HAVE A NICE DAY!

- The American Experience

STUDY TOUR -

KING'S FUND

TRAVEL FELLOWSHIP.

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MRS G.J. PHARAOH

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INTRODUCTION

This report is made following the study tour of the United States of America which was undertaken from 4th November to 2nd December, 1988 through a Travel Fellowship awarded by the King's Fund College, London, with added financial help from the Chairman's Fund, East Anglian Regional Health Authority.

Title of Study:

In Search of Excellence - an examination of the role of management in determining Quality Assurance in Nursing.

Aim of Study:

To achieve the highest possible level of patient care within the available resources and to secure the best motivation of all the staff.

Objectives of Study:

1. To examine strategic and manpower planning within the Unit for Quality Assurance.
2. To examine current nursing practice; the setting of standards and criteria through which the safety of patients can be ensured, and systematic evaluation of the planning and delivery of care can be carried out.
3. To examine the development of nurses through continuing education.

Although in the time available I obviously concentrated on the issues outlined above, I inevitably absorbed a great deal of information regarding the wider aspects of the U.S. Health Care system and the American culture as a whole.

CHAPTER 1.

HEALTH CARE SERVICES IN THE U.S.A. - AN OVERVIEW

To understand the provision of Health Care Services in the U.S.A. it must be realised that it is based on a radically different principle to that in the United Kingdom. Americans see Health Care as a commodity which is bought and sold as a marketable unit. It is widely understood that the individual is responsible for financing this commodity for himself and his family. This is in direct contrast to health care in the U.K. where until recently it has been taken very much for granted and not recognised as a marketable commodity . This however may be slowly changing as private health care is encouraged by the present Government, as an acceptable and desirable alternative.

The overall organisation of the health care system in the U.S.A. is not centrally managed at Federal level as in the U.K. where all health care services are directly controlled by the Government. The United States system is de-centralised, fragmented and un-cordinated in its arrangements, which is confusing to consumers and professionals alike. Legislation emanates from Federal, State and County level, none of which is co-ordinated in any way.

The emphasis for health care in the U.S.A. is based largely on hospital provision. This again is a factor in the fragmented, un-cordinated picture, as each hospital with the exception of

the Veterans Administration, tends to function as a relatively discreet organisation working to meet its own health care objectives. Centrally organised community services do not exist, although some hospitals are now recognising the need for continuity of care into the community, and there are some hospital based initiatives for community health care services. The community sector is the fastest growing area of privately run agencies.

Types of Hospital Provision

Hospital provision in the U.S.A. falls into the following broad categories:

1. Federal Hospitals	5%
2. Privately run hospitals - for profit	12%
3. State/Municipal Hospitals	25%
4. Voluntary Hospitals - not for profit	58%

1. Federal Hospitals

These generally are made up of the Veterans Administration Hospitals; these number 172 throughout the U.S.A.. The Veterans Administration (VA) was established in 1930 to administer a federal programme providing assistance to the nations veterans. This was originally established to deliver health care to anyone serving in the Armed Forces, but now sees anyone service connected; for example, families and those with problems as a result of service in the Armed Forces. This function has close links with the compensation and benefits administration.

Benefits for todays 28 million veterans are administered through a nationwide network of health care facilities, veterans benefits offices, data processing centres and national cemeteries.

The Health Care delivery system currently consists of over 170 Medical Centres (hospitals) with at least one in each state and one in Puerto Rico. In addition there are over 100 Nursing Homes and more than 226 Outpatient Clinics.

I visited the V.A. Medical Center in Boston, Massachusets, an acute hospital of 684 beds, although only 400 were currently being used because of staffing problems. Recruitment was very difficult I was told and it was especially difficult to staff the medical wards.

One programme that I found interesting at the Boston V.A. was their Respite Care Programme (R.C.P.) a colabrative programme of the nursing, neurology and social work services. The R.C.P. is designed to provide the primary care taker of an eligible disabled or chronically ill veteran with temporary respite from extended periods of home care. R.C.P. allows periods of relief to ease the burden of continuous home care; it is of a supportive nature and does not provide acute medical care.

R.C.P. may be used for a variety of reasons; the caretakers hospitalisation; the need for a week-end away or a holiday; or just the need for a break from the home care responsibilities. Admission is decided and arranged by the

R.C.P. Co-ordinator, (the Social Worker) together with a nurse who makes the nursing assessment. The caretaker is encouraged not to visit during the admission period which may be for up to a maximum of four weeks annually.

Private Hospitals - for profit

Contrary to common belief in this country only 12% of hospitals in the U.S.A. are motivated solely by profits, which are paid to shareholders. This is due to the very high cost of independent private health care, which only a minority can afford to pay unaided. An example of a Group of hospitals is the Humana Hospital Corporation.

State/Municipal Hospitals

Public Municipal Hospitals were originally set-up from taxes and are now funded from taxation and subsidised by each City. In some States, Massachusets being one, the remaining hospitals within the area pay into a "poor pool" and contribute to the short fall of funds, experienced by the Public Hospital. They are generally considered to be bottom of the league table in terms of in-patient facilities and even patient care. This is partially due to the fact that they cater for everybody who present, and for the poor people without insurance of any kind. This is very often their only patient contact with the health care service.

Voluntary - Not For Profit Hospitals

Voluntary not for profit hospitals contribute the largest provision of institutionalised health care in the U.S.A.. They provide mainly acute hospital services varying in size from the small - 150, to the very large - 1000 plus beds. Many Voluntary Hospitals were founded with charitable funds from private individuals and are now Institutions.

Not for profit hospitals need to make an operational profit which must be sufficient to meet the running costs, inflation and new capital projects. However, the hospital is free to change it's service provision, to correspond with resource constraints or demands, for financially viable new services.

Financing Health Care

How does the patient pay for what is often very expensive care? For some 90% of American citizens this will be met chiefly through some form of health insurance scheme. Aproximately 65% of costs will be funded through Medicaire and Medicaid programmes. Of the remaining 10%, some will have sufficient independent funds to meet medical costs without participating in health insurance, but a proportion will have little or no resources, but not be eligible for care under Medicaid.

People in this last category, currently estimated at 37 million, are receiving care at no charge, placing the state system under great strain. Two thirds of the 37 million are in employment, but cannot afford health insurance and therefore do not qualify

for any welfare benefits. This group suffers, in that services such as health promotion and highly expensive specialities, for example Burn Centres or Intensive Care Units, are not available to them.

Health Insurance Schemes

Health insurance in the U.S.A. was traditionally with commercial companies offering indeminity insurance on a for profit basis. Developments during World War II strongly influenced the evolution of health insurance in the United States. In 1940 less than 10% of the population had health insurance. Federal measures to relieve the pressure on the wage control system towards the end of the war, particularly the treatment of employers contributions towards health care coverage for employees and their families, as a non taxable element of compensation exempts from wage controls, enormously accelerated the development of todays fringe benefit economy.

Another boost came from a Supreme Court ruling that health care is an appropriate subject for collective bargaining under the National Labour Relations Act. These events greatly stimulated the growth of group health coverage, by plans such as Blue Cross and Blue Shield Commercial Insurance Companies and a prototype of Health Maintenance Organisations.

The Blue Cross and Blue Shield Insurance Schemes are based on deductions from salaries, and hospital reimbursement is regulated by the State Commission for Insurance. However, membership of this scheme is declining in the face of private sector competition.

By the early 1960's most economically self sufficient people in the United States had a significant amount of health care coverage. The standard thus established, gave rise to the concept that health care is a right, and this concept in turn brought forth tax support funds to ensure that economically dependent people would have access to health care services. The Governments role was reinforced and amplified by the enactment of the Medicaire (for the aged) and Medicaid (for the indigent) programmes.

Medicaire

This Federal Goverment Health Insurance Programme for people aged 65 and over, is divided into two parts: Hospital Insurance (Part A) helps pay for most in-patient hospital care and certain follow up care; Medical Insurance (part 2) helps pay for most of the Doctors services and other medical services and items. A supplementary insurance scheme Medigap can also be purchased to give added cover. This whole programme is critised as a "racket", in that the elderly do not understand the complicated rules and purchase far more insurance than they really need.

However, the Medicaire Catastrophic Coverage Act 1988 should improve the costs of hospital care, and commencing in 1990, the out of pocket expenses for Part B of Medicaire will be limited. Currently elderly people are responsible for 20% or more of what Medicaire reimburses physicians, without any limitations on total outlays. Other new changes include limited coverage of prescription drugs, respite care, home health care and partial payment for mammograms for women.[1.]

Medicaid

This is a series of combined Federal and State Governnment assisted programmes to provide public aid or welfare recipients with health care. It is means tested.
Initially reimbursement of hospitals for people with Medicaire and Medicaid programmes was cost based and retrospective as with the Blue Cross and Blue Sheild plans, but this method gave no inducement to be cost-effective. In 1983, in the face of an ever escalating spiral of health care costs paid ultimately by the tax payer, a Prospective Payment Scheme (P.P.S.) was introduced to reduce the burden of the costs of Medicaire and Medicaid.

P.P.S. is a payment method by which the amount a hospital will receive for patient treatment is set in advance by the Federal Government or Insurance Companies. The mechanism for P.P.S. for Medicaire was introduced in 1983 by the Federal Government, based on 468 diagnostic related groups (DRG's). This was prompted largely by the increasing concern with the growing costs of Medicaire and Medicaid programmes. The price of health care has grown more rapidly in the past ten years than almost any other item on the consumer price index.

Similar programmes have been adopted by Blue Cross, Blue Shield Plans and other Commercial Insurance Companies. Several States have adopted P.P.S. for Medicaid as well. In DRG's each group attracts a specific pre-determined payment per patient, depending on which group was specified initially. The amount is fixed regardless of what care actually costs.

Hospitals therefore have an incentive to reduce the cost of treatment and keep the length of stay in hospital to as short as possible. Should the patient incur costs over that specified in the DRG's, then the hospital incurs a deficit.

In order to maintain the hospitals financial viability, everyone is under great pressure to keep the service provided within each DRG to a level which avoids a deficit. One effect of this is to discourage hospitals embarking on service development and expansion, unless reimbursement is a known safe factor.

It can be appreciated that DRG's play an important part in the management of clinical services. The pressure to discharge early and so accrue a profit against that of safe care, perhaps resulting in longer hospitalisation, therefore resulting in a deficit, creates a dilemma for all involved in health care.

<u>Have DRG's resulted in restraining health care costs?</u>

DRG's are reported to have cut 5% off the Federal health budget, but at what cost? Ultimately to the detriment of health care services provided. The American Hospital Association reports 57% of the countries Community Hospitals

lost money on patient care in 1986. Certainly there is a question of survival, if a hospital is in an area serving a large number of the poor and elderly. I visited the Lynn Community Hospital in just such an area, a suburb of Boston; it is an acute hospital of 300 beds and is reported to have a <u>deficit of 25 million dollars.</u>

Health Maintenance Organisations.

The remaining feature of the U.S. health care market is the Health Medical Organisation (HMO). These organisations have risen to prominence in the last two decades, although they originated as far back as the 1920's. HMO's both insure health care and are providers of care. The philosophy of which, is to keep people well and out of hospital. In this pre-paid health care plan the consumers health care costs are fixed regardless of how much service the HMO provides. To control costs, HMO's stress preventative care and emphasise the use of outpatient facilities and wellness programmes.

I spent a day with the Kaiser Permanente Corporation in Washington, one of the largest HMO's in the U.S.A.. They operate Hospitals and Health Centres. Health Centres are very similar to those in the U.K., except all services are under one roof i.e. all Consultant Physicians visit, of whatever speciality, and they see the patients as necessary, as we would here in an outpatients department. As already mentioned the accent of the Kaiser Permanente is on health promotion and ilnness prevention and I observed ante-natal classes, mental health therapy sessions, paediatric health clinics, healthy heart screening and obsesity clinics. The pharmacy is provided on site, but should a patient choose to obtain medicines elsewhere, then this is at an extra added cost. The full medical records are held in the centre for every patient, an assessment is made of the health risks to each client.

An interesting facility provided at the Health Centre and unique to HMO's was the Advice Nurse. This is a 24 hour answered

telephone service, where any patient can speak to a Registered Nurse and ask advice on any topic.

When I visited, there were six nurses on duty in one room sitting at desks looking a little like telephonists. Each nurse receives on average of fifteen telephone calls per hour. She takes the history, gives the appropriate advice and makes a decision as to whether an appointment is needed with the Doctor immediately, tomorrow or indeed, if at all. Each Nurse has a computer terminal and can make an appointment then and there if necessary . I was told that these nurses do not receive any post basic training to do this work. They work strictly to policies and procedures, but they did draw on their own past experience and background and used peer support. I was shown three very large manuals which gave the exact questions to ask and procedures to follow for any health query ranging from a sore throat to a patient on home dialysis, right through to obstetrical queries.

In the absence of Community Midwives, District Nurses or Health Visitors in the U.S. this scheme appeared, to me, quite useful and was certainly used by the patients, Incidentally, the Advice Nurse was paid at staff nurse rate.

Originally HMO's only functioned for the well young population, however this has changed and I observed the full range of ages attending the Health Centre. Criticism is made, however, that H.M.O.'s can operate subtle means of selection by discouraging high risk patients, which are obviously going to cost more. Over competition, in high efficiency areas and poor provision

in the unpopular groups, can be a feature of HMO's.

What of the future?

In the 1980's the U.S. health care environment has changed in rapid and unprecedented ways. Major interrelated forces have been loosened in the national economy, including surpluses of Phyicians and hospital beds, spiralling health care costs, economic pressures on many American industries to lower costs, foreign competitors and actions by American business and government to reduce their share of health care costs. In this new environment competition has become intense.

Physicians and hospitals have begun a trend of affiliating with HMO's and other types of managed care plans, in attempts to secure a ready flow of patients and revenue. Many health care analysts applauded competition as a force for restraining costs and improving quality of care and services.

However, the forcasted benefits have been variable. For profit, HMO's earnings have disappointed security analysts and the investing public. Some of the largest hospital firms, insurance companies and service plans that started up managed care plans have since shut down or sold them. Investors have tried to help profitablity, by demanding that participating physicians and hospitals accept more financial risks and controls.

Concerns are being raised that physicians pressured or urged to control costs will compromise their professional judgement and quality of care. Confusion and competition in the market place, together with a few isolated but widely publicised scandals

involving managed care plans, feed a growing interest in the monitoring and measuring of quality of care. There is no general agreement on where the turmoil and trend will lead.

During my study tour, the 1988 election for United States President took place, and I was interested to note the emphasis, or rather lack of emphasis, that health care had as a political campaigning factor which is in direct contrast to the U.K...The inherited problems of the elderly requiring protection from the heavy burden of long term care services; middle class and near poor Americans without health insurance at the work place seeking federal protection; the continuing nurse shortage and inflation in costs associated with physicians services, all need to be addressed.

Elderly people in the U.S. form a large and powerful lobbying group. The secret of this success is simple. They tend to vote in elections and they are extremely active in lobbying in the form of the American Association of Retired Persons. At present, the 65 plus age group account, for 12% of the U.S. population, but those now in late middle age, identify with health care services for the elderly, as they recognise that this will effect them in the near future.

However, it is not felt generally that health care will appear as a priority at the top of the President's list when apportioning finances in his first budget. Despite, in the campaign, promising Medicaid reform, mal-practice laws and financial relief for rural hospitals. The campaign documents also promised to rely on the private sector, not the Federal

Government to make long term care insurance, afforable and available for more Americans; it remains to be seen.

The issue of health care inequality between the different social groups, i.e. the elderly, children, mothers, single parents, minorities etc., is one that many professionals, that I spoke to, found very worrying and again they could not see an easy quick solution on the horizon.

