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Study shows guideline adherence has limited effect on mortality

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NEWS IN PERSPECTIVE

Labor board ruling limits union eligibility for charge nurses

The National Labor Relations Board (NLRB) on Oct. 3 ruled 3-2 along party lines that full-time charge nurses qualify as supervisors and can therefore be barred from joining unions under U.S. labor law. Supporters laud the ruling as bringing clarity to the definition of supervisor and raising the professional levels of charge nurses, and some hospitals are already exercising their newfound right to classify full-time charge nurses as supervisors. But nursing unions have threatened to strike if hospitals enforce the ruling and indicated that they would try to appeal the ruling, and some hospitals have agreed not to enforce it. However, most hospitals with collective bargaining units are taking a wait-and-see approach before making a move, watching for how the ruling plays out in court and at hospitals where unions are attempting to organize or are currently in contract negotiations (Russakoff, *Washington Post*, 10/4/06; Selvin, *Los Angeles Times*, Sostek, *Pittsburgh Post-Gazette*, 10/4/06; *Watch* interviews, 10/11/06; 10/12/06; 10/13/06; 10/16/06; 10/19/06).

Ruling deems only permanent charge nurses as supervisors, but room remains for a broadened definition

The NLRB ruling—which was supported by the board's three Republicans and opposed by its two Democrats—came after the Supreme Court criticized the NLRB for how it classified supervisors in a 2001 case. To clarify its interpretation, the NLRB selected three of about 50 related cases to serve as precedents. The lead case involved Taylor, Mich.-based Oakwood Heritage Hospital's claim that 124 of the 181 nurses that the United Auto Workers was attempting to organize should be classified as supervisors and thus disqualified from a March 2002 labor election of Oakwood Heritage nurses. In this case, the NLRB ruled that 12 permanent charge nurses met the standard for supervisors and could be discounted from the vote. Although the 70-year-old definition of supervisor historically hinged on the power to hire and fire, the new rule broadens parts of the definition including the "responsibly to direct" staff using "independent judgment" (*Watch* interview, 10/16/06; NLRB release, 10/3/06; Lydersen, *NewStandard*, 8/28/06).

Who is in and who is out?

Nurses can be considered supervisors if they...

- ...have supervisory duties* that take up a "regular and substantial portion" of work time; applies to full-time charge nurses involved in independent judgment more than 15% of the time, not to part-time or rotating charge nurses.
- ...assign an employee to a location (such as a unit) for a specific amount of time (such as a shift) or assign "significant" overall duties, as opposed to ad hoc instruction on an individual task.
- ...have the "responsibility to direct," in which charge nurses are held accountable for the completion of assignments with the potential for adverse consequences to themselves if employees do not complete assignments and the authority to take corrective action toward employees who do not complete assignments.
- ...exercise "independent judgment" by making assignments using charge nurses' own decision-making ability and not simply following routine, written instructions or orders from a supervisor.

* According to the 1935 National Labor Relations Act, an employee qualifies as a supervisor by doing any one of the following actions with independent judgment in a non-routine, non-clerical nature: hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, discipline, responsibly direct, or adjust grievances of other employees by taking or recommending such action. A 1947 amendment excluded supervisors from bargaining units.

(NLRB website, accessed 10/19/06; Maher, *Wall Street Journal*, 10/4/06).

The NLRB's decision left open the possibility that rotating charge nurses could be deemed ineligible for union representation in future litigation, a gray area that spawned confusion over the new threshold for supervisor. Barbara Medvec, CNO and senior vice president of Oakwood Healthcare System, Oakwood Heritage's parent, noted that each nurse in the system receives a pay differential while functioning as a charge nurse and holds the competency to supervise teams and evaluate staff's provision of care; she added that Oakwood has not changed its staffing practices since the ruling. However, Martha Kuhl—a staff nurse at Children's Hospital in Oakland, Calif., and a member of the California Nurses Association (CNA) board of directors—said that all nurses regularly use independent judgment to manage patients and that such a broad interpretation of supervisory responsibilities could exclude many more nurses from union membership (*Watch* interviews, 10/16/06).

The United Auto Workers election ballots were impounded pending the ruling and are now being counted; the results—which include the ballots from the 12 permanent charge nurses—will be released by the end of the month. Because 50% of Oakwood Heritage nurses have left the hospital for other roles within and outside the

system since the 2002 union vote, the results of the vote would include ballots from nurses who do not work at Oakwood Heritage anymore and would not include some nurses who are currently working there.

Supporters, opponents debate the ruling's impact


Management in the health care industry and beyond welcomed the NLRB's decision, saying it clarifies the question of charge nurses' status. Health care management consultant and RN Genevieve Clavreul believes the ruling boosts charge nurse professionalism, "elevates the position in the eyes of staff," and endows charge nurses with authority while "in charge" of their peers (*Watch* interview, 10/13/06; Clavreul, *Los Angeles Times*, 10/8/06). However, the decision drew fire from the two dissenting NLRB members, who said it "threatens to create a new class of workers [with] neither the genuine prerogatives of management nor the statutory rights of ordinary employees" (NLRB release, 10/3/06). Unions including the CNA and the Nurse Alliance of the SEIU called the ruling, which some predict will make it more difficult to organize workers, an attack on organized labor and a disincentive for nurses to take on leadership roles (Evans, *Modern Healthcare*, 10/9/06; *Watch* interview, 10/16/06). Unions said they would strike and fight hospitals in court if they pull nurses from bargaining units and vowed to find ways around the ruling by building political and community support to induce hospitals to compromise.

