Mention “productivity measures,” and many nurse leaders will intrinsically clench up, ready to defend their FTEs. “They think it’s evil,” says chief nursing officer Jill Fuller, PhD, RN, who thinks many nurses still associate labor and productivity management with the downsizing agendas of the 1990s. A firm believer in productivity standards, Fuller thinks it is high time this valuable tool got an image makeover among nurse leaders.
Fuller’s hospital, Prairie Lakes Healthcare System in Watertown S.D., is a case example of a kinder, gentler approach to managing labor costs—and the approach has paid off for patients, nurses, and the bottom line.

**A Lean—Not Mean—Approach**

The hospital’s 52-bed medical-surgical unit used to run about 10.2 hours per patient day (which includes, nursing, clerical, and management hours). It took about five years, but the unit recently met a daunting productivity benchmark of 7:5 hours.

“The senior leaders approached this as, ‘We know it will probably take you years to get to this goal, and if you need resources, we’re going to help you.’” says Fuller.

In other words, layoffs were not part of Prairie Lakes’ vernacular. “Most people would say, ‘If you’re going to go from 10.2 to 7.5, you have to do more with less.’ That’s kind of classic productivity management. We decided to do less with less. In other words, we decided to get rid of a lot of wasteful practices and processes.”

Senior management empowered frontline staff to identify and implement ideas for reducing unnecessary work. (See the case study on page 10.) In addition, the hospital invested in an integrated information system and electronic medical record, medication servers, and other upgrades that helped reduce workload and improve patient care.

The med-surg unit has seen labor expenses related to inefficient staffing decrease. Yet the nurse-to-patient ratio has remained the same: 1:4 or 5 (depending on medical severity). Unit nurses would argue that patients now receive better quality care, which is reflected in higher patient satisfaction scores. Nurses are also happier, with job satisfaction skyrocketing to 83 percent in 2006 from 46 percent in 2000.

Of course, adopting productivity standards did not miraculously cause all these good outcomes. The productivity measures—along with biweekly labor management reports—are simply tools that have helped nurse leaders set labor goals, monitor performance, and get to the root cause of staffing and scheduling issues, says Fuller. “Peter Drucker said that ‘productivity is the first test of a manager’s competence.’ We love that quote. What it means, I think, is that you have to redesign the way you work, which is a competency issue.”

Fuller and other experienced leaders urge nurse executives and managers to be more open-minded about using productivity management to rein in labor costs. Here’s some advice to heed.

**Embrace Fiscal Responsibilities**

There is great room for improvement in the way labor costs are managed at many hospitals. Medicare cost reports indicate that not-for-profit hospitals spend about 20 percent more on personnel expenses than for-profit hospitals do. (See the exhibit on page 3.)

“CFOs need to help nurse leaders understand that they have a great responsibility for the hospital’s fiscal well-being, potentially even more than the CFO does,” says Daniel Heckathorne, CFO and associate administrator for finance, Pioneers Memorial Healthcare District in Brawley, Calif. “Nurse salaries and benefits can account for close to one half of a hospital’s entire labor costs, and...
nurse leaders need to manage those expenses well. It’s a significant component of a nurse leader’s job.”

Ensure Nurse Input
Five years ago, 541-bed Saint Thomas Hospital adopted a workforce management tool that enables nurse leaders to analyze labor productivity based on data gathered from payroll, patient accounting, time and attendance, and budgets.

But selling nurses on the advantages of using the tool wasn’t easy. “Initially, there was some resistance,” recalls Sue Willoughby, RN, BSN, a coordinator for benchmarking and productivity at the Nashville-based hospital. Many nurses questioned the validity of the data and the value of benchmarks that compared Saint Thomas’ labor hours with similar hospitals nationwide. “Their reaction was one of denial: the feeling that our patients are sicker, that our geography is different, our resources are different, and our support systems are different,” she says.

To bridge the gap between finance and the hospital’s nursing staff, nurse managers and finance had to agree upon a common language for productivity. “Everything we do in the clinical world is based on volume—and there is a lack of understanding about how finance measures that volume and how clinicians have to measure that volume,” says healthcare executive consultant Kathy White, RN, MS, who has a background in critical care and trauma nursing. “Clinicians think shift to shift, hour to hour: ‘I have a train wreck in the ED, so it’s going to take this many people.’ Finance people think in pay periods and in months, connected to operating statements and averages.”

Saint Thomas’s finance and nursing departments worked together to create biweekly productivity reports that are useful to clinical managers in managing their volumes. (Visit www.hfma.org/boc for a sample report from Saint Thomas.) “The advantage of biweekly reporting is that it gives nurse managers a warning sign when their labor utilization is off target,” says Willoughby. The new reports included volume-adjusted productivity and staffing information, such as:

- Patient days and equivalent observation days
- Target and actual hours worked
- Overtime and agency hours
- Variances

Aim for Simplicity
While a proponent of productivity management, consultant Paul Fogel thinks many hospitals currently use unnecessarily complicated, excessively detailed workforce monitoring systems. “It’s a paradox, but more frequency and detail introduces complexity and random variation that confounds understanding,” says Fogel, a former financial and productivity analyst who is now president of Executive Information Systems, Inc. “Nurse managers aren’t hired to be in the business of mathematics; they are there to care for patients and to corral teams of people to work in a similar direction.”

