

Charting Nursing's Future

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Reports on Policies That
Can Transform Patient Care

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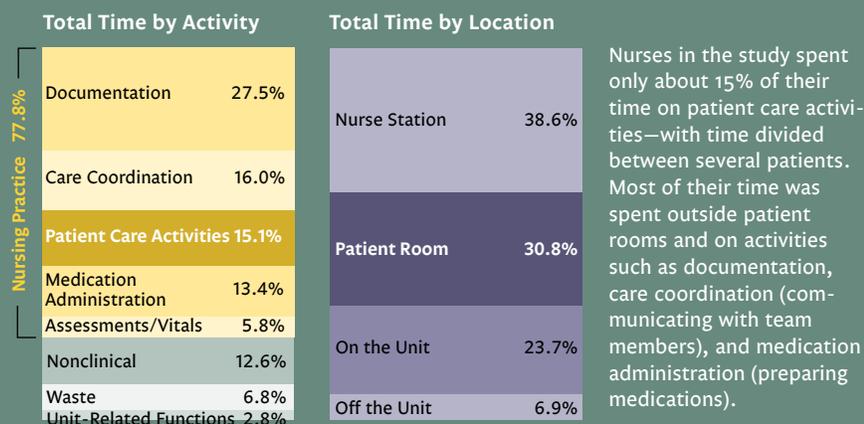
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Addressing the Quality and Safety Gap—Part I: Case Studies in Transforming Hospital Nursing and Building Cultures of Safety

Between 44,000 and 98,000 Americans die each year as a result of hospital errors, while many others sustain serious injuries, according to the Institute of Medicine's groundbreaking report *To Err Is Human* (1999). As the largest single health care workforce, nurses are playing a leading role in addressing this alarming problem. This issue of the series begins a three-part exploration of quality and safety innova-

tions by looking at how four health care systems and a state government are using quality improvement strategies to strengthen care processes, optimize staffing, and promote safe work habits. Policy recommendations appear on page 8. For more on safety and quality, see Part II (issue 11), exploring health information technologies (HITs), and Part III, examining evidence-based physical design, due out in 2010.

Figure 1 How Medical-Surgical Nurses Spend Their Time



Source: Adapted from data and conclusions presented in Hendrich, A., M. Chow, B. A. Skierczynski, and L. Zhenqiang. 2008. A 36-hospital time and motion study: How do medical-surgical nurses spend their time? *Permanente Journal* 12:25–34. Percentages for this chart are recalculated from time values presented in the original study.

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The Value of Nursing



Photo: Prairie Lakes Healthcare System



Photo: Bill Pollard/Cedars-Sinai Medical Center

Substantially increasing nurses' time for bedside care and eliminating errors and waste are major innovation themes.

Medical-surgical nurses at Prairie Lakes Healthcare System (far left) have gained more time for bedside care by working in new “Agile Teams” and streamlining other activities by using wireless portable computers, hands-free walkie-talkies with earbuds, and bar code technology.

Nursing teams on Cedars-Sinai Medical Center's new “Universal Floor” (near left) are educated to provide multiple levels of care so critical care patients can remain in the same room throughout their stay—avoiding unit transfers that can waste staff time and increase the risk of errors.

Creating Highly Reliable Organizations

Why does American hospital care claim more needless fatalities each year than do motor vehicle accidents (43,458), breast cancer (42,297), and AIDS (16,516), according to *To Err Is Human* (Institute of Medicine, 1999)?

Patient acuity (severity of illness) and workforce trends are part of the problem. Cost containment has caused an escalation in patient acuity that makes the nursing practice environment more complex and stressful. “The ICU patient of the 1970s is today’s medical-surgical patient,” says Marilyn P. Chow, RN, DNSc, FAAN, vice president, National Patient Care Services, Kaiser Permanente, and director of the Robert Wood Johnson Foundation Executive Nurse Fellows Program. And though patients are sicker, hospital stays are shorter.

For nurses, this means much more frequent admissions, transfers, and discharges, more complicated conditions to treat, and less time to provide bedside care and develop relationships with patients and families. Nursing workforce shortages—expected to reach 285,000 nationally by 2020—compound these problems.