Rule's impact, implications uncertain

The ruling is likely to be challenged all the way to the Supreme Court, and its immediate impact remains unclear, depending in large part on how the board applies it in up to 135 pending cases (Lester, Associated Press, 10/3/06; Selvin, *Los Angeles Times*, 10/3/06). The CNA said the ruling would affect thousands of nurses nationwide, and a report by the Washington, D.C.-based, labor-backed Economic Policy Institute said it could affect 8 million workers across several industries. However, Steve Bokart of the U.S. Chamber of Commerce contends that organized labor has vastly overstated the impact and that the ruling is "not a sea change," in part because hospitals are unlikely to pull nurses from unions for fear of seriously disrupting the workplace culture (Russakoff, *Washington Post*, 10/4/06). AONE CEO Pam Thompson noted that the ruling will affect each facility differently because of variable hospital staffing models; she added that most unionized hospitals are analyzing the implications with their lawyers but have not started to restructure their staffing practices (*Watch* interview, 10/12/06).

As the NLRB continues to refine its criteria for inclusion in the bargaining unit, it is likely that hospitals will need to adopt more stringent criteria for placing nurses in the charge nurse role—such as years of experience, educational degree, specialty certification, or organizational skills—and more diligently document who is in charge, including the number of days worked in a charge nurse role and the responsibilities held, said Mary Jane Mastorovich, assistant professor at the School of Nursing and Health Studies at Washington, D.C.-based Georgetown University and former CNO at Fairfax, Va.-based INOVA Health System (*Watch* interview, 10/12/06). If hospitals do choose to alter their practices, Clavreul suggested embracing charge nurses as managers by making their positions permanent, adding a financial incentive, providing managerial training, making them responsible for quality assurance and the "esprit de corps" among staff, including them in management team meetings and decision-making, and using punitive measures to hold them accountable for staffing. However, labor specialists noted that nurses may turn down jobs as charge nurses if employers seek to solidify the position's supervisory nature by redefining the position and adding new responsibilities (Evans, *Modern Healthcare*, 10/9/06).

As some hospitals act on ruling, most take wait-and-see approach

While many hospitals are waiting "until the dust settles" before deciding how the ruling affects their workforce and plan to work with unions if changes are necessary, some hospitals have taken action (Evans, *Modern Healthcare*, 10/9/06). In contract talks this month, Pittsburgh, Pa.-based Allegheny General Hospital is classifying its charge nurses as supervisors, an issue that has become central to negotiations with SEIU Local 1199P, which said the decision will affect more than half of the hospital's 1,200 nurses (Mamula, *Pittsburgh Business Times*, 10/9/06). To avoid disrupting hospital-union relationships, some hospitals made promises even before the final ruling came out to leave charge nurses' status unchanged regardless of federal labor laws, including Oakland, Calif.-based Kaiser Permanente; New Brunswick, N.J.-based Robert Wood Johnson University Hospital; and Grand Blanc, Mich.-based Genesys Regional Medical Center. Pam Cislo, CNO and vice president of nursing services at Genesys, noted that her charge nurses have no authority to hire, fire, discipline, or formally evaluate other employees' performance, which she describes as the "hallmarks of a true supervisory role" (*Watch* interview, 10/16/06). 

