Inclusive Leadership: The Best Way to Support Progressive Care Nurses

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Since their inception, progressive care units have represented the “step down” from critical care and the “step up” from the general medical-surgical floor. Patients on progressive care units are typically not sick enough to be in an intensive care unit (ICU), but too sick for medical-surgical nurse-to-patient ratios. As a result, progressive care nurses often feel as though they reside in “no-man’s land”—neither a part of the critical care service nor a part of the medical-surgical division.

Traditional organizational charts place progressive care units in the medical-surgical arena, though the 2 care environments are very different. Today, again despite differences, progressive care units are grouped with critical care. What can progressive care nurses do? Where do they go for resources and support? How can they get past the “us versus them” scenario that is all too common between the staffs at various points along the continuum of care?

Shared Leadership

One answer is a reporting mechanism that has staff at several points along the continuum of care accountable to the same leadership team. With the advent of service lines, grouping like patients and providers into a division or service has helped to ameliorate the divisiveness and isolation that has plagued progressive care unit staff.

For example, having 1 director over the coronary care unit (CCU), cardiothoracic ICU, and the cardiac progressive care unit (CPCU) can bring the environments of care and the care providers together. Instead of being distracted by the geography in which the care is delivered, one leadership team responsible for care delivery throughout the acute phases of cardiac care can take a more patient-focused approach to problem solving. When one director or manager is responsible for these 3 cardiac units, he or she can see the issues more globally and remove the “us/Them” language from conversations. In effect, such an organizational structure helps to put the “we and us” back into the dialogue.

This type of shared leadership structure can best support a philosophy of shared decision making, open dialogue, and mutuality. Instead of saying, “That’s how we do it in the CCU,” the conversation becomes more driven by what the cardiac patient and family need as they move through the continuum. The “dumping syndrome” is no longer acceptable when all nurses within the service are accountable to the same standards of practice and communication expectations, and to seeing the patient’s needs through to discharge. When nurses are all part of the same larger team, all reporting to the same leadership team, it can break down many of the barriers and obstacles that have fragmented patient care for too long.

A Success Story

I have seen such an inclusive leadership concept work wonders in a cardiac setting in New England, after the director responsible for the CCU and cardiothoracic ICU resigned. The CPCU director had...
been in his role for many years, had dealt with many of the “stepchild” symptoms related to managing a progressive care area. I decided that appointing him to also lead the 2 critical care areas might help to bridge the gaps that existed among these areas.

The assistant directors in the critical care areas joined the assistant director of the CPCU and 2 clinical nurse specialists in rounding out the leadership team. They spent considerable time initially getting to know the director, who had to convince the critical care nurses that he could support them and advocate for their needs. At weekly team meetings, issues about patient flow, giving report, visiting hours, and floating quickly surfaced.

At first, the dialogue centered around “turf,” with each leader advocating for what was best for his or her own staff. However, as greater understanding developed, the dialogue became focused on the patient’s experience, and what could be done to best meet the patient’s wishes and to achieve the best outcome for the patient. Gradually, both physical and imaginary, started to crumble.

The CPCU staff was teamed with critical care nurses to learn new assessment skills, while enhancing continuity of care. When the critical care nurses reluctantly accepted an assignment on the CPCU, they learned that the CPCU nurses had admirable expertise, time management, and delegation skills. Issues, concerns, and praise were shared openly at joint staff meetings monthly. Social events encompassed all 3 areas, and an all-inclusive cardiac esprits de corps evolved.

Embracing such an inclusive leadership model was certainly a stretch for all involved. By focusing on how the areas were alike instead of how they were different, the staff involved was able to rise to the challenges. The outcomes were positive for the patients, for staff retention and comradery, and for leadership development. An unexpected outcome was that the physicians started to communicate better.

Although not a panacea, this model moved the organization closer to a patient- and family-centered environment in which cardiac nurses, including CPCU nurses, made their optimal contribution.

Bibliography