Seán Collins (00:03):
There's a nursing crisis in this country.

Clip of striking nurse (00:06):
They brought in traveler nurses. It doesn't fill the gap. We still have a bunch of vacancies and we're overworked.

Seán Collins (00:18):
But nurse leaders are proposing a new way to staff hospitals.

Cynthia Salisbury RN (00:22):
When we first started to explore this model, we started by listening to our nurses and saying, how can we use your way? What are some things that you would like to see taken off of your plate that would help with your feelings of exhaustion and burnout? And many of the things that they mentioned were those administrative burdens, you know, not being able to work at the top of their license.

Seán Collins (00:45):
And are nurses doing the work that relies on their expertise?

Jennifer Gentry RN (00:49):
When we think about a different model of care, it really is all inclusive, right? We need to look at all of the things that a patient may require during a hospital stay and evaluate, are we doing this in the best way we can? Maximizing the resources that we have

Seán Collins (01:07):
On today's program, how to fix hospitals, exploring new models of care in nursing. I'm Sean Collins, so glad you're with us today. Thanks for listening.

(01:29):
I am really happy to introduce you to two senior nurse leaders from Providence here to talk with me about new ways of thinking about hospital staffing, new models of care, if you will. Cynthia Salisbury is the Chief Nursing Officer for the Northern Division of Providence. That includes Alaska and Western Washington. Jennifer Gentry is her counterpart a little further south. She's the Chief nursing Officer for the central division of Providence, that's Eastern Washington, Montana, Oregon, Texas, and New Mexico. I'm really happy you both are able to talk with me

about these ideas that really amount to pretty radical change in hospitals. Welcome to you both.

Jennifer Gentry RN (02:16):
Thank you. Thank you for having us today.

Cynthia Salisbury RN (02:18):
Happy to be here. Thank you.

Seán Collins (02:21):
You know, I've been doing some reading and nurse leaders around the country have been writing pretty provocative things like “tinkering at the edge won't cut it. The house needs to be demolished and we need to start all over again.” Essentially saying, throw out the model of nursing that we have operating in hospitals now, and come up with a new one for the rest of the 21st century and beyond. What do you think of that?

Cynthia Salisbury RN (02:48):
Yeah, I agree with that.

Seán Collins (02:51):
That's Cynthia's Salisbury.

Cynthia Salisbury RN (02:52):
You know, we are predicting a, a shortage of nurses worldwide of about 13 million, you know, by 2030 worldwide. We're looking at a huge shortage of nurses. We're already feeling that now. We've had a shortage of nurses for a while, but of course that was exacerbated by the pandemic when we started to see a lot of nurses leaving the profession retiring early. 6 million nurses, I think, plan to retire in the next decade. So whenever you combine all of those things that the way that we have been practicing nursing for years, many, many years it, we can't continue to practice in that way. We have to adapt to our current situation and practice in a way that we can support with our current resources. So it's, it's almost like we have to stop thinking of it as a nursing shortage and just say, this is our new reality and how are we going to adapt to that and change our models of care delivery so that we can be successful and we can provide the kind of care that we want to deliver and that our patients deserve today.

Seán Collins (04:05):

Jennifer Gentry, what do you think of that?

Jennifer Gentry RN (04:07):
Yeah, there are a few components that I'd like to add. Cynthia's absolutely right in the statements that she's made. When we talk about the way nurses provide care, we're talking about a model of care. So you might hear those, those terms interchangeably. And the model of care in place in the United States is the same model that's been in place for decades. And while we know the pandemic really exacerbated the problems and the challenges nurses were facing as they worked in the healthcare environment, we know that they existed well before the pandemic and the stress and burnout of nurses has been steadily increasing over many years, well before the pandemic. And so, not only are we facing this staffing challenge and this you know, nursing shortage that Cynthia described, but we also have to look at what has gotten us here. And it really is trying to do the same thing the same way that we know has not worked for a very long time within the profession. So being open-minded and working with the nurses, providing care at the bedside is really a top order of business for us right now because we have to find a new path forward. One that doesn't create as much stress and anxiety for the nurses providing care at the bedside. So we can have a healthy workforce as we move into these new tasks.