From the picture that I have portrayed of the U.S. health care system it is obvious that it is far from perfect. Health Care as a marketable commodity means that hospitals in the U.S. tend to be more consumer orientated, epitomised by the philosophy "Smile" and "Have a nice day!" But I would suggest that fierce competition has not restrained costs; has reduced the quality of health care in some cases, and therefore has not benefited the consumer.

In the U.K. the Government is encouraging private health care and recently announced in the Review of the N.H.S., White

3.

Paper, that many hospitals may opt out of the N.H.S. Health Care System. Having observed the U.S. system closely, I feel the U.K. should err on the side of caution before embarking on health care as a totally marketable commodity.

CHAPTER 2

HOSPITAL MANAGEMENT STRUCTURE

In the U.K. there is a a relatively standard approach to management structure especially following the Griffiths Report,[4.] but as already mentioned this is far from the case in the U.S.A.. There is no prescribed approach or national directive, and each hospital is free to follow their own choice of structure. Each State, through relevant legislation, will have certain distinct organisational characteristics as far as management arrangements are concerned, and the arrangements they adopt, to some extent, reflect the commercial influence within which health care is provided.

The three main elements of the U.S. Hospital management system particularly in the Not for Profit sector are:

The Governing Body/Board of Trustees

The Medical Excecutive Committee

The Administration (See Appendix.A.)

Governing Body/Board of Trustees

The role of the Board of Trustees which is similar to that of the management board of a commercial company, is to be responsible for the operational and financial strategy of the Hospital. It is made up of local business men, politicians and influencal members of the community, none of which necessarily are knowlegable regarding health care. The appointments are generally part-time.

Medical Executive Committee

Historically this body exercised considerable influence concerning the hospital's philosophy of care, service provision and standards of performance.. U.S. hospitals remain very medically orientated, although this traditional influence has diminished, as increasing financial constraint has proved necessary.

All the physicians have the opportunity to elect members to this body, where usually one member acts as a Medical Director. He or she is accountable to the Board of Trustees for the medical services provided. This blend of accountability to the Board and the loyalty to the peer group, calls for someone with a high degree of subtlety and diplomacy. Whilst expressing the concerns and points of view of colleagues and acting as their figurehead, the Medical Director's responsibility to the Board of Trustees in the final analysis, takes precedent over any professional loyalty to medical colleagues by whom he was elected. The main feature therefore, which distinguishes a Medical Director's role from any equivalent in the N.H.S., is that he is formally and unequivocably the head of the medical staff of the hospital. His pre-emminence on the Medical Executive Committee means he is responsible for the quality of professional standards of the medical care provided by the hospital. He will be held directly accountable by the Governing Body on this issue. The equivalent of this responsibility is not yet to be found in the N.H.S.

Peer review amongst physicians is not a new idea in the United States, and although primarily brought about by the necessity for all to work within the financial constraints prevailing, this has had an added bonus, in that quality of clinical practice is now examined and rectified if necessary.

I discussed this aspect of his work with Dr. Minogue, the Medical Director of the George Washington University Hospital, Washington D.C., a hospital of 500 beds which employs 200 medical staff and has an extensive network of some 22 committees on which doctors are represented. He does not have any clinical responsibilities, a deliberate choice, as he felt there could be conflict with the detachment necessary to be an effective administrator and manager.

Doctor Minogue's philosophy was for continuous improvement to make care better and better. He quoted to me the following saying by President Kennedy 'Errors only become mistakes, when you fail to learn from them and take corrective action.' He believed strongly in the corporate culture of medicine and in offering the safest medicine, leading to the safest environment for every patient.

Since the mid-1970's at George Washington University Hospital, medical audits have been undertaken examining high problem areas and Doctor Minogue stressed this process of peer review was not punative, but of value to improve clinical services. He had found that his medical colleagues needed documentation to convince them of the worth of peer review. Examples of audits undertaken, are those examining the utilisation of blood

products in the obstetric department; the use of antibiotics in the post partum period; and in the operating theatres, accidents involving 'sharps'.

In the U.K. Peer Review has not as yet become accepted practice, but as Dr. Minogue remarked to me " would it not be more acceptable to be answerable to ones' own colleagues, than to someone external to the profession, which may be forced upon the profession, without choice?"

Administration

The Administration Department was for many years the junior partner in the tripartite structure of the U.S. hospitals. However, the increasing complexities and pressures of the reimbursement process, and the enormous cost of beaurocracy of health care, has enhanced the value of the contribution of administration. The Chief Executive Officer has considerable influence in the management of the Hospital, reporting to the Governing Body on specialities, manpower needs or particular clinical services causing problems.

The Chief Executive Officer is by far the most powerful voice in hospital management in the United States. This Officer usually heads a management team which will include the Vice President for Nursing (C.N.O.), an operational expert, an information expert, a financial controller and possibly an estates manager. This team is similar to the Senior Management Group within the NHS. It is responsible for the financial and operational organisation of the hospital. Subsequently, managers within

the organisation will have the responsibility devolved down to them to implement the decisions as indicated.

Nursing Management Structures

Consistent with other aspects of the health care system I found that there was no uniformity in the nursing structures in the hospitals that I visited. Each structure was unique to the institution, having evolved to meet demands of the service. There were, however, certain similarities.(See Appendix B for 2 examples) Essentially a flat matrix type organisation exists, rather than a hierarchial organisation. This mainly consists of two divisions, an operational division and a support division. The latter covers such areas as finance, staff development, quality assurance and information systems. Structures continue to evolve under the influence of new Directors of Nursing.

CHAPTER 3

NURSING SERVICES IN THE U.S.A.

Having given a picture of the overall management structure of hospitals in the U.S.A., I will now describe the organisation and philosophy of nursing services of each of the hospitals, visited as this differed in many aspects.

I commenced my study tour in Boston, Massachusets, where I stayed for one week. There are approximately 3 million people in the Greater Boston area, making it amongst the ten largest metropolitan areas in the country. It is a centre of trade and commerce and considers itself one of the leaders in the nation for cultural, educational,scientific, medical and commercial activities. I visited four hospitals - the Beth Israel, Massachusets General, the Veterans Administration and Lynn Community Hospital.

One of the most striking impressions I received from 95% of the nurses that I spoke to, was their deep concern regarding the low profile in which nursing was held generally, in the U.S.A.. This was not only within the health care system, but by the public at large. More than once I was told how much they envied the high esteem in which nurses are held in the U.K.. One of the main reasons given for this, was that the health care system in the U.S. has always been traditionally medically orientated. Nurses were there to serve the physician. However, I felt a further possible reason was that the nursing service presented a similar fragmented, uncoordinated picture, as did the health care system

as a whole, a fact on which I have commented previously.

Amongst the nursing profession themselves, there is no agreement over the preparation and training of nurses. The Report of the National Commission of Nursing: Implementation Project,[5.] the equivalent of Project 2000,[6.] which presented its initial findings in 1986, and is due to produce a final report in the near future, has examined this whole matter. Nursing is searching for a new direction and questioning its current approach.

Another factor which I felt contributed to the problem, was the culture in the U.S.A. which has always been to allow everyone to do their own thing! This has extended to uniform and the general appearance of the nurse. I did not observe a uniform dress for nurses in any of the hospitals I visited. In some there was a requirement to wear a white top or bottom, but this did not seem to be strictly enforced, and footwear tended to be extremely casual. Added to this was the general wearing of every kind of jewellery and no identification of any kind, as to the grade of the nurse, apart from the obligatory identification pass with the name and photograph.

Now I realise that this is in stark contrast to the culture of nurse uniform in the U.K. which I am used to, but I observed that the physicians had not discarded their starched white coats and I felt that if the nurse wanted to be treated as equals and professionals in their own right, that it might behove them to look like a professional. I discussed this with the Vice President of Nursing at the George Washington University

Hospital, Miss Sheila McCarthy, and she has thought much along the same lines and was actively looking at some form of uniform, similar to those worn by airlines.

Preparation and training of nurses in the U.S.

In the U.S., as in the U.K., there are currently two levels of nurse. The Licensed Vocational or Practice Nurse, (LVN/LPN) who undertakes a one year training, usually at a local high school or secondary school. This is similar to a Technical College of Further Education in the U.K.. The LVN/LPN grade originated as a technical nurse during the second world war when additional numbers to the workforce, were necessary. It can be compared with the British Enrolled Nurse, although this training is of course longer. The first level nurse in the U.S., is the Registered Nurse, (RN) but there are three routes of varying length and complexity to achieve registration. The three tier system is as follows:

A two year associate degree programme taken at a Community College of Further Education.

A three year diploma programme, hospital based (the equivalent of our RGN training) although these hospital based programmes are being phased out.

A four year University Baccalaureate degree programme.

There is a considerable movement to make the entry to Registration at University level, which poses the question, who

receives the title of RN? Also, there is a proposal to cease LVN/LPN by 1992 and create a new 'technical nurse' with a two year training to work alongside the 'professional nurse'. This proposal has a familiar ring about it!

Nursing in the Beth Israel Hospital Boston Massachusets

This was the first Hospital that I visited after my arrival in the U.S. and it proved to be an excellent introduction. The Beth Israel Hospital is an acute hospital of four hundred beds and an internationally renowned centre of excellence for nursing, known especially for its work in piloting primary nursing. However, this has not always been the case.

In conversation with Marjorie Bachman, the Assistant Vice President for Nursing, and Joyce Clifford, Vice President, Nurse in Chief, I learnt that in 1973 when Joyce Clifford arrived at the Beth Israel, the nursing services faced the issues confronted by hospitals all across the country - a chronic shortage of nurses. The shortage lead them to rely heavily on private duty nurses, (similar to agency nurses), to supplement the nursing staff. Whilst many hospitals are now relying routinely on temporary nursing services, Beth Israel has not used this method of staffing since 1976.

In 1973 direct care was provided to patients by non-licenced personnel or nursing assistants, who although working hard did not have the knowledge or clinical capabilties to meet the

complex needs of patients in the evolving health care system. Overall there was a high level of dissatisfaction on the part of the patient, the nurse, the physician and the hospital, in terms of the care that could be provided under these circumstances.

Critical decisions were made, that began to change nursing practice and patient care. These decisions were supported not only by nurses, but also by the Beth Israel Hospital Board of Trustees, Hospital Administrator and the Medical staff. There followed the re-designing of support systems for patient care; de-centralisation took place, down to the head nurse, and the nurse managers developed and monitored their own budgets. The greatest single change factor as far as nurses were concerned was the implementation of Primary Nursing. Beth Israel was one of the first hospitals to pilot Primary Nursing.

Commenting on change, I was told that it was a revolutionary process, it must be management led, with clearly defined values and philosophies. The Nurse in Chief, whose background was a Nurse Educator, believed strongly in accountability and being seen as a colleague to nursing staff, chiefs of service, physicians and peers.

I spent a day on Reisman 12 an acute medical ward of 45 beds. In charge was the Head Nurse whose title had recently been changed to Nurse Manager! (See appendix C for job description.) She lead an all RN staff with degrees in nursing. They work full time, 40 hours per week, working three shifts 7.00 a.m. to 3.00p.m., 3.00p.m. to 11.00p.m. and 11.00p.m. to 9.00a.m., with

internal rotation, two weeks on days, and two weeks evenings or nights. There was a minimum number of 11 staff rising to 15 on any one shift. The Head Nurse held a budget of 1 million dollars and primarily saw her role as that of Nurse Manager/ Administrator. She also offered staff, communication. She held weekly staff meetings with her staff and attended a weekly meeting with the other Nurse Managers of the speciality, with the Director of Nursing for Medicine. She also had an individual weekly meeting with her Director of Nursing to discuss any problems. She devised and held workshops on varying topics, based on the needs and the level of the experience of her staff.

In this, she was assisted by the Clinical Nurse Specialist who had a Masters Degree in Nursing, who was ward based and with whom she worked in close liaison. The Clinical Nurse Specialist's role was that of teaching and development. She undertook the internal organisation of the ward in the absence of the Head Nurse and was a Resource Nurse, whom the Clinical Nurses, (see appendix D for the job description), could consult if necessary. The Clinical Nurses, were also supported by hospital wide clinical specialists for the following specialities: Psychiatry, Gerontology, Stoma Care, Incontinence, Cardiac Nursing and Intravenous Therapy. These all held training workshops as necessary.

During the evening and night, or weekends, the Clinical Nurses could consult the Clinical Advisor who acted as a resource person. The Head Nurse holds 24 hour accountability for the

ward and is always consulted if any important decisions needed to be made. She works 8 - 5 pm, Monday to Friday. (See appendix E for organisational chart).

At the Beth Israel, I formed the opinion that the nurses considered themselves 'professional'. I asked a second year Clinical Nurse, "What is your image of nursing?" Her reply was, "To be a primary nurse, responsible for the full programme of assessment, planning, implementation, and evaluation of the individual patient's care, and to work as part of the team with my medical colleagues."

Massachusets General Hospital, Boston

Following my visit to the Beth Israel I went to Massachusets General Hospital (M.G.H.). This was quite a contrast, if only in the size. It is an acute hospital of 1000 beds, made up of 52 wards and 109 clinics. There are 8700 employees in total. The nursing service is headed by the Director of Nursing, Yvonne Munn, assisted by various Support Directors and Directors of Clinical Nursing. Again, management is decentralised down to the level of the Head Nurse. M.G.H. was founded in 1821 and has always been an Institution where invovation is practiced. In 1846, Ether was demonstrated for the first time in the U.S. in the operating theatres. In 1898, the School of Nursing was founded, one of three in the U.S., based on the Nightingale Model. However this was discontinued in 1981, with much regret on the part of all nurses. I was told that the philosophy has always been to open a new service in the "closet" if the need was perceived! I thought this a refreshing philosophy when I

reflect on the length of time of projects, planning committes etc, etc., in the U.K..

All patients at M.G.H. were cared for in single or double rooms; wards being variously 18, 20 or 36 beds. I was told that the average number of R.N.'s would be as follows:-
On the day shift - 4/5, evening shift - 3/4, night shift - 2/3. The School of Nursing, having discontinued Registered Nurse training in 1981, had evolved a programme for the second career nurse, the average age of which was 28 years and above. It was a three year programme taking anyone with a degree in any subject allied to health care, which culminated in a Masters Degree in Nursing. It was one of five such schools in the U.S.A.

Primary nursing was practiced throughout the hospital, and as yet, recruitment had not proved a difficulty. I was shown a sophisticated programme called the Performance Based Development System, which all new nursing personnel were introduced to. There was great emphasis on documentation being seen as the cornerstone of professional practice.

Clinical Nurse Specialists, with expertise in psychiatry, cardio pulomonary, gerontology, neurology, orthopaedics, oncology, cardio vascular and paediatric nursing, provided support to staff through care, consultation, collaboration, and education. They organise educational programmes, conduct research and consult with non nursing members of the patient care team. They contribute to discharge planning, to educational follow up for patients and families, and to the quality assurance programme. They also co-operate in developing olinical procedures,

protocols and policies, and standards of care. I was told that the Clinical Nurse Specialist was considered essential, with the single objective of promoting and supporting excellence of care.

A further group of Specialist Nurses practising at and from M.G.H. are the 20 or so Nurse Practitioners. As primary care providers, Nurse Practitioners carry a case load of patients, providing health maintenance and preventative care; health screening, and referral to physicians and other specialists. Their role is to facilitate client access to health care; to co-ordinate the care for clients amongst various disciplines and agencies and to provide clients specific nursing intervention. This role appears to be a mixture of the District Nurse and Health Visitor role in the U.K..

