

Nursing Executive Watch

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News in Review

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'Home hospital' model frees beds, may reduce costs, LOS

Several U.S. hospitals are testing a "home hospital" model that gives patients hospital-quality care in their own homes. Home hospitalization has been shown to free up hospital beds, reduce costs, and speed recoveries. Supporters say the model could play an important role as the U.S. population ages and the demand for chronic disease care and acute hospital services increases.

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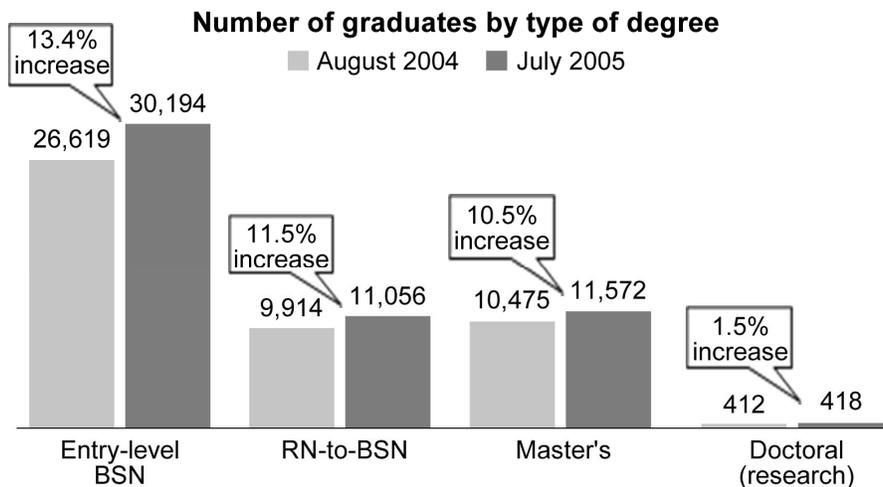
COVER STORY

AACN survey: BSN enrollment up for fifth consecutive year, but schools still turning away thousands

Enrollments in and graduations from entry-level BSN and higher-degree programs continue to increase, reflecting national efforts to attract new recruits to nursing, according to the recently released American Association of Colleges of Nursing (AACN) annual survey. The survey, titled "2005-2006 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing," found that enrollments in entry-level BSN programs increased 9.6% from 2004 to 2005, marking the fifth consecutive year of enrollment increases but a slightly smaller increase than was seen in the previous two years. Despite the enrollment gains, AACN noted that 37,459 qualified applications to entry-level BSN programs were not accepted into nursing schools in 2005, in large part because of a lack of faculty.

Improvements span variety of degree programs

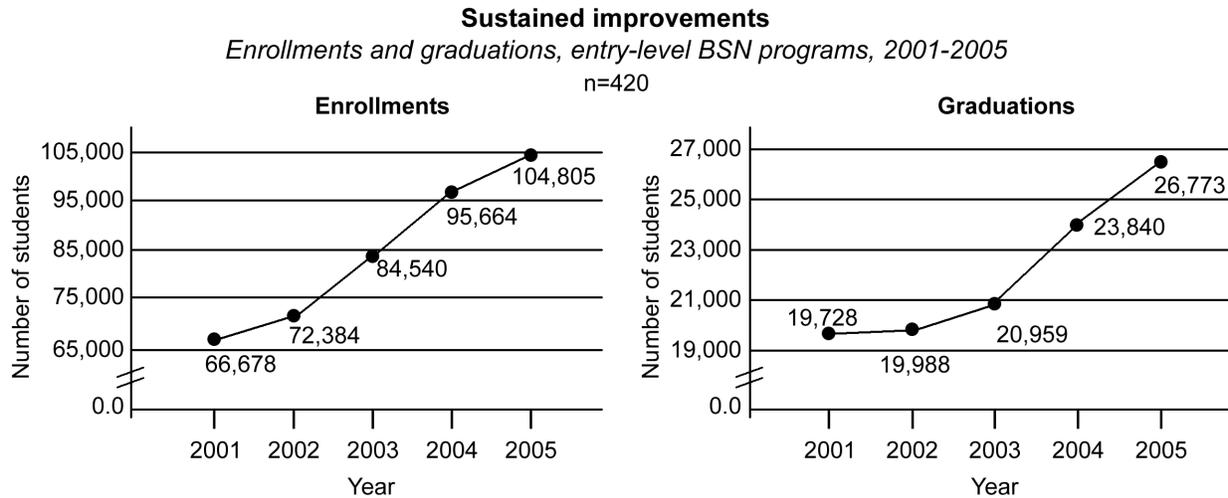
In September 2005, researchers mailed instructions for accessing AACN's online survey to 699 institutions with baccalaureate and higher-degree nursing programs, and 591 institutions responded by Jan. 9, 2006. According to the findings, entry-level BSN, RN-to-BSN, MSN, and research-based doctoral programs all experienced growth in enrollments and graduations across the past year. The rate of increase in graduations rose more steeply than the rate of increase in enrollments for all nursing programs except research-based doctoral programs.