Yet there is another, deeper cause for health care’s troubling safety and quality record. Many factors leading to safety failures are systemic—caused not by the poor performance of an individual employee but rather by flawed systems and dysfunctional interactions between interdependent systems, according to *To Err is Human*.

For example, taking steps to reduce crowding in the emergency department will cause congestion in other departments unless flow is reorganized hospital-wide.* Without system change, overwhelmed nurses downstream from the emergency department will be forced to patch together a work-around that is likely to fail at some point.

“More attention needs to be given to the design of the care delivery system and how components work together,” says Kerm Henriksen, PhD, human factors adviser for patient safety, Center for Quality Improvement and Patient Safety, Agency for Healthcare Research and Quality. “Work-arounds and quick fixes exhaust nurses and hide underlying system problems. Nurses need to see themselves as change agents of the system, not just fixers of the immediate problem. This will require leaders to practice—and support nurses and other providers in practicing—the five tenets of highly reliable organizations” (see “Five Tenets” below).

Leaders must also give employees tools that promote safe personal work habits, say experts (see pages 6–7).

The following case studies highlight the methods and early results of organizations striving successfully for greater reliability (see pages 3–7). Their difficult work—often undertaken against stiff resistance to change—is marked by strong executive nurse leadership, empowerment of frontline nurses, collaborative approaches, and rapid field-testing of ideas. Innovators are also bringing technology and the physical design of hospital units into supportive alignment with new care processes and staffing models.

These transformations are producing safer, more patient-centered care and, often, reduced nurse turnover.

For a look at how policymakers can drive advances in safety and quality, see pages 7–8.

For More Information

• Visit: <http://www.rwjf.org/pr/product.jsp?id=33055> for tools from Transforming Care at the Bedside (TCAB), a major quality improvement initiative jointly led by the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement (IHI).

*See Harrison, M., K. Henriksen, and R. G. Hughes. 2007. Improving the health care work environment: A sociotechnical systems approach. *The Joint Commission Journal on Quality and Patient Safety* 33, suppl. no. 11:3–6.

The Five Tenets of Highly Reliable Organizations

- 1. Preoccupied with Failure:** Focused on ways systems can fail and courageous about acting on their concerns.
- 2. Resistant to Oversimplification:** Inclined to question conventional or convenient interpretations for failures.
- 3. Sensitive to Operations:** Constantly integrating broad-ranging information and the actions of others into a big picture.
- 4. Committed to Resilience and Self-Examination:** Mindful of past errors and planning ahead to prevent future errors.
- 5. Deferential to the Best Expertise:** Responsive to the knowledge of those closest to the action, regardless of their rank or organizational power.

Adapted from Henriksen, K., E. Dayton, M. Keyes, P. Carayon, and R. G. Hughes. 2007. Understanding adverse events: A human factors framework. In *Patient safety and quality: An evidence-based handbook for nurses* (prepared with support from the Robert Wood Johnson Foundation), ed. R. G. Hughes, 1:67–85, 08-0043. Rockville, MD: Agency for Healthcare Research and Quality. For the original five tenets, see Weick, K., and K. Sutcliffe. 2001. *Managing the unexpected: Assuring high performance in an age of complexity*. San Francisco: Jossey-Bass.



“Work-arounds and quick fixes exhaust nurses and hide underlying system problems. Nurses need to see themselves as change agents of the system, not just fixers of the immediate problem. This will require leaders to practice—and support nurses and other providers in practicing—the five tenets of highly reliable organizations.”

Kerm Henriksen, PhD, human factors adviser for patient safety, Center for Quality Improvement and Patient Safety, Agency for Healthcare Research and Quality

On-the-Job Nurse Education Enables Major Care Improvements

Case Study: Cedars-Sinai Medical Center

Creating a “Universal Floor”

U.S. hospitals often devote only 1 to 3 percent of their nursing budgets to education, says Ann Hendrich, RN, MSN, FAAN, vice president, Clinical Excellence Operations, Ascension Health. Yet broadening the skills of nurses is imperative, she says, because nurses are caring for sicker patients and because transferring patients repeatedly to different levels of care is problematic: “Hospitals cannot, for example, afford the costs and risks of transferring every complex medical-surgical patient to and from a critical care bed as acuity changes.”