Fogel believes that productivity monitoring reports should be simple enough for nurses to understand intuitively. (See Business Tool Exchange on page 14 for an example.) “I think the rank and file nurse manager should not be reluctant to say, ‘I don’t get this report, this doesn’t work for me, and you need to consult with me before you put a reporting procedure in place.’”

“Nurses aren’t against monitoring systems—after all, they use staffing grids every day,” says Fogel. “But the whole area of productivity management needs to be cleaned up so that we have simplicity, understanding, and acceptance. More sophisticated software and hardware is not the answer, but part of the problem.”

Fight for a Realistic Benchmark
Nurse leaders may also need to push back if administration suggests a

| Financial Indicators for Acute-Care Hospitals, For-Profit Versus Not-for-Profit* |
|----------------------|-------|-------|-------|-------|-------|
| **Financial Indicators** | FY03  | FY04  | FY05  | FY06  | FY07  |
| Personnel expense (% of operating revenue) | For-profit | 40.85% | 41.59% | 41.40% | 41.01% | 40.42% |
| Not-for-profit | 52.13% | 51.36% | 50.66% | 50.38% | 50.76% |
| Operating margin (%) | For-profit | 8.87% | 4.78% | 4.63% | 5.33% | 5.45% |
| Not-for-profit | -1.86% | -1.45% | -0.99% | -0.83% | -0.54% |

*Government hospitals are not reported. Source: Cost Report Data Resources. Reprinted with permission.

Not-for-profit hospitals spend about 20 percent more on personnel expenses than for-profit hospitals, which may explain why for-profits consistently have better operating margins.
Productivity Measures: In Need of an Overhaul  continued from page 3

productivity standard for a unit that could jeopardize patient care or cause nurses to look elsewhere for work. “I had to work with the CFO and CEO and be able to say when enough was enough,” says Prairie Lake’s Jill Fuller. “The original med–surg standard that was established was 6.5 nursing hours per patient day, which is one hour less than our current standard. I explained why that wasn’t going to work, and we horse-traded to get the standard up to 7.5. I have to have the ability to say, ‘No, that’s not going to work and here’s why.’”

Fuller also stresses the need to adjust productivity standards from time to time. “If a department is really having a hard time meeting a productivity standard, we’ll look at what’s going on,” she says. “For example, with med–surg, we decided there was work intensity around observation patients, because they don’t show up on hospital systems as a head in the bed at midnight. Only inpatients show up that way. So we found a way to adjust the system so they got a credit for observation patients. We regularly make decisions about whether we need to change or adjust a productivity standard. It has to be a dynamic process.”

Reanna Thompson, RN, MSN, agrees: “If your productivity standard is right, your nurses will tell you it’s right. If it’s not, they’ll tell you that too,” says Thompson, who is CNO at Presbyterian Intercommunity Hospital in Whittier, Calif. She cautions to ask questions when benchmarking productivity standards since standards are inconsistent across hospitals. For instance, some units include their charge nurse in the nursing hours per patient day, and others do not.

Consultant Paul Fogel advises establishing productivity standards based on the unit’s own history and current operations—rather than adopting external benchmarks from unknown hospitals. He also advocates keeping a consistent standard that does not go up or down when budget time rolls around. “In a lot of my work, I simply ask the managers, ‘What’s a good unit of service for you? What’s a good workload measure? How do we best capture your mission, patients, or purpose? Is it patient days?’” This might be the first time anyone has ever asked this question. A lot of the managers will complain, ‘Well, the midnight census doesn’t really measure me.’ Then I’ll say, ‘What if we count up the census for all three shifts’ and ‘What if we weight each census by patient acuity, the way you actually make your staffing decisions?’ And they say, ‘You can do that?’ And I say, ‘Why not?’ The question is, ‘What would you do?’

Fogel says millions of labor dollars could be saved across hospitals if departments/units simply aimed to maintain a realistic “hours per patient day,” and held it there over time. “Once we’ve eliminated productivity losses and we’re on a stable foundation, the next step is to reform our internal processes to make them more efficient.”

Make Managers Accountable
Fogel is a big believer in making managers more accountable for meeting productivity standards—as long as the manager had a strong say in setting the standard.

To create accountability, a productivity committee might set the following rules, says Fogel:

> If either hours or salary standards are unfavorable by >1 percent last quarter, a correction plan from the vice president is presented before the committee.
> If both hours or salary standards are unfavorable by >1 percent last quarter, the vice president and the manager go before the committee to present an action plan.

Hospitals may consider a policy that clearly states what the consequences are when managers continually fail to meet productivity standards (for example, demotion or even dismissal), says Fogel. Nurse executives can also motivate nurse managers to meet standards by offering bonuses or other rewards when productivity measures are exceeded; this makes for a balanced approach.

Quality and Cycle Time Count, Too
Productivity standards cannot, of course, be considered in a vacuum. Reducing hours per patient day is not positive if nosocomial infection rates skyrocket or nursing turnover escalates. Productivity is just one aspect of quality care and a quality workplace.