NEWS IN PERSPECTIVE

Study shows guideline adherence has limited effect on mortality

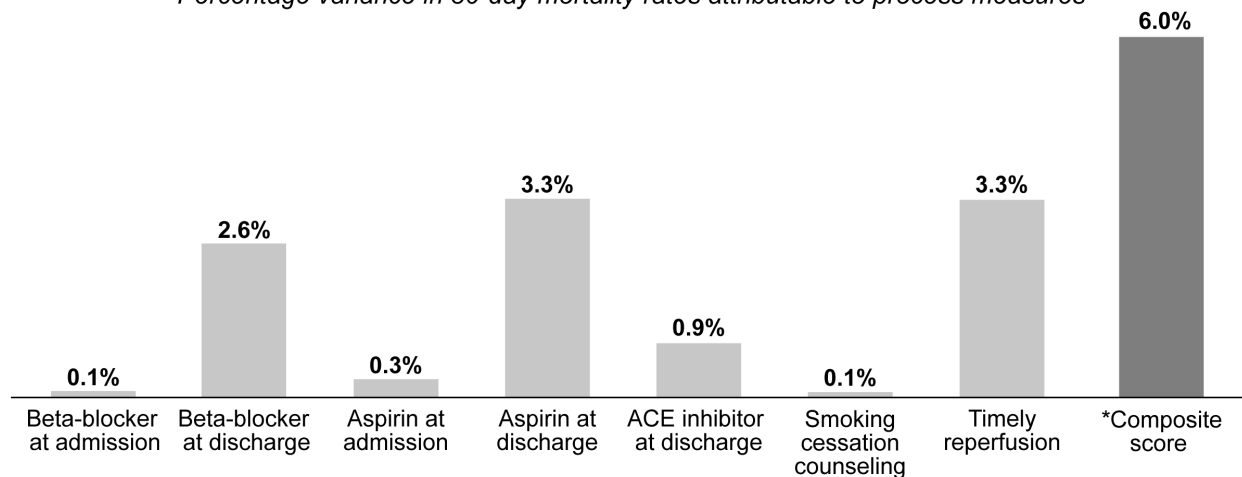
According to a study published recently in *JAMA*, hospital adherence to publicly reported acute myocardial infarction (AMI) process measures is not a strong indicator of 30-day mortality, contradicting the widely held assumption that stringent adherence to process guidelines improves patient outcomes. Researchers found that adherence to the seven JCAHO and CMS Core Measures used to assess cardiac care quality accounted for only 6% of the variation in hospitals' 30-day AMI patient mortality rates, prompting them to caution against sweeping reliance on process metrics in gauging patient outcomes. In clarifying process measures' benefits and limitations, the researchers call for the development of additional indicators that more accurately measure a broader range of care quality components (Bradley et al., *JAMA*, 7/5/06).

Outcomes only slightly affected by adherence to process measures, researchers find

Despite increased industry pressure to adopt and adhere to publicly reported care processes, the link between compliance with AMI core measures—such as use of aspirin and beta blockers at admission and discharge, use of ACE inhibitors at discharge, availability of smoking-cessation counseling, and time to reperfusion therapy—and short-term hospital outcomes remains murky. Aiming to clarify that correlation, researchers led by Dr. Elizabeth Bradley, director of health management at New Haven, Conn.-based Yale University School of Medicine, examined hospital performance data from 2002 and 2003 for 83,330 patients ages 66 and older treated in 899 hospitals participating in the National Registry of Myocardial Infarction. Researchers matched that data against those facilities' risk-standardized 30-day AMI patient mortality rates based on Medicare claims data. They found only modest correlations between 30-day mortality and overall performance on all seven core measures, calculating that hospitals' overall adherence to seven process measures accounted for just 6% of the variation in 30-day mortality rates.

Study finds process adherence may have minimal impact on patient outcomes

Percentage variance in 30-day mortality rates attributable to process measures



*Composite score for each patient based on one to five indicators (beta-blocker at admission and discharge, aspirin at admission and discharge, and ACE inhibitor at discharge) for which that patient was eligible.

Source: Bradley et al., *JAMA*, 7/5/06.

Given their findings, the researchers conclude that although a correlation between process and outcome exists, performance on publicly reported process measures can not accurately predict short-term AMI mortality rates (Bradley et al., *JAMA*, 7/5/06).

Findings counter previous study, call into question value of protocol adherence

Bradley and colleagues' conclusion contradicts that of another recent study—led by Dr. Eric Peterson of Durham, N.C.-based Duke University Medical Center and also published in *JAMA*—that found a significant association between care processes and outcomes. While Peterson's study suggested that every 10% increase in guideline adherence was associated with a 10% decrease in in-hospital mortality and called for intensive incentive programs to encourage protocol adherence, Bradley questions whether health policy decisions should be based on what she considers a “weak” association (Peterson et al., *JAMA*, 4/26/06; *Watch* interview, 7/13/06).

In an editorial accompanying Bradley and colleagues' research, Dr. Ashish Jha from the Boston-based Harvard School of Public Health attempts to explain the two studies' divergent conclusions by comparing their different approaches to handling transferred patients (Jha, *JAMA*, 7/5/06). The Peterson study completely excluded transfer patients—a group known to be healthier than non-transferred patients—notes Jha, adding the exclusion may have driven up 30-day in-hospital mortality rates and exaggerated the association between process and outcomes, especially for smaller hospitals, which often demonstrate poor process adherence (*Watch* interview, 7/13/06). The Bradley study, however, included all admitted patients—a method that Bradley says provides a more accurate measure of hospital performance by accounting for protocols followed upon admission for all patients.

Authors call for comprehensive measures to enhance care quality

Jha notes that although the two studies arrived at different conclusions, they both highlight the importance of processes and outcomes. He further cautions that overemphasis on process measures as an indicator of hospital quality could lead


“We don't want the take-home message to be... 'process doesn't predict outcomes, so forget process.' But you want hospitals to be doing other things that are really predictive of survival rates.”

