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Driving Hospital Improvements by Empowering Front-line Nursing Staff

Transforming Care at the Bedside–New Jersey

SUMMARY

In October 2009, the New Jersey Hospital Association launched a three-year program to empower the state's 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 (TCAB–New Jersey), it was the only state-specific application of a staff-driven, bottom-up approach to hospital improvement developed by the Institute for Healthcare Improvement in partnership with the Robert Wood Johnson Foundation (RWJF), which previously supported nationwide dissemination of the TCAB model.[1]

A total of 48 hospitals—about two-thirds of the state's acute care facilities—participated in the New Jersey program. Each designated a medical–surgical unit to pilot the TCAB model. Two non-acute care providers also joined the program.

Evaluation Findings

Researchers from the RAND Corporation and the University of California, Los Angeles, evaluated the New Jersey program and in April 2013 reported that, overall, the findings "suggest that TCAB provided a set of activities of high value to nursing units."

Among the findings:

- The hospitals' pilot units showed statistically significant improvement in three outcomes: prevalence of pressure ulcers and two measures of patient satisfaction. Changes in four other outcomes tracked by the evaluators were not statistically significant.
- Survey responses of pilot unit managers "suggest that large proportions of the participating nursing units implemented the key TCAB processes."

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[1] Read more about TCAB in the Program Results Report online at www.rwjf.org/en/research-publications/find-rwjf-research/2011/07/transforming-care-at-the-bedside.html.

- The unit managers "expressed very positive perceptions of the value of TCAB participation."
- Staff responses to a survey on teamwork "suggest the nursing work environment significantly improved in the TCAB units over the course of the program."

Funding

RWJF supported TCAB–New Jersey with a $732,159 grant to the Health Research & Educational Trust of New Jersey, an arm of the state hospital association. The grant ran from September 2009 through April 2013.[2]

CONTEXT

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*[3]—underlined the critical link between patient outcomes and nursing vigilance and called for a fundamental redesign both of 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.

Related Issue: Nurse Turnover

A second issue intertwined with that of patient safety is nurse job satisfaction—or, more accurately, dissatisfaction. Research has shown 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.[4]

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[2] The grant (ID# 66289) was originally for $800,000 but reduced to reflect lower-than-expected training costs. Also, the grant period—initially three years—was extended eight months, to April 2013, so that the evaluation could be completed.

[3] The report 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 each year from preventable medical errors. Available online at www.iom.edu/Reports/2003/Keeping-Patients-Safe-Transforming-the-Work-Environment-of-Nurses.aspx.

[4] In one study, published in the May 2001 issue of *Health Affairs,* 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. Available online at www.ncbi.nlm.nih.gov/pubmed/11585181

"Chaotic and complex, inefficient environments contribute to nursing dissatisfaction, nursing staff turnover, and diminished capacity to provide quality care," says Linda Burnes Bolton, DrPH, RN, chief nursing officer and vice president of Cedars-Sinai Medical Center in Los Angeles.[5]

The recession that began at the end of 2007 helped erase the nurse shortage in many areas of the country, including New Jersey. A reluctance to leave the profession when other jobs are scarce, coupled with spousal layoffs, meant that some nurses shelved their retirement plans and others were more willing to take overtime. But as the economy continues to improve and the nation's fast-growing elderly population places increasing demands on the health care system, the need for a stable nurse workforce is expected to become critical.

RWJF's Interest in This Area

The mission of RWJF is to improve the health and health care of all Americans, and the Foundation views nurses—who make up more than half the health care workforce—as central to that endeavor.

Over the years RWJF has invested millions of dollars in initiatives to increase the supply of nurses, improve the quality of nursing-related care, and otherwise strengthen the nursing profession.

"We recognize that it is impossible to pursue our mission...without addressing the challenges facing the nursing profession," RWJF president and CEO Risa Lavizzo-Mourey, MD, MBA, has said. (For information on RWJF's overall efforts in the nursing field, click here.)

TCAB: A Response

In 2003, the RWJF team responsible for nursing-related programming was anxious to try a new strategy to resolve hospital workplace issues. Instead of the top-down approach typical of quality improvement efforts, the team proposed giving hands-on nurses a central role in redesigning hospital practices and systems.

