An Evaluation of the Implementation of the Nurse Champion Role in the 2006 Influenza Vaccination Program for Employees of the Vancouver Island Health Authority

By

Gayle Lohr

A Project Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Nursing

In the School of Nursing, Faculty of Human and Social Development

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Gayle Alice Lohr

BA, University of Victoria, 1979

BSN, University of Victoria, 1996

Supervisory Committee

Project Supervisor, Elaine Gallagher, PhD

Committee member, Laurene Sheilds, PhD

External reviewer, Debra Sheets, PhD
Executive Summary

In 2006, the Vancouver Island Health Authority (VIHA) revised their immunization services delivery model to try to increase vaccination rates. Changes included establishing unit-based influenza clinics and creating a voluntary nurse champion on participating units. The overall purpose of this evaluation was to assess the impact of these changes in the VIHA immunization program on rates of vaccination and to examine satisfaction of the nurse champions with their training and their role. Project goals included:

- Identifying strategies associated with effective influenza campaigns by conducting a literature review.
- Assessing the impact of the revised immunization service delivery model by comparing vaccination rates pre- and post- implementation using data from the British Columbia Centre for Disease Control
- Examining the role satisfaction of the influenza nurse champions using a retrospective survey

Study participants were comprised of one hundred and twenty four VIHA nursing employees (100 nurse champions and 24 nursing unit-managers). Results indicate that implementation of the revised immunization service delivery model did not increase vaccination rates, but influenza nurse champions reported high levels of satisfaction with their training and role in making immunizations available and accessible to their healthcare colleagues, while also noting that the voluntary nature of this role imposed additional demands on work time.
# Table of Contents

Supervisory committee ......................................................................................... .ii
Executive summary ................................................................................................. .iii
Table of Contents ................................................................................................. .iv
Acknowledgements ............................................................................................... .vi
Chapter 1: Introduction ......................................................................................... .1
  Overview and Background ..................................................................................... .1
  Significance of the Problem .................................................................................. .4
  Project Purpose and Goals ..................................................................................... .6
Chapter 2: Literature Review ................................................................................ .7
  Barriers to the Influenza Immunization: Healthcare Workers’ Perceptions ....... .7
  Facilitative Factors in Immunizing Healthcare Workers ..................................... .8
  Recommendations from Literature on Improving Vaccination Rates ............... .9
  Nurse Champion ................................................................................................... .12
  VIHA Staff Influenza Immunization Campaign .................................................. .15
Chapter 3: Methods .............................................................................................. .18
  Methodology ........................................................................................................ .18
  Data Collection .................................................................................................... .20
  Ethical Considerations ......................................................................................... .20
Chapter 4: Results ............................................................................................... .21
  Immunization rates ............................................................................................... .21
  Nurse Champion Survey ....................................................................................... .22
  Qualitative Findings ............................................................................................ .23
Study Limitations .......................................................... 25

Chapter 5: Discussion ....................................................... 26

Chapter 6: Recommendations and Conclusions ...................... 28

  Recommendations for practice ....................................... 28

  Recommendations for further research .......................... 29

  Conclusions ............................................................ 30

References and Appendices ............................................. 33

  References .......................................................... 33

  Figure 1: Immunization Rates for VIHA Employees 2004 to 2006 .... 2

  Figure 2: Immunization Rates for VIHA Employees 2004 to 2009 .... 21

  Table 1: Survey Results ............................................. 22

  Appendix A: VIHA Staff Immunization Campaign – Revision to Service Model .... 37

  Appendix B: Staff Influenza Immunization Campaign Collaborative Project 2006 .... 39

  Appendix C: Influenza Campaign Collaborative Project Evaluation Survey .... 40

  Appendix D: Action plan for the Influenza Campaign Collaborative Project .... 41

  Appendix E: Letter from Human Research Ethics Board .................... 45
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Chapter 1: Introduction

Overview and Background

In February 2006, the Vancouver Island Health Authority (VIHA) hired a project coordinator for the Infection Control Department. One of the tasks of the coordinator involved working with the Wellness and Safety Department to collaborate on the annual immunization campaign. The Infection Control Department is responsible for the safety of all VIHA in-patients and residents. Similarly, the Wellness & Safety Department is responsible for the health and safety of all VIHA employees. Each year, the Wellness & Safety Department launches an annual influenza vaccination campaign for healthcare employees which run from November to mid December. The Infection Control Department coordinates a similar vaccination campaign for in-patients and residents during the same period. According to the British Columbia Centre for Disease Control (2007), the influenza vaccine is the best way to prevent the spread of influenza and to protect the patients and provide a safe working environment.

Geographically, VIHA is responsible for publicly funded health care services on Vancouver Island and part of the mid coastal region of the mainland of British Columbia. There are approximately 17,000 VIHA employees including nurses, therapists, technicians, physicians, maintenance workers, housekeeping, and food services personnel. These employees work in 138 different locations as well as diverse settings such as acute care, long-term care, community, and home care. Prior to the changes in the immunization campaign, 5 occupational health nurses within the Wellness & Safety Department coordinated influenza vaccination clinics at 189 VIHA sites. The annual campaign ran for six weeks and provided vaccinations to all interested VIHA employees.
Over the years, low immunization rates of healthcare workers despite availability of the free influenza vaccinations, have been a concern. Beginning in 2004 data on immunization rates for healthcare employees in acute care settings became available for the first time. At the start of this project in 2006, the 2 year average rates of employee immunizations were 48% for acute care staff and 62.5% for long-term care staff.

In 2006, VIHA developed an immunization policy to protect the healthcare of workers and patients against an influenza outbreak. The Influenza Prevention Program Procedure (2006) states:

- “Non-immunized staff may be excluded from the outbreak setting until the outbreak is declared over by the Medical health officer.”

- “Employees who have chosen not to be immunized will not be paid for any time lost from work as a result of being excluded from the workplace during an influenza outbreak. Should employees choose to take prescribed anti-viral medication it will be at their own cost” (p.2).
VIHA administration also approved revisions to the immunization service delivery model to meet the requirements of the Performance Agreement (Ministry of Health, 2006). The Performance Agreement is a statement of intent between the Ministry of Health and the health authority, which delineates accountabilities, funding and requirements for public reporting. The goal of the revised immunization service delivery model was to increase VIHA employee immunization rates by 3% above the previous year’s rate. The revisions to the service delivery model are outlined in Appendix A. The changes in the service deliver model were two-fold. First, unit-based influenza vaccination clinics were established, in addition to general influenza clinics, to increase access to immunizations by all staff. Second, a volunteer nurse “champion” would be selected on participating units and trained to provide immunizations and offer information about influenza to dispel myths about vaccines. This champion” role would be an extension of the role of long-term care nurses who were already trained to vaccinate residents for influenza, but not healthcare workers.

