Amplify Your Leadership; In Times of Crisis

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Disclosure(s)

Conflict of Interest: None
Learning Objectives

• Implement some easy steps into interactions with staff that will result in increased morale, department buy in, better work flows and an improved care experience even during a Crisis.

• Describe a variety of tactics to employ meaningful ways you, as a leader, can continue to support your team and care for yourself in times of Crisis.

• Use insightful tips from leaders on the ground to remain transparent and facilitate open communication in times of Crisis.
Who We Are

- **Volume:**
  - 42,000 Visits

- **Demographic:**
  - Mixed age ED

- **Size/Bed Count:**
  - 17 monitored beds in the Main/Major Care ED
  - 6 monitored beds in the Minor Care/Fast Track portion of the ED
  - 4 additional monitored beds in the EDO/Observation holding area of the ED
  - 2 dedicated psychiatric “safe” rooms

- **Additional Flexible Care Spaces:**
  - 6 Overflow/Hallway beds in the Main/Major Care ED
  - 5 Treatment recliners shared between Triage and Minor Care/Fast Track
  - 40 “Care Spaces” in total count

- **Staffing/Roles:**
  - At maximum staffing (during peak hours) we are staffed with:
    - 1-Charge RN
    - 1-Flow Coordinator (currently coverage only exists 4 days per week during peak hours)
    - 9 ED Staff RN’s
      - Plus 1 additional RN if needed for Holds or Observation Patients (usually provided by inpatient nursing)
    - 2-3 Advanced Technicians (RN’s can take the place of an Advanced Tech if needed)
    - 2 Regular ED Technicians
    - 1 ED Unit Clerk

- **Provider Coverage:**
  - 2-3 Physicians on a staggered schedule based on time of day
  - 3 Mid-level Providers (PA/NP)
**Leadership Team**

Responsible for Processes, Operations, Staff Oversight

- **Quality Director**
- **Director of Emergency and Urgent Care Services**
- **VP Clinical Integration**

**ED/Minden Nurse Manager**

- **ED Charge Nurses**
- **Minden Charge Nurse**

**UC/Clinic Nurse Manager**

- **UC Charge Nurses**

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**ED Support Staff**

- **Quality Director**
- **Director of Emergency and Urgent Care Services**
- **VP Clinical Integration**

**ED Flow Coordinator**

- **Assist Charge RN with the coordination of flow in and outside of the department, leads special projects and implementations as assigned by Manager or Director.**

**Specialty Designation Coordinator**

- **Dual reports to the Quality Department. Leads organizational goal of gaining specific designations such as Stroke, Trauma, etc.**

**ED Nurse Navigator**

- **Community/EMS/Patient Liaison. Performs call backs, education, and special projects.**

**Data Registrar**

- **Performs administrative functions related to mandated data entry for the Specialty Designation Coordinator/Manager/Director.**

**Designated Team Leads**

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Who am I?

“I never claim to have all the answers, I just like to share what I have done and experienced, whether I have succeeded or failed when I tried, and I hope to create dialogue surrounding what many of us are struggling with as nurse leaders. I continue to learn everyday.”

Michael Dustin Bass, MHA BSN RN CEN NE-BC, currently serves as the Director of Emergency and Urgent Care Services for Carson Tahoe Health in Carson City, Nevada. He is a diverse and multi-faceted nurse leader who is passionate about improving the lives of nurses at the bedside. He is currently the President for the State of Nevada Emergency Nursing Association (ENA) and also serves as the 2020 Co-Chair of the ENA National Education and Conference Planning Committee. Before starting his career as a nurse, Dustin worked as the Service Manager of a nationally renowned catering/event planning company where he picked up valuable lessons about leading diverse groups. He holds a Bachelor of Science in Liberal Studies with a Biological Science concentration from Mountain State University. He began his career in nursing after graduating with his Nursing Diploma from Mercy School of Nursing in Charlotte, NC. He went on to obtain his Bachelor of Science in Nursing from UNC-Charlotte and his Master’s in Healthcare Administration from Ohio University. Recently he was accepted into Yale University’s DNP program focusing on Healthcare Policy and System Leadership. He is also a Board Certified Emergency Nurse (CEN) and a Board Certified Nurse Executive (NE-BC). Throughout his career, he has spent time as a bedside nurse in the ED, Trauma ICU, Pediatric Trauma Unit, and Float Pool. In leadership, he has served as a Charge Nurse, Clinical Supervisor, and Nurse Manager in ED’s across the country before his current position. In his free time, Dustin likes to travel and spend time with his friends and family that are scattered all over the United States or relax at home with his partner Michael and their two dogs, Scarlett and Fitzgerald.
“Regular” Strategic Leadership Planning

• How do you know how to get there if you don’t even know where you are going?
• We knew we wanted to be “highly functional” or “exceptional”
• Defining what it takes to be “highly functioning and exceptional”.
Quality Care

What makes up Quality Care?