Source: AACN 2005-2006 report.

BSN enrollments, graduations maintain steady climb

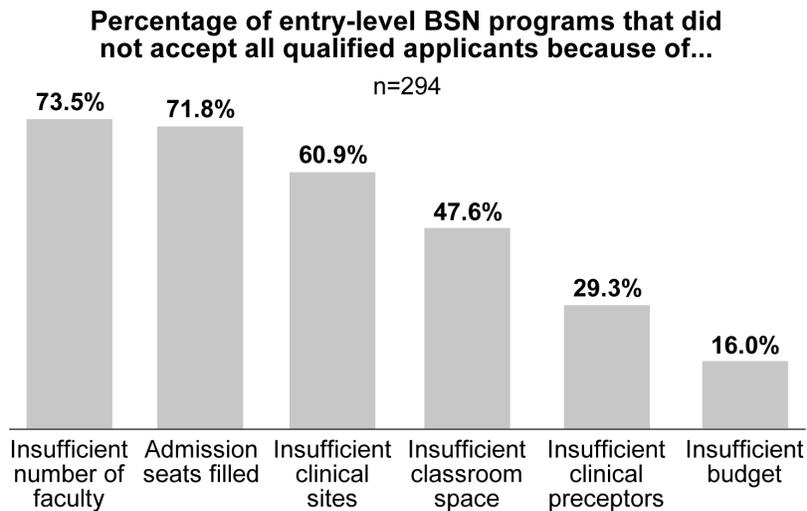
Meanwhile, data on baccalaureate enrollments and graduations suggest a strong and growing interest in the nursing profession (AACN release, 12/12/05). According to the findings, 124,814 students were enrolled in entry-level BSN programs in 2004, representing an increase of 57.2% across the past five years; prior to the upswing, BSN programs experienced six years of declining enrollment. Officials attribute the improvement to a variety of national efforts, including hospital-school partnerships; state and federal funding; and media campaigns encouraging people to become nurses, such as Johnson & Johnson's Campaign for Nursing's Future and the Nurses for a Healthier Tomorrow's careers in nursing and nurse educator recruitment campaigns.



Source: AACN 2004-2005 report.

Thousands of applications rejected because of lack of faculty

Despite the improvements, the authors note that entry-level baccalaureate programs rejected 37,459 qualified applications, with “insufficient number of faculty” the most frequently cited reason for not accepting all qualified applicants.



Source: AACN 2005-2006 report.

The study found that the top reason for inadequate faculty staffing for both entry-level BSN and RN-to-BSN programs was the “inability to recruit faculty due to competition for jobs with other marketplaces.” In response, AACN is working to increase federal funding for nursing faculty recruitment to help make the job more financially appealing to higher-educated nurses. AACN also is pursuing legislation related to more directly expanding the nursing workforce and the number of nursing students, in part because nurses are “much more likely to pursue graduate education and achieve the credentials needed to serve as nurse educators,” said AACN Executive Director Polly Bednash (AACN release, 12/12/05). AACN urges health care leaders to encourage nurses to pursue baccalaureate degrees, which AACN believes are key to meeting the growing and increasingly complex health care needs of the U.S. population. &

NEWS IN PERSPECTIVE

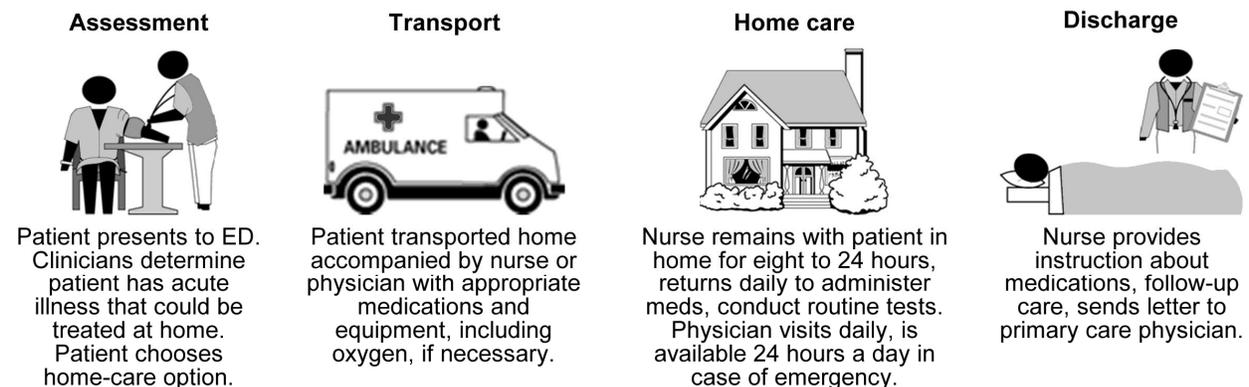
'Home hospital' model frees beds, may reduce costs, LOS

