



Transforming Care at the Bedside—New Jersey

A Progress Report

INTRODUCTION

In October 2009 the New Jersey Hospital Association launched a three-year program to empower front-line hospital nurses to implement innovative practices aimed at improving the hospital work environment and the quality of patient care.

*Entitled *Transforming Care at the Bedside—New Jersey* (or *TCAB—New Jersey*), the program is a state-specific application of a staff-driven, bottom-up approach to hospital improvement developed by the Institute for Healthcare Improvement (IHI) in partnership with the Robert Wood Johnson Foundation (RWJF).*

The TCAB model was initially pilot-tested at a handful of high-performance hospitals across the country and then disseminated to more than 100 hospitals nationwide by IHI and the American Organization of Nurse Executives.

TCAB—New Jersey is the first effort to introduce TCAB concepts to hospitals in a single state. RWJF is supporting the program with a \$732,159 grant to the Health Research & Educational Trust of New Jersey, an arm of the hospital association. RWJF, which is located in Princeton, N.J., has a national focus but recognizes a special responsibility to its home state.

WHAT IS TCAB ABOUT?

In a nutshell, TCAB is about streamlining hospital practices so nurses can spend more time caring for patients—or, to use the TCAB metaphor, more time at the bedside. Wait a minute; isn't that what nurses are already doing—caring for patients?

That's certainly what they want to do, but the fact is that hospital nurses spend a big chunk of each work shift away from the bedside—filling out paperwork, hunting down supplies, picking up medication and performing other tasks that the experts call non-value added. That is, work that doesn't directly add to the safety and quality of patient care.

The goal of national TCAB—and TCAB in New Jersey—is to change hospital workplace practices and policies to free nurses from these extraneous demands and enable them to focus more completely on their patients' safety, comfort and overall hospital experience.

So What's New Here?

Efforts to increase health care efficiency are, of course, not new. Quality-improvement initiatives are a staple of all good hospitals. What sets the TCAB model apart is that it relies on front-line nurses—those providing hands-on care in the patient units—to redesign the workplace.

Typically hospital improvement efforts are top-down—from the C-suite via the quality-improvement department to the patient floors. TCAB is bottom-up. Certainly, support of the hospital's chief nursing officer and other senior executives is essential to success. But a key TCAB tenet is that staff nurses are themselves fully capable of recognizing opportunities to improve care in their units and implementing measures to achieve that goal.

More than capable, in fact. Because they are so intimately involved in patient care, front-line nurses are ideally positioned to change what needs to be changed—that's the philosophy behind TCAB.

WHAT PROBLEM IS TCAB ADDRESSING?

TCAB is aimed at two, interrelated issues. The first—no surprise—is patient safety. Nurses are the largest group of professionals providing direct care in hospitals, and research shows that their performance has a significant impact on the safety and quality of the patient experience.

A 2003 Institute of Medicine report—*Keeping Patients Safe: Transforming the Work Environment of Nurses*¹—underlined the critical link between patient outcomes and nursing vigilance and called for fundamental redesign of both how nurses work and the culture in which they work.

The "typical work environment of nurses is characterized by many serious threats to patient safety," including heavy patient loads, long hours and inefficient work processes, the report said.

¹ The report (available [online](#)) was a follow-up to the institute's 1999 landmark report *To Err Is Human*, which estimated as many as 98,000 hospital patients die a year from preventable medical errors.

Nurse Retention: An Effort to Increase It

The second issue targeted by TCAB is nurse job satisfaction—or, more accurately, dissatisfaction. Research shows a high rate of job unhappiness among hospital nurses and one common complaint is that workplace conditions make it difficult for nurses to do what they entered the profession to do: care for patients.²

"Chaotic and complex, inefficient environments contribute to nursing dissatisfaction, nursing staff turnover and diminished capacity to provide quality care," says Linda Burnes Bolton, Dr.P.H., R.N., chief nursing officer and vice president of Cedars-Sinai Medical Center in Los Angeles, one of the hospitals that piloted the TCAB model.

