Nurse Conference Committee (NCC) Meeting Minutes

Date: July 26th, 2023

Time: 1:00-3:00 PM Location: WebEx

Name	7/26/23	9/6/23	9/20/23	
Bonnie Fryzlewicz	Present			
Danica Pytte	Present			
Dinarte Viveiros	Present			
Holly Beauchene	Present			
Calli Komban	x			
Kara Yates	Present			
Kelsey Gellner	Present			
Kristie Page	Present			
Laura Licea	x			
Linda Burbank	Present			
Lindsey Kirsch	Present			
Lori Chudnofsky	Present			
Maureen O'Brien	x			
Molly Aaseby	Present			
Nic Maurice	x			
Sam Forte	x			
Tammy York	x			
Annika Hoogestraat	Present			
Stefanie Chandos	Present			
Katie Podobnik	Present			
Te'onna Adams	Present			
Therese Hill	x			

Guest(s): Sue Anderson**,** Lauren Huxtable**,** Maya Scott, Sharon French, Shannon Currier**,** Chris Patin, Deb Ridling, Jonathan Jones
Notetaker: Sarita Wall

ITEM NO.	AGENDA TOPIC	DISCUSSION	COMMITTEE ACTION
I.	Approval of June 14, 2023, minutes	• 6/14 minutes approved at 1:02pm • Approved posting future minutes on WSNA site at 1:03pm	• 1st Bonnie • 2nd Dinarte
II.	**End of shift OT at 2300: new** Poor staffing at 2300 resulting in mandatory OT	• The group discussed how to prevent mandatory overtime (especially overnight). Kristie described to the group what is being done, current state. *See below.* o The medical unit recently started a pilot to do recorded reports, defining criteria around how patients will be covered until the next person comes (touchpoint normally happens before hand-off). The pilot consists of: ▪ Monitoring and balancing numbers to avoid excessive swaps between 3-11pm. ▪ Charge Nurses will be reorganizing the assignments when there isn't a nurse to take over. ▪ Watching skills mixed issues continuously. ▪ Monitoring in Housewide Staffing.	• Kristie to give an update on the recorded report pilot during an upcoming NCC meeting.
III.	**Tier 3 incentive unavailability: new** Clear messaging from management on reason why	• With the schedule that started on 7/10/23, it has been determined that tier 3 is no longer needed because there isn't as large of a gap to fill as previously and costs savings. Tier 2 is still offered. • It was pointed out that CICU has been having technology needs gaps to the point where they had to use Acute care nurses. Nurse believe that it should meet the criteria for tier 3 in this case. o Kristie to analyze recent data to understand the gaps, as a whole, to determine if tier 3 should've been initiated. This will continue to be monitored with each schedule. o Leadership does understand CICU is experiencing record breaking numbers requiring technology. In result, there are now 64 trained specialists in case of spikes. • The question was raised of how to quantify and qualify reassessment for RSV surges that may increase in the fall? o It would be by schedule and projected staffing. • The group agreed that although tier 3 doesn't guarantee staffing availability, that it does help in certain moments.	• Kristie to provide an update via email after reviewing CICU data. • Bonnie, Kristie, and Dinarte will meet on how to reiterate previous communication about the tier 3 decision.

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		• The nursing team advised the leaders that managers are asking about the sunset of tier 3 and requested leadership send out a communication about tier 3 and why it is no longer offered. • Communication has gone out about it; however, the leadership team will meet to discuss how to reiterate the message.	
IV.	**Supervisors/managers at bedside/CN roles: new** Frequency, competency, liability, safety	• The group discussed an instance when there were 4 days where the supervisor had to provide direct patient care. The group is concerned about competency, understanding flow, liability, and safety. ○ Leadership reiterated that this was a request during negotiations for leaders to step in and support. Although, it is not daily operations, leaders are expected to step in. In example, stepping into a charge nurse role where their competency lies. Leadership doesn't want to see this as a trend, but as a contingency that shouldn't need leveraging consistently. • The group agreed upon the need to make sure competencies are up to date prior to assigning. • The group spoke on the importance of the leaders acting as a resource and avoiding taking over a role, as it could negatively impact the whole floor. • The question was asked if there is a mechanism to track when a leader has to do bargaining unit work and if there is an incentive to get nurses to bedside?	• Invite Michelle to discuss at the next NCC meeting.

