Use of the ADKAR® and CLARC ® Change Models to Navigate Staffing Model Changes During the COVID-19 Pandemic

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In early 2020, hospitals faced unprecedented patient volumes resulting from the COVID-19 outbreak. Nurse executives at a faith-based, not-for-profit health care system quickly responded to ensure safe staffing, conservation of personal protective equipment, and implementation of infection prevention strategies. A significant challenge was safe staffing for the expected patient surge. To address this, a team of nurse executives utilized the ADKAR change model to guide a transition from primary to team nursing. The processes varied between hospitals, but core principles and implementation strategies were the same. This article discusses the quick, but methodical, journey one health care system experienced.

In early 2020, the world collectively faced a global pandemic that challenged modern health care as never before. As the coronavirus disease 2019 (COVID-19) crisis unfolded, nurses across the country were faced with the challenge of managing a high volume of patients with an emerging infectious disease, the stress of personal protective equipment (PPE) shortages, while simultaneously implementing ever-changing guidelines around infection prevention strategies. At the same time, hospital routines and processes drastically changed to ensure social distancing, increasing bed capacity for the anticipated surge of patients, and implementing new clinical practices to ensure staff and patient safety.

A significant challenge for nursing leaders was how to prepare for the anticipated surge in patients, particularly for those requiring critical care if there was a mismatch of supply and demand of nursing staff. To address this issue, a team of nurse leaders at the faith-based, 25-hospital Texas Health Resources health care system utilized the ADKAR and CLARC change models to guide a change in the staffing model from primary nursing to team nursing. These models allowed nurses to be safely deployed and practice within the systems hospitals from areas that had services closed or significantly decreased. Even though the processes varied between small (*Figure 1*), medium (*Figure 2*), and large (*Figure 3*) hospitals, the core

principles and implementation strategies were very similar throughout the system.

TEAM NURSING: WHAT IS IT?

Team nursing is a care delivery system model developed in the 1950s in which a team of clinicians shares responsibility for a group of patients under the direction of an RN.[1] The original design of team nursing was in response to a nursing shortage, and this was the primary reason we chose this model.[1] The implementation of the team nursing model was part of our emergency planning response to the likelihood that we might have more patients than nurses, due to the increasing number of patients with COVID-19, as well as the possibility of nurses becoming ill themselves.

KEY POINTS

- **Change must be managed through the use of a change model, such as ADKAR, to guide the process.**
- **Ongoing communication and collaboration at all levels are essential.**
- **Role clarity and responsibility are key to staff understanding and implementation of the new model**

A Message from the CNO

As we prepare for an influx of patients during the COVID-19 Pandemic, I wanted to provide information and **assurance** about the nursing plan in place to maintain safe and reliable care to our patients.

One of the primary ways to extend our nursing care team on inpatient units is to leverage the expertise and support of our procedural area clinical teams.

► In order to provide reassurance to the procedural teams, we have begun providing education and orientation to inpatient units.

► We know there are many things that will need to be accomplished by RNs and can be done by our procedural team members in a Resource RN role. The Resource RN does not have a specific patient assignment but provides clinical care (within scope of expertise) to an assigned unit such as medication administration, vital signs, documentation, ambulation, etc.

The Team Nursing Model will allow us to leverage the expertise we have available while also providing reassurance to both the Primary RN and the Team RN (procedural nurse) that safe nursing care will be provided.

The following slides describe the Team Nursing Model which will be used to extend care to a larger number of patients if a period of unprecedented patient volumes at THC should occur.

I hope you find this information helpful as we prepare to care for our community.

Vicki

Team Nursing

What is it?

A method of providing nursing services to inpatients in which responsibility for planning and coordination of care is shared by members of a group; the team may include registered nurses, practical nurses, and other nursing personnel, but the team leader is most often a registered nurse. Medical Dictionary for the Health Professions and Nursing © Farlex 2012

In other words, shared responsibility and accountability for a group of patients

Who are the team members?

Team lead RN, Resource RN, PCT

As always, support staff are available (respiratory, PT/ST, EVS, FNS, pharmacy, lab)

Why would we do this?

· Nurse satisfaction when caring for large group of patients

· Patient satisfaction

· High quality patient care

Team Nursing

When will we implement?

Out nurse:patient ratio will be different on the Covid unit as compared to the non-Covid units. The team nursing concept will be put in place once the ratios go beyond the routine nurse:patient ratio

How will this look?

Team lead: RN who routinely works on this unit; coordinates and supervises, evaluates and participates in the deliver of care to patients

Resource RN: tasks as assigned by team lead (medication administration, assessments, etc.)