A further subject that was discussed and demonstrated to me, was the Rush Medicus classification tool. At M.G.H. it is felt that it is critical to determine nursing resources required by a department and to identify and measure the workload of that department in order to meet that requirement. The patient classification system provides that measurement for the Department of Nursing. Because nursing workloads can be described and measured, the system provides data used to describe the relationship between actual or potential workloads in nursing. This data together with other available data and clinical judgement, is the basis for projecting personnel resource needs and for evaluating resource utilisation on a continuing basis.

I enjoyed my visit to M.G.H. but unfortunately it coincided with the two yearly visit of the Joint Commission for Accreditation of Hospitals Organisation, which is only notified to a hospital, two to three weeks in advance. This meant that several of my interviews had to be cancelled.

Lynn Community Hospital, Lynn, Boston

Although I had not made a prior arrangement to visit this hospital, the Director of Nursing Services, Mrs. Diane Fair, very kindly gave me some of her time. As I have already mentioned, this hospital is in a suburb of Boston and serves a large proportion of the poor and elderly population, which by virtue of this fact, means that the hospital has problems with reimbursement. Added to this, I was told that a weak management system, which has resulted in expenses being 'not in line', had resulted in a 25 million dollar deficit. A firm of consultants had been approached to produce an efficiency package. (The interest on the debt was 15%). An added contributing factor was the total lack of any modern information system, which obviously was going to need a major capital outlay.

The nursing budget was 100,000 dollars overspent, largely due to an increase in salaries, necessary to compete with other hospitals in the area, and the cost of agency nurses. The skill mix was approximately 40% RN's, 10% LPN's, and 50% Nursing Auxiliaries. This was in direct contrast to the very high RN ratio at the other hospitals that I visited. When I enquired

what was seen as the priority I was told, quality assurance in all departments; to develop a quality assurance programme and identify written standards of care and to determine the length of stay in agreement with the physicians. It appeared to me that this hospital was on a downward spiral and needed some drastic action to pull it together. Interestingly, I met a second year Staff Nurse from Yorkshire, who commented that she was getting good experience! The Director of Nursing Services was actively recruting in the U.K. Salaries for staff nurses are in the region of 30,000 dollars (16,500) depending on education and experience.

The Veterans Hospital, Boston

Having already given a background to the Veterans Administration previously, I will concentrate on the nursing services. I was somewhat perplexed on arrival at the hospital at the enquiry desk, when I asked for directions to Miss Coulter, Chief of Nursing Services, to be asked "Coulter, who is she?" However, I soon became used to the fact that outside security firms were employed by most hospitals and were available inside the lobbies and at desks. This was sometimes counter-productive as they did not always know the necessary answers!

This hospital was run by an Executive Board made up of the Chief of Staff, a Physician, Chief Executive Officer and the Chief Nurse. They controlled a budget of 22 million dollars. The Chief Nurse was assisted by Directors of Clinical Nursing service, Education and Outpatient service. The clinical

service division was then split between four Nurse Co-ordinators, one for surgery, medicine, psychiatry and ambulatory care. These were all either Baccalaureate or Masters Degree prepared. Finally, in the last level of the management tier, were the Head Nurses, again all Baccalaureate educated. Management was decentralised down to the Head Nurse with support from the Nursing Co-ordinators.

The Chief Nurse saw her priorities as running the hospital as a corporate body; improving recruitment and retention; (the turn over of RNs was currently 22%), and ultimately to keep the wards open. The main difficulties with recruitment were competition with adjacent centres of excellence; and the increasing numbers of new services in the city, for instance, neighbourhood health centres; and the broader horizons now open to nurses, including technology and reearch.

Team nursing was practiced with some evidence of task orientation. The Chief Nurse did not believe in an all RN staff, feeling that patients gained from different skill mix currently 59% RN's, 17% LPN's and 24% Nursing Auxiliaries. The vacancy factor was 9.8%. The Chief Nurse was a nurse from the "old school" and in 1987 had been sworn in by oath and presented to the House of Senate in Washington DC., the health care problems, as she saw them. This, apparently was a very rare event.

The Veterans Administration Hospital is affiliated with both Boston University and Tufts University, Schools of Medicine and Nursing, and has some 200 student nurses at any one time. An interesting staffing initiative was the student nurse summer

programme. Student Nurses are employed as Student Nurse Technicians from June to August, during the University vacation. The salary was 284 dollars per week. (approximately 160). The student had to have completed one year in a registered nurse programme. Consideration was given to the students interest for clinical ward assignment and they were free to attend all the in-service and continuing education programmes.

I then moved on to New York City where I stayed for the second week. A very different place to Boston, where everything moved at a fast, furious and noisy pace. New York is the largest city in the United States with a population of over 7 million, living in an area of 320 square miles. I visited three hospitals, the Mount Sinai, New York University and St.Clares Hospital.

Mount Sinai Hospital

Mount Sinai Hospital is situated adjacent to Central Park in New York City. It is an acute hospital of 1100 beds split into 7 divisions, namely, medicine, surgery, women and children, psychiatry, cardio thoracic and operating department, ambulatory care and gerontology. This hospital was founded in 1852; many of the buildings are old, but an ambitious building programme of three new tower blocks has commenced. 625 beds are incorporated including 66 in specialised intensive therapy units and 22 operating rooms. There are uniquely designed centralised nursing stations to allow direct visibility to each patient's room. It is a centre of excellence with many "firsts" to its name.

The hospital employs 1500 nurses, who are led by the Vice President of Nursing, Miss Gayle Weissman, assisted by the Assistant Director of Nursing Operations and the Director of Clinical Nursing. (See appendix E). The management is decentralised down to the Clinical Supervisors on each ward. The nursing department policies were in a very sophisticated form and I was very impressed with the vision statement, the description of the organisation, the philosophy, and the goals and objectives for the Department of Nursing, which I have included. (see appendix F.). In the U.K. the nursing profession generally has not yet asked itself what it stands for, stated its vision, its philosophy or its aims and objectives. I believe that in the present climate of change within our profession, we must be clear and tell others what we stand for and where we are going.

I spent an afternoon with Miss D. Porter, the Clinical Supervisor of F5, a surgical ward specialising in gastro-intestinal disease. She has 24 hour responsibility for the 31 beds in two or four bedded bays, and manages the ward with the physician, working together. She has an average establishment of 6 RN's plus 1 to 2 Auxillary Nurses on day duty, (the shifts are 7.00 to 3.30p.m. and 3.30pm to 11.00pm), and 4 RN's and one Auxiliary Nurse on night duty. The ward team is made up of the Clinical Supervisor, Senior Clinical Nurse and Staff Nurses. They are supported by a Clinical Resource Nurse who covers three wards, and various Nurse Specialists, such as specialists in intravenous therapy, stoma care, nutrition etc.. There is also an equipment and supplies technician who works Monday to Friday and covers two wards. This person deals with

all ordering of supplies, checking of equipment, etc.

At Mount Sinai, primary nursing care has been the central focus for some eight years, but with diminishing human resources each ward now decides on its own organisation. On F5 they practice primary nursing. All the RN's on day and evening shifts are primary nurses and the night nurses are associate nurses. When I enquired if any problems were encountered, I was told that the geography of the ward sometimes meant that a patient requiring intensive nursing care had to move to another bay and perhaps change to another nurse. Doctors must be educated to speak to the primary nurse, plus other members of the hospital staff, for example pharmacists. Patients must clearly understand the concept of primary nursing care and realise that they have their own nurse and not just any nurse will do! From the management perspective,primary nursing is easier, as each nurse has to be accountable for her own actions with peer review encouraging high standards of care. If the system does fall down, it is immediately apparent who is responsible. For the wards who are not practising primary nursing, some were practising a group management model, and others examining the system of case management in nursing. Both these systems appear to be akin to team nursing but with more responsibility being taken by the Group Leader and Case Manager. (See appendix G for the general description).

Despite its size, the nursing service at Mount Sinai Hospital appeared to me, to be very well organised into a cohesive unit, with good communications at all levels.

New York University Hospital

On the opposite side of the City overlooking the Manhattan Bridge spanning the East River, I visited the modern New York University Hospital. This again was a large hospital, 726 beds, with an average occupancy rate of 90%. The departments were medicine, surgery, obstetrics and gynaecology, urology with oncology, paediatrics, E.N.T. and cardiac surgery. There was a separate rehabilitation unit of 150 beds which took admissions from other hospitals, which specialised in 'stroke' patients, patients with multiple deficiencies following neuro-surgery, and spinal cord injury patients. Another interesting unit was the Co-operative Care Center of 104 beds, which was a discharge unit where the focus was on preparation for independence on discharge to the patient's own home situation.

On the morning of the first day, when I visited the staff restaurant, free coffee and Danish Pastries were being served . This was the managements "thank you" to all hospital employees following the Joint Commission for Accreditation of Hospitals' successful visit in early November. Needless to say this was appreciated by all. I felt it was a small gesture which did a great deal in ensuring high morale amongst staff. How often are our staff thanked in any tangeable way?

I was interested to note during my visit that an Inspector from the New York State Department unexpectedly arrived to investigate a patient's complaint and every single record appertaining to this patient had to be produced. I felt that it certainly must concentrate the mind with the knowledge that

ones records may be produced to an External Inspectorate at any time. In the U.K. this is an area where improvements could be made.

The nursing services were led by the Executive Director of Nursing, Miss Karen Ballard, assisted by the Assistant Director of Support and Clinical Services (see appendix H). Management was again decentralised down to the Head Nurses who managed as the ward team, Staff Nurses, Senior Staff Nurses, Nurse Clinicians and Senior Nurse Clinicians. (see appendix I for the job description). Recruitment did not appear to be a problem, for there was a small flow pool for relief purposes and no Agency Nurses were used.

I spent two hours with the Director of Hospital Information who discussed with me the Hospital Information System - an advanced hospital communications system. This Hospital Information System (HIS) is one of one hundred installed in hospitals in the U.S.A. and was introduced to the nursing services in 1981. All admissions are entered on to the HIS, plus all physicians orders inputted by the individual doctor. All test results are available and there is input from some support services; 34 in all, e.g. dietitian. Each nurse unit of 34 beds has four terminals and one printer, with additional terminals in the operating room and ITU. Before the beginning of each eight hour nursing shift the HIS prints a patient care sheet for each patient. Care sheets are printed in triplicate at the appropriate nursing station; one copy is retained by the Head Nurse; one by the Team Leader, and the other copy is used by

the nurse with responsibility for patient care for the shift. The patient care sheet consolidates all appropriate information (i.e. current medical orders, nursing procedures and orders and general patient information) that has been entered into the computer at various times by various personnel. The care sheets contain the following sections:

Basic patient data (name, age, sex, consultant, etc.)
Diagnosis and surgical procedures
Vital signs orders
Diet and fluid balance orders
Hygiene activity
Safety orders
Procedures orders
Medication orders
Other departments' orders (laboratory tests, X ray etc)
Miscellaneous orders
Restrictions
Discharges

The care sheet is used during the shift change report and throughout the shift. New information and notes are added on the care sheet during the shift.

With HIS, there need be no Kardex files or medication sheets, instead the computer can print an hourly 'medication due' list for each nursing station, showing all medications to be given during that hour. After medications are adminstered they are charted at the VDU by selecting given or not given in conjunction with each order. When a medication is reported as

not given, the VDU immediately displays a reason why the medication was not given from which the nurse selects the proper choice. If a particular medication is not reported, a reminder note is printed by the computer. Medication reporting, including observation, is included in the daily nursing record report for each patient and also triggers charges for the precise amount of the medication that was administered.

Medications are sent to the nursing station by the pharmacy, based upon computer produced print outs in the pharmacy. If the central service supplies are needed, the nurse uses the VDU to request the desired items. The computer prints the requisition in central services.

Nursing data entered into the computer can include the vital signs, including blood pressure, intake and output, including observations, the results of unit specimens and patient care plans. All nursing data entered into the VDU is printed on the nursing record summaries which are printed daily during the night shift and filed in the patients chart.

Clinical information may be obtained by selecting a patients name and the specific category of information desired, e.g. laboratory tests. Instantly displayed on the VDU, will be the patient's results for the last twenty four hours.

The computer also carries care planning capabilities. Individual and specific care plans can be developed from patient care information on the computer. These can be used in conjunction with the daily patient care sheet in the planning and delivery

of care. All medical record notes are on the computer, access to which is determined by grade and the post held. For example a Staff Nurse would have access to the ward based information and management would have the overall information for the speciality. The response time was very fast, less than one second with information stored in short-term on disc drive and long term on magnetic tapes. Bearing in mind the difficulties experienced at Newmarket General Hospital when the computer goes down in medical records, I was interested to note that the system is scheduled to routinely go down 2.00 to 3.00 a.m. with a back up system in operation, with the incident rate of the system going down during the day, less than 1%.

I observed several examples of usage - pharmacy orders, central services supply orders, the production of medication due list and the patient care sheet (see appendix J), however, there are difficulties with the nurses updating care plans I was told, especially with the outcomes. It appeared that even technology is not the answer to completing care plans! I was told that a patient classification tool was used but not to determine staffing needs, only to assess patient acuity levels, trends and for budgeting purposes.

I left the New York University Hospital with the impression that it was an Institution where the changing face of nursing was very well displayed, by the example of the use of technology.

St.Clare's Hospital

Should I have been seeking a direct contrast to New York University Hospital, I could not have succeeded better in the choice of St.Clare's. It is a small hospital of 250 beds administered by the Catholic Archdiocese of New York, previously administered by the Franciscan Order of Missionary Nuns, which had become bankrupt and virtually dismantled a few years earlier. It is situated in downtown Manhattan where it definitely is not safe to walk out alone after dark. Predominantly the surrounding community served, is strongly working class, mainly Irish, but, multi ethnic, racial and lingual, referred to me as "Hells Kitchen"! There is an enormous problem with drug dependency. The area is fast becoming one of transisition however, property values are soaring,and old apartment blocks are being replaced with new apartments, office buildings, etc.. Although St.Clare's is an acute hospital with general medical and surgical wards, I concentrated my visit on two departments. The Accident and Emergency Department and the Spellman Unit. I was told it was a political decision to keep this community hospital open, partly because of its position in the city and partly because of the Spellman Unit, which I will describe later.

The Accident and Emergency Department certainly was not sophisticated regarding surroundings or equipment. It catered on average for 1500 cases per month, 20% of which were admitted to the hospital, mainly business workers from the surrounding locality, compensation work, ie. work with the injured at the place of work, local community and visitors etc. At night the

scene changed to hobos, down and outs and the drug takers.

It was staffed by a Nurse Manager plus two full time Staff Nurses, these being the only permanent staff in the department, the rest were Bank or Agency Staff. Throughout the Hospital there was a 70% vacancy rate, (the national average being 22%) On questioning, I was given several reasons for this situation:-

1. The Hospital could not afford to pay as high a salary as the larger hospitals in the city;

2. There were problems with third party payers i.e. Blue Cross, Medicaire and Medicaid schemes, with reimbursement, as many of their patients stayed in longer than the DRG's stated.

3. The hospital, because of its geographical location and surrounding community, received no endowment.

I found this was a recurring story for small Community Hospitals in the poorer areas.

I found the Ambulance Service interesting. There being no centralised Ambulance Service, as in the U.K. , some ambulances were owned by the hospital and some owned independently, but I was told that the patient numbers in Accident and Emergency Departments sometimes fluctuated if the ambulances were not working, as they suffered from mechanical failure! The Emergency Medical Technicians and the Ambulance Staff, receive some training in life support, but it is by no means at the level of the service offered in the U.K.

