The Essence of Nursing

Advancing the Art and Science of Patient Care, Quality, and Safety

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The essence of nursing

It's time to put basic nursing care back in the spotlight.

By Melissa A. Fitzpatrick, MSN, RN, FAAN

In health care today, technological advances grab headlines while clinicians' documentation duties mount almost daily. Is basic nursing care receding into the background?

Recently, *American Nurse Today*'s Editorial Advisory Board (EAB) had a spirited discussion on the current state of nursing and patient-care delivery. We concluded we need to shift the focus back to basic nursing care. Hence, the special supplement you're now reading—*The Essence of Nursing: Advancing the Art and Science of Patient Care, Quality, and Safety.*

So what is the essence of nursing? It's what some people call "high-touch" nursing, where the nurse has plenty of face-to-face time and a personal connection with patients and their families. In a sense, the essence of nursing is the very heart of nursing.

During our discussion, EAB members shared examples of extraordinary nurses who've had a significant impact on patient outcomes and the patient-family experience. We also shared anecdotes in which nurses didn't behave like the compassionate, competent caregivers we all aspire to be. This dichotomy underscored our belief that nurses need to get back to the basics—to living and breathing the essence of nursing in every patient encounter to realize the full potential of our profession.

Certain characteristics and competencies set nursing and nurses apart from other professions and practitioners. As EAB members discussed the essence of nursing, we asked each other: What's distinctive about a nurse's DNA? How does that distinction manifest when it comes to providing safe, high-quality patient care? How can nurses deliver the essence of nursing to its fullest extent possible—especially when caring for such vulnerable patients as low-birth-weight infants and elderly adults? What factors or circumstances enable or prohibit nurses from doing this? In today's fast-paced, high-acuity, multidimensional, and penalty-driven healthcare delivery system, it's crucial that we find answers to these and related questions.

Nursing presence

The nurse is the key to providing safe, effective, and compassionate care at both the individual and organizational levels. Despite the rapidly changing healthcare environment, one constant remains: The nurse, in a collective sense, is the healthcare professional who's with the patient and family 24/7/365.

The nurse creates and nurtures an intimate bond with the patient and family through a constant presence and hands-on care. She or he gets to know the patient and family better than any other healthcare provider, learning their wishes, fears, capabilities, and challenges. It's the nurse in whom the patient confides in the middle of the night and to whom the patient's loved ones turn for information, support, and solace.

When a patient experiences overt distress or deteriorates suddenly, the nurse is likely to be the first one on the scene, initiating rescue procedures. More often than not, it's the nurse who detects subtle changes in vital signs or behavior that signal a serious or life-threatening event. The literature tells us that when nurses have the right preparation and are present at the right place and the right time, patient outcomes improve. In collaboration with interdisciplinary colleagues, nurses' highly skilled, competent, compassionate care can help prevent the patient's functional decline, eliminate knowledge deficits for the patient and family, and promote their engagement in health care.

Presence and vigilance are key elements of the essence of nursing. But along with the privilege of being "the one who's there" comes a tremendous responsibility and accountability. Nurses are, and always have been, the patient's first and last line of defense. Keeping the patient safe from preventable adverse events—such as falls, pressure ulcers, infections, and immobility complications—are high on nurses' priority list as they manage and coordinate the patient's care to ensure safe passage through the care-delivery system.

Spotlighting basic nursing care

This supplement puts basic nursing care back in the spotlight where it belongs by:

- revisiting key elements of patient care, updating them in the context of today's healthcare environment
- emphasizing the nurse as the patient's sentinel, who protects the patient from injury and acts quickly when potential danger arises
- stressing the nurse's role in marshalling appropriate resources to ensure optimal patient outcomes
- highlighting the significance of nursing observation and evaluation of the patient.

Where the topic of technology arises in this supplement, the authors make it clear that its most important role is to support the decision making of nurses and other clinicians. Although technology can help improve patient care, it also can distract us from basic care. If we get caught up in technology, we can lose sight of the higher purpose of health care.

The essence of nursing and the organization

Many of the indicators that drive a healthcare organization's performance, profitability, and image in the community it serves hinge on how well its nurses practice the essence of nursing, The essential elements of nursing care are crucial in reducing lengths of stay, cost per case, adverse events, and litigation. Nurses have a measurable and significant impact not just on safety, quality, and economic outcomes but also on patient satisfaction and engagement, as shown in scores on Hospital Consumer Assessment of Healthcare Providers and Systems surveys.

Who better than the nurse to coordinate the many disciplines involved in a patient's care? To consider the multiple facets of the patient-family dynamic when exploring care needs across the care-delivery system? Effective nursing care is critical in preventing readmissions and ensuring that patients successfully navigate the many hand-offs that occur during their stay.

With today's focus on quality and cost and the financial penalties of suboptimal care, validating and quantifying nurses' impact and recognizing their value to healthcare organizations and communities at large is crucial. As we work to enhance the patient experience and promote care across the continuum, our ability to uphold the essence of nursing will make or break our efforts.

Recipe for success

The essence of nursing encompasses a fundamental set of ingredients that serves as the "recipe" for success at many levels—the individual patient and family experience, an organization's success as measured in outcomes and costs, and the health of our nation and the global community. Multiple factors influence how successfully this recipe turns out:

- Everyone involved must understand what it takes to create an environment that fosters full expression of the essence of nursing.
- Healthcare organizations must learn and replicate best practices that validate, appreciate, and recognize the essence of nursing. This, in turn, helps raise the standard of patient care while nurturing nursing staff and making their work more satisfying.
- The art of nursing must coexist with today's technology-driven, evidence-based science of nursing. To ensure such coexistence, nurses must manifest the essence of nursing in every patient and family encounter.

To a large degree, the future of healthcare delivery hinges on our ability to optimize the work of nurses and enable them to practice the essence of nursing. We believe this supplement gives you the tools you need to achieve that optimization and the power that comes with it. ♋

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Creating the environment for nursing excellence

It's time for staff nurses and nurse leaders to help create a work environment that fosters basic nursing care.

By Lillee Gelinas, MSN, RN, FAAN

It's not easy to define basic nursing care in terms relevant to academia, research, and practice. Yet ensuring the delivery of basic care has never been more important. As Pipe and colleagues wrote in 2012, "As the work of nursing becomes increasingly more complex and significantly more technical…, nurses are beginning to find that the basic nursing interventions that were once the hallmark of good nursing care are being left behind."

Articulating when basic care is *not* done, termed "missed" care, has advanced work in this area. In the last 6 years, studies have shown that significant amounts of care are missed in acute care hospitals. Missed care is important not just from a patient safety and quality of care perspective, but also from a business perspective. Hospital reimbursements are reduced or eliminated for acute care services when any one of a common set of complications occurs.

To avoid missed care, staff nurses and nurse leaders must collaborate to create an environment where basic nursing case is a priority. Here are five evidence-based strategies that can help.

1 Improve collaboration

Collaboration needs to occur at all levels, from the bedside to the boardroom. Traditional centralized command and control management structures are ineffective for today's transparent and ever-demanding healthcare market. We must put structures in place that support rapid, multi-directional collaboration and communication, and patients must be made an integral part of that collaboration. As some have noted, patients want "partnership, equity, accountability, and mutual ownership in their own healthcare decisions and those of their family members."

