

Interview with Susan VanDeVelde-Coke

Susan VanDeVelde-Coke, RN, MA, MBA, PhD, is Executive Vice President, Programs/Chief, Health Professions and Nursing Executive, Sunnybrook Health Sciences Centre, Toronto; former Vice President, Operations, of the Victorian Order of Nurses (VON), Ottawa; and Adjunct Professor at the University of Toronto. In this interview, Dr. Coke reflects on the state of nursing today from the perspective of a senior nurse administrator.

What is the biggest challenge facing you as a nurse leader?

Managing the fiscal constraints while addressing current healthcare issues – increasing service demands, integration of services and wait time strategies are some of the most challenging issues. The second major challenge is recruitment and retention of all levels of healthcare workers, as well as managing the multicultural and multigenerational workforce.

Most Canadians realize we cannot continue to fund healthcare at a rate that is approaching 30% to 40% of provincial budgets. Increased funds to shorten wait times for certain procedures have improved confidence in the system, but we have not addressed the chronic care issues that affect the majority of our client population. Significant improvements in effectiveness and efficiency of healthcare delivery have been shown in some European countries through expanding the role of the registered nurse and allied health professionals and improving integration of

services between the acute and community sectors. I would like to see the development of new nursing roles that can bridge the community and acute care sectors, which may be through access points like the ER or community health stations. My experience in the community sector taught me that there are huge opportunities to break down the sector silos. The community sector is extremely efficient in doing more with less; we can learn from them in the acute care sector. The challenge for nurse managers in the two sectors is to develop new roles together, and brainstorm possibilities, especially around the theme of chronic care. A consortium to brainstorm new nursing roles to better integrate services, and investigate the application of some of the European models of care, would be very interesting (see Morgan et al. 2007).

Recruitment and retention of front-line nursing staff and nurse managers is our constant challenge. Many positive actions have taken place, with additional spaces in university settings and government initiatives. For example, in Ontario, the new nurse graduate strategy increased opportunities for late-career nurses, and additional funding is available for full-time positions. I was also encouraged to read about new projections in the United States, from the research done by Dr. Buerhaus, that predicted the nursing shortage in the next decade to be approximately 340,000 nurses rather than 800,000 (Buerhaus, Donelan et al. 2007; Buerhaus, Auerbach et al. 2007). In Canada, we too, are making progress in improving our supply and demand predictions through improved data collection, but we still lack sufficient teachers for the new spaces that have been created by the universities.

In the provinces, and especially in the larger cities, multiculturalism and diversity are reflected in all levels of the nursing workforce, as well as in our patients. Sometimes healthcare workers inadvertently impose their own value system on patients because they do not understand or have never been exposed to the particular values of the patient. The challenge for all senior administrators is to help the patients, nursing staff, physicians and allied health professionals understand one another's cultural and value systems, particularly as these relate to health and wellness. At my institution we have had informational sessions to address these complex and emotional issues, but we have a long way to go to raise consciousness.

An additional challenge is the multigenerational workforce. There are now four generations working at the bedside and in community settings. The challenge for the nurse manager is to understand and know how to deal with the value systems, work ethic, expectations of work life and the technical expertise of the over-55 nurse versus the brand new graduate. Education for managers and staff is the key to understanding and making the workplace a more pleasant and friendly atmosphere for all groups.

Do you think that people are attracted to nursing as a career? Are there enough people to fill the new openings in the universities?

I would answer “yes” to both questions. There will always be people who choose nursing as a career. Nursing is a challenging career, working with equally educated colleagues in a rapidly changing environment, helping clients reach their potential within their physical and mental capabilities. I stress to new orientees that nursing has multiple options as a career choice, from the different sectors (community, acute, long-term care) to the roles within the sectors. In addition, nurses have numerous learning options. I am amazed at how many nurses go back to university for additional education, courses or degrees, or to become teachers themselves. Nurses seem to have a healthy appetite for continuous learning.

Regarding the supply of nurses, I am encouraged by the increased number of spaces that have been added and filled at the universities and colleges. I understand that the applicants in Ontario were up 4% this year, which amounts to 4,000 additional applicants. I noticed at the annual CNA and RNAO meetings that students are actively participating and are enthusiastic about the profession. I thoroughly enjoyed watching them in action. The concern, as I mentioned, is the inadequate number of professors and teachers, which is related to retirements and the increased demand. One solution being explored by Ontario teaching hospitals is to provide opportunities for advanced nurse practitioners and clinical nurse specialists to assist more on the education front; these staff are an untapped source for student education.

How do you decide what to focus on in your daily activities?

In my role as Executive Vice President, Programs, I focus on the strategic directions of the institution, as well as the operational issues. In my role as Chief Nurse Executive, I concentrate on the practice and academic directions for the profession. Some institutions split the role of EVP and CNE, but I find that having control and responsibility of the resources, reporting directly to the CEO and sitting at the executive table are critical to advance practice.

The majority of my time is spent on the program issues. Each program (cardiac, oncology, perinatal and gyn, trauma, neurosciences, acute and medicine, mental health, musculoskeletal) determines its priorities, which must be academically and fiscally balanced. There is an incredible amount of diversity of priorities within each program, and it is exciting and satisfying to work and assist them in balancing and managing their priorities.

