

# Nursing Executive Watch

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News in Review

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## NEWS IN PERSPECTIVE

### Delirium: Programs aim to build awareness, improve outcomes

Recent studies call attention to the clinical and economic toll of inpatient delirium, reinforcing the importance of preventive measures and proactive management. Seeking to stem delirium's impact, 60 hospitals are implementing the multi-component Hospital Elder Life Program developed at the Yale University School of Medicine.

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### Automated cardiac care tutorials aim to improve patient education

In response to industry emphasis on informed consent, some hospitals have implemented computerized education programs for cardiac patients. Hospital leaders say the tools increase patient satisfaction, reinforce prevention efforts, and save nurses time by supplementing nurse-led congestive heart failure education.

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At Loma Linda University Medical Center (LLUMC) in Loma Linda, Calif., the executive director of nursing partners with a nursing professor at Loma Linda University to formally introduce nursing students to the fundamentals of the nurse manager role. Together, the two teach a three-month unit management course that includes classroom learning, hospital internships, individual mentors for each student, and unit-based projects. Required for BSN students, the class not only exposes students to the nurse manager role but also helps them develop critical thinking, interpersonal, and organizational skills. Since its inception in 2000, the course has been so successful that LLUMC now hires more than 80% of course graduates.

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## CASE STUDY

## Case Study: Unit management course grooms BSN students for nurse manager careers

At 701-bed Loma Linda University Medical Center (LLUMC) in Loma Linda, California, the executive director of nursing partners with a nursing professor at Loma Linda University to formally introduce nursing students to the fundamentals of the nurse manager role. The two team-teach a three-month unit management course that includes classroom learning, hospital internships, individual mentors for each student, and unit-based projects. Required for BSN students, the class not only exposes students to the nurse manager role but also helps them develop critical thinking, interpersonal, and organizational skills. Since its inception in 2000, the course has been so successful that LLUMC now hires more than 80% of course graduates.

### Case Element #1: Dedicated mentorships spark interest in nurse manager career path

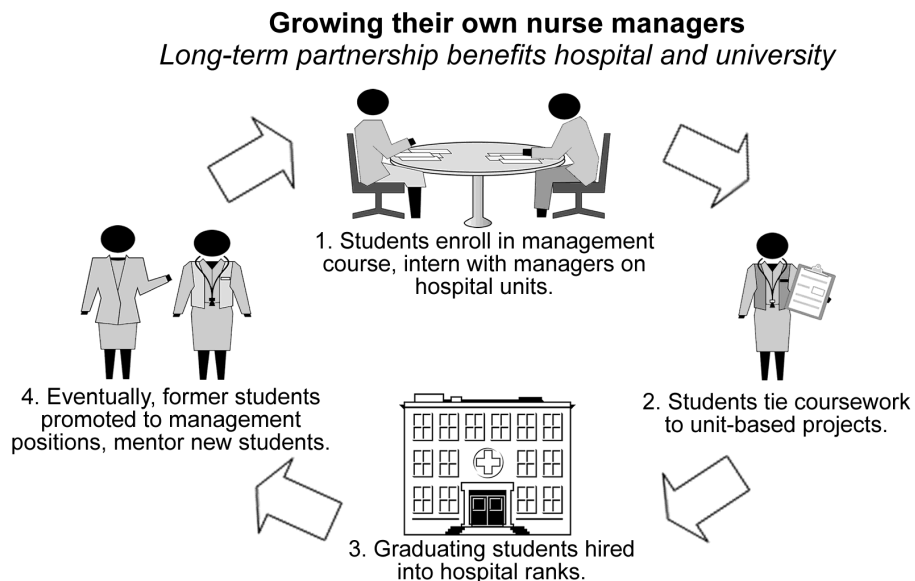
Although few students enter nursing school with the intention of pursuing a career in management, hands-on education can foster student interest in such a career path by demonstrating the tremendous impact that nurse managers have on patient care. At the beginning of the management course, each student is paired with a LLUMC nurse manager mentor. Students spend six hours per week, for a total of 80 hours, shadowing their mentors through their daily routines, participating in everything from performance improvement initiatives to hospital leadership meetings.

### Case Element #2: Unit-based projects bring coursework to life

Students are also required to complete one major unit-based project—such as using budget variance reports to analyze unit financial performance—that ties their coursework to a real-life management challenge. In addition to building technical skills, these projects allow students to experience the rewards of management by identifying and executing a solution to a real unit problem.