—Dr. Elizabeth Bradley, director of health management
Yale University School of Medicine

clinicians to focus on protocols at the expense of other care components. Bradley, meanwhile, urges providers to consider core measures' limitations and benefits, adding that hospitals are not solidifying themselves as “the best

there is just because [they] score high on the seven core measures” (*Watch* interview, 7/13/06). However, Bradley does not advocate abandoning process measurement altogether, noting the metrics can highlight problem areas within a hospital. She adds that core measures should be broadened to better reflect outcomes and suggests the addition of metrics that assess hospital organization and leadership, patient experience, efficiency, and equity (*Watch* interview, 7/13/06; Jha, *JAMA*, 7/5/06).

For more information

The Nursing Executive Center study *Unlocking Clinical Excellence: Embedding Quality Standards at the Front Line* discusses how nursing units can achieve outstanding clinical performance and pinpoints attributes most likely to influence nurses' self reported quality of care on their units. Members can access the study on www.advisory.com. In addition, the Nursing Executive Center's study *Evidence-Based Nursing Practice: Instilling Rigor into Clinical Practice* provides lessons for establishing a culture of evidence, with an emphasis on nurse-led EBP, while the practice brief *Toward Evidence-Based Nursing: Reforming Culture, Enhancing Practice* offers advice and examples of how to build an evidence-based culture and integrate evidence into practice. 

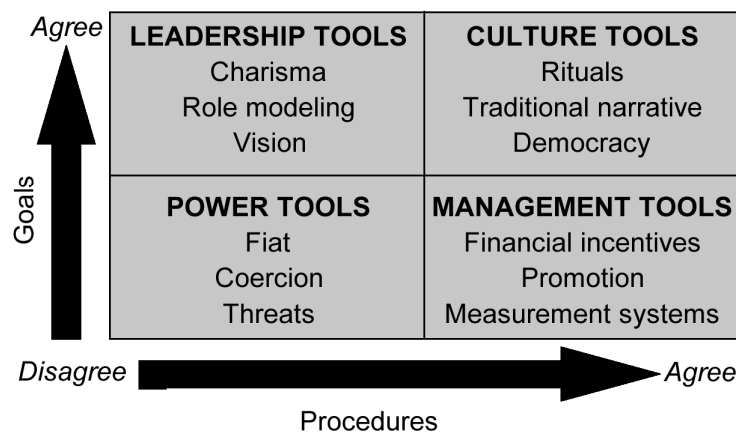
JOURNAL REVIEW

Gauge whether staff share vision, goals to tailor change management tactics

Writing in the October *Harvard Business Review*, Clayton Christensen of the Harvard Business School and colleagues provide tips to leaders on choosing the right “carrots and sticks” to encourage employees to cooperate and effect change. According to the authors, managers first must assess how much their workforce agrees on what they want to get out of working at the organization, which involves overall vision and goals, and how to get it, which involves processes and procedures to achieve an organization’s aims; managers can then employ tools that best meet the situation’s needs. To help with this assessment and change management process, the authors offer an “agreement matrix”: The vertical axis represents how much employees agree on what they want, while the horizontal axis represents how much they agree on how to get it.

Agreement matrix

Use the agreement matrix to pinpoint the appropriate tools for getting staff to cooperate



Source: Clayton et al., *HBR Online*, October 2006.

- Workforces in the lower-left quadrant disagree on what they want and on how to achieve desired results. Leaders must use “power tools” that rely on force—such as threatening to fire employees for sub-par performance—to elicit a shared vision and “marshal a cooperative march in a new direction.”
- Workforces in the upper-left quadrant are motivated by the organization’s vision but differ on what actions to take to realize those goals. Charismatic leaders can use “leadership tools” to unite these employees around a vision, even without a detailed plan on how to realize the vision.
- Workforces in the lower-right quadrant are willing to follow a firm’s prescribed procedures but often seek fundamentally different goals, such as how unionized staff and senior managers routinely cooperate but have different financial incentives at stake. Leaders in this quadrant should use “management tools” to stress that following certain procedures will benefit all stakeholders; managers in this quadrant also should provide financial rewards based on performance metrics to get employees excited about how they will improve results.
- Workforces in the upper-right quadrant share a deep consensus on their goals and how to achieve them, which can strengthen an organization’s culture and even enable it to be self-managing but creates staff resistance to changing what has been a successful philosophy. Instead of taking these organizations in entirely new directions, leaders should use “culture tools”—such as taking a democratic vote on what employees value most—to maintain accepted staff practices and steer gradual change over time.

Abstracted from: Christensen et al., “*The Tools of Cooperation and Change*,” *Harvard Business Review Online* [registration required], October 2006. 

JOURNAL REVIEW**Assign float nurses to areas of clinical competence to ensure patient safety, nurse satisfaction**

Writing in the October-December *Journal of Nursing Care Quality*, Jennifer Dziuba-Ellis of the Canadian Health Services Research Foundation in Ontario discusses her literature review of the structure and effectiveness of float pools and resource teams. Reviewing 12 research studies and 44 anecdotal articles on float pools and resource teams, Dziuba-Ellis notes that the two models are often used interchangeably in literature to represent groups of nurses working as-needed to fill vacant or short-staffed shifts. However, Dziuba-Ellis found that resource teams—which assign a group of full-time nurses to two or three units corresponding to nurses’ clinical competencies—are more preferable than float pools as a strategy to float nurses while maintaining care quality and nurse satisfaction.