Fogel and other experts encourage nurse leaders to establish and track a variety of measures that provide a bird’s eye view of how well a unit cares for patients and staff. These measures should cover the various dimensions of quality, including:

> Cycle time (e.g., length of stay, transit time through the hospital for X-rays)
> Clinical effectiveness (e.g., recidivism rates, fall rates, infection rates)
> Employee satisfaction (e.g., nursing turnover, employee satisfaction)
> Productivity (e.g., nurse time in direct patient care)

“The question is: ‘How does a nurse manager know that she’s really doing a wonderful job for her patients and for the hospital?’” says Fogel. “And the answer is: Most of them don’t. They may have a good perception about it. But they need to establish quality control measures so they can demonstrate quality objectively.”

4 July-August 2008 The Business of Caring
What Defines Nurse Productivity?

Many definitions of productivity talk about improving efficiency or using fewer resources. The formula output ÷ input is often used, demonstrating that productivity will increase if the output (e.g., number of patient days) goes up or the input (e.g., number of nursing hours) goes down. Nurses tend to give more concrete answers. “Productivity to a nurse is really about how much care they can give to their patients,” says Coreen Vlodarchyk, vice president of patient care services and CNO at Barnes Jewish Hospital in St. Louis.

“When they go home from the end of their shift, they’re not talking about how many patients were discharged on the unit,” says Vlodarchyk. “They’re talking about being able to sit with their patient, teach a new diabetic, comfort somebody in pain. That’s what they would call ‘productivity.’”

In other words, to nurses, the best way to increase their productivity is to increase the amount of time they can spend taking care of patients. Studies show that patients tend to do better clinically when more nursing hours are devoted to them. Increasing nurse-patient interactions also makes sense economically now that Medicare has stopped paying for preventable complications, such as pressure ulcers, that develop during a hospital stay. Greater nursing hours per in-patient day have been linked with lower rates of pneumonia, blood-stream infections, and other complications—as well as lower lengths of stay. (Anderson, S., Deadly Consequences: The Hidden Impact of America’s Nursing Shortage, National Foundation for American Policy, Sept. 2007.)

Vlodarchyk is a believer in increasing patient care hours at the bedside, which drives adequate nurse-to-patient ratios. “At Barnes Jewish, we’re making more time for nurses at the bedside the rule,” she says. But Vlodarchyk also recognizes that healthcare organizations have to help nurses use their time efficiently. A recent time-motion study found that medical-surgical nurses spend more than twice as much time documenting and coordinating patient care as they do actually engaged in patient care-related activities. (See the exhibit.)

“Nurses want to be efficient,” says Vlodarchyk. “But you have to create an environment that allows nurses to practice patient care.” In recent years, nursing leaders at Barnes Jewish have focused on making sure nurses have the right things to do their work. “We call it the ‘work of doing the work,’” says Vlodarchyk. “We have been very industrious about making sure that the right amount of IV pumps are in the room, the right amount of linen is there, that medications are being delivered in a timely way, etc. We’ve worked hard with different disciplines trying to make sure that nurses have what they need to do their work.”

Barnes Jewish also implemented a new model of care in 2004. A charge nurse, clinical nurse specialist, and case manager are now assigned to each unit and work together as a team.

> The charge nurse coordinates all the work flow on the unit—from helping with a new patient admission to following up on missing lab tests.
> The clinical nurse specialist operates as a clinical resource, teaching new nurse graduates and patients/families.
> The case manager oversees patient throughput and discharge plans.

The triad works as a team, talking two or three times a day to help the unit run efficiently. With this three-person team in place, the RN caregivers have more time to spend with patients.

“Our metrics of success show increased patient, physician, and employee satisfaction. You have to always keep looking at your outcomes, and this positive trend in our satisfaction scores over the last four years are good indicators that we are making a difference. Our vacancy rate and attrition rates have been going down, and these are the measurements that I use as a CNO,” says Vlodarchyk.

“At Barnes Jewish Hospital, we hold our clinical standards to the top decile of the national indicators as well as the Magnet criteria,” she says. (Barnes Jewish was just redesignated a Magnet hospital for another four years.) “These changes continue to support our quality of patient care,” says Vlodarchyk. ☞

### How Many Minutes Do Nurses Spend On ...?

A recent time-motion study followed 767 nurses from 36 medical-surgical units. Here’s how many minutes these nurses typically spent on various activities during their 10-hour shifts.*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wasteful activities (e.g., waiting, looking for items)</td>
<td>147.5 min.</td>
</tr>
<tr>
<td>Assessing patients and reading vital signs</td>
<td>147.5 min.</td>
</tr>
<tr>
<td>Nonclinical tasks (e.g., personal time, patient/family care)</td>
<td>147.5 min.</td>
</tr>
<tr>
<td>Administering medications</td>
<td>147.5 min.</td>
</tr>
<tr>
<td>Documenting</td>
<td>147.5 min.</td>
</tr>
<tr>
<td>Involved in patient care activities (e.g., responding to rapid response code, preparing patient for admission)</td>
<td>147.5 min.</td>
</tr>
<tr>
<td>Coordinating patient care, or communicating with other team members</td>
<td>147.5 min.</td>
</tr>
</tbody>
</table>

*About 63.5 minutes were not accounted for.