### Case Element #3: Hands-on experience develops pipeline of future managers and mentors

The innovative course has helped LLUMC to create a long-term pipeline of ambitious and capable nurse managers who are already familiar with the institution; many of Loma Linda's current charge nurses went through the program while they were in nursing school and are now being groomed to become nurse managers and mentors to a new generation of students.



Source: Nursing Executive Center interviews.

**For more information**

This case study was uncovered during research for the Nursing Executive Center's 2005-2006 national meeting series, *Safeguarding Frontline Care: Optimizing Current Resources, Elevating Future Practice*. A special makeup session of this series will be held in Washington, D.C., on Sept. 26 and 27. To register, visit [www.advisory.com/nec](http://www.advisory.com/nec) or contact the Meetings Department at 202-266-6780 or [meetings@advisory.com](mailto:meetings@advisory.com). For more information about these meetings, please contact Kimberly Randle at 202-266-6495 or [randlek@advisory.com](mailto:randlek@advisory.com). 

**NEWS IN PERSPECTIVE****Delirium: Programs aim to build awareness, reduce incidence, improve outcomes**

Recent studies call attention to the clinical and economic toll of inpatient delirium, reinforcing the importance of preventive measures and proactive management (Rubin et al., *Journal of the American Geriatrics Society*, 6/1/06; Inouye, *NEJM*, 3/16/06). Often undetected by clinicians or discounted as an expected consequence of aging, delirium—also known as acute confusional state—may precipitate a “cascade of events” that can result in patient loss of independence, increased mortality risk, and inflated costs. Seeking to stem delirium's impact, 60 hospitals are implementing the multi-component Hospital Elder Life Program (HELP) developed at the Yale University School of Medicine (*Watch* interviews, 7/24/06; 5/8/06).

**Condition often goes unrecognized, compromises care quality**

Although delirium is widespread—up to 56% of general inpatients and up to 87% of elderly ICU patients experience its symptoms during their hospital stays—clinicians fail to diagnose between one-third and two-thirds of cases (Inouye, *Cleveland Clinic Journal of Medicine*, November 2004). Among the principal barriers to diagnosis is clinicians' tendency to conflate delirium with dementia, which is characterized by chronic rather than abrupt onset and consistent rather than fluctuating levels of consciousness. Diagnosis also may be confounded by delirium's complex etiology, which often involves “predisposing factors,” such as co-existing conditions or sensory impairment, and “precipitating factors,” such as surgical intervention or prescription drugs. Moreover, physicians—who often are not attuned to the condition—tend to dismiss nurses' concerns about patients' cognitive status as clinically insignificant.

However, a growing body of research establishes delirium as a “life-threatening clinical syndrome” that affects 2.3 million hospitalized elderly patients, accounts for 17.5 million inpatient days annually, and potentially increases hospital costs by \$2,500 per patient. The condition also generates case fatality rates akin to acute myocardial infarction and sepsis; studies have found that patients experiencing delirium have mortality rates ranging from 10% to 65%, roughly double the mortality rate for matched controls (*NEJM*, 3/16/06; *Cleveland Clinic Journal of Medicine*, November 2004). Dr. Sharon Inouye, professor of medicine at Harvard Medical School and a leading delirium researcher, noted that despite the clinical and business case for delirium prevention, the condition has “not been a priority” in inpatient quality improvement (*Watch* interviews, 7/24/06; 5/8/06).

**HELP pre-empts delirium through interventions**


Recognizing a need to boost medical staff members' propensity to recognize and remedy delirium, 60 hospitals are partnering with HELP—a program Inouye designed—to implement a set of preventive protocols. Once nurses or physicians flag patients as being at high risk for delirium, the HELP toolbox offers a variety of strategies targeted at each of the condition's six principal risk factors (HELP website, accessed 7/21/06; Inouye et al., *NEJM*, 3/4/99).

**HELP targets six risk areas with standardized interventions**

<i>Risk factor</i>	<i>Sample interventions</i>	
<b>Cognitive impairment</b>	● Hang board in patient's room with team members' names	● Provide cognitive stimulation such as word game three times daily
<b>Sleep deprivation</b>	● Follow nonpharmacologic sleep protocol, such as music at bedtime	● Launch unitwide noise reduction program; reschedule medications
<b>Immobility</b>	● Engage patient in exercise three times daily	● Minimize use of bladder catheters, other devices that impair mobility
<b>Visual impairment</b>	● Reinforce use of proper glasses or magnifying lenses	● Offer large-print books
<b>Hearing impairment</b>	● Perform earwax disimpaction	● Provide portable amplifying devices
<b>Dehydration</b>	● Monitor for signs of dehydration and volume repletion	● Encourage oral intake of fluids

Source: HELP website, accessed 7/21/06; Inouye et al., *NEJM*, 3/4/99.