To address these challenges, Cedars-Sinai Medical Center (C-S), a 952-bed academic center in Los Angeles, California, has implemented a Universal Floor (UF). Inspired by a model Hendrich helped pioneer,* its UF allows certain patients to remain in one adaptable room and bed while receiving different levels of care from nurses who have received specialized on-the-job education. The UF admits patients with a variety of critical care diagnoses and acuities (though not pediatric cases or patients needing ICU care or ventilator support).

The model’s capacity to eliminate transfers is no small blessing, given that on average nationally, 40 to 70 percent of patients on the typical inpatient nursing unit are transferred every day, and many patients move three to six times during their hospital stay, say experts.

Research shows that patient transfers carry significant risks of harm because of lost information, delays in treatment, and incompatibilities in unit record-keeping systems. Transfers may also waste staff time and supplies.



“We have increased nurses’ time in direct patient care by decreasing documentation, placing patient supplies inside the room, and improving teamwork.”

Linda Burnes Bolton, DrPh, RN, FAAN, vice president and chief nursing officer, Cedars-Sinai Medical Center.

“We need to look at systems, processes, and equipment with the patient at the center of our attention,” says Joanne Pileggi, RN, MSN, manager of the UF. “We need to ask, ‘How will the process affect and engage the patient?’”

C-S did extensive research before establishing the 30-bed unit in a new tower. An interdisciplinary team led by nurses spent a full year examining patient and staff work flows, using Transforming Care at the Bedside quality improvement tools.

C-S recruits nurses from feeder units such as its ER, ICU, and medical-surgical floors. Recruits complete a critical care course, do in-service education on special topics, and shadow critical care nurses before becoming part of an eight-person UF nursing team. C-S provides additional compensation to nurses who earn certification in care specialties.

Special technological and design features support the teams. The headwalls of beds accommodate infusion and monitoring devices for different levels of care, beds incorporate alarms and scales to minimize the risk of patient falls, and all rooms can be set up for telemetry surveillance. Placing work stations next to rooms and supply carts in rooms has reduced wasteful nurse travel time. A cell phone-based messaging system gets critical lab values to appropriate caregivers and signals when bed alarms sound—“a big patient safety benefit,” says Ray Hancock, RN, MSN, director of Critical Care Services.

Hancock has also seen positive staffing and efficiency outcomes. “We’ve been able to accommodate internal staff with no outside recruitment, and my new-hire turnover rate



Photo: Bill Pollard/Cedars-Sinai Medical Center

Locating supply cabinets in patients’ rooms saves nurses hunting-and-gathering time that can be better used for bedside care.

has been reduced dramatically.” Because UF patients are directly admitted—bypassing the ER—congestion there has eased. Two more units will adopt UF no-transfer features in 2009.

“Career Pool” Aims to Reduce Use of Agency Nurses

Registry, or agency, nurses typically work on a per diem basis as “floating” part-timers hired from outside a hospital. They are objectionable to permanent employees who often see them as unprepared for the variety of unit assignments they receive.

As part of its commitment to error reduction, C-S is building an in-house professional pool of full-time permanent nurses who develop clinical competencies in more than one of eight areas. The pool—now 110 strong and growing—is defined as a nursing unit, with its own staff meetings and quality improvement initiatives. Member nurses receive a 10 percent pay differential and an additional 3 percent for each certification they earn.

“Career Pool nurses make 90 percent fewer errors than agency nurses and get quite a few ‘standing ovations’ from patients,” says Michael Roberts, RN, MAOM, C-S director of Nursing Resources.

For More Information

• Email: Linda Burnes Bolton at Cedars-Sinai (linda.burnesbolton@cshs.org).

*The Methodist Hospital campus of Clarian Health (Indianapolis, Indiana) implemented a Universal Floor in 1999.

