Getting Started

Membership on the Progressive Care Nursing Committee

One of the first steps in committee development was determining committee membership. The shared decision-making model, already embraced by our nursing department, helped guide selection of committee members. This model encourages staff nurses to take an active role in making decisions, forming policies, and/or controlling actions and behaviors that affect professional practice. To ensure that practice decisions are made by those most affected by the decisions, this model encourages a committee structure in which the majority of members are registered nurses (RNs) in nonmanagement positions. Each of the 7 PCUs selected an RN staff nurse to represent that unit. In addition, the committee included an RN representative from the department float pool because those RNs are intermittently assigned to deliver care in the units.

The nursing department embraces a leadership model titled the Collaborative Practice Framework. In this model, each unit in the nursing department has a leadership team that includes a clinical nurse specialist, a nurse manager, and a nursing committee was developed. In this article, we describe the steps taken in committee development, summarize committee actions that promoted evidence-based practice in our PCUs, and discuss institutional support requirements to maintain such a committee’s effectiveness.

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goressive care units (PCUs) are recognized as an effective strategy for providing safe and cost-effective care to a large number of patients with ever-increasing acuity. Institutions have developed PCUs to reduce transfers of patients between units, promote the effective use of intensive care unit (ICU) beds, and meet the monitoring and specialty nursing needs of the more acutely ill patients. The rapid increase in numbers of these PCUs, however, has not been accompanied by establishment of consistent patterns of clinical practice and care delivery unique to this practice environment. There was an opportunity to promote consistent clinical practice patterns in our institution, which has 7 distinct PCUs called intermediate care areas (Table 1). At our institution, the titles of the relevant committee and Web site are being changed from intermediate care to PCU terminology. For clarity in this article, the term PCU is used. In order to promote consistent evidence-based care in those units and to create a forum to recognize the unique nature of progressive care nursing practice, a progressive care nursing practice
education specialist. The members of the leadership team, together with unit staff, work toward common goals for each of the PCUs and for the nursing department as a whole. In order to maintain the collaborative practice model for the PCU committee, the membership included a nurse manager, a nursing education specialist, and clinical nurse specialists from both medical and surgical PCUs.

Having a diverse group of roles among the committee members was important because each member offered unique perspectives, knowledge, and skills. Staff nurses could identify practice opportunities on each unit, determine the feasibility of implementing new practices, ask critical questions about the effectiveness of changes, and provide insight into barriers that might influence the change process. As persons with a stake in the changes, staff nurses also functioned as the champions for change among their coworkers. Nurse managers assessed the impact of suggested changes on budgets, staffing, and equipment needs. Nursing education specialists were valuable for facilitating education on new practice initiatives endorsed by the committee and also proposed suggestions for new educational initiatives. Clinical nurse specialists evaluated pertinent literature and advised the committee about best practices. Clinical nurse specialists also monitored and evaluated current evidence-based practice to ensure that standards and desired outcomes were being met. They advised the committee on accessing resources to support the change process.

Committee Purpose

The purpose of the committee was discussed at initial and subsequent meetings. Members felt strongly that one of the committee’s

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### Table 1: Characteristics of 7 progressive care units

<table>
<thead>
<tr>
<th>Type of unit</th>
<th>No. of beds</th>
<th>Patient population/specialty services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical cardiovascular</td>
<td>40</td>
<td>Patients with medically treated cardiovascular conditions: myocardial infarction, arrhythmias, heart failure, endocarditis Patients awaiting cardiac transplantation</td>
</tr>
<tr>
<td>Medical cardiovascular</td>
<td>16</td>
<td>Unit designated as the primary one to care for patients with heart failure but admits patients with other medically treated cardiovascular conditions</td>
</tr>
<tr>
<td>Medical cardiovascular</td>
<td>26</td>
<td>Patients with coronary artery disease or arrhythmia who require invasive interventional procedures Patients with pulmonary hypertension Patients with other medically treated cardiovascular conditions</td>
</tr>
<tr>
<td>Cardiovascular surgery</td>
<td>37</td>
<td>Patients requiring cardiovascular surgery Pediatric and adult patients requiring surgery for congenital heart disease Patients requiring LVAD therapy</td>
</tr>
<tr>
<td>Cardiopulmonary transplant</td>
<td>14</td>
<td>Adult and pediatric patients requiring heart and heart/lung transplantation Patients requiring cardiovascular surgery Patients requiring LVAD as a bridge to transplantation</td>
</tr>
<tr>
<td>Thoracic surgical</td>
<td>33</td>
<td>Patients requiring surgery for pulmonary and esophageal conditions 90% of patients admitted directly from PACU Patients requiring noninvasive ventilatory support Post-PACU care for patients undergoing general surgery who require a higher level of cardiopulmonary monitoring and assessment than that available in general care Dedicated respiratory therapist assigned to unit</td>
</tr>
<tr>
<td>Vascular surgical</td>
<td>36</td>
<td>Patients requiring post-PACU care for procedures, such as carotid endarterectomy, distal arterial bypass, and endovascular repair of an abdominal aortic aneurysm Post-PACU care for patients undergoing general surgery who require higher level of cardiopulmonary assessment and monitoring than that available in general care areas Patients requiring post-ICU care for procedures such as open repair of an abdominal aortic aneurysm and interventional angioplasty after completion of thrombolytic therapy</td>
</tr>
</tbody>
</table>