An analysis of the program's efficacy in the *Journal of the American Geriatrics Society* confirms the HELP interventions' potential (Rubin et al., 6/1/06). For the study, researchers evaluated 4,763 elderly patients admitted to one nursing unit at the University of Pittsburgh Medical Center Presbyterian Shadyside on across 3.5 years and found that those targeted with the HELP interventions were 35.3% less likely to develop delirium than patients in the control group ( $p=0.002$ ). The intervention unit also had a net cost savings of \$562,611 across six months, in large part because averted delirium reduced LOS. Moreover, both nurses and families reported high satisfaction, with nurses rating "my job is more satisfying due to HELP" an average of 3.8 on a five-point scale.

According to Inouye, hospitals hoping to capture such benefits must devote an average of nine months to training and implementation, designate a program champion, and track data to demonstrate gains (*Watch* interviews, 7/24/06; 5/8/06). In addition, HELP organizers recommend that hospitals looking to implement the program for approximately 250 patients per year form a dedicated, interdisciplinary team composed of a geriatric nurse specialist (0.5 FTE), a geriatric specialist (1.0 FTE), an Elder Life Specialist or program coordinator (1.0 FTE), a geriatrician (0.1 FTE), a program director (0.1 FTE), and part-time volunteers. In addition to financing the 1.7 program-related FTEs, a hospital must invest \$10,000 for HELP-supplied training materials, \$3,500 for equipment, and \$2,000 for annual maintenance. Inouye added that facilities may have to customize the interventions; one facility, for instance, adapted the program because its liability insurer would not allow volunteers to feed patients or assist them with beverages. 

**NEWS IN PERSPECTIVE****Informed consent: Automated cardiac care tutorials aim to improve patient education, save nurses time**

In response to growing industry emphasis on informed consent processes and the shortage of nurses available to educate patients, some health care facilities have implemented computerized education programs for cardiac patients. Although hospital administrators say the automated education tools should never replace face-to-face interactions between patients and nurses, they note that the automated tutorials—which educate patients on the risks and benefits of cardiac procedures, as well as alternative treatment options—increase patient satisfaction and reinforce prevention efforts by supplementing nurse-led congestive heart failure education (*Watch* interviews, 7/19/06; 4/12/06; 4/14/06).

### Informed consent processes help boost patient education, satisfaction

Once a legal formality, the informed consent process now refers to a range of communications that prepare patients for elective procedures. According to research presented at the 2003 ACC Scientific Sessions, cardiac patients who are able to recall a procedure's associated risks and benefits are more likely to be satisfied with their decision to undergo that procedure, yet studies indicate that as many as 45% of patients forget surgical risks even after signing consent forms. In addition, patients who discuss treatment options with their caregivers also are more likely to be satisfied with their overall care, said Dr. Scott Pollak, a cardiologist at Orlando-based Florida Hospital who helped design the facility's automated informed consent interface (*Watch* interviews, 7/19/06; 4/13/06). Pollak added that a comprehensive informed consent process can reduce hospital liability exposure, noting that nurses can be sued for malpractice directly or, more commonly, "under the umbrella of a hospital."

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*"We need to provide education that's a proper balance between fully informing patients and not scaring the daylights out of them."*

— Dr. David Cook, medical director of quality and safety services, Central DuPage Hospital

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However, given the time constraints and some cardiac procedures' complexity, cardiac clinicians often struggle to properly explain the risks of undergoing—or refusing—certain interventions (Woolf et al., *Annals of Internal Medicine*, 8/16/05). Uncertainty about how much and what kind of information patients can handle emotionally may lead clinicians to gloss over certain details, potentially compromising patient education. Furthermore, hospitals often have a shortage of nurses available for comprehensive preprocedure education, further hindering efforts to secure patient consent (*Watch* interviews, 7/19/06; 4/13/06).