V.	**Addendum D: continuation**
	ETM updated for daily end of shift overtime; Status of plan to implement 6- and 9-hour shifts
		• Danica advised as of 8/1, payroll has been updated to account for any end of shift OT in ETM. Addendum D was presented at Housewide Staffing on 7/25. There were no objections on moving forward on the 6-9 hours shifts. Provider deployment was discussed. Per the contract, end of shift OT will start on 8/1.
		• The group asked about consistencies for individual nurses.
		  ○ It doesn't fluctuate much, because changing every six weeks isn't ideal for nurses that have personal obligations like childcare, etc.
		  ○ The only concern would be emergent LOA.
			• Kelsey to forward questions to Danica offline.

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		• Ambulatory nurses are still asking quite a few questions, so the group requested we are being consistent communications.	
VI.	**GCO WSNA Orientation: new** Discuss and establish a single agreed upon day and time; plan for ensuring only bargaining unit eligible nurses are present for session	• Lindsey requested the following for GCO Orientation: o Move from Thursdays to Fridays to allow bargaining unit nurses to attend. o Arrange where there are only bargaining unit nurses attending and not managers or non-bargaining unit nurses. ▪ Accommodate so that Therese Hill can attend.	• Deb to follow up with the team on both asks via email.
VII.	**Ambulatory Residency: new** Orientation model and final hiring into the float pool without internal float pool postings	• There were some clarifying questions in regard to Ambulatory Residency. o Nurses coming into Ambulatory Residency are being hired to be trained in various areas after 1 year and then placed in an Ambulatory float pool without posting. o Current work is being done on how to hire into the float pool. o The strategy is to fill buckets with people that are trained with Ambulatory. o The nurses are oriented into 2 multi-disciplined specialties. The idea is to get them to see a broad range of diagnosis. o They aren't hired directly into float pool, but instead, placed there. There was a discovered gap where nurses weren't placed in the float pool, so they didn't have a position when they completed their residency. ▪ Moving forward resident roles will be posted. ▪ They can apply for any role org wide. ▪ Do current nurses have the opportunity to apply for Ambulatory float pool roles internally?	• Danica to clarify with Holly, via email, if Ambulatory float pool roles will be posted internally first.
VIII.	**Adaptive Social Response: new** Open dialogue with representatives from all the groups under the ASR umbrella (BST, CDHE, Support and Engagement, Social Work, Security) as well as a	• The group had dialogue about what the nursing team should do when there is a behavioral challenge with a patient that is a minor vs. a patient or adult family member that is over the age of 18. • Steps: o Activate the BST team.	• Hux will take the ask about the one-page tip sheet for ASR support and resources back to the healthy

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	representative from the SA group if possible	○ The BST team will make an assessment (in-person) and triage to the correct teams at the bedside. ▪ BST will start with background and expressing acuity of the request. ▪ BST is trained to respond to both minor and adult escalations. Q&A: Q: Is there ever a case to ask a parent/caregiver to leave bedside? A: CDHE and social work have been working on getting support plans in place as a multidisciplinary conversation (wanting to standardize and follow the same type of criteria to avoid discrimination). It's unsure if there will be job aid or policy. There are plans in place, but CDHE is trying to shift the framework to support all needs in the situation. Q: In regard to equity, what we are doing to communicate to families about the available support and resources? A: There is more that could be done; however, the information is out there, but never looked at until it's actually needed. It's up to the org. overall (rounding staff, check in staff, etc.). We need to continue to think about how we support the delivery of communications and create a space for families to ask for support and receive those resources. The CDHE is aware it needs to be worked on further and open to dialogue about how to upstream, being proactive and not reactive. Q: Regarding constant flow of new staff, can we offer a one-page ASR tip sheet with information about the support teams, how they support, and hours available? A: This will be discussed with the healthy work environment group to see if there's a way to work on it and create something for post class. Q: Could there be a set of criteria (quantitative) to initiate an ethics consult to get away from the stigma that it's punitive, but to create more of a partnership with the families? A: CDHE is open to the idea and also trust the nurses to loop them in based upon their observations and experiences, which is the only criteria needed.	work environment group. • Leadership to consider setting an order set for every patient admitted. • Maya to come speak to the units on best practices and catch phrases for difficult conversations.