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**Abbreviations:** ICU, intensive care unit; LVAD, left ventricular assist device; PACU, postanesthesia care unit.
purposes was to provide a forum in which nurses practicing in the unique environment of progressive care could voice concerns and identify opportunities to enhance patients’ care. Staff and leaders recognized the opportunity to establish a specialty committee to represent all 7 PCUs.

Another purpose of the committee was to promote consistent, evidence-based patterns of practice in all the PCUs. Our goal included examination and evaluation of practice patterns and adoption of evidence-based practice for the unique environment of each PCU. The nursing administrative group recognized the importance of ensuring consistent practice patterns across all PCUs and supported the committee when the committee’s purpose was refined to support and guide changes in practice. Ultimately, the committee developed its purpose statements (Table 2).

Defining PCU Nursing Practice

In order to gain recognition as a specialty practice that endorsed practice changes within the institution and to earn representation in the Department of Nursing practice committee, it was important to define the scope of progressive care practice and to specify characteristics that make this practice unique. This task was exceedingly difficult because at the time, no universal definition of progressive care existed. Since the development of the PCU committee, the American Association of Critical-Care Nurses Progressive Care Task Force has developed a definition of progressive care and provided a Web site for related information.

As committee members reflected on their practice and patients’ needs, several conditions and characteristics of patients were identified. Patients in the PCUs had clinical conditions that commonly required electrocardiography and respiratory monitoring along with subsequent interventions. Some patients required technology, such as temporary pacemakers, ventricular assist devices, monitoring of arterial catheters, and noninvasive ventilatory support, and intravenous medications not commonly used in general care areas. As a result, these patients required greater intensity of nursing assessment and intervention than would patients cared for in a general care area. In addition, patients needed intensive education about self-care practices, rehabilitation, and coordination of care to prepare them for discharge to home or the next level of care. Patients cared for in PCUs have been described as stable critically and acutely ill patients with a need for frequent monitoring because of the risk for rapid deterioration in their status. After considerable discussion, the PCU committee arrived at the following definition of PCU scope of care:

The PCU provides care for hemodynamically stable patients who require cardiac monitoring and ongoing assessment and intervention due to risks of dysrhythmias, hemodynamic instability, or respiratory compromise.

This definition is similar to the description offered by Quintero and reflects the concepts in the American Association of Critical-Care definition of progressive care (Table 3). After it identified its purpose and defined the scope of care in PCUs, the committee was recognized by the nursing department as a valid representative and decision-making body for progressive care practice. Once this status was achieved, the committee’s focus turned toward the goal of promoting evidence-based practices in each PCU.

Promoting Evidence-Based Practice in PCUs

Through the years, the PCU committee engaged in activities to promote evidence-based practice in the PCUs. The committee used Goode’s model of evidence-based practice to guide decision making. In this model, clinicians who provide evidence-based care use knowledge synthesized from multiple sources in addition to research findings. Such sources include quality improvement data; benchmarking data; clinical expertise; chart reviews; international, national, and local standards; pathophysiological

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### Table 2 Purpose statements of the progressive care nursing committee