### Automated tool facilitates patient education, enhances staff resources

In light of these challenges, Florida Hospital in April 2005 strengthened its informed consent process by implementing an internally designed, automated system consisting of a mobile computer and digital printer mounted on a mobile cart. The hospital first introduced the Interactive Consent program in the cath lab, which performs 18,000 procedures annually. The tool, which required a \$25,000 outlay for 10 units, supplements prior patient-specialist conversations and tests comprehension on 15 cardiac procedures and post-procedure care, including defibrillator implantation, diagnostic catheterization, PCI, CABG, and smoking cessation. Nurses wheel the cart to the patient's bedside in advance of a scheduled procedure and leave it by the bedside for up to one day so that the patient can use the tool at his or her leisure, taking breaks as needed. The patient views videos and reads related text on the computer screen; using the touchscreen's keyboard, the patient answers simple questions to verify comprehension and can enter follow-up questions for nurses.

#### Interactive Consent tool emphasizes multiple avenues of communication

##### 1 Procedure education



Patient views 30-minute presentation outlining procedure protocols, risks, and post-procedure care tips.

##### 2 Assessment



Patient answers true-or-false questions, types any follow-up questions; system logs patient responses.

##### 3 Nurse review



Nurse educator reviews test results, answers patient's questions; patient can review presentations and re-take test.

##### 4 Informed consent agreement



Patient signs consent form, or hospital obtains consent from family or health care surrogate if patient unable to answer questions correctly.


Source: *Watch* interviews, 7/19/06; 4/12/06.

According to Danielle Thompson, Florida Hospital's director of cardiovascular services, the Interactive Consent tool eases the burden on the limited number of cardiac nurses available to educate CHF patients on prevention and rehabilitation, enabling nurses to spend more time treating patients. In addition, analysis of patients' Interactive Consent comprehension test results can help cardiac nurses focus their face-to-face

teaching on areas that patients do not understand rather than potentially overwhelming patients with lectures on entire procedures. Given the Interactive Consent tool's success at Florida Hospital, system administrators have purchased 25 additional units for use at the other facilities in the Florida Hospital system and have begun collecting data to gauge the tool's impact; they plan to have complete return-on-investment figures by September.

According to Pollak, patient satisfaction surveys conducted at the end of each Interactive Consent presentation indicate that since the program's implementation, 95% of patients have been satisfied with the informed consent process. Furthermore, Thompson said the tool guards against malpractice lawsuits. By documenting the patient education process—particularly patient comprehension—the hospital can demonstrate that it thoroughly educates every patient about his or her elective cardiovascular procedure. Thompson added that if the system prevents even one lawsuit, it will be worth the hospital's investment.

### **Central DuPage adopts online education tool for elective CABG patients**

In a similar effort, Chicago-based Central DuPage Hospital in February began offering elective CABG patients access to Expectation Management and Medical Information (EMMI), an online patient education program developed by Chicago-based Rightfield Solutions. EMMI's online platform—used by 85,000 patients nationwide during the past two years—enables patients to access information on their conditions, procedures and associated risks and benefits, alternatives, and follow-up care from home or their physicians' offices, said Dr. David Cook, a cardiologist and Central DuPage Hospital's medical director of quality and safety services (*Watch* interview, 4/14/06). EMMI technology—which costs \$75,000 to \$300,000 annually per hospital, depending on bed size and program use—allows patients to pause or repeat slides, print information for future reference, and pose questions to clinicians via e-mail; the online course lays the groundwork for caregivers to conduct a more thorough, in-person discussion. Meanwhile, the EMMI system logs each keystroke and stores the information in a database, which can be accessed if needed to address malpractice claims. Cook added that EMMI has boosted staff efficiency and eased time constraints, noting that although “we want to spend all of our time answering all of patients' questions...we can't” (*Watch* interview, 4/14/06). 

## **JOURNAL REVIEW**

### **Data source comparison indicates that AHA needs to improve staffing survey**

Writing in the Second Quarter 2006 *Journal of Nursing Scholarship*, H. Joanna Jiang, social scientist at the Rockville, Md.-based Agency for Healthcare Research and Quality, and colleagues compare hospital nurse staffing measures from two widely used secondary data sources: the American Hospital Association (AHA) 2001 Annual Survey of Hospitals and the 2001 annual report sponsored by the California Office for Statewide Health Planning and Development (OSHPD). Aggregate nurse staffing research is most often based on the AHA survey, which involves voluntary responses from a nationwide sample of member hospitals. However, researchers also use databases sponsored by state departments of health such as OSHPD, which mandates reports from California hospitals. After comparing AHA's and OSHPD's measures of nurse staffing and skill mix, Jiang and colleagues concluded that AHA should augment its survey to make it more useful for researchers and policymakers.