Seeking to offer an alternative to in-hospital treatment for chronically ill patients, several U.S. hospitals are testing a "home hospital" model that gives patients the option of receiving hospital-quality care in the comfort of their own homes (Naik, *Wall Street Journal*, 4/19/06). Supporters say home hospitalization is a promising alternative particularly for elderly patients, whose conditions can deteriorate sharply in the hospital because of increased vulnerability to hospital-acquired infections, falls, delirium, and even loneliness. In addition to freeing up hospital beds, home hospitalization also has been shown to reduce costs and speed recoveries, according to studies led by Baltimore-based Johns Hopkins University. Although current fee-for-service and Medicare payment structures may prohibit the model from becoming readily applicable at many hospitals, it could play an important role as the U.S. population ages and the demand for chronic disease care and acute hospital services increases (Leff et al., "Hospital at Home," *Annals of Internal Medicine*, 12/6/05).

The home hospital movement began with a 1996 pilot study of 17 patients at Johns Hopkins University that found that home hospitalization is as safe and satisfactory as in-hospital care and costs 60% less than hospital care because of lower overhead costs and fewer expensive tests. To evaluate the model on a larger scale, Johns Hopkins researchers in 2000 enlisted three other facilities to participate in a study of the Hospital at Home program: Univera Healthcare and Independent Health in Buffalo, N.Y.; Fallon Health Care System in Worcester, Mass.; and the Portland VA Medical Center (PVAMC) in Oregon. The study, which was financed by a grant from Johns Hopkins Bayview Medical Center and published in the December 2005 *Annals of Internal Medicine*, analyzed the outcomes of 455 hospital- and home-based patients with either community-acquired pneumonia, chronic heart failure, chronic obstructive pulmonary disease, or cellulitis over a 22-month period. During the study, PVAMC used nurses from an affiliated clinic for home-based care, while the other two hospitals contracted with a home health agency to obtain additional nurses.

Homeward bound

Snapshot of the Hospital at Home process



Source: *Watch* interview, 5/8/06; Naik, *Wall Street Journal*, 4/19/06; Leff et al., *Annals of Internal Medicine*, December 2005.

Hospital at Home program benefits quality, safety, finances

The 2005 study found that patients treated at home fared the same as or better than similar patients treated at one of the hospitals (Hospital at Home website, accessed 5/10/06). Compared with patients admitted to the hospital, home hospital patients were less likely to experience complications such as delirium or require sedative medications. Patients at home also were less likely to undergo "difficult" procedures ($p < 0.001$); have foley catheters inserted ($p = 0.011$); or receive chemical restraints ($p = 0.014$). Moreover, patients and their families found home hospital care to be as safe as care provided within the hospital and reported that patients felt more comfortable at home than in the hospital. In addition, the home hospital model was just as likely to meet illness-specific quality indicators, and patients and families reported that

care quality was better at home than in the hospital. And although two-thirds of the patients in the study stayed with family members who supplied care or services normally offered by the hospital, such as meals, families reported that caring for patients at home was less stressful than having them at a hospital.

In addition to safety and quality, patients in the home-based program had shorter LOS than those receiving hospital-based care (3.2 vs. 4.9 days, $p=0.004$), reducing the cost of care. The average cost of treating a patient at home was \$5,081, compared with \$7,480 for a patient treated in the hospital ($p<0.001$). Lynda Burton, associate professor at Johns Hopkins Bloomberg School of Public Health, noted that most of the patients who are eligible for home hospital acute care “bounce in and out of the hospital quite frequently” and added that the new model could save money and improve access to care by freeing up hospital beds for more acute patients and helping patients with chronic conditions avoid hospital-acquired infections (*Watch* interview, 5/8/06).

Nurses, patients satisfied with home hospital model of care

According to Burton, the home hospital model scored significantly higher than hospital-based care in many satisfaction areas. For example, home hospital patients rated the admission and discharge processes higher than did similar patients treated within the hospital. Burton noted that discharge from a home hospital is easier for nurses because the paperwork is “much more straightforward” and nurses do not need to arrange for patient transportation. Patients and families also were very satisfied with their relationship with home hospital nurses, who reported that they preferred practicing in the home setting. Nurses who worked with home-based patients said they had greater independence in case management and could more effectively tailor discharge education about disease management to patients’ environment; therefore, Burton believes that if the program were to become more widely implemented, “it might get back some nurses who were frustrated by hospital nursing.” Although home hospital nurses had to participate in some housekeeping responsibilities, such as making beds, tidying rooms, and preparing food, Burton said that these tasks were infrequent and that the nurses did not report them to be a problem.

