

INTRODUCTION

“There’s a way to do it better—find it!”

–Thomas A. Edison

When problems arise, opportunity exists for creative solutions. Most people, however, have trouble viewing change positively. As you read this book, think about the gifts and strengths of the people on your team and who can best help you achieve successful results. You will need to surround yourself with colleagues who can embrace change and feel energized and excited about the prospect of creating positive outcomes. We were able to make it happen, and so can you.

We found that the unit council structures typically found in the clinical arena struggled to keep up with the rapid changes occurring in healthcare today. The FLIGHT Model of unit-based professional governance was developed by a group of registered nurses working in a large community hospital in the East Bay area of California. The model was developed out of frustration. These registered nurses, in varying levels of leadership at their organization, came to the realization that the traditional model of unit council was no longer meeting the needs of the organization, the nurses working on the units, or the inter-professional team members they worked alongside. They wanted to make a change in the organization at the unit level—but competing forces, budgetary restrictions, and the way in which councils were organized hindered the ability of many councils to be successful. The overwhelming frustration felt by these nurses is summarized in the words of a unit council chair: “There *must* be a better way.” The FLIGHT Model is that better way.

The FLIGHT Model stands for Fostering Leadership, Innovation, and Growth through Healthcare Teams; it is a framework within which a team can achieve the ideals of professional governance. It empowers the entire interprofessional team to develop and implement change to improve patient care, influence professional development, and promote collaboration among the care team. Projects developed within the FLIGHT Model connect and unite team members toward achieving overarching organizational goals. Momentum remains as leadership and clinical employee move together toward a unified destination. While there may be the occasional change in flight plan or unexpected turbulence, all are working together toward the ultimate organizational destination.

Because of the limitations and frustrations felt under the traditional unit council structure, we experienced an increase in burnout among unit council members. A commitment of two years was required to be a part of the council, and typically each unit contained 8 to 10 members at one time. The challenges faced by the unit council members made it difficult to recruit new members. There have been many studies over the years regarding stress and burnout among health-care professionals. As Laschinger and Leiter note, “A major source of burnout is an overloaded work schedule, that is, having too little time and too few resources to accomplish the job. Lack of control, performing tasks that conflict with employee values and beliefs, and a breakdown in social work factors are also factors that lead to burnout” (2006, p. 260). The members on each unit council were being asked to complete projects that did not always affect them, and they were not necessarily passionate about every topic or project they worked on. Perhaps it was a request from the manager to improve workflow on the unit or responding to complaints from employees and being responsible for “fixing” those problems. One can imagine how these council members became overwhelmed with the demands and sometimes lacked the recognition they deserved.

Havens, Gittell, and Vasey (2018) define *relational coordination* as “a mutually reinforcing process of communication and relating for the purpose of task integration” (p. 133). In their recent study, they compared relational coordination with nurse job satisfaction, work engagement, and burnout. They determined that there was a consistent relationship between relational coordination and nurse reports of well-being. “This finding is highly relevant, given current concerns about healthcare provider burnout, morale, and general well-being” and plays an important role in navigating ways to improve the interprofessional experience (Havens et al., 2018, p. 137). Initiatives such as “selecting providers for teamwork, measuring team performance, resolving conflicts proactively, investing in frontline leadership, developing shared protocols, broadening participation in team meetings and developing shared information systems” can go a long way in improving employee morale and preventing burnout (Havens et al., 2018, p. 138). The identified characteristics in these studies are directly related to the development and benefits of the FLIGHT Model.

Change is continual and ongoing. When we started our journey with the FLIGHT Model, the terminology used was *shared governance*. A shift toward *professional governance* is taking place in the literature. We embrace this changing terminology and believe it supports our vision of professional nurses working with interprofessional teams. In most instances in this book, you will find we use *professional governance* with the exception of direct quotes or situations where a historical perspective is better served with *shared governance*.

The next sections describe our journey and the genesis for developing the FLIGHT Model. We are certain you will be able to identify with our struggles but also see that there is hope for an engaged, outcome-focused, and collegial employee-driven option.

Our Story

Something Amiss

Jacqui, a unit council chair on a busy 34-bed medical unit, realized a need for change within her council. Members vacillated from being engaged to essentially being absent. The council projects progressed slowly and felt never-ending, and there was a lack of energy and support from the general unit team members. When networking with other unit council chairs, Jacqui learned that many others felt similarly.

One day, Deborah, a supervisor on Jacqui's unit, sent a unit-wide email soliciting employee interest in forming a small task force. The email outlined the task force's role—to review a specific workflow proposal that a clinical nurse had learned at a recent nursing conference and determine feasibility of implementing this new practice. Jacqui responded with interest and was selected to join the work group, which included other nurses who weren't currently involved in the unit council. As the task force began to work on the proposal, Jacqui noticed a tremendous amount of energy and excitement. Various disciplines were involved in the task force and appeared highly engaged in contributing—something she rarely saw in her unit council projects. Jacqui attributed this energy to their desire to be involved in this project and that the team was eager to make a change on an issue they were passionate about. Every member felt inspired and empowered to contribute toward a positive change.

Jacqui began to question the current, traditional way of her unit council structure. Some of her questions included:

- What if this kind of energy and engagement were seen with unit council projects?
- Why is our unit council having so much difficulty when there are clearly people working on the unit who are passionate about creating change?

- Is the current structure too rigid? If so, what if we created a more flexible and inclusive environment?
- Would more people be willing to share their ideas and work on a project if it didn't involve an extended time commitment?
- There are so many employees on each unit—why are we limiting our council to a finite number of members?

When networking with chairs from other departments, Jacqui shared her experience with being a member of the interprofessional task force on her unit. She shared with these chairs the difference in engagement, enthusiasm, and ownership of the work she witnessed as compared to her own unit council.