#### **Methodology**

The authors used descriptive statistics to compare staffing data from 372 acute care hospitals in California and regression analysis to assess the association of staffing measures with three risk-adjusted patient outcomes: decubitus ulcers, failure to rescue, and a composite mortality rate for 10 common conditions and procedures. Because AHA reports staffing with total FTEs on payroll and OSHPD reports productive hours, Jiang and colleagues standardized data by converting productive hours into total paid hours.

### Differences between AHA, OSHPD vary depending on hospital characteristics, patient outcomes

The study found no substantial differences between AHA and OSHPD on average RN hours per patient day (HPPD), average licensed nurse (RN and LPN) HPPD, or the proportion of RNs among all licensed nurses; additionally, both databases had statistically significant inverse relationships between RN HPPD and rates of patient mortality and ulcers. However, discrepancies between the two sources varied by hospital characteristics, with AHA reporting considerably higher RN HPPD than OSHPD for nonteaching, rural, and small hospitals.

#### Comparison of AHA and OSHPD measures of HPPD based on hospital characteristics\*

	Nonteaching	Teaching	Rural	Urban	<100 beds	100-249 beds	250+ beds	Public	Not-for-profit	For-profit
RN HPPD	21.2%	4.7%	49.0%	14.3%	33.4%	18.7%	-1.1%	21.3%	15.4%	22.6%
RN+LPN HPPD	10.1%	4.1%	19.0%	7.8%	16.2%	10.0%	-1.5%	10.4%	3.5%	21.8%

\*Discrepancies are measured as the percentage difference between the AHA and OSHPD measures. For example, for nonteaching hospitals, on average, the total RN HPPD derived from AHA was 21.2% higher than the OSHPD data.

Source: Jiang et al., *Journal of Nursing Scholarship*, Second Quarter 2006.

The study also found that the association between RN HPPD and mortality was stronger for OSHPD than for AHA (OSHPD:  $p < 0.001$ ; AHA:  $p < 0.01$ ), and OSHPD data on the proportion of RNs were significantly associated with all three patient outcomes, while AHA data were significantly associated only with ulcers ( $p < 0.01$ ).

### OSHPD more comprehensive; AHA should expand data collection, partner with state organizations

Although AHA has the advantage of national representation and standardized reporting, the authors conclude that OSHPD is more closely associated with patient outcomes and provides “more complete information.” The authors suggest that hospitals may be less likely to voluntarily report to AHA because of lack of time, staffing resources, and incentives. Therefore, Jiang and colleagues urge AHA to partner with state data organizations to collect similar data, including measurements on productive hours and unlicensed nursing staff, and to categorize staffing data by nursing unit, activity type (such as direct care or management), educational level, and national origin. Given the wide variations between data sources, the authors also urge researchers to consider the limitations of each data source before estimating safe nurse staffing levels or the effects of nurse staffing on patient outcomes.

Abstracted from: Jiang J et al., “Disparities Between Two Common Data Sources on Hospital Nurse Staffing,” *Journal of Nursing Scholarship*, Second Quarter 2006, 38 (2): 187-193.

#### JOURNAL REVIEW

### Knowledge@Wharton: Good mood at start of day linked to positive performance

An article in the July 26, 2006, *Knowledge@Wharton* contends that mood affects employee performance and that the type of mood employees bring to work has a stronger effect than workday events on overall mood. The article is based on a study titled “Walking in the Door: Sources and Consequences of Employee Mood on Work Performance” by Nancy Rothbard, a Wharton management professor, and Steffanie Wilk, a professor at Ohio State University’s Fisher School of Business. Rothbard and Wilk explain that “non-work and work domains are permeable,” causing emotions from home life to spill into work life. Because start-of-day mood brought from home strongly affects workday mood—which is associated with performance—Rothbard and Wilk suggest that employers strive to address employees’ non-work stressors.

## Methodology

Rothbard and Wilk studied call-center employees across three weeks at a major insurance company, focusing on 29 customer service representatives who each fielded an average of 64 calls daily. Through online questionnaires that “popped up” on their computers several times per day, the reps were asked to rate on a five-point scale their moods, customers’ moods, and personal performance. The researchers also tracked the number of calls each rep handled per hour, the percentage of time each rep answered calls (i.e., was not on break), and the number of times each rep forwarded a call to a supervisor, which was considered “undesirable.”

### Good mood lasts throughout the day, may improve performance

The study found that positive and negative moods “partially” affect worker productivity. Bad mood was significantly associated with fewer calls per hour while good mood was associated with fewer transferred calls to supervisors and less time on breaks, demonstrating to Rothbard and Wilk that happy employees were more engaged in their jobs. However, good mood did not cause reps to take more calls per hour.