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		Q: Is there a way to add it as an order set similar to the Social work order set with all ICU and ED patients as a catch all to be more proactive? It is already part of the ICU patient order set. Social work does check in and can partner with the nursing teams. Can we ensure we are communicating together? A: We are still trying to figure out how to layer on all these resources so as not to overwhelm but be thoughtful and responsive. These are things that we can discuss. Q: Which team helps with support of staff? BST or the Chaplains? A: Both. We would like BST to be the first stop. BST may pull in other support teams, such as the Chaplains. Q: How do we empower nurses to have difficult conversations with families? A: There is a training called "Ground and Reset" that can be embedded in our units. We can train unit leaders to be able to support their teams in the moment. Q: How do we help nurses set boundaries in regard to patient and family relationships with the nurses? Are they able to take a break from a particular family? How do we teach the nurses to have conversations with the family that won't taint the relationships? A: We are framing the Safe and Healthy Workplace training to add more scenario-based practice so that when things get heated, the nurses have the ability to pause or step in that space and de-escalate. Q: What if things are getting escalated and it's not safe for the nurse to leave the room? A: Try to check your own physical body for cues of elevation (getting hot, elevated heart rate, jaw clenching, etc.). Try the above tips. Figure out what is really being said. I may not make you feel better but could calm the chaos in the room. Tips: • Lean on reflective listening skills. • Acknowledge family member.	

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		○ "That sounds like a scary intervention for you. I'm not sure I have a good answer right now". • Give space to leave room. ○ "Can I step out of this room for five minutes and then come back and follow up with you?" • Wash hands to physically wash off to come back to a fresh interaction. • Pressure point work to calm down. • If leaving room is unsafe check in with own physical body, queues using grounding techniques. • Breathing to regulate mood. • Check physical position in the room to make sure you feel comfortable in the space. • Do not engage in "blame based discussions".	
IX.	**Roster: new**	• Since staffing changes, the new roster has not been sent to the below officers: ○ Kara ○ Annika ○ Therese ○ Lindsey	• Holly to check with WSDA to confirm who will provide the roster.
X.	**Education Budget Metrics: new**	• The education budget metrics are: ○ Used for nurses to put in requests to attend conferences. ○ Broken down by unit. ○ Includes who put in a request. ○ Includes who was approved to attend. ○ Includes how much was spent.	• Bonnie and Deb to ensure it's routed to Lindsey.
XI.	**Follow up Meeting Necessity:** August 9 meeting	• The group agreed that the 8/9 meeting is not needed and the team will follow up via email as needed.	• Team to meet next on 9/6

Committee Action Items: *Inform, Discussion/Feedback, Decision, Action*
Include: *Who, What, When*

Next Meeting: September 6, 2023, Virtual Meeting

Committee Action Items – Rolling Queue		
Topic	**Frequency**	**Next Agenda this would be on**
Expense reimbursement	Twice per year	June 2023
Education Budget Metrics: ● Education leave hours (budgeted vs actual) ● Professional leave hours (budgeted vs actual) ● Total funds awarded (can report out on this 2x/year) ● Any denials of leave requests (and the nature of the denials)	Twice per year	June 2023
WSNA Roster	Quarterly	June 2023