Taking the Mystery Out of Productivity Measures

When hospital CFO Daniel Heckathorne teaches nurses about productivity measures, he first talks about patient vital signs. “When a patient’s blood pressure is 190 over 140, you know something is wrong because there are established medical standards and parameters for monitoring a patient’s health,” he says. Similarly, hospital executives rely on industry measures and standards when monitoring their organization’s financial health. Productivity is one aspect of a hospital’s health. “When we see that the hours per patient day are running over an industry standard by a significant amount, we know that we need to do something to correct it,” says Heckathorne, who works at Pioneers Memorial Healthcare District, Brawley, Calif.

Labor Productivity Measures and Targets

Productivity Measure: Measuring productivity gives you a picture of how much work it takes to produce a desired result (i.e., quality patient care, low nurse turnover, etc.). A productivity measure can be very simple or very complex. In either case:

> It should be the or a key result produced by your unit or department.
> It should be the key driver of revenue and/or resource consumption.

Examples of simple productivity measures:

> Nursing unit: Hours per patient days
> Radiology department: Number of hours worked per procedure
> PACU: Hours worked per recovery minute

Productivity Target: Taking a patient’s temperature would mean nothing if you didn’t know that 98.6 degrees Fahrenheit was normal. Similarly, measuring productivity is meaningless unless you have a productivity target or expectation.

Hospitals identify productivity targets in various ways. One way is to look at a unit’s past labor hours over months or years and determine what is optimal based on history. Hospitals should also use benchmark comparisons available from national benchmark firms, state hospital associations, etc.

The $ Implications of Missing the Target

Let’s say a medical-surgical unit’s productivity target is 9 hours per patient day (HPPD). What happens if the unit does not meet this target? As the following scenario shows, running overbudget by 5.5 percent can cost a hospital thousands of dollars, which means the organization will have less money to devote to nurse recruitment efforts, needed medical equipment, etc.

Financial Case 1: The Unit Meets the Target

Productivity: 9 HPPD

- Patient days for 2009: 12,000 days
- Paid hours for 2009: 108,000 paid hours
- Average salary cost per hour: $25*

Total cost: 108,000 hours × $25/hr = $2.7 million

Difference: $150,000

* This example does not include benefits.

Financial Case 2: The Unit Runs Over Budget

Productivity: 9.5 HPPD

- Patient days for 2009: 12,000 days
- Paid hours for 2009: 114,000 paid hours
- Average salary cost per hour: $25*

Total cost: 114,000 hrs × $25/hr = $2.85 million
Calculating Hours per Patient Day

Nursing units typically use hours per patient day (HPPD) as a productivity measure. HPPD shows how many staff hours are needed to care for patients and run the unit.

\[
\text{Total Staff Hours Worked} \div \text{Daily Census} = \text{HPPD}
\]

This formula generally takes all staff hours into account (i.e., RN, nurse aide, manager, unit clerk, etc.). Some hospitals may only include nursing staff in their formula. Whatever is measured, remember to be consistent when comparing actual outcomes to budget or industry targets.

Example: Identifying a Unit’s Productivity Target

Below is an excerpt of a staffing plan for a hypothetical 48-bed medical-surgical unit at ABC Hospital. Shirley Jones, RN, the unit director, bases her staffing plan on a 1:5 nurse-to-patient ratio.

<table>
<thead>
<tr>
<th>Census Number</th>
<th>Number of Staff Needed (assumes two 12-hour shifts, except manager, who has one 8-hour shift)</th>
<th>HPPD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Managers</td>
<td>RNs</td>
</tr>
<tr>
<td>28</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>29</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>30</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>31</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>32 (average census)</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>33</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>34</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>35</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>36</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

* For the purposes of illustration, this example uses the same staff levels for the day and night shifts. Units typically have separate staffing plans for the night and day shifts since fewer staff are typically needed at night. The HPPD would be lower in this example if this hypothetical unit had done this.

Fred Smith, the CFO at ABC Hospital, works with Shirley to determine a reasonable productivity target for the unit. Together, they determine that the unit currently requires 9 hours per patient day (HPPD) during average census days. Fred tells Shirley that the industry benchmark for medical-surgical units in their state (obtained from a benchmark firm) is only 8.5 hours. Shirley thinks 8.5 HPPD is unreasonable given the unit’s case mix and patient acuity. After some debate and additional calculations, Fred and Shirley arrive at a productivity target of 8.75 HPPD.

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Possible approach: Ask about using a “case-mix adjusted” approach, which takes patient acuity and case-mix intensity into account.

Objection: “We take care of a lot of outpatients (or observation patients). Would this affect our target?”

Possible approach: Ask finance about adjusting your target to take these workload factors into consideration.

Objection: “The midnight census doesn’t really measure me.”

Possible approach: Ask whether there is a different way to determine average census for your particular unit. (Consistency in measuring is the key.)
Despite these challenges, a number of nurse leaders are finding ways to increase nurses’ time with patients—with many positive results. Here are their stories.