PCT: vital signs, bath / linen changes, patient rounds

With team nursing, the team usually cares for larger group of patients

Documentation?

Disaster navigator will include the minimum elements of documentation required; this will be turned on for across the system when requested by the CNOs and will be used by all staff

Figure 1. Example From a Small Hospital

A Note from your CNO, Julie

As we prepare for an influx of patients during the COVID-19 Pandemic, I wanted to provide information and **assurance** about the nursing plan in place to maintain safe and reliable care to our patients.

One of the primary ways to extend our nursing care team on inpatient units is to leverage the expertise and support of our procedural area clinical teams.

- In order to provide reassurance to the procedural teams, we have begun providing them education and orientation to inpatient units.
- We know there are many things that will need to be accomplished by RNs and can be done by our procedural team members in a Resource RN role. The Resource RN does not have a specific patient assignment but provides clinical care (within scope of expertise) to an assigned unit such as medication administration, vital signs, documentation, ambulation, donning/doffing coach etc.
- We understand redeployed RN's will <u>not be proficient to work in all areas</u>, which is not the expectation. However, they can be an excellent resource and supplement to delivering care which is why we are implementing a team nursing model – to maximize our workforce.

The <u>Team Nursing Delivery Model</u> will allow us to leverage the expertise we have available while also providing reassurance to both the Primary RN and the Team RN (procedural nurse) that safe nursing care will be provided.
The following slide describes the Team Nursing Model and which will be used to extend care to a larger number of patients if a period of unprecedented patient volumes at THHEB should occur.

I hope you find this information helpful as we prepare to care for our community.

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Why Team Nursing During COVID Surge?

Team Nursing Delivery Model of Care
- Care Team is group of care providers of varying skills and training
- With team nursing, the team usually cares for larger group of patients
- Team leader (Primary RN) coordinates and supervises, evaluates and participates in the delivery of care to patients
- Team includes
  - ➤ Primary RN
  - ➤ Team (resource) RN
  - ➤ PCT
- Team RN supports the Primary RN by providing care to include VS, medication administration, personal care, bathroom assistance, hourly rounding, etc.
- Advantages
  - ➤ Nurse satisfaction when caring for large group of patients
  - ➤ Patient satisfaction
  - ➤ High quality & reliable patient care

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Figure 2. Example From a Medium Hospital

With team nursing, coordination of care is shared by members of a group; the team may include registered nurses (RNs), licensed practical nurses (LPNs), and other nursing personnel, but the team leader is most often a RN.[2] The team holds shared responsibility and accountability for a group of patients.

A care team using the team nursing model is a group of care providers of varying skills and training levels working together to provide care for a group of patients.[3] We believed the team nursing model would allow us to capitalize on underutilized and available nursing resources, such as those from outpatient clinics and procedural areas. At the time, elective procedures were placed on a state-ordered hold for several weeks to ensure staffing, supply, and hospital capacity resources were conserved.

With team nursing, providers usually care for a larger group of patients. This allows each caregiver to leverage their individual skills, competency, and talent to care for patients when demand exceeds staffing resources. Typically, in a team nursing model, the team leader coordinates care and utilizes team members

Figure 3. Example From a Large Hospital

most efficiently and effectively to meet the patient's needs.[3] There are various roles on the team, based upon composition. Still, a collaborative approach allows for patient care needs to be met, while also reassuring staff they would not be in a situation where patient safety would be compromised, and the integrity of their license would be maintained.

At Texas Health, we were fortunate to have more time on our side to plan and prepare than many of our colleagues in other parts of the country. The time allowed us to quickly conduct basic nursing competency refresher labs for those nurses who had been out of the acute care and intensive care settings for an extended period. The Texas Health Resources (THR) University team quickly mobilized these skill labs and competency checkoffs to allow our labor-management

pool to assign staff, based on skill level and clinical competence.

Team nursing is a more productive option when utilizing staff who are not familiar with a unit or not familiar with some tasks. Tasks were delegated based on competency rather than patient assignment.[4] Additionally, using a change management tool to quickly educate and deploy the team nursing care model, it allowed this change to be entity- and even unit-specific, depending on the current status of staffing resources. Although deploying team nursing was initially planned as a temporary solution to ensure safe patient care, this conceivably could be used beyond the initial crisis brought on by COVID-19 as a tactic to manage future crises that may impact staffing resources.