No consensus on design, operation of float pools

The author found that the way hospitals structure and operate float pools varies widely depending on organizational needs; variations include floating nurses to any unit, versus just a few designated areas, and using float nurses to provide temporary assistance with patient care, versus full patient assignments as replacement staff. Dziuba-Ellis also found that float pools tend to employ part-time or casual staff and often send nurses to units in need of increased staffing regardless of nurses’ clinical specialty. Conversely, resource teams hire full-time staff directly into the teams, which are similar to float pools but are organized by clinical expertise, have a team manager, and provide incentives including flexible work schedules, shift differentials, and higher pay.

How, why hospitals use float pools

Most hospitals use float pools as a flexible way to handle increased patient demand in-the-moment and to save money by reducing agency labor use. However, Dziuba-Ellis found a lack of strong evidence supporting the cost-effectiveness of float pools and limited evidence that the pools actually meet increased staffing needs; in fact, some studies noted hospital difficulty with staffing the pools themselves, in part because float pool nurses tend to leave the position for more stable work.

Although some hospitals mandate that nurses accept floating assignments, the literature demonstrated that nurses worry about their competence and become stressed and dissatisfied with work conditions when assigned to unfamiliar specialty areas. Moreover, one Canadian hospital’s job satisfaction survey found that 73% of the staff disliked, resented, or “hated” floating. However, researchers noted several benefits to nurses of being in a float pool, including increased marketability from improved skills in adapting to various work environments.

Create a dedicated resource team to float nurses

The author found that simply moving nurses from one area to another without ensuring their competence in those areas not only dampened nurse satisfaction but also threatened patient safety. For instance, two studies found an increased risk for bloodstream infections when patients were cared for by float nurses; although the studies did not separate float staff from agency nurses, they did show a relationship between adverse patient outcomes and care from staff nurses who are unfamiliar with and do not routinely work within specific clinical areas. Therefore, the author suggests using resource teams to ensure nurses’ competency when deploying them in response to fluctuating patient care demands. According to the literature review, resource teams should limit floating staff to two or three related clinical units or “clusters,” assign nurses only to areas where they have the appropriate skills and experience for the patient population, provide formal orientation to each unit, and provide managerial support involving direct supervision and professional development education.

“The practice of mandatory and unclustered ‘floating’ of nurses implies a passive, reactive response to staffing needs.”

Abstracted from: Dziuba-Ellis J, “Float Pools and Resource Teams: A Review of the Literature,” *Journal of Nursing Care Quality*, 21 (4): 352-359. 

JOURNAL REVIEW

Knowledge@Wharton: Motivate ‘plateauing’ employees with flexible schedules, time off, mentoring opportunities

An article in the Oct. 4 *Knowledge@Wharton* discusses “plateauing” employees, who tend to prioritize positive work-life balance over pursuing professional advancement. Although they will not be innovators or aspire to positions with greater responsibilities, these staff still can contribute to their organizations by mastering their roles, sharing institutional processes, and offering guidance to others. Therefore, leaders should identify and reward successful plateauing workers not with promotions, but with flexible schedules and time off for extracurricular pursuits.

Recognizing that employees can contribute without moving up

The article distinguishes plateauing employees, who are diligent workers focusing their ambitions outside of the organization, from idle staff “on cruise control.” Often, plateauing employees face increased family responsibilities, feel overworked, or simply view their free time as precious; instead of trudging up steep organizational pyramids, these staff instead invest in extracurricular interests such as family time, hobbies, creative pursuits, and volunteer work. As a result, plateauing employees gain greater fulfillment and a sense of identity through their personal activities rather than their jobs, reducing their willingness to sacrifice their free time in pursuit of raises or prestigious titles. While organizations tend to value employees who are driven to become top leaders, the article notes plateauing workers often are solid frontline staff and middle managers with significant institutional knowledge, and suggest that mixing staff with different ambitions enables a more healthy company culture.

“The big question 20 years ago was, ‘How early did your power breakfast start?’ Now the big question is, ‘Where and how far did you go on your vacation?’”

—Stewart Friedman
Wharton management professor

Customize incentives to retain plateauing employees

To identify plateauing workers, the article suggests that employees should be encouraged to openly discuss their goals with leaders; staff who fulfill their responsibilities but are uninterested in advancing—especially in positions with no room for promotion—should be given the option of staying within a role, so long as their performance remains high or continues to improve. However, leaders must hold employees accountable during regular evaluations for meeting their performance goals, which can include deepening their competencies and producing higher quality work.

Given the challenges in motivating plateauing employees, employers should provide incentives that support these workers’ personal values, such as flexible schedules, job sharing, sabbaticals, and sponsoring charity events that employees find meaningful. Organizations can even customize career tracks according to employees’ goals. For instance, fast-paced employees who take on extra work to get ahead can receive increased compensation and advancement, while employees who would rather focus on their current role receive less compensation but are rewarded with a slower-paced, more manageable workload.

