Back to the floor Friday: evaluation of the impact on the patient experience

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Aim The aim of the study was to evaluate the Back to the floor Friday (BtfF) initiative, whereby senior nurses returned to the floor, in particular its impact on patient experience and patient care.
Background Propositions were that improvements would result from strengthened visible clinical leadership through monitoring standards, supporting staff, resolving problems, acting as advocates and implementing change.
Method Participatory action research: BtfF population surveyed; five focus groups comprising 20 multi-professional staff; interviews with nine therapists, 45 nurses, one nurse specialist and four patients. Data analysed using qualitative content analysis.
Results Empowerment, learning together, professional networking, communication, championing change and 'Matron Power' were positive themes and perceived staff benefits arising from BtfF. Staff provided anecdotal examples of patient benefits but tangible evidence of improvements were more difficult to identify.
Conclusions Long-term evaluation of the impact of BtfF on patients is needed. Nurse specialists, matrons and clinical educators felt that the initiative did not impact significantly on day-to-day roles. Nurses across the workforce needed clarity around propositions behind the change.
Implications for nursing management Enablers to the initiative were supportive line management, senior leadership and peer support. Clarity of purpose is important to drive effective change.

Keywords: action research, change, nursing, patient experience, standards of care

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Introduction

The Back to the floor Friday (BtfF) initiative was launched across an acute NHS Trust in England in January 2009 with an overall aim to improve patient experience through strengthened and visible clinical nurse/midwife leadership. The Trust comprised five hospitals located on four sites in an inner-city metropolitan area and employed 3250 nurses. The initiative was part of a Trust-wide patient experience improvement programme and a BtfF implementation model based on best practice at a neighbouring NHS Trust was developed and agreed by the senior nursing team in December 2008. As a result all nurses/midwives above Band 7 (n = 171) returned to clinical practice in uniform on Fridays from January 2009 to provide visible clinical leadership and to support staff at ward and department level to deliver improved patient care.

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The cohort of BtfF staff included Senior Nurses, Clinical Nurse Specialists (CNS), Nurse Consultants, Practice Educators and the Nurse Director's corporate nursing team. While acknowledging that many of these staff already spent a considerable amount of time in clinical practice, the nurses and midwives were asked to organize their weekly workload so that they undertook clinical work relevant to their role each Friday. A programme of audit activity based on nurse-sensitive clinical indicators was developed by the participants to underpin the initiative, with morning briefing sessions established to direct and focus effort for the BtfF staff and their clinical teams. Afternoon feedback/discussion sessions were also implemented to build networks, share learning, analyse and debate audit results, and to promote best practice.

Literature review

The study site's nursing and midwifery strategy articulates the Trust's mission to provide world class health care. World class in this context is defined as an organization that is considered to be at the leading edge of health care either at a national or international level (Trofino 2000). The BtfF initiative was implemented to realize the Trust's vision that empowerment of nurses at all levels will enable innovation and creativity to occur in the clinical environment (Kanter 1983). Furthermore, in the present economy where costs need to be contained and standards improved, the need to include nurses at all levels in driving this agenda forward is self-evident.

There is relatively limited evidence around the relationship between nursing leadership and patient outcomes (Vance & Larsen 2002). Although initiatives that use leadership and management strategies have been found to have a significant impact on the patient experience this is reliant on a workforce that holds appropriate management and leadership skills to facilitate the change (Alleyne & Jumaa 2007). While limited, the data that is available identifies the impact of positive leadership behaviours on patient outcome and falls largely into the following categories: patient satisfaction, patient safety outcomes, adverse events and complications (Wong & Cummings 2007). Furthermore, an increase in patient satisfaction is associated with positive leadership (McNeese-Smith 1999, Doran *et al.* 2004). Some studies have gone so far as to claim to have found an association between leadership and patient mortality rates (Houser 2003, Pollack & Koch 2003, Boyle 2004). However, within Houser's study the correlation can be attributed to the experience of the staff working in that area, rather than leadership behaviours.