“Agile Teams” Increase Bedside Care and Nurse Retention

Case Study: Prairie Lakes Healthcare System

“Train wreck.” That’s how Jill Fuller, RN, PhD, chief nursing officer at Prairie Lakes Healthcare System (PLHS), described nursing morale, productivity, and turnover on the medical-surgical unit when she and the rest of the system’s new leadership team arrived in 2000 to take up the reins of the 81-bed rural community hospital in Watertown, South Dakota.

Shelly Turbak, RN, BSN, the unit’s current director, remembers the situation vividly: “It felt like bedside nurses were deprofessionalized. We had gotten into a ‘Mamma, may I?’ culture—with floor nurses having to go through charge nurses to get information to and from doctors. There were too many policies, no teamwork, a sink-or-swim mentality, and a 65 percent nurse turnover rate.”

Transforming the Care Model

Nurses found the 90-minute admissions process especially stressful. Often called on to admit a patient when already overloaded, an unaided nurse would have to gather supplies from distant storage areas, assess the patient, establish a written plan of care, give prescribed medication and other treatments, and complete 14 separate paper records—some of which were redundant.*

“If you have too many cognitive shifts and policies in an environment, there won’t be enough time to think,” says Fuller. “So how do you engineer an environment so nurses can do critical thinking and use clinical judgment?”

With intense support from the Institute for Healthcare Improvement’s Breakthrough Series Collaborative and later Transforming Care at the Bedside, small frontline staff groups began finding solutions, by using rapid-cycle testing of ideas for change.

Turbak explains management’s approach: “Instead of saying, ‘You don’t know what you are doing, and we are going to control your every move,’

*Facts in this paragraph are from the cited articles.

we said, ‘Your ideas matter, and no idea will be discounted. What ideas are you going to test today?’”

To improve the admissions process, the charge nurse role was eliminated—because this nurse didn’t “touch” patients—and replaced by a “Resource Nurse”

to provide patient care support. A second position, “Care Tech,” was created by cross-training unit secretaries and nursing assistants.

Nurses now work as part of an “Agile Team” consisting of an RN, an LPN, and a Care Tech (or two RNs and a Tech), with the Resource Nurse as backup. Team members are free to determine their respective roles on shifts on the basis of patient needs and census. PLHS has purged 40 percent of its policies to give nurses more room for exercising clinical judgment.

Each team covers a cohort of 10 to 12 patients. Though the nurse-to-patient ratio hasn’t changed (1:4 or 1:5), the teams have dramatically increased staff efficiency and satisfaction, with positive effects on quality and safety (see “Agile Team Outcomes” below).

The Value of Nursing



Photo: Prairie Lakes Healthcare System

Nurses admit new hospital patients with intensive services such as assessment, documentation, and treatment. Prairie Lakes Healthcare System’s “Agile Team” admissions process allows nurses to work in tandem, reducing admission time by an average of 73 percent, boosting nurse retention, and making more time for bedside care.

Aligning Staff, HITs, and Design

Teams are supported with a redesigned electronic medical record built from scratch after the previous paper system was scrapped. Nurses now carry walkie-talkies for instant communication and wireless portable computers that allow for bedside charting, automatic referrals, and clinical decision support, among many other capabilities. Pharmacists work alongside Agile Teams and save them time by reviewing online patient data, dispensing medications, and creating the electronic medication administration record. They also place medications in bedside “patient servers” specially built to hold medications and supplies that nurses previously had to hunt down on foot.

“Agile Teams are wonderful,” says medical-surgical nurse Alissa Iverson, RN. “Your job is so much easier when you work together. Before, nurses were so frazzled.” Unit turnover has plummeted from 65 to less than 10 percent.

- ...For More Information.....
- Email: Jill Fuller (fullerj@prairielakes.com).
 - Fuller, J. 2007. Regarding work intensity, less is more. *Nursing Management* 38:12, 16.
 - Homola, R., and J. Fuller. 2008. Team admission: Changing the way we work. *American Journal of Nursing* 108 (11):35-39.
 - About “Lean Principles” (article on page 5): Contact: Diane Miller (206-341-1600).