2 Make basic care a priority for staff as well as patients

The 2011 report "Through the Eyes of the Workforce" from the National Patient Safety Foundation states, "Workplace safety is inextricably linked to patient safety. Unless caregivers are given the protection, respect, and support they need, they are more likely to make errors, fail to follow safe practices, and not work well in teams."

But instead of protection, respect, and support, too often nurses and other healthcare workers experience physical and psychological harm. On-the-job injuries are significantly higher in health care than in other industries. And instead of getting respect, some nurses suffer emotional abuse, bullying, and even threats of physical assault.

What can be done? Staff and leaders must shape a safety cul-

ture through practices that show safety is a priority. We must put systems in place that engage the workforce and encourage staff to speak up and report errors, mistakes, and hazards that threaten safety—their own or their patients'. When nurses feel valued and safe, the work environment improves and patients are safer.

3 Implement shared governance

The shared decision-making that comes with shared governance is vital not just to patient safety but also to nursing's future. Examples of how to engage frontline staff in shared decision-making include appointing unit-based champions for specific issues and establishing unit, departmental, and organizational practice councils, which enhance staff communication networks while increasing accountability for practice. Such engagement pays off. For example, a recently implemented CHRISTUS Health System shared governance structure for the emergency services service line led to quick triage policy standardization by staff nurses on the committee. They accomplished in record time what usually takes months.

4 Articulate the business case for nursing

Many researchers have made the business case for nursing through effective nurse staffing. For example, studies associate better nurse staffing with shorter stays and complications, which results in lower costs. Such results highlight why hospitals should focus on nursing care to improve clinical quality and patient safety, use research that

Staff and leaders must shape a safety culture through practices that show safety is a priority.

links nursing care with clinical outcomes, and ensure nurses have time at the bedside to care for patients.

5 Stop wasting nurses' time

Nurses are the primary hospital caregivers. Increasing the efficiency and effectiveness of nursing care is essential to hospital function and delivery of safe patient care. Yet evidence shows inefficiency is common in nursing practice. A 2008 study of medical-surgical nurses found they spend more time documenting (28% of their shift time) than on any other activity. How much of that documentation is really relevant to the patient's outcome as opposed to being collected because of legal and regulatory requirements? Excessive documentation is a prime example of what's called type I waste in lean terms: a non-value-creating activity made necessary by the way hospitals organize work.

The same study found nurses walk about an hour per shift. But variation in distance traveled was greater within a single unit than among units of very different physical layout. That's because a major factor in how far nurses walk is how closely their patients are to each other—something easily under our control through scheduling and assignments.

Nurses in this study also classified 7% of their day as "dead waste." If we could eliminate all of the dead waste and half of the type I waste just from walking and excessive documentation, we'd free up about one-quarter of all nursing hours. And that's even if we do nothing about the waste in the rest of a nurse's workday. If properly conducted, redesigning processes and work can improve worker retention.

Forging a partnership

With healthcare reform, new technology, and a solid base of evidence for the powerful influence of nursing care over patient outcomes, the time is ripe for staff nurses and nurse leaders to partner in creating a work environment that fosters solid basic nursing care. ✇

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Enhance patient engagement through sharing

Sharing stories, health information, and decision making promotes active engagement.

By Susan C. Hull, MSN, RN

We are in the midst of a patient experience revolution. The e-patient movement is igniting patients to become empowered, engaged, equipped, and enabled in their health and healthcare decisions.

At the same time, providers and healthcare organizations are recognizing that patient engagement and participation are essential to achieving the triple aim of health care: improving care, optimizing health, and reducing cost.

Achieving these goals requires a culture that prioritizes patient engagement as a core value. (See *Patient engagement and patient satisfaction: What's the difference?*) This requires practices that include the active collaboration of providers, patients,

and their families and caregivers. Here are some ways nurses can lead the way.

Discover and share your patient's story

Patients have complex life and health stories that run deeper than the reasons they seek care. Put your patient's voice first and learn what matters most to the individual and what he or she wants to accomplish in his or her health encounter. Uncovering the full story will help you to personalize the best evidence-based care plan for that person.

Unfortunately, limited time and extensive forms often encourage data collection, rather than storytelling and meaningful conversations. This can make barriers to health and self-care, such as lack of social support, isolation, and issues at home, hard to detect.

Patient stories can also be trapped in provider "silos" and not get shared across collaborative care teams. Strategies to help you discover and share your patient's story include:

- Practice health story conversations with the entire care team using forms or computer screens as a guide, but not the medium. For example, begin a conversation with "Tell me about the health patterns or issues you

are most concerned about today, such as getting enough rest, tolerating exercise, or breathing easily."
- Encourage and support patients to tell their stories to better articulate their own health goals and challenges. Make the patient feel at ease by asking open-ended questions, such as "What's the most important health goal you have for yourself over the next month?"
- Create "living" documentation, not just a one-time admission data form. Living documentation is easily accessible and updateable by all members of the collaborative team, rather than siloed in a paper chart or electronic health record. Personal details that are learned by nurses and others can be added as multiple entries over time as more is learned about the patient and family.
- As a patient's story unfolds, update all appropriate care team members. Do this as needed and routinely during rounds and shift changes.

Learn the story of caregivers and family

Engage and learn the story of significant others in a patient's life. This includes the history, needs,

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Patient engagement and patient satisfaction: What's the difference?

Patient satisfaction is a patient's own subjective rating of healthcare experiences. Patient engagement, on the other hand, as defined by the Institute for Healthcare Improvement, refers to actions people take for their health and to benefit from care. Engagement spans the continuum of experiences within healthcare settings, including the community and the home.

and expectations of family and other caregivers. In many cases, learning their stories reveals hidden barriers to health and recovery. Sharing this information across disciplines helps the care team address them promptly.

Here are some tips:

- Assess how the caregiving team is supporting the patient. Who is the primary caregiver? Who is responsible for coordinating communication with the care team?
- Evaluate what barriers are most significant to continued recovery. Ask how well rested the team is, and consider their capacity for continued physical and emotional caring. For example, ask what caregivers do to relax and recharge.

Share health data

Effective patient engagement includes exchanging data before, during, and after health encounters. Federal programs for the meaningful use of health information technology (HIT) require offering secure electronic messaging. Patients must be able to view, download, and transmit their health information.

Here are some HIT tools that support patient engagement.

- **OpenNotes, Our Notes, and other electronic documentation tools.** These tools give patients electronic access to their entire record. Patients are encouraged to view their records and make corrections, in conjunction with their providers, as needed. This promotes transparency and puts provider and pa-

Tap into a patient-engagement resource

The *Guide to Patient and Family Engagement in Hospital Quality and Safety* is a tested, evidence-based resource developed by the Agency for Healthcare Research & Quality (AHRQ). The comprehensive guide offers opportunities and guidance for meaningful engagement that can improve quality and safety. The guide is available at: www.ahrq.gov/professionals/systems/hospital/engaging families/guide.html.

tient on the same page.