Seán Collins (05:23):
It makes perfect sense the way you described that, and maybe to help me and our listeners sort of understand the scope of the problem as it exists now, why don't we do a little task list, build a list that tells people what the problems are now, how nurses are being pulled away from the sort of care that you think and they think they should be doing. So what's at the top of the list? What's, what's problem number one?

Jennifer Gentry RN (05:51):
Well, I think number one, of course, as Cynthia said, is just a shortage. We're not able to staff the same way we have, and that is even more challenging because we're seeing a greater number of patients that require hospital care than we have in the past. So we have more people coming in with fewer nurses to provide care for them. And those patients coming into the hospital are much sicker than they used to be. Cause now we have resources that keep patients home at a much greater scale than we have in the past. So the patients actually requiring hospital care are higher acuity. Then you compound that with a few of the challenges that we're experiencing within healthcare, such as a lack of beds outside of the hospital setting. So when a patient's ready to be discharged, it's not unusual for us not to be able to

find an appropriate place for that patient to go. So these patients are still in the hospitals as well, and the needs that they have at that point in time of their road to recovery are not the resources that we have in the acute hospital setting.

Seán Collins (06:59):
You're suggesting that that patients should be able to be discharged from an acute care hospital to some other facility like a rehab hospital or some other place where they could continue their recovery but not have the same level of acute care provided, or am I getting that right?

Jennifer Gentry RN (07:19):
You're correct. So we have, you know, long-term care facilities. We have skilled nursing facilities, we have foster homes, we have, you know, rehabilitation and the focus in those areas of care are really about bringing someone back to their baseline ability to function while in the hospital. Our focus really is about taking someone who is acutely ill and moving them out of that acute illness phase and ready to start the rest of their road to recovery.

Seán Collins (07:50):
As we continue this conversation, we're gonna talk about different professionals that are involved in providing care, and we'll, we'll talk about that in, in great detail coming up. But it seems like those long-term facilities are really the bailiwick of physical therapists and occupational therapists and less acute care provided by registered nurses.

Jennifer Gentry RN (08:15):
That's correct.

Seán Collins (08:16):
And are your colleagues in physical therapy and occupational therapy and other allied professionals, are they on board with a change in the model?

Jennifer Gentry RN (08:24):
You know, for the most part when you're looking at those therapy modalities, they happen adjacent to the way care is provided by the nurses and the, the nursing assistants. So they come in their consulted for their patients, see their patients, and then go to their, their next patient. Whereas the nurses are responsible for all care for the patients that they're, that are assigned to them. So a little bit different dynamic, but said, you know, our therapists also

struggle with getting the support they need in order to ambulate a patient or having the resources readily available to do the work that they need to do as well. So when we think about a different model of care, it really is all inclusive, right? We need to look at all of the things that a patient may require during a hospital stay and evaluate, are we doing this in the best way we can, maximizing the resources that we have and allowing nurses, therapists, everyone to really work at the top of their license and having folks that can take care of more of the activities of daily living partnered with them to allow them to focus in that space.

Seán Collins (09:42):
I love the phrase operating at the top of your license, cuz I think it does really encapsulate this issue that nurses end up doing a lot of tasks that other people who don't have a license are able to do, but because of tradition more than anything else, probably the task falls to nurses.

Cynthia Salisbury RN (10:03):
Yeah, Sean, this is Cynthia and you're, you're exactly right. And we, we've kind of created the monster that, where that exists now. And it seems like when there is something new, a new task that must be done in the hospital it is very easy to think, oh, well, the nurse is with the patient all the time. And so, and then adding that on as a task for the nurse when it, that doesn't require their level of training, their level of skill their, their license to be able to do these tasks. We nurses, a lot of the reason for burnout is you know, documentation is a part of that. There's a tremendous amount of documentation that has been added on. Sometimes it's for regulatory purposes or, you know, it always seems like a great idea at the time. But then it becomes redundant.