The study also found that employees generally maintained their start-of-day moods throughout the workday, regardless of potentially mood-altering events. The correlation coefficient ( $r$ ) measuring the association between start-of-day mood and mood throughout the workday was reportedly “strong” at 0.38 for negative mood and 0.36 for positive mood (1.00=perfect correlation). Conversely, employees’ moods worsened from interactions with customers who were in bad moods at a “mere”  $r=0.08$  and improved with customers in good moods at  $r=0.25$ . Interestingly, tenured employees were less affected by customers’ moods compared with new employees; the authors surmise that employees were “hardened to unpleasant interactions” over time or left the job if they could not weather the storm of customer moods.

### Target sources of pre-work discontent to foster positive mood

The authors suggest that start-of-day moods may be more potent than interactions with customers because they are caused by events that are more important to employees. Moreover, workers receive training on responding to customer interactions but lack similar training to cope with their own life stressors. The authors suggest that by helping employees cope with issues that affect start-of-day moods—such as by offering family counseling and providing advice on how to dodge commuting hassles—businesses could reap improved staff productivity.

*Abstracted from: Knowledge@Wharton, “Waking Up on the Wrong Side of the Desk: The Effect of Mood on Work Performance,” July 26, 2006.*

## JOURNAL REVIEW

### **Nurse Leader: Tailor retention strategies to specific source of nurse manager dissatisfaction**

Writing in the June 2006 *Nurse Leader*, Katherine Vestal, president of Lake Leelanau, Mich.-based Work Innovations Inc., discusses the difference between burnout, boredom, and fatigue among nurse managers and strategies to address each condition. Vestal writes that because nurse managers face stressful situations daily and often work in a state of damage control, it is common for them to say they are tired and frustrated when asked about their jobs. However, senior leaders tend to lump such complaints under the category of burnout without digging deeper to determine whether the issue is actually boredom or fatigue. To ensure job satisfaction and retention, senior leaders must continuously take the “pulse” of their managers by asking them how they feel about their jobs and identifying the underlying source of job dissatisfaction.

**Beat boredom with new skills development**

Vestal notes that a substantial portion of nurse managers' jobs involves repetitive tasks—such as preparing schedules, approving time cards, and tracking supplies—that are challenging at first but become rote over time. If managers are bored by their current responsibilities and filling time gaps with nonproductive activities or seeking new roles, senior leaders should ask them to identify which chores were mastered long ago and to delegate less engaging tasks to subordinates. According to Vestal, managers must strive to tackle new challenges during the time gained from increased delegation instead of simply expanding their workload, which can cause fatigue or burnout. To help identify these challenges and develop managers' professional skills, senior leaders can stretch managers' existing goals or introduce new ones, modify their job focus, and change their organizational responsibilities.

**Fight fatigue with revamped schedule, short-term down-time**

In addition to becoming bored with repetitive tasks, nurse managers tend to stretch themselves thin running between meetings, filling staffing holes, and trying to support the hospital's around-the-clock needs during work hours. To deal with hospitals' fast-paced environments, many managers develop a "survivor mentality" that channels all their energy into getting through the day; Vestal cautions that this mentality works in the short-term but leads to physical exhaustion for individuals who use it daily across several months. Fatigued nurses are usually enthusiastic about their roles, interested in their daily tasks, and committed to the organization, but they seem to be "running on empty" and talk about not getting enough rest. To support fatigued managers, Vestal suggests examining their schedules and making changes to save time and boost efficiency. Vestal also suggests that senior leaders relieve key job stressors on a short-term basis to temporarily slow the work pace without significantly decreasing productivity.

**Bust burnout with stress management, organizational improvements**

Although burnout can include boredom and fatigue, it also involves the constant feeling of powerlessness to solve problems and hopelessness about situations improving. Symptoms of burnout include dreading work, speaking cynically about the job, and getting easily irritated by coworkers. To address burnout, senior leaders must re-establish managers' sense of "personal power" by speaking openly with them about how the work environment contributes to burnout. While listening to managers, senior leaders must be willing to acknowledge the organization's shortcomings without being defensive, Vestal writes. After working with managers to determine which organizational processes cause the most stress, senior leaders should present action steps that the organization will take to resolve procedural problems and long-term organizational issues; Vestal notes that making a plan for improvement goes "a long way in renewing [managers'] hope that things will get better." Because changing organizational procedures takes time, senior leaders also should teach managers stress management techniques and point them toward resources for daily support.