SUGGESTED TEAM ROLES

Executive RN Sponsor (Officer) and Sponsor Coalition

Nursing officers and directors responsible for making decisions and giving direction that impact the care team. Sponsors are responsible for:

- Being active and visible in leading initiatives
- Building a coalition of leaders and peers who can support effective change
- Communicating directly with managers and employees who are impacted by decisions and changes

Unit Manager and Supervisor

Nurse leaders who direct daily operations and team management in a care unit. Managers and Supervisors are responsible for, but not limited to:

- Approaching change with a positive attitude and proactive mindset
- Using both the ADKAR and CLARC models to lead themselves and others through change (see reference[6] for more information)
- Developing just-in-time training or a resource manual for the team to quickly orient and be brought up to speed on recent updates.
- Address questions or concerns raised by the nursing staff or providers

Primary RN (Team Leader)

Home unit RN who is assigned to a group of rooms or patients to coordinate and supervise care. This RN is responsible for, but not limited to:

- Complete initial admission, physical assessment, patient screening, medication administration and reconciliation, and to delegate tasks of care
- Complete head-to-toe physical assessment
- Medication administration, including pain management and titration of drips
- Assess changes in patient condition
- Complete specialized skills where team RN is not trained
- Complete patient teaching
- Communicate with provider(s)
- Primary contact for patient's family and significant others
- Complete, review with patient and print discharge instructions
- Documents interventions and details of care in the department-specific portion of the medical record
- Delegate as needed

Team RN

Float RN or cross-trained RN assigned to the unit who will:

- Complete patient screening and medication reconciliation
- Complete focused patient assessment as needed
- Assess changes in patient condition and escalate concerns to the primary RN and/or charge nurse
- Medication administration, including those in which they have a level of comfort
- Complete patient ambulation, range of motion, activities of daily living, bathroom assistance
- Perform nonspecialized skills such as routine dressing changes, and IV starts, phlebotomy, insert/remove Foley catheters, empty gastroduodenal drains
- Complete patient teaching as delegated by the primary RN
- Transport patients with monitoring
- Delegate tasks to patient care technicians (PCTs)
- Donning/doffing observer, hall monitor, emotional support, and assist with meal breaks
- Documents interventions on the disaster navigator
- Routine rounding

Home Unit or Float PCT/2nd Team RN/LPN

- Follows current unit routines and tasks as directed by the primary RN
- *Runner*—Bring items to and from the rooms, so staff in rooms do not have to remove PPE and put back on, also assist with donning/doffing, keeping isolation stocked

THE USE OF ADKAR IN IMPLEMENTING TEAM NURSING

Before implementing the team nursing model, the leaders at Texas Health looked to the ADKAR change model for support. The Prosci ADKAR model provided leaders with the tools to better communicate, explain, and train care team members while implementing a change. There are 5 tenets of Prosci change management, and these include:

1. *We change for a reason.* In our case, it was in response and part of our emergency planning related to the anticipated surge from the COVID pandemic.
2. *Organizational change requires individual change.* Although moving from primary nursing to team nursing would impact almost our entire nursing team, staff verbalized relief that there was a plan in place to manage the unknown ahead.

Table 1. ADKAR Change Management at Texas Health Resources

	Questions to Ask Yourself	Action Steps to Take	Without ADKAR You Will See…	With ADKAR You Will Hear…
A Awareness	What is the nature of the change? Why is the change needed? What is the risk of not changing?	Draft effective and targeted communications Share the why and the vision Provide ready access information	More resistance from employees Lower productivity	I understand why…
D Desire	What's in it for me (WIIFM)? How is this a personal choice Will I decide to engage and participate?	Demonstrate your commitment Advocate for change Engage influencers to foster employee participation and involvement	Higher turnover Delays in implementation	I have decided to…
K Knowledge	Do I understand how to change? Where can I be trained on new processes & tools? How do I best learn new skills?	Provide effective training with the proper context Facilitate education for, during, and after the change Create job aides and real-life applications	Lower utilization or incorrect usage of new processes and tools Greater impact on customers and partners	I know how to…
A Ability	Am I demonstrating the capability to implement the change? Am I able to achieve the desired change in performance or behavior?	Facilitate coaching by managers, supervisors, and subject matter experts Offer hands-on exercises, practice and time Eliminate any potential barriers	Sustained reduction in productivity	I am able to…
R Reinforcement	What actions can I take to increase the likelihood that this change will continue?	Celebrate successes individually and as a group Reward and recognize early adopters Give feedback on performance and accountability	Employees will revert to old ways of doing work The organization creates a history of poorly managed change	I will continue to…