Agile Team Outcomes

Down	Admissions Time from an average of 90 to 24 minutes
	Nurse Turnover from 65 to less than 10 percent/year
	Time Managing Paperwork by approximately 50%
Up	Staff Satisfaction from 36% to 83% (2000-2006)
	Nurses’ Time at the Bedside by approximately 27%

Source: Outcomes data taken from articles cited at right in “For More Information.”

“Lean Principles” Standardize and Streamline Key Care Processes

Case Study: Virginia Mason Medical Center

When Rowena Ponischil, RN, MSN, began as nurse manager of the Intermediate Care and Telemetry units of Virginia Mason Medical Center (VMMC) in 2004, surveying the long hallways of her new work home made her feel like she was inside a “pinball machine. Call lights were going off all the time. Patients were falling. Staff were walking fast. It seemed like chaos.”

Work Process Problems

Under the chaotic surface were a host of work process problems. In the 27-bed Telemetry Unit—where heart patients are continuously monitored electronically and nurses must be free to respond to distress signals at a moment’s notice—random nurse-patient assignments forced staff to work the whole hallway, supplies were stored far away from the bedside, staff frequently missed breaks, and the nursing budget was chronically in the red.*

“Health care has been, for the most part, an ‘artisan’ industry,” says Charleen Tachibana, RN, MN, senior vice president, hospital administrator, and chief nursing officer at VMMC, as well as point person for process improvement in the 336-bed Seattle hospital. “It hasn’t had the ability to develop products with high standards. It has seen itself as different from other industries, and it has focused on innovating with technology, not systems and work processes.”

In 2002, after being rocked by both financial problems and the Institute of Medicine’s seminal reports on quality and safety, VMMC committed to becoming a national leader in quality health care. Following a yearlong study of the Toyota Production System, VMMC adopted Toyota’s “Lean Principles” for its new management model, the Virginia Mason Production System.

In 2005, a Rapid Process Improvement Workshop (RPIW) made up of nurses, patient care technicians, and a patient brought Lean Principles to Telemetry. Its goal was to rid care

processes of waste and variation so that patients would receive the services they needed on time, every time, without errors.

Lean Transformations

After study and measurement of existing work processes, the RPIW implemented and tested a series of Lean concepts that have since become the norm.

A nurse’s patients are all located in a U-shaped cell to minimize walking, morning rounds are sequenced to meet all the immediate needs of one patient before moving to another, nurse-to-nurse patient handoffs during shift changes are scripted to avoid errors and occur at the bedside to involve the patient (see picture and caption below), supplies are delivered to bedside containers as needed, and a flagging system highlights the status of patients, nurse staffing, and supplies so that reinforcement can be seamless.*

These changes have dramatically reduced waste (see table 1), giving nurses more time for bedside care. Complications such as skin breakdown and falls have been reduced, and the heavy use of call lights has ended. “It took us out of chaos,” says Ponischil. “The bedside handoff has improved safety and caused patient satisfaction to skyrocket.”

The Challenges of Change

Lean Principles have now spread to all inpatient units. Both Ponischil and Tachibana freely acknowledge the huge demands change has made and the resistance it has encountered.

Jane Hill-Littlejohn, RN, BSN, CCRN, chairperson and grievance officer for the VMMC local unit of the Washington State Nurses Association, articulates what she regards as a common staff position. While acknowledging that Lean Principles have worked in some of the small departments with predictable patients and processes and for functions such as supply stocking and billing, she sees problems with Lean applications for more complex situations: “Patient acuity is the wild card. If you happen to get three high-acuity patients at once, you may need to split up the cell, which means more walking and less time for patient needs. It’s important to recognize that Lean can’t fix everything. We’re dealing with sick people, not new cars.”

Tachibana sees criticism as inevitable with difficult and constant change. “We’ve had a cultural shift from, ‘Aren’t we good!’ to ‘Where’s the next area to look for errors and come up to higher levels of reliability?’ It’s not an easy shift to make. And it’s pick-and-shovel work unraveling these complex processes and simplifying them. We’ve got a long way to go.”

A Commitment to Creating “Standard Work” and Banishing Waste



Photo: Bob Riedinger/VMMC

Two VMMC nurses complete a patient hand-off at shift change. To avoid errors, handoffs now occur at the bedside where nurses can evaluate their patients directly. A memory prompt called SBAR ensures a standardized review of patient **situation** and **background**, an **assessment** of greatest patient safety risks, and **recommendations** for care.