<table>
<thead>
<tr>
<th>Purpose Statements</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create and support an environment for professional nursing within the specialty of progressive care</td>
<td>Reuters, promote patient-centered nursing care within the specialty of progressive care.</td>
</tr>
<tr>
<td>Facilitate and promote patient-centered nursing care within the specialty of progressive care</td>
<td>Promote and support evidence-based practice and continuous improvement activities related to clinical nursing practice within the progressive care environment.</td>
</tr>
<tr>
<td>Provide leadership for nursing practice issues within the specialty of progressive care</td>
<td>Provide leadership for nursing practice issues within the specialty of progressive care.</td>
</tr>
<tr>
<td>Operationalize the vision, mission, philosophy, and goals of the department of nursing and institution within the specialty of progressive care</td>
<td>Collaborate with other specialty nursing committees.</td>
</tr>
<tr>
<td>Collaborate with other specialty nursing committees</td>
<td></td>
</tr>
</tbody>
</table>
Admission, Transfer, and Discharge

Examination of Criteria for Admissions, Transfers, and Discharges

An examination of the type of patients cared for in each PCU assured us that staffing and criteria for admission, transfer, and discharge were consistent with recommended practices. It was important that our department used a nationally recognized patient classification and acuity system to assist in determining hours of nursing care needed per day on the basis of patients’ needs. RNs in the PCUs had the role of entering accurate data related to patients’ needs within a 24-hour period into the classification system. Use of an acuity system to determine staffing rather than use of fixed ratios ensures more appropriate staffing for patients’ needs.1,11

For each PCU, existing admission, transfer, and discharge criteria were examined and compared with the Guidelines on Admission and Discharge for Adult Intermediate Care Units of the Society of Critical Care Medicine.2 This document is based on expert opinion and provides guidelines on the clinical characteristics of patients that make the patients suitable for admission to the PCU. The guidelines recommend that patients be in a hemodynamically stable condition and require 12 or fewer hours of nursing care in 24 hours to qualify for PCU care. The document provides guidelines based on common diagnoses or conditions in body systems: cardiac, pulmonary, neurological, drug ingestion and drug overdose, gastrointestinal, surgical, endocrine, and miscellaneous.2 The guidelines are considered a diagnosis model.2 Other models for determining criteria for admission, transfers, and discharge have been described; however, the diagnosis model was the most useful. Each specialty’s physician colleagues endorsed each unit’s guidelines. As a result, nursing staff and physicians used evidence-based guidelines to assist with collaborative decision making when doing triage for admissions, transfers, and discharges to and from PCUs.

Developing Guidelines for Intravenous Drug Infusion

The second common practice issue the committee evaluated was the infusion of intravenous drugs not commonly used in the general care units. Table 4 provides a list of intravenous drugs studied by the committee. Before the committee was formed, no clear guidelines specified how these drugs were to be used in the PCUs. Which drugs could be administered varied from unit to unit. Committee members proposed that if equipment, staffing, staff competencies, and patients’ acuity were consistent across the units, then practices and policies for the use of intravenous drug infusions should be similar.

A subgroup of committee members was assigned to work collaboratively with the medical directors and a designated pharmacist to develop guidelines for the use of the

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Table 3 Definitions of the scope of care in the progressive care unit

| PCUs provide care to stable, critically ill patients of varying acuities with a high potential for life threatening changes.9 |
| The American Association of Critical-Care Nurses1 recognizes progressive care as part of the continuum of critical care... Progressive care defines the care that is delivered to patients whose needs fall along the less acute end of that continuum. Progressive care patients are moderately stable with less complexity, require moderate resources and require intermittent nursing vigilance, are stable with a high potential for becoming unstable and require increased intensity of care and vigilance. Characteristics of progressive care patients include a decreased risk of a life-threatening event, a decreased need for invasive monitoring, and an increased ability to participate in their care.7 |

PCU Nursing Practice Committee description (1999): The PCU provides care for the hemodynamically stable patient who requires cardiac monitoring and ongoing assessment and intervention due to the risk of dysrhythmias, hemodynamic instability, or respiratory compromise. The American Association of Critical-Care Nurses6 recognizes PCUs provide care to stable, critically ill patients of varying acuities with a high potential for life threatening changes.9 |

Abbreviation: PCU, progressive care unit.