Two studies have found the impact of leadership on adverse events and complications highly significant (Anderson *et al.* 2003, Houser 2003). Anderson *et al.* (2003) found a direct correlation between the utilization of open communication, encouraging participation in decision-making and modelling positive leadership attributes with a significant reduction in the number of adverse events. Other studies found a correlation between positive leadership qualities and an increase in patient safety outcomes (Houser 2003, Pollack & Koch 2003).

The BtfF initiative was centred on three core themes – leadership, management and delivery of evidence-based practice – with the aim of promoting critical debate and evaluation of service provision, and discussion of clinical issues faced in everyday practice. This would enable the senior nurses to fulfil their role as leader and innovator in patient care. Central to the strategy was the strengthening of nursing and midwifery leadership to positively impact on, and to improve, the patient experience of care with leadership a key facilitator in driving up the patient experience. The Trust's nursing and midwifery strategy is central to service transformation and the delivery of world-class patient care. So, the study was designed to evaluate the BtfF initiative, to explore and identify the activities staff were undertaking during BtfF and the impact those activities had on the patient experience and on direct patient care.

Aim

The overall aim of the study was to evaluate the BtfF initiative, in particular its impact on the improvement of the patient experience and on patient care.

Research questions

To provide a framework that would focus the study, the following research questions were formulated:

1 Do the activities BtfF nurses/midwives undertake have an impact on patient care?
2 What future activities would BtfF nurses/midwives undertake to further improve the patient/client experience?
3 What are the perceived support needs of the BtfF nurses/midwives in undertaking current and future activities?

Methodology

A participatory action research approach (Meyer 2006) was used with the Plan-Do-Study-Act (PDSA) learning

cycle (Berwick 1998) providing operational infrastructure to the study. Action research is particularly relevant when applied to health-care settings because it focuses on the 'real world' (Kelly *et al.* 2002) and has as its central tenet the principle of involvement. The senior nursing team co-created the BtfF initiative and from the outset were involved in the evaluation of its impact. Friday afternoon feedback/discussion sessions with the cohort of BtfF nurses were used to formulate the propositions and the study design. Action research is considered to be a 'collaborative approach to inquiry or investigation that provides people with the means to take systematic action to resolve specific problems' (Stringer 1996, p. 15). Within health care the overarching impetus for action research has been the need to improve professional practice and to enhance service delivery (Nichols *et al.* 1997). The BtfF initiative had been approved by the Trust Board and its collective ownership focused staff efforts to drive the improvement. The PDSA learning cycle is considered to be a powerful tool to achieve learning and change within complex systems (NHS Modernisation Agency 2004) and was used to structure the evaluation. It is an approach that enables improvement of practices, whereby a problem or issue is identified and a series of phases within the action research cycle (plan, do, study and act) deliver improvements or change (Table 1). A series of PDSA cycles were designed to focus on the implementation of the BtfF initiative and to explore the research questions outlined.

Ethical considerations

The research proposal, objectives and methodology were reviewed by the Trust Research and Development department. The study was designated as a service evaluation and therefore exempt from the legal requirements for ethical approval by a Research Ethics Committee. The research was directed by the Deputy Director of Nursing from the study site and a Head of School from a partner higher education institute. Although the study was designed in collaboration with the senior nursing team and the BtfF participants, the researchers gave written and/or oral information about the study to all of the participants and questions were answered before obtaining their informed consent to participate in any method of data collection. Participants were informed that they could withdraw from the study at anytime without penalty or consequence. All data were anonymized and handled in accordance with ethical requirements (Burns & Grove 1997).

Sampling

All nurses/midwives undertaking the BtfF initiative were invited to take part in the study with the total population of BtfF participants surveyed on two occasions: August 2009 (n = 163, response 21%) and November 2009 (n = 183, response 21%). An invitation sent by e-mail to a convenience sample of BtfF participants using a Trust distribution list resulted in 20 self-selecting multi-professional staff who comprised the five focus groups. In addition, purposive sampling techniques were used to identify nine therapists, 45 ward and department nursing staff, one clinical nurse specialist and four patients who also contributed to the data collected.

