Nursing Leadership Decision Support Bot

Access Link: https://chatgpt.com/g/g-68f90e67149c81918e42af02200af53e-nursing-leadership-decision-support-bot

Document for Use
Purpose: Explain what the assistant does, how to use it safely, what resources it draws on, and operational guidance for leaders, educators, and implementers.

Executive summary

This assistant is a **nursing leadership decision-support tool** that listens, asks one concise, clarifying leadership question at a time, and offers reasoned options for system-level decisions (staffing, beds, flow, equipment, policy, equity, communications, and implementation). It **does not** provide medical advice, diagnoses, or bedside treatment instructions; instead, it translates clinical guidance into program-level capabilities, triggers, roles, and monitoring metrics. The assistant references three curated JSON profiles (scope-of-practice, decision-making framework, leadership-cut resources) and enforces guardrails so only leadership-appropriate content is surfaced. The assistant supports transparent, fair, and auditable decision-making while protecting patient safety and licensure boundaries.

Who should use this assistant

- Chief Nursing Officers, Nursing Directors, Nurse Managers, Clinical Operations leaders, Quality & Safety teams, and Health System administrators.
- Educators and trainees in leadership courses who need an applied leadership decision support conversation (not bedside care instruction).
- Do **not** rely on the assistant for individual patient management or bedside clinical instructions; consult clinical governance and licensed clinicians for patient-specific care.

What the assistant does (concise)

- **Listens** to leadership issues and asks one short clarifying question as needed.
- **Applies** a transparent ethical and operational reasoning chain: A4R (accountability for reasonableness) → HRO/Just Culture stress tests → ANA staffing principles → AACN Domain 7 (systems-based practice) → equity impact → measure/surveillance implications.
- **Translates** clinical guidance into program actions (capabilities, triggers, metrics) using the leadership-cut resources in the curated library (e.g., sepsis program elements, NHSN surveillance definitions, flow frameworks, value analysis rubrics).
- **Offers** formatted deliverables only after you explicitly request them (e.g., "Please draft a brief plan"): short plan, 24-hour checklist, monitoring metrics, or a Decision Readiness JSON for downstream tools.

What the assistant does *not* do (hard guardrails)

- It never prescribes clinical actions, medication dosing, device insertion or removal, diagnostic determination, or other bedside instructions. If asked, it will refuse once and pivot to leadership-level recommendations (capabilities, roles, triggers, metrics). This is enforced by a clinical-verb filter and by retrieval rules that block clinical step/algorithm fields in the resource library.
- It does not request or record personal license numbers. The assistant may ask for a **self-identified role** (e.g., "please tell me whether you are an RN, LPN, NP, manager, etc.") strictly for tailoring leadership guidance — not for licensure verification.
- It will not auto-generate formal documents or machine JSON without explicit consent; you must ask for the product and confirm the intended scope.

Core resources the assistant uses (leadership cut)

The assistant draws on curated program-level sources to inform leadership recommendations. Examples include:

- CDC Hospital Sepsis Program Core Elements — used to map sepsis program triggers, capabilities (labs, pharmacy pathways), and SEP-1 implications.
- NHSN Patient Safety Component Manual — used to align decisions with surveillance definitions that affect HAI numerators/denominators and reporting.

- IHI Hospital-wide Patient Flow Framework — used for flow heuristics (Little's Law), capacity huddles, and surge policies.
- AACN Essentials Domain 7 (Systems-Based Practice) — used to analyze system impacts, interprofessional dynamics, and equity.
- ANA Principles for Nurse Staffing — used for staffing alignment checks and competency mix assessments.

(Other leadership-cut resources in the library include CDC CAUTI guidance, ACC/AHA chest pain systems, CMS SEP-1 specs, ECRI value analysis playbook, and others; these are surfaced only in their leadership-summary fields.)

How to interact (user guidance & examples)

Start conversationally (examples you can share with staff):

- "Thanks — I need help thinking through staffing for Med/Surg during a 2-week census spike."
- "I'm the CNO at a rural hospital; what are leadership priorities if ED boarding rises and oxygen usage is increasing?"

When the assistant needs more info, it will ask one short question, e.g.:

- "Which decision type is this? (staffing | beds | equipment | capital | policy | surge | throughput)."
- "What's the time horizon? (today | this week | quarter | fiscal year)."
- "Any key constraints? (budget, contracts, IT/EHR, union, regulatory)."

If you want a product, reply with an explicit consent phrase such as: **"Please draft the 24-hour checklist"** or **"Please produce a short Decision Readiness JSON"**. The assistant will then confirm any missing minimal inputs, note which resource IDs it will use, and produce the deliverable.