The recession that began at the end of 2007 helped erase the nurse shortage in many areas of the country, including New Jersey. But as the economy improves and the nation's fast-growing elderly population places increased demands on the health care system, the reprieve is certain to be temporary.

"Because of the nursing shortage projections and the changing demographics of our society, we must change the environment in which nurses work to increase retention and decrease turnover," says Aline Holmes, M.S.N., R.N., senior vice president for clinical affairs of the New Jersey Hospital Association.

TCAB seeks to do just that by empowering hospital nurses—specifically those caring for general medical and surgical patients—to find new, better ways to do their work, producing greater nurse engagement and job satisfaction as well as improved patient care.

TCAB focuses on medical–surgical units because that's where most inpatient hospital care is delivered (maternity and critical care are the chief exceptions) and where nurse turnover is typically highest.

"The idea is that nurses will actually enjoy their job," says TCAB–New Jersey Program Manager Barbara Chamberlain, Ph.D., M.S.N., M.B.A., R.N. "They will come to work energized. They'll have more time to spend with the patients. That's one of the things we hear all the time: 'I wish I had more time to spend with my patients.'"

HOW DOES TCAB–NEW JERSEY WORK?

The hospital association recruited 48 acute care hospitals—two-thirds of the acute care facilities in New Jersey—to participate in the TCAB program. The number subsequently increased to 49 when one of the participating hospital systems acquired another facility.

² Researchers surveyed some 13,500 hospital nurses in Pennsylvania and found 41 percent were dissatisfied with their jobs—four times the dissatisfaction rate of American professional workers in general. Almost 23 percent planned to leave their jobs in the next year, the researchers reported in *Health Affairs* (Aiken LH, et.al. May 2001).

Two other providers—a pediatric rehabilitation hospital and a home-care agency—also joined the program, providing an opportunity to see how TCAB works outside the acute care setting. That made a total of 51 participating organizations.

The hospital association divided the organizations into two cohorts and scheduled a two-day training session for each in Princeton, where the association is located. Cohort I trained in November 2009, Cohort II in March 2010. To conduct the trainings, the association hired the American Organization of Nurse Executives (AONE), which had experience disseminating TCAB nationally.³

Each of the participating hospitals selected a medical–surgical unit to pilot TCAB and sent two staff nurses from the unit, their nurse manager and the hospital's chief nursing executive or other senior officer to Princeton to learn how TCAB worked. (The rehabilitation hospital designated one floor as its TCAB unit; the home-care agency selected one of its countywide teams of visiting nurses.)

The two staff nurses—their hospital's "TCAB Champions"—returned home to initiate the TCAB process in their units, with the backing (it was hoped) of the unit manager and chief nursing officer.

The hospital association provides ongoing support to the hospital teams through monthly conference calls, Web-based seminars, site visits, a dedicated listserv and website and other technical assistance. The association hired Chamberlain, a retired acute care nurse, to manage the program day-to-day under Holmes' direction.⁴

In March 2011 Chamberlain initiated a series of one-day TCAB re-training sessions—"the CliffNotes version," she calls it—for nurses new to a TCAB unit or anyone "who needs to be energized."

In addition, the hospital association periodically convenes face-to-face meetings of the site teams so they can exchange notes on their work.

³ In December 2006, AONE, a subsidiary of the American Hospital Association, got the first in a series of RWJF grants totaling \$1.8 million to organize and manage a two-year program that introduced TCAB to 67 hospitals across the country. The organization subsequently continued TCAB dissemination on its own.

⁴ TCAB–NJ is a program of the hospital association's Institute for Quality and Patient Safety, an arm created in 2002 to help hospitals improve their care processes. Holmes directs the institute.