(10:54):
And also it, it just takes a lot of time from the nurses. So really stepping back, examining our electronic medical records and the documentation that we require of our nurses in there and saying, do we really need all of this? Is this information available somewhere else? How can we make our systems function more efficiently to allow our nurses to step back to really caring for the patients, which is why they went into nursing in the first place. So really examining those administrative duties that are pulling our nurses away from that calling that drove them to nursing. And a lot of that, you're exactly right, is tied to allowing our other disciplines our teammates, our colleagues to function at the top of their scope as well.

Seán Collins (11:45):

You know, everyone in the world is talking about artificial intelligence and AI and chat G P T and you know, it, it's taking everyone by storm in the last couple months, and I think that there's real potential isn't there for that technology to assist in documentation. You know, I could see nurses wearing a wearable device that is making a recording of the interaction at the bedside and summarizing what was discussed and what treatment decision was made.

Jennifer Gentry RN (12:20):
Absolutely. I think that's, you know, an area any nurse would celebrate not having to sit down at the computer to add documentation in and instead capture the work real time. And, you know, there are methods that exist today to move into that space. And again, this is the type of thing we're talking about when we say we want to change the care model. You know, there are also robots that can be used in the hospital, and these are some of the simpler things, but robots that can be used in, in the hospital to you know, such items for patients to deliver supplies, et cetera, so that the people providing care can stay on their unit taking care of patients. Another component of technology that we're really interested in is the wearable technology for something as simple as vital signs. We know this exists today, yet in our practice we continue to have a nurse or a CNA going room to room and taking vital signs at whatever, you know, frequency is appropriate for that patient when we could use technology and instead have that information readily available real time.

Seán Collins (13:26):
I'm gonna play devil's advocate for just a second on that particular topic. Those visits at the bedside where a nurse comes in and says, Mr. Collins, how are you doing? And you say, fine. And they say, is there anything I can get for you while I'm here? And you say, you know, I would love to have this picture of water refilled if someone could do that. And they do it, but mm-hmm. <Affirmative>. But the point is, there's an interaction and it gives the nurse a chance to sort of lay hands on someone, see how they're doing, check their mood, see how they look. There's value in that, isn't there? And and if a robot is doing vital signs or some of this stuff is being done remotely, you lose that, you lose that interaction with the bedside.

Jennifer Gentry RN (14:10):
Well, I would speak of that in a different way. To me, what it does is it free up time for that nurse and whomever it's at the bedside to really engage in a meaningful conversation. When they come into the room and they're doing an assessment or they're just checking in to say, how are you doing today? It's really uncommon for them to have time to actually take a seat and engage them in, you know, tell me about yourself. Tell me about your home environment. How

are you gonna take care of yourself whenever you leave here? Those deeper, more meaningful conversations are hard to have because of the number of tasks that are on nurses, CNAs, on, on all healthcare providers list to complete. So if the nurse is able sit down and engage in the discussion while the robot goes and gets the you know, fills their, their cup with ice and brings it back, then that's an improved interaction between the nurse and the patient as opposed to a transactional interaction.

Cynthia Salisbury RN (15:06):
Sean, you're exactly correct. We need to, and as nurses, we want to maintain that relationship building and those communications and really building that relationship with our patients. And so we don't wanna lose that, we just want to do it in a more meaningful way.

Seán Collins (15:25):
We're talking today about new models of care in nursing as a way to counter the exodus from nursing that we've seen over the past few years. My guests are both senior nurse leaders for Providence. Jennifer Gentry is the chief nursing officer for the central division, and Cynthia Salisbury is the chief nursing officer for the Northern Division of Providence. So going back to our punch list for fixing hospitals, what else is a priority? What needs to be on the list? Jennifer Gentry?