- **Patient-Generated Health Data (PGHD).** These tools include a variety of health information created, recorded, and gathered by patients or their designees. Patients, not providers, are primarily responsible for capturing or recording such data, which are distinct from data generated in clinical settings. Patients direct the sharing to recipients of their own choosing.
- **Patient-Reported Outcomes (PROs).** These tools document outcomes important to patients. PROs reflect how well their needs have been met and their care coordinated. PROs are collected through a series of questionnaires sent to a patient electronically (SMS text message) to quantify medication adherence and describe the nature of side effects and reasons for nonadherence.

Share decision-making

Care planning and outcome evaluation should include the voice of the patient and home caregiver team. Shared decision-making (SDM) brings providers and patients together as collaborators. Techniques that support SDM include:

- Ask the patient what his or her care goals are for today, the care episode, for dis-

charge, and overall health. Compare these goals to those set by the clinical team.
- Clarify what decision points can be shared, what actions the patient and caregivers can take and what they can expect from the team.
- Establish continuity with a shareable care plan. Show the patient the design of the plan, how ownership is shared, and who can make changes or updates.

For more patient engagement ideas, see *Tap into a patient-engagement resource.*

Heart of nursing

Assessing a patient's knowledge, skills, and assets for self-care has always been at the heart of nursing. You can help take patient engagement to the next level. ✺

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Reducing functional decline in hospitalized older adults

Learn how to detect and prevent hidden dangers of hospitalization for these patients.

By Denise M. Kresevic, PhD, RN, APN-BC

Older adults make up 13% of the U.S. population but account for 36% to 50% of hospital admissions and 44% of hospital charges. About 20% of Medicare patients are readmitted within 30 days; an estimated 75% of these readmissions are preventable.

A dramatic event at any age, hospitalization poses unique challenges for older adults. Hospitals harbor such dangers as adverse drug events, restraint injuries, and falls, which can be lethal in the elderly. For these patients, hospitalization also is linked to a significant risk for delirium, malnutrition, infection, and loss of functional independence—possibly leading to persistent disability, nursing home placement, and death. Evidence-based nursing care models to prevent these complications continue to gain support. Many of these models embrace multidisciplinary assessment, communication, and coordination.

Hospitalized older adults have an uncertain trajectory; many never regain their previous mobility. Some studies show up to 35% of older hospitalized patients experience a decline in baseline activities of daily living (ADL) after admission.

As a nurse, you can help prevent patients from leaving the hospital with worse function than they came in with. You're in a pivotal position to observe their independence level in performing basic ADLs. A standardized screening instrument, such as the Katz Index of Independence in Activities of Daily Living (bathing, dressing, toileting, eating, and transfer), can help the healthcare team identify deficits and plan posthospital care. Mobility routines that include getting the patient up for meals or sitting in a recliner or rocking chair may improve mobility among weak or fatigued older adults.

This article discusses some of the hidden dangers of hospitalization for older adults—delirium, reduced mobility and falls, malnutrition, dehydration, and infections.

Delirium
The hallmark of certain acute illnesses, delirium or acute confusion is the leading complication of hospitalization in older adults. It affects 25% to 60% of older hospitalized adults in the United States and costs about $8 billion yearly.

The complex pathophysiology of delirium includes neurotransmitter alterations. Processes that may contribute to delirium include hypoxia, infection, electrolyte imbalance, constipation, and pain.

The good news: Delirium may be preventable in at least 40%

of cases. Assess all hospitalized older adults for confusion during each shift, noting inattention or fluctuating mental status. Ask them what brought them to the hospital and ask them to name the days of the week or months of the year forward and backward. If you note changes, document these and discuss them with all care team members.

Try to identify the cause of delirium. Know that restraints and certain medications can prolong or worsen this condition. If you note sudden or worsening confusion in a patient with known cognitive impairment, evaluate for potential acute reversible causes.

The following interventions can help prevent delirium in older adults:

- Use appropriate pain medications in dosages tailored to older adults.
- Avoid sleeping medications.
- Correct sensory deficits, such as hearing and vision loss.
- Encourage increased visits from family members and volunteers.
- Provide access to music and art therapy.
- Create a quiet environment for sleep at night.

An "aging tool kit" that includes hearing amplifiers and magnifying glasses can be assembled to enhance communication and provide safe options for distraction, including books and puzzles.

Reduced mobility and falls

The hazards of immobility and prolonged bed rest have been known for decades. Many

Ensure that the patient has assisted or supervised ambulation (especially to the bathroom).

healthcare professionals have noted the negative effects of bed rest, including orthostatic hypotension, atelectasis, decreased muscle strength, increased bone loss, constipation, incontinence, pressure ulcers, and confusion.

Maintaining the patient's mobility is the best way to prevent falls. Provide opportunities to enhance mobility safely. Consult a physical therapist, who can assess for balance and gait abnormalities and provide exercises and equipment to help the patient regain strength, avoid complications, and promote return to baseline function. Use devices such as slings and lifts as needed to move patients so you protect them (and yourself) from injury while still providing opportunities for mobility.

Ensure that the patient has assisted or supervised ambulation (especially to the bathroom). Provide ongoing education to the patient and family, using the teach-back technique, to identity the patient's safe level of function and encourage exercise and use of mobility aides. For example, tell the patient, "Show me what you would do if you had to go the bathroom." Or ask, "What would you do if you called for the nurse and she didn't come immediately?" Suggest

that plan B might be to call for the nurse again.

Another way to help prevent falls is proactive rounding to provide assistance for toileting and ensuring a safe environment. Such rounds strongly encourage and assist older adults to go to the bathroom before they feel the urge and need to rush. Other effective interventions include:

- placing frail patients in rooms near the nurse's station
- keeping the bed in the low position
- keeping the call light, water, and accessories within reach
- using dim lighting at night
- placing furniture in nonobtrusive positions
- raising the toilet seat.

Malnutrition and dehydration

At least half of older adults are admitted to the hospital with dehydration and malnutrition. Both conditions are independent risk factors for falls, confusion, pressure ulcers, impaired immunity, longer stays, and even death.

Assess your patient's nutritional status on admission to identify and correct nutritional deficits in a timely manner. For lethargic older adults, assess safe swallowing ability at the bedside. During an acute illness, avoid aggressive restricted diets (including nothing-by-mouth) for prolonged periods.

Preventing constipation is crucial. Prevention strategies include providing adequate fluids and warm prune juice and promoting mobility. In some older adults, nutrition can become critical, signaling depression and end-of-life

issues. Feeding-tube placement must be evaluated carefully.

Provide nutritional and speech resources to help manage nutritional problems. As needed, arrange for an ethics consultation to give the patient and family the information they need to set realistic goals. Be sure to honor the patient's wishes.

Other interventions to prevent malnutrition and dehydration include:

- assessing and honoring the patient food's preferences
- providing a "liberal kitchen" with snacks available 24/7
- performing oral care before meals to help the patient maintain nutrition and prevent infections.
- getting the patient out of bed for meals and for 20 minutes afterward, if possible, to prevent indigestion.

Infections

Older adults with decreased immune function are at special risk for infection. Urinary tract infections and pneumonia commonly necessitate hospital admission in older adults. However, antibiotic therapy to treat infection can be particularly complex in older adults who may have unique illness presentations, are at increased risk for resistant organisms, or are receiving multiple medications that may increase adverse effects.