Table 1
Reduced Waste in Telemetry Unit

Activity Metric	% Reduction
RN Distance Traveled	85
RN Cycle-of-Care Time	48
RN Hunting/Gathering	85
Supply Set-up Time	85
Patient Call Light Use	100
Overtime	2
RN Hours/Patient-Day	7 (below budget)

*Source (for table and selected case study facts): Adapted from Nelson-Peterson, D., and C. Leppa. 2007. Creating an environment for caring using lean principles of the Virginia Mason Production System. *Journal of Nursing Administration* 37 (6):287-94.

Promoting a Culture of Safe Work Habits and Behaviors

Case Study: Sentara Healthcare

Frustration with the slow pace of change put Sentara Healthcare on a path to becoming a “robust culture of safety,” says Gary Yates, MD, chief medical officer. An integrated system in southeastern Virginia, Sentara includes seven hospitals, 10 senior facilities, a physician medical group, a member health plan, and a home health/hospice division.

“We had looked at our serious safety event rates, and for about six years that metric hadn’t changed significantly,” says Yates, though Sentara was implementing many innovative safety strategies “We weren’t sure we were giving our frontline people—those at the ‘sharp end’—the skills and tools to impact patient safety.”

Establishing the Five Required Safety Behaviors

In 2002, determined to place new emphasis on human behavior’s role in safety, Sentara consulted experts primarily in the nuclear power industry, who had already spent decades turning complex, high-risk operations into highly reliable organizations (see “Five Tenets,” p. 2).

Sentara’s new approach rests on a “common cause” analysis performed to determine what behaviors were responsible for the most frequent serious safety events. “When we analyzed the most apparent causes of why things failed and patients suffered harm, we could put them into five categories and from these categories develop five Behavior-Based Expectations (BBEs) for error prevention,” says Lois Kercher, PhD, RN, Sentara’s chief nursing officer. The BBEs are now commonly called safety behaviors.

For frontline staff, including nonclinical personnel such as housekeepers and schedulers, the required safety behaviors are (1) pay attention to detail, (2) communicate clearly, (3) have a questioning attitude, (4) hand-off effectively, and (5) never leave your wingman (check and coach the behavior of others, regardless of

their rank). At least one simple tool helps staff remember each safety behavior.

Kercher explains, “Many mistakes occurred when staff did patient handoffs; for example, if pain meds and sedation are administered in the operating room, and you don’t tell nurses back in the patient’s room, you can oversedate a patient.” Now during such handoffs, staff stop momentarily and mentally run through steps cued by a memory prompt called the 5 Ps: patient/project, plan, purpose, problem, precautions. The precautions P would remind staff to mention prior medications. For more on the five required safety behaviors, see “Clear Expectations” below.

Sentara physicians and leaders have separate but related sets of required safety behaviors. “We are trying to create a culture of many small pauses and safer personal habits,” says Yates.

Since the introduction of the five required safety behaviors (2003–2008), Sentara has experienced a 66 percent reduction in its serious safety event rate and a 50 percent reduction in suits and claims.

Adding the Red Rules

To ensure safety in carrying out decision-based acts that have the highest level of risk to patients and staff if not performed correctly, each of Sentara’s 67 departments has created its own short list of so-called Red Rules.

One Red Rule appears on many departmental lists: “Verify and match patient identification with two identifiers [such as social security number and birth date] before administering treatment.”

Clear Expectations and Simple Tools Encourage the Use of Sentara’s Five Required Safety Behaviors

Behavior: Pay attention to detail.

Tool: STAR (stop, think, act, review)

Case example: When an OR nurse opening and counting surgical supplies gets interrupted by a question, she restarts the count to ensure accuracy.

Behavior: Communicate clearly.

Tool: Ask clarifying questions.

Case example: A doctor asks a nurse to administer 25 mg of Fentanyl—not the drug of choice for the patient. The nurse asks, “Do you mean Demerol?” The correct drug for the patient is then administered.