Case Study 1
Creating Purposeful Work Patterns at Presbyterian Intercommunity

One way to see more of your patients is to schedule more time with them. That’s one of the lessons that nurse leaders can take away from Presbyterian Intercommunity Hospital, a 444-bed hospital in Whittier, Calif.

“We have created deliberate work patterns that allow nurses to go in and have conversations with patients,” says CNO Reanna Thompson, RN, MSN.

Both patients and staff are benefiting from the extra interaction. One试点 unit at Presbyterian Intercommunity saw call light usage decrease 24 percent from January/February 2007 to January/February 2008. Nurses are also noting an improvement in patient outcomes. For example, one pilot unit has documented a major decrease in hospital-acquired pressure ulcers—from 20.22 percent for the second quarter of 2007 (prior to the project) to zero in June 2008.

**Identify Problems**

Another lesson to be gained from Presbyterian Intercommunity: Listen to your frontline staff. “They are the ones who know what’s broken, and they are the ones who know the solutions,” says Thompson.

Recognizing this truism, hospital leaders launched 34 partnership councils in 2006. These teams follow a nursing shared governance type approach; however, the teams are interdisciplinary and include representatives from all the disciplines involved in patient care.

One issue kept coming up again and again in the partnership councils, says Denise Authier, RN, BSN, professional practice coordinator. “Virtually all the nursing units said we needed to improve how we worked as a team and how we communicated.”

Since this was a global theme, Authier set up a hospitalwide work team, which included nurse leaders, RNs, and certified nurse assistants (CNAs), to come up with a solution. Team members interviewed staff on various nursing units and identified several problems:

> There was no standard method for staff to share information about patients.
> The shift assignments—with CNAs reporting to up to six RNs per shift—were causing dissatisfaction and confusion among staff.
> CNAs were often working independently—as opposed to under the direction of an RN.
> RNs were not delegating nursing tasks as they should.

**Working as a Team**

To address these problems, the team piloted a new RN–CNA team approach that encompasses the following:

> A defined nursing scope of practice. The RN is now identified as the “captain of the ship” who delegates appropriate nursing tasks to the CNA or licensed vocational

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**Structured Shift Report Tool**

Nurses and certified nurse assistants (CNAs) at Presbyterian Intercommunity Hospital in Whittier, Calif., use this shift report tool to guide discussions about patients. Below is the information the RN/LVN shares with the CNA at the beginning of the shift. Staff at Presbyterian Intercommunity call these “shift points.” CNAs have these shift points printed on their employee badges.

> Patient goals this shift
> Code status
> Diet (NPO, feeder, etc.)
> Activity (BRP, dangling, needs assist, etc.)
> Tests (daily weight, I&O, etc.)
> Skin condition and turn schedule
> Restrictions/precautions (fall, no b/p left arm)
> Off floor (expected discharges/transfers, procedures)

Source: Presbyterian Intercommunity Hospital. Reprinted with permission.
nurse (LVN), says Michele Grams, RN, BSN, care center coordinator, medical/respiratory. The team developed a formal scope of practice based on The Joint Statement on Delegation by the American Nurses Association and the National Council of State Boards of Nursing. (This statement is available at www.ncsbn.org.) RNs and CNAs also attended educational classes about their roles and responsibilities on the patient care team.

“Nurses began to understand on a practical level that they are responsible and accountable for the care that’s delivered to that patient that day, not only by themselves, but by whomever they delegate care to,” says Thompson. “Another positive thing is that the CNAs have raised their level of functioning, and they now see the true value of their work. They also now appreciate the role of the nurse … that the nurse must truly oversee what they do.”

Limit RN-CNA ratios. Each CNA has eight to nine patients and reports to no more than two or three RNs.

Put Communication Tools in Place
Finally, the team put several formal communication methods in place that encourage staff to communicate with patients and with each other.

Structured shift reports. The CNAs now wear badges that list eight “shift points,” or important patient care issues they need to pay attention to, including diet, skin condition, and code status. (See the exhibit on page 8.) When CNAs arrive for their shifts, they meet all their patients and then report back to the RN for a start-of-shift meeting. The RN and CNA use the list of shift points to guide their discussions about each patient and set goals for each patient. The CNA continues to check in with the RN throughout the day, and reports back to the RN for an end-of-shift report.

White boards in patient rooms. The goals for each patient are written on the white board. “We’ve really engaged patients and their families more in the plan of care,” says Katrina Rodriguez, RN, BSN, care center coordinator, medical/surgical. “A lot of times, a patient will say something like, ‘I’ve only gotten out of bed once today and I’m supposed to get up three times. When am I going to get up again?’”

Hourly patient rounding. “Every hour, we have a member of the team (RN/LVN or CNA) round on the patient, observing or assessing the patient and making sure the patient and the environment are safe,” says Grams. “We plan on the RN/LVN round on the even hours, and the odd hours, a CNA rounds on the patient. On rounding, we make sure the patient has everything he or she needs. We are really trying to anticipate patients’ needs. If the patient is awake, we ask, ‘Is there anything I can do for you.’ We tell nurses to say they ‘have time’ so the patient doesn’t feel rushed or that they are imposing on the staff’s time.”