Also, know that certain hospital routines may pose undue risk of infection. To help decrease the risk of atelectasis and pneumonia, avoid bed rest when possible. Carefully evaluate the need for indwelling urinary catheters, considering their risks, benefits, and alternatives. Discontinue these catheters as soon as possible.

Consider the following interventions as well:

- Remind older adults to perform ongoing oral care, including teeth or denture brushing, mouth rinsing, and lip care for dryness. As needed, assist them with this care.
- Be sure staff and visitors wash their hands before and after contact with the patient.
- Instruct older adults to perform daily hygiene, including hand washing.

The value of discharge planning

Appropriate discharge planning helps avoid functional decline in older adults. Planning for the patient's discharge begins at the time of admission and must be integrated into daily care by all care providers. Due to insurance requirements and financial constraints, discharge planning has become increasingly complex.

Choices for posthospital care depend on the patient's health status and illness trajectory, as well as available support persons and resources. The interdisciplinary team must be able to give the patient and family a realistic trajectory of recovery as well as recommended options.

Nurses in all care settings, particularly acute-care hospitals, are well placed to help older adults avoid functional decline. In some cases, this may require a change in the hospital culture and additional education for nurses regarding older adults' unique needs. Special areas of focus include the patient's particular needs, care transitions, and possible changes in hospital routines, such as bed rest and restraint use. ෨

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Get your patients moving—now!

Learn about early progressive ambulation protocols that promote better outcomes.

By Amanda Veesart, MSN, RN, CNE, and Alyce S. Ashcraft, PhD, RN, CNE, ANEF

To keep patients on the move, healthcare professionals need to make planned mobility a priority intervention. Progressive mobility (also known as early mobilization) starts slowly and moves the patient toward more range-of-motion exercises, longer sitting times in a chair, and more frequent and longer walks in the hallway.

Although progressive mobility isn't a new concept, one aspect is relatively new—the initial start time. Traditionally, patients haven't been encouraged to ambulate or sit up early during their stays or after surgery. Instead, clinicians viewed bed rest as an important aid to healing, especially during an acute illness. For example, patients used to be placed on 3 days of bed rest after an uncomplicated acute myocardial infarction. But with research now supporting early mobilization, this no longer happens. Today, most patients are encouraged to move from the beginning of their stay, to prevent negative bed-rest outcomes, such as blood clots, pneumonia, delirium, and ultimately, patient dissatisfaction and longer stays.

How can nurses get patients moving earlier? Ambulation is the most common way. If your patient is unable to ambulate, consider other methods, such as elevating the head of the bed, passive range of motion (ROM), manual turning, dangling, and assistance to a chair. No set standard of care exists on when to start the mobilization process. What's more, in some situations, barriers exist. (See *Barriers to mobilization*.)

As a standard of care, mobilization requires planning. If the provider hasn't given orders to

Barriers to mobilization

Barriers to early mobilization of hospital patients include:
- patient (or family) refusal due to patient pain and discomfort
- large patient size
- lack of personnel
- lack of safe-patient handling and mobilization equipment
- lack of provider orders
- failure to make mobilization a priority.

If moving causes pain or the patient lacks the will to move, take the time to inform the patient and family of the importance of mobilization, explain its benefits, and provide pain medication (if required and ordered).

Some patients may be reluctant to begin mobilization. But in many cases, they later admit that moving made them feel better, even though it caused discomfort at the time. Remember that the family must be on board with the importance of mobility. Otherwise, they could sabotage the plan of care to avoid "hurting" their loved one.

mobilize your patient, contact him or her to validate the mobilization plan. Normally, this isn't a major issue—just one that takes precious nursing time. But forgetting to contact the provider or relegating this task to the bottom of your to-do list isn't an option.

Get assistance—and assistive devices

Mobilizing patients also requires access to staff and resources. Some patients are unable to move or ambulate without assistance. For these patients, turn to devices such as lifts and slings to transfer patients and use assistive tools such as gait belts and walkers to help them move. As needed, recruit other team members to help mobilize patients.

Keep in mind that lack of assistive devices isn't an excuse for failing to implement mobility protocols. Advocate within your organization to obtain these devices, which protect patients and staff.

Progressive ambulation protocols

Progressive ambulation protocols

serve as implementation guides in setting mobility expectations for a specific patient population throughout the hospital stay. Because these protocols standardize bed, transfer, and ambulation activities, they eliminate the need for nurses to wait for physician rounds or new orders to progress patients to the next step in the protocol.

Early mobilization in the ICU

In the ICU, the first step in progressive mobility is assessing the patient for mobility initiation. The healthcare team evaluates the patient to ensure early mobility isn't contraindicated and communicates all steps of the process to the patient. Contraindications for early mobility in the ICU include one or more of the following:

- unstable blood pressure (mean pressure below 65 mm Hg)
- heart rate below 60 or above 120 beats/minute
- respiratory rate less than 10 or more than 32 breaths/minute

- oxygen saturation below 90%
- anxiety or agitation requiring sedation
- insecure airway device
- difficult airway access.

Be aware that patient devices, active intubation, or continuous I.V. medication infusions are not contraindications.

The scenario below illustrates an early progressive mobilization protocol for an ICU patient.

Mr. Jones, age 52, just had coronary artery bypass surgery. Awake and still intubated, he is receiving I.V. infusions, with sequential compression devices applied to his legs. His plan of care includes early progressive mobilization.

Before mobilization begins, the nurse explains the process to Mr. Jones and instructs him on how to signal anxiety, pain, or a feeling that something is changing. To ensure he is fully prepared for mobilization, a designated team member is assigned a communication-only role. Charged with instructing the patient, this team member stays directly in front of him during the entire exercise.

After assessing Mr. Jones for contraindications to early mobility and explaining the process to him, the team determines if early progressive mobility can safely begin. To ensure the patient, healthcare team, and equipment are secure and safe,

the nurse assesses all devices for secure attachments, stops unnecessary I.V. infusions, and moves indwelling devices to the side of the bed. Other team members verify that the wheelchair is secure and close to the bed for the transfer. The respiratory therapist confirms that the mechanical ventilator is switched to a transport ventilator and the endotracheal tube is secure.

After verifying the safety of all devices, the team assists Mr. Jones to the side of the bed. Then they implement active range-of-motion (ROM) exercises in this position before transfer. The designated communicator uses one-sentence commands to ensure that the patient and all team members understand each step of the transfer process.

Early mobilization on the orthopedic unit

Early progressive mobility on the orthopedic unit resembles the process used in the ICU. After joint- replacement therapy, progressive mobility starts by moving the patient to the side of the bed or implementing active ROM exercises. Patients who've had this type of surgery or other leg surgery typically have difficulty at this stage and may need pain medication before mobilization. Remember—although progressive mobility should begin early, this doesn't necessarily mean the patient should ambulate quickly.

The scenario below describes an early progressive mobility protocol on the orthopedic unit.

Mrs. Smith, age 65, is recovering from right total knee re-

placement surgery. Her plan of care includes early progressive mobility. The nurse assesses her for contraindications to mobility. She knows that patients who've just had joint replacement may progress to ambulation more slowly than other patients.

After the nurse determines it's safe for Mrs. Smith to move, she has her perform active ROM exercises three times. Before advancing her to standing, the nurse recruits a second staff member to assist her for added safety.