"Snorkeling" for Innovation: The TCAB Process

The health care experts who designed the original TCAB in 2003–04 set four primary goals for the program.⁵ The New Jersey participants were expected to make changes in their units aimed at advancing one or more of them. The goals were:

- Improve the quality and safety of patient care
- Increase the vitality and retention of nurses
- Engage patients and families and improve their hospital experience by making care patient-centered
- Improve the effectiveness and efficiency of the entire care team through value-added care processes

Specifically what to improve and how to improve it—that was up to each hospital team. "Remember, it's staff driven; they get to choose," says Chamberlain. There is, however, a prescribed TCAB process to guide the decision-making. As the teams learned in Princeton, the key steps are to:

- **Form an improvement team to lead the change effort.** In addition to nurses, members can include other disciplines (social workers, pharmacists, dietary workers—and physicians) as well as patients, former patients and family members.
- **Hold staff brainstorming sessions—called "snorkels"⁶—to identify opportunities for improvement and generate ideas for achieving it.** The ideas do not have to be original. Nurses are encouraged to look at others hospitals, even other industries, for inspiration. "Steal shamelessly" is a TCAB mantra.

Nor do the ideas have to be grand in scale or cost. In fact, it's just the opposite. Most changes made by hospitals in the earlier TCAB programs were relatively small on both counts, and that continues to be true in New Jersey. (Chamberlain says a wheelchair purchase—to expedite a unit's discharges process—is the biggest capital investment she's aware of.)

- **Conduct a rapid, progressive series of tests of each proposed change, starting small—as small as one nurse interacting with one patient.** If initial results are promising, the idea is refined and retested on a broader scale, with more staff and patients. If there is no or little measurable impact, the staff quickly drops the idea and moves on to another.

⁵ The IHI team that designed TCAB initially identified these four goals. Later in the pilot phase, the team added a fifth goal: To spread successful TCAB innovations to other units in the hospital and to other hospitals in the same system.

⁶ The sessions were an adaptation of a structured brainstorming approach called *Deep Dive* developed by the firm IDEO. The TCAB version was shorter and less involved, thus the terminology change to *snorkel*.

Here are three examples of the kinds of changes tested by TCAB units in New Jersey; they are also typical of changes at TCAB hospitals elsewhere:

- Safer, faster processes for getting medications to the patient
- Expanded menus to give patients more food choices
- Relocated supply closets to cut down on staff time and steps fetching materials
- **Spread successful changes first throughout the pilot unit, then to other units in the hospital and, ultimately, to other hospitals in the same system.** The creators of TCAB considered replication essential to sustaining the TCAB movement in individual hospitals and in the health care field overall.

One Trainees' Initial Thought

Eddie A. Perez, M.H.A., R.N., manager of the 33-bed med-surg unit piloting TCAB at St. Joseph's Regional Medical Center in Paterson, attended the Princeton training and remembers hearing right off the bat how TCAB would produce "a culture change." He also remembers being thoroughly skeptical.

"I said, 'I hope they're not going to have me sit here and listen to them talk about culture change.' Because how many initiatives, how many kickoffs, how many other things have I been to that they preach about it being a culture change. And you never see it."

This time, however, Perez would become a true believer.

HOW IS TCAB-NJ PROGRESSING TO DATE?

Back at home, the TCAB teams began putting their Princeton training into practice, testing new ideas, implementing some and rejecting others. TCAB–NJ still has a year to go, so it's too early for any overall results.

What the program leaders see at this point is a range of effort and impact across the 51 sites. "Everybody's at a different place," says Chamberlain. "Some [sites] are doing really well; some are still struggling."

But based on anecdotal evidence, it seems safe to say that where the level of support and enthusiasm is high, TCAB is making a real difference. That's certainly been the experience at St. Joseph's, according to former skeptic Eddie Perez.

By enabling nurses to mold the hospital environment to more closely fit their work needs, he says, TCAB at his hospital created a new sense of staff engagement and empowerment that translated into greater job satisfaction, better patient interactions and higher patient satisfaction survey scores.

"It *is* a culture change," he says.