Classifying home as a ‘hospital unit’ could allow wider implementation

Despite the simplicity of the process, the Hospital at Home model currently is not widely viable because there is no DRG classification to allow for Medicare payment for home-related services. In addition, the home hospital model “takes an admission away from the hospital,” said Burton (*Watch* interview, 5/8/06). However, two of the study’s three sites have continued to provide Hospital at Home care. Since the end of the study, Univera has limited its focus to patients with congestive heart failure, and PVAMC has expanded the program to include early discharge patients; Fallon Health Care ended its program because of a nursing shortage. To date, the PVAMC program has treated more than 300 patients with an average LOS of three days, compared with an average LOS of four days for patients treated at the hospital, and nurses report continued satisfaction. Burton noted that the two hospitals that have continued the program employ a maximum of eight hours of initial nursing observation upon admission to the home hospital program, which was the largest expense of the pilot program and seen as unnecessary in most cases.

To facilitate national dissemination of the home-hospital model, Burton and colleagues at Johns Hopkins are seeking a waiver from CMS to classify the Hospital at Home program as a unit of the hospital. Although JCAHO accreditation issues arise when considering the home as a hospital unit, Burton said hospital leaders have expressed considerable interest in the program, and she expects the model to spread nationally once the waiver is obtained. In the meantime, Burton is planning to set up training at Johns Hopkins to educate acute care nurses and physicians on transferring their skills to the home setting. Once implementation is more feasible, hospitals interested in adopting the program could expand the number of diseases they treat to any acute condition that does not necessitate many diagnostic tests, such as urinary tract infections and dehydration. Burton added that hospitals implementing the program as a separate hospital unit also could employ staff nurses dedicated to that unit. 

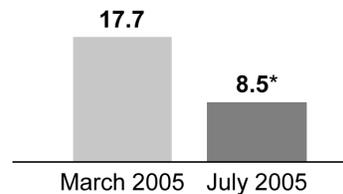
NEWS IN PERSPECTIVE

Case Study: Mentorship-focused management structure reduces staff vacancies, builds leadership potential

At 395-bed Banner Thunderbird Medical Center in Glendale, Ariz., the director for telemetry reorganized her department's structure to facilitate staff development and strengthen succession planning. The new organizational model appoints select staff nurses to be junior-level managers, providing them with stretch roles and freeing senior managers from staffing and operational responsibilities. The revised structure substantially decreased the department's staff vacancy rate and increased staff interest in management roles.

Prioritizing mentorship reduces staff vacancies

Number of vacant FTEs in telemetry unit



* Total number of FTEs held constant

Source: Nursing Executive Center interviews.

Case Element #1: Revamped organizational model provides stretch roles for staff

Recognizing that staffing and operational responsibilities were diverting unit managers' attention from staff development and succession planning, the telemetry director worked with staff, unit managers, and other nursing directors to revise the organizational structure for her department's three units. Before the change, each unit had one manager, who was responsible for all unit management functions, and one resource nurse, an informal position held by rotating staff members. Under the new configuration, which was implemented in spring 2005, each unit has six clinical managers and one senior clinical manager. The clinical managers, most of whom are novice leaders, oversee staffing and scheduling; direct process improvement initiatives; and mentor staff nurses, allowing them to develop leadership and management skills while they continue to provide bedside care. Meanwhile, the senior clinical managers, who are ultimately responsible for unit performance, coach the clinical managers to achieve unit goals and become seasoned leaders.

Case Element #2: Reapplication process prepares internal candidates for new roles

The department demonstrated its commitment to the new model by asking all unit managers to reapply for the senior clinical manager positions and recruiting internal and external applicants for both new roles. Thirteen staff members selected by their peers developed interview questions for the senior clinical manager candidates—focusing on staff development and communication skills—and then participated in the interviewing and selection process. Once chosen, the senior clinical managers worked with the department director to select the clinical managers. Most of the job openings, including one senior clinical manager position and 17 of the 18 clinical manager positions, were filled by internal candidates. Following their selection, clinical managers attended an orientation; they continue to meet monthly with their senior clinical managers for additional coaching.

Case Element #3: Tailored development plans encourage most promising leaders

In the four months following implementation of the new model, the department's staff vacancy rate fell dramatically, and three of the 18 clinical managers expressed interest in pursuing the senior clinical manager role. These managers have worked with their senior managers to create tailored development plans that include elevated roles on system-level teams and application for hospital leadership awards.

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." The Center is currently offering a teleconference series based on this material. For more information on the teleconference series or to register, please visit www.advisory.com/nec. Members interested in scheduling an onsite presentation based on NEC research should contact Kate Palm at palmk@advisory.com.

JOURNAL REVIEW**JONA: Recruit inactive nurses with flexible schedules, shorter shifts**

Writing in the April 2006 *Journal of Nursing Administration*, Kimberly Williams, assistant professor at the University of South Alabama College of Nursing, and colleagues discuss their study of inactive RNs and the factors that could bring them back to the workforce. According to the Health Resources and Service Administration's National Sample Survey of Registered Nurses, there were 151,900 inactive U.S. nurses under age 50 in 2000. The authors say that reinstating many of these inactive nurses could help alleviate the current nursing shortage and that hospitals could successfully recruit them by offering part-time positions and flexible schedules.