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data; infection control data; patients’ preferences; and cost-effectiveness analysis.30 When available, evidence-based guidelines developed by professional societies are used to guide activities that promote practice improvements. Although discussion of the depth and breadth of evidence-based practice changes is beyond the scope of this article, examination of criteria for admission, transfer, and discharge; development of guidelines for administration of intravenous drug infusions in the PCU; customization of documentation for PCU use; and initiation of ST-segment monitoring are described in the following sections.
The subcommittee used an evidence-based approach by reviewing pertinent literature related to pathophysiology and pharmacology, surveying current PCU practices of administering the drugs in our institution, examining costs of administration in the ICU and PCU, and comparing drug infusion practices in other facilities before developing guidelines. After that information was synthesized,

### Table 4 Drug infusions administered in progressive care units*

<table>
<thead>
<tr>
<th>Drug class</th>
<th>Drug name</th>
<th>Indication for use in PCU</th>
<th>Considerations/exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiarrhythmic</td>
<td>Amiodarone (Cordarone)</td>
<td>Loading and maintenance infusions for treatment of supraventricular arrhythmias</td>
<td>Drug may be started in PCU for unstable ventricular tachycardia in patients awaiting transfer to ICU</td>
</tr>
<tr>
<td></td>
<td>Vaughn Williams class III</td>
<td>Maintenance infusions for treatment of hemodynamically stable ventricular tachycardia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lidocaine</td>
<td>Initial and maintenance infusions for treatment of hemodynamically stable ventricular tachycardia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vaughn Williams class IB</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Procainamide</td>
<td>Loading and maintenance infusions for treatment of hemodynamically stable supraventricular arrhythmias or ventricular tachycardia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vaughn Williams class IA</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diltiazem (Cardizem)</td>
<td>Loading and maintenance infusion to control rate of ventricular response in patients with supraventricular arrhythmias</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vaughn Williams class IV</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Esmolol (Brevibloc)</td>
<td>Loading and maintenance infusion to control rate of ventricular response in patients with supraventricular arrhythmias</td>
<td>Patients requiring treatment for hypertensive emergency are cared for in the ICU</td>
</tr>
<tr>
<td></td>
<td>Vaughn Williams class II</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vasoactive</td>
<td>Dopamine</td>
<td>Patients requiring doses &gt;5 µg/kg per minute for circulatory support are cared for in the ICU</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Used in doses to increase renal perfusion</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maintenance infusions of 5 µg/kg per minute for cardiac transplant patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nitroglycerin</td>
<td>Hemodynamically stable patients with anginal signs and symptoms, acute coronary syndrome, uncomplicated non–ST-segment myocardial infarction, or after percutaneous coronary intervention; patients awaiting cardiac surgery; postoperative patients requiring stable dose</td>
<td>Patients who require continued upward adjustment of dosage to relieve symptoms Patents requiring treatment for pulmonary edema and hypertensive emergency are cared for in the ICU</td>
</tr>
<tr>
<td></td>
<td>Vasoactive</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inotropic</td>
<td>Dobutamine</td>
<td>Initial infusion and titration takes place in ICU; patients may be transferred to PCU when tolerating a stable dose</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maintenance infusion to improve cardiac output in patients with chronic heart failure; used primarily for patients awaiting cardiac transplantation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Milrinone (Primacor)</td>
<td>Maintenance infusion to improve cardiac output in patients with chronic heart failure; used primarily for patients awaiting cardiac transplantation</td>
<td>Initial infusion and adjustment of dosage takes place in ICU; patients may be transferred to PCU when tolerating a stable dose</td>
</tr>
<tr>
<td></td>
<td>Naturetic peptide</td>
<td>Nesiritide</td>
<td>Drug is used primarily in medical cardiovascular PCUs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Loading and maintenance infusion to treat decompensated congestive heart failure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prostacyclin</td>
<td>Epoprostenol (Flolan)</td>
<td>The majority of patients receiving their initial treatment are cared for in the medical cardiac intervention unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maintenance infusions to treat pulmonary hypertension</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: ICU, intensive care unit; PCU, progressive care unit.

* The recommendations in the above guidelines are not rigid rules. Specific needs of patients and clinical situations may require actions other than those presented here.
and analyzed, the subcommittee recommended requirements for various types and frequencies of monitoring based on each drug’s actions and potential side effects.

Recommendations for limitations of drug use in the PCU were developed and are reviewed regularly. For example, dopamine is allowed for use solely at doses to promote renal perfusion, and loading infusions of amiodarone are limited to use in treating supraventricular arrhythmias. Patients can be transferred from the ICU to the PCU with dobutamine or milrinone infusions only after stabilization on their current dose.