TCAB in Action: Stories From the Field

St. Joseph's Regional Medical Center: A New Admissions Process

Immediately after returning from Princeton, the two staff nurses from Perez's unit—3 North—sent their colleagues personal invitations to participate in TCAB and conducted the inaugural snorkel. "We didn't wait until we perfected what it is that we learned. We kind of just jumped in and learned as we went," he says.

There was, however, one Princeton lesson that Perez says he himself tried hard to follow from the start, a lesson not always easy for a manager: Be supportive but not overbearing—"Allow the staff to work the process, make their own mistakes."

The 3 North staff proceeded to test and implement a mix of innovations that included both physical changes that were quick to accomplish ("easy wins," Perez calls them) and fundamental shifts in work practice that took multiple rounds of testing to get right.

In the easy win category, for example, the unit installed an "appreciation board"—a prominently placed corkboard to which nurses, physicians and other staff could attach notes acknowledging each other's good deeds. Soon patients' letters of thanks were going up, too. A simple device but one that quickly engaged the staff and helped get TCAB buy-in, says Perez. "Staff engagement is definitely the key."

Changing work practices proved more complicated. Improving patient admissions is an example from the unit's harder-to-do list. Before TCAB, when 3 North got a new patient, one nurse handled the entire process: interviewing the patient for medical history, conducting a physical assessment, initiating the plan of care and documenting it all—plus helping the patient get settled in.

That took a big chunk of time, as much as 90 minutes, and cut into the nurse's capacity for other duties, including meeting other patients' needs. Tackling the problem as part of TCAB, the staff experimented with assigning two nurses to process each new patient and comparing their time expenditure to the single-nurse approach.

The final solution was to divide the admission process among three nurses—two bedside nurses assisted by the nurse in charge of the shift. The result was a sharp reduction in the disruption of any one nurse's workday. When the new system was fully implemented, each nurse was spending only 10–15 minutes per admission on average, Perez and Chamberlain reported in a trade publication.⁷

It was a "huge process change," says Perez. "As soon as they (the unit nurses) saw the impact, they just really went with it and adopted it unit-wide."

⁷ "Team admissions: Initiative shifts focus from admissions to patient care at St. Joseph's Regional Medical Center, Paterson, NJ" in *Advance for Nurses-Northeast*. See the Bibliography for details.

Promoted to nursing director for the entire medical surgical division, Perez is now helping spread the TCAB approach throughout St. Joseph's. Teams from other units—including those as diverse as radiology and housekeeping—are attending structured TCAB training sessions that he conducts with two staff nurses and a performance improvement coordinator.

Elmer Hospital: A Redesigned Patient-Handoff System

At South Jersey Healthcare's hospital in Elmer (self-proclaimed "Small Town with the Big Welcome"), a new patient-handoff system was a key TCAB change. Previously at shift changes, the outgoing nurse huddled in private with his or her replacement to discuss each patient's condition and upcoming needs.

The hospital's TCAB unit, 2 East, moved the shift-change briefing into the patient's room—in front of the patient. Termed "bedside reporting," it's a strategy to more fully involve patients in the care process.

The TCAB team first studied what a high-quality shift-change report should cover and then used those findings to develop guidelines for the information that nurses on 2 East would exchange at the bedside with each other and with the patient.

Under the new system, the outgoing and incoming nurses introduce themselves to the patient, go over how the patient is progressing and identify what needs to be done to meet the goals of the care plan.

They also solicit information *from* the patient—information that helps the incoming nurse provide quality care, explains Elizabeth Sheridan, M.A., R.N., South Jersey Healthcare's chief nursing executive.⁸ "For example, pain medication. 'Mrs. Jones, How did you feel after we gave you that pain medication?'"

(Under the new system, nurses continue to discuss sensitive information outside the patient's room—details, for example, that might be inappropriate for visiting family members or others in the room to hear.)

After six months of development, the new handoff system was rolled out and, according to the hospital leadership, quickly won acceptance. Patients liked the interaction and the reassurance that they would not get lost in the nurse shuffle. "They're comfortable hearing one nurse telling the other nurse what needs to be done," says Sheridan.