Jennifer Gentry RN (16:01):
Well, I think looking at how we assign patients to a team as opposed to a nurse. So in most of our healthcare system today patients are assigned to a nurse. So one nurse has a group of patients that they have complete responsibility for. What we'd like to see is a shift in that, a bit so that the patient is assigned to a team. So one person doesn't have sole accountability, again, addressing that, that stress and burnout factor. And instead you have at least two people right there on the unit who are working together in order to meet the needs of the patients emotionally and physically and reduce the stress because you have a partner in your day. There's another component of that that I'm gonna let Cynthia talk about because it's an area that she has most recently been working in, but that is including a virtual nurse in that co carrying that team-based model. So I'll let Cynthia speak a little bit more.

Cynthia Salisbury RN (17:08):
Thank you, Jennifer. Yeah, so, and you know, on that, on that team-based approach where we are teaming up an RN with a certified nursing assistant, this is a model that is, is proving to, to have many benefits. So typically on a nursing unit, you will have an RN with a patient

assignment, and then there will be certified nursing assistants or CNAs that are assigned to that unit, and you might have two or three depending on the number of beds on that unit. And those CNAs then take care of all of those patients. So they're, you know, kind of running up and down the floors and, and, and doing tasks for those patients. In the model that Jennifer was describing, we changed that and instead of just having the CNAs without a a, a particular assignment of patients, we actually pair them with an rn.

(18:11):
So now you have an RN and a CNA pair who are assigned a number of patients to take care of together. And so now you have a CNA who is assigned a a reduced number of patients, maybe six patients that they are now assigned to with that rn, and those are the patients that they will take care of. So what what we see in that transition is better relationship building between not only the RN and the patient, but also the C N A and the patient. That patient gets to know that when they call for help, that C N A is going to respond and they, it's gonna be that same C N A that's coming in to respond to them, and if they need a higher level of care, it will be that RN coming in to respond as well. So this increases satisfaction for patients and being able to know and rely on that.

(19:05):
And it's, what we're also seeing is that it's increasing the satisfaction in that C N A because the C N A previously was not able to build those relationships with those patients, and now they are, and they are loving that. They are loving, being able to get to hear the stories from the patients, take the time to really provide care for only those patients that they are assigned to. And it it, so again, our satisfaction amongst our nurses, our CNAs and our patients is increasing by that. Then adding to that, once we, we have that model down because sometimes it's, it, it, it is a little bit difficult for an RN who has been practicing in a way where they have done everything for a patient. It, it can be difficult to delegate after that's how you've been practicing for many, many years.

(19:56):
So it takes some practice to to, to trust that the delegation is gonna work. But once they see the benefit of that, again, it, they are very appreciative of it. So once we have that down and have that model set up, then adding to that, the virtual care rn is the next step in that model. And so that is something that we have added and we are piloting in, in one of our hospitals within Providence and looking forward to spreading soon because we're seeing fantastic results from it. But what we do is we add then a virtual rn into this, in, into this team. And the

virtual RN performs all of the admissions patient admissions, doing the patient interviews on their health history, their medication list and they're able to provide all of that documentation that is very time consuming for the r for, for an RN that is working bedside.

(21:00):
So the virtual RN takes care of the interviewing, the documentation of the admission assessment while the bedside RN is doing the physical assessment, and the CNA is addressing the patient needs at bedside. The virtual RN also does, provides education for the patient and also performs the discharge for the patient which is again, can be another time consuming task. And also provides the documentation. And so those are very important parts of a patient's stay in a hospital, they must be done accurately, and the RN must have the time to be able to spend with that patient to answer questions and, and do it most effectively. And the virtual RN is able to provide that in, in a better way. And we are seeing patients appreciating that and benefiting from that as well as our care team.

Seán Collins (21:57):
And that virtual RN is in a remote facility on a telehealth hookup of some sort? How, how is that working?

Cynthia Salisbury RN (22:05):
Yeah, they are. So they can be located anywhere and they within the patient room, we have a very high tech camera that is the, the capabilities of the camera are quite impressive. The virtual RN from their location there is a speaker and a microphone in the patient room, and the virtual RN can you know, beam in to the patient's room. They will appear on the television a large television monitor for the patient to see, and they will use the camera and they can actually control the camera from their location to be able to view different parts of the patient's body and zoom in and get a really nice look at at, at any, anything that they need to see within that patient's room. So it is it, it does use technology and the, the virtual care RNs can be located anywhere and just tied into that technology. And then of course, they also have the ability to get into the electronic medical record and provide the documentation of the care that they are providing.