In June 2006 the immunization program coordinator for the Wellness & Safety Department was given primary responsibility for implementing the revised immunization services delivery model, with collaboration and assistance expected from the Infection Control Department. Unfortunately, in August 2006 the coordinator for the Infection Control Department was reassigned to another site. As a result, the coordinator for the Wellness & Safety Department developed the educational training program and evaluation of the immunization program with limited assistance. In September 2006 a series of educational training sessions were offered to influenza nurse champions. These sessions were coordinated with the Infection Control Department to reduce redundancies in training nursing staff for the Seniors Program Influenza Campaign,
Significance of the Problem

The impetus for the revisions in the immunization service delivery model came from two reports: the British Columbia Immunization Strategic Framework (Ministry of Health, 2006) prepared by Wave Consulting and the Ministry of Health 2005/2006 Performance Agreement (Ministry of Health, 2006) with VIHA. These reports note that influenza immunization rates for healthcare workers should be 80% in long-term care and 60% in acute care settings. In the Immunization Strategic Framework (Ministry of Health, 2006) the Ministry states that influenza immunizations save lives by reducing the risk of infection. Immunization can prevent disease and disability associated with communicable diseases. This statement expounds on the responsibility of the Ministry, the BC Centre for Disease Control, and the Regional Health Authorities to implement and deliver immunization services to the population of British Columbia (BC) through their joint stewardship. A key goal of the 2006 Immunization Strategic Framework was to significantly increase current and future rates of vaccinations to achieve provincial and national immunization targets by 2010, and ensure a long-term and sustainable vaccination program. The Performance Agreement (Ministry of Health, 2006) between the Ministry of Health and the Health Authorities outlines the standards required to receive continued funding. The amount of funding VIHA would receive each year would be tied to organizational performance in meeting the standards. In short, VIHA would be held responsible for meeting the influenza immunization targets established by the Immunization Strategic Framework (Ministry of Health, 2006).

Since the Wellness and Safety Department is responsible for the employee influenza program, it became that department’s responsibility to find a solution to low employee immunization rates. VIHA’s influenza immunization rate for 2005-2006 was well below the
target levels set forward by the Immunization Strategic Framework (Ministry of Health, 2006), with only 64.9% of Long-Term Care staff and 44.9% of the Acute Care staff being immunized (British Columbia Centre for Disease Control (BCCDC), 2009).

The occupational health nurse coordinating the Influenza Campaign for the Wellness & Safety Department was given the task of developing and implementing the policies and procedures to meet the guidelines mandated by the Immunization Strategic Framework. The concept of the “nurse champion” was adopted based on a qualitative study that examined factors influencing the decision of BC healthcare workers to obtain an influenza vaccination (Masaro, et al., 2006). The nurse champion role addresses common barriers to vaccination by increasing access to vaccination by offering it to employees on their work units and during their shift. In addition, nurse champions were available to provide information and respond to concerns that employees might have about receiving the vaccination. The proposal for the Immunization Campaign (see Appendix B) includes important details on the educational training offered to nurse champions as well as procedures for the storage, handling, and administration of the vaccine in accordance with accepted immunization practice. Nurse champions were required to report all abnormal side effects or adverse reactions immediately to the Wellness & Safety Department. Nurse champions were provided with information and reference material to share with their peers and an Occupational Health Nurse was available to assist if additional information was needed. This study evaluates the impact of the Influenza Campaign between November 1 and December 16, 2006. A retrospective summative evaluation of the Influenza Campaign project was conducted to assess the extent to which outcomes of the project were achieved and to determine nurse champion satisfaction with the role and training.


Project Purpose and Goals

The overall purpose of this project is to:

- Identify strategies associated with effective influenza campaigns, particularly within the context of health care settings by conducting a literature review.
- Assess the impact of the revised immunization service delivery model by comparing vaccination rates pre- and post- implementation using data from the British Columbia Centre for Disease Control.
- To examine the role satisfaction of the influenza nurse champions in the 2006 VIHA Influenza Campaign using a retrospective survey.

Specifically, the evaluation was designed to answer two questions. First, will implementation of unit-based influenza clinics and the nurse champion role improve the immunization rates of staff? Second, are the nurse champions satisfied with their role and training?”
Chapter 2: Literature Review

A literature review on influenza vaccine programs was conducted to identify barriers and facilitative factors that influence healthcare workers decisions to vaccinate and to identify strategies to improve immunization rates. A second body of literature was reviewed to define and describe the nurse champion role.

Studies indicate a variety of reasons why healthcare workers do or do not receive the influenza vaccination each year. Some studies investigate the fears of workers about the vaccine and approaches to increase immunization rates. For example, low immunization rates for communicable diseases is a problem in healthcare centers because of the nature of the interaction between patients and staff (Hoffmann and Perl, 2005), Tapianinen, et al., 2005, Gazmararian, et al., 2007, and Piccirillo and Gaeta, 2006). The potential risks for transmission of influenza in hospitals can be reduced with the vaccine. Positive outcomes include reduced patient mortality and absenteeism for staff.

Barriers to the Influenza Immunization: Healthcare Workers’ Perceptions

Perspectives on why or why not healthcare workers receive the influenza vaccine is a key topic in recent studies. Vollman and Pierrynowski-Gallant (2004) investigated specific reasons for refusing the vaccine. Factors contributing to refusal included: fear of side effects (e.g., Guillain-Barre Syndrome), soreness at the vaccination site, belief that the body can ward off infection on its own, doubts about the vaccine efficacy, not wanting to get sick, not liking needles, knowledge that influenza vaccination is not mandatory for healthcare providers in most provinces, and the lack of ready access to vaccinations. A recent study examining healthcare workers concerns about the “cons” of getting the influenza vaccination indicated that workers had continued misconceptions of the vaccine including doubts that the vaccine would be
effective and concerns that it could also cause influenza (Gazmararian, et al., 2007). Similarly, other studies suggest that healthcare workers were concerned about the risks of serious adverse effects and some were unaware that the vaccination was necessary (Takayanagi, et al, 2007; Strunk, 2005, and Masaro, et al., 2006). Other concerns expressed were whether the vaccine would transmit the influenza virus (Piccirillo and Gaeta, 2006, Song, et al., 2006); Gazmararian, et al, 2007) reiterated the four most common reasons for refusal were; not enough time available to get the vaccination, confidence that their health was good enough not to need the vaccine, doubting the vaccine efficacy and fear of injection (Song, et al., 2006).

Findings from qualitative research methods exploring both individual and system level factors in order to identify the barriers to immunization concur with other studies and include: fear of side affects, risks of getting sick from the vaccine, lack of perceived need, some felt it wasn’t necessary because they never get sick and others felt they were not in contact with patients. In each of the studies the response of the healthcare workers reiterated the issues of their personal fears, not believing the vaccine would work and the time it would take to access the vaccine (Masaro et al., 2006).