The theory behind nurse involvement was that nurses, as front-line staff, could identify new ways to carry out caregiving tasks that would generate practical, sustainable solutions to safety and other workplace problems while also increasing nurse engagement and job satisfaction.

To flesh out the concept, RWJF turned to the Institute for Healthcare Improvement, a Cambridge, Mass., organization that specializes in identifying and testing new

[5] Burnes Bolton, a national nursing leader, joined the RWJF Board of Trustees in January 2012.

approaches to improving care. The result was an improvement model christened *Transforming Care at the Bedside* (TCAB).

From 2003 to 2008, RWJF partnered with the institute to develop and pilot the TCAB model and disseminate it nationally. The Foundation also supported dissemination efforts by the American Organization of Nurse Executives, a subsidiary of the American Hospital Association. Altogether, more than 100 hospitals across the country implemented TCAB in one or more caregiving units.

For a detailed description of the TCAB model and RWJF's national TCAB dissemination effort, see the Program Results Report.

In 2009, RWJF initiated a separate TCAB program solely for New Jersey hospitals. The Foundation, which is located in Princeton, N.J., has a national focus but recognizes a special responsibility to its home state. TCAB–New Jersey was the model's first and only single-state application.

THE PROJECT

The goal was to implement the TCAB model in a large number of New Jersey acute-care hospitals and evaluate the impact on selected measures of care, such as frequency of patient falls and pressure ulcers.

The New Jersey Hospital Association ran the program under the direction of Aline M. Holmes, MSN, RN, senior vice president for clinical affairs. The day-to-day program manager was Barbara Chamberlain, PhD, MSN, MBA, RN.

As with the national TCAB effort, the objective was to streamline hospital practices and policies so nurses could spend more time at the bedside and less time filling out paperwork, hunting down supplies, and performing other tasks not directly related to patient safety and quality of care.

> *"The idea is that nurses will actually enjoy their job," Chamberlain said after the program got underway. "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.'"*

Also like the national program, TCAB–New Jersey focused on medical and surgical units because that is where most inpatient care is delivered (along with maternity and critical care) and also where nurse turnover is typically highest.

The expectation was that once TCAB took root in the pilot unit, the hospital would see the value of the process and spread it to other medical–surgical units and eventually across the entire organization.

Nuts and Bolts I: What the Hospital Association Did

The hospital association recruited 48 hospitals—two-thirds of the state's acute care facilities—to participate in the program. Two additional providers—a pediatric rehabilitation hospital and a home-care agency—also joined.[6] See Appendix 1 for the list of participants.

Each hospital selected a medical–surgical unit to pilot TCAB and sent four people—two staff nurses from the unit, their nurse manager and the hospital's chief nursing executive or another senior officer to one of two centralized, two-and-a-half-day TCAB orientation sessions. (The hospital association contracted with the American Organization of Nurse Executives to conduct the sessions, the first in November 2009, the second in March 2010.)

After being trained, the two staff nurses—designated "TCAB Champions" for their unit—returned home to initiate the TCAB process—it was hoped with the backing of the unit manager and chief nursing officer.

Chamberlain provided ongoing support to the hospital teams through site visits (she attempted to visit each hospital twice a year), monthly conference calls, web-based seminars, in-person training, and other technical assistance. The hospital association devoted a section of its website to TCAB resources[7] and set up a listserv for the hospital teams.

Communications

The program concluded with a one-day conference to showcase the TCAB initiatives at each hospital. The hospital association invited the TCAB hospital teams and also opened the event to non-TCAB hospitals, nursing organizations, nursing school faculty, and any other interested parties. About 190 people attended.

In conjunction with the conference, the hospital association produced a "tribute booklet" describing the TCAB improvements made by 26 of the hospitals. (The association

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[6]At one point, the program had 52 participating organizations. The two additional participants were hospitals that joined were acquired in 2010 by a hospital organization already in the program. The two additions, however, did not remain active and were dropped from the roster, according to Holmes, so the total remained at 50.

[7] The association discontinued the TCAB website section at the end of 2012. While the TCAB materials (including instructional slides, tools, and articles) are no longer online, the association provides them to hospitals on request, Holmes says.

encouraged all the participating organizations to provide material for the booklet and included all that did, Holmes says.)