- Patient Safety
- Evidence Based Nursing Practice
  - Physician Collaboration
- Staff Education

Efficient Care

What makes up Efficient Care?

- Thru-put metrics aligned with National benchmarks and standards
- Supply Management
- Reduction of waste in current processes
- Effective staffing and skill mix aligned with patient volume

Patient Pleasing Care

What makes up Patient Pleasing Care?

- Staff Engagement
  - Staff Satisfaction
  - Staff Retention
- Patient Satisfaction
Crisis Leadership Planning

- Communication is Key
  - Transparency is too!
- Standardized Work for Visualization of what is changing
- Change is hard, constant change is exhausting; especially in high-stress situations

Acknowledgement of effects on Mental Health

Continuous Multi-Format Communication with Transparency

Evidence Based Standardized Work with Centralized Decision Making (Incident Command)
Communicate, Communicate, Communicate

- **Department-wide:**
  - Creating and utilizing visual “DATED” algorithms, laminated, posting in conspicuous places
  - COVID-Binder; printed emails and information kept on the unit with the most recent first, discussed in huddles and available to staff

- **Leadership:**
  - Group-me app with Charge Nurses and Team leads
  - Daily Charge RN “re-cap” to keep everyone on the same page
  - Weekly Video Update from a trusted Leader within the organization released to the community and the board

Me trying to explain the COVID-19 policies that were changed 6 times today to the oncoming shift
Organizational Communication

- All information located in a centralized place on the Intranet
- Multi-faceted formats: Visual, Video, Writing
- Information is approved by daily Incident Command and then posted and emailed for easy reference.

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Transparency

• Lead with Love
• It is “OK” not to have all the answers
• Communicate the Organizational Structure changes that take place once an “Incident Command Structure” is put into place
  – Utilize the Incident Command team in collaboration with a Daily Management System (K-Cards) to answer questions, make decisions, and close the loop so all Stakeholders are at the table.
Resources

• Don’t “re-invent” the wheel, utilize resources that are available, understand that these resources, just like the situation are changing rapidly to “keep up” and you have to communicate that.
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Priorities for Testing Patients with Suspected COVID-19 Infection

**Priorities:***

1. Maintain optimal care options
   - Lessen risk of healthcare-associated infections
   - Maintain integrity of US healthcare system

2. Identify and triage
   - Identify symptomatic patients:
     - In long-term care facilities
     - 65 years of age and older
     - With underlying conditions

3. Test and reduce spread
   - Test in order to decrease in-hospital community spread:
     - Critical infrastructure workers
     - Healthcare facility workers and first responders

Prepared by Sue Anne Bell, PhD, FNP-BCC, NHACP-BCC
ENA Visual Abstracts

What Emergency Nurses Should Know about Caring for Patients with Confirmed or Possible COVID-19 Infection

Your Safety is the Priority

- Minimize chances for exposure
- Monitor CDC guidelines for latest updates
- Manage visitor access and movement
- Advocate for your safety

Source: https://www.cdc.gov/coronavirus/2019-ncov
Prepared by Sue Anne Bell, PhD, FNP-BC, NNP-BC

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Self Care for Emergency Nurses During COVID-19

Daily Self-Care
- Practice a Daily Routine
  - Daily Exercise
  - Adequate Sleep
- Maximize Opportunities for Support
  - Healthy Nutrition
  - Minimize Social Media Use

Workplace Self-Care
- Prioritize Your Safety
- Prioritize Regular Breaks
- Ask for Help
- Connect with Care Team

After-Care
- Healing is Different for Everyone
  - Emotions May Vary
  - Talking Helps Some, But Not Everyone
  - Lean on Friends and Family
  - Make Time for Yourself

Adapted by Sue Anne Bell, PhD, FNP-BC, NHDP-BC from “The Well Nurse,” 2015 ENA topic brief