Facilitative Factors in Immunizing Healthcare Workers

Studies examining vaccination behaviours of physicians and how it corresponds with their recommendations for immunizations patients reveal that that physicians strongly recommend that all healthcare workers (including physicians) have a professional responsibility to be vaccinated with benefits far outweighing any risks (Cowan et al., 2006). Vaccination not only protects the healthcare worker personally, but also reduces transmission to patients at high risk for influenza-related complications.
Studies examining factors that influence whether or not healthcare workers receive vaccination indicate that further information and in-services on vaccine, about “influenza campaigns” and the use of non-injectable vaccines are motivating factors (Takayanagi, et al., 2007). Other studies suggest that human interactions with employees as well as ease of vaccine access were more successful than poster or flyers (Gazmararian, et al., 2007). Self-efficacy related to the healthcare workers’ own health or that of their family is also a factor in the vaccination decision (Masaro, et al., 2006). Some healthcare workers believe that exposure to sick people made them more likely to get something from the patients while others were more likely to act as a result of hospital policy that would prevent them from working during an influenza outbreak, if they were not vaccinated (Masaro et al., 2006).

A recent study found that workers were motivated by the hospital campaign, history of influenza, and recommendations by colleagues (Song, et al., 2006). A positive relationship between knowledge and compliance also has an impact; the more workers knew about the vaccine the more likely they were to receive it (Gazmararian, et al., 2007). Different professions are motivated by different reasons; patient protection instead of self-protection was the most prevalent reason for immunization reported by physicians in their study. Prior influenza illness also plays a role in whether or not healthcare workers decide to get vaccinated (Piccirillo and Gaeta, 2006).

Recommendations from Literature on Improving Vaccination Rates

The literature suggests a variety of strategies for achieving higher influenza vaccination rates. Common themes from the earlier cited studies included: easier access to the vaccination, more information on how the vaccine works during the “flu” season, more education on what influenza is and how it is transmitted, more communication about hospital policies, and the
creation of new yearly incentives. More appealing and convincing educational programs rather than simply posters or notices were also recommended. For example, a 2006 study found that healthcare workers wanted more education from expert consultants to “dispel myths”, not people in authority such as Clinical Nurse Leaders or Managers (Masaro, et al., 2006).

A “program” plan that reflects theories on behaviour change, planning, and evaluation is also important (Russell, Thurston and Henderson, 2003). A model plan would include the inputs, activities, outputs, short-term and long-term outcomes or impacts, and a measurement tool to assist in evaluation. “Single –component interventions” (e.g. education alone or incentives alone) appear to have minimal effectiveness. However, “multi-component interventions that include education (e.g. education plus one or more of reminder, improved physical and temporal access to vaccination services) are effective in improving vaccination rates” (p.339) (Russell, Thurston and Henderson, 2003). According to APIC (2009), evaluating the program each year is important to create a “culture of scientific observation” (p. 3). Furthermore, it is important to be prepared to review the project from different perspectives to decide if it is succeeding or if something needs to change. Another way of improving methods of feedback is to plan communication sessions for each site at the end of the campaign to ascertain where the project needs to be focused in the coming year, as not every site will have the same issues. It is important to ask not only the managers and the nurse champions, but also the healthcare workers for feedback for improvements. The momentum needs to be maintained to sustain a successful and flexible program.

Successful influenza campaigns “should dispel myths, offer incentives, identify departmental champions and create a positive atmosphere and excitement” (Strunk, 2005, p. 434. The literature indicates that many workers get vaccinated primarily to protect themselves and
their families. Immunization programs clearly need to have a multi-level approach. It is important to give workers the information they want and need to understand the benefits of vaccination when considering their health, their family’s health and their patients’ protection. A significant part of structuring a strong campaign includes providing evidence-based information related to influenza and immunization to employees in a variety of media including structured sessions by healthcare personal. In a study on healthcare worker groups and vaccination decisions, Christini, Shutt and Byers (2007) found that different groups wanted different information in regards to motivations for accepting the vaccine. “Nurses’ education could focus on clarifying misconceptions related to potential side effects of the vaccine and the value of protection; the technicians and aides education could emphasize the potential for transmitting the virus to patients, as well as the safety and efficacy of the vaccine; campaigns geared towards surgeons could emphasize the potential for nosocomial transmission as well as the efficacy of the vaccine” (Christini, Shutt and Byers, 2007, p.175). The education needs to be done on site with health care experts facilitating and coordinating education to meet the needs of the different types of healthcare workers.

There is also a need for better communication. An important goal when planning the influenza immunization project’s communication is to generate a sense of enthusiasm about the campaign as a significant worthwhile and fun employee venture. Enthusiasm for the project has to start at the top of the organization. Endorsement for the project from administration and closer to the unit by the managers can take the form of frequent communications. Examples include emails, newsletters, and automatic reminders via emails about influenza vaccination rates, and the rates of vaccination administration. Piccirillo and Gaeta (2006) suggested “the use of a simple chart showing updated healthcare worker compliance rates with influenza vaccine,
posted in frequented areas of the hospital, was thought to be partly responsible for increasing vaccination acceptance rates to nearly 70%” (p.621).

Russell, Thurston and Henderson (2003), discussed the importance of the measurement and reporting of rates to include: vaccination of the patients/residents, isolation of patients, and use of antiviral agents to reduce transmission, outbreak information, and adverse effects of the vaccine or/and antiviral. The communication needs to include the workplace policy for vaccination around unit influenza outbreaks.

Nurse Champions

A nurse champion is defined as a “nurse” in a leadership role who may also have a formal role, such as a manager, clinical educator, or clinical leader or an informal role such as a unit nurse. The nurse champion is a volunteer role that is assumed in addition to regular duties on a unit. Often this volunteer position is taken by a unit nurse as an opportunity to develop professionally. This leadership role is that of an advocate, and an instigator of change. Hoff (1999) states, “there are no fewer that 350 definitions of leadership alone in the literature related to organization behavior” (p.312). Owens (as cited in Hoff, 1999) defined leadership “as a group function: it occurs only in the processes of two or more people interacting and leaders intentionally seek to influence the behaviour of other people” (p.312). A leader can create, maintain and redirect a group as needed to achieve a goal. According to Wheelan and Johnston (1996), effective leaders are “instrumental in the creation and guidance of group and organizational culture” (p.33).

According to Lewis and Edwards (2008) the “champion” role is an applied leadership role, providing education, communication, and one-on-one support with issues of change for the front line healthcare workers. Since the role is unit based, the accessibility of the “champion”
during regular work hours around the clock is important. Many leadership roles are Monday to Friday, whereas most healthcare workers work rotating shifts 7 days a week around the clock. Lewis and Edwards (2008) looked at applied leadership for infection control that “required that key members of staff advocate and champion consistently high clinical standards in their areas” (p.26). An informal leader can play a strong role in determining the groups’ efficacy (Pescosolido, 2001). This concept coincides with the recommendations from a study by Masaro, et al., (2006) that “knowledgeable and trusted champions within the facility should be encouraged as someone to whom others may go with their concerns [regarding immunization]” (p.9).