Among the association's other efforts to disseminate program information, Chamberlain:

- Conducted workshops for the hospital teams on how to write and submit articles for publication.
- Made presentations on TCAB at meetings of the hospital association and spoke in Buffalo, N.Y., to a group involved with *Aligning Forces for Quality* (AF4Q), RWJF's signature effort to lift the overall quality of health care in targeted communities. (See Afterward for more about the AF4Q–TCAB connection.)
- Joined with Holmes in authoring a 2010 article ("Transforming Care at the Bedside: the CNO's Role") in *Nursing Management*.[8] Each also wrote one article in collaboration with other program personnel (see the Bibliography).

Nuts and Bolts II: What the Hospitals Did

TCAB's central tenet is that rank-and-file nurses are fully capable of identifying and implementing measures to improve care in their units—and that improvement is a continual process. The model also views support of the hospital's chief nursing officer (CNO) and other senior executives as essential to success of TCAB. As a nurse at one of the early pilot sites (this one in New York) put it: "TCAB is not a project; it's a philosophy."

In TCAB–New Jersey, nurses and other front-line staff on the pilot units were expected to brainstorm new ideas, test them on a small scale (conduct *tests of change* in TCAB lingo), evaluate the outcome, and—based on data—spread those that worked and discard those that did not. For a more detailed explanation of the TCAB process, see Appendix 2.

TCAB innovations did not have to be grand in scale or cost. In fact, as in the national TCAB program, most changes made by the New Jersey hospitals were relatively small on both counts. Chamberlain said the purchase of a wheelchair—to expedite the discharge process in one unit—was the biggest capital investment she knew of.

Here are examples of the kinds of changes tested by the TCAB–New Jersey pilot units:

- Developed safer, faster processes for getting medication to patients. One unit included individual pill crushers and splitters on the medication cart, another

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[8] Holmes AM and Chamberlain B. "Transforming Care at the Bedside: The CNO's Role." *Nursing Management,* 41(6): 45–47, 2010. Available online at http://journals.lww.com/nursingmanagement/Fulltext/2010/06000/Transforming_Care_at_the_Bedside__The_CNO_s_role.10.aspx

developed a discharge instruction sheet for medications, and a third introduced rules to prevent nurses from being interrupted as they made medication rounds.

- Relocated supply closets to cut down on staff time and steps fetching materials. To gain hospital approval for the expense of building a supply cabinet in each patient's room, one team conducted time studies and documented the savings that could be achieved. Another developed a checklist of all supplies a patient needed in the first two hours following a surgical procedure and stocked individual bins with those materials so the nurse did not have to hunt for them.
- Improved strategies for handing off patient care. One unit developed a standardized report sheet at the bedside for nurses to fill out when shifts change, rather than relying on verbal communication place at the nursing station. Another developed a "buddy system" so that more than one nurse became familiar with a patient's status.

The TCAB–New Jersey hospitals got training and technical assistance from the hospital association but no funding from RWJF.

An Example: Trinitas Regional Medical Center in Elizabeth

As one of its TCAB innovations, Trinitas's pilot unit, 8 South, established a new schedule for the routine taking of patients' vital signs. "It seems like something small, but it is important," says Mary McTigue, MA, RNC, Trinitas vice president for patient services. The reason: vital signs impact how RNs care for their patients during that shift.

On 8 South, the RNs work 12-hour shifts, starting at 7 a.m. and 7 p.m. But the nursing assistants, the folks responsible for taking routine vital signs, are on eight-hour shifts. The practice was for nursing assistants to take vital signs at the start of each eight-hour shift—at 7 p.m., 3 p.m., and 11 p.m.

That meant the data was four hours old when the evening RNs came on—too old, the RNs thought. The TCAB team reviewed the issue and proposed a change: taking vital signs twice—at 7 AM and 7 PM., thus assuring the evening RNs had up-to-the-minute patient data.

The change increased nurse satisfaction while eliminating nighttime disturbance of patients, according to the hospital. (Vital signs can and are taken more frequently when considered medically necessary.)