In November 1985, St.Clare's Hospital became the first hospital on the East Coast of the United States (the second in the Country) to open a separate dedicated Unit for AIDS patients - the Spellman Unit. Despite some seemingly impossible problems i.e. the Hospital did not have the financial resources, facilities or AIDs patients case load of the larger well known New York Medical Institutions, a unit was established. Until then, all AIDS patients were nursed on all the wards around the hospital, but, the then Director of Nursing Services and Head Nurse Terry Miles, felt a discreet AIDS unit would offer a better service. However, they had some reservations, these included patients on the Special Unit might be stigmatised and their privacy violated; the hospital might be labelled an AIDS hospital and be shunned by the regular surgical/medical patients; the Unit might be labelled as "death row", isolated from the rest of the hospital, with staff refusing to work there; patients would become more depressed alongside others with more advanced stages of the disease.

However, after research and discussion, it was found that the patients scattered around the hospital already felt isolated, abandoned and suffering from depression and the nursing staff found it stressful dealing with specialised infection control requirements, and the demands of these patients in addition to the other patients on the general wards. A dedicated Unit offered numerous advantages:-

- A better more effective use of resources by standardising procedures and co-ordinating workloads.

- Patients, their families, and significant others would be together for emotional support, as well as educational and other formal and informal group activities.

- Staff would receive immediate feedback from patients and family as to their concerns about this "stigmatised" illness and the care they were receiving.

- Medical and Nursing Staff would share common concerns. They would be there because they wanted to work with this patient group and could share their knowledge, experience and education with each other, helping in mutual skill development.

Once the unit was in operation, all the original fears proved to be unfounded. On November, 26th 1985 the first 15 bedded unit opened with seven patients transferred from other wards in the hospital. Today the Unit has 90 beds, 25 of which are for prisoners. The Unit works closely with the New York State Prison Authority. On the Spellman Unit, there was a higher level of permanent staff, who I was told, were not afraid of the knowledge gained today, but worried regarding the work they had carried out with drugs and heroin addicts, ten years ago. A roundabout way of testing themselves was to become a blood donor, where it would be picked up if they suffered from AIDS. 95% of the patients nursed were male. Drug trials were taking place with ACT and Interferon. A nurse run project was taking place with Retrovir, a medication to combat the effects of the virus.

Terry Miles, now the Co-ordinator for the Unit, stated that there were many problems regarding staffing - lack of

numbers and lack of in service training, as the staff could not leave the ward and he was very worried at the fine line between a safe level of care and accountability.

In accordance with state requirements, the AIDS unit at St.Clare's is managed by a multi-disciplinary team, that includes: a Physician, Nurse, Social Worker, Patient Educator, Occupational Therapist, Physiotherapist, Dietitian and Discharge Planner. The Model of nursing care is Case Management. Although this approach had been in place on the AIDS unit before negotiations began with the State, the approach has become more defined and now functions as the backbone of the programme.

Every patient is assigned a Case Management Nurse (CMN) who is an RN. Immediate care needs of the patient are met by the CMN with assistance from LPN's, Nursing Assistants and other RN's. The CMN also co-ordinates other health care professionals who interact with the patient and help make up the multidisciplnary team.

The Case Management Nurse develops the comprehensive patient management plan that reflects the physical, psychological, social, and financial needs of the patient. It also includes transfer, discharge and follow-up plans. The Case Manager is known by the patient , family and/or significant others. The CMN also has to be known by any allied agencies involved with the patient, for example, Substance Abuse Agency, Home Help Care Agency.

Weekly multidisciplinary rounds are chaired by the Medical

Director but are conducted by nursing staff. With this procedure the entire team is aware of the patient's status and each member's involvement in meeting the holistic needs of the patient.

In March 1988, a separate comprehensive outpatient programme commenced, seeing patients from the initial screening to the final stages of the illness. It provides diagnostic and treatment services which include dental, dermatology, psychiatric and infusion therapy programmes. There is a toll free hot line which provides information on AIDS and the resources available for persons with AIDS. The hotline receives approximately one thousand calls per week. A number of new services for patients with AIDS will be added to the Spellman Unit over the next twelve to eighteen months. These include:

- establishment of a ten bed Neuro-Psychiatric Unit for persons with dementia and neurological complications caused by HIV infection.
- The creation of a fifteen bed residential care facility for homeless person with AIDS.
- The establishment of a Methadone Maintenance Treatment Programme, specifically for persons with AIDS and HIV infection.
- The development of an Outpatient Mental Health Programme for persons with AIDS and HIV infection.

I left St.Clare's Hospital with the mixed feelings of depression, humbleness and elation. Depressed by the seemingly enormous odds that the hospital worked against (the Director of Nursing Services had suddenly resigned the day I visited);

humbleness, that I dare to complain about the conditions with which I work, and elation that despite such difficulties, there were nurses with sufficient vision, perseverence and initiative to carry on. As Terry Miles remarked to me "we have a job to do, come what may. Through education and media coverage, who knows what the future holds". Incidentally, earlier in 1988 the hospital was visited by Norman Fowler M.P. and Sir Donald Acheson, Chief Medical Officer for the DHSS.

The final stage of my study tour was spent in Washington D.C. the capital city of the U.S.A. situated on the Potomac River - home of the White House, Capital Hill and the Pentagon. A graceful city and in great contrast to New York. Here I visited the George Washington University Hospital, Greater South East Community Hospital, the Kaiser Permanente Corporation, Prince Georges Hospital and lastly, I travelled to the Johns Hopkin Hospital, Baltimore.

<u>George Washington University Hospital</u>

The George Washington University Hospital (GWUH) is one of the two University Hospitals in Washington DC. It is a centre of excellence with 500 beds. The departments I examined in detail, were the Operating Department and the Day Case Unit. The Nursing Management Structure (see appendix K) comprises of the Director of Nursing, Miss Sheila McCarthy, who is currently the President of the Association of Nurse Executives, (a National Body of Senior Nurses), with four Assistant Directors of Nursing responsible for the following units:-

Medicine and Surgery

Obsterics and Neonatalology

Operative and Dialysis

Special Care

Added to this team is an Assistant Director of Nursing Administrative Operations, who is responsible for organising staffing in the evenings, night duty, weekends and holidays, and the Assistant Director of Nursing Continuing Education and Research. The role of the Assistant Directors of Nursing for Clinical Services, corresponds broadly to the role of our Senior Nurse/Clinical Nurse Managers. Accountable to them, are the Unit Nursing Co-ordinators, (Head Nurse), who have 24 hour responsibility for a Unit/Ward - this will be of varying size, from 24 - 40 beds. At GWUH they are moving towards decentralisation and full budget control at ward level. At present only some wards have the responsibility for the appointment and dismissal of staff, with limited budgetary control. They are all, however, responsible for covering the ward with the ncessary numbers of staff, using Bank Nurses if necessary. There are two interesting features which make up this Nurse Management Structure, namely the existence of the Nursing Education Co-ordinator and the Administrative Divisional Co-ordinator. The Nursing Education Co-ordinators, usually one to each ward, undertake the responsibility for the Continuing Education Programme of the staff. They are likely to be found mainly in the clinical areas working with nurses, although they do participate in formal education activities across the wards. They are particularly proactive in orientation programmes for the newly appointed members of staff, however, they have no

involvement with the educational preparation of student nurses undertaking their practical experience modules. Student nurses are accompanied by their own Tutors from the University Schools of Nursing. The Nursing Education Co-ordinators have a dual responsibility to both the Assistant Director of Nursing for Clinical Services and the Assistant Director of Nursing for Continuing Education and Research. It appeared to me that the role of the Nursing Education Co-ordinator was similar to that in the U.K. where joint appointments have been made, as in the nursing development unit for the Care of the Elderly at Tameside in Greater Manchester.

Each ward also has the support of the Administrative Divisional Co-ordinator whose background is likely to be in business administration, and who takes full responsibility for the ordering of supplies, payroll administration, documentation of staff commencing and leaving the hospital, environmental problems and budget preparation. In addition to the Administrative Divisional Co-ordinator, each ward has clerical support equivalent to our ward clerks, dealing with the routine clerical duties. This level of support to the Nursing Unit Co-ordinator, (Head Nurse) does mean that she is free to manage her ward and carry out the exclusive functions of the nurse. I felt that this would be a great asset in the U.K.!

This was the only hospital that I visited where I was positively told, that the role of the Director of Nursing was seen to be equal to the Chief Executive Officer and to the Dean of Medical Affairs, and I found this was evident in the corporate identity

throughout the Hospital. The Director of Nursing maintained a high profile in the hospital and was particularly keen that all her nurses had commitment to the Philosophy of Nursing of GWUH, Department of Nursing (see appendix L).

Throughout the Hospital, the Rush Medicus Patient Classification System was used as a monitoring tool to provide data to show trends as evidence in acuity levels, staffing development and new technology. It was not used to determine in-patient costs, i.e. nursing care hours given, a standard nurse care cost was included in the basic room rate.

A new patient information system computer package had recently been installed and I toured the wards with the Special Projects Co-ordinator who was monitoring how the wards were coping with this system. She was somewhat disillusioned to find that over three quarters of the in-putting of data had not been carried out as the computer terminals were not working! One of the Head Nurses commented that technology decreases staffing in all industries except health care!

Primary nursing has previously been used at the GWUH but again with the decreasing human resources and following a survey amongst, staff it was identified that not all nurses enjoyed primary nursing and therefore wards were given a choice of the system to be used. Team nursing or case management seem to be the alternatives of choice.

GWUH has as support to all wards, Clinical Nurse Specialists, one of which is a new post - a Clinical Nurse Specialist for

Continuing Care/Discharge Planning. This post was created following the identification of the nurses role in planning for discharge on the patients admission. The postholder has a Masters Degree in Community Health Nursing and works in close liaison with the Social Workers and Clinical Education Nurses on the wards. She is used as a resource person for effective planning of continuing care and discharge.

As I have already mentioned, care in the community is extremely fragmented. There is an increasing trend for hospitals to develop their own home care programmes and at GWUH there are two Cancer Home Care Nurses. The ward staff usually assess and tackle the home nursing needs but three factors are very important - there must be a an available home carer; there must be sufficient finance and the nursing care needs must be defined. Outside Agencies include the Private Not for Profit Organisations, the visiting nurses organisations, and there are many for profit Agencies which the JCAHO has only just started accrediting. There are also commercial companies which undertake home visits, such as drug companies dealing with intravenous therapy or equipment companies advising on equipment in the home. I was interested to note that increasingly, the acuity level of the patient is rising in those discharged from hospital. This is in direct answer to the need to keep costs down, and maintain shorter length of stay as an in-patient. It is common for patients requiring intra venous therapy, respiratory care with chest tubes or mechanical ventilation, etc, to be cared for at home.

With the increasing cost of in-patient care, will the trend to shorter hospital stay, become apparent in similar practice in the future in the U.K..

The Greater South East Community Hospital

Again, I experienced a great contrast when I visited the next hospital - the Greater South East Community Hospital some eight miles south-east of Washington City.

It is a modern 450 bed acute hospital providing all the usual services plus a Home Care/Home Help Service. It is a Not for Profit Hospital owned by the Greater South East Community Foundation, a Holding Corporation which either owns, leases or manages a variety of concerns, for example, office buildings, a Pharmacy, Home Care Centre, two Geriatric Day Care Centres, plus it is a Real Estate Company with apartment complexes that it has bought, renovated and subsequently let to the elderly and low income families. The profit from which is re-invested into the Foundation. It is situated in, and serves, the poorest, toughest area in Washington, where the community is multi-ethnic, predominently coloured, plus Hispanics, Oriental, Cambodian, and Vietnamese. However, it also serves the Prince Georges County area made up the lower and middle classes. Housing conditions are extremely poor. I observed many 'squats', all of which were state owned, the equivalent of our council housing. The unemployment rate is very high amongst the young coloureds. Poor schooling, crime, drug abuse and gang warfare is common (the day I visited there had been two killings in the near vicinity). There is a high teenage pregnancy rate with the associated high

perinatal and mortality rates. I was told that there was a very poor uptake in ante natal care.

I found the role of the midwife in the U.S. interesting. The midwife has the lowest profile of all the health care professionals I encountered during my stay. Traditionally, obstetrics in the United States has always been very medically orientated, and today, a doctor and an anaesthetist must be present at all hospital deliveries. There is a minority group of Independent Midwife Practitioners, mainly in the rural areas, with a few centres in some cities. I was told, however, that they are not popular with obstetricians and therefore very few doctors will work with them. In the hospitals, general nurses staff the ante natal and post natal wards.

I formed the opinion that despite its' environment and the population it served, the Great South East Community Hospital was very well managed indeed. (See appendix M for the management structure). Nursing enjoys a very high profile; the image had changed from 'handmaid' to 'helpmate'. Nursing staff here are unusual in the U.S. in that they are totally non-unionised and enjoy good relationships with administration and management. There are nurse members on all the committees. Staffs' ideas are sought and acted upon. If this results in cost efficiency savings, then they receive a percentage of the money saved. A 'Think Tank' is in operation where all staff are encouraged to submit their ideas to benefit the patient, the staff and community.

Management is decentralised including budgetary control, down to the level of the Assistant Director of Nursing. (The nurse budget was the only budget not overspent). On questioning, I was told there was a RN vacancy factor, but nurses were generally better at monitoring and budgeting, and it was easier to forecast nursing needs, than say, estate buildings. It was felt however, that a critical period had been reached in the last three months, and that if the recruitment of RN's continued to be difficult, then management would have to look at employing more LPN's or Medical/Surgical Technicians. At present no Agency Nurses are being employed.

Despite the very depressed area in which it was situated the Greater South East Community Hospital maintained a very pleasant well managed environment and I enjoyed my visit there.

Prince George Hospital, Cheverley, Maryland

I visited this 460 bed hospital briefly for a morning, when a prior engagement had to be cancelled. It is situated ten miles west of Washington D.C. in Maryland; a very pleasant wooded hilly area. It is a Not for Profit Private Corporation which has suffered a somewhat chequered career. It started life in 1945 as a Public County Hospital, funded by Prince George County to offer low cost health care to the community, but in 1981 with a large deficit, the County decided not to continue with the management and it is now under the control of a private corporation.

The main factor of interest here was the organisation and structure of the hospital. It is based on the standard operating system used in many industries - service line management. Through the centralisation of both planning and operations, under a single responsible executive, service line organisations have demonstrated increased efficiency, reductions in duplicated services, optimal use of resources, increased revenue and accelerated decision making. Because the service line approach requires that managers define proposed activities and target markets, opportunities exist for understanding cost and developing costing strategies. Key elements to the success of a service line are the development of a clear mission statement and business plan which define internal and external relationships. The management structure was very different to those that I had encountered previously, with a Chief Executive Officer dealing with external issues; the Chief Operations Officer, who deals with internal day to day operations and an Administrator. The nursing services are managed by two Directors of Nursing Services who have no input at senior management level. They are assisted by six Assistant Directors of Nursing services, the Product Line Directors, who organised the six service lines. The two Directors of Nursing Services are equal to each other and meet daily, working in close liaison. They in turn meet with the Product Line Directors weekly, to discuss strategic planning and problem solving etc. They share the responsibility for quality assurance. When I asked if there was any disadvantage to this system I was told that the mission statement tends to get lost!

Whilst discussing the systems of patient care I was told by one of the Directors of Nursing Services that they had given up primary nursing in February, 1988. She posed the question "did nurses undertake a four year university degree course in order to remain at the bedside?" The system now in operation is case management. This was described to me in the following way:-

"Nurses prefer to participate in the management of patients;
the RN to co-ordinate the activities of the team;
The LPN to assist the RN who may or may not handle drugs;
The AN who undertakes the basic nursing care e.g. bathing, vital observations, feeding etc."