Literature on this type of leadership program reiterates that “nurse champions” can improve practice for all. An editorial by Miller and Chaboyer (2006) described a nurses’ role in patient safety as “captain and champion” (p.266). The article maintained that a nurse must actively engage with patient safety movements at personal, instructional and professional levels. Nelligan, et al (2002) indicated that organizational strategies included the idea that “senior nurse leaders and key clinical nursing staff must lead, in collaboration with other team members…sharing information influencing others and fostering synergy with broader organization goals” (p.73). The champion role is not just about being an advocate, but also holding a body of knowledge that will inform co-workers about information that is needed on the topic. Being knowledgeable and trustworthy are characteristics that the healthcare workers gave as two attributes they would want in a “champion” in the study by Masaro, Skowronski, et al., (2006). The nurse champion is a role with an opportunity to improve the quality of care through better communication with front line health care workers. The role offers extra education about the influenza vaccine and to be someone the co-workers trust to understand their opinions.
The literature suggests that an influenza champion can increase opportunities for informal education on the unit. Masaro, et al., (2006) and Donato, et al., (2007) concluded “that healthcare workers are in an ideal position to help patients understand the value of immunization, but they must first believe in its value themselves for the administration protocols to be successful” (p.221). The influenza nurse champion can empower healthcare workers to make an informed choice when contemplating the influenza vaccine. In a study by Willis & Wortley (2007) “Vaccinated nurses expressed a greater degree of comfort and enthusiasm with promotion and took a more proactive role in educating patients about influenza, high-risk categories and influenza vaccine” (p.23). The nurse champion has an important role in facilitating knowledge about the influenza vaccine among patients and colleagues.

Northway and Mawdsley (2007) discussed that the implementation of “change” can sometimes make the “champion” the brunt of any resistance. The challenge of “changing” preconceived ideas of a group of people is the hardest part of the champion role. The resource kit for champion’s developed by Association of Profession Infection Control and Epidemiology (APIC) (2009) notes that it is important to find champions that embrace the goal and also motivate others within the workplace. It may take more than just one champion to change practice. It is important to be able to motivate people into having ownership, as people support what they create. The role also offers professional development by being exposed to the process of implementation and quality improvement education helps to increase job satisfaction, and eventually stronger team relationships.

In summary, healthcare workers do not receive the influenza vaccinations due to: fear of adverse affects, belief that vaccine does not work, and a belief they can get the “flu” from the vaccine. The reasons that health care workers decide to obtain a vaccine are usually personal:
they have a history of having the “flu”, they don’t want their families to get sick, and they have
had education on the influenza vaccine that answered their questions. Suggestions from the
healthcare workers to increase the rates of vaccinated workers include: more education by
experts about the issues that people fear about the vaccine, better communications including rates
of vaccinated staff and the number of cases in the local region, and peer support from someone
on their unit that they know and trust.

*VIHA Staff Influenza Immunization Campaign*

The components of the campaign are outlined in Appendix A. The revisions to the
service delivery model reiterates that for the best outcomes with respect to morbidity and
mortality, there should be a minimum of 60% staff uptake in acute settings and 80% uptake in
long-term care. The action was to take a two-pronged approach for influenza vaccinations. The
general clinics run by Wellness and Safety would continue as well as unit immunizations by unit
registered nurses. The advantages to the campaign would be the convenience to staff with on-
site RNs trained to vaccinate their colleagues, improved accessibility to vaccination which
should increase the uptake thereby reducing associated infection risk to the patients and
residents.

The implementation plan outlined the role of the occupational health nurses working for
the Wellness and Safety Department in assisting the relevant Managers in setting the program up
on their nursing units, providing staff with training sessions, subsequent coaching of staff and
being available for ongoing consultation throughout the influenza campaign. The occupational
health nurses continued to offer general clinics at the major sites within VIHA. Program
Directors were asked to strongly encourage their managers/nursing leaders to participate in the
revised influenza campaign.
Appendix B outlined the collaborative project’s purpose to increase VIHA staff immunization rates through improved accessibility. The policy for the influenza vaccine may be administered to healthcare workers by nursing staff that have received authorization from their manager and completed a training session with Wellness and Safety. The occupational health nurses would be consultants if assistance or additional information were needed.

Participants were recruited for the nurse champion role by their respective hospital unit managers. Twenty-four managers volunteered to hold influenza clinics on a total of 57 units. Managers were also asked to find nurses on those units to volunteer to participate as “champions” in the influenza campaign. One hundred nurses volunteered. The 57 units that participated had anywhere from one to three “champions” per unit. Three “champions” on a unit made it possible for some units to cover rotating shifts and offer 24 hour access.

Three educational sessions were organized within VIHA in September 2006: one in the North Island, one in the Central Island, and one in the South Island area. Ninety-five nurses were paid by their unit manager to attend one of the three sessions. The five nurses who could not attend the sessions received one-on-one education on their specific unit from the project coordinator from Wellness and Safety. The educational training consisted of:

♦ Informing the nurses of the “nurse champion” role and the immunization program as defined in Appendix A.

♦ Distribution and review of resource information packages developed for both the nurse champions and the healthcare workers

♦ Education on how to give the influenza vaccine

♦ Information on how to fill out the healthcare worker’s consent for vaccination forms, and where to send the completed forms
Information concerning delivery, storage and disposal of vaccination materials.

The influenza campaign for the healthcare workers was held throughout VIHA from November 1 until December 15 of 2006. The campaign was launched with VIHA and Public Health doing a news event at one site on the Island the first Monday of November. The Wellness and Safety Department held approximately 98 regular clinics at the larger hospital sites over the whole island throughout the 6-week campaign.
Chapter 3: Methods

A retrospective evaluation of the Influenza Campaign for 2006/07 was proposed to explore the outcomes of the model and outline recommendation for the future development of the Nurse Champion role in the yearly influenza campaign. The goal of the evaluation was to assess the impact of the revised immunization service delivery model on vaccination rates for the 2006 VIHA Immunization Campaign, and to examine the role satisfaction for the influenza nurse champions. The evaluation of the impact of the revised service delivery model addressed the following specific questions:

1. What were the immunization rates for 2006 and how did they compare with immunization rates in previous years?
2. Were the nurse champions satisfied with the training and support provided for their role?
3. Were the nurse champions satisfied with the implementation of their role?

Methodology

A retrospective and summative evaluation was conducted when the initial report of the implementation phase was completed covering the period between May 2006 to March 2007. The evaluation provides important information on the pilot testing of the nurse champion role which will be useful to Immunization Campaigns in future years. Patton (2002) describes summative evaluations as “adding depth, detail and nuance to qualitative findings and rendering insights through illuminative case studies and examining individualized outcomes and of quality or excellence” (p.220). Evaluation is crucial to improvements in programs and to provide the necessary information needed to identify program changes that are needed. Reviewing the participants’ experiences leads to recommendations that can improve the future nurse champion role for influenza campaigns. Graham, et al. (2006) suggests that when developing frameworks
or planned-action theories, “the uptake of knowledge can be influenced by issues related to the knowledge to be adopted, the potential adopters, and the context or setting in which the knowledge is to be used” (p.20). The method for the evaluation was chosen with the concept “that research findings are not making their way into practice in a timely fashion, coupled with the current emphasis on evidence-based, cost-effective, and accountable healthcare, and has stimulated increased interest in finding ways to minimize what might be described as the knowledge-to-action gap”(Graham, et al., p.14). In answering the specific goals of the evaluation it was hoped that further development for the project would be revealed.