*Vestal K, "Bored, Burned Out, or Just Plain Tired?" Nurse Leader, June 2006, 4 (3): 6-7.*

**ON OUR WATCH**

## Care Quality

*Tracking news, strategies, and the latest research*

### Groups call for increased nurse participation in health IT planning

Advocates for nurse informatics and health information technology (IT) are calling on hospitals to involve nurses in designing new hospital IT systems, *Federal Computer Week* reports. A 2005 poll of nurses by the Healthcare Information and Management Systems Society's Nursing Informatics Task Force shows that nurses view health IT positively, are not concerned that it will "cloud their clinical judgment," and believe it will improve patient care. However, the survey also found that nurses are anxious about technology when it interrupts their work processes. For instance, some nurses "feel anxious" about systems that do not indicate whether physicians have seen or acted on critical messages; in these cases, nurses revert to traditional communication techniques. In addition, nurses prefer to have IT equipment at the bedside so that they do not have to walk back and forth from the nurses' station while caring for patients. According to nurse leaders, comments like these demonstrate the importance of including nurses in the decision-making stages of IT implementation and ensuring that systems improve patient care (McAdams, 8/7/06; RWJF News Digest, 8/7/06).

### Commonwealth Fund calls for 'significant and systemic' U.S. health system reforms

A recent report by the Commonwealth Fund finds that although the United States spends more than any other nation on health care services, it trails other industrialized countries in implementing policies to improve care quality and expand access to care. The report was prepared by the Commission on a High Performance Health System, which is composed of 18 experts, including health care delivery professionals, insurance administrators, state and federal lawmakers, business executives, academics, and professional society representatives. Tasked with examining the sources of failure within the U.S. health care system, the panel concluded that the nation must "implement significant and systemic changes to increase access, quality, and efficiency for all Americans," particularly vulnerable populations, such as the poor and disabled. The commission suggests adopting far-reaching policies and practices to improve patient safety, expanding use of health information technology, structuring reimbursement to reward high-quality care, increasing health care cost and quality transparency, and expanding health insurance options. Furthermore, the panel said health care providers should be "held accountable for meeting quality, safety, and efficiency benchmarks." The commission's chair, who is also the president and CEO of Boston-based Partners HealthCare System, said there is consensus among health care professionals, lawmakers, and the general public that Americans should "get more from [the] health care system." He added that the commission's message to the nation is that the "future of [its] health and economic well-being depends on acting now to begin the transformation" ("Framework for a High Performance Health System for the United States," 8/3/06; Abruzzese, *CQ HealthBeat*, 8/3/06; *AONE eNews Update*, 8/4/06). To view the full report, please visit [www.cmwf.org](http://www.cmwf.org).

### Hospitals turn to mystery shoppers as patient satisfaction scrutiny grows

Medical facilities are enlisting the help of mystery shoppers to guide patient satisfaction improvements in anticipation of looming public reporting requirements, the *Wall Street Journal* reports. The efforts come as CMS plans to begin assessing and publicizing hospital-specific patient satisfaction scores on Oct. 1, enabling comparisons across facilities nationwide. To identify opportunities for service improvements, hospitals are dispatching mystery shoppers—a fixture in the retail and hospitality industries—and providing staff with a general timeframe during which evaluations will occur. The mystery shoppers then make inquiries over the phone, feign symptoms in the ED, or visit a physician for a routine medical check-up, recording their observations and filing a detailed report about their experience. While some hospital leaders fear that staff may feel "spied on," they noted that the evaluations have led to improved ED wait times, new scripting protocols, escorts for patients prone to getting lost, and "less-stressful programming" on waiting room televisions. OhioHealth recently began rewarding employees who received praise from mystery shoppers with gift cards, special parking spaces, and public recognition, efforts that coincided with decreased employee turnover. Despite evidence supporting the use of mystery

shoppers, some providers worry that the imposters will divert attention from legitimately ill patients, a threat mystery shopping companies say they are working to address by telling mystery shoppers to seek care during off-peak hours (Wang, 8/8/06).