That change along with other, more extensive TCAB innovations—including new measures to decrease patient falls and the development of more comprehensive patient-information tools—have improved staff communication, teamwork, and efficiency as well as patient care and safety, McTigue says.

"As time has gone on, our projects have become more sophisticated," McTigue adds. "It's almost like the staff has become more TCAB mature."

Data Collection: A Difference From Earlier TCAB

TCAB–New Jersey placed fewer data demands on participating hospitals compared to the earlier national TCAB effort. Most noticeably, there was no attempt to track nurses' actual time at the bedside.

In the national program, TCAB nurses periodically used personal digital assistants (PDAs) to record their activities and locations. The electronic devices and related software generated a report that broke down how the nurses spent their time and indicated whether the proportion of direct patient care was increasing.

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

The New Jersey participants, however, were expected to track and report certain measures of care, but the requirements were simpler. The original TCAB program had set specific targets for the sites to meet—for example, a maximum of 0.1 patient falls with harm per 1,000 patient days. TCAB–New Jersey used a simpler yardstick of impact: Did the pilot unit improve as measured against its own pre-TCAB outcome data?

EVALUATION FINDINGS

The hospital association contracted with the RAND Corporation and Jack Needleman, PhD, a professor at the University of California, Los Angeles, School of Public Health, to evaluate the TCAB–New Jersey program's implementation and impact. (RAND researchers and Needleman were also the evaluators of RWJF's national TCAB efforts).

Led by RAND's Marjorie L. Pearson, PhD, MSHS, the evaluation team:

- Analyzed baseline and quarterly hospital data on seven unit-level outcome measures: falls and falls with harm per 1,000 patient days, pressure ulcer prevalence, length of patient stay, and three patient satisfaction measures: how often nurses treated them with courtesy and respect, how often nurses listened carefully, and how often nurses explained things in a way that could be understood. (The analysis excluded the program's two non-acute care hospitals.)
- Analyzed data from two surveys:
  - A survey of the pilot unit managers, conducted shortly before the program ended. The survey included questions about TCAB improvement processes, the managers' perceptions of the results and usefulness of TCAB, and barriers experienced. Some 83 percent of the unit managers participated in the survey.

— A survey of TCAB unit staff on nursing teamwork, administered three times during the program: baseline (early 2010), Spring 2011, and Spring 2012. The response rate ranged from 77 percent on the first round to 54 percent on the third.

- Reviewed program documents, including conference call minutes, pilot unit reports, and training materials.

In an April 2013 report to the hospital association, the evaluation team said that overall its findings "suggest that TCAB provided a set of activities of high value to nursing units." The findings reported by the evaluators included the following:

Outcome Measures

- **Over the course of the program, the TCAB pilot units showed statistically significant improvement on three outcomes.**

  — Pressure ulcer prevalence significantly declined, from a mean of 3.39 ulcers per quarter at baseline to 1.65 ulcers per quarter during the last measurement period.

  — Two of three patient satisfaction measures significantly improved: satisfaction with how often nurses treated them with courtesy and respect and how often nurses listened carefully.

- **Changes in the four other measures tracked by the evaluators were not statistically significant.** Those measures were: falls, falls with harm, length of stay, patient satisfaction with how often nurses explained things in a way that could be understood.

TCAB Implementation

- **Survey responses of the TCAB unit managers "suggest that large proportions of the participating nursing units implemented the key TCAB processes."**

  — Of the managers who responded, 98 percent reported convening a unit-level TCAB team within the last six months; 85 percent of the teams met monthly or less frequently.

  — Some 83 percent of the respondents said their unit organized at least one brainstorming session, and 53 percent reported more than one such session.

  — Some 85 percent reported conducting small tests of change.

- **Respondents indicated a number of barriers existed to carrying out TCAB:**

  — The most frequently reported barrier to carrying out TCAB was insufficient staff time; 56 percent of the unit managers cited that as a significant or moderate barrier.

- — Low levels of staff commitment ranked as the second biggest barrier (reported by 41 percent of unit managers). However, the managers' responses suggested that support for TCAB among unit nurses increased as the TCAB program progressed.