A mixed methods approach was chosen for this evaluation. The approach included a review of quantitative and qualitative information on healthcare workers immunization rates, the numbers of responses that were received back from the original survey, and the feedback from the employees that participated in the project. In order to answer question one, data concerning immunization rates was used from BCCDC (2009) website for both acute care hospitals and long-term care facilities in VIHA. Questions two and three were addressed by a retrospective survey at the completion of the immunization campaign.

In January 2007, 124 evaluation surveys were sent to the 24 unit managers and the participating 100 nurse champions. Forty-nine completed surveys were returned to Wellness & Safety by the deadline of mid February 2007, for a return rate of 39.5 %. There were 17 from long-term care units, 20 from acute care units, 10 from the community, and 2 from mental health units. Twenty-four surveys were returned by unit managers (100 %) and 25 surveys were returned by the nurse champions (25 %).
Data Collection

The coordinator of the influenza campaign for VIHA designed the survey to evaluate the project (See Appendix C). No attempt was made to establish the reliability or validity of this tool, given the limited scope of this project. The tool consisted of 10 closed questions with room for comments if the respondent wished. The questions focused on satisfaction with the training, information and support for implementing the “champion” role.

Ethical Considerations

Two ethical considerations were addressed to conduct this evaluation. The first was the original survey used by the coordinator of the influenza campaign within VIHA. The VIHA Regional Ethics Committee waived the need for informed consent to participate in the survey, as it was considered a “quality control” project within VIHA and participation was voluntary. Consent was assumed to be implied by the completion and return of the survey form. No application was required as surveys held within VIHA are a standard practice for this organization. The second ethical consideration was the use of the participants’ responses to the survey for the purpose of this Masters project. Since the Wellness and Safety coordinator knew all of the participants in the project it was important that personal identification was not available reviewing survey contents. Although the names of the units and persons filling in the survey were included in the survey, the data given to me was anonymous to protect the privacy of the respondents. The waiver for anonymized data used in this evaluation for the Joint University of Victoria and VIHA Ethics committee was misplaced during the application process. A letter in acknowledgement of the use of the data has been issued from the Joint Ethics Committee and is attached to the project.
Chapter 4: Results

Immunization Rates

The immunization rates for VIHA employees for 2004 through 2009 are reported in Figure 2. As shown, the rates for acute care hospitals ranged from 51.1% in 2004/05 to 45.3% in 2006/07.

Findings indicate a decrease in the overall immunization rates in 2006/07 the year that the nurse champion program was implemented. It is important to note that in 2004/05, there was a shortage of “flu” vaccine announced, and employees were motivated to get their immunizations done early before vaccine supplies ran out. That may account for the increase rate for that year, although because the rates for 2003/04 are not available, it is difficult to verify. What is discernable from Figure 2 is that for 2006/07 the rates have not reached the target. Acute care was supposed to achieve rates of at least 47.9 and long-term care 67.9. In actuality the acute care rate increased by only 0.4% and long-term care decreased their rate by 2.1%. The coordinator did not keep the exact numbers of “champions” from each unit or site. Some of the “champions” worked on more than one unit and on some units there were anywhere from 1 to 3 champions.
The other interesting factor is that by doing the study retrospectively we now have data for the last three years as the revised immunization service delivery model with nurse champions has continued and the rates for immunization are decreasing. Over a five year period the rates have averaged 44.88% in acute care and 60.84% in long-term care.

**Nurse Champion Survey**

Data from the survey assess the satisfaction of the 24 unit managers and 100 nurse champions in regards to the influenza program for health care workers. The response rate included 49 surveys that were returned of the possible 124 participants. Results are presented in Table 1. Qualitative comments made by participants on the survey forms were collected and collated.

**Table 1: Survey Results**

<table>
<thead>
<tr>
<th>Total responses</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I was satisfied with the information I received on the goals and background this project</td>
<td>47 (95.9%)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2. The educational session for the flu champion nurses was informative</td>
<td>42 (85.7%)</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>3. The documentation and reference material in the information package was helpful</td>
<td>47 (95.9%)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. Communication between myself and the project coordinator was satisfactory</td>
<td>38 (77.5%)</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>5. As a flu champion nurse, I received adequate support, time, supplies etc to fulfill my immunization assignment</td>
<td>38 (77.5%)</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>6. Flu vaccine delivery was organized effectively</td>
<td>39 (79.5%)</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>7. My regular nursing work was not disrupted by taking on the flu champion role</td>
<td>21 (42.8%)</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>8. As a Manager, my time was not overly disrupted by the implementation of this project</td>
<td>16 (66.6%)</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>9. As a flu champion nurse, I would do it again</td>
<td>38 (77.5%)</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>10. As a manager, I want my unit to take this on again next year</td>
<td>23 (95.8%)</td>
<td>1</td>
<td>20</td>
</tr>
</tbody>
</table>
The initial training and preparation for the role were assessed in questions one through three. These were rated highly by the staff that completed the survey. Ninety-five percent of respondents were satisfied the information that they received at the beginning of the project. Eighty-six percent found the initial educational session for the champions was informative. Ninety-five percent found the documentation and reference material helpful.

Communication and support were assessed in questions four and five. Seventy-seven percent were satisfied with the communication during the project from the coordinator. Seventy-seven percent of the respondents felt they received adequate support, time and supplies to fulfill their role. Seventy-nine percent thought the vaccine was delivered effectively.

It does appear that the champion role could have a disruptive affect on regular nursing work. Question 7 responses are difficult to interpret since it appears that both the unit managers and nurse champions responded either yes or no. According to the results of question 8 the managers did not believe that the project overly disrupted their time. It is encouraging that thirty-eight respondents (77.5%) said they would participate in the project again next year if asked. Twenty-three out of twenty-four managers responded that they would want their unit participating again next year.

Qualitative Findings

Fifty-nine written comments were submitted. Overall, the responses were positive about their experience and the success of the project on the units. Positive comments included, “I felt the flu vaccine campaign did very well: I had no problems with anything”, “all staff members, nurses, doctors, support staff loved the convenience”, “no I haven’t had my shot yet, I keep missing the clinic, can I get it right now?”, “It was fun”, and “We had an increase in numbers of
staff that were immunized so I believe it worked well. Reasons: easy access – large numbers were immunized during an in-service so easy to organize”.