Methodology

Researchers mailed a questionnaire to a randomly selected group of 245 RNs from the Mississippi Board of Nursing's list of 428 inactive nurses under age 60. The 170 RNs who completed and returned the survey spanned all areas of clinical practice, and nearly half had been out of nursing for five to 10 years; 50% of respondents had associate's degrees, 35% had bachelor's degrees, and 45% had master's degrees.

Parenting, long shifts are RNs' top reasons for leaving the profession

Survey questions focused on factors that could encourage inactive RNs to return to the workforce. Given 13 options for why they left the nursing profession, 28% of respondents cited parenting duties and 14% cited long shifts. Although 13% of respondents cited "salary" as their reason for leaving the nursing profession, it was not an important factor for 44% of the participants. In response to an open-ended question about why nurses left the profession, the most common reasons were personal illness/disability and stress or burnout.

Many inactive RNs would return for part-time schedules, decreased workload

The study found that 48% of respondents would return to nursing if they could work part-time and 36% would return to work if their patient load decreased. Only 9% of respondents said they would be willing to return to work full-time, and the majority of those who would consider returning to work in some capacity preferred day shifts, with 41% willing to work 10 a.m. to 2 p.m. during the week or on Saturdays, which are peak times for many hospitals. Among disabled RNs, 41% were willing to perform non-patient care duties.

Given the survey results, the authors conclude that nurse executives can best encourage inactive nurses to return to work by providing decreased workloads and flexible schedules, including part-time work, shorter shifts, self-scheduling, and split shifts. The authors note that these strategies also would likely help retain current RNs. However, the authors suggest that nurse leaders first schedule full-time staff and allow part-time staff to choose from the shifts that are left to avoid dissatisfaction among full-time staff. The authors also suggest that nurse executives analyze the strategies they use to retain current nurses and extend those strategies to attract inactive nurses. Moreover, the authors recommend tapping into the pool of inactive disabled nurses by offering them lighter, nonclinical workloads.

Make broad-based work environment improvements to facilitate re-entry

In response to open-ended questions about what would bring RNs back to the workforce, the most frequent responses were refresher courses and flexible work environments; respondents rated educational accommodations and increased input in decision-making as the least influential factors. The study also found that nurses were moderately satisfied with their previous careers, with neither strong satisfaction nor strong dissatisfaction in any area. Therefore, the authors suggest that broad improvement on multiple fronts—including autonomy, organizational policies, professional status, and co-worker relations—would boost the work environment and make inactive nurses more likely to return. The authors also write that developing refresher courses would be a cost-effective, practical way to facilitate re-entry into the profession.

Abstracted from: Williams K et al., "Inactive Nurses: A Source for Alleviating the Nursing Shortage?" Journal of Nursing Administration, April 2006, 36 (4): 205-210.

JOURNAL REVIEW**Request help, communicate clearly to smooth transition into leadership role**

Writing in the April 2006 *HR Magazine*, Jim Jenkins—president of Frederick, Md.-based Creative Visions Consulting, a change management firm that helps CEOs, managers, and supervisors develop their leadership skills—offers advice to recently promoted managers on acclimating to their new role. Jenkins writes that many organizations “thrust new, untrained employees into positions of authority with little or no formal training” and that embarking on a new management role without proper training can decrease managers’ morale and lead to higher turnover. However, employees who move from frontline to management positions can prepare themselves for their new role and ultimately have a positive impact on their team by assessing the strengths they bring from their previous role, asking others for help in developing needed leadership skills, and targeting communication to motivate their team.

Assess skill gap to leap from frontline to management level

Jenkins writes that new managers must first realize the full scale of the transition from individual contributor to supervisor to move successfully from their old role to their new role. Acknowledging the magnitude of the transition requires managers to let go of many aspects of their old role—including some hands-on activities—and take on the responsibility of ensuring that the work is performed correctly by others. To make a clean transition, Jenkins suggests that new managers take a day away from the office to “reflect on [their] old responsibilities and consciously consider the focus of [their] new role.” Managers then will be able to identify the skills from their former role that are still applicable to their new role and recognize the managerial skills they still need to develop.

Ask for help from both supervisors and subordinates

The author says one of the worst mistakes new managers make is trying to avoid admitting that they don’t know everything about their new role. Jenkins writes that acknowledging ignorance and asking for help does not demonstrate weakness but rather a willingness to learn. Therefore, Jenkins encourages managers to consult with a mentor, coach, or human relations representative as an “objective third party” to help identify the skills that managers need to develop. Then, managers should ask for organizational support to fill in the skill gaps. Because new managers can have trouble prioritizing, they also should speak with their supervisors to clarify their expectations and “ultimate objectives” related to the organization’s strategic goals; this information will help managers lead their team with confidence toward the organization’s goals. The author also suggests that managers talk with peer team leaders to find out how they managed the initial transition to their positions.

In addition to asking for help from supervisors and coworkers, the author suggests bringing questions to staff members. Because staff often are able to “see through” managers who are unsure of themselves, managers who solicit input from their own team members when making decisions can establish greater credibility than those who pretend they have “all the answers.” Jenkins adds that asking subordinates for advice also can “facilitate an instant bond.”