Between her conversations with other unit council chairs and more self-reflection, Jacqui realized she had additional questions:

- What if employees came up with ideas and felt empowered to bring forth solutions?
- What if the employee who had the solution was the person in charge of the project?
- What if they could ask others interested in the project to work collaboratively, thus being more flexible, fluid, and inclusive?

In addition to her observations, a survey of all unit council chairs had been conducted three months prior. According to this survey, the top three areas where unit council chairs struggled were:

- Recruiting new members
- Managing projects
- Using evidence-based practice to guide projects

A New Vision

These questions and the results of the survey began to congeal, and the beginnings of a concept emerged. Jacqui wanted a process that would engage more employees and tap into individual talents and interests. She felt her concept could potentially address many of the problems the councils had long been facing.

Approximately every other month, the chairs and coaches of all unit councils meet as a group. Jacqui used this meeting to share her thoughts and rough concept regarding a need to find a new way. Roxanne, a clinical educator and the facilitator of this meeting, encouraged Jacqui to meet with the Director of Professional Practice and share her idea.

Jacqui and Deborah (the unit council coach) met with Beth, Director of Professional Practice, Quality, and Safety. They shared Jacqui's innovative idea and her thoughts about a more inclusive and flexible environment where employees could feel empowered to create and lead change. Jacqui shared her vision and the thought process that evolved. To Jacqui's relief, Beth was supportive of this new and innovative concept. The excitement and energy were palpable as this small group became infused with hope. Because of organizational initiatives, Beth realized the window of opportunity for this change was very narrow and encouraged immediately forming a work group to brainstorm and flesh out a new structure.

Change is difficult. The same unit council structure had been in place for almost 10 years. Clinical nurses and nursing leaders knew what to expect of the unit council process and were comfortable with it—even though it wasn't working. As is typical with any type of change, doubts immediately began to surface, and there were reservations when the idea was brought back to the unit council leader group. However, because there was enough evidence of lack of employee engagement, frustration, and the general sense that something had to change, the decision was made to move forward. Rather than looking back at how it had once been, it was time to start building a new council structure.

A work group was formed to envision an ideal unit council structure. The work group identified a gap between organizational priorities and malalignment with unit council projects. They knew this needed to be addressed or unit council work would not have the needed organizational support to be successful. To help this process, they envisioned three focus areas that unit council projects should align:

- Patient satisfaction/engagement
- Employee satisfaction/engagement
- Quality and safety improvements

They found a second gap in quantifying improvements. In the previous structure, there were great projects, but they were not structured to include pre- and post-project improvement metrics. It was realized that more focus on measuring the results of change and developing evidence was necessary. Projects would no longer be based primarily on employee complaints, but rather on consistently using data in a more efficient way to show outcome improvements.

The last gap that we identified was the composition of a unit council. The work group agreed the new unit council structure would focus on the entire unit as the council—and not an identified group of nurses as seen in the past. They wanted every employee member to have the opportunity to create a project, join in on a project, lead a project, and feel empowered by having a voice in creating positive changes for the unit and the hospital.

This team knew they needed to develop a new model, outline new tools, and create an entirely new structure that would take months to design and implement. This was exciting yet daunting, as redesigning an entirely new unit council structure would be a new adventure. This book is the result of that work and the model that was developed.

We are so excited to share our story with you and hope that you will be able to successfully implement the FLIGHT Model into your organization, as we have done in ours.

Book Overview

Rethinking Your Unit Council Structure is divided into three parts:

Part 1: The Mechanics of FLIGHT

We set the stage for you in Chapter 1 by identifying the changing healthcare environment, including changing patient demographics, the multigenerational workforce, and the financial picture healthcare organizations face today.

In Chapter 2, we outline the history of shared governance and its importance in supporting ownership, accountability, equity, and partnership. We illustrate why the FLIGHT Model is effective and beneficial for any healthcare organization.

Part 2: Mastering Aerodynamics

Chapter 3 covers the FLIGHT Model in detail, including a visual depiction, the four pillars, and the innovative ways the model can change project flow when implemented.

Chapter 4 identifies characteristics of leadership and how the styles of leadership influence the success of professional governance and implementing the FLIGHT Model.

In Chapter 5 we discuss how to analyze the current state, envision opportunity, and engage leadership and clinical employees. This chapter helps you evaluate how effective your current state is and what your ideal state could look like.

Part 3: Taking FLIGHT

Chapter 6 outlines different change theories and their necessity in the process of transformational change. We apply John Kotter's Change Theory to the FLIGHT Model and show you how you can do the same for your organization. We provide examples, using case studies, to illustrate the different stages of change.

Chapter 7 includes the tools and training tips you need to implement the FLIGHT Model. In this chapter we provide you with everything you will need to create a successful unit council structure.

Chapter 8 covers how to maximize and sustain project results across an organization through project sharing. We recognize the importance and value of celebrating successes of all sizes, communicating that success, and encouraging others to do the same.

Throughout the book, you will find case studies that illustrate real-world examples using the FLIGHT Model, as well as tips to keep in mind while implementing changes using this innovative unit council structure.

Our Goals for This Book

It is our hope that, through this book, whether you are a clinical employee feeling encouraged to propose a new idea or create change, or you are a leader who realizes the need to improve a less-than-ideal process, you feel inspired and motivated to do so. Our desire is to provide you with the tools and evidence you need to create a successful new process for your organization.

References

- Havens, D. S., Gittell, J. H., & Vasey, J. (2018). Impact of relational coordination on nurse job satisfaction, work engagement and burnout: Achieving the Quadruple Aim. *JONA: The Journal of Nursing Administration*, 48(3), 132–140. doi:10.1097/nna.0000000000000587
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