Once Mrs. Smith has mastered standing, the nurse helps her ambulate with a walker or other assistive device. During ambulation, one staff member is designated to communicate with Mrs. Smith to avoid confusion or mixed messages about her next step. To promote early discharge and enable her to remain in her home, team members provide thorough instructions on proper ambulation techniques and the assistive device she'll be using at home.

Early progressive mobility on the orthopedic unit resembles the process used in the ICU.

Obtaining appropriate assistive devices is important for both patients' and employees' safety. After discharge, these devices can help the patient ambulate at home and in the community.

Although some nurses may be uncomfortable about moving a patient only a few hours after major surgery, receiving training in progressive early mobility protocols can give them more confidence. These protocols promote better patient outcomes and help reduce hospital stays and readmissions. So get your patients moving—now! ∞

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Keeping patients safe from falls and pressure ulcers

In your patient advocate role, push for hospital policies that help prevent these "never events."

By Amy Moore, DNP, RN, FNP-C, and Rebecca Geist, MSN, RN, APHN-BC

Keeping hospital patients safe from untoward events is a crucial aspect of the essence of nursing. Every healthcare organization is accountable for the care and safety of its patients. Patient falls and pressure ulcers are costly—in time, money, and lives. (See *The high toll of falls and pressure ulcers*.) What's more, falls and pressure ulcers are "never events"—healthcare errors that should never occur, as defined by the National Quality Forum. Considered preventable and serious, "never events" reflect a problem in the healthcare delivery system. In this article, we present a case study to illustrate how to help prevent falls and pressure ulcers.

Anna Roberts, age 75, is admitted to the orthopedic-surgical unit on your shift to recover from surgery for a fractured patella. After misjudging a small step when entering a store, she fell and injured her left knee and was taken to the hospital by ambulance.

Mrs. Roberts arrives on your unit with a dressing, a long soft splint, and I.V. access for pain-control medication. When you assess her, you find her alert and oriented to time, person, and place. She states she is a widow and has been living independently at home. She is able to drive and keeps busy with various hobbies. Her daughter lives nearby and visits often. She tells you she has been planning a trip to Europe with friends next year. Now she worries her knee injury could prevent her from going.

You know that for Mrs. Roberts and other elderly patients, a fall may lead to a functional decline. You also know she has multiple risk factors for falls and skin breakdown. Naturally, you want to help her avoid another fall and prevent skin breakdown. Risk factors for falls include advanced age, certain medications, and inactivity due to medical conditions that cause weakness or dizziness. Because of her injury, Mrs. Roberts is at increased risk for falls due to the new pain medications she's taking, clumsiness caused by her leg splint, the need for crutches, and her decreased activity level. Splint use and decreased mobility also raise her risk for pressure ulcers.

To promote her recovery in the hospital and plan her return to previous activities, you set the following care goals: preventing falls, keeping her active while controlling her pain, promoting skin integrity, and helping her feel comfortable about going home without fearing she'll fall again.

Assessing your patient's fall risk

Multiple tools are available to help clinicians assess patients for fall risk:

The high toll of falls and pressure ulcers

According to the Centers for Disease Control and Prevention, falls in elderly persons are among the most serious safety issues for hospitals, with costs expected to reach nearly $68 billion by 2020. Each year, about one-third of adults older than age 65 fall. About 20% to 30% of older adults who fall suffer injuries that alter their ability to perform activities of daily living. Although many patients recover from their injuries, they may return home with decreased mobility due to fear of falling again.

Pressure ulcers are the fourth leading cause of preventable errors in the United States, with medical costs ranging from $2,000 to $70,000 per ulcer. Pressure ulcers increase the risk of readmission and death.

- The **Timed Up and Go test** is a short, simple, and reliable screening test for balance problems. The evaluator times the patient as she rises from a chair, walks 3 meters, turns, and walks back to the chair. Performance is graded on a scale of 1 to 5, with 1 indicating normal and 5 denoting severely abnormal. A score of 3 or higher indicates an increased fall risk.
- The **Balance Evaluation Systems Test** differentiates among balance deficits. It consists of 36 items in six underlying systems that affect balance, helping clinicians focus on treatments for specific balance problems. It takes 30 minutes to complete.
- The **Tinetti Scale** evaluates balance and gait to determine the patient's risk for falling in the home. Assessing both gait and balance, it's useful for patients with a history of or high risk for falls. A healthcare provider or family member may administer the Tinetti Scale.

Preventing falls

Universal fall precautions, which apply to all patients regardless of fall risk, revolve around keeping the patient's environment safe and comfortable. They focus on keeping all patients SAFE: **S**afe environment, **A**ssist with mobility, **F**all risk reduction, **E**ngage the patient and family. (You can read more about risk assessment elsewhere in this supplement.)

In the hospital, engagement includes promoting communication among employees, family members, and friends regarding the patient's need for help getting to the bathroom, nonskid socks, and use of a walker or bed alarm when no one is with him or her. A bed alarm signals the healthcare team that the patient is getting out of bed. Special floor mats that protect patients if they fall out of bed also may be appropriate. These measures can be especially helpful with confused patients.

In some facilities, at-risk patients wear colored armbands to alert others of their fall potential. This helps caregivers determine how much assistance the patient needs during transport and whether to house him or her in a room near the nurses' station. Some facilities assign different levels of fall risk, indicated by color-coded armbands or markers on the outside of the patient's door.

Keeping the bed rails down is important, too. When all rails are up, the patient is more likely to try to crawl over them to get out of bed, increasing the risk of falling. In rare cases, a confused patient must be restrained. However, restraints should be used only as a last resort because they can increase patients' agitation and cause serious injury. Make sure you're familiar with your facility's restraint policies and procedures. If your patient is restrained, check the restraint throughout your shift for appropriate tightness and skin irritation. Ensure the patient has easy access to the call button.

Before discharge, evaluate the patient's risk for falling in the home. (See *Reducing risk factors for falls at home.*)

Promoting skin integrity

Starting on admission, assess patients daily for potential skin breakdown. Unless existing breakdown is documented on admission, the insurer will assume skin breakdown occurred after admission and won't reimburse the hospital for related medical costs.

Use the Braden Scale to evaluate the patient's risk for pressure ulcers. This scale assesses skin breakdown risk using six criteria—sensory perception, moisture, activity, mobility, nutrition, and friction and shear. Scores range from no risk to very high risk. For more information on the Braden scale, see http://consultgerirn.org/uploads/File/trythis/try_this_5.pdf. You

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Reducing risk factors for falls at home

Risk factors for falls in the patient's home include slick floor surfaces, rugs, cluttered pathways, and poor lighting. Also, someone who has fallen in the previous 6 months has a high risk of falling again.

Communicating with family members is essential and should include education on preventive measures, such as an optional home assessment; family members should communicate assessment findings to the nursing staff. Together, the family and nursing staff can determine what changes need to be made in the home. For instance, they may consider use of a fall monitor to alert them in case the patient falls. Monitoring systems vary in price and can help prevent more serious harm if a fall occurs. Some systems automatically call a family member or emergency services if the patient falls or activates the system.

Preventing, detecting, and managing pressure ulcers

Nurses must stay vigilant and act promptly to prevent and manage pressure ulcers.