Tailor team communication to language of leadership

As managers come up to speed on the various aspects of their new role, they also must learn the best way to communicate with their team. To “elicit great performance [and] achieve company goals,” new managers must “make effective requests, delegate with clear guidelines for performance, and provide effective feedback.” To provide the best motivation, new managers should articulate clear, specific instructions on team goals and highlight the resources available to achieve those goals, Jenkins says, adding that it also is important to use inclusive language that speaks to the growing diversity of the workforce in terms of gender, race, and nationality. To further harness the power of language to promote team building, the author suggests devoting 15 to 30 minutes per week to engage in “some form of healthy dialogue” with the team.

“The reality is that learning leadership communication skills is like learning a foreign language.”

Abstracted from: Jenkins J, “Getting Up to Full Speed,” HR Magazine, April 2006, 51 (4): 117-120.

JOURNAL REVIEW

American Journal of Nursing: Many hospital nurses work longer hours than recommended by IOM

Writing in the April 2006 *American Journal of Nursing*, Alison Trinkoff, professor at the Baltimore-based University of Maryland School of Nursing, and colleagues discuss their finding that many hospital staff nurses work longer than the IOM's recommended maximum of 12 hours per day. The authors said this information should "raise industry-wide concerns about fatigue and health risks to nurses as well as the safety of [their] patients" and suggest collaboration among health care leaders to set optimal scheduling limits.

Methodology

As part of the ongoing Nurses Worklife and Health Study, which examines work influences on nurses' health, researchers mailed an eight-page questionnaire to a nationally representative sample of 5,000 active RNs in two states between November 2002 and March 2003; 2,273 RNs responded to the survey, which asked nurses to describe their work schedules in the preceding six months, including shifts, breaks, overtime, and on-call requirements. Respondents spanned multiple positions and health care settings, with about 67% of the total sample describing themselves as staff nurses and 59% of respondents reporting working at a hospital.

Hospital nurses work long days, fail to take breaks

Of respondents in all care settings, 16.5% of staff, 4.1% of managers, and 6.8% of advanced practice nurses reported regularly exceeding the IOM's proposed work-time guidelines, which also recommend against nurses working more than 60 hours per week. Hospital staff reported working more than 12 hours per day more frequently than nurses in any other work setting ($p < 0.001$); 30.6% of hospital staff nurses ($n = 1,020$) reported working 13 or more hours per day at least every other week, compared with 22.5% of all nurses who participated in the study ($n = 2,273$). However, hospital staff nurses were less likely than nurses who work in other settings to report working more than five days per week ($p < 0.001$), with only 2.6% of hospital nurses reporting working six or seven days per week, compared with 5.2% of the overall sample. In both the total sample and the subset of hospital staff nurses, only 5.9% of respondents reported working 60 or more hours per week. The authors explain that hospitals are more likely to schedule compressed workweeks with fewer, longer days and note that despite the long hours, 11% of hospital nurses reported that they typically did not take breaks during their shift.

Overtime, on-call hours compromise time off

The study also found that the primary jobs of 16.7% of the total sample and 18.4% of the hospital nurses included mandatory overtime, and two-thirds of these respondents said they are required to work overtime with less than two hours' notice. Moreover, on-call requirements were "very common" among the total sample (38.6%) and more prevalent among hospital staff (43.5%). For both the overall sample and hospital staff, jobs requiring on-call hours were significantly more likely to also have mandatory overtime ($p < 0.0001$). These findings led the authors to conclude that "for many nurses, time off the job was not well protected."

Authors recommend 'collective action' to improve nurses' working conditions

The authors say that the percentage of nurses exceeding the IOM's recommended hours and the common combination of mandatory overtime and on-call status is unhealthy and dangerous. They note that long work hours often result in nurse fatigue and lower retention rates, therefore leading to staff shortages and a need to extend the hours of already-tired nurses. The authors conclude that nurses, employers, and policymakers should take "collective action" to improve working conditions by offering predictable work hours and giving nurses greater control over their schedules. State and federal efforts to limit or prohibit mandatory overtime also should be studied to determine if they have been effective in increasing nurse recruitment and retention.

Abstracted from: Trinkoff A et al., "How Long and How Much Are Nurses Now Working?" American Journal of Nursing, April 2006, 106 (4): 60-71.