Data collection

In line with the principles of participative action research, data were collected and analysed to inform a sequence of three PDSA cycles that evaluated the BtfF initiative. The data were collected from August 2009 to March 2010 commencing with a baseline survey distributed to 163 participants to ascertain the activities undertaken by BtfF participants, the future activities that they would like to undertake and the enablers and inhibitors to them undertaking the activities. Also, whether they would like to take an active role in future data collection, analysis or interpretation during the course of the evaluation. This was followed up by a focus group. A second survey distributed to 183 participants was undertaken to explore the construct of role clarity, in particular for those staff who felt that they were 'on the floor' everyday, and the format and

Table 1
The Plan-Do-Study-Act cycle

Plan	Define the objectives, questions and the change to be tested or implemented. Plan to answer questions around who, what, where and when?
Do	Carry out the plan, collect the data, test the change and begin analysis of the data
Study	Complete the analysis of the data, compare data from before and after the change and reflect on what has been learnt
Act	Plan the next change cycle or full implementation

organization of future BtfF activities. Themes arising from this second survey were correlated and cross-referenced with data from cycle 1. This data was further enriched by four focus groups conducted with BtfF participants, Matrons and CNS. The third cycle involved conducting interviews with specialist groups: CNS, multi-disciplinary team members and patients, along with scrutiny of web-based grey data, for example a blog in a nursing journal following a feature on the initial research findings (Thompson 2009). Although the cohort of BtfF staff was invited to participate in the data collection none chose to do so, and all data were therefore collected by the two staff who directed the research. All focus group data was tape-recorded and transcribed verbatim by an experienced secretary.

Data analysis

The volume of data generated throughout this study demanded the use of an analytical methodology that could deal with the wealth of data and contextual material. Therefore, a systematic approach was used to sift, chart and organize the data according to key issues and themes (Ritchie & Spencer 1994) and is outlined in Figure 1. This approach allowed simultaneous and cross-method analysis in order to shape future data collection activities to address the research questions (Stake 1995).

Reliability and validity

Reliability in the qualitative paradigm differs from that used within the empirical school of research because of the contextual nature of the research (Sandelowski 1986). However, participants involved in the study are able to establish reliability through the evaluation of the findings (Stern 1985). For this study, reliability was served through the presentation of sufficient data, in this case narratives, to allow the participants to validate the data presented under the key themes (Sandelowski 1986). Although the sampling strategy resulted in a non-probability sample, the participants were selected because of the likelihood that they would provide information relevant to the needs of the study and would be most likely to confirm or refute the propositions held (Flyvbjerg 2001).

Findings

The findings are presented according to the research questions posed.

The activities undertaken by nurses and midwives and their impact on patient care

The activities that staff were undertaking included: nursing ward rounds; providing direct patient care; covering staff shortages; taking a clinical caseload; role modelling and coaching; mentoring and supervising junior staff; undertaking education activities; participating in focused and themed activities, for example cleaning inspections; carrying out focused audits (e.g. hand washing); and collecting and collating nursing sensitive metrics data (e.g. falls and catheter care). Examples given were:

> I provided clinical cover and looked after a bay of six gentlemen for an early shift as the ward was extremely short of staff (Focus Group Participant).

> I either go and work with our new staff that are on rotational posts… or I'll go round and actually just eye ball the unit and see where we are…it gives you a chance to go round and have a look at what's going on in the unit (Focus Group Participant).