Satisfaction and Outcomes Improve
This new team approach has now been piloted on two medical–surgical units at Presbyterian Intercommunity—with great success. A survey conducted on the medical–respiratory unit found that 95 to 97 percent of staff were more satisfied overall after the new team model was implemented than before. The same unit had zero voluntary turnover between January and December 2007. “I’ve always had pretty good turnover rates,” says Grams. “But this is the first time I can say that I have a waiting list for people who want to work on my unit.”

“Our unlicensed staff tell us, “We feel more respected and more like members of the team,”” says Rodriguez, who manages the other med–surg pilot unit.

“Nursing tends to be a hierarchical culture, but this approach has helped break down this hierarchy. The patient is everyone’s responsibility. It’s not, ‘I’m in charge of this part of patient care, and you’re in charge of that.’ We work together toward the same goals.”

Nurses also think that patients are safer now that nursing staff are visiting them more regularly. One hundred percent of the nursing staff surveyed on medical–respiratory unit thought patients were safer under this new team model. And they have the data to prove it. In addition to seeing pressure ulcer rates fall to zero, unit staff have happily seen patient falls decrease from 2.98 falls per 1,000 patient days March 2007 (prior to project) to 2.0 falls per 1,000 patient days March 2008.

In addition to seeing pressure ulcer rates fall to zero, unit staff have happily seen patient falls decrease from 2.98 falls per 1,000 patient days March 2007 (prior to project) to 2.0 falls per 1,000 patient days March 2008.

Back to Basics
The nurse leaders at Presbyterian Intercommunity provide a third lesson worth remembering: “Get back to the basics of nursing practice: delegation, communication, and scope of practice,” says Grams. “How did we get away from these things? We outlined all of these.
Increasing the Amount of Time Nurses Spend in Direct Patient Care  continued from page 9

formalized them, and made it clear that these were expectations. It’s very empowering to have a clear understanding of your scope of practice.”

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Case Study 2
Blowing Up Bureaucracy at Prairie Lakes

“Broken” is the term Shelly Turbak, RN, uses to describe her 52-bed medical-surgical unit in 2001, the year she took over as unit director at Prairie Lakes Healthcare System. Nurse turnover was at 65 percent, and job satisfaction was less than 50 percent.

“The turnover was very hard to handle, and we really needed to get to the core of why people were leaving,” says Turbak.

Flash forward to present day. Nurse turnover is down to 5 percent or less. Plus, unit nurses now spend about 50 percent to 60 percent of their time in direct patient care activities, up from 35 percent to 40 percent. The unit has accomplished all of this while significantly reducing hours per patient day (see the front page article), and maintaining low fall rates, low medication error rates, and other positive clinical outcomes.

“We started blowing up things, if you will, and really asking ourselves, ‘Why are we doing things this way?’” says Turbak.

Innovation definitely comes to mind when Turbak describes some of the radical changes made at the Watertown, S.D., hospital. Turbak is quick to credit the ingenuity of her unit staff. Core to Prairie Lakes’ success is a decentralized management approach that encourages front-line staff to identify and implement ways to improve patient care—and increase productivity and efficiency.

From the Mouth of a Physician
During the med-surg unit’s initial soul-searching, a physician said something that struck a nerve: “He told us, ‘I want the nurses on med-surg to work like the nurses in the critical care unit,’” says Turbak. “He said, ‘The nurses on med-surg do not have time to know their patients. They do not have time to make rounds with me. They do not have time to engage in the type of care planning that is needed.’”

“So we decided we needed to change how we worked,” says Turbak. She formed a team of nurses, patient care technicians, and others to identify potential ways to give nurses more time with patients, increase efficiency, and improve turnover. The team then tested improvement ideas on a 10-bed pilot wing, a self-contained mini unit.

A New Care Model
One of the first problems nurses wanted to fix was the unit’s admission process. It used to take a single nurse about 90 minutes to complete just one patient admission. The unit also had a bed traffic control problem caused, in part, by frequent census surges.

The team developed a new position called “resource nurse.” An experienced RN, the resource nurse works with nursing staff to determine who is going to take incoming patients. The resource nurse then partners with the patient’s primary nurse. Together, they complete the admission assessment via a wireless laptop while initiating all orders for IVs, medications, etc. Now about 75 percent of all unit admissions are completed in 15 to 20 minutes.

The resource nurse is just one element of Prairie Lake’s new care delivery model which includes the following:

Fewer managers. Three assistant management positions were eliminated: charge nurse, assistant nurse manager, and case manager. As a result, the unit did not add any additional FTEs with the new resource nurse role.

A care technician role. The unit created another new role—care technician—by combining the nursing assistant and unit secretary positions. Care

Paying for Improvement Ideas
A lot of the improvement ideas implemented at Prairie Lakes Health System cost little—or nothing at all. But some of the changes were expensive, including the construction and installation of supply and medication servers in every patient room. Unit director, Shelly Turbak, RN, says she worked with finance to develop a business rationale. “It is very hard to measure return on investment when it is not a revenue-producing product,” she says. “So you have to do some time studies to determine how much time nurses spend on a particular activity. For example, you can show that nurses spend X amount of time searching for supplies every day. Or you can show that nurses get interrupted X times on average while preparing medication. So having medications and supplies in each patient’s room would save X number of minutes of the nurses’ day, which would impact payroll, overtime, etc.”