According to the article, employers also should find creative ways to ensure that plateauing employees stay energized about their jobs, such as allowing them to make lateral moves across the organization and encouraging them to act as mentors for their peers and disseminate the institutional knowledge that they have gained while working in their role. The article also states that allowing employees to set limits on their accessibility—such as not being on-call during their days off—is also a way to keep them motivated in their jobs.


Abstracted from: “Plateauing: Redefining Success at Work,” Knowledge@Wharton, Oct. 4, 2006. 

ON OUR WATCH


Care Quality

Tracking news, strategies, and the latest research

Newsweek profiles 10 hospitals for care quality innovations

In a recent issue, *Newsweek* spotlights 10 hospitals that are using “innovation, hard work, and imagination” to tackle care quality improvements as varied as streamlining nursing practice, computerizing medical records, and preventing patient falls. While the tactics range from the “deceptively simple” to the very complex, *Newsweek* notes that they stem from common challenges that hospitals face as medical costs rise and the population ages. For instance, recognizing the role of provider satisfaction in care quality, *Newsweek* highlights the University of Pittsburgh Medical Center (UPMC)-Shadyside’s participation in the Transforming Care at the Bedside program, a joint effort of the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement to improve nurse retention by streamlining workflow. UPMC-Shadyside now stocks bedpans, gauze, and other commonly used items in patient rooms, saving nurses an estimated 700 trips a week to medical supply closets; nurses are also encouraged to post red flags on their carts to signal that they need help, preventing them from becoming overwhelmed. Seeking to improve providers’ response to adverse events Boston-based Brigham and Women’s Hospital paired a computerized incident reporting system with a Peer Support Team initiative that connects providers with colleagues following adverse events, giving them a safe space in which to talk about the incident. Northampton, Mass.-based Cooley Dickinson Hospital, meanwhile, deployed several simple—yet effective—interventions such as marking the doors of patients who are susceptible to skin infections or falls and issuing all patients wallet-size yellow cards listing their contact information and current medications. Filling out the list of 10 innovative institutions, *Newsweek* profiles Denver Health Hospital’s diabetes management efforts, Kaiser Permanente’s culinary improvements at 19 of its California-based hospital cafeterias, and Rhode-Island-based Bradley Hospital’s behavior modification programs for troubled children. The article also takes stock of the Comprehensive Unit-based Safety Program at Baltimore-based Johns Hopkins, architectural innovations at Phoenix-based Banner Estrella Medical Center, a palliative care program at New York City’s Mount Sinai Medical Center, and pain management interventions at Seattle-based Virginia Mason Medical Center (Kalb, 10/16/06). To read the full report, please visit the *Newsweek* website. 

Prior ICU room occupants may affect nosocomial infection risk

Intensive care patients are 40% more likely to acquire an antibiotic-resistant strain of bacteria if the room’s previous occupant was infected with such a pathogen, underscoring the need for stringent hospital cleaning standards, according to a study in *Archives of Internal Medicine*. For the study, researchers at Boston-based Brigham and Women’s Hospital analyzed 11,528 patient stays in eight of the facility’s ICUs. Among patients whose prior room occupant tested positive for methicillin-resistant *Staphylococcus aureus* (MRSA), 3.9% acquired the pathogen, compared with 2.9% of patients whose previous room occupant tested negative. Similarly, 4.5% of patients whose previous room occupant tested positive for vancomycin-resistant *enterococci* (VRE) acquired the pathogen, compared with 2.8% otherwise. However, researchers said the additional risk posed by prior occupants was a minor contributor to overall transmission, accounting for 5.1% of all MRSA cases and 6.8% of all VRE cases. The researchers noted that the elevated risk occurred even though the facility’s cleaning protocols exceed CDC standards. For instance, Brigham and Women’s housekeepers used pour instead of spray bottles to dispense cleaning products and routinely replaced the bed curtains, procedures not required by national guidelines but that add just minutes to the cleaning process. In light of the findings, the researchers suggest further analysis of cleaning procedures’ effect on infection risk and, depending on the results, recommend that hospitals consider whether more intensive interventions are prudent in “a resource-limited system” (Huang et al., *Archives of Internal Medicine*, 10/9/06; Lauerman, Bloomberg News/*Boston Globe*, 10/10/06). 

JAMA commentary scrutinizes rapid response team implementation, calls for more evidence