ON OUR WATCH

Care Quality

Tracking news, strategies, and the latest research

N.J. hospitals seek to reduce bedsores through statewide initiative

A group of 125 New Jersey health care organizations—including hospitals, nursing homes, home health care agencies, and rehabilitation centers—have launched the first statewide effort to track pressure ulcers in an effort to prevent the painful sores, which cost the nation \$1.3 million to \$3.6 billion to treat each year, the Newark *Star-Ledger* reports. New Jersey hospitals reported 99 cases of the deepest and most dangerous types of pressure ulcers during a recent one-year period, making the wounds the second most common preventable adverse event in state hospitals after falls. In response, the New Jersey Hospital Association provided \$150,000 to “bring protocols and knowledge back to bedside nurses” and help pay for nurses to attend training seminars. The seminars teach nurses to use a checklist to determine which patients are at the greatest risk for developing pressure ulcers. In addition, nurses are instructed to routinely monitor the blood pressure and body temperature of patients who are confined to bed because of recent surgery, illness, injury, pain, or paralysis. To prevent sores from developing in high-risk patients, including those with incontinence, low blood pressure, poor nutrition, and dehydration, nurses help immobile patients move around at least every two hours, apply moisturizer to dry skin, and work to improve patients’ nutritional intake. New “tissue-redistribution mattresses” also are used to reduce pressure on areas of the body prone to developing sores, including the tailbone, heels, hips, and elbows. Although there has been no official data collected on how the collaborative is affecting bed sore rates at New Jersey hospitals, a state hospital association official said some facilities have informally reported as much as a 50% decline in bedsores since the program began last September (Campbell, *Star-Ledger*, 5/7/06; AP/*Kansas City Star*, 5/7/06).

Duke’s APN-led training program aims to improve post-discharge care

A new program at Durham, N.C.-based Duke University Medical Center aims to improve post-discharge care for elderly cancer patients and reduce costly ED visits by providing at-home caretakers—usually friends and family members of the patients—with specific training to meet their loved ones’ complicated medical needs, the Raleigh *News & Observer* reports. Using a \$195,000 grant from the National Institute of Nursing Research, Duke researchers plan to study the success of the program, which will enroll 120 caretakers over a two-and-a-half-year study period. Advanced practice nurses will provide each caregiver with two hours of case-specific training in basic care measures such as ensuring good nutrition, recognizing signs of depression, checking a patient’s blood sugar, identifying infections, and anticipating side effects of medication and radiation. Duke researchers will track the physical and mental well-being of both patients and caretakers throughout the program, which they hope will “enhance the safety and skill with which a family member can offer care” and reduce instances in which a patient must return to the hospital. After completing the initial research project, researchers then will study whether the program reduces hospital costs. Although the program is targeted specifically at caregivers for older cancer patients, the initiative could apply to the roughly 1.7 million state residents and 50 million U.S. residents who spend time providing care for an older family member or friend (Goldsmith, 5/10/06).

Website provides health care information, common phrases in Spanish

The Virginia Department of Health has developed a website that provides common health care information in Spanish and offers guidelines to help English-speaking providers communicate with patients who speak only Spanish, the *Richmond Times-Dispatch* reports. The website—created to meet the needs of Virginia’s growing Hispanic population—offers translations of commonly used health care phrases such as, “You are going to feel a needle stick” and “I need to draw a blood specimen.” The website also provides links to resources on cultural differences in immigrant populations that can affect health care delivery. State officials plan to add audio features to the site so users can hear how words are pronounced and eventually add health care information in as many as 24 different languages (Smith, 5/12/06).

Politics, Rules, & Regs

Regulations, legislation, and the debates they spark

Mass. lawmakers to vote on nurse staffing measure

The Massachusetts House of Representatives next week is expected to debate and vote on a measure that would require the state Department of Public Health to limit the number of patients a single nurse could be required to care for at any given time but would not establish fixed nurse-to-patient ratios, the *Worcester Telegram & Gazette* reports. The bill would identify an “optimum” nurse-to-patient ratio that hospitals should strive for and a maximum ratio that hospitals could not exceed except in emergencies. Hospitals could be fined up to \$3,000 for exceeding the ratio at other times. The bill also includes provisions to fund nursing scholarships, nursing faculty, and refresher courses for nurses returning to the bedside. If the bill becomes law, the health department would have up to 18 months to develop the staffing standards based on scientific data. Hospitals would need to implement the plans by 2010, but financially strained hospitals would be permitted to delay implementation for six months. The Massachusetts Nurses Association strongly supports the measure, saying that unenforced staffing levels could lead to substandard patient care and cause nurses to leave the profession. However, the Massachusetts Hospital Association opposes the latest version of the measure, saying that the state should measure hospital performance by hours of care per patient day—including care by nursing assistants, physical therapists, and other staff—rather than by a strict RN-to-patient ratio. A competing state Senate measure, sponsored by Sen. Richard Moore (D-Uxbridge), would confront the state nurse shortage by providing financial incentives to recruit more nursing students and faculty, limiting mandatory overtime, requiring hospitals to post nurse staffing plans, and making the state collect more staffing data from hospitals (Sutner, *Telegram & Gazette*, 5/8/06; Brodtkin, *MetroWest Daily News*, 5/19/06; Ring, *Springfield Republican*, 5/9/06; Norris, *Springfield Republican*, 5/3/06).