Prevention

Wash the patient's skin with warm water as needed. Avoid using rough edges of the washcloth. Pat the skin gently to dry. Also follow these guidelines:

- Check for incontinence and perform perineal care daily.
- Provide an appropriate support surface for the bed and the wheelchair or other sitting surface. Use a lateral rotation bed as indicated.
- Create individualized turning and repositioning schedules.
- Help patients stay as mobile and active as possible.
- Keep the heels elevated from the bed in patients who aren't mobile.
- Assess for nutrition and hydration needs. Provide a referral to a dietitian, as needed.

Detection

To help identify pressure ulcers early, perform a comprehensive skin assessment that includes observing and touching the skin from head to toe. Consider temperature, color, moisture level, turgor, and skin integrity. Stay especially alert for signs of pressure and friction on these areas:

- back
- buttocks
- heels
- under splints
- areas affected by wrinkled bedsheets
- areas under clothing buttons.

To find time for a thorough skin assessment, incorporate it into your daily care. For example, when auscultating lung sounds or turning the patient, inspect the patient's shoulders, back, and sacral/coccyx regions.

Management

If a pressure ulcer or other type of skin breakdown occurs, take these steps as appropriate:

- Advise the patient to increase calorie intake and consume adequate amounts of protein, vitamins C and D, and zinc. Encourage the patient to stay well hydrated.
- Consult a wound care clinician to ensure that the patient receives the proper care.
- When bathing the patient, use a soft sponge and avoid scrubbing. Try to bathe the patient every other day (rather than every day) to avoid drying the skin.
- Make sure the patient stays hydrated.
- Avoid placing a pillow under the knees. Instead, place it under the calves to relieve pressure on the heels.

Documentation

If a pressure ulcer develops, evaluate for and document the following:

- pressure ulcer category or stage
- location
- depth
- size
- erythema
- blanching
- drainage
- odor.

also can use the Norton scale to identify at-risk patients (see www.ahrq.gov/professionals/systems/long-term-care/resources/pressure-ulcers/pressureulcer toolkit/putool7b.html).

Evaluate the patient's age, mobility, and type of illness or injury. Elderly patients are at high risk for skin breakdown—especially those with hip fractures and others who must endure long periods of immobility.

To help prevent pressure ulcers, use a special mattress and turn the patient at least every 2 hours; patients at high risk may need to be repositioned and turned more often. Caregivers' failure to recognize the need for an appropriate bed or mattress for a high-risk patient can lead to skin breakdown. A patient who is expected to be on prolonged bedrest may need a special air mattress to help prevent skin breakdown.

Be sure to assess skin areas under clothing, dressings, splints (as with Mrs. Roberts in our case study), or other devices. Remember—skin can start to break down within hours of compression. (See *Preventing, detecting, and managing pressure ulcers*.)

Adequate skin care may necessitate readjusting a splint or using special padding, such as under the patient's heels. Clean the skin regularly; as you do this, evaluate skin under the padding for signs of breakdown.

Communication counts

Be sure to convey the patient's risk for skin breakdown to other healthcare team members, particularly during handoff to other clinicians—especially if the skin has already started to redden. Improving communication

among healthcare professionals, as by using the TeamSTEPPS® and SBAR (Situation, Background, Assessment, and Recommendation) methods, can help patients stay safe.

Patient education

Patient education plays a key role in preventing pressure ulcers. From the time of patients' admission, teach them about the risk of potential skin breakdown and how to prevent it at home after discharge.

Promoting adequate nutrition

Nutrition helps maintain skin integrity and healing. Energy requires protein; during hospitalization, patients with a poor appetite may replace protein foods with simple carbohydrates. Some patients may make meals out of "junk" food instead of healthy proteins; for instance, they may eat a breakfast bar thinking it's full of protein when it's actually full of sugar, empty calories, and little protein. Healthy adults should consume 0.8 g of protein/kg/day. Many hospitalized patients need more—as much as 1.5 g/kg/day.

Proper wound healing requires amino acids, such as arginine and glutamine (found in red meat, fish, nuts, and dairy products) and a good multivitamin supplement containing vitamins A, B complex, C, and E, as well as magnesium, manganese, selenium, and zinc. Although nutrition research in the area of pressure ulcer care is limited, we know vitamin D is crucial to skin proliferation and plays a potential role in ulcer prevention. To help ensure your patient is obtaining adequate

hydration and nutrition, arrange for a dietary consult, and educate the patient and family about proper nutrition.

The nurse's advocacy role

Falls and pressure ulcers in elderly patients are nothing new, but these "never events" are getting more attention. They also have potential legal ramifications: A pressure ulcer that develops during a patient's hospital stay may be grounds for a professional liability lawsuit. Hospitals may suffer financially because their reimbursements may decrease if safety measures aren't carried out properly.

Acting as a patient advocate from admission through discharge can help you keep your patients safe. Advocate for hospital policies that help ensure patients stay safe. For instance, policies for fall-risk assessment programs with comprehensive guidelines for reducing and preventing falls can be created and implemented through fall-prevention teams and quality-improvement or risk-management teams.

Of course, nurses alone aren't responsible for patient safety. All hospital employees must make patient safety a goal, including housekeeping, food services staff, certified nurse aides, and administrators. We often criticize patients for being nonadherent when the real problem may be lack of available services or inability to access them. Such services include a home hazards assessment, implementation of a fall-proofing plan, an at-home exercise program, and installation of a fall-proof alert system. Preventing falls both in the hospital and at home and increasing your knowledge of pressure

ulcer prevention and management can help you keep patients in good health.

Before Mrs. Roberts is discharged, family members assess her home for fall risks. They remove throw rugs, install safety bars in her bathroom and shower, and purchase an affordable fall-alert system. Nine months after her surgery and discharge, Mrs. Roberts is back to her normal routine and is planning her upcoming trip to Europe. ∽

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How nurses can help reduce hospital readmissions

Learn how to help mitigate readmission risk starting from the time of admission.

By Joan M. Nelson, DNP, RN, ANP-BC, and Laura Rosenthal, DNP, RN, ACNP-BC

For too many patients, the hospital door is a revolving one. About 20% of Medicare patients leave the hospital only to be readmitted within 30 days. Failure to create standard discharge processes, adequately prepare patients and family caregivers for discharge, educate patients about medications, and communicate effectively with postdischarge providers contribute to preventable readmissions. The Hospital Readmission Reduction Program (part of the Affordable Care Act) reduces payments to hospitals with high readmissions rates within 30 days of discharge.

Through efficient coordination, communication, planning, and education, nurses and nurse case managers (NCMs) can play a pivotal role in reducing readmissions. Starting at admission, we can mitigate readmission risk at multiple points during the predischarge and postdischarge periods by:

- appropriately determining the patient's readiness for discharge
- compiling a comprehensive and accurate discharge summary
- helping to determine an appropriate postdischarge care setting
- coordinating care with multiple settings and providers
- involving the patient and family caregivers in the plan of care
- conducting postdischarge follow-up phone calls.