Turbak worked closely with the hospital CFO and CNO to determine what type of information would help justify the capital investment. “The CFO worked with me, teaching me, as a new director, about what I needed to do, what I needed to write out, etc.,” says Turbak.
technicians provide basic patient care and process orders.

A flexible bedside team. A three-person team (two licensed nurses and a care technician) now cares for groups of 10 to 12 patients. Nurses from other inpatient units are cross-trained so they can float as needed to meet surges in patient census. Float nurses may assume a full patient assignment or they may function as care technicians.

(The Prairie Lakes model was chosen as one of 24 innovative patient care models. For details, visit www.innovativecaremodels.com.)

More Radical Changes

Turbak and her team have rolled out a number of other successful improvement ideas.

Interdisciplinary conference replaces written care plan. “It used to be that nurses wrote care plans when they found time,” says Turbak. “But no one ever looked at the care plan to actually deliver their care.” The unit now holds interdisciplinary care conferences (ICCs). During the ICC, nurses, social workers, home health, pastoral care, and therapy services gather to plan each patient’s care. Evidence of this care planning is then recorded in the electronic medical record during the ICC meetings.

Walkie-talkies for nurses. “If you are looking for a piece of equipment, you can “walkie” and ask if anyone knows where that piece of equipment is,” says Turbak. “We know when doctors arrive on the unit for rounds so nurses can come to the desk and be right there to dialogue and round with physicians.”

In-room patient servers. Putting medication and supply servers in all patient rooms was a major capital investment, costing about $4,000 per room. But it’s worth it from a patient safety perspective, says Turbak. Nurses no longer have to prepare medications at a noisy, central location, which raised the risk of errors. Nurses now prepare medications by the patient’s bedside, which allows them to answer patients’ questions at the same time. The in-room servers also save nurses time because they no longer have to hunt and gather supplies and medications.

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Elimination of annual performance reviews. “The CNO asked me to look at my own workload and figure out what was unnecessary, and what bogged me down,” says Turbak. As a result, she no longer spends hours conducting annual performance reviews. Now she has a lot more time to interact with and observe her staff nurses. Instead of face-to-face, formal performance meetings, Turbak makes a point to contact each staff member on a regular basis and to observe nurses carrying out patient care tasks. “I am out there giving kudos for things that are happening when they happen.”

When Forces Collide
A lot was going on behind the scenes at Prairie Lakes Healthcare System that encouraged and enabled Turbak and her staff to successfully redesign care processes on the med-surg unit. About eight years ago, the hospital went through a major leadership change, bringing on a new CNO, CEO, and CFO all within six months of each other.

Along with a new leadership team came an increased focus on improving productivity and reducing wasteful practices. While Turbak and her staff did away with non-valued added work at the unit level, the CNO and other leaders worked to reduce bureaucracy and unnecessary work across the hospital. For instance, the hospital no longer participates in Joint Commission surveys, which eliminated a lot of committee meetings and documentation. (The hospital still undergoes Medicare surveys to maintain Medicare conditions of participation.) Also, nurses have witnessed a 30 percent reduction in nursing policy and procedures, says Turbak. “Our CNO was instrumental in asking ‘Why do we need that policy?’”

The 81-bed hospital has also been busy building an electronic medical record, which allowed the med-surg unit to automate many tasks that used to be done manually. Clinicians now have electronic access to the majority of current patient information, including patient charts, X-rays, and home care notes.

The most significant change to occur at Prairie Lakes over the last eight years is the major culture shift that has occurred, says Turbak. “We have really empowered the front-line staff and allowed them to be decision makers. They now know that they can offer any idea and it will be considered.”

This type of culture requires a hands-off management style that comes more naturally to Turbak than to many leaders. “I feel that my job is to manage boundaries, and not to manage the processes. I let the staff know what tasks are essential, the unit’s nurses have more time to spend on patient care. “The nurses ... were spending an inordinate amount of time looking for equipment,” says Cindy Gumm, nurse manager. Read more at www.hfma.org/boc.

Additional Provider Case Studies

Visit www.hfma.org/boc to read organizations that are increasing the amount of time nurses spend in direct patient care.

St. Mary’s Hospital. The progressive telemetry unit at St. Mary’s has saved money since it started electronically tracking equipment. Now $200 thermometers and other must-have items are less likely to go missing. More important, the unit’s nurses have more time to spend on patient care. “The nurses ... were spending an inordinate amount of time looking for equipment,” says Cindy Gumm, nurse manager. Read more at www.hfma.org/boc.

Virginia Mason Medical Center (VMMC). RN time available for patient care has increased from 32 percent to 90 percent at VMMC in Seattle. Read how nurses at the hospital redesigned work processes at www.hfma.org/boc.