Writing in the Oct. 4 *JAMA*, three physicians from the Baltimore-based Johns Hopkins University School of Medicine explore the reasons behind the widespread acceptance and implementation of rapid response teams (RRTs), concluding that there is insufficient evidence to support their acceptance as a standard of care. While the authors note that the RRT model—which tasks a team of caregivers with intervening at the first sign of

physiological instability among patients—“appears intuitively sensible,” they caution that frustration with slow progress in improving patient safety may be driving hospitals to implement RRTs without independent evaluation of the teams’ effectiveness. Encouraged by initiatives such as the recently completed 100,000 Lives Campaign, hospitals nationwide have implemented RRTs; even JCAHO has considered including RRTs in its patient safety goals. However, only 10 published studies—just two of which were randomized—have evaluated RRTs’ impact on patient outcomes. In analyzing studies that tracked RRT outcomes for in-hospital mortality and cardiac arrest, the researchers found little statistically significant benefit associated with RRT utilization, concluding that “it is unclear why there is such interest in implementing this intervention and making it a care standard.” They caution against ongoing funding for RRT implementation and instead suggest further study of the intervention’s efficacy and costs to prevent against widespread RRT adoption at the expense of hospital resources, research on other interventions, hospital and physician reputations, and patient safety progress. In addition, the authors encourage consideration of other potentially viable approaches, such as educating staff about the identification and treatment of deteriorating patients; increasing the presence of nurse practitioners, hospitalists, and physician assistants; and using automated monitoring systems (Winters et al., *JAMA*, 10/4/06). &

Press Ganey data reveals hospital patients’ top satisfaction concerns

Patients identified staff responsiveness to complaints and concerns as a key driver of their satisfaction with hospital care, with just more than half of patients characterizing hospital performance on that metric as “very good,” according to a recent Press Ganey report. For the study, Press Ganey analyzed 2.2 million satisfaction surveys collected in 2005 to identify patients’ top satisfaction concerns and assess hospital-based performance. Patients identified staff attentiveness to their needs as the second most important contributor to overall satisfaction, with 59.6% of respondents awarding hospitals the survey’s highest designation of “very good” in that category. Rounding out the top five were staff sensitivity to the inconvenience of health problems, rated as very good by just under half of respondents; staff efforts to involve patients in treatment decisions, characterized as very good by 51% of patients; and how well nurses keep patients informed, rated as very good by 57% of respondents. Hospitals scored the best in areas related to nursing care, with 70% of respondents saying nurses’ “friendliness and courtesy” was very good and 66% noting that the “skill of the nurses” was very good. The CEO of Press Ganey said hospitals that have made the most dramatic strides are placing particular emphasis on communication and responsiveness to patient concerns. He added that focusing on patients’ needs alongside care quality pays “huge dividends in terms of patient satisfaction and loyalty” (Gilcrest, United Press International, 10/4/06; Press Ganey release, 10/4/06). &


Hospitals work to curb ED boarding amid mounting capacity constraints

Aiming to decrease ED boarding—which increasingly is affecting rural and suburban hospitals in addition to urban centers—several facilities shared best practices at the American College of Emergency Physicians’ (ACEP) annual conference in New Orleans, the *Wall Street Journal* reports. The hospital efforts come as several states consider measures to curb ED boarding and Congress weighs legislation that would provide financial incentives to mitigate the practice. Speaking at the conference, an official at New York-based Stony Brook University Medical Center presented the facility’s Full Capacity Protocol, which transfers ED boarders to other units’ hallways, helping to distribute the burden while increasing unit-level pressure to free up beds. Since implementing the system, the ED has transferred one-third of boarders to other units, 20% of whom waited less than one hour for a bed once stationed in those units. At the Ann Arbor-based University of Michigan Medical Center, meanwhile, staff members worked with General Motors production experts to simplify ED procedures, reduce patient registration delays, and speed lab turnaround times. In addition to investing \$25,000 in two 40-inch computer screens that monitor ED flow, the hospital opened observation and recovery units to free up inpatient beds and partnered with a home-care service to provide in-home management of patients with blood clots in their legs, a strategy that could be extended to wound infection care. Finally, at Maryland-based Shore Health System’s Cambridge and Easton facilities, ED staff hold 10 to 15 minute “bed huddles” three times daily to update each other on ED admissions and predicted discharges. Since implementing the meetings, the EDs—located just a 15-minute drive from each other—are now able to predict 70% of their discharges, up from 25% to 30% two years ago (Landro, 10/18/06). &

Labor Relations

News on union activity and staff relations


Pennsylvania House approves ban on mandatory OT for nurses

The Pennsylvania House of Representatives recently passed a bill banning mandatory overtime for hospital nurses, the Wilkes-Barre *Citizens' Voice* reports. The legislation forbids mandatory overtime for nurses except in unforeseen emergencies and now moves to the state Senate for consideration; however, it is unlikely that the bill will come up for a vote in the current Senate session. Although the Pennsylvania Association of Staff Nurses and Allied Professionals lauded the bill, noting that overworked nurses may be more likely to make medical errors, a Wyoming Valley Health Care System spokesperson said the mandate would hinder hospital efforts to “adopt constructive long-term solutions” to the local shortage of nurses (Allabaugh, Wilkes-Barre *Citizens' Voice*, 10/6/06; Pound, Beaver County *Times*, 10/6/06; Wenner, *Patriot-News*, 10/9/06). 