As for nurses, they liked the new system, too, because it streamlined the handoff process, says Bruce Alan Boxer, Ph.D., M.B.A., M.S.N., R.N., South Jersey Healthcare director of

⁸ In addition to being corporate chief nursing executive, Sheridan is chief operating officer of South Jersey Healthcare's Regional Medical Center in Vineland.

nursing quality/Magnet Program. While there was concern initially that nurses might find it harder to get away on time, the result was just the opposite, according to Boxer.

Bedside reporting, he says, keeps the nurses' discussion focused on the patient, eliminating talk about last week's vacation and other extraneous topics that invariably creep into—and draw out—private one-on-one meetings.

Boxer and Sheridan hypothesized that if TCAB was successful, the pilot unit's patient satisfaction scores would go up. Indeed, they did, and as a result South Jersey Healthcare has spread bedside reporting throughout its system, Boxer says.

Children's Specialized Hospital: More Cohesive Teamwork

The big difference between a rehabilitation hospital and an acute care facility is that rehab patients have a busy therapy schedule, says Karen M. DeWitt, Ed.D., R.N., vice president for patient care and chief nursing officer of Children's Specialized Hospital in New Brunswick, the lone pediatric rehab facility in the TCAB program.

Instead of spending the day in bed, rehab patients spend much of theirs outside their rooms, at appointments with speech, occupational and other types of therapists. For rehabilitation hospital nurses, coordinating their care of patients with these other activities can be challenging, DeWitt says.

"What we've been working on is how to deliver care as a team in a more cohesive manner...how to help streamline the work and collaborate with the [therapist] team to make the patient's day proceed in a better way," she says.

One TCAB initiative changed the process for assessing patients each morning—a necessary step to determine if the patient's condition is appropriate for the day's scheduled therapies. Before TCAB, the assessment had two steps; first a nursing assistant checked vital signs, and then—separately—a nurse talked to the patient.

As a result of TCAB, the assessment now has just one step: the nurse takes vital signs and interviews the patient all at the same time. "It sounds almost trivial, but it's not," says DeWitt. The new system is more efficient and lessens the chance that the assessment will delay the patient's start on the day's therapies, she says.

The unit also formalized the way nurses report updated patient information to the therapy team responsible for the patient's care. That, too, is seemingly minor, but the result has been greater care continuity, says DeWitt.

The hospital's second floor, where the patients are school age and adolescent children, was the TCAB pilot. Impressed by the results, the second-floor nurses convinced their third-floor counterparts, who care for infants and young children, to initiate TCAB—and they did.

The spread happened, says DeWitt, without any prodding from the hospital administration. "It was really impressive to me that the staff took it on themselves and said, 'This is really great, and you ought to try it.' That's been very gratifying to see."

Of the hospital's TCAB experience in general, she adds, "I think it's brought a breath of fresh air onto to the nursing units, and staff feel empowered and energized."

Visiting Nurse Association of Central Jersey: Improved Logistics

"I know how it works in the hospital because they are under the same roof. But what are we going to do?" That was Eileen Fay's first reaction when she heard the Visiting Nurse Association of Central Jersey, a member of VNA Health Group, was joining the TCAB program.

VNA Health Group, a nonprofit organization, provides home care, hospice and community-base care statewide in New Jersey, and Fay, M.S.N., R.N., is clinical director covering Middlesex county. Her responsibilities include the 10-nurse team selected to be the association's TCAB pilot unit.

The team is responsible for patients in three Middlesex towns (North Brunswick, East Brunswick and Old Bridge), and through the TCAB process has made a number of changes in how they members do their job—with results sufficient to overcome Fay's initial uncertainty about TCAB's applicability to home care. "It does work," she says, citing the following as an example:

Patients who come home from the hospital on blood thinning medicine, Fay explains, need to have their blood tested regularly to ensure it doesn't get too thin (a risk for hemorrhage) or too thick (clotting).