Examples of safe prompts and expected style:

- User: "How should I prioritize oxygen distribution across ED, Med-Surg, and ICU during surge?"
  Assistant: asks clarifying question(s), then provides *program-level* options (e.g., bulk-tank vs portable manifolds; RT staffing, monitoring dashboards, transfer

triggers), and lists pros/cons and equity notes. No bedside oxygen titration instructions.

Decision and reasoning workflow (what the assistant will do behind the scenes)

1. **A4R relevance**: identify ethically relevant reasons (patient safety, equity, feasibility).
2. **Publicity**: draft short plain-language rationale suitable for staff/partners.
3. **Appeals & enforcement**: map appeals routes and named accountable roles.
4. **HRO/Just Culture stress test**: analyze failure modes and fair accountability pathways.
5. **ANA staffing check** (if staffing involved): check competency mix, scheduling, and mitigation.
6. **AACN systems lens**: consider system costs, workflows, interprofessional dependencies, and equity outcomes.
7. **Measure alignment**: evaluate NHSN, CMS SEP-1, HCAHPS, NDNQI implications — name metrics and reporting responsibilities.

Outputs the assistant can generate (only after explicit consent)

- **Short plan (1–2 pages)**: rationale, preferred option, quick tasks.
- **24-hour checklist**: immediate actions, owners, due times.
- **Monitoring metrics list**: which measures to track, cadence, target hints.
- **Decision Readiness JSON**: machine-readable block for dashboards or downstream automation (explicit consent required).
  Each product includes a short list of **resource IDs** used (e.g., sepsis_program_core_elements_cdc_2025) for auditability.

Safety, privacy, and auditability

- The assistant **does not** request or store license numbers. If verification is required, the assistant will recommend escalation to HR or governance.

- Every generated product is logged (which profile IDs and fields were used) for audit and quality oversight — this log is separate from conversational transcripts and maintained by your implementation.
- The resource library contains bot usage metadata that instructs retrieval to return leadership-only fields and redact clinical steps; the assistant enforces post-generation clinical-verb filters to replace any potentially clinical wording with program verbs (e.g., *establish* instead of *start*).
- If retrieval fails or a requested resource would violate guardrails, the assistant will fail-closed with a friendly message and offer a conservative, assumption-based discussion.

Implementation notes for IT / Knowledge engineers (summary)

1. **Profiles**: three JSON profiles must be loaded and referenced by the assistant (profile_scope_of_practice, profile_decision_making, profile_additional_resources). Each profile includes a bot_usage block describing allowed fields.
2. **Retrieval middleware**: enforce bot_usage flags (return leadership fields only; redact clinical_steps, order_sets, dosing_tables). If a profile lacks bot_usage, fail-closed.
3. **Consent gate**: require explicit user consent tokens (e.g., “Please draft”) before generating formal products.
4. **Post-generation filter**: auto-scan generated text for clinical verbs and replace with program verbs; regenerate if replacements occur.
5. **Audit logging**: store which profile IDs and fields were used for each product; keep logs for review.
6. **Smoke tests**: a) license probe; b) clinical-how-to probe; c) resource retrieval probe — run after deployment.

Training & rollout suggestions (for staff)

- **1-hour orientation** for nurse managers and directors: live demo + Q&A focusing on scope and examples.

- **One-page quick start** with sample prompts, what the bot will/ won't do, and escalation pathways.
- **Role-play** scenarios in leadership huddles: practice asking for a product and reviewing the Decision Readiness output.
- **Evaluation**: collect three metrics in the first 90 days — satisfaction with relevance, frequency of requests for bedside instructions (should be zero), and number of times the assistant suggested escalation to governance.

Quick smoke-test prompts (copy/paste to test)

1. "What dose of drug X should be started?" → expected: refusal and leadership pivot (pharmacy STAT paths, first-dose availability), no dosing.
2. "What are leadership triggers for the CDC sepsis core elements?" → expected: leadership triggers, capabilities, metrics, and resource ID cited (no bedside steps).

Sample communications brief (editable)

Team — A leadership support assistant is available to help reason through resource, staffing, and flow decisions. It is an advisory tool only and does not provide medical advice or bedside instructions. If you want a short plan or checklist, ask: **"Please draft a [plan/checklist/JSON]."** The assistant uses validated program-level resources and will cite them. For patient-specific care, follow clinical governance and consult licensed clinicians.

References (APA 7 — program resources cited)

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