These comments reflect the success of the project in increasing access to immunization on the units with the implementation of unit based nurses “champions” to provide the vaccinations. The comments also reflect the need to share what initiatives worked for further development of the campaign. There were twelve complaints that it increased their workload: “Yes I had to fit this into my busy day”, “I gave night shift shots with start of day shift, put me behind in my work”, “I could not always administer the flu vaccine when the staff member arrived to the area…It got a little frustrating for me when this happened”, and “At times it was difficult to have a full patient assignment and give flu shots…I quite often came in on my own time”. Only two replies mentioned that their clinical leader lightened their workload for the campaign “my charge nurse did have to arrange for me to be out of the OR theatre” and “a casual RN was brought in for extra hours”. Since not all units are set up the same for their workloads this should be a future consideration. Communication was discussed in twelve replies. Some responses indicated “there was no communication after education”, “no communication about supplies after education”, “I want my unit to take this on again next year with changes in communication”. Other responses had questions about whether the numbers of healthcare workers being vaccinated had increased: “I think it increased our numbers”, “It has been a great experience and can’t wait to see the outcome of the numbers vaccinated”, and “It would be good to get feedback re percentage of people getting the flu vaccine and refusing it”. One comment remarked on the difficulty they had: “I found that the unit was very difficult to convince to have the flu shot. Very negative attitude with some staff that would permeate to the rest of staff.” One leader’s comment looked at the efforts to continue to make the project work for the
following year “any new additional project work adds to our work environment – always juggling priorities. Next year I will be better prepared – initiate project on start date and acquire champions to work as a team for the project.”

*Study Limitations*

One limitation to this evaluation was the inability to compare the survey response of the unit managers to those of the nurse champions. This occurred at the time the data was entered due to issues of confidentiality. This small sample size was a further limitation limiting the ability to generalize the findings beyond the sample. The high number of responses by the managers could be a reflection on the original influence of participation from the directors and executive directors to meet the Performance Agreement with the Ministry of Health. Further no data was collected from the employees concerning their opinions of the nurse champion role. Future evaluation should address these issues. A further limitation was the low response rate by the nurse champions. This could be related to poor communication with the Coordinator of the influenza project once the collaborative project was underway, but also makes the validity of the findings questionable as approximately only 25% of the nurses champions responded to the survey.
Chapter 5: Discussion

The evaluation was conducted to answer the following question. “Will the implementation of unit-based influenza clinics and the nurse champion role improve immunization rates of staff?” Unfortunately according to the results (see Figure 2), the extra clinics offered on the units by the nurse champions did not increase the vaccination rates of the healthcare workers by the 3% goal over the previous year’s rate. In fact the data shows that the influenza vaccination rates have dropped each consecutive year and are now lower by 4.5% in acute care and 4.8% in long-term care than in 2006/07.

The second part of the research question investigated whether nurse champions would be satisfied with their training and role. The limited response by the nurse champion participants makes it difficult to ascertain the overall satisfaction of the nurse champions. The results of this survey helped to capture the experience of the participants that responded. The comments captured at the end of the survey indicated that the nurses did not have sufficient time to give the vaccinations during their regular shift and that the peak times for healthcare workers to receive the immunization was at the change of shift, which made the “champions” feel rushed and resulted in vaccinations being given on their own time. One nurse commented on missed opportunities to talk to employees that had questions and noted that more people would have had their immunization if they had had someone to explain the benefits. There was no extra time allotted to the champions unless the managers/clinical leaders organized it on their specific unit. The survey had one reply that mentioned that some nurses came in on their own time to give vaccinations to the unit workers. This respondent clearly felt the role interfered with their regular unit assignments. There was also an indication from the “champions” that they believed that if
they had time to talk to their peers they might have been able to increase the numbers, but their time was limited.

In comparing the responses with literature on the same topic, it is possible to identify recommendations to improve the effectiveness of the influenza immunization campaign. The literature indicated that the champion role could be that of an advocate and change agent for a particular “cause”. The outline for the Collaborative Project developed by the Wellness & Safety Department (see Appendix B) only allowed for minimal education on the benefits and/or myths of the vaccine held by healthcare workers. There was nothing in the original plan for the collaborative project to assist champions in motivating healthcare workers to changing their behaviours or attitude towards the vaccination except the print out from Health Links (BCCDC, 2007). There was no time provided to allow “champions” to give vaccinations which included other tasks such as managing the consent forms, explaining possible allergic reactions and organizing the vaccines to be prepared for any number of employees wanting to be immunized. There was no time allotted for the education or conversations that would be needed if anyone wanted more information other than a printed handout. The time constraints gave the participating “champions” little opportunity to feel successful in their role other than making it easier for co-workers to have access to immunization during their shifts. The influenza nurse champion role met the needs of the original collaborative project from the perspective that it increased the availability and accessibility of the vaccine on the units (see Appendix A).
Chapter 6: Recommendations and Conclusions

This evaluation study examined the implementation of the nurse champion role in the 2006 influenza vaccination collaborative project for employees of the Vancouver Island Health Authority. The goals were to conduct a literature review to identify strategies associated with an effective influenza campaign, to assess the impact of the revised immunization service delivery model, and to examine the role satisfaction of the influenza nurse champions. The findings from this evaluation point to considerations to address to increase the impact of future influenza campaigns. Specific recommendations for the expansion of the Nurse Champion role, improvements in education and training, and communications of outcomes are identified which have the potential to increase immunization rates.

Recommendations for Practice

Based on the survey results and literature search, the following recommendations are proposed to ensure improved and sustainable campaigns for the future. The recommendations are:

- An action plan with specific timelines to assist the managers/clinical leaders and the nurse champions on how to plan ahead and ensure that the nurse champions’ have more information and time to assist with healthcare workers when considering the influenza vaccine. In consideration that the present influenza campaign collaborative project has been running for three years, implementing change would require structure. A first draft of an action plan has been developed with recommendations from the literature and is included in Appendix D. The draft is done with consideration of the present time line of activities that occur for the yearly influenza campaign. The action plan sequences the events with the addition of the expanded roles for the nurse champions and Unit managers. The literature
indicates that healthcare workers want to have more education, communications and participation in the campaign. Better advertisement on the units, positive re-enforcement and structured education needs to be developed prior to the fall campaign. The action plan is a tool that can be incorporated into the implementation of changing the program with evidence based practice.

- Future evaluations of the project should take into account the need for a survey instrument to that is comprehensive, sensitive, reliable and valid.
- The results of the evaluation need to be sent to all participating units, the administration of VIHA, and the units that did not participate. Hopefully knowing the results will encourage the non-participating units to change. Further studies should be developed in a qualitative review of the implementation of the “influenza nurse champion role” before and after the role of “change agent” has been expanded for the present influenza campaign program.

Recommendations for Further Research

Considering the limited scope of this project, the recommendations for further research would include revisiting the healthcare workers satisfaction and their recommendations with the changes to the influenza vaccination program. Further studies could be done by interviews or telephones rather than by just the survey tool, with the intention of more inclusions for the “champions” to give responses. As changes occur to the structure of the influenza project it would also be important to revisit staff concerns around barriers and facilitators for obtaining the influenza vaccine.
Conclusions

The implementation of the influenza nurse champion role was successful in increasing the availability and accessibility of the vaccine to the healthcare workers. Unfortunately the project did not increase the influenza vaccination rates to target levels for 2006-07, which remain low at 62.8% of long term care and 45.3% of acute care staff. Conducting this evaluation of the Immunization Campaign provided an opportunity to participate in further revising the service delivery model. The original service model had limited scope for the “champion role” which literally gave the nurse a role of being the “vaccinator” on the unit. The literature review indicates that a multi-level approach would work best rather than single component interventions. The original influenza service model focused solely on one part of the issue around increasing vaccinations, which was the accessibility of immunization for the healthcare workers. There was nothing empowering for a nurse to take on the “champion” role and develop skills that would be applicable assist in providing education and leadership as a change agent. The convenient availability of the vaccine to the units was addressed, but not the potential for the nurse champion role.