I thought that perhaps this was the path the U.K. would ultimately tread with the RN, some EN's and other support workers as the team of the future. Staffing was according to patient workload and staff needs. Patient activity is monitored for each shift and the ward staffed accordingly. There is a central pool of staff for any emergencies which might arise. This did not appear to me to give either continuity of care to the patient, or job satisfaction to the nurses. I found the visit to Prince Georges Hospital interesting, but I did not get the feeling that certainly, at senior management level, there was enormous satisfaction in the system being practiced.

Johns Hopkins Hospital, Baltimore

The final days of my study tour were spent at the Johns Hopkins Hospital, Baltimore, which is a 1100 bedded hospital with a compliment of 1500 w.t.e. nursing staff, 1100 of which are RN's.

It is situated near the centre of Baltimore serving the city with a population of one million people and it is internationally renowned for its unique decentralised management system. The hospital in effect, is made up of eight relatively automonous hospitals within one Institution. Each of which are based on a division of specific clinical service, e.g. medicine, surgery, paediatrics, etc.. (See appendix N) Each division is managed by a functional Unit Director who is a Physician, and a Nursing Director assisted by an Administrator. This team has total responsibility for the organisation of the patient care services in that department. Ultimate accountability is to the functional Unit Director. The team report to the President of the hospital, who is responsible and accountable for the day to day running of the entire Institution. There is nursing input at the highest level at Johns Hopkins, as the Vice President for Nursing sits on the Medical Board, and I was told there was excellent team work.

Founded in 1889, previously Johns Hopkins was an independent institution, but now belongs to the Johns Hopkins Health Centre and Health Plan. It was necessary to diversify as a result of DRG's to open up the market. In 1983 it acquired three other hospitals with specialities not already catered for, i.e. the Burns and Alcohol Units, plus a Community Hospital which offers training in routine General Medicine and Surgery.

In the Spring of 1988 the Department of Nursing discussed the following question:-

"How can we continue to give patient quality care when we have

fewer nurses, fewer nursing students and tighter financial constraints?"

The conclusion was reached that this trio of shortages, presents "a great opportunity for nursing to re-define itself into something that is more logical and more satisfying" said the Vice President for Nursing. "There is a need for the nursing profession to be proactive as well as reactive to these shortages. We really need to ask ourselves, what is really important? What have we been educated for? What is okay for someone else to do? This is the struggle, not only at Hopkins but throughout the entire nursing profession". At Johns Hopkins they were striving for an all RN staff but this has become increasingly difficult within the last year. The vacancy rate varies from 0% to 27%, the average being 11% for RN's, depending on the speciality. Critical Care and Oncology have the highest vacancy rate. It was reported that the number of Agency Nurses being used is increasing. One factor regarding the vacancy rate was the level of competition around from such areas as Washington and Philadelphia. The skill mix is changing rapidly from an all RN staff to RN's assisted by untrained staff, who have undertaken a six month training programme (the support worker). They wish to maintain primary nursing but are now looking at how to delegate to other levels of nursing staff. In some units, however, team work and case management are being implemented.

I found the organisation of the eight different hospitals within one Institution difficult to assimilate and fully understand.

It appeared to me when I attended the Quality Assurance Steering Committee meeting, which was attended by the Vice President of Nursing and all the Directors of Nursing, that there was no overview held by any one person, and that therefore the system could become very fragmented. For example, there was no basic system for Cardio-Pulmonary Resuscitation throughout the Institution; there was no overall plan for discharge planning (I recorded in my notes there was a problem in getting an overview of the problem!); information was fragmented, as copies of various committee notes were not circulated to all Directors of Nursing, only to the committee members. It may appear from what I have said that I felt that all was negative at the Johns Hopkins system, this was not so, however, undoubtedly this system does create the right environment for innovation, research and independent thinking. (see appendix O. for the philosophy for the Department of Nursing), but perhaps this system is not one that attracts everyone.

General observations made during the various visits

- All the Hospitals I visited except St Clare's, had a proportion of AIDS patients on the general wards. At the GWUH 20-25 patients, per day were HIV positive -

- Pharmacy - The ward drug trolley

Each patient has their own drawer in the drug trolley, these were delivered each morning from the Pharmacy Department with the next twenty fours drug supply. Very little stock is kept on the wards.

- Patients meals. A set tray system was used almost everywhere, delivered by a Dietary Aide, but monitored by the nurses. All disposable ware was used.

- Staff Cafeteria/Restaurant- all disposable ware was used and a self clear system was in operation, which worked!

- Smoking - All hospitals visited were no-smoking areas. This rule was strictly enforced, as it was on all public transport - shops, etc. The increase in litigation has prompted some Physicians to record in the patients notes, that the patient had been advised not to smoke. The Physician could not then subsequently be sued for allowing the patient to develop cancer!

CHAPTER 4.

QUALITY IN HEALTH CARE

Quality at National Level

As a nation, quality is emphasised in every aspect of American life. In a recent national bestseller, two academics gained fame and fortune by defining their criteria for quality in American business and going forth "In Search of Excellence"[8.] among large corporations. Service and manufacturing firms spend millions persuading consumers that top quality is their unrelenting standard and creating incentive programmes to enlist their workforces in quality assurance campaigns. Medical care is no exception to this upsurge of interest in quality. Since the early 1970's the major concern about health care has been its rising cost, and cost remains a pervasive issue, but it is not the only one; other factors include:

Increased government funding
Rapid advances in medical practice
Demonstrated poor level of quality
Increased consumer expectation and demand
Malpractice litigation
Perceived inequality of health care resources.

Large corporations with costly employer health benefit programmes are asking insistent questions about the quality of care. State and Federal Governments are increasing efforts to monitor quality and are pressurising providers to improve voluntary quality assurance programmes. The Congressional

Committees overseeing the Federal budgets for Medicaire and Medicaid are searching for a more effective Federal role for assuring the quality of care purchased with public funds. Research and devlopment of methods for measuring and monitoring quality are intensifying. For example, the National Academy of Sciences Institute of Medicine conducted a major survey on quality, and private foundations are increasing support for private research on measuring quality of care.

The Federal Government has maintained a major role in quality assurance particularly since the enactment of Medicaire and Medicaid in 1965. Currently that role is most actively persued through federal funding and legislative support for Utilisation and Quality Control Peer Review Organisation, or PRO's. PRO's are regional groups that review Medicaire admissions as part of a nationwide approach to examining the appropriateness of Medicaire - covered care and its quality. PRO's have a broad mandate and considerable disciplinary power, for example, PRO's can disqualify a hospital from participation in Medicaire. They need not be physician dominated. They are authorised to conduct whatever enquiries they believe would improve quality of care for Medicaire beneficiaries in their jurisdiction.

This Federal initiative in quality assurance augments the broader and more fundamental state regulations that impinge directly on quality of care. Individual States licence hospitals, physicians and health care providers. State Agencies have a legal responsibility to protect the public safety. Accordingly, States have adopted standards for

licensure with many standards focused on quality issues.

A further monitoring process for quality of care is the Joint Commission on Accreditation of Hospitals and Health Care Organisations (JCAHO). JCAHO accreditation is the most pervasive and influential accreditation mechanism in the health care industry. The JCAHO functions as an independent accrediting body with representation from the American Hospital Association, American Medical Association, American College of Surgery and the American College of Physicians. Approximately 75% of hospitals across the U.S. are reviewed by JCAHO. Accreditation can be given for three years on an unconditional basis, or contingencies can be established which may require episodic reporting or an additional on-site review. Approximately 50% of all hospitals reviewed receive full three year unconditional accreditation with only a minority of 1 - 2% not approved.

It is important to note that a hospital requests a review by the JCAHO which costs 10 - 15,000 dollars, however, without this accreditation the hospital would not qualify for reimbursement of Medicaire or Medicaid.
The JCAHO developed a working definition of the term Quality Assurance as follows:
"A system to evaluate and monitor the quality of patient care and the quality of facility management"

Hospitals have been obliged to "demonstrate a consistent endeavour to deliver patient care that is optimal within available resources and consistent with achievable goals"

A co-ordination of quality assurance efforts throughout the hospital is required and includes all involved in health care. Retrospective audit is carried out and all aspects of care are monitored and scored against set standards with the required characteristics set out in the accreditation manuals for hospitals. There is also accreditation available for hospices, community services, ambulatory care and psychiatric care.

What is Quality?

A definition of quality in the health care system is difficult to state and where statements have been made they can be controversial. It depends very much on the view point of the person making the statement. For instance, to the producer it may mean conformity; to the customer, meeting or exceeding expectations. Quality is meeting the set standards each time, but what of quality meeting different expectations or higher set standards - what of excellence? Is quality a task or an opportunity? Is it a requirement over and above getting the job done, or a means of achieving key objectives?

In manufacturing industries "quality" is meeting the customers requirements at the lowest cost, first time, every time." In health care, however, quality is more than getting it right first time - that is the prevention of mistakes, it implies that the health care provided will improve the health and functioning of the patient. As such, quality of care can be seen as an all encompassing term, which includes anything that influences the health and well-being of the patient, from the environment to

staff morale, training, the evaluation of programmes and the efficiency of various departments within the Hospital. Within this framework, quality assurance can be defined as the process that sets the standards for performance, provides information about the achievement of those standards and monitors whatever improvement has taken place and whether the standards are being met.

In a way, the philosophy of quality is like honesty and integrity! It must be an integral part of every individual and the Institution. To be effective and to reflect the character of the Institution, quality of care must be the paramount value in all the processes that make up the totality of a hospitals operations.

Quality Assurance Systems

The arrangements for monitoring the quality of care will vary from hospital to hospital and can be very complex. The majority of the hospitals that I visited organised quality assurance on two levels:

1. Quality Assurance Departments, with a hospital wide responsibility.

2. Departmental quality assurance, for example, quality assurance in nursing.

The Quality Assurance Department

It is the responsibility of the Quality Assurance Department to

co-ordinate and improve the monitoring activities of the hospital, both clinical services and support services. The quality assurance programme in addition, will provide the mechanism for the co-ordination, discussion and resolution of problems that cross various departments and decisions. This mechanism can be extremely complex, an indication of this complexity can be seen from a study of appendix P. Virtually every committee within the hospital will have a bearing on quality in one way or another.

The goals of the quality assurance programme are:-

- The on-going and systematic monitoring of all patient care activities in the hospital
- The identification of actual and potential problems related to patient care
- A corrective action programme
- The evaluation of outcomes to ensure effective continuation of problem resolutions

In addition to responsibility for monitoring the activities of the hospital, the quality assurance department is responsible for utilisation review management. This includes practices, bed allocations, bed usage to ensure that all resources are used appropriately and efficiently. The monitoring of third party payment and patient appeal activities for example, connected with Medicaire, Medicaid, Blue Cross or Blue Shield etc., are also undertaken by the Department of Quality Assurance.

The last function that this department performs is the risk

management function. The integrated quality assurance/risk management approach minimises malpractice litigation and claim, reduces patient, visitors or staff injury and therefore reduces the financial component. The concept of risk management developed as a result of the malpractice crisis in the mid-seventies, which demonstrated a need to respond to or prevent patient injuries which might result in hospital liability. The main focus on the process is to identify and respond to, or prevent, a potentially compensatable event. The conduct of risk management activities varies from discipline to discipline, many maintaining a traditional safety programme that focuses on environmental hazards and merely screens incident reports. Others have established formal programmes that anticipate risks by using screening criteria and claims analysis to detect and analyse adverse events. Finally, they are used to plan corrective measures and prevent further occurences. Whether the activity is part of the safety programme or a separate division in the discipline, risk prevention and response can be considered a component of the overall quality assurance programme. Just as infection control is a discipline wide function aimed at minimising cross infection, risk management can be considered a discipline wide function aimed at minimising risk to patients and to the discipline itself.

The information needs of a quality assurance programme require the co-ordination of many components of the health care delivery system. As a result quality assurance programmes in health care institutions have become dependent on data from many sources within the hospital. Data sources may include:

- Medical Records
- Appointment system and panel changes
- Hospital utilisation information
- Complication rates and analysis
- Re-admission information
- Mortality statistics
- External review and survey results
- Member complaints and suggestions
- Malpractice claims
- Incident reports
- Discharge planning information
- Billing and accounting information

Every data source has its value, not only for the internal management of the hospital, but also for the external Agencies who review the Institution, such as the JCAHO, Federal, State and Local Regulatory Agencies and third party reimbursers. In order to co-ordinate and manage this large volume of data relating to quality assurance function, many hospitals will have developed computer programmes to meet this need. At present, the application of information systems and computer technology, to quality assurance, presents an excellent opportunity to develop a system linking clinical and administrative information for planning and control purposes. Most Institutions use a mix of direct evaluation of practices, retrospective review of medical records, cost analysis reports and regulatory Agency recommendations. The new technology available through the use of computers has made possible the integration of direct evaluation and retrospective review as well as the projection of

events through the use of forecasting techniques.

Evaluation

Throughout the health care industry the complex issue of how to best evaluate treatment outcomes is a subject of intense interest. Systems are under development to include severity of illness factors in differentiating between expected and realised outcome.

Several simple indicators of outcome are utilised in quality assurance programmes including:-

- Member satisfaction studies which are specific to clinical departments
- Complications of surgical procedures
- Infection rates
- Readmissions to the hospital
- Adverse events - such as falls occuring during the hospital stay
- Complaints
- Claims

The results of outcome studies provide physicians and managers with valuable information about past events that can be applied prospectively to prevent similar occurences or to manage and reduce risk to patients.

The quality of care provided can be assessed through the peer review process. The results of peer review are used to identify trends and patterns in patient care practices. Profiles are

provided to assist in privileging and credentialing and suggest improved treatment statements and protocols.

A less formal process of peer review occurs during committee work in multi-disciplinary and physician groups. Improved communication and enhanced standards of care results from discussion of treatment, effectiveness and patient outcome. Trending of indicators of important aspects of care, point out patterns of high risk activities which are then more closely monitored and studied.

Action and follow up

Action plans may be developed by services departments or facilities as appropriate. The level of responsibility closest to the problem source is usually the most effective in problem resolution and follow up monitoring.

CHAPTER 5.

QUALITY ASSURANCE IN NURSING

The striving for quality assurance in nursing has a long history. Credit for the first documented study in nursing and health care is usually given to Florence Nightingale for her use of standards to assess care provided to military personnel. When she and her team of nurses arrived at the Barrack Hospital Scutari in 1854, the mortality rate was 32% . Within six months, the mortality rate had fallen to approximately 2%, this is arguably the best performance indicator for the effectiveness of her nursing care! Since Miss Nightingale's study, the assessment and assurance of quality nursing care has remained a priority for nurses throughout the world.

9.

Efforts to establish quality assurance programmes began in 1918 in the U.S.A.. Rapid growth and development of nursing quality assurance activity took place throughout the 70's, and has evolved to sophisticated quality programmes incorporating statements on the purpose, philosophy, aims and objectives of the nursing department; the setting of standards; methods of monitoring nursing practice and the evaluation of outcomes. All aspects of nursing are included - clinical practice, staff education, standards of care and research, through a network of committees. (See appendix Q)

Nursing Quality Assurance programmes

The Purpose

Quality Assurance involves all staff in the nursing department and other disciplines, in an on-going programme concentrated and executed to promote excellence in nursing practice. Methods employed systematically monitor and assess the calibre, appropriateness, and cost of care, based on current nursing standards, and or new or revised policies procedures and equipment. Additionally, the method evaluates a degree of compliance and, or improvement, in health care delivery. The nursing quality assurance programme will provide direction for the developmment and implementation of change towards the improvement of quality of care and efficient use of hospital resources.