The participants reported that in their view, the BtfF initiative had had a positive impact on the patient experience. In particular, that improvements had resulted from them taking part in focused activities, enhanced through shared learning and networking, with nursing and midwifery peers. Examples given were:

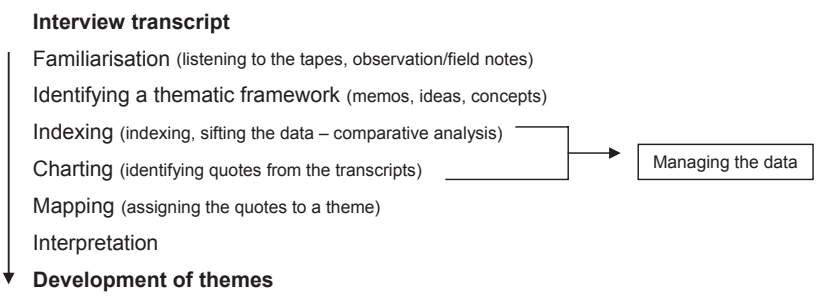

Figure 1
The data analysis process.

> I think this initiative is absolutely superb it ensures that at least one day per week one can solely focus on nursing within the department. It gives the chance to audit and to maintain a presence on the unit enabling me to role model for the junior nurses. One of the most important things for me is that we get the opportunity to meet other nurses at our level… (Focus Group Participant).

> It also gives you an absolute brilliant time to find out what their (staff) issues are. When you are standing side by side with them, doing work that they do, day in, day out, making beds – key time (Focus Group Participant).

Although BtfF participants provided anecdotal examples of the impact of the initiative on the delivery of patient care, for example the impact of focused audit activity, tangible examples of improvement were more difficult to identify. However, evidence from hand-held patient experience real-time trackers showed demonstrable improvements in patient reports of hospital cleanliness in June and July 2009, which coincided with a focused effort from BtfF participants on the audit of the hospital environment. This evidence was replicated in improvement scores for cleanliness in the 2009 hospital in-patient survey. Taking the view that longer-term, or frequently admitted patients might be able to comment on the impact of the initiative, visits were made to two wards delivering care to patients with long-term conditions. However, of only four patients available for interview on the day that the data were collected, two were able to explain the role of the BtfF nurse and two were not.

Perceived support needs of the nurses and midwives

Many of the participants referred to the role of supportive line management in enabling them to participate in the BtfF initiative; there was also an understanding from multi-professional colleagues of the need to focus clinically on Fridays. Examples given included:

> Fridays as much as possible are kept free from meetings or any other activities so that BtfF can be achieved. It is important for ward staff to see senior nurses willing to participate in delivering patient care. Other disciplines appreciate the 'burgundy brigade' (colour of BtfF uniform) being on the ward (Survey Respondent).

> That others understand this must be the prime focus of my day (Survey Respondent).

Some participants articulated a tension between the expectation to be visible and to participate in themed activities, and the expectation that they deliver against existing work commitments and negotiated job plans. Some felt that they were 'on the floor' everyday and did not work differently on Fridays. Examples given included:

> I already have clinical commitments on a Friday so am already 'on the floor (Survey Respondent).

> The only difference is that on Friday I wear a uniform (Survey Respondent).

> For Clinical Nurse Specialists and Nurse Consultants… we need clarification of the commitment and contribution expected of us, and more creative thinking re: best use of our clinical skills and knowledge of the organization (Survey Respondent).

The Trust comprises five hospitals located on four geographical sites. Protected clinical time was felt to be compromised by some because of the need to travel across sites to attend BtfF briefings and meetings. However, for others travel arrangements provided an opportunity to discuss clinical practice and to network. Examples given were:

> I try to attend (BtfF briefs and meetings) when I can, particularly if it does not involve travelling cross site. If I have to travel, this takes up a large part of my clinical day which does not allow a great deal of time to meet objectives (Survey Respondent).

> Going across sites on that [hospital] bus, I have actually heard so much discourse about audit, and the audit process... I found Back to the Floor Friday extended on the bus onto yet another platform (Interviewee).