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Incident Command Structure

- Daily Zoom meeting & days a week with each “Chief” reporting
- Internal IC structure equated to official FEMA title for potential reimbursement
  - Documentation of “time spent” for FEMA (HICS 214 form)
Standard Work with ALL the Stakeholders

- **Surgical Mask**
  - Use for patients that have fever and cough.
  - Patients exposed to COVID-19.
  - Staff exposed to COVID-19 for 14 days after exposure.
  - When caring for a patient suspected of COVID-19 or respiratory illness. (Unless the use of an N95 is necessary).
  - Patient must also use a surgical mask.
  - Mask the patient with suspected infection using a surgical mask. This is the most effective way to prevent the spread.
  - Per ACEP & ENA recommendation ALL ED Staff will wear surgical mask at all times. 1 mask per day unless mask is visibly soiled or compromised.

- **N95**
  - Caring for patients in Airborne precautions (T8).
  - Clinical staff collecting any nasopharyngeal and/or oral specimens to be tested for. **Eye protection is required.**
  - Staff involved in intubating patients. **Eye protection & face shield is required.**
  - Patient in rule out Covid-19 is not wearing a mask.
  - Any Aerosolizing procedures such as Nebulizer treatments, High Flow Oxygen, etc...
  - Any prolonged or repeated care of patient with suspected or confirmed Covid-19.
  - N95 masks are in short supply and should not be placed on patients or family.

- **PAPR**
  - A PAPR can be used to substitute an N95 or Surgical Mask when those are unavailable.
  - Staff with physical attributes that do not allow proper fit of an N95.
  - PAPR hoods should be cleaned with bleach wipes and can be reused. The hood is specific to the employee and should be labeled with their name in a safe place.
Standard Work with ALL the Stakeholders
Standard Work with ALL the Stakeholders
Visual Cues

Everything is changing so fast!
Building Another Department in a Week

• All the things to consider
  – Building it—Supplies, Where, Access
  – Staffing
  – Processes/Standard of Work
  – Future Use (Surge Planning)
  – IT
  – Clean/Dirty (Hot, Warm Cold Zone)
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Staffing:
- Security
- Runner
- Registration
- Outside Flow RN
- Car Provider
- Tent RN
- Tent Provider

PPE INSTRUCTION FOR HEALTHCARE WORKERS WITH DIRECT CLOSE CONTACT OF PATIENTS
- Don PPE in designated area: Reusable Gown/Issued N95/Full Face shield
- Once PPE donned, you do NOT need to change PPE between patients, EXCEPT for gloves between each patient, or if PPE becomes soiled.
- Clean PPE after collection of any specimens
- Hand hygiene is the MOST important preventative - you MUST perform hand hygiene using the hand sanitizer provided inside the tent (allow to dry) and put on NEW gloves BETWEEN EACH PATIENT.

Special Notes:
All equipment and chairs need to be thoroughly wiped down BETWEEN EACH PATIENT.
Give patient preprinted discharge instructions with return precautions and home quarantine.
There will be a supply cart located outside of the tent with additional supplies.
Please DO NOT take any additional supplies into the tent that are not needed at that time.
Tent operating hours from 0900-1800, should be cleaned and sprayed by EVS after closure each day.
The Budgetary Piece of All of This---$$$

• Very individualized to the Hospital
• Should at minimum be charging to a different cost center or keeping track of expenses
• Potential but no guarantee for reimbursement by FEMA
• See your CFO/Accounting Department for clarification, as well as your Disaster Management guru.
• Low Volumes might not mean flex staff, use the time to prepare for “The Surge” if you can by cross training:
  – ER Nurses to ICU for 4 hour Vent Training
  – Surgery Nurses mini orientation to ICU and ER
  – Extending the float pool to orient in ER (sustained outcome)
  – Greeter Staff at all entrances to enforce visitor restrictions and screen individuals as they enter

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The 40-70 Rule

Colin Powell has a rule of thumb about making tough decisions that I feel is helpful when facing such situations. He says that every time you face a tough decision you should have no less than forty percent and no more than seventy percent of the information you need to make the decision.