Cedars-Sinai Medical Center and VHA Inc.
In hopes of encouraging more hospitals to increase nurses’ time in direct patient care, VHA spearheaded “Return to Care,” an effort designed to improve medical-surgical clinical quality and patient safety. “We are identifying leading practices and sharing those with nursing leaders,” says Patricia Tyler, RN, CCRN, director performance improvement. “Nurses want to make a difference. We just need to help them improve the processes of care so that they are able to deliver the best patient care.” Leading-practice organizations, including Cedars-Sinai in Los Angeles, have worked with VHA to “blueprint” or diagram the leading practices they have discovered for increasing nurse time at the bedside. You can view an excerpt of VHA/Cedars-Sinai’s blueprint at www.hfma.org/boc. VHA hospital members can view the entire blueprint, at www.vha.com.

A Different Way of Managing
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This type of culture requires a hands-off management style that comes more naturally to Turbak than to many leaders. “I feel that my job is to manage boundaries, and not to manage the processes. I let the staff know what tasks are essential for the functionality of the unit, for the organization, and for patient care. The staff all know how to get there; they know how to be nurses. Far be it for me to tell them exactly how to get there.”

Shelly Turbak, RN, is director of medical and surgical services at Prairie Lakes Healthcare System, Watertown, S.D. (turbaks@prairielakes.com).

Web Exclusive

Spreading Improvements to Home Health
Learn how Prairie Lakes’ home health department reduced hours per home care visit from 2.68 to 2.11 hours. Following the med-surg unit’s lead, home health is “unpackaging what we were doing and repackaging it in a fashion that allows for more time for nurses at the bedside and other positive outcomes,” says Charleen Weismantel, RN, home care director. Visit www.hfma.org/boc for more.
TCAB Improvements Double Nurse Time at the Bedside

A key goal of the Transforming Care at the Bedside (TCAB) initiative is to increase the amount of time nurses spend with patients. Now in its fourth year, the project is generating promising results: “It looks like some of the changes we have been testing at TCAB hospitals can double the time nurses are spending at the bedside,” says Pat Rutherford, MS, RN, vice president, Institute for Healthcare Improvement (IHI).

TCAB, a joint effort by the Robert Wood Johnson Foundation and IHI, began with 10 pilot hospitals. Successes from the original pilot hospitals are spreading; more than 50 hospitals have joined the TCAB Learning and Innovation Community in IHI’s IMPACT Network, and 68 hospitals are participating in the American Organization of Nurse Executives TCAB collaboratives.

In the following interview Rutherford provides more details about TCAB’s efforts to increase nurse time with patients.

Why has TCAB focused on increasing the time that nurses spend in direct patient care?

Rutherford: There is a large body of research that shows that if nurses spend more time in direct care, clinical outcomes are better and complications are fewer. I think many regions of the country are trying to mandate nursing ratios to ensure that patients receive adequate professional nursing care at the bedside. While those favoring mandated ratios are well-intended, I think the strategy and methodology are flawed.

We need to optimize the working conditions for the nursing resources that we currently have at the bedside and remove all of the inefficiencies and barriers that are preventing nurses from providing optimal care for their patients. The typical professional nurse spends only about 30 percent of her or his day in direct patient care. The rest of the time, nurses are on the phone, looking for other staff or equipment, tracking down medications, documenting at a central nurses’ station, running errands, etc. These scenarios are symptoms of broken and inefficient processes.

We can redesign care processes to remove the waste and re-invest that time into activities that provide value for patients and family members. In TCAB, staff have been able to redesign key clinical processes, and on average, have been able to double staff time at the bedside.

So what makes more sense? Increasing the number of nurses on a shift, or doubling the amount of time nurses spend in direct patient care? Both scenarios may result in nurses spending more time in direct patient care, but reducing inefficiencies and redesigning processes of care is not only less costly, but will also improve nursing morale and satisfaction.

Can you identify any specific improvements at TCAB hospitals that have really helped to increase nursing time with patients?

Rutherford: One strategy that really seems to make a difference is decreasing redundant documentation. Another is moving supplies and equipment closer to where nurses are using them (perhaps in the patient room or nearby) so nurses spend less time hunting and gathering. A third tactic is to move nursing workstations closer to where the patients are.

Are there any challenges you want to point out?

Rutherford: Trying to do things differently can be challenging. Sometimes there is not sufficient room to move supplies and equipment closer to where the nurses work. Or a hospital might not have the budget for reconstruction.

There may also be reluctance from the nursing staff or other disciplines to do things differently. So you really have to get cooperation. For example, if you wanted to have one care plan, you would have to let go of the need for the nursing care plan. Physicians, physical therapists, dieticians, etc. would also have to let go of the need to have their documentation and their own care plans. So you really need a spirit of cooperation in order to get rid of some of these redundancies.

“…”

Pat Rutherford, MS, RN, is vice president, Institute for Healthcare Improvement, Cambridge, Mass. (prutherford@ihi.org). To learn more about the TCAB project and how to increase nurses’ time at the bedside, visit www.ihi.org.
Sample Productivity Report

A productivity report is not productive if you can’t make sense of it—or if you need to spend hours wading through paper to figure out whether you are meeting your labor targets or not. By working together, nursing and finance can create tracking reports that work for nurse leaders. Here is an example of a monthly report. Visit www.hfma.org/boc for an example of a six-month productivity trend report.

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Source: Executive Information Systems, Inc. Reprinted with permission.

This monthly productivity report is short (just one side of one page). And it shows ICU managers where they are in terms of hours and cost per unit compared to where they should be.
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