Although the allied health professional therapy team felt BtfF was a high-profile, highly visible initiative, the BtfF initiative was not always well understood at 'grass roots' level by front line staff. The majority of a convenience sample of ward and department nurses (n = 45) accessed on one of the hospital sites on a Friday were unclear about the purpose of the initiative and the activities that the BtfF nurses undertook. Also, some staff articulated expectations that the BtfF nurses should deliver bedside nursing care.

Planned future activities

Future activities that the participants would like to undertake included: providing more direct 'hands-on' care; undertaking clinical shifts; focusing on privacy and dignity; running patient focus groups; tailoring specific audit activities relevant to own area; auditing each others' practice, particularly in areas where the participants did not normally work; thinking through delivering services differently; cross-boundary working; and collaborative improvement work with other professionals.

Discussion and implications for nursing management

> 'It brings together a level of people who can action change a lot quicker. So you've got this grade of people that have been pulled out of the office that have a little bit more power within an organization, and they get to see first-hand some of the issues. So it kind of improves and speeds up that gap between what is not happening on the shop floor and what can be done'
>
> (BtfF participant)

Propositions assumed that improvements would be made as a result of strengthened and visible clinical nurse/midwife leadership. Overall, the positive themes arising from the initiative focused on staff benefits and were: empowerment; learning together; professional networking; communication; championing change; and 'Matron Power'. Subjective examples of patient-centred improvements resulting from the initiative were provided by the participants but objective examples of improvement were more difficult to identify. The data collected thus far has, to some extent, answered the research questions posed, in particular, information about the activities undertaken by the nurses and midwives and their support needs. However, the evaluation is incomplete with more data required to investigate any benefits, or otherwise, of the initiative for patients. A further PDSA cycle has been designed to investigate the impact of the initiative on patient experience and on delivery of patient care. Back to the Floor Friday is now an established way of working at the Trust and the senior team have established a set of nursing sensitive metrics to underpin the initiative that, together with evidence from hand-held patient experience real-time trackers, will provide methods of measurement for PDSA cycle four.

In terms of implementation infrastructure, strong leadership was pivotal to the operational success of the initiative with the Director of Nursing and her senior team leading from the top. This included role modelling of effective personal management behaviours to enable full participation in clinical activities, for example cleared diary schedules with no expectation of sending or responding to e-mails on Fridays and 'out-of-office' notifications as standard. Supportive line management and peer support were also important to the success. Further exploration of the following themes arising from the dataset will improve the operational implementation of the initiative: role clarity, in particular for those on the floor every day; clarity of purpose and engagement, to better align the initiative to improvements in patient care delivered by all staff groups; and format and organization of Fridays, to make best use of staff time.

The findings contribute to the existing body of knowledge about nurse leadership. In particular, the staff benefits of strengthened and visible clinical nurse/midwife leadership; and the benefits of a formal leadership structure to manage clinical activities through peer support. Because of its focus on evaluation, the study is distinct from reports of 'back to the floor' initiatives to date (Nursing Standard 2006, Wedderburn Tate 2007, Harris 2009, Nursing Times 2010) that focus as news items or personal reports only.

Limitations of the research

This small study used a qualitative design, underpinned by the principles of participatory action research and an improvement-focused learning cycle, to begin to understand the impact of a leadership initiative on the improvement of patient experience and on delivery of patient care. The approach was selected because of its over-arching impetus to improve professional practice and to enhance service delivery, and inclusion of participants in the study design and implementation. Although the sampling strategy yielded a non-probability sample, every attempt was made to enhance reliability and validity at all stages of the research process. The whole cohort of BtfF participants were invited to participate in collecting and analysing data but none did so. As a result, the data were collected by the senior staff who directed the research with findings discussed with the senior nursing team within an existing forum, and this may be considered a weakness. Also, the study was located in one NHS Trust and so the findings are tentative. However, the data were considered sufficient to explore the phenomenon of interest and have contributed to iterative implementation of the improvement initiative within the study site.

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