At the executive level, there is increased emphasis on accountability and stewardship. We are mandated to measure how, on what and with what outcomes we spend our healthcare funding. I find I spend a considerable amount of time with

my executive colleagues explaining how we manage the resources. Measurement of healthcare outcomes must be done internally and externally, and therefore, having good benchmarking data is critical. Measuring nursing outcomes is particularly difficult and not well understood by government personnel, our non-nursing colleagues and board members. Therefore, the development and implementation of improved methods to measure nursing outcomes, like the HOBIC initiative in Ontario, are extremely important for nursing executives.

About a third of my time is spent in my role as Chief Nurse Executive, where I have the opportunity to work with all levels of staff – front-line staff, managers, advanced nurse practitioners, clinical educators and program directors – on our three professional goals, which are to develop and implement nursing best practice initiatives in each program, improve the quality of nursing work life and improve knowledge transfer and exchange.

Examples of best practice include a hospital-wide initiative of 12 projects to improve our support of families, as well as best practice initiatives in skin, pain and patient safety projects. The choice of quality of nursing work life projects has been determined by interviewing staff and asking “what prevents you from doing your job?” We have been working on the list for three years and have a long way to go. Better scheduling, heavy workloads and inadequate equipment, as well as the need for increased respect, lead the list of concerns.

We are fortunate to have access to education funds that allow a fair number of staff to receive education and conference support. In addition, five years ago, Sunnybrook started Practice-Based Research Awards, which are \$5,000 to \$10,000 grants that are available to nursing and allied health staff for basic research on a practice issue. These awards allow front-line staff to get acquainted with the research process with small studies that whet their appetite for inquiry. We also assist them in setting up the methodology and statistical measurement, which is always the most intimidating aspect for staff.

You’ve commented that nurses are not as unhappy as the media have led us to believe. Can you elaborate or provide specific examples?

I don’t deny that there is unhappiness in the nursing profession, but I am an optimist, and I do think we are making progress to mitigate some of the discontent. I mentioned that we did a survey asking staff what interferes with their practice, which has provided a great deal of information on what makes nurses unhappy: scheduling, workload, lack of respect, not enough education time. Our data are consistent with the literature. However, our scores did not indicate that nurses were ready to leave the workforce, and there are opportunities for us to increase satisfaction in the workplace.

The financial data show us that there have been improvements in the ratio of patients to staff over the past five to six years. At Sunnybrook, on the medical–surgical units, the average ratio is four to five patients on the day shift, and six to seven on the night shift. Five years ago it was six to one and eight to one, respectively. The staff always work hard, but we must acknowledge that ratios have improved.

I was surprised to see how many of the staff asked for more educational advancement. In that regard, we are trying to leverage our education and conference funds, and are working on a proposal with the nursing union to provide increased opportunities for education. We are also looking at the opportunities for e-learning and correspondence learning over the Internet, which is the standard method of learning for our younger staff.

Succession planning is also an area of dissatisfaction. A new front-line manager is not well prepared for the job, and the education required is not easily obtainable. We are working on a front-line manager education plan that will provide initial orientation, though not enough. Continuous education for managers is required in their challenging job; we need to do a much better job in this area. I frequently tell the front-line managers that they have the toughest and most important job in the hospital. If the unit does not run well, the ramifications are enormous for the patients, families, staff and physicians.

I acknowledge that there is unhappiness among nursing staff, but I believe our job as nursing executives is to work with the staff and do something about it, and to celebrate the successes.

How do you set up the right environment to allow the goals and objectives and priorities to happen?

The structure and modus operandi for the nursing governance within an organization are key. Every nursing group must have a voice at the decision table. The Nursing Advisory Committee (NAC) is the decision-making body, made up of a constituency that represents every major nursing group in the institution: the front-line staff, patient care managers, advanced nursing practitioners, continuing education staff, and directors of operation, practice, education and research. Members are responsible for representing their particular constituency, generating feedback, opinion and discussion of the issues, and bringing back their information to the NAC.

The NAC is part of a tripartite group, the two others being the Medical Advisory Committee (MAC) and the Professional Advisory Committee (PAC), which are responsible for identifying, managing and monitoring the physician, nursing and

health disciplines practice issues for the institution. As the Chief Nursing and health disciplines executive, I am also responsible for representing the NAC and PAC issues at the senior executive table. This tripartite structure, as well as representation at the senior leadership level, facilitates bringing the nursing and health disciplines concerns forward expeditiously.

The second most important mechanism to facilitate nursing priorities is the program management structure. Each program is led by a dyad: the program chief (a physician) and the Director of Operations, the majority of whom have a nursing background. The EVP Medical and myself worked through a job description for both roles, delineating the different but complementary responsibilities of each role. This exercise has differentiated the responsibilities for each role in strategic planning, fiscal and quality management and human resources planning. The roles are equal but different, and both are necessary to lead the strategic plan for each program. This structure has helped nursing, medicine and health disciplines staff work together in an interprofessional manner for the success of the program goals and objectives.

References

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