- **A large proportion of unit managers indicated that they intended to continue the TCAB processes when the program ended.**
  - — At least three-quarters planned to continue TCAB team meetings and involve staff in selecting changes to test and adopt. Around two-thirds planned to continue brainstorming sessions and using data to assess tests of change.
  - — Only 13 percent of the unit managers expected their unit staff to become less engaged in making changes after the collaborative ended.

Perceptions of Change

- **"The TCAB unit managers expressed very positive perceptions of the value of TCAB participation."**
  - — The vast majority of unit managers (90% or more) perceived improvement in the safety, patient-centeredness, and efficiency of the care provided on the unit and in the teamwork and vitality displayed by unit staff.
  - — Some 56 percent or more attributed a significant or exclusive role to TCAB for these improvements.
  - — Almost all the managers (98%) indicated that "if they had to do it over, they would participate in TCAB again."
- **Staff responses to the survey on nursing teamwork "suggest the nursing work environment significantly improved in the TCAB units over the course of the program."**
  - — There was significant increase in the survey's overall teamwork score and in each of five sub-measures of team behavior:
    - Trust
    - Team orientation (working together to improve each other's weaknesses)
    - Backup (helping each other when overloaded)
    - Shared mental model (team members' understanding of their roles and responsibilities)
    - Leadership

Limitations

The evaluation report acknowledged that the lack of a control group limited the team's ability to attribute observed changes to the TCAB program itself:

> *…while we can conclude with confidence that nursing teamwork, pressure ulcer prevalence, and patient satisfaction with nursing improved in the TCAB units over the three years of [the program], the design does not allow us to differentiate the effect of the TCAB collaborative from other influences and activities that were occurring in New Jersey at the same time.*

The Hospital Association's Perspective

In its final report to RWJF, the hospital association cited a number of the evaluators' findings as indication of the program's effectiveness. In an interview for this report, Holmes singled out the improvement in three outcome measures and teamwork as particularly positive.

"I think it was overall a success," she said. "We've gotten a lot of positive feedback. When we had our final session (the July 2012 conference) people were still very enthusiastic about it."

While the association does not track how many additional hospital units adopt TCAB, Holmes said, "I know that many organizations are continuing to spread it through their institutions."

The View from RWJF

Senior program officer Maryjoan D. Ladden, PhD, RN, says the program met RWJF's goals—engaging a large number of the state's hospitals and impacting their quality improvement efforts.

While some quantitative measures showed no improvement, qualitative outcomes are also important, she says. "Did it [TCAB] get groups together to problem solve? Did it energize people around a goal of quality improvement? Did it bring different types of staff together? Is it something they are then going to use to solve other kinds of problems?"

The answer, she says, is a definite yes.

For a look at how one hospital—St. Joseph's Regional Medical Center in Paterson—implemented and spread TCAB, see Sidebar at the end of this report.

LESSONS LEARNED

1. **Management and leadership are not the same.** While TCAB is a bottom-up process, the unit nurse manager's ability to facilitate the process proved critical. A key lesson from TCAB–New Jersey, says Holmes, was that many unit managers lacked 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."

   In response, the hospital association in 2011 hired Edna Cadmus, PhD, RN, professor and director of the nursing leadership program at Rutgers College of Nursing, to provide leadership training and mentoring to the TCAB unit managers.

   In addition to giving online and in-person instruction, Cadmus assessed each TCAB manager's leadership skills through confidential surveys of subordinates and supervisors and counseled the managers on the results.[9]

2. **The degree of TCAB success in a hospital tends to be directly related to the degree of support from the chief nursing officer.** The 50 organizations made varying degrees of progress in implementing and spreading TCAB, and the involvement of the chief nursing officer was a major factor, says Holmes.

   To what extent does the chief nursing officer want to learn about TCAB, attend TCAB meetings, and ask what the team is working on? The answers, and the level of enthusiasm and engagement that person demonstrated, had an impact on the staff's momentum, she says.

   A related lesson, adds Holmes, is that chief nursing officers must learn to "let go."

   "Chief nursing officers are very comfortable in saying, 'You need to do it this way,'" she says. "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.

3. **Provide remedial training to accommodate personnel turnover.** Although not in the original program plan, Chamberlain added TCAB-retraining or "remediation" sessions to her technical assistance menu in response to staff turnover in the TCAB pilot units.