Seán Collins (23:20):
Yeah, again, I feel like I need to ask the devil's advocate question, which is h how fulfilling a job would it be to be a virtual rn?

Cynthia Salisbury RN (23:30):
We, we are finding it to be highly fulfilling. So the virtual care RNs and when we went to hire the virtual care RNs, we were looking for very specific characteristics. We, we needed a nurse who was very experienced, who could had great critical thinking skills, could pick up on things, recognize things and you know, before we had alluded to the number of nurses that were retiring early and leaving the, the, the workforce at the bedside. But many of these nurses, they have been working bedside for years and they are highly experienced and still have a lot of skill and still have a lot to offer. Sometimes it just becomes challenging to keep up with that physical demand of being a bedside nurse. These are the perfect nurses to fill those roles, and this allows them to continue to practice, to continue to provide patient care to, to continue to get that reward as a nurse by, by caring for patients, by speaking to their families, by being available to answer their questions. And also to serve as a mentor, a, a mentor to our newer nurses that are entering the workforce by being present with them. Virtually in the patient's room as perhaps a newer RN is doing their assessment and doing things, the virtual RN can be there and serve as an additional mentor and preceptor for them.

Seán Collins (25:00):
What are you hearing from patients?

Jennifer Gentry RN (25:02):
Yeah, we're actually seeing really positive response to the entire model. We see that patients feel less rushed. They feel like they're getting the attention they need. They feel safe asking questions about whatever the education is or what their issues are coming in to the hospital. As we look at, you know, patient experience across that department, we're seeing significant improvement in a lot of the, the different areas that we monitor, such as the amount of teamwork that they experience, communication that they experience feeling heard that they're experiencing. So we're seeing a very positive reaction from our patients using this technology.

Seán Collins (25:50):
That's great. You know, we've talked about nurses operating at the top of their license. It might be helpful for our listeners to hear what's not at the top of the license. What are some tasks that nurses are burdened with now that they would shed if they were focused more on the top of their license?

Jennifer Gentry RN (26:11):

So right now they're a myriad of things that nurses are doing that others can do as well. I think that's the best way to talk about this. There's not nurses have a scope of practice that a, a good portion of it only a nurse can do, but then there's a another whole piece of the care that a patient is that needs while they're in the hospital that anyone can do. But right now, nurses are doing. And so, you know, when we look at things like transporting patients from a test back to the unit or even ambulating a patient in the hallway in order to, you know, measure how well they're doing or if they're improving in the right direction, that doesn't require a nurse. Even activities of daily living. So the bathing feeding, there's several areas there that don't require a nurse.

(27:05):
And so they're spending a lot of time in that space. Cause those are very time intensive activities. But as we look at the, how few nurses we're going to have to work with in the future will have to change that, that model. I think the other area that it would help us address that's important that i I it falls into this problem category, is our ability to include families and friends as the patient desires in their care plan and in their education. Yeah. So today, if you're not able to be present at the hospital for, you know, a good portion of the stay, it's highly likely that you might miss the time when the doctor comes into the room to give instructions or when discharge instructions are being given. And because of the, you know, the nature of the way healthcare works, those are things that are very hard to schedule. But using that virtual technology, a family member or a a friend of the patient can remote in to the conversation and be present for that conversation. So that also helps our patients be more successful when they go home as opposed to potentially ending up back in the hospital cause they didn't understand.

Cynthia Salisbury RN (28:11):
Yeah. And that's such an important part of our current, of our current day. That's, that's how we live life, right? We are, we, we use technology and our everyday life for everything that we do. And so for me, for example, if my parent was in the hospital and I am not local to where they live, the ability for me to be able to beam in and be there and listen and be able to see is amazing. And that is something that I would expect in other facets of my life. So why shouldn't I have that available to be able to be a part of as a caregiver for my parents even remotely?