Before TCAB, the team shared one new-generation blood-testing machine—the kind that provides an immediate reading, allowing the nurse to consult a physician by phone and, if necessary, adjust the patient's medication right then, during the visit.

It's a big advance from older testing systems that entail lab work and a 24-hour wait. But having just one machine for 10 nurses in three towns made the logistics difficult. A nurse who needed the machine first had to find out which colleague had it and then drive what could be a long distance to get it.

Through the TCAB process, the team came up with a solution: they added two more machines⁹—making a total of three, one for each town—and assigned one nurse in each town to be the custodian for that machine.

⁹ The visiting nurse organization obtained the two new machines free of charge through negotiations with a vendor who supplies materials necessary to support the machines' use, according to Fay.

Now, no matter where a machine is needed, the nurse knows there is one nearby and where to get it—and where to return it at the end of the day. Each custodian is keeping close tabs on her machine, says Fay. "She treats it like her baby."

IS EVERY TCAB CHANGE A SUCCESS?

Definitely not.

South Jersey Healthcare includes the Regional Medical Center in Vineland, and it, too, is participating in TCAB. The pilot unit there and the one at Elmer Hospital have both "come up with some great ideas," says Boxer, South Jersey Healthcare director of nursing quality/Magnet Program. But, he is quick to concede, not all pan out.

The Regional Medical Center's TCAB team, for example, tested what it dubbed "Turn Team." The idea was that every two hours the staff would turn all patients—either physically turn them or tell mobile patients to turn themselves. As a reminder, the computers in the unit sounded a bell every two hours.

The purpose, of course, was to prevent pressure ulcers—a "very noble cause," as Boxer puts it. However, despite efforts to adapt and tweak, Turn Team wasn't happening, he says. The 36-bed unit was just too busy with too much variability for a standardized turning schedule, he explains. A patient might have just returned from radiology and be having lunch when the bell sounds. Or maybe a patient has had trouble sleeping and finally dozes off as Turn Team time rolls around. Concluding that individualized turning made more sense, the unit dropped the idea.

"We're very high achievers here," says Boxer. "We always want to achieve and excel, and so failure is not an option. But it really is an option. TCAB helps people realize it's okay to fail if you do it in a controlled way, and you learn from it."

South Jersey Healthcare is by no means alone. At Children's Specialized Hospital, for example, the TCAB unit worked on revising the patients' bathing–showering schedule, trying to align it with the therapy schedule and nurse workload. A good solution, however, proved elusive, reports DeWitt. "Not every idea is going to work, and that's okay," she says.

For the VNA Health Group visiting nurses in Middlesex County, the car trunk is their supply closet. That's where they carry the medical materials and equipment they need on their rounds. To make things easier to find, several TCAB nurses came up with a uniform system for organizing trunk contents.

However, the car trunk, it turns out, is a personal matter, like keeping house. The rest of the team members wanted their trunks to be the way they wanted them to be and not according to some pre-set plan, explains Fay. "The team determined that how you

maintained your supplies in your trunk was not important as long as you had what you needed to care for the patient when you got to the home." End of the trunk test.

HOW DOES NEW JERSEY TCAB DIFFER FROM PREVIOUS TCAB DISSEMINATION EFFORTS?

There are two differences. The single-state focus, of course, is one. Previous RWJF-supported TCAB initiatives involved hospitals located across the country.

With geographic proximity comes an advantage, one especially relevant when times are tight: It's easier and less expensive to bring the local teams together for information-sharing meetings. Most TCAB–New Jersey participants, says Chamberlain, can travel by car and be home that night, eliminating the need for airline tickets and hotel rooms.¹⁰

Those conditions also facilitate Chamberlain's heavy schedule of site visits—which are appreciated by the local teams and would be impractical in a national program, says Holmes.