Behavior: Have a questioning attitude.

Tool: Validate and verify.

Case example: An ER nurse notices the same results are reported for three different patients, calls the lab, and initiates retesting. Errors are discovered and corrected.

Behavior: Hand off effectively.

Tool: 5 Ps (patient/project, plan, purpose, problem, precautions)

Case example: A radiology scheduler must schedule an MRI for a non-English-speaking patient who wears an insulin pump—both possible problems for a smooth procedure. As precautions, the scheduler alerts the MRI manager in advance, arranges for translation services, and calls the patient’s daughter to ensure that the patient brings proper documentation to the appointment.

Behavior: Never leave your wingman.

Tool: Peer coaching

Case example: A nursing assistant reminds the chair of the department of surgery to wash his hands and put on a protective barrier before entering a patient’s room.

Source: Adapted from Safety success stories: Examples of behaviors for staff (a compilation of actual experiences shared by staff with Sentara management).

Washington State Staffing Pact Aims for Quality and Safety

“Red Rules are a way to help focus people’s behavior toward acts that promote patient safety,” says Shannon Sayles, RN, MA, formerly Sentara’s director of safety and performance excellence. “You must comply with them or stop and check out the situation with an expert. After all, no one would go around a stopped school bus with flashing lights.”

Work processes are being simplified and physical design made more intuitive to ease compliance with both the five safety behaviors and the Red Rules. A lengthy period of training and practice preceded actual enforcement. Now there are clear consequences for staff who choose not to comply and extra compensation for those who make safety a priority.

For More Information

• Google “AHRQ’s Innovations Exchange” and put “Sentara Healthcare” in the search engine box for a detailed profile and other source references.

The Value of Nursing



Photo: Bill Pollard/Cedars-Sinai Medical Center

Nurses play a critical role in preventing medication errors, yet they are subject to interruptions that can affect their concentration on safety-critical tasks. Cedars-Sinai Medical Center has created separate rooms with “no interruption zones” around medication carts, where nurses (like the one crushing pills above) cannot be disturbed while preparing medication for their patients.

A growing body of research links the safety and quality of patient care, as well as nurse retention, to adequate staffing. Yet efforts to mandate staffing standards through legislation typically end in contentious standoffs between nurses’ unions and hospital associations, tying the hands of legislators.

Until 2008, the Washington State legislature was the scene of many polarizing battles over staffing legislation, says Leo Greenawalt, president and CEO of the Washington State Hospital Association (WSHA). “There was a new staffing bill every year. Positions would get taken, and nothing could be done in the legislature.”

“It had become embarrassing to fight it out with the legislature,” says Gladys Campbell, MSN, executive director of the Northwest Organization of Nurse Executives (NWONE).

In addition to the WSHA and the NWONE, other major players in state staffing policy are the state’s three nurses’ unions, representing some 75,000 active RNs: SEIU Healthcare, 1199 NW; the United Staff Nurses Union, Local 141 UFCW; and the Washington State Nurses Association.

Embracing Collaboration

After yet another staffing bill died in the 2007 legislative session, Greenawalt proposed that all parties participate in an intensive, voluntary dialogue aimed at finding consensus

solutions, with the William D. Ruckelshaus Center providing mediation. Housed jointly at the University of Washington and Washington State University, the center is well known in state government for its expertise in conflict resolution, mediation, and nonpartisan analysis of issues with broad policy importance.

The state legislature—which includes eight nurses—and Governor Christine Gregoire strongly backed the mediation idea and committed to contributing resources to the process.

“Leo’s proposal warranted serious consideration and some trepidation,” says Judy Huntington, MN, RN, executive director, Washington State Nurses Association. “But we were willing to give it every effort to try to reach win-win.”

She and the other union leaders saw voluntary mediation as a way to suspend “the war” so that more productive dialogue could go forward, while maintaining the option of returning to power politics if the process failed.

By February 2008, a steering committee composed of the leadership of all five parties had signed a Memorandum of Agreement and supported legislation (House Bill 3123) that together define several goals to be advanced through steering committee leadership (see “Goals” below).

continued on page 8

Goals to Ensure Quality and Safety

Develop nurse staffing committees in all hospitals drawn from staff and management and composed of at least 50 percent direct-care nurses—all trained to develop staffing plans for each unit and shift that ensure safety and quality of care.