Seán Collins (28:52):
Yeah. You know, I think one of the unforeseen benefits of the pandemic has been that all of us have become more comfortable with these electronic video conferencing apps. You know, if

you think about it, four years ago, very few of us used this technology and now everyone's using it and feels pretty comfortable doing so I think the thing that, that I notice is that I don't feel like technology is interfering with the conversation anymore. It's enabling conversations that wouldn't have happened otherwise.

Cynthia Salisbury RN (29:28):
Sean, I, I agree with that completely. And even to take that a step further, think about the generation that is entering the workforce right now. They, technology has been a part of their life since, since they were babies, since they were toddlers. They, you know, they have been on personal computers on iPads. They, this, this has always been a part of their life. And so think about those new nurses now entering into the workforce and walking into a hospital and not seeing those same cap, those same capabilities available to them to make their work more efficient. I think that they are expecting this and they are expecting for their employers and, and for their leaders to be looking at that and looking for ways to, to ease their, their day. While, while they are at work and we have it available to us, we now as the leaders need to lean into that because our workforce is ready and I think they're expecting it.

Seán Collins (30:34):
Tell me about one of the pilot programs in one of the hospitals.

Jennifer Gentry RN (30:38):
Maybe I'll start Cynthia and then hand it over to you. Cuz we both have work in, have worked in this space of, of one of the significant pilots we have in our organization. So what we're piloting, it's on a single unit in one of our hospitals and in that unit it's a co-parenting model. So we have the team nursing on the floor with a CNA and an RN partnered together, and then using that virtual registered nurse for some components of, of care as Cynthia described earlier. And while right now it's going very well and we're seeing, you know, excitement and a lot of passion building behind the model, and we're now in a place where the nurses and the CNAs that work there, they don't want to go back to the way it was. Of course it wasn't that way from the start, right?

(31:30):
This is pretty significant change from the way they had been operating. And so it was a lot to really get them started with here's a concept of a model of doing things differently and we need your partnership to turn this into something real. And so the problem in the, the project ensued and we have learned a tremendous amount along the way, thank you to those CNAs and those

nurses and the, the virtual nurses participating in the model. Because I think the key component as we start to look at how we do this work differently is making sure that the people actually doing the work are part of that build. And so creating an environment where they knew they could speak up when things weren't going well, that we could stop the line and make an adjustment to move in a different direction, really giving 'em that autonomy and empowering them to make those decisions and be a part of building the pathways and building the way we provide care made a very big difference in moving from what they were doing to this great place that they're in today. So I think from an overview, you know, it just has been, it's challenging. It's a huge amount of change, but has been incredibly rewarding in the end. I know, Cynthia, you may have some details about those middle pieces that you might wanna share.

Cynthia Salisbury RN (32:52):
Yeah, Jennifer, no, that, that is great and you know, a lot of, of of what you said, just to emphasize that it, it, it's important the listening to the team is important and when we first started to explore this model, we we started by listening to our, to our nurses and saying, how can we use your way? What are some things that you would like to see taken off of your plate that would help with your feelings of exhaustion and burnout? And many of the things that they mentioned were those administrative burdens. Those you know, not being able to work at the top of their license because they're having to spend so much time doing things that others could be doing. A lot of that had to do with running as Jennifer was talking about previously. So having to take samples down to the lab, having to go and pick up things from the pharmacy having to go and find equipment to bring back.

(33:49):
Those are things we do not want an RN leaving the floor to be running around the hospital to do those things. And so that's where that robot technology comes in and can be very helpful for that. Another one of the big things was documentation and all of the documentation that they have to do and how that pulls them away and causes them to stay late, not able to leave on time because they're having to go back and complete the mountainous amounts of documentation that we have them doing in the electronic medical record was another one. And then also some of the activities of daily living that they are pulled away from doing an assessment on a patient or doing their medication passes because they are having to stop to help patients now they want to do that. And so this is, this is an interesting thing because let's say a nurse goes in and she's delivering, she or he is delivering medications to their patients and the patient says, Hey, could you help me with this?