3. *Organizational outcomes are the collective result of individual change.* The communication of "the why" behind this change was extensively communicated to our nursing team across the THR system. Communication strategies included e-mail, town hall meetings, staff meetings, leader rounding, and weekly webinars.
4. *Change management is an enabling framework for managing the people side of change.* During times of change, it is stressful; add in a global pandemic, and it adds a layer of complexity that most of our leaders had never experienced in their careers. Leaning on an evidence-based change management theory was essential to provide structure during this period of great uncertainty.
5. *We apply change management to realize the benefits and desired outcomes of change.* Planning for this degree of change in the unit practices included education in staff meeting presentations and via electronic communication.[5]

There was a consistent message and a unified approach to the plan from the top down. Ongoing evaluation was necessary to elicit feedback and monitor the level of morale, while identifying barriers, crucial to navigating change. It was important for primary RNs to arrange for the team to meet at regular intervals daily/weekly to brief on new developments of information and provide a supportive role.[2]

LEADING OTHERS THROUGH CHANGE
The nursing leaders used the CLARC model to lead our teams by playing the following roles throughout this change:

- **Communicator:** Explain why changes are being made and how they impact the team and their patients.
- **Liaison:** Report to sponsors (senior leaders) how the change is impacted and being received by your team, and share information from leadership with your team.
- **Advocate:** Demonstrate your commitment to the change and promote a positive attitude.
- **Resistance Manager:** When resistance to change arises, make time to understand and address the root causes of resistance.
- **Coach:** Help your employees build knowledge and ability to adopt new behaviors and practices successfully.[5]

Using the aforementioned CLARC principles to support the teams during this event facilitated a smooth transition that we believed was due to the intentional communication and ongoing presence of leaders who made themselves available to discuss concerns, address immediate issues, and provide overall reassurance. One example of this occurred at a smaller entity when staff exhibited some resistance because they did not feel their roles were clear. The CNO and nursing leaders used additional tools from CLARC to work through the concerns, assisting in clearly defining the staff patient care responsibilities with the team nursing model.

CHANGE MANAGEMENT
ADKAR is an acronym that represents the 5 tangible and concrete outcomes that people need to achieve for lasting change (*Table 1*).[6] Below, we outline these outcomes and how they looked at Texas Health during this process.

Awareness for the need for change: The leaders identified what information individuals needed about the team nursing model and who should share that information, such as the sponsor (CNO) and entity nursing leaders. Although we did not have all the answers, it was necessary to communicate in an open, direct and honest way. We were truly in it together.

Desire to support the change: Leaders identified how willing our nursing team was to participate in the team nursing model and approach. We discovered that most of our nurses wanted to help in whatever capacity he or she was able to do so safely. We initially received hesitation from our operating room (OR) staff. Once they understood this was a task-driven model, they volunteered to lead the proning efforts for our patients in the intensive care unit, leveraging their expertise related to safe patient positioning, a critical skillset in the OR.

Knowledge of how to change: We shared information in various forms on team nursing and how it would look at each of our entities. During leader rounding and town hall meetings, we validated that individuals had an understanding of the team nursing model and why we were taking this approach.

Ability to demonstrate skills and behaviors: As we set up skill refresher classes for some of our nurses from nontraditional practice areas, we validated which individuals could support the team nursing model and approach. This also included educating our nurse managers and supervisors on this nursing care delivery model, as this was new to them, too.

Reinforcement to make the change stick. We identified how and who should reinforce the use of the team nursing model/approach. This included daily shift safety huddles led by the nurse manager or charge nurse to check in with the team and receive feedback on how to maintain this change. Outcomes related to patient quality and safety continued to be measured during this change in our patient care delivery model. We found our outcomes remained consistent at similar levels to what we measured with primary nursing.

CONCLUSION
When hospitals were faced with unprecedented patient volumes resulting from the COVID-19 outbreak, Texas

Health nurse executives needed to utilize a rapid-cycle change model to prepare for a variety of scenarios. While keeping patient safety and nurse satisfaction as a priority, the nurse executive team quickly responded by developing an alternative staffing model based on a team nursing approach to ensure safe staffing. By using the ADKAR and CLARC change models to guide a change from primary to team nursing, they were able to put plans in place to meet the demands, whether it was caused by a decrease in the available workforce or a surge of patients. The processes varied between hospitals, but core principles and implementation strategies were the same. As a result, the goal of the safe patient staffing was achieved, and plans remain relevant in the event there is another situation to warrant a change in our primary nursing care delivery model in a short period of time.

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