### **VA Pittsburgh Healthcare to lead nationwide effort to prevent MRSA infections**

The VA Pittsburgh Healthcare System is spearheading an effort to help veterans' hospitals nationwide reduce methicillin-resistant *Staphylococcus aureus* (MRSA) infections, the *Pittsburgh Post-Gazette* reports. Armed with best practices that have successfully reduced MRSA infections at VA Pittsburgh, local officials have joined with HHS, the CDC, the Plexus Institute, the Delmarva Foundation, and Tufts University to share their expertise with 17 other VA hospitals nationwide. The initiative is ultimately expected to expand to all of the more than 150 VA medical centers in the United States. To control the spread of infection, VA hospitals will implement procedures such as using nasal swabs to test patients for MRSA; patients who test positive will be isolated to prevent the spread of the bacteria. The project will be funded with an \$850,000 budget that will mainly be used to help hospitals hire support staff, purchase supplies, and improve lab testing. A CDC epidemiologist noted that MRSA has been a "particularly recalcitrant problem" and added that the project could result in a "fundamental change in the way we think about MRSA prevention" (Fahy, 8/2/06).

## **Recruitment & Retention**

*News on hospital strategies from across the nation*

### **Maryland report predicts increasing nurse shortage over next decade**

Although the Maryland state nurse vacancy rate generally has held steady during the past three years, the Maryland Hospital Association (MHA) annual statewide staffing survey projects a worsening of the shortage, *Baltimore Business Journal* reports. The new results show that among state hospitals the vacancy rate for nurses was 10% in 2005, compared with 9.2% in 2004, 10.8% in 2003, and 15% in 2001. Despite this overall improvement, the MHA report projects that the shortage of nurses will grow from 6,000 in 2005 to 9,960 nurses by 2016, attributable in part to the aging patient population and the increasing number of competing job opportunities for health care workers. To address understaffing, many hospitals are strengthening recruitment and retention strategies, employing staffing agencies, and increasing hours for part-time staff (Zibel, 8/1/06; RWJF News Digest, 8/2/06; MHA release, 8/1/06).

## **Education**

*News on academic programs and training strategies*

### **Nurse faculty shortage continues despite increase in part-time faculty**

A report by the National League for Nursing (NLN) finds that U.S. nurse faculty vacancies are increasing despite efforts to hire more full- and part-time instructors, *AONE eNews Update* reports. According to the study—"Nurse Educators 2006: A Report of the Faculty Census Survey of RN and Graduate Programs—the nationwide nurse faculty vacancy rate for baccalaureate and higher degree programs was 7.9% in 2006, representing 1,390 budgeted, unfilled, full-time positions and a 32% increase since 2002. The faculty vacancy rate for associate degree programs was 5.6% in 2006, an increase of 10% since 2002. The study also highlighted major trends, including the increasing number of part-time faculty, which has grown 72.5% since 2002; however, the report noted that despite the benefits of part-time arrangements, they are not ideal because many part-time instructors are not involved in developing nursing curricula and have competing time commitments from other positions. In addition, the report found a decrease in doctorate-prepared faculty, noting that more than 56% of full-time nursing instructors do not hold doctorates. The report also underscored the aging of the full-time faculty population, noting that almost two-thirds of nursing school faculty are 45 to 60 years old (*AONE eNews Update*, 8/4/06; NLN release, 7/24/06; RWJF News Digest, 7/28/06; *Advance for Nurses*, July 2006).

## Labor Relations

*News on union activity and staff relations*

### Tenn. hospital wins \$1.2M grant to train nurse leaders

In an effort to improve care and reduce employee turnover, Memphis-based Methodist Healthcare will use a \$1.2 million grant from HHS to hire coaches to train nurse managers to be more effective leaders, the *Memphis Business Journal* reports. The grant, which will be dispensed across five years, is supplemented by \$613,000 from Methodist. Starting this fall, 100 nurse managers will be trained across a three-year period, at which point Methodist will measure the program's effect on nurse satisfaction and turnover and on patient outcomes, safety, and satisfaction (*Journal*, 8/3/06; Methodist release, 8/2/06).

## Last Word

### Question leadership instincts to promote innovation

A recent column in *Fast Company* discusses the potential for leaders' instincts to stifle innovation. The column notes that leaders hone their skills through experience, and these skills become second-nature after several years. As leadership becomes instinctual and organizations reuse strategies proven successful in the past, organizations run the risk of resting on their laurels and blocking growth in new directions. Large, established organizations are especially susceptible because leaders and decision-making teams reinforce the organization's "shared instincts." To ensure innovation, the author suggests that leaders avoid building teams with their "friends from within" and instead hire "outsiders" and place them in influential positions to challenge the status quo. In addition, the author suggests that leaders systematically identify and question organizational assumptions with managers during their performance reviews. Then, when new practices arise, leaders can examine how effective their current approaches are in the new context and make changes accordingly (Trimble, *Fast Company*, 6/19/06).

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