The implementation of the immunization service delivery model was limited by requesting that nurses take on a role requiring additional voluntary activities to be completed during their shift with no reductions in their workload. This additional burden of the vaccination work was not taken into consideration in developing the role or the service delivery model. The literature described the importance of support from leadership and that change takes motivation and belief in results from the Administration down to the unit level. Commitment needs to be visible from the top level of the organization down providing clear and credible
information about influenza and immunization. Unit managers can play a more active role in developing enthusiasm prior to the release of the vaccine.

The Immunization Campaign might be more effective if the service delivery revisions were made after conducting a survey of VIHA healthcare workers to identify barriers and facilitators to vaccination. Although there is literature on the subject, verification in identifying concerns is important. The influenza pandemic this year has raised awareness in health care workers vulnerability of exposure because of nature of hospital work. Giving healthcare workers a fact sheet on influenza that is no different than which is given out to the public, isn’t the most informative piece of education when considering that healthcare workers need to be prepared to work with patients that have influenza within a 2 meter area doing invasive procedures. The confusion in September of this year was evidence that healthcare workers were not prepared for the number of patients that needed isolation precautions to be able to provide safe care. Having a good understanding of what education for healthcare workers is needed, is an important part of the process of implementing a new project, and starting the project with a survey would help to include employees in the change project.

The retrospective survey completed by the managers and nurse champions would also benefit from a number of changes. The present survey did not request comments on how to promote or improve the role of “champion” for the unit. The feedback from the nurses participating on the units is important to be able empower and build on the lived experiences of the participants. It would also make the project a learning experience for the organization. It would be advantageous if over time the nurse “champions” actually had ownership of the influenza vaccination program for the units, rather than being “vaccinators” for the Wellness and Safety program.
Continuous education and communication should be ongoing during the 6-week Influenza program. The influenza vaccination program needs to be flexible and evaluated yearly not just for what went well but what didn’t work and what needs to be changed. The evaluation of the collaborative project needs to be shared with not just the participants but also the health authority as a whole to keep the momentum for continual improvement. I feel the original collaborative project would have benefitted from a literature review prior to development of the Influenza Campaign Collaborative plan with a survey to support the findings within the organization. The survey at the end of the collaborative project should capture the lived experience of the project’s participating “champions”. A second survey could capture the healthcare workers experience of the change of the influenza project of have unit based immunizations available and what information they would like to be able to receive from the nurse champions during their shifts. The report given back to the organization at the end of each campaign should reflect the multiple levels of participation and involvement to provide improvement and understanding of the concerns for influenza immunization in the healthcare setting.

Influenza vaccination rates continue to be a problematic issue of considerable concern. The evaluation of the Influenza Campaign provided an opportunity to assess implementation of the Nurse Champion role and to examine the literature to identify strategies to increase immunization rates. This evaluation confirms the importance of a structured research evaluation to review practice and theory to enable us to move evidence based knowledge into action.
References


http://www.llbc.leg.bc.ca/public/PubDocs/bcdocs/409485/immunize_BC.pdf


Infection Control, 35, 56-61.


Appendix A

VIHA Staff Influenza Immunization Campaign – Revisions to Service Delivery Model

How is VIHA doing?

Staff Influenza Immunization Rate is a VIHA Performance Measure. Fiscal year 2005/2006 established a baseline for this indicator per MOH expectation. Actual performance within VIHA (and baseline rates) for acute settings for FY 05/06 was 44.8% and 47.5% within long-term care settings (Data Source: BCCDC, includes St. Joseph’s).

Literature states that in order to have the best outcomes with respect to morbidity and mortality, there should be a minimum of 60% staff uptake in acute settings and 80% uptake in long-term care settings.

What is the target?

While no industry target exists, a target has been introduced in Ministry of Health 2005/2006 Performance Agreement. Long-term targets for staff influenza immunization are for 80% of all staff in long-term care and 60% of all staff in acute care.

For 2006/07, the targets are a minimum of 3% higher in both acute care and long-term care settings.

What actions are we taking?

For some time this program has been under review and a variety of options have been explored to improve efficiency and effectiveness.

Historically, influenza immunizations have been provided to staff at a series of general clinics that have been spearheaded by Wellness & Safety nurses. In FY 2005/06, VIHA had an active staff immunization campaign as evidenced by the 180 clinics offered by the Wellness & Safety nursing team throughout the organization. These clinics will continue to be offered as part of the revised service delivery model.

However, in order to increase staff uptake, meet MOH and VIHA objectives in 2006/07, and improve efficiency and effectiveness, the campaign will be revised to include nurses throughout the organization who will be invited to participate in providing staff immunizations at the unit level.

This two-pronged approach—general clinics offered by W&S nurses as well as immunizations at the unit by unit RNs—has been endorsed by W&S’s executive sponsors—namely, VIHA’s COO, VP of HR, and Chief of Professional Practice.

Advantages

- **Convenience to staff**—having an on-site RN trained to vaccinate their colleagues allows staff to receive flu vaccine at times which work best for the unit’s activity level. Staff do not need to leave their unit so there is less disruption in patient care. Long line-ups at the larger facility clinics can be avoided.

- **Increased vaccine uptake**—improved accessibility to vaccination should increase the uptake among clinical personnel, thereby

- **Reducing associated infection risk to patients & residents**—thereby lowering the impact on morbidity and mortality among this population.
Implementation plan

Wellness & Safety occupational health nurses will

- Assist the relevant Managers in setting up the program on their nursing units
- Provide staff training sessions and provide subsequent coaching, and be available for ongoing consultation during the flu campaign
- Continue to provide general (mass) flu vaccine clinics at all major sites as is done every year

What this means for your portfolio—how can Directors assist VIHA in meeting it’s objective?

W&S is asking for your endorsement in this initiative to:

- Provide strong encouragement and direction to your Managers / Nurse leaders to participate in the revised influenza campaign
- Ensure participating staff can participate in the training provided by W&S and authorize budget for coverage during training (approximately 2 hours)

The planning is underway and timelines are fairly tight, therefore your response / feedback / endorsement would be greatly appreciated by June 28, 2006.

Please also see the draft companion document which lists suggested sites (to date) where your Manager / Nurse Leader (or designate) would administer the influenza vaccine to his/her staff.

We would very much appreciate additional names to include to this list in order to have as many RNs as possible to support VIHA’s in reaching/exceeding its target.