This kind of efficiency is one reason that *Aligning Forces for Quality (AF4Q)*—RWJF's premier quality-improvement program—recently reorganized its TCAB component from a single dissemination effort into a series of separate geographically defined hospital collaboratives. Aspects of the New Jersey program were a model for AF4Q's new regional approach to TCAB, says RWJF Senior Program Officer Susan R. Mende, M.P.H.

No Additional Data Collection: The Second Difference

The New Jersey program places fewer data demands on participants. Most noticeably, says Edna Cadmus, Ph.D., R.N., there is no attempt to track nurses' actual time at the bedside.

Up until June 2010, Cadmus was chief nurse executive of Englewood Hospital and Medical Center, a participant in both TCAB–New Jersey and the earlier national TCAB dissemination program of the American Organization of Nurse Executives (AONE).

In the AONE version, Englewood's TCAB nurses periodically carried electronic devices known as PDAs (personal digital assistants) to record their activities and locations. The equipment and related software generated a report that broke down how the nurses spent

¹⁰ The TCAB–New Jersey organizations do not pay a participation fee but contribute their staffs' time and related expenses. The organizations get no funding from RWJF.

their time and showed whether the proportion in direct patient care was increasing. Other TCAB programs used the same methodology.¹¹

There are no PDAs in TCAB–New Jersey, and so there will be no outcome measure for time spent in direct care. The hospital association, Holmes says, promised the participants at the outset not to ask for any data that the units were not already collecting—a good selling point for report-weary hospital staffs.

"Less data...is always nice for those that have to participate and provide the data," says Cadmus, now a faculty member at Rutgers College of Nursing.

That doesn't mean there are no data requirements. The New Jersey participants are expected to track and report some measures of care (including falls, falls with harm, pressure ulcers and patient satisfaction scores), as well as indicators of nurse satisfaction and staff teamwork. These data, once analyzed, will be a gauge of TCAB's effectiveness, say the program leaders.

There is another but related data difference. The original TCAB program set specific quantitative targets for the sites to meet—for example, a maximum of 0.1 patient falls with harm per 1,000 patient days. But TCAB–New Jersey is using a simpler yardstick of impact: Did the pilot unit improve as measured against its own pre-TCAB data?

WHAT ARE TCAB–NEW JERSEY'S CHALLENGES AND WHAT HAVE WE LEARNED?

Lesson: Management and leadership are two different things.

While TCAB is a bottom-up process, the unit nurse manager's ability to facilitate the process is critical. A key lesson from TCAB–New Jersey, says Holmes, is that many unit managers lack the leadership skills to do that:

Health care organizations tend to promote people on the basis of clinical ability, she says, and "so we put them in these management positions, and we teach them tools of management. We teach them how to discipline; we teach them how to do scheduling and budgeting. But we don't do a lot of work around how to be a leader.

"But leadership is being able to create this vision with your staff about where you want patient care to be, and what you want it to look like, and then getting all your staff to adopt that vision and want to be a partner with you in doing that. So

¹¹ As of mid-2011 there were no reported results for the AONE program. An evaluation of the earlier TCAB pilot program found essentially no change in nurse time spent in direct patient care.

it's a whole different skill set, and there are lots and lots of managers out there who are not leaders."

In response, the hospital association hired Cadmus to provide leadership training and mentoring to the TCAB unit managers. Cadmus, a self-described TCAB "believer" from her Englewood experience, directs Rutgers' nursing leadership program.

In addition to providing online and in-person instruction, she assessed each TCAB manager's leadership skills through confidential surveys of subordinates and supervisors and counseled the managers on the results.

How to solicit ideas for fixing a problem instead of simply fixing it themselves. How to collaborate with personnel in other hospital units, and how to recognize and celebrate staff accomplishments are the kinds of leadership skills that managers need to have, says Cadmus. The good news is that those are skills that managers can be taught. "Once you give them the toolkit, they usually flourish," she says.

Lesson: The degree of TCAB success tends to be directly related to the degree of support from the chief nursing officer.