Recruitment & Retention


News on hospital strategies from across the nation

Survey: ED nurses exhibit job satisfaction, intent to remain in profession

A survey by the Emergency Nurses Association (ENA) finds that most emergency nurses are satisfied with their jobs, despite facing workplace violence. One thousand ENA members were surveyed by telephone in September, with 64% reporting that they are very or extremely satisfied with their jobs and 75% saying that they expect to be in the nursing industry 10 years from now. Nurses cited patient interaction, workplace camaraderie, and the potential to help pediatric patients as top drivers of professional satisfaction. However, 86% of nurses reported that they had been the victim of workplace violence within the past three years, with almost 20% reporting that they experience workplace violence frequently. To improve ED nurses' working conditions, the ENA supports increased funding for training programs and establishing a governing body to reform emergency care at the local, state, and federal levels (United Press International, 10/10/06; ENA release, 10/10/06; RWJF News Digest, 10/11/06). 

Last Word

Use education—as well as monetary rewards—to boost referral campaigns

A recent *Wall Street Journal* column discusses employee referral programs, noting that it takes more than financial incentives to get employees to refer quality candidates. Employee referrals are a common recruiting practice, with most organizations paying employees hundreds or thousands of dollars for successful hires. However, the promise of rich rewards can lure employees to blindly refer candidates without regard for their fit with the targeted positions. To ensure that a referral program is effective, organizations should educate employees about the qualities candidates should possess and encourage employees to look at candidates' resumes before making referrals, especially if employees do not have experience working with the candidates. The *Journal* underscores the importance of a thoughtful approach when forwarding candidate resumes, noting that referrals are a reflection on the referring employee, who shares responsibility with the organization if a new hire turns out not to be a good fit (Sopp, 9/26/06). 

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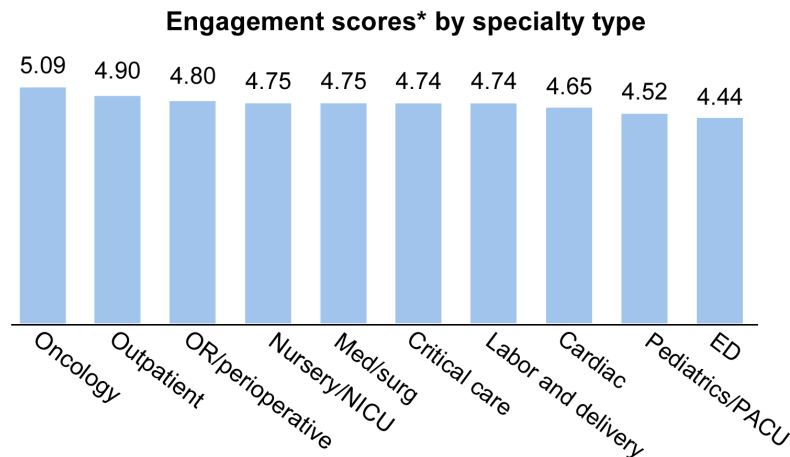
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ANNOUNCEMENT

Center offers frontline nurse engagement survey opportunity

The Nursing Executive Center is conducting pioneering research into the area of staff nurse engagement. With the nursing shortage beginning to worsen while more is being asked of staff nurses, chief nurse executives are facing the challenge of engaging and retaining their workforce. To shed light on this issue, the Nursing Executive Center has developed a nurse-specific engagement survey with two principal objectives: first, to identify the most important determinants of staff nurse engagement, and second, to allow Nursing Executive Center members to benchmark their own performance in relation to other nursing programs.

Preliminary research shows significant and intriguing variations across multiple dimensions, including unit type, tenure, and age. The following graphic, taken from a sample of more than 2,500 frontline staff nurses, shows engagement levels by specialty type. Scores were lowest for the emergency department, pediatrics/PACU, and cardiac units; across these specialties, 41% to 43% of staff nurses were ambivalent or disengaged with their jobs. Highest scores clustered in oncology, outpatient, and OR/perioperative care.



* Average response rate to four statements: I would recommend this organization to my friends as a great place to work; This organization inspires me to perform my best; I am likely to be working for this organization three years from now; I am willing to put in a great deal of effort in order to help this organization succeed. Definition of scale: 6-Strongly agree; 5-Agree; 4-Tend to agree; 3-Tend to disagree; 2-Disagree; 1-Strongly disagree.

* Percentage ambivalent or disengaged (engagement scores 4.49 or below): Oncology: 14%; Outpatient: 19%; OR/Perioperative: 32%; Nursery/NICU: 29%; Med/surg: 31%; Critical Care: 31%; Labor and delivery: 33%; Cardiac: 41%; Pediatrics/PACU: 42%; ED: 43%

Source: Nursing Executive Center research.

Once the Center's survey instrument has been refined, it will be available to members wishing to compare their performance on staff nurse engagement to national and peer group norms. In addition, **the Center has a limited number of spaces available for hospitals wishing to participate in the alpha group over the next couple of weeks. If you would like to participate in the alpha group of this survey, please contact Andrew Shelton at 202-266-6476 or sheltona@advisory.com.** This research will be presented during the 2006-2007 National Member Meetings to be held on 10 occasions from December 2006 through May 2007. To register, please visit the NEC homepage on www.advisory.com or contact the Meetings Department at 202-266-6880.