

6 PHYSICAL RELOCATION OF BIRTHING SERVICES

At the end of August 2003 the service made the long awaited move to its new facilities.
The immediate increase in delivery numbers presented staff with their greatest challenge to date.

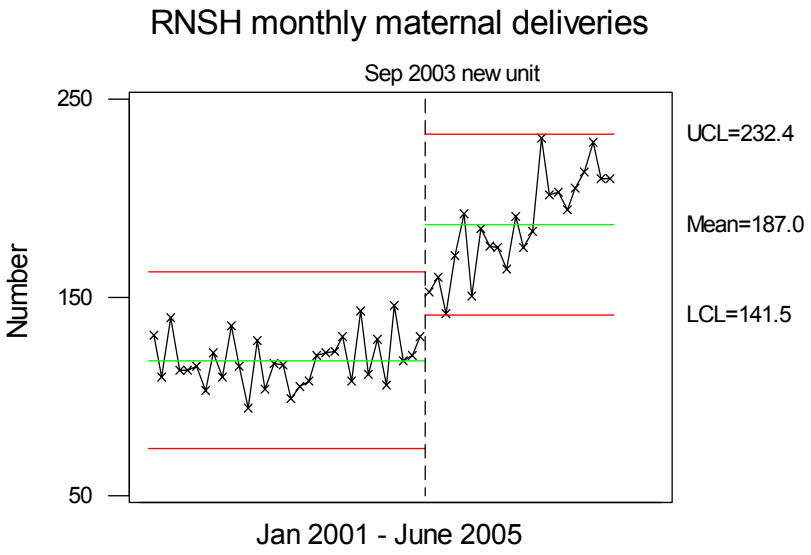

Figure 2

7 INFORMATION TECHNOLOGY

The Divisional intranet site was launched in August 2003. The site was developed by the Health Service's Information Technology unit. It utilised the Australian Council of Health Care Standards, Guidelines for Maternal and Infant Care Services as its framework.
The site begins with information about how women can access RNSH services. It outlines New Birthing Options Royal North Shore (NEWBORNS) and progresses through the Continuum of care encompassing how to enter the level of care provided by the service through:

- Assessment
- Care planning (ante natal, intra partum and postnatal in each stage)
- Implementation of care (ante natal, intra partum and postnatal in each stage)
- Separation
- Community care.

It is envisaged the site will be accessible by the public through the internet in the near future.

Currently Birthing services Royal North Shore Hospital is fully staffed. The unit has retained and developed staff.

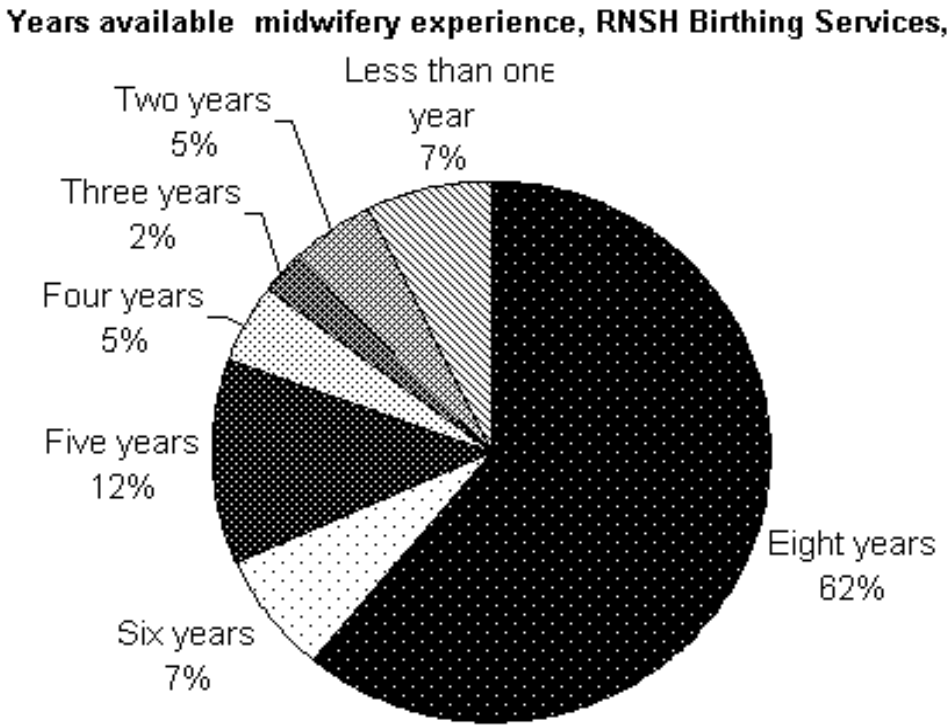

Figure 3

8 CONCLUSIONS

The RNSH birthing services team are aware of their ability to influence safe practice. Graduates of midwifery and medicine are our greatest assets.

Leadership and commitment to assisting staff to achieve their full potential DOES improve patient out comes.

Royal North Shore Hospital is:

- A great place to have a Baby.
- A great place to become a Midwife .
- A great place to be a Medical Officer.
- A great place to be a part of the RNSH Collaborative Team.

9 ACKNOWLEDGEMENTS

The staff of Birthing Services RNSH

Catriona Andronicus Systems Analyst Maternity Services RNSH

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