   "People move on, people [on the unit] change, and we recognized that early on," she says. One hospital had to train a whole new TCAB unit when declining patient

[9] Cadmus and Holmes wrote about the program's leadership training component in "Leadership's 'Triple Chance.'" published in the February 2013 issue of *Nursing Management*. Available for purchase or by subscription at http://journals.lww.com/nursingmanagement/Citation/2013/02000/Leadership_s__triple_chance_.11.aspx.

numbers forced the original unit to close down. These one-day, in-person sessions also benefited staff on the units to which TCAB was spread.

4. **Give local teams a chance to share information in person.** Although Chamberlain conducted monthly conference calls, the hospital TCAB teams wanted a greater opportunity to meet face-to-face. "That was something we learned; they really enjoy learning from each other," says Holmes.

   "I think it has to be a combination," she adds. "Bringing people together for group teaching works because they learn from each other…But I think you have to be able to provide on-the-unit training, too, because it's not very often that you can actually bring large numbers of nurses to an off-site program."

5. **Where possible, use metrics that the hospitals are already collecting to measure the impact of an intervention.** Even with reduced requirements, collecting data from the TCAB–NJ hospitals proved to be a major challenge for hospital association staff. One lesson, says Holmes, is to make sure the chief nursing officers understand they are responsible for data collection, possibly by signing a written agreement to that effect.

   Holmes also suggested getting the hospital's permission for a third-party organization already receiving the data to report the needed items directly to the manager of the intervention.

AFTERWARD

When the RWJF grant ended in April 2013, the New Jersey Council of Magnet Organizations—a group that grew out of the hospital association[10]—took over responsibility for leading and sustaining the TCAB movement in the state, according to Holmes.

Eddie Perez, MHA, RN, director of medical surgical services at St. Joseph's Regional Medical Center in Paterson and an enthusiastic booster of the TCAB process, volunteered to lead the council's TCAB effort.

RWJF: No New TCAB Funding Planned

RWJF has no plans to support additional TCAB initiatives in New Jersey or elsewhere, according to Program Officer Ladden. As with other new models, she says, the Foundation saw its mission as providing the seed money to get TCAB underway.

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[10] The group was formed in 2009 by the chief nursing officers of the state's Magnet® hospitals and was in the process of organizing as an independent nonprofit as of September 2013, according to Holmes. The Magnet program was developed by the American Nurses Credentialing Center to recognize organizations providing quality patient care.

Now, she hopes the results are compelling enough that the TCAB approach will expand on its own—whether or not the TCAB name itself survives. “We care less about that—sustaining the TCAB name—I think, than the fact that the principles of TCAB get embedded in the work that units and hospitals and nurses do around improving quality.”

At the conclusion of TCAB–New Jersey, *Aligning Forces for Quality* (AF4Q) had a small TCAB component. Two of the 16 regional AF4Q alliances—Minnesota and Wisconsin—had active TCAB collaboratives (as of September 2013), according to AF4Q staff.

Sidebar

ST. JOSEPH'S REGIONAL MEDICAL CENTER: SPREADING TCAB

Eddie A. Perez, MHA, RN, was manager of the 33-bed medical-surgical unit that piloted *Transforming Care at the Bedside* (TCAB) at St. Joseph's Regional Medical Center in Paterson, N.J. He attended the November 2009 orientation and training session with two staff nurses and remembers hearing how TCAB was going to 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.

“Easy Wins”

Immediately after returning from that initial training, the two staff nurses from Perez's unit—3 North—sent their colleagues personal invitations to participate in TCAB and conducted the inaugural brainstorming session. “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 lesson that Perez says he 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 one another's good deeds. Soon letters of thanks from patients went 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."

A Not-So-Easy Win: Improving the Admissions Process

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 the care needs of other patients. Tackling the problem as part of TCAB, the staff experimented with assigning two nurses to 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 sharply reduced 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 *Advance for Nurses,* a trade publication.[11] The new approach also promoted teamwork and coincided with a rise in patient satisfaction scores and a decrease in incidental overtime, according to the hospital.

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."