Post and make available staffing plans and actual staffing.

Select five nurse-sensitive quality indicators collected by all hospitals, and create a new system capable of aggregating the indicator data.

Incorporate key nurse staffing data in the state’s Adverse Events Report form.

Create an “immediate staffing alert” mechanism to ensure rapid management responses to nurse requests for more unit staff.

Determine whether minimum staffing standards and public disclosure of nurse-sensitive patient outcomes are needed.

Sources: Memorandum of Agreement (February 4, 2008) and House Bill 3123.

Outcomes and Prospects

“Steering committee members are all proud and perhaps a bit surprised at how well they’ve done,” says Jon Brock, center associate director and process mediator. “Good faith has prevailed, and the power of collaboration is allowing all this to happen.”

Staffing committees have been established in most hospitals, and approximately 600 staffing committee members have undergone a first round of training in conflict resolution and other skills needed for developing the staffing plans. The steering committee will spend 2009 evaluating and supporting the implementation of the staffing committees.

“The committees give staff nurses a much-needed channel for communicating their bedside knowledge to help hospitals see what is needed to safely care for patients,” says Sharon Ness, RN, steering committee representative for the United Staff Nurses Union, Local 141 UFCW.

The quality indicators have been chosen, the data collection system is in place, the state has agreed to modify its Adverse Events Report form, and several hospitals are piloting “immediate staffing alert” models.

To prepare for its consideration of whether minimum staffing standards are needed, the steering committee reviewed a summary of staffing research and policy commissioned by the center and prepared by Pamela H. Mitchell, PhD, FAAN, Elizabeth S. Soule Distinguished Professor and associate dean for research at the University of Washington School of Nursing, and president of the American Academy of Nursing.

Two questions remain unanswered: Will the plans of the hospital staffing committees actually be implemented

“We are trying to drive up quality and safety while driving down cost. Proper staffing is an absolute key.”



Washington State governor Christine Gregoire

by management? And will the steering and hospital committees successfully address the issue of minimum staffing standards?

Already, participants see promising signs. For example, the steering committee is focused on exploring the range of variables that go into making more direct nursing hours available for patient care in hospitals that vary greatly in size, staff skill mix, architecture, and technology.

There is guarded optimism that the steering committee and hospital staffing committees can achieve important change through the use of evidence-based staffing standards tailored to different hospital types and sizes. “If we don’t accomplish this, we won’t have succeeded,” says Greenawalt.

“Safe patient care is the most important issue for nurses in hospitals today,” says Diane Sosne, RN, MN, president of SEIU Healthcare, 1199 NW. “If, by working together, we can improve the quality of care and also address one of the key reasons for the nursing shortage, then we will have succeeded.”

For More Information

- Email: Jon Brock, associate director, William D. Ruckelshaus Center, jbrock@u.washington.edu.
• Order: Issue 5 of the Charting series for more on staffing policy models (see order information below).

Promote Evidence-Based Standards That Focus on Outcomes

- Take a systems view of quality and safety and focus on desired outcomes rather than on requirements that don’t promote results (e.g., onerous documentation).
• Ensure that standards setting and reimbursement policies enable rapid adoption of evidence-based practices.
• Implement uniform standards for the pooling and reporting of error data.
• Publicly report health care’s performance and include measures that reflect nursing’s contributions.
• Increase funding for quality improvement research and innovation dissemination tools.
• Design value-based purchasing so that it raises the standard of care, incentivizes health care team work, and controls costs.
• Support standards development for proprietary bedside medical devices and the interoperability of health information technologies, ensuring broad-based input that includes nurses.

Support the Creation of a Highly Skilled Nursing Workforce and Optimize Nurse Staffing Levels

- Expand education, training, and scholarship programs for nurses at all levels of practice.
• Devise policies that address the nurse and nurse faculty shortages.
• Encourage the development of voluntary and mandatory programs that optimize nurse staffing levels and produce high-quality care outcomes.



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