Quality assurance programmes are ward based. On each ward there is a quality assessment committee, made up of the Ward Sister or Head Nurse with a number of the staff. Their role is to develop standards of care, specific to their ward; plan and conduct quality assessment activities and then develop a plan of action to address the problems and issues identified. One member of the ward based committee sits on the quality assurance steering committee. This group meets with other ward representatives regularly to collaborate on the issues concerning quality assurance. Departments study results that are reported, and feedback is given and this committee also develops and conducts studies that have hospital wide implications. As the studies are completed, a summary of report

is written and forwarded to the Vice President for Patient Care Services, they are then reviewed and presented to the Quality Assurance Committee of the Hospital Board.

Philosophy of Nursing

In all the hospitals that I visited the Departments of Nursing published a Statement of Philosophy. I feel that before any nurse can start addressing the question of quality he/she must be certain what it is that the corporate body to which he/she belongs, the Department of Nursing, believes in - what is it that they stand for - the philosophy that governs their working life? This philosphy must be published, accepted and a committment made to the beliefs stated. In addition any ward or department may identify their own philosophy of nursing practice, specific to their own sphere. Without this, I believe there can be no clearly identified direction.

I have reproduced the philosophy for the Department of Nursing, Massachusets General Hospital, Boston, because of its simplicity, content and presentation, also the philosophy of patient care services for the Greater South East Community Hospital, Washington which although very different, states the beliefs of the whole hospital, nursing practice, nursing education and research and nursing management.
(See appendices R and S)

Having identified the philosophy for nursing - to ensure quality, the objectives of the Department of Nursing should be clearly defined and stated.

For example:-

1. To deliver nursing care through the use of accepted standards of nursing practice sufficiently flexible to meet the individual needs of patients and their families, the hospital and the community at large.

2. To ensure an environment conducive to quality patient care through the recruitment, retention and education of well qualified staff at all levels.

3. To ensure an environment conducive to efficient nursing care through the provision of appropriate and adequate supplies and equipment.

4. To encourage the participation of all levels of nursing staff in the planning and implementation of nursing department programmes as well as patient care programmes.

5. To promote the professional growth of Registered Nurses and to foster the development of potential strength in all members of the nursing staff.

6. To systematically evaluate organisational structure, nursing practice and educational content and appropriately implement change or revision as indicated.

7. To formulate and implement sound nursing standards, policies and procedures.

8. To provide a climate conducive to learning for students of professional nursing.

9. To promote inter-departmental co-operation and collaboration towards common goals.

10. To participate in hospital committees and community programmes dedicated to improving patient care services and institutional operations.

11. To initiate or participate in research, related to the improvement of health care or staff development.

12. To plan, implement, evaluate and revise nursing department budgets to ensure adequate staffing and patient care and supplies.

The Setting of Standards of Care

Standards are a key factor in quality assurance monitoring. They are statements that define the parameters of nursing care to legally describe how nursing care is to be provided to each patient or groups of patients. This standard setting activity then permits the nursing department to defend its practices should the need arise; to conduct research to improve nursing practice guidelines, standards and protocols; and to compare the nursing care provided to the patient, against the standards of practice for both quality and appropriateness review purposes.

External bodies will influence a nursing quality assurance programme such as the JCAHO standards, addressing the structure, process and/or outcomes of patient care activity for nursing services. These focus on the provision, management and monitoring of hospital based nursing care.

Table 1.

Eight Standards "Nursing Services" Chapter from the Accreditation Manual for Hospitals[10.]

NR.1 There is an organised Nursing Department/Service.

NR.2 The Nursing Department/Service is directed by a qualified Nurse Administrator and is appropriately integrated with the Medical Staff and with other hospital staffs that provide and contribute to patient care.

NR.3 The Nursing Department/Service is organised to meet the nursing care needs of patients and to maintain established standards of nursing practice.

NR.4 Nursing Department/Service assignments in the provision of nursing care are commensurate with the qualifications of nursing personnel and are designed to meet the nursing care needs of patients.

NR.5 Individualised, goal-directed nursing care is provided to patients through the use of the nursing process.

NR.6 Nursing Department/Service Personnel are prepared through appropriate education and training programmes for their responsibilities in the provision of nursing care.

NR.7 Written policies and procedures that reflect optimal standards of nursing practice guide the provision of nursing care.

NR.8 As part of the hospital's quality assurance programme, the quality and appropriateness of the patient care provided by the Nursing Department/Service are monitored and evaluated, and identified problems are resolved.

Hospitals will differ in their interpretation of standards and some will develop and implement generic standards of care, for example, the Beth Israel Hospital, Boston, specifies that a nursing assessment will be carried out within eight hours of admission and a written progress report completed on every patient, once in every twenty four hour period. Ward specified criteria are then developed and used to determine the appropriate component of the nursing assessment for each patient on that specific ward. In other hospitals there is a very detailed approach to standards of care setting, for example, the standardised nursing care plan for the patient who has undergone repair of inguinal hernia.

Monitoring and Evaluation

A fundamental activity of quality assurance is the monitoring and evaluation of patient care. Monitoring should be on-going; that is data should be collected and assessed at regular intervals to determine whether care is meeting the desired performance levels. Monitoring is therefore:

- an on-going planned systematic process, to identify problems in patient care and gives an opportunity to improve care

- evaluates all nursing personnel and all major clinical functions

- measures quality (the adherence to standards of care and nursing practice)

- measures the appropriateness of nursing care.

Quality Assurance Monitoring and Evaluation Process

An example of the process that the individual or group responsible for implementing a quality asssurance activity can implement, is as follows:-

1. Assign responsibility

    * Individual/group responsibility
    * Nursing Management
    * Unit based quality assurance responsibility

2. Delineate the scope of patient care/identify important aspects of care

    Scope - what type of patients are cared for?

    * Disease groups
    * Age group
    * Case mix
    * Nursing diagnoses
    * Diagnostic preventitive therapeutic patient care services
    * In-patient/Out-patient

Important aspects of care

* What aspects of nursing care are high volume?
* What aspects of nursing care are high risks?
* What aspects of nursing care are high problem areas?

3. Identify indicators

Indicator: well defined objective and measurable variables used to monitor the quality and appropriateness of an important aspect of care.

* Structure, process or outcome
* What is monitored to indicate that patient care is appropriately delivered and of high quality in high risk, high volume, problem prone activities (as identified under Important Aspects of Care)

4. Establish Criteria

Criteria: Ward/departments statement of acceptable practice.

* Identify specific criteria to measure nursing practice and patient care standards in order to evaluate indicators.

* Identify objectives, measurable criteria which defines acceptable patient care.

* Focus on care of the patient and outcome of care.

* Criteria must be clinically valid and derived from authorative sources; nursing service standards professional standards

* Criteria must be approved.

5. Monitor Patient Care Outcomes/Nursing Care Being Delivered

* Determine data source:

Direct observation

Patient interview

Patient questionnaire

Medical record

Nursing care plan

Generic screening/utilisation review data

* Determine data collection method:

Retrospective, con-current or prospective

Assign responsibility

* Utilise monitoring and evaluation tool

* Objective criteria should yield yes/no response

6. Analyse the data collected for monitoring

* Tabulate data collected - utilise charts/graphs

* Analyse for variations from the criteria

* Initial monitoring will establish base line

* Peer review will determine acceptable variations

* Subsequent monitoring will allow for comparison with the base line variations (establishment of a threshhold)

* With repeated monitoring resultant variations and/or trends will identify problems in care delivery or opportunities to improve care.

* If no variations or opportunities for improvement are found after sufficient monitoring period the indicator, criteria and data collection method should be either:

a) evaluated

b) discontinued

7. Take Action

* If monitoring has identified a problem, a plan needs to be developed and implemented to resolve the problem.

* The action plan should be appropriate for the cause, scope and severity of the problem.

* If monitoring does not reveal a problem, but an opportunity to improve care exists, an action plan should be developed.

8. Evaluate Outcomes of Action

* Evaluate outcomes of action taken to ascertain if a) action has been effective and b) problem has improved or been resolved.

* Allow sufficient time for changes and improvements to take place prior to follow up monitoring (evaluation)

* If evaluation reveals that the action has been effective and the problem resolved, follow-up monitoring is still indicated in order to prevent re-occurrence. However, the time interval may certainly be lengthened, thereby reducing the frequency of monitoring.

9. Documents Findings/Action Taken

Each step of the monitoring and evaluation process should be documented and include the following:

* Summary tables of the number of variations from criteria

* Evidence that variations resulted in detailed review/analysis

* Identification of serious deficiencies in knowledge, judgement or skill.

* Results of corrective action and follow up monitoring.

* Identification of opportunities to improve care.

10. Communicate findings

* Results of all QA activities should be shared with all staff members and peers.

* Graphs and charts depicting compliance/variations should be posted on each unit.

* QA reports should be submitted to the Quality Assurance Co-ordinator.

To summarise - by monitoring specific indicators staff receive information concerning care. Analysis of information may indicate that high quality care is being provided; findings are reported and monitoring continues. If analysis uncovers an area for improvement or a problem, the cause is determined and corrective action taken. Findings are reported and monitoring is continued to ascertain whether improvement has indeed occurred. Staff should examine the information they receive to detect trends and patterns of performance.

Quality Assurance Programmes in Individual Hospitals

At the Beth Israel Hospital, Boston, the ward based Quality Assurance Resource Nurse works with the Head Nurse and the Director of Quality Assurance (Nursing) in implementing a ward based programme. Her role is to co-ordinate the twice yearly nursing service wide quality assurance audits for the wards: to follow up recommendations documented in the quality assurance study report; to orientate all nursing staff on the ward with the quality assurance programme and complete the yearly summary to the Head Nurse and the Director of Quality Assurance (Nursing).

In March 1988 a new hospital wide Patient Care Assesmment Programme was established to replace and expand the hospital's existing quality assurance and risk management programmes. The aim of the new programme is to help ensure delivery of optimal patient care through establishment of on-going patient review mechanisms. (See appendix T for the information to employees on this programme).

The Massachusets General Hospital (MGH) in Boston, also implemented a Patient Care Assessment Programme (PCAP) in 1988, which is the basis of the hospital's system for assessment of quality patient care. Like the Beth Israel, the system involves all levels of MGH providers and multiple monitoring methods.

A self directive learning guide has been produced designed to introduce all employees to the PCAP, and the specific learner

objectives include:

- State the purpose of the PCAP
- discuss the six components of PCAP
    * concurrent review
    * risk management
    * patients rights
    * questionable conduct
    * credentialing of Physicians
    * incident reports
- describe general categories of reportable events

The focus of the quality assurance programme for nursing is on what nurses can do something about, for example, patient falls, the prevention of decubitus ulcers and inefficient/ineffective bowel pattern. There is a quality assurance committee for each of the ten nursing services, which has a representative on each ward. These meet monthly and examine the services relating to quality assurance. There is a proactive problem solving approach helped by the Director of Quality Assurance if necessary.

The Veterans Administration Hospital, Boston, being as already explained a Federal run institution, has a clearly defined and well documented quality assurance programme, stating the purpose, the policy of monitoring and evaluation occurring through nursing practice committees, nursing service programmes, mandatory continuing education programme, nursing services committees and hospital wide committees. At present the Chief Nurse is monitoring drug errors, licensure for nurses and sickness/absence rates.

The Mount Sinai Hospital, New York, has been involved in quality assurance activities for over ten years. The Director of Quality Assurance (Nursing) is in a support post to the Vice President for Nursing. In such a large institution as Mount Sinai, with 1100 beds, this post is essential in co-ordinating all the quality assurance activities. The Director of Quality Assurance (Nursing) sees her role as a resource to clinical nurses, with a significant educational element where the need is identified.

I was given a copy of the extremely structured organisation of the Department of Nursing which includes in the contents:

- The Vision Statement for Nursing
- Description of the Organisation
- Philosophy, goals and objects
- Table of Organisation
- Standards for clinical and resource divisions
- Communication
- Committee Structure

The Director of Quality Assurance (Nursing) feels it essential that all staff understand and can clearly identify the need for quality assurance and she encourages wards to focus on priority problems in nursing care of the high risk, high frequency and problem prone areas, and not on aspects that cannot be changed. For example, problems regarding intra-venous therapy and 'running into the tissues'.

She teaches all staff, that the use of outcomes is to their advantage to substantiate the work of their clinical practice.

There are four elements to the hospital wide nursing quality assurance programme:

-selective monitoring is undertaken with six major dimensions of nursing practice; four being based on each aspect of the nursing process and two on documentation. This is undertaken twice a year using random criteria from the Rush Medicus Index. It is the responsibility of the Continuing Education Co-ordinators to carry out this examination.

- consumer satisfaction

-infection control monitoring

The Quality Assurance Infection Control Nurse visits each ward once a month by appointment. She examines every patient with the following:

- I.V.Therapy; identifying the date on the tubing, the date of insertion, redness of skin, tissuing

- Catheter; is the tubing taped to the leg, is the urinal or container marked with the patients name

- Wound; she examines the dressing, when it was changed

- Medication; does the patient know and understand what he is receiving

- Isolation cases; precaution procedures etc.

- Occurrence reports; e.g. patient falls, drug errors etc.

The New York University Hospital had a covered printed book 1/2" thick as its Quality Assurance Plan, running into 86 pages. This gives very detailed procedures for monitoring activities of every service in the hospital, a utilisation review plan, table of organisation, and further policies and procedures, ranging from "orders not to resuscitate" to "patient access to health and mental health records". In 1987/88 the Department of Nursing monitored occurrence reports related to problems with skin, intravenous therapy, falls, medication and equipment. These are ongoing into the 1989 programme, with a task force being implemented to monitor activities identified that show significant non compliance to the patient care plan criteria, plus the overall poorly documented nursing data.

I have already described the enormous problems that St.Clare's Hospital, New York, was experiencing and although there was a nursing quality assurance plan devised in January 1987, with a programme for 1988, the current staff shortages made it very difficult for this to be implemented in parts.

The major approach to quality assurance at George Washington University Hospital, Washington, is through review of data and identification, study, and solution of problems. It is closely linked to the Hospital Quality Assurance Programme. The Director of Nursing submits quarterly reports of all quality assurance activities to the Chairman of the Quality Assurance Committee.

Concurrent review is undertaken six monthly by the Associate Director of Quality on a random selection basis of five to eight patients per ward.

Quality indicators being examined currently include:

- medical errors
- patients falls
- clinical procedure
- missed counts in the operating room
- infection control e.g. perineal infection

The Assistant Director of Quality Assurance holds other responsibilities and feels that she is struggling with the size of the quality assurance programme and that it needs a post-holder with no other responsibilities.

In April 1988 at the Greater South East Community Hospital, Washington, a self directed study guide on the Nursing Quality Assurance Programme at the Hospital had been introduced. This was given to all existing and new staff, the objective being to offer information on the Quality Assurance Programme and inform staff how they should be involved in the programme. On completion of the study, a member of staff would be credited with 0.5 contact hours for the Mandatory Continuing Education Programme. I felt it to be well presented and an excellent method of ensuring all staff were informed regarding quality assurance.

In the Johns Hopkins Hospital, Baltimore, with its decentralised organisation, each of the eight departments have their own quality assurance committees. The quality assurance programme was re-structed two years ago and the following committees were set up:-

Quality Assurance Steering Committee - made up of all Directors of Nursing Services who make the decisions regarding quality assurance; set priorities and establish the agenda. This relates to the Medical Care and Evaluation Committee which is an inter-disciplinary hospital wide committee.