Spreading TCAB

Later promoted to nursing director for the full medical–surgical division, Perez helped spread the TCAB approach throughout the hospital. Teams from other units—including those as diverse as radiology and housekeeping—attended TCAB training sessions, which he conducted with two staff nurses and a performance improvement coordinator.

TCAB "has really become part of our nursing care model," he says.

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[11] "Team Admissions: Initiative Shifts Focus from Admissions to Patient Care at St. Joseph's Regional Medical Center, Paterson, NJ." *Advance for Nurses-Northeast,* 11(1): 12–13, 2011. Available online at http://nursing.advanceweb.com/Archives/Article-Archives/Team-Admissions.aspx.

Perez is now aiming to spread TCAB to other New Jersey hospitals. The former skeptic is heading an ongoing effort at the New Jersey Council of Magnet Organizations[12] to sustain and expand TCAB in the state.

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[12] The Magnet program was developed by the American Nurses Credentialing Center to recognize organizations providing quality patient care.

APPENDIX 1

The 50 Organizations Participating in TCAB–NJ

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

- Atlanticare Regional Medical Center
- Bayonne Medical Center
- Bergen Regional Medical Center
- Capital Health Regional Medical Center
- Capital Health Medical Center—Hopewell
- Centrastate Healthcare System
- Children's Specialized Hospital—Robert Wood Johnson Health System, New Brunswick
- Chilton Hospital
- Clara Maass Medical Center—Barnabas Health
- Community Medical Center—Barnabas Health
- Cooper Health System
- Deborah Heart and Lung Center
- East Orange General Hospital
- Englewood Hospital and Medical Center
- Hackensack University Medical Center
- Hackettstown Regional Medical Center
- Holy Name Medical Center
- Hunterdon Healthcare
- Jersey City Medical Center—Libertyhealth System
- Jersey Shore University Medical Center—Meridian Health
- JFK Medical Center—JFK Health System
- Kennedy University Hospital Washington Township—Kennedy Health System
- Kimball Medical Center—Barnabas Health

- Lourdes Medical Center Of Burlington County—Lourdes Health System
- Memorial Hospital of Salem County
- Monmouth Medical Center—Barnabas Health
- Mountainside Hospital
- Newark Beth Israel Medical Center—Barnabas Health
- Ocean Medical Center—Meridian Health
- Our Lady Of Lourdes Medical Center—Lourdes Health System
- Raritan Bay Medical Center
- Riverview Medical Center—Meridian Health
- Robert Wood Johnson University Hospital—Robert Wood Johnson Health System, New Brunswick
- Robert Wood Johnson University Hospital at Hamilton
- Robert Wood Johnson University Hospital at Rahway
- Saint Clare's Health System
- Saint Michael's Medical Center
- Saint Peter's University Hospital
- Shore Medical Center
- Somerset Medical Center
- South Jersey Healthcare—Elmer Hospital
- South Jersey Healthcare—Regional Medical Center
- St. Francis Medical Center
- St. Joseph's Regional Medical Center—St. Joseph's Healthcare System
- St. Luke's Hospital—Warren Campus
- St. Mary's Hospital
- Trinitas Regional Medical Center
- University of Medicine and Dentistry of New Jersey
- Underwood-Memorial Hospital
- VNA of Central Jersey

APPENDIX 2

"Snorkeling" for Innovation: The TCAB Process

The health care experts who designed the national TCAB model set four primary goals:

- 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.

The New Jersey participants were expected to make changes in their units aimed at advancing one or more of these goals. Each TCAB team got to decide what to improve and how to improve it. "Remember, it's staff driven; they get to choose," says Chamberlain.

There was, however, a prescribed TCAB process to guide the decision-making. The key steps were:

- **Form an improvement team to lead the change effort.** In addition to nurses, members could 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"[13]—to identify opportunities for improvement and generate ideas for achieving it.** The ideas did not have to be original. Nurses were encouraged to look at others hospitals, even other industries, for inspiration. "Steal shamelessly" was a TCAB mantra.
- **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 were promising, the idea would be refined and retested on a broader scale, with more staff and patients. If there was little or no measurable impact, the staff quickly dropped the idea and moved on to another.
- **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.

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[13] 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*.

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