Nursing interventions on admission

Project BOOST® (Better Outcomes by Optimizing Safe Transitions) recommends interventions begin at admission. To help identify concerns that may warrant additional interventions during the patient's hospital stay, be sure to evaluate key psychosocial issues, including cognitive status, substance abuse or dependence, abuse or neglect, and documentation of advanced care planning. Communicate areas of concern to the NCM for potential interventions and referral to appropriate resources and referrals.

The General Assessment of Preparedness (GAP) tool helps nurses and NCMs with early patient evaluation. This simple checklist, which various healthcare team members can complete, addresses potential logistical and psychosocial issues. To learn more about GAP, visit www.hospitalmedicine.org/Web/Quality_Innovation/Implementation_Toolkits/Project_BOOST/Web/Quality___Innovation/Implementation_Toolkit/Boost/BOOST_Intervention/BOOST_Tools.aspx.

Nursing interventions throughout the stay

It's crucial to identify who will provide care for the patient after discharge and to involve this person in discharge planning. To increase the chance that family caregivers will be involved in planning, write the name of the postdischarge caregiver on the whiteboard in the patient's room. Preparing the patient and home caregiver for discharge throughout the hospital stay can ease information overload and confusion during the discharge process. Readmission rates decline when patients and family caregivers participate in discharge planning as active care team members. (See *IDEAL discharge planning method*.)

Nursing interventions during discharge

Many studies link readmissions with lack of prompt follow-up by primary care providers (PCPs) or other healthcare professionals. Ideally, patients should have a follow-up appointment within 48 hours to 7 days after discharge. NCMs may use the following strategies to increase the chance of successful follow-up:

- Develop scheduling agreements with local clinics, such as system-affiliated ambulatory care clinics.

- Create processes for assigning patients to a PCP if they don't have one.
- Educate patients and home caregivers about the importance of timely and appropriate follow-up.
- Identify and address barriers that contribute to cancelled healthcare appointments.
- Give the patient and family caregivers the discharging unit's phone number so they can call with questions or concerns.

Communication

During this critical transition time, clear communication must occur among PCPs, home healthcare agencies, long-term care facilities, and other facilities. Nurses and NCMs can assist in gathering written chart information as well as giving verbal report to the caregiver who's receiving the patient.

The National Transitions of Care Coalition encourages use of a standardized universal transfer tool to promote transfer of necessary patient information during care transitions. The Reducing Avoidable Readmissions Effectively Campaign provides transition information templates in its Safe Transitions of Care Toolkit, which includes checklists for important patient information. Available at www.mnhospitals.org/patient-safety/current-safety-quality-initiatives/readmissions-safe-transitions-of-care, this tool can be faxed to the receiving facility and reviewed before the patient-report phone call and patient transfer occur.

IDEAL discharge planning method

The Agency for Healthcare Research and Quality has developed a guideline and toolkit to help nurses and other clinicians involve patients in discharge planning. Using the acronym "IDEAL," this guide encourages nurses to use the following strategies with patients and family caregivers.

Include

Include the patient as a full partner in discharge planning, bedside rounds, and shift reports. Review medications daily and at each dose administration. Have at least one meeting specific to discharge planning at least 1 or 2 days before discharge. During this meeting, you can use the "Be Prepared to Go Home Checklist," available at www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_2a_IDEAL_Checklist_508.pdf.

Discuss

Focus on these five key areas to prevent problems at home:
- Describe life at home after discharge, including home safety, dietary changes, activity restrictions. and support services.
- Review medications using a reconciled medication list.
- Review red flags for changes in the patient's condition and action plans. Ensure that the patient has a contact phone number to call with questions or if his or her condition changes.
- Review test results, including pending results, and explain how to access this information.
- Highlight required follow-up appointments and provide assistance in making them, if needed.

Educate

Using plain language, educate the patient and family about the patient's condition, discharge process, and next steps on an ongoing basis throughout the hospital stay.

Assess

Assess the quality and effectiveness of healthcare professionals' explanations of the patient's diagnosis, condition, and next steps in care. Also assess how often healthcare professionals use teach-back techniques.

Listen

Listen to and honor the goals, preferences, observations, and concerns of the patient and family caregivers. Provide a whiteboard or other area for the patient and family to write questions as they arise. Elicit the patient's goals for the hospital stay.

For more information on IDEAL discharge planning, visit www.ahrq.gov/professionals/systems/hospital/red/toolkit.

Postdischarge nursing interventions

The period immediately after discharge is a vulnerable time for patients—one in which rapid changes can occur. Following up with patients and home caregivers soon after discharge can decrease confusion and reinforce follow-up plans. Common topics to discuss during the first postdischarge phone call include medications and pending services or appointments. Healthcare providers should inform patients about the purpose of the call.

Training nurses or NCMs to make these calls using a script and an electronic documentation template can help ensure important issues are covered and documented in the medical record.

Discharge to a setting other than home

When a patient is discharged to a setting other than the home, nurses and NCMs can play a crucial role in preventing transfer back to the hospital. Interventions to Reduce Acute Care Transfers (INTERACT) is a quality-improvement program that provides an evidence-based guide, web-based educational materials, and tools designed to reduce transfers (including readmissions) from long-term care and assisted living settings to acute-care hospitals. INTERACT can improve patient safety and satisfaction and reduce readmissions through early identification and evaluation of changes in the patient's condition, optimal documentation and communication about these changes, and management of the patient's condi-

Hospital **readmissions** are **costly to patients and healthcare facilities.**

tion in a way that's consistent with the patient's and family's wishes. (See *INTERACT tools*.)

Halting the readmission cycle

Hospital readmissions are costly to patients and healthcare facilities. Nurses and NCMs are natural communicators and educators, putting them in an excellent position to help prevent readmissions at multiple points—from admission through discharge and beyond. Becoming familiar with and using easily accessible, evidence-based resources and tools can help nurses and NCMs manage patient transitions optimally and consistently.

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A bold move to improve collaboration

One hospital system is empowering frontline clinicians in all disciplines to move the quality journey forward.

By Susan Blackmer Tocco, MSN, CNS, CCNS; Darwin K. Clark, MD; and Amy C. DeYoung, MBA, RRT

Interdisciplinary collaboration is the cornerstone of high-quality patient care. Several years ago at Orlando Health (Florida), we made a bold move and flipped the existing hierarchy to improve collaboration. The goal was to empower frontline clinicians in all disciplines to push innovative patient safety and quality improvement ideas to the forefront. In this article, we share our successful experience in the hope that other organizations can use a similar model.

To bring the vision of improved collaboration to life, Jamal Hakim, MD, chief quality officer, partnered with us and other likeminded leaders in the organization. Together we created a forum—the Collaborative Quality Advisory Committee (CQAC)—where nurses, physicians, and allied health team members could develop and send quality suggestions to the medical executive committee for approval.

Building the team

Our hospital system consists of eight hospitals with more than 14,000 team members and 2,000 physicians. It was important for the CQAC to represent all hospitals, specialties, and professional disciplines, so it was a daunting task to select members for the committee.

CQAC members needed to have certain personal attributes to make the group's dynamic succeed— respect, teamwork, and consistent demonstration of patient safety behaviors in clinical practice. Members also needed good listening skills and the confidence to offer justifiable opposing viewpoints to discussions. We wanted two patient and family representatives for the group as well. Each hospital's leadership team recommended members; the list of potential members was refined to ensure appropriate representation from hospitals and specialties.