The Risk Management Committee

This reviews patients at risk, e.g.:

falls

potential suicides

Monitoring and Evalutaion Committee - monitors indicators

It identifies two subjects in depth yearly. At present these are discharge planning and universal precautions. On an on-going basis it looks at:-

* controlled substances
* patient incidences
* conducts a retrospective audit on the documentation of nursing practice plus concurrent audit in the form of a mock JCAHO visit

Standards of Practice Committee

This looks at the standards of practice for nurses:-

* job descriptions
* IPR/Appraisal
* Exit interviews

Standards of Care Committee

This focuses in on the patient:-

* it asks what are the minimum standards required to care for patients

Staff Education Committee

Monitors Continuing Nurse Education and orientation programmes.

Research Committee

Monitors and sets criteria for research

There was one criticism of the above programme - a lot of Committees! These often involved the same personnel. I was told that as much data as possible was to be automated and would produce trends for forecasting etc., but this in the future.

Conclusions

Quality Assurance is a continuing activity that involves all aspects of the organisation in most U.S. hospitals. The influences which determine this have no direct parallel with the situation in the U.K.. External monitoring by such Organisations as the JCAHO for reimbursement requirements, or the upsurge in the litigation costs have been a strong influence, but the culture of the U.S.A. is also a strong influence - that is - Service to the customer, smile etc.

Quality Assurance is big business in the U.S.A. employing many people. I estimated that 12 w.t.e. were employed at the George Washington University Hospital, Washington, in various Quality

Assurance activities plus many other staff having some involvement. Quality Assurance in nursing has close links with continuing education and clinical research in nursing practice.

Quality Assurance is a means to an end - the end being to improve care; to prove it is good care and to prove the need for development either in human or physical resources. The idea of quality assurance has to be "sold" to staff, they have to be shown how it can be useful to them. It must be seen to be "top management led" with efficient on-going organisation down through the service to ward level. A quality assurance programme has many facets assuring a quality service for staff, such as continuing nurse education, job descriptions, IPR etc. There are some obvious disadvantages with the programme I have described - the complex committee structure, which will be criticised immediately, and the cost of the specific number of personnel, would be difficult for the majority of Health Authorities to bear, but the essential elements of the implementation of a quality assurance programme can be adapted to the U.K. system.

RECOMMENDATIONS

1. There should be a District Strategy for Emphasis on Quality.

2. Each Hospital/Unit/Department/Ward should state its own Philosophy.

3. Each hospital should implement its own Quality Assurance Programme similar to the one I have outlined, which must be management led.

4. Training should be offered to all staff regarding Quality Assurance, this may be carried out in various ways; workshops, seminars or self directed learning.

5. There should be created a clearly defined post to co-ordinate district-wide, the Emphasis on Quality.

CHAPTER 6.

MANPOWER ISSUES

Recruitment

As previously mentioned, the nursing shortage is a current problem in the U.S.A. just as it is in the U.K... College enrolments for nursing were down by 12.3% for 1986/7 compared to a drop of only 8.4% in 1985/6 for full time students. Although turnover has decreased from 25-30% two to three years ago to 10-15% in 1987, the registered nurse vacancy has escalated.[11.] At the George Washington University Hospital, Washington, the RN vacancy rate on the Medical/Surgical Units was estimated to be 25% by the Director of Nursing.

The nursing shortage problem has been in the past of cyclical nature, but it is generally felt that the present situation may result in a crisis point being reached. Nursing School enrolments are down, due to the decrease in the number of available young people, and the greater career options for women generally. These points, together with the unsocial hours required of nurses, plus the low financial status, make nursing as a career an unattractive option at present.

In an effort to overcome these problems, hospitals are having to make strategic plans to deal with the crisis. As in industry where market forces produce fierce competition so it is in the health care system, and hospitals have to recognise that health care is now market driven, and act accordingly. During my visit I encountered the following recruitment measures being adopted:

- Once a month an open house is held - this being advertised by using posters in Colleges of Further Education and Universities etc. A light finger buffet is served with Senior Nurse Managers available for discussion, and offers of employment made then and there. I was told that an average attendance was 12 to 40 people and if three nurses were subsequently recruited, then the session was felt to have been worthwhile.

- Contributions are made to removal costs

- Active measures are undertaken to recruit from overseas; the U.K., Ireland, the Phillipines and Scandinavia - but problems have been experienced with licensure, visa's, and difficulties with settling in to a new culture.

- Active canvassing is undertaken at schools, career conventions and career agencies.

- A survey was recently undertaken of recently hired staff nurses to pin point where to concentrate efforts for recruitment in the future.

- The report of the survey showed that personal recommendation by current employees, influences new staff.

    * Advertising was useful.
    * Promotions in Schools of Nursing were useful.
    * Many nurses were positively influenced by the interviews with Nursing Recruiters/Managers.

* Suggestions for improvements included:
    * Better car parking
    * In house staff to attend career days and visits to School of Nursing.
    * Prompt reponses to enquiries/applicants
    * Prompt arrangements for interview
    * Prompt responses to the results of an interview

(See appendix V for questionnaire and report findings).

Retention

Retention methods are created from assessing and monitoring whether the nurse is satisfied with employment both personally and professionally; whether certain aspects of the job and of interpersonal relationships are important to the nurse; and from analysis of documentation.

12.

Questions that Managers should be asking:

* What makes this Unit/Hospital/Ward an attractive place to work in?
* What rewards are there?
* What are the needs of new members of staff, are they identified and met?
* What development and training is offered?
* What part do nurses play in the corporate management of the unit?
* What communication and feed back is there?

When these questions are answered and the data analysed, areas

can be identifed where improvements can be made and a strategic plan developed to meet these needs.

Amongst the strategies which were discussed with me, were the following:

1. Increasing links made with external bodies, for example, Universities and Local Colleges. This type of affiliation can offer Nursing a broader view which is essential if the profession is to move into the year 2000 successfully.

2. Personal benefits to staff, for example, removal expenses allowance, free car parking, tuition benefits for staff and dependents, nursery facilities for staff members children, attractive leisure surroundings and out of hours activities.

3. Recognising that unsocial hours are a necessary evil in the nursing profession, the almost universal shift system of 7.00a.m. to 3.00p.m. 3.00p.m. to 11.00p.m. and 11.00p.m. to 9.00a.m. with internal rotation where appropriate, does allow staff time for personal activities each day. Flexible hours are offered to part-time staff where possible.

4. A personalised orientation programme or performance based developmental system (P.B.D.S.) as it was called at the Mount Sinai and Massachusetts General Hospital, can be used when an employee:-

* Commences in the hospital

* Transfers from one unit or context to another
* Promoted to new/different role
* Being considered for promotion to a management position
* Being considered for advancement in the clinical ladder

A base line assessment is carried out with the Preceptor to assess the individuals ability to perform - what can the person do now? This is followed by a developmental plan being designed based on the needs of each individual staff member.
The use of the Preceptor who guides a new member of staff towards the achievment of the mutually agreed and clearly identified goals, assures that staff are not left to sink or swim! The Preceptor, coordinates the new staff members' learning activities; functions as a primary role model and clinical resource and supports as appropriate. Progress is measured by the Preceptor through an on-going process of assessment, validation and documentation. The Nurse Manager supports the Preceptor in the development and implementation of this role.

The advantage of this system is that both Manager and new staff member have assessed and identified together a programme for orientation, followed by a development and action plan. The action plan can include any of the following:

* Learning activities to acquire a skill or knowledge
* Practice.... clinical or simulated

* Review of specific information such as a policy
* Positive reinforcements/recognition
* Coaching
* Being held accountable
* Revalidation
* Non intervention

5. Regular participation in a system of IPR with a clearly identified professional nurse advancement recognition programme, tied in with merit rises/salary review.

6. A reward system such as bonus, for successful referrals of a new member of nursing staff being employed for at least six months.

7. Nurse representation on committees, councils etc. so providing Nursing with a "voice" in the corporate management of the Unit as a whole.

8. Implementation of de-centralisation down to ward level affords senior members of nursing staff a central role in the decision making of the Unit/Hospital.

9. Implementation of an information system to clearly identify the acuity level of patients, nursing workload, staffing needs, which aids management to respond accordingly.

10. A clearly defined agreed system of communication with regular staff meetings; in house magazines to

disseminate information and afford an opportunity for feed back.

11. An enlightened approach to management, where attitudes are examined and new approaches made, can enhance the overall climate of the work environment for nurses.

12. Exit interviews which afford management the opportunity for feedback on the success or otherwise of current clinical practice, staff programmes, working conditions and relationships and which allow the staff member to evaluate the experience they have gained during employment. Evaluation of this kind by both parties is very beneficial.

Whilst at the George Washington University Hospital, Washington D.C., I was invited to an evening dinner and lecture engagement, held quarterly for members of the Nursing Management Staff, and open to neighbouring hospitals. The Speaker was Miss Vernice Ferguson, Deputy Assistant Chief Medical Director for Nursing Programmes, who is a Fellow of the Royal College of Nursing. The title of her lecture was "The Nurse Shortage - Strategies for Survival". She started by likening the approach made to the current nursing shortage, as that which is similar to another current problem - AIDS

a) In the beginning people thought "Oh it will be alright we have seen it before. It will pass"

b) This was followed by a dawning of reluctant acceptance

c) Now there was constructive willingness to tackle the problem.

However, all this being so, she said, there was no one solution in this pluralistic culture. To address the title, she felt it should be, "Strategy for Viability", because nursing will survive whatever!

In the 1960's it was stated that it was a right for all, for care to be:

available,
accessible,
affordable,
appropriate,
acceptable.

At this time in the U.S.A., 8% of the gross national product was being spent on health care; now all that is considered, is that health care should be affordable and appropriate, and yet, spending is up to 11% of the gross national product, and rising.

There have been chronic nursing shortages experienced previously, so why is the current situation so different? Miss Ferguson felt that it was because of the rising numbers in the aged population with chronic illness, and therefore resultant high acuity levels; the continual pressures to reduce the length of stay in hospital and the increasing pressures of high technology, plus two other important factors: for the first time, shortages in other disciplines, for example Physiotherapy, Path Lab Technicians, Occupational Therapists and Pharmacists, were apparent, and some groups of staff, including nursing, were

out to exploit the situation and to obtain maxmimum financial reward for the least return possible in productivity, allegiance, etc..

Research has been carried out amongst University populations, showing, that at present, the three highest values held by freshmen, are power, status and money. The first choice of a degree is Business Studies, with work in the business world the ultimate goal. All this demonstrates a declining interest in altruism and social concern generally. Added to all these factors, are the known effects of womans liberation; far greater choices of career opportunities; wider horizons and entrepreneurism.

She continued with her strategies for success:

1. Recognition of the Family or Alternative Care Giver - What is sancrosanct to nursing? she asked, what should the nurse be doing? She should risk more, and see what the Care Giver can do, for example, self medication of drugs. Why are all drugs given by a Registered Nurse in hospital and yet on discharge, often complicated drug regimes suddenly become the responsibility of the patient and/or the Care Giver?

2. Fostering Independence of Patients/Client - Does the nurse keep the patient dependent on her to satisfy her own needs? - "I know what is best for you" mentality; in effect an ego trip for the nurse. There must be increased trust between patient and

nurse to undertake mutual problem solving towards independence of the patient ultimately before discharge.

3. We must Formulate the Role of the Professional Nurse. At present we do all things for all people and none well. There will be ultimately an elite category of trained registered nurses undertaking high level tasks with a variety of different helpers, as yet undefined, to achieve the set goals.

4. Value the Nurse - at present the nurse programmes activities; a few have influence at management levels but there are very few nurse leaders in power sharing position at top government levels.

5. Shedding Support Service Activities. At present the nurse supports herself, the doctors and then anyone else when needed, for example, the Administrator, Physiotherapist, the Path Lab Technician etc etc.

6. Use Computerised Information Systems Effectively. At present banks spend 8% and insurance companies 11%, on information systems, but hospitals, only 3%.

7. Restructure the Work Environment in Which Nurses Find Themselves. How often is there an atmosphere between nurses themselves, doctors and all the other care givers, making an unhappy working environment?

8. Lobby for Financial Support for Effective Patient Care. How often do nurses not take meal breaks, work over the time of the shift, because orders have been given regardless of realistic staffing situations. Nurses must be firm, stand up and say no - enough is enough!

9. We Must Recruit into Nursing the Minority Groups, for example, men, mature entrants, trained "Back to Nursing" candidates.

She concluded her talk by repeating there was no one solution, but that each group must find which solution works for them. She cited two examples:

Why don't we send a male and female nurse into the pre school and primary schools? By the leaving year, it is too late to promote nursing as a career. Perhaps we should try to keep small cohesive automonous groups, but bonded with a central unit. We must make work more attractive - Michael Maccoby in his new book "Why work - Leading the new generation" cites the five types:

* the innovators- creators
* the experts - with power, mastery and automony
* the helpers - carers
* the defenders - protecting dignity
* the self developers - striving upwards

We must recognise these people and fit them into the scheme. Finally she quoted Benjamin Johnson "We can make these times better if we bestir ourselves".

I felt there were many points here that needed careful thought and consideration.

RECOMMENDATIONS

1. Recognise the current crisis situation and develop a strategic plan to meet this crisis.
2. Define the role of the nurse and cease inappropriate activities.
3. Conduct research into why staff enter and leave employment within the District/Unit/Ward.
4. Provide benefits, for example:
    * removal expenses,
    * temporary housing,
    * financial help with mortages,
    * improved working conditions, with a review of shifts and staff rotas,
    * offer free car parking,
    * nursery facilities, subsidised
    * social activities.
5. Increase recruitment activities and affiliation with Primary and Secondary Schools, Colleges, Universities and attend career conventions.
6. Hold regular open sessions within the Unit/hospital.
7. Offer individual personalised orientation programmes.
8. Undertake regular IPR for all staff.
9. Offer personal development and training programmes.

10. Improve job satisfaction by decentralised management down to ward level.

11. Improve communications for staff with regularly held staff meetings and in-house professional magazines.

12. Implement modern information systems to provide a scientific base for workoads/staff ratio patterns.

13. Offer nursing a "voice" within the corporate management of the unit/hospital.

14. Managers to be seen to be approachable and to examine attitudes of the past.

15. Conduct exit interviews.

CHAPTER 7.

CONTINUING NURSE EDUCATION

I chose to examine the development of nurses through continuing education, as I believe in order for nurses to meet the changing needs of the service, technology, the consumer and society, continuing education must receive high priority, so allowing the opportunity for professional development.

I was especially interested in the system of mandatory continuing education and re-licensure. The State of Massachusets is one of the seven states in the U.S.A. at present, to mandate continuing education. There were previously eleven states, but four have repealed, mainly because a) insufficient finance available and b) insufficient knowledge of the systems.

Mandatory Continuing Education.

The Purpose.

The purpose of mandatory continuing nurse education is to require evidence of the nurses' efforts to update knowledge of nursing science, and to develop and/or maintain the skills of nursing practice. The priority consideration in granting approval to continuing education providers for programmes, is to ensure that the learning activity, promotes the skills required for decision making and problem solving, in relation to nursing practice, nursing administration, nursing education and nursing research, as appropriate, with regard to the performance of those acts for which nurses are licenced to practice.

Only those continuing education programmes approved by the North East Region Accredited Committee of the American Nurses Association will qualify to grant credit for licensure renewal. Providers of continuing education may be any Organisation, State or Local Nursing Association, Employing Agency, College/University or individual, approved by the committee.

Criteria for Programme

Strict criteria are laid down for application for approval of continuing education credit, in order to promote uniformity consistency and quality in the learning experience. All applications must give written evidence regarding the following:

* resources,
* target audience needs assessment
* objectives
* content/time frame
* faculty/presenters
* teaching methods
* physical facilities
* evaluation
* verification of attendance and record keeping
* Coprovidership - if a submission is to be coprovided a written agreement must exist between two parties which identify responsibility for the above criteria. (See appendix V)

There is strong focus on the belief that nurses must teach nurses. At least two nurses must assess, plan and design any programme presented for approval. Not all continuing education programmes are eligible for the granting of credit. In-service training such as philosophies; policies and procedures; orientation performance based development programmes; core induction programmes consisting of fire, lifting; cardio pulmonary resuscitation and equipment demonstrations, WILL NOT apply for licensure renewal requirements.