If you make a decision with less than forty percent of the information you need you are shooting from the hip and you will make too many mistakes. The second part of the decision making rule is what surprises many leaders. They often think that they need more than seventy percent of the information before they can make a decision. But, I explain to them, if you get more than seventy percent of the information you need to make the decision then the opportunity has usually passed and someone else has beaten you to the punch.
Surge Planning

• Preparing for the Worst and Hoping for the Best
• Changing your assignments from traditional to teams
• Having a plan to effectively use a NON-ER Nurse in the ER
• Track and Trending Now:
  – Labor Pool (Sick Calls)
  – % of Fever, Cough, Resp complaints compared to prior to COVID (could indicate the Surge)
  – Surrounding Counties and areas (Positive COVID patients/Vents in Use)
  – PPE; Days on Hand
Take Care of YOURSELF as a Leader

- You won’t have all the answers or even all the information…and THAT IS OK..IT HAS TO BE!
- Let yourself rely on others…oftentimes as leaders we think it is easier to “just do it myself” rather than seek help.
- There is lots of time to be serious…but also a time for Levity…
- Take a day off, or even a few hours if you can and do something mindless, or fulfilling, whatever works for you…but find that and DO IT!
COVID-19 and the Grief Process;
How everyone is trying to process what is occurring around them, including your team.

• Dr. Elisabeth Kübler-Ross gave us our first clinical insights into the somewhat universal process of how human beings grieve. Essentially, she provided us with a listing and explanation of the five common stages of grief.
  – Denial
  – Anger
  – Bargaining
  – Despair
  – Acceptance

As leaders we have to “meet people where they are”, but you have to understand where they could be to do that.
Denial

• Today, denial sounds like:
  – This whole thing is so overblown. What a media circus.
  – It’s the same as the flu. People get the flu every year and hardly anyone dies.
  – I’m not (old, immune-compromised, susceptible to lung ailments), so I’ll be fine.

Anger

• Today, anger sounds like:
  – This is all China’s fault. If they’d quarantined earlier, we wouldn’t be having this problem.
  – I don’t care what the governor of my state says about sheltering in place, I’m going to work today.
  – Forget what they told us. I’m bored and I’m having some friends over.
Bargaining

• Today, bargaining sounds like:
  – It’s OK to spend time with others as long as they wash their hands before they see me.
  – This will all be over by Easter. I’ll be safe until then, and then we can go back to normal.
  – I know when people look sick. I will be fine as long as I stay around people who are healthy.

Despair

• Today, despair sounds like:
  – I can’t go to work, I can’t earn money. Pretty soon, I’ll be broke and homeless.
  – This epidemic is the new normal. I can say goodbye to my hopes and dreams.
  – I am high-risk and likely to die alone. No one will come to help me when the time comes.

Today, acceptance sounds like:

- I can’t control the pandemic, but I can do my part by sheltering in place, washing my hands, and staying positive.
- The fact that I can’t leave my house doesn’t mean my life has to stop. I can work from home, and I can still connect with my friends and family via phone and the internet. I can also enjoy the extra time I have with my spouse, my kids, and our pets.
- The world is going to change, but maybe when all this is over, we will be kinder to one another.

Reference:
What to focus on to get us through

- Find balance in the things you are thinking, doing, eating, drinking, etc…
- Come into the present, the anticipation of the unknown complicates everything
- Let go of what you can’t control
- Stock up on compassion; My words of the day have been Patience, Grace, Understanding since this all started…

- Reference: [https://hbr.org/2020/03/that-discomfort-youre-feeling-is-grief](https://hbr.org/2020/03/that-discomfort-youre-feeling-is-grief)
Keeping Morale Up

• Community Partnering
Putting a Face to the Nurse Behind the PPE

Kleine S.
ED RN

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Facial Hairstyles and Filtering Facepiece Respirators

Intended for workers who wear tight-fitting respirators

- Clean Shaven
- Stubble
- Long Stubble
- Full Beard
- French Fork
- Douchette
- Veris
- Garbaldin
- Bandholz
- Soul Patch
- Goatee
- Chin Curtain
- Extended Goatee
- Circle Beard
- Anchor
- Balbo
- Van Dyke
- Imperial
- Side Whiskers
- Mutton Chops
- Parti
- Horseshoe
- Zappa
- Walrus
- Painter’s Brush
- Chevron
- Handlebar
- Pencil
- Toothbrush
- Lampshade
- Zongro
- Villain
- Fu Manchu
- English
- Dali

*Your respirator does not have an attachment with one of these styles may benefit from additional sealing property if your facial hair causes it to seal poorly. This graphic may not account for all potential styles or occupations. Not every style should be considered a respirator sealing concern.

Source: CDC/NIOSH Respiratory Protection Standard, 39 CFR 1910.134

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Questions? Discussion?