(34:52):
And the nurse is absolutely 100% going to stop and help that patient. And they want to do that. They are there to serve and that is what they want to do. So in order to help to alleviate that and make sure that the patient is taken care of and the nurse is comfortable that the patient is taken care of, what if we have the CNA round with that nurse when the nurse is giving the medications, now the nurse goes in to give the medications and the patient says, can you help me with this? And if it's something that the C N A can do, the c n A is right there to immediately address that need while the nurse goes on and continues doing what they are needed to be able to do. So it was really those things that we have talked about previously in this conversation of help me work at the top of my license in delivering the care to my patients in a compassionate, rewarding way. That's what I went to school for and I don't wanna be pulled away to do these other things that just don't require my level of training.

Seán Collins (35:53):
That's such a great image of the, the two of them, the C n A and the RN at the bedside. And being able to sort of immediately hand off a task that that doesn't require a license. And it's much more personable because both of them are there. Yes, it immediately becomes more complicated if the nurse says, oh, I'll go get someone to do that for you. The fact that the CNA is there at the bedside, it's a sort of natural handoff.

Cynthia Salisbury RN (36:23):
Mm-Hmm. <affirmative>. Yeah. And Sean, I'll tell you that a nurse, they're, they're not gonna say that to a patient. They would take care of of it, right. You know, they're going to address that need because that's what they're, they're there to serve and they're there to address that need and, and they wouldn't say, I'm gonna, I'm gonna leave and have somebody take care of that for you. But having it immediately taken care of by a member of that team right then works work works so much better.

Seán Collins (36:49):
I'm gonna put two ideas together from different parts of this conversation. One is the, the realization that was made early in the program that the people who are hospitalized now are sicker than they used to be. The other thing I want to hitch onto that is this, that sort of traditional role of nurses as educators, if you all have more time at the bedside and more interaction with family, I would think that that's a pretty important dynamic. If you have sicker patients and you're able to meet with the family over the course of that person's

hospitalization, there's more chance for that educational component to come back into the relationship.

Jennifer Gentry RN (37:33):
I would say absolutely. You know, it's one of the hallmarks of the nursing profession is to educate and ensure that our patients and their families know and understand the dynamics that led to illness and then how to care for themselves and get back to health on the other side of that illness. Or even manage a chronic illness that they may have. And so we have seen the profession challenge to have the time to spend with patients doing the level of education that most nurses want to give and they know that they should be giving. But the, the current model, we struggle to give them enough time to spend in that space dedicated to just education. Now it's often an add-on to other care that's being provided. You're giving medications, and I'm doing education on these medications as well, but we know that patients that are ill are having trouble with their, their health.

(38:25):
They're really not in a great place to receive education. So finding that moment whenever they feel well enough and they're ready to engage in that conversation is crucial. And we do feel like to this different model will create more of that time and space for the nurses to do that. As I said earlier when I talked about, you know, being able to engage and sit down and really engage in a meaningful conversation as opposed to going to fill up a, a cup with ice. In addition, as Cynthia talked about with the virtual registered nurse, you know, the benefit of that model in this space specific around education is that they aren't answering other call bells. They don't have other patients with urgent physical needs that they need to attend to. And so they really are able to focus in on the patient, their family, and talk about those topics that need further education and answer questions in a robust manner.

Cynthia Salisbury RN (39:16):
One of the great benefits of the virtual care model is that you now have two RNs, right, that are participating in that education for the patient and the patient's families. So you have the virtual care RN that is providing that in-depth education and and, and doing that at the patient and the family's timing when it works for them and able to provide that, as Jennifer said, at the right time. And then you have the bedside RN that is coming in and reinforcing that and doing answering questions and just reinforcing the education that the patient and the family of caregivers is going to need to keep that patient healthy once they leave.

Seán Collins (39:59):
You know, it, it occurs to me that if a virtual RN is doing the discharge instructions and helping someone sort of get get their life together as they're leaving the hospital, it, it would make sense for that person to be able to do a follow up, you know, the next day when the patient is at home to have some continuity there where it's the same nurse that discharged you is also the nurse that follows up with you and once you're home.