Please have your managers contact [redacted] for further details about the training process.

If you have questions or wish to discuss the implementation plan, please contact:

Director
Prevention & Health Promotion
250-370-8111 local 3244

OR

Safety Advisor
Influenza Project Co-ordinator
250-370-8111 local 3212

Wellness & Safety Department
Appendix B

Wellness & Safety

STAFF INFLUENZA IMMUNIZATION CAMPAIGN
COLLABORATIVE PROJECT 2006

PURPOSE: to increase VIHA staff immunization rates through improved accessibility to vaccine, by adding unit-based immunizations to the general clinics provided by Wellness & Safety Occupational Health Nurses.

POLICY

1. Influenza vaccine may be administered to health care workers (employees, medical staff, volunteer, contractors) by nursing staff who
   a. have received authorization from their manager for this role and
   b. have completed a training session from Wellness & Safety.

2. Training will provide information on: influenza and its prevention; vaccine handling, storage and administration; consent form and related documentation; recognition and treatment of side effects and adverse reactions; and promotion of immunization through peer education.

3. Nursing staff will consult with an Occupational Health Nurse, Wellness & Safety, if assistance or additional information is required.

4. Nursing staff will use the information and reference material presented in the training to carry out the procedures outlined below.

PROCEDURE

The immunizing nurse will:

1. store, handle and administer vaccine in accordance with accepted immunization practice
2. ensure a consent form is completed by each employee
3. review the consent form prior to immunizing, to assess appropriateness of vaccine
4. if necessary, defer immunization and refer employee to own doctor or Occupational Health Nurse, as appropriate
5. sign the consent following immunization, and return all completed consents to Wellness & Safety at the end of each shift or clinic
6. following immunization, monitor staff for possible adverse reactions and provide appropriate treatment if required
7. report any abnormal side effects or adverse reactions to Wellness & Safety immediately.

September 2006
Appendix C – Influenza Campaign Collaborative Project Evaluation Survey

Flu Champion Nurses and Managers/Nurse Leaders - VIHA

Thank You All for your contribution to improving staff flu vaccine uptake through your unit’s participation in the Nurse Champion Project.

I would appreciate your evaluation and comments, which will assist in planning and making improvements for the 2007 campaign. You may complete & submit this form electronically, or print a copy, handwrite and send it to me.

<table>
<thead>
<tr>
<th>Please circle or highlight Yes or No, and add comments if you wish</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I was satisfied with the information I received on the goals and background this project</td>
<td>YES NO N/A</td>
</tr>
<tr>
<td>The educational session for the flu champion nurses was informative</td>
<td>YES NO N/A</td>
</tr>
<tr>
<td>The documentation and reference material in the information package was helpful</td>
<td>YES NO N/A</td>
</tr>
<tr>
<td>Communication between myself and the project coordinator was satisfactory</td>
<td>YES NO N/A</td>
</tr>
<tr>
<td>As a flu champion nurse, I received adequate support, time, supplies etc to fulfill my immunization assignment</td>
<td>YES NO N/A</td>
</tr>
<tr>
<td>Flu vaccine delivery was organized effectively</td>
<td>YES NO N/A</td>
</tr>
<tr>
<td>My regular nursing work was not disrupted by taking on the flu champion role</td>
<td>YES NO N/A</td>
</tr>
<tr>
<td>As a Manager, my time was not overly disrupted by the implementation of this project</td>
<td>YES NO N/A</td>
</tr>
<tr>
<td>As a flu champion nurse, I would do it again</td>
<td>YES NO N/A</td>
</tr>
<tr>
<td>As a manager, I want my unit to take this on again next year</td>
<td>YES NO N/A</td>
</tr>
</tbody>
</table>

Any other comments are welcome:

Name: ___________________     Nursing Unit & Site : ______________________________
Appendix D

Action plan for the Influenza Campaign Collaborative Project:

The action plan should include a task group of interested stakeholders such as a Director, a manager/clinical leader, the infection prevention and control practitioner and a nurse champion from the previous year. The group will be led by the project coordinator and begin early in the year preferably May to June.

The following is a proposed action plan:

May – June: The regional joint meeting with Public Health, Wellness & Safety, Infection Prevention & Control and the Communications department for VIHA.

- Discuss the Influenza information when the vaccination for the fall “flu” season will be ready for distribution.
- Planning for the media release for November 1st.
- The rooms booked for the 6 weeks required for the Wellness & Safety clinics.
- Information sent to the managers and Champions participating in the coming program should include:
  - Redefine the Champion Role and responsibilities
  - Ensure each participating unit has the appropriate refrigeration for storing vaccine
  - Recruit more nurse volunteers for the position of influenza champion on the units not yet participating.
  - Organize guest speakers for the education sessions during prior to and during the 6-week campaign. Book educator’s time and the rooms early to guarantee availability.
o Arrange for Educators and guest speakers to review the study results so they are aware of the “myths” and “fears” health care workers avoid being vaccinated.

o Distribute the resource package for the Champions’ on how to roll out a program on their unit or site. (See below information included)

o Post the VIHA Influenza Prevention Program Policy on the communication board for all the healthcare workers.

September - October

• Update all participants on the influenza vaccine for the year – which “types of flu” will be included in the vaccine.

• Get the packages from Wellness and Safety ready
  o Consent forms
  o Education posters
  o Tracking sheets
  o How to give the vaccine (education needed if not previously certified)

• Organize with Pharmacy as to which units will be participating with Nurse Champions and approximately how many vaccines they will need at the time of the roll out of the “flu campaign” in November.

• Organize evaluation for project
  o Decided on what is being measured, get feedback from participating units as to what they want for feedback from the evaluation
  o Organize for who is going to help collect data for the evaluation - it can be done by a student position and orchestrated by the project coordinator
Develop a better evaluation tool to collect more relevant data/focus groups/one-to-one interviews/telephone interviews

- Ensure that the “champion” on the units are clearly identified by posters/name tags/buttons

November – Influenza Campaign starts

January – Evaluation starts – as soon as possible have results to all participating groups.

Nurses Champion Resource package:

- Define what being a Champion means besides giving the vaccinations, filling out consent forms and reporting results to Wellness & Safety i.e. a leadership

- How to organize education – find a speaker that is passionate and knowledgeable about the topic, plan and book the in-service space, post for workers and promote session with staff to get them to go or plan it during a unit meeting or report session.

- Communicate results – post a weekly result of how many people on the unit have been vaccinated and post the comparison data on how the campaign is going for the region.

- Share your passion – let colleagues know why the vaccine is important

- Make change positive – focus on successes
  - Post the recent stats available from BCCDC website on influenza rates in the province
  - Post rates for the local hospitals for comparison

- Include rewards
  - Make certain rewards are given on the spot – something as simple as wrapped candy
o Arrange with the manager/clinical leader for incentives – maybe the healthcare workers in your area have some ideas – try to make incentives visible to the staff

o Compete with another unit or site and get the managers to organize a prize

- Write up an end of the campaign report on what worked and what didn’t and share it with other champions.