Frontline nurses were well represented on the CQAC and included staff from medical telemetry, orthopedics, pediatrics, labor and delivery, critical care, and intermediate critical care areas. Later, we added a clinical assistant nurse manager, nursing operations manager, and chief nursing officer to partner with their frontline colleagues

A name isn't just a name

Names mean a lot. Members of the Collaborative Quality Advisory Committee at Orlando Health learned an important lesson about names in their journey to improve interdisciplinary collaboration. Previously, we'd used the term "ancillary" when referring to our allied health colleagues. Medline Plus® and Merriam-Webster define ancillary as "being auxiliary to or supplementary."

However, the U.S. Department of Labor, universities, and colleges consider allied health disciplines (which include physical therapy, pharmacy, and dietitians) far more than just supplementary to high-quality patient care. Merriam-Webster defines *allied* as "joined in a relationship in which people, groups, countries, etc., agree to work together."

After learning the true meaning of *ancillary*, our nurses and physicians were dismayed that we'd been using this term to refer to our valued colleagues. Our healthcare system currently is eliminating "ancillary" from job titles and other references. This long-overdue change is a positive step in our effort to respect and empower our team members.

in the group's initiatives.

Selecting allied health team members for the committee was especially challenging because of the number of potential participants. This large group includes staff from the cardiovascular, clinical nutrition, imaging, laboratory, pharmacy, respiratory care, and therapeutics (physical, occupational, and speech therapy) departments. To chair our allied health executive council, we added an administrator to be the voice of all the disciplines. Interestingly, we learned we hadn't been using the correct terminology for some of our colleagues. (See *A name isn't just a name*.)

Once our clinician members were in place, we asked them for recommendations of patients and family members from their clinical practice to consider for the committee. Through an interview process, we identified two valued individuals who shared many of the same attributes of the clinical members. The final committee consisted of about 40 regular attendees.

Establishing structure and priorities

Structured to be nimble and bureaucracy-free, the CQAC meets every other month. Official officers are limited to a chairman (our chief quality officer) and vice chairman. The director of patient safety, who traditionally has been a nurse, rounds out the group's leadership. The director is instrumental in planning the agenda and promoting discussion during meetings.

It was important to the group's leadership for members to establish their own strategic priorities. Before their first meeting, members received an email asking, "What keeps you up at night?" related to patient safety. These issues were compiled and used to form meeting agendas.

It became clear ineffective communication was the root of many problems. During interdisciplinary discussion, the team learned that communications that should be exchanged directly from physician to physician were being abdicated to nursing. Examples included the use

of conditional orders, such as "Discharge home if OK with consultants" and "MRI of brain if OK with obstetrician."

Physicians and nurses gave examples of how these orders led to patient harm. Some physicians stated they'd written these orders to save time. Patient and family representatives said it was important to them for their physicians to take the time to speak to other physicians as needed about their care. Nurses stated that being placed in the middle of physician-physician communication was wasteful and dissatisfying and led to suboptimal patient care.

Taking action

After this discussion, the group unanimously decided that this type of communication shouldn't be permitted. The group worked with the chief of the medical staff and her team to win medical executive-committee approval of this idea. Medical staff bylaws were amended to reflect this practice change.

Everyone on the team believed the rationale for the change should be communicated to physicians by physicians. The physician chief quality officers at each hospital in our system volunteered to lead the communication plan with physicians in their buildings. Before the change, they discussed it with the physicians who'd been writing conditional orders. They also agreed to talk personally with physicians who resisted the change. This relieved nursing of the task of "policing" the change.

Allied health team members wanted an opportunity to identify how this change might affect colleagues. Historically, practice

changes hadn't been vetted sufficiently with allied health in the dominant physician/nurse culture. To address this, a core group from the CQAC and hospital leadership developed a communication and change plan for implementation that was targeted to physicians, nurses, and allied health staff. Nursing and allied health leaders communicated the changes to their teams in a series of huddles supplemented with written communication about the rationale for the change, which included frequently asked questions developed by the team.

Realizing results

The implementation plan succeeded. The entire team felt empowered by their "win" and were eager to take on additional multidisciplinary communication problems. The group currently is addressing physician-to-physician communication for consults and is transforming the process for disclosing harm to patients.

Our nursing members have expressed meaningful personal and professional satisfaction with their participation in the committee, such as:

- "I enjoyed meeting physicians and clinicians who practice outside my 'silo.' We talk about how we are trying to be less 'silo-ed' as an organization, but this group with corporate membership made it seem as if we were really taking action."
- "I got to learn the big picture for some of the problems, and now I can speak to my nursing colleagues about the 'why' behind the changes we're implementing."

Keep the atmosphere informal and encourage use of first names to help level the hierarchies.

Tips for success

Our experience over the past several years has taught us valuable lessons and tips to share. A small core group is crucial to keeping the committee focused and action oriented. This structure promotes direct interdisciplinary communication within the committee and throughout all system facilities. In addition, conducting the meetings with small group sessions promoted nurses' willingness to share their experience with physician and allied health colleagues. In addition, nurses benefited from feedback from colleagues regarding their perspectives and experiences.

Other tips include the following:

- Keep the atmosphere informal and encourage use of first names to help level the hierarchies found in many healthcare professional meetings.
- Be aware of the need for strong communication with staff members who aren't on the committee. Nurses often reported that their coworkers were unaware of the committee's existence and function. They also suggested a need

for greater member input in setting the agenda, as well as guidance for topics the council should discuss and issues it should address.

- Consider a structured process for rotating off team members and incorporating new ones. Nurses suggested recommendations from current members that would improve the likelihood of recruiting motivated, engaged replacements.

The CQAC has shown us that empowering frontline team members in problem solving is the path forward in our quality journey. Committee members have successfully tapped into an abundance of collective knowledge from a diverse care team. The CQAC has helped bridge communication gaps and align quality and patient-experience goals with our organization's strategic priorities. 🔗

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The Essence of Nursing

These key points can help you provide patients with the essence of good care.

Advancing the art and science of patient care, quality, and safety.

Engage patients

Learn the stories of your patients, their family members, and home caregivers.

Share health data and decision making with patients.

Set expectations

Share the organization's caring mission.

Empower employees to practice to their fullest authority.

Prevent readmissions

20% Medicare patients readmitted within 30 days

Use the acronym **IDEAL** for discharge planning: **I**nclude, **D**iscuss, **E**ducate, **A**ssess, **L**isten.

Patient

Prevent problems

Understand the dangers of hospitalization. Assess patients. • Promote nutrition.

Keep the patient **SAFE**: **S**afe environment, **A**ssist with mobility, **F**all risk reduction, **E**ngage patient and family.
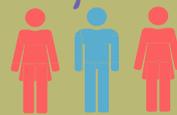
Keep patients moving

Get patients moving early.

Use assistive devices to keep you and your patients safe.

Collaborate with other disciplines

Build multidisciplinary teams.

Encourage the use of first names to keep a level playing field.

Communicate effectively.

Above all, be a patient advocate.

Remember—the nurse is the only healthcare professional with the patient and family 24/7/365.
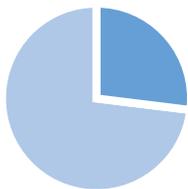
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