Cynthia Salisbury RN (40:25):
Absolutely. Absolutely. And also, you know, Jennifer was talking about involving other disciplines in the virtual care team. Pharmacist is, is is very important as she mentioned. And the other one is social workers and making sure that they are engaged so that when the patients leave, ensuring that they're going to have everything that they need again to stay safe and healthy out in the community. So we have a, a great opportunity to continue to grow this model and we're looking forward to doing that by the addition with the addition of a extra disciplines and then also at the virtual care nurse follow up with that patient upon discharge. It will be a very important piece to that as well.

Seán Collins (41:07):
What, what should we be looking for next? What's, what's next on the horizon for the two of you as you continue to study this and think about it and pilot ideas?

Jennifer Gentry RN (41:18):
Well, I think both of us are pretty engaged with all of the hospitals in our, in our separate divisions to talk about how do we expand some of the learnings and how do we take that out to other hospitals. One of the things that we learned very clearly in the pilot that we discussed was that learning how to function in that team model was very important before you added the virtual component in. And so we're doing pilots throughout our, our health system to really start to move people thinking in this team-based nursing model and helping them become more comfortable working with partnership as opposed to, you know, two different entities doing two different lists of tasks. And so that work is underway while we do some additional assessment and gain more data to support the model as a whole, including that virtual component in preparation to spread that in other areas.

Cynthia Salisbury RN (42:15):
That, that is exactly where we're heading right now is, is looking at really solidifying that that team, that RN and c n a pairing and spreading that model. If you think about that and you think

about that in terms of a nursing shortage, imagine how much that alone spreads the capacity of our patients to get care of our nurses to care for patients. So that is a big focus. And then adding that virtual care component, expanding that virtual care team to include other disciplines. And then as Jennifer talked about some of the other technology, including the robots and adding those in and then also the, the the, the dictation type of technology so that our nurses are documenting real time without a actually having to go and document after they do their assessments. And then also having the technology to assist us with routine tasks like vital signs and helping the that to happen as well. So really again, leaning into that technology, leaning into the team-based care and to all of our disciplines practicing at the top of their scope of practice.

Seán Collins (43:26):
Yeah. And leaning into listening to the nurses that are on the floor now for ideas, right?

Cynthia Salisbury RN (43:32):
It has to start with that. It has to start with that. You won't be successful if you don't start with that.

Seán Collins (43:39):
Cynthia Salisbury. Jennifer Gentry, I'm so grateful for you taking the time to talk with me about this. Will you come back say in a year or so and let us know where things stand? Would

Jennifer Gentry RN (43:51):
Love to?

Cynthia Salisbury RN (43:52):
Absolutely. We'd be excited to do so.

Seán Collins (43:55):
Cynthia Salisbury is the Chief Nursing Officer for the Northern Division of Providence, that's Alaska and Western Washington. Jennifer Gentry is the Chief nursing Officer for the central division of Providence. That includes Eastern Washington, Montana, Oregon, Texas, and New Mexico.

(44:16):

This episode was prompted by reading a LinkedIn post, written by Syl Trepanier, a friend of the program and the boss of all nursing bosses at Providence, the system chief nursing officer. We've included a link to Syl's post and pay attention, not only to Sy's words, but to the reaction they're getting from other nurse leaders across the country. Clearly, they've hit on something here and things are gonna change, and you'll notice it someday in the hospital.

(44:49):
The Hear Me Now Podcast is a production of the Providence Health System and its family of organizations. Find us on the web at www.hearmenowpodcast.org.

(45:00):
Our program is produced by Scott Acord and Melody Fawcett.

(45:04):
We have research help from medical librarians, Carrie Grinstead, Basia Delawska-Elliot, Sarah Viscuso, and Heather Martin.

(45:14):
Our theme music was written by Roger Neal.

(45:17):
The executive producer is Michael Drummond.

(45:20):
I'm Sean Collins. Thanks for listening. Be well.