Some TCAB–New Jersey organizations "are just very high energy and [they] love it; they're doing really great work and have made an impact on the nursing unit and have started to spread it already throughout the organization," says Holmes.

"Then we have other hospitals..." Holmes leaves the sentence unfinished as she makes her point: "I've come to think this [difference] is a function of the chief nursing executive of the organization."

To what extent does the chief nursing officer want to learn about TCAB, attend TCAB meetings and ask what the team is working on? Again, TCAB is bottom-up, but the level of enthusiasm and engagement demonstrated by the senior hospital leadership, particularly the chief nursing officer, has an impact on the staff's progress, according to Holmes.

The 51 organizations have made varying degrees of progress, and the chief nursing officer is a major factor, she says.

Lesson: While supportive, the chief nursing officer must learn to "let go."

"Chief nursing officers are very comfortable in saying, 'You need to do it this way,'" says Holmes. "They've got lots of experience, and one of the things they had to learn—and it was initially very difficult for them—was they had to sit back and not dictate how" the TCAB team did its work.

Holmes tells the story of a TCAB unit that came up with an idea that the chief nursing officer thought "was one of the dumbest things she had ever heard of."

"But she kept remembering to sit back and let them do it, and she did. And it worked spectacularly. The nurses loved it and the patients loved it and their [patient survey] scores went up.

"So it's letting go, developing a team and letting them do the performance improvement."

Lesson: Provide supplemental TCAB training to address the problem of personnel turnover.

The one-day retraining sessions that Chamberlain is offering this year were not part of the original program plans but added largely as a response to staff turnover in TCAB units. "People move on, people change and we recognized that early on," says Chamberlain.

In addition to the normal staff comings and goings, one organization had to train a whole new TCAB unit when declining patient numbers forced the original unit to close down. Chamberlain is also training staff of the organizations' "spread" units.

Related to the spread issue, RWJF staff members were concerned that some New Jersey hospitals might try to replicate TCAB too quickly—before it was sufficiently rooted in their pilot units. That was a challenge identified in the pilot program. Chamberlain, however, says that has not been a problem so far in New Jersey. "The ones who are spreading are doing it well," she says.

Lesson: Give local TCAB teams a chance to share information.

Although the hospital association was conducting monthly conference calls, the local TCAB teams wanted more feedback and information sharing. As a result, the hospital association added an extra face-to-face meeting to the 2011 schedule.

"That was something we learned; they really enjoy learning from each other," says Holmes. The local teams also enjoy Chamberlain's site visits for the opportunity they provide to show off their TCAB projects and get feedback, Holmes says.

WHAT DOES THE FUTURE HOLD?

The hospital association's RWJF grant includes funding for a statewide conference to showcase the participants' work and to interest additional New Jersey health care organizations in the TCAB process. The date is not set but will be in 2012 near TCAB—New Jersey's August 31 conclusion, says Holmes.

The grant also will fund an outside evaluation of the program. The hospital association expects to hire Jack Needleman, Ph.D., a professor at the University of California, Los Angeles, School of Public Health. Needleman evaluated RWJF's national TCAB program. His report on TCAB–New Jersey will presumably include an analysis of the sites' reported performance data.

RWJF's funding of TCAB–New Jersey was a one-time investment, and there is no expectation of a follow-up grant, according to Senior Program Officer Maryjoan Ladden, Ph.D., R.N., who oversees the initiative. The hope, she says, is that the hospital association will continue to offer TCAB training and support through its own resources.

That is a real possibility, says Holmes. The association now has all the necessary TCAB training tools in hand, she notes. The difference would be that without grant support the association would have to start charging a participation fee.

As for the current participants, Chamberlain's expectation is that they will continue to use the TCAB process in their pilot units and spread the process throughout the full organization.

Her hope is that TCAB will not stop there. "I think it would be wonderful to have it in ambulatory care, to have it in long-term care. To be able to spend more time with the patient is so important. I think that's the big thing to come away with," says Chamberlain.

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