In keeping with the framework of shared decision making and multidisciplinary collaboration, the proposed guidelines were circulated to each unit’s nursing practice committee, physician colleagues, and the institutional pharmacy committee for review and feedback. On the basis of the feedback, the guidelines were revised. The final document was forwarded to the institution’s pharmacy and therapeutics committee for institutional endorsement. When approved, the guidelines were published on the pharmacy and therapeutics Web site, which was linked to the PCU Web site. This dual publishing allowed easy access to the information to all staff and promoted consistency in practice. The document also provided guidance to resident physicians for making decisions about placement of patients. The recommendations in the guidelines are not rigid rules. Specific needs of patients and clinical situations may require alternative decisions. A decision-making process for situations that fall outside of the recommendations is included in the guideline document.

**Documentation**

Over time, as committee members worked together on common practice issues, they noted that documentation of care was fragmented. In 5 of the PCUs, nurses receiving a patient from the ICU were required to review computerized printouts and transcribe information onto a paper record. In the other 2 PCUs, handwritten charting completed in the ICU was reviewed and again transcribed to different documentation forms.

In addition to transcribing critical information upon transfer of patients from one level of care to another, nursing staff in the PCUs were required to provide documentation on multiple forms. Vital signs and 24-hour intake and output data were noted on one form, intravenous medication and fluids on a second form, medication administration on a third form, patients’ education on a fourth form, and results of head-to-toe assessment on the assessment documentation form. Use of multiple forms leads to a fragmented 24-hour view of patients.

One goal was to have nursing staff in all 7 PCUs use the same forms for documentation. However, these forms did not allow efficient documentation of data on intravenous medication, fluid management, monitoring of vital signs and respiratory status, nursing interventions, patients’ education, or care planning. The forms used to record objective data and results of nursing assessments did not fully reflect patients’ acuity. Because of those findings, the committee chose to develop a new documentation form. Committee members were also aware of the institution’s directive to move all documentation to an electronic medical record. Committee members thought that developing a new documentation form would promote a smoother transition to the electronic medical record.

The process for developing the new documentation form included reviewing current documentation used in all 7 PCUs and examining documentation forms within our institution and from several other institutions. The committee’s primary goal was that progressive care practice would guide the design of the new documentation form. To facilitate transition to electronic documentation, the committee met with a nursing informatics representative to review the approved electronic documentation package. The committee also assigned a member to represent the PCUs on the nursing informatics committee and nursing practice committee. The members chosen to represent the PCUs on the 2 committees were asked to communicate institutional practice changes to the progressive nursing care committee to ensure incorporation of practice changes into the new documentation form and to represent PCU practice at the larger institutional meetings.

Ultimately, the committee developed a single-sheet documentation form that included the following data elements: cardiac and respiratory monitoring, increased room for frequently recorded vital signs, hourly intake and output, catheter management, and administration of drug infusions. The reverse side of the form was used to document the standard nursing assessment completed for all patients.

Several institutional practice changes were incorporated into the
PCU documentation form. The committee recognized that effective pain management is a national healthcare priority and therefore included a pain rating intensity scale on the data-collection side of the form. To facilitate efforts to track patients’ nurse-sensitive outcomes of coping, knowledge of the disease process, tissue integrity, and mobility, the form included a place to record daily the degree to which these outcomes were achieved.

The PCU committee modeled the PCU documentation form after the current paper ICU documentation form. The data documented on this form accurately reflected the frequency and complexity of monitoring activities required and the acuity of the PCU population of patients. It allowed consistent and comprehensive flow of data from the ICU to the PCU and was designed to promote a smoother transition to documentation in the electronic medical record.

Electronic Medical Record

Stahl discussed the need for choosing appropriate technology to serve the needs of the PCUs. The PCU committee representative on the institutional nursing informatics committee facilitated that activity. A survey completed by the management team and practice committees from each PCU provided information about the type and frequency of data collected during care of patients. The survey included questions on complex intake and output management, frequency of assessment of vital signs, continuous monitoring of cardiac and respiratory status, and administration of drug infusions. Results of the survey indicated a need to change the documentation software that was originally allocated for the PCUs. After presenting the data from the survey, informatics nurses were able to secure departmental approval for PCUs to use the same electronic medical record as the ICU. This approval provided institutional financial support for computers to be placed in each patient’s room, allowing the bedside monitors to transfer information to the computer without a need for additional data entry by nurses. This change promoted continuity of information when patients were in transition from areas of care such as the ICU, procedure areas, or postanesthesia care unit to the PCU.