Recruitment & Retention

News on hospital strategies from across the nation

California’s nurse-to-resident ratio 20% below national average

A report from the Berkeley-based California Institute for Nursing and Health Care found that California has significantly fewer nurses per 100,000 residents compared with the U.S. average, the *San Francisco Business Times* reports. According to the study, California has an average of 622 RNs per 100,000 residents, which is 20% below the national average of 787 RNs per 100,000 people. For the study, researchers from the VA Long Beach Healthcare System and the University of California-Irvine, School of Medicine analyzed data from the Employment Development Department and the Bureau of Labor Statistics for 24 metropolitan regions in California. No regions in the state greatly exceeded the national average for nurse density, and many areas in the state fell far below the national average. Officials noted that high housing costs in some areas of the state make it difficult to hire qualified nurses, while the nursing shortage and the state-mandated minimum nurse-to-patient ratios have forced hospitals to rely on traveling nurses, require overtime, and reduce the number of hospital beds. To improve the nurse-to-resident ratio, the California Institute for Nursing and Health Care executive director suggests that hospitals support nursing schools by providing scholarships and other financial backing and that schools help hospitals with their recruitment efforts (Rauber, *San Francisco Business Times*, 5/9/06; Purewal, *Monterey County Herald*, 5/10/06).

Labor Relations

News on union activity and staff relations

OR nurses give surgeons low marks for teamwork

A new study from Baltimore-based Johns Hopkins University has found that operating room (OR) nurses and surgeons have very different views about the current quality of collaboration and communication in the OR, raising concerns that poor teamwork could increase the risk of medical errors, *HealthDay* reports. “Basically, the surgeons thought there was great teamwork, and the nurses thought there was terrible teamwork,” said Dr. Martin Makary, an assistant professor at Johns Hopkins School of

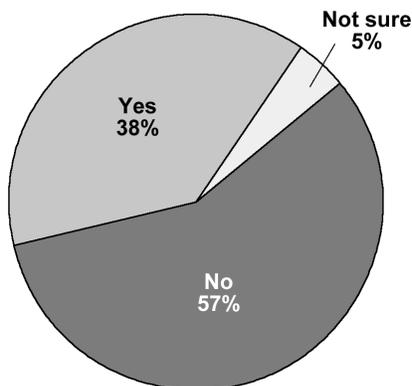
Medicine. The researchers surveyed 2,135 OR workers at a large, Catholic health system with about 60 hospitals in 16 states using a survey adapted from one that measures aviation workers' attitudes about flight safety communication in the cockpit. The study found that circulating and scrub nurses scored the highest in teamwork, while surgeons scored the lowest. In fact, most surgeons reported that everyone on the team—themselves included—communicated and collaborated effectively and that 87% of nurses “demonstrated a high level of teamwork.” However, less than half of nurses rated surgeons' teamwork skills highly. A project director at the Cambridge, Mass.-based, not-for-profit Institute for Healthcare Improvement (IHI) said the “gap in perceptions speaks to the way nurses and physicians are trained,” with nurses taught to collaborate and surgeons trained to act as “captain of the ship.” Furthermore, surgeons who are not receptive to feedback or do not “naturally invite people to talk” may discourage OR personnel from bringing up questions or concerns about patient safety. In response to the findings, Johns Hopkins now requires OR teams to participate in pre-surgery briefings modeled on cross-checks performed by flight teams prior to take off. During the briefings, team members introduce themselves, review goals and expectations, and discuss concerns. However, the IHI project director noted that unless surgeons encourage the team members to speak up, briefings likely will not improve communication (Pallarito, *HealthDay/Yahoo! News*, 5/5/06).

Fast Fact

Health care organizations less likely to have succession plans, study says

Development Dimensions International, which aims to help businesses hire quality employees and develop exceptional leaders, recently released a study on the current state of health care leadership. The study was based on responses from 504 leaders of about 25 health care organizations. According to one of the study's findings, health care organizations are 20% less likely than other organizations to have succession plans in place. In addition, health care leaders at organizations with succession plans said such plans were in place for only about 18% of management and leadership positions (DDI, Health Care Global Comparison Leadership Forecast 2005/2006).

Percent of health care leaders who say their organization has a succession plan



Source: DDI, Health Care Global Comparison Leadership Forecast 2005/2006.

ANNOUNCEMENT**Nursing Executive Center offers teleconference on online Best Practice Compendium**

The Nursing Executive Center is pleased to invite members to participate in a teleconference introducing the online Best Practice Compendium, the Center's next-generation research library, on **Tuesday, May 23 from 2 p.m. to 3 p.m. EDT**. Across the past seven years, the Center has published hundreds of best practices for enhancing nursing's operational, clinical, and business performance. To improve member access to the Center's past work, the Compendium offers instant access to more than 250 best practices across 40 research initiatives—all individually downloadable and organized into easily understandable categories. All interested executives, managers, and staff at member institutions are highly encouraged to participate.

For more information

For more information or to register, please visit the NEC homepage at www.advisory.com/nec or contact Tonushree Jaggi at jaggit@advisory.com or 202-266-5841.

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