ST-Segment Monitoring

Initiation of ST-segment monitoring for patients at risk for myocardial ischemia in PCUs was a practice change the committee recommended and promoted. As already noted, patients in the PCUs were acutely and critically ill, and many had multiple comorbid conditions. A substantial number had coronary artery disease or had clinical conditions that put them at risk for myocardial ischemia. Studies have indicated that patients monitored via telemetry may experience myocardial ischemia and, when myocardial ischemia is present, are at higher risk for adverse in-hospital outcomes. ST-segment monitoring is useful for detecting silent ischemia. Nurses in our ICUs used ST-segment monitoring technology to monitor patients for silent ischemia; however, such monitoring was not commonly practiced in all PCUs. Guidelines for ST-segment monitoring describe which patients are at risk and offer recommendations about ST-segment monitoring for those patients. Clinical nurse specialists on the committee recognized that some patients in all the PCUs were at risk for unidentified myocardial ischemia and could benefit from ST-segment monitoring. Clinical nurse specialists asked the committee members to consider the initiation of ST-segment monitoring for patients at risk for myocardial ischemia.

With leadership from the clinical nurse specialists, committee members reviewed recommendations from a consensus statement on multilead ST-segment monitoring in patients with acute coronary syndromes. That consensus statement provides recommendations on selection of patients, monitoring time frames for various clinical conditions, configurations for electrocardiography leads, and required skills and equipment. The statement also highlights clinical benefits of ST-segment monitoring and heightened committee members’ interest in promoting use of this technology in all 7 PCUs.

Factors considered in establishing this practice included education of PCU staff, consistency in practice, and evaluation of the effectiveness of the practice. Nursing educators coordinated educational programs for staff, and ST-segment monitoring was included in the curriculum for ICU and PCU orientees. The committee formulated a plan for evaluating compliance with the guideline and providing staff feedback in regard to selection of patients, setup, lead selection and placement, and documentation of actions taken when ST-segment deviation occurred.

Departmental Support

Departmental support of a shared decision-making model was the key
that empowered nurses in the PCUs to make changes in practice, documentation, and nursing environment. The shared decision-making model supported by the nursing department is based on the belief that consensus decisions are best made by those persons who will be clinically implementing the decisions. The department's commitment to the shared decision-making model was evidenced by its support of a committee structure that empowered nurses to make changes in clinical practice. Staff are empowered to act because they are involved and their voices are heard through councils and committee structures such as the PCU nursing practice committee. When committees make evidence-based decisions, those decisions are respected and supported by the administration. The Department of Nursing practice committee provided recognition and support for PCU committee members when the committee was being established and during implementation of evidence-based practices. The nursing department provided human, financial, and technical resources that promoted the effectiveness of the committee.

Each PCU needed support of the nurse manager to facilitate staff involvement in committee work. This support included encouraging the involvement of staff nurses in the committee, planning budgets to allocate hours for committee time and professional activities, and self-scheduling that allows nurses to plan attendance for the committee meetings. Nurse managers’ support of the PCU practice committee and value of PCU practice was possible because, at a higher level of administration, directors of clinical nursing recognized the value of the progressive care environment and the unique nature of progressive care nursing. This higher level of administrative endorsement of the activities of the committee was necessary to support practice decisions made by the progressive care nursing committee that required financial support for additional equipment, staff, and educational initiatives for all 7 PCUs.

Clinical nurse specialists promoted practice changes. The clinical nurse specialists on the committee served as mentors to staff nurses. They assisted staff in identifying opportunities for improvement in current practice and encouraged staff members to critically analyze research. They helped staff nurses identify institutional resources to make practice changes and encouraged committee members to consider potential institutional implications when making the practice change.

In order to successfully implement practice recommendations and enhancements in the clinical area, communication of practice changes and education are critical. The PCU teams were supported by nursing education specialists who developed a curriculum to educate staff in skills required for successful PCU practice. The education specialists collaborated with committee members on curriculum content and coordinated education in new policies or practices.

Secretarial support was a valuable resource to the PCU committee. A secretary produced and distributed minutes, agenda, and updates for committee members and performed clerical activities such as making copies, tabulating audit data, and making room reservations. Secretarial support ultimately increased nurses’ productivity during the change and implementation process.

A PCU practice Web page provided easily accessible information (Table 5). The PCU practice Web site contained information related to policies such as admission, transfer, and discharge criteria, policies and procedures related to PCU nursing practice, educational material, available institutional resources, and supports and links to outside educational and informational resources such as the American Association of Critical-Care Nurses Web page. One of the committee members served as a Web editor to coordinate submissions to the Web page and keep the Web site updated and accurate.

**Lessons Learned**

The practice changes just described did not come to fruition...
without challenging experiences for committee members. Looking back, we can see the value of attending to some common principles related to managing change.

**Realize That Shared Decision Making Takes Time**

Arriving at decisions through consensus may require more time in the planning phase of the practice change. Arriving at decisions by command may take less time in the beginning, but implementation and integration of the practice change may suffer because of poor acceptance. Seven PCUs were represented on the committee. When a practice issue or proposal for practice change was brought to the PCU committee for consideration, preliminary discussion about the issue or change occurred in the committee meeting. After the PCU committee meeting, each member was expected to communicate the proposal for practice changes or issue to his or her own unit committee and then return to the PCU committee with feedback from the unit. At a subsequent meeting, PCU members discussed the various units’ comments and concerns and attempted to arrive at a consensus about how to address the issue or whether to adopt the practice change and how to implement the change. If the issue or practice change was complex, or needed more research, revisions to the proposal would be required, and the cycle would be repeated. Some practice changes endorsed by the PCU committee required review by department or institutional committees. The time frame to endorse and plan for some practice changes spanned months, but consensus was gained, department and institutional considerations were addressed, and the implementation of the changes was successful.

**Engage in Multidisciplinary Collaboration**

None of the practice changes just described involved nurses only. In each instance, physicians’ collaboration and endorsement was important. Proposals for practice changes were discussed with each unit’s physician director and, as appropriate, with physician practice committees. This step allowed committee members to learn the physicians’ perspective on proposed changes and proactively address questions and concerns. Formal written endorsement by established physician groups promoted acceptance by the larger physician group as the changes were implemented. In the instance of developing drug infusion guidelines, the pharmacist also was critical in providing the evidence on which decisions were made and in bringing those decisions to the larger group of pharmacists serving the PCUs. Successful implementation of the ST-segment monitoring could not have been achieved without collaboration with the monitoring technician supervisor and staff.

**Explore the Upstream and Downstream Effect of Changes While Planning for the Change**

Examine the number of departments that will be influenced by the change. Staff from the emergency department, postanesthesia care unit, and ICU needed to know about specific admission and discharge guidelines for patients admitted to the PCU. ICU personnel were informed about the details of the intravenous infusion guidelines so that they could plan for transfers into and out of the ICU. We found that the ability of PCUs to take on patients receiving some drug infusions affected the census and flow of patients in the ICUs. Development of the new PCU documentation form affected multiple users of the form. Users included anyone documenting or reviewing information on the form. Multiple departments, such as dietary, respiratory therapy, pharmacy, and nursing in general, and ICU units, unit secretaries, and physicians required information about the new documentation form.

**Be Prepared to Devote a Substantial Amount of Resources to Solidify the Practice Change**

A single educational intervention before implementation of the practice change was not adequate to ensure that the practice change would be adopted and implemented by staff. After the initial implementation date, staff members had frequent questions and concerns and needed further coaching and mentoring to integrate the change into their practice. We addressed this need by having resources such as staff nurse champions for the change, nursing education specialists, and clinical nurse specialists available to reinforce information and answer questions. We created reminders via pocket cards and posters on the units and posted a PowerPoint presentation on the PCU Web site. Prompt feedback of staff performance was provided through concurrent chart audits.
In summary, progressive care nurses can have a voice in promoting evidence-based care for acutely and critically ill patients in the progressive care environment. Presence of a shared decision-making model that promotes staff participation in a progressive care nursing practice committee makes this possible. In order to enhance the committee’s effectiveness, it is important to define the scope of PCU care, determine the roles and functions of key members, seek and maintain endorsement from nursing leadership, ensure support for staff participation, and provide clerical assistance. Resources such as education specialists and the availability of Web-based education and information opportunities are needed to educate and inform staff about practice changes and recommendations made by the committee.

References
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