Only staff development, as defined for the purposes of mandatory continuing education, as organised, planned, implemented, evaluated and controlled, in accordance with the committee standards, can qualify. Self directed learning methods under the guidance of, and monitored by, an approved provider can however be used for credits towards the necessary contact hours.

Continuing Education Programmes

These may include a variety of presentation formats:

* Conferences
* Sessions of one or more days duration with presentation on a central theme
* Credit courses: those which award academic credit by a College/University, the curriculum of which was not included in the curriculum for original licensure.
* Non credit courses: those for which no academic credit is awarded

* Lectures: Instructive presentation with little or no audience involvement

* Seminars: presentation of reports by participants followed by discussion led by an Educator.

* Workshops: active involvement by participants in problem solving sessions guided by an Educator.

Licensure Period and Contact Hours

Registered Nurses and Licenced Practical Nurses are required to give evidence of 15 contact hours, every two years for re-licensure in the State of Massachusets. Contact hours are awarded for the actual time spent in learning activities, exclusive of travel time, meal breaks, announcements, welcome addresses etc.

One contact hour equals 50 minutes.

No contact hour is awarded unless the nurse successfully completes the requirements of the programme as identified by the provider, who has committee approval. Each member of staff is responsible for obtaining and keeping a record of the necessary number of hours gained.

Finance

In addition to the charge made for continuing education programmes, each nurse is required to pay for relicensure, similar to the system now in operation for registration with the U.K.C.C. in the United Kingdom.

CONCLUSION

I formed the opinion that mandatory continuing education for relicensure is a method of ensuring that nurses have experienced exposure to current knowledge of nursing science. It is difficult, however, to determine whether the outcome can be measured in terms of quality, i.e. improvement of nursing care. I feel it is essential that the individual nurse has to take the responsibility for his/her own continuing education, in order to gain relicensure.

I was fortunate to be able to discuss in detail the part that continuing education plays in the following hospitals:

Massachusets General Hospital, Boston

Mount Sinai Hospital, New York

George Washington University Hospital, Washington, D.C.

Massachusetts General Hospital

The training and devlopment activities of the MGH Department of Nursing are facilitated by the Staff Development Services Department. The department is led by the Director, with 4 Educators, all Masters prepared, helped by 3 assistants; registered nurses, with Baccalaureate degrees. Programmes are based on the expressed needs and collaborative planning with nurses, and other departments.

The department is responsible for:

* orientation
* in service education
* continuing nurse education.

In collaboration with Head Nurses, Clinical Nurse Specialists and Clinical Teachers, there is increasing emphasis on orientation, using a self learning technique, which was felt to produce better understanding, rather than knowledge 'produced on a plate'. The staff development services encourages the awarding of contact hours for Services and/or Ward /Department based training activities. Staff are available to serve as consultants in the preparation of quality programmes, and applications for approval to the Massachusets Nurses Association.

Development of Education Programmes

A modified Delphi technique was used to determine the educational needs for nurses in 1988. This technique was developed in 1944 at the Rand Corporation, in an attempt to elicit forecasting information in a systematic manner, for useful results. The process consists of the administration of 2/3 consecutive questionnaires at spaced intervals - rounds.

In Round 1, participants were asked to "list five educational topics which would improve your ability to provide patient care" These topics were then collated for each clinical service, and in Round 2, the participants were asked to rate the importance of each training topic. The study population was the approximate 1,110 nurses of the MGH Department of Nursing. A total of 731 questionnaires were returned during the study: 438 training topics were suggested, some of which were common across the services. Three to five topics were then selected to form the training programmes for each clinical service. (See appendix W for results of the study). This technique is an inexpensive

and non threatening method to determine educational needs.

Management Development

This is organised centrally, aimed primarily at the Head Nurse level. It consists of monthly seminars held over a two year period. Management development at Senior Nurse level is very similar to that in the U.K., in that it is not clearly defined nor organised.

MGH is increasingly using training and development as a recruitment tool. The fact of belonging to the Harvard Consortium of five hospitals offering 33 places on an inter hospital programme, was felt to be a great advantage.

The Mount Sinai Hospital, New York.

The philosophy of the Division of Education in Nursing at the Mount Sinai is "Excellence through Education". This is carried out through two pathways - 1) Clinical Resource Division (CRD) 2)Clinical Career Pathway (CCP)

The CRD/CCP provides all levels of nursing personnel with learning opportunities for competent job performance in the delivery of quality patient care. The Division also assists the Department of Nursing to maintain and advance the standards of nursing practice through quality monitoring and other evaluative systems, that help to assess the functioning of the organisation.

The Division of Education developed the Clinical Educator Model (see appendix X), to meet the needs of the Department of

Nursing, with both centralised and decentralised focus. It is believed that the rapid increase in health care technology, the increasing acuity level of patients, together with the current nursing shortage, has resulted in a ward based, Staff Development/Education Model, becoming essential. Simultaneously, the need for centralised education programmes is necessary, to comply with standards set by accredited Agencies, to reflect changes in nursing practices, and to market education programmes to the outside nursing community.

The Clinical Education Model emphasises both centralised and decentralised roles for the Staff Development Educators. This operational model, provides orientation and staff development programmes that meet the patients needs, ward/staff needs, and the Philosophy of the Department of Nursing. The department consists of a Director of Education, a Coordinator of Education in Nursing (Career pathway) with 28 Educators - 4 being centralised, and 24 are decentralised. All are Masters prepared Registered Nurses.

The centralised programme consists of:

* orientation core programme
* leadership workshop
* Auxiliary Nurse training
* Preceptor programme
* quality monitoring
* the yearly JCAHO mandated programme for fire prevention and intervention
* safety

* infection control

* cardio pulmonary resusitation

The programme leaders are responsible for the planning, scheduling, implementing and evaluating of all programmes.

The 24 decentralised Clinical Educators have 24 hour training responsibility for 3 - 4 wards, and meet the educational needs of all new staff, and those on the wards and departments. There is enormous committment to the continuation of the orientation programme - Performance Based Developmental System. (PBDS); to staff development; Preceptor development; individual learning assessment and quality monitoring.

Some programmes are open to outsiders on a fee paying basis, for example, cardio pulomonary resuscitation, venepuncture etc.

Each nurse, as a right of contracted employment, is entitled to a grant of up to 2,400 dollars per year to study part-time, in their own time, for a Baccalaureate, Masters or Doctorate Degree in Nursing or allied subjects, such as public health, business administration etc. This does influence the high number of academic nurses employed at Mount Sinai Hospital.

<u>Auxiliary Nurse training.</u>

As a result of the nursing shortage, as in many other hospitals, Mount Sinai has had to examine the role of the nurse and the tasks being undertaken by Registered Nurses. Many more Auxiliary Nurses are being hired and offered a three week learning programme. The role includes the following tasks:

* routine monitoring of TPR and BP

* Naso-gastric tube feeding

* Irrigation - colonic, rectal, bladder, vaginal
* bed making
* feeding
* assisting with diagnostic examination

I found this programme very interesting in view of the current proposals regarding support workers and their training programme.

George Washington University Hospital, Washington, D.C.

At the George Washington University Hospital, the activities of the Department of Nursing Education are divided into three spheres, with a centralised and decentralised focus, concentrating on in-service education and continuing education. At central level, the department is staffed by an Assistant Director of Nursing Continuing Education and Research, together with two Co-ordinators; one for Continuing Education Programmes and the other the Special Projects Coordinator. The 10 clinical departments are staffed with their own ward based Clinical Specialist/Educator, who is required to practice competently in the clinical setting and who devises programmes entirely dictated by the current patients on the ward.

Continuing Education

Four programmes a year are organised centrally and open to outsiders on a fee paying basis, to help off set the cost of University programmes for nursing staff. The programme for 1989 includes:-

* ethics,
* nursing diagnoses,
* AIDS - structured to examine:
  1. the economic impact at government level; third party insurers; hospice care and nursing homes,
  2. Policy making - the personal aspects of staffing etc, what is fair and right?
* Occupational health needs (industry dictated)

In addition to these specific programmes, there is an obligation to train support staff, i.e. Auxiliary Nurses, secretaries and ward clerks. Topics covered, include, stress management, communication, positive effects of good health and working relationships. I was interested to note in this hospital there had been a decline in the numbers of staff undertaking continuing education because of the economic climate. However, education is seen and used as a method of income generation. There is a system of exchange with the University, whereby nurses such as the Clinical Specialist, Research Nurse and Nurse Educators, teach at the University and Masters Degree students are accepted into the Hospital undertaking a Preceptor based teaching programme; all this in return for nurses undertaking part-time degree courses at the Mount Sinai Hospital.

<u>Management Training</u>

This consists of:

1. A specialised nurse management course based on identified

needs which mainly focus on economics. This was seen as a response to the increase in responsibility and power regarding budgeting, given to Nurse Managers over the last ten years.

2. Graduate training - for example a Masters Degree in Business Administration.

3. At junior management level, i.e. staff nurses; in-service training is carried out on such topics as time management, delegation and decision making etc.

I discussed with the Assistant Director of Nurse Education and Research, whether ward based education is better than centrally organised education? She was undertaking research to evaluate the benefits of education totally at ward level, Educators with a dual role and those centrally based.

CONCLUSION

From the observations made during my study tour I formed the opinion that ward based Educators with the dual role of clinical expertise and that of educator/resource person, was the most effective method of providing the necessary 'on the spot' tuition for nurses. It could be argued that this role would be in direct conflict to that of the Ward/Department Head Nurse/Ward Sister, but in the situations I encountered, this was not the case. If anything, the dual roles complimented each other, both with the common aim in improving the quality of care offered to the patient. Obviously it is essential that each member of staff clearly understands the others role and liaises very closely.

I observed a greater awareness and interest in the quality of patient care; positive staff attitudes; improved hospital climate and increased personal job satisfaction, when nursing staff felt themselves to be supported by continuing education.

RECOMMENDATIONS

1. All nurses should be responsible for the keeping of personal records of continuing education.

2. The perceived needs of nurses for continuing education should be systematically identified by an approach such as the Delphi Technique.

3. The actual needs of nurses for continuing education should be identified through and with, IPR and nursing audit.

4. Continuing Nurse Education Departments should be organised on a centralised and decentralised basis with Clinical Nurse Specialist/Educators based at ward level.

5. Consideration should be given to offering continuing education programmes externally on a fee-paying basis.

6. Links should be made with neighbouring Universities and Colleges of Further Education to offer development for nurses.

CHAPTER 8.

PRIMARY NURSING

Although I have described the nursing practices of each hospital that I visited, which in many instances were based on primary nursing, I would like to comment on the past, present and future of this system of patient care.

As the technology of health care grows and specialisation increases, medicine saves and prolongs more lives and enhances the quality of life, yet ironically, it could be argued that technology and specialisation have contributed to the decrease in standards of patient care and the overall professional satisfaction of nurses. In many cases nurses have received little respect and recognition from each other, other health care professionals, and have been denied appropriate automony and authority.

The total system change to primary nursing care has come about in response to the need and desire to "improve nursing practice" Primary nursing differs from the traditional team approach, in which several nurses are responsible for different aspects of the patients care. Proponents of primary nursing, feel that team nursing, does not encourage creativity or intellectual growth as a professional nurse; does not allow nurses to interact fully with their patients; to know their illnesses and treatments and to understand their emotional needs. In short, team nursing does not allow an individual nurse to be truly accountable for an individual patient.

However, the decision to undertake a total system change to primary nursing is not one to be taken likely. It requires committment and understanding from everyone - Management, Administration, Physician, Patients and the Community. Also, it must be realised, that primary nursing is not a static system. It represents only the first step in the development of a professional practice system. It grows and develops in response to the changing needs and patterns of staff, needs of the patient and needs of society as a whole.

I witnessed this evolution in several of the hospitals that I visited. Where primary nursing has been the nursing delivery care system of choice, the current crisis position of shortage of nurses, has made it necessary for alternative systems to be examined, for example, case management, or a group management model has been introduced.

I find this particularly interesting, when in the U.K. at present, there are many intiatives underway to explore nursing practice and to change to primary nursing, but many professionals have doubts regarding the feasability of this in view of the present shortage of nurses. I do firmly believe however, that the proverb of "where there's a will, there's a way" is very true and that the nursing profession in the U.K. must continue to strive to improve nursing practice for the future.

At the Beth Israel Hospital, Boston one of the first hospitals to undertake a total system change to primary nursing, I was

told that there was no doubt that through this system of delivery of nursing care, professional nurses expand their knowledge and skill, enabling them to join with other members of the health care team in a collaborative relationship, whilst continuing to be a direct care provider.

A direct result of this system of nursing care is an increase in job satisfaction on the part of the nursing staff, as evidenced by the average length of stay for a nurse at the Beth Israel which is now 2.5 - 5 years, with a substantial number staying over 10 years. This satisfaction bridges all levels of the nursing service and so supports and fosters the high quality of care for all patients.

In conclusion there appears to be no doubt that primary nursing provides a framework which enables a full relationship with the patient and an all embracing approach to care delivery, even in this climate of severe nurse shortage. As Mrs. Marjorie Bachmann, Vice President of Nursing at Beth Israel commented to me, "perhaps every patient cannot have a primary nurse, but every nurse could have a primary patient!"

CONCLUSION

This was a stimulating, beneficial and thought provoking study tour. I feel that I achieved my objectives and through the recommendations that I have made, will undoubtedly be able to influence the improvement of patient care at Newmarket General Hospital and the West Suffolk Health District.

As I have identified, the organisation and delivery of health care in the two countries is very different, but, with the present climate of change in the delivery of health care in the U.K. there are many aspects of the U.S. system of delivery, from which we can learn and benefit.

The study at first hand of such diverse activities as an advice nurse; respite care; primary nursing; risk management; twenty four hour pharmacy system; day case surgery; same day admit; hospital structure; management budgeting; pre admission screening service; a cell saver system and AIDS, to name but a few, has provided me with many ideas to use locally and with which I hope to be able to help others.

Finally, I feel the following quotation is appropriate:-

"Change: different practices require learning different skills and forgetting years of habit. Different practices necessitate acquiring a body of new knowledge. These changes will only become reality when and if someone really cares - for it is the caring person who dares to act to preserve that which is good, to revitalise that which has been spent, and who derives satisfaction from innovation". Margaret D Rosso

13.

SUMMARY OF RECOMMENDATIONS

1. Each District/Hospital/Department/Ward must publish a clearly defined:

vision statement

description of the organisation

philosophies and goals

objectives

2. There must be a committment to aim for highly trained managers of the health care delivery system, in this District.

3. There must be a committment to providing management with the appropriate - support staff

- information systems

4. Emphasis on quality must be management led throughout the District, with a clearly defined planning, implementation, monitoring and evalauation system.

5. Consideration should be given to the creation of a new post for Emphasis on Quality for the District.

6. Professional development should be identified as a priority for all nurses with decentralisation down to ward sister level.

7. The development of an Educational Support System should be implemented for the Department of Nursing - together with further development of clinical support.

8. Consideration should be given to alternative systems of nursing practice to be implemented.

9. Manpower utilisation should be reviewed through a change in the shift systems and an assessment of manpower needs in relation to nursing practice and patient acuity levels, should be undertaken.

10. Continued representation should be made to the U.K.C.C. questioning the proposals in Project 2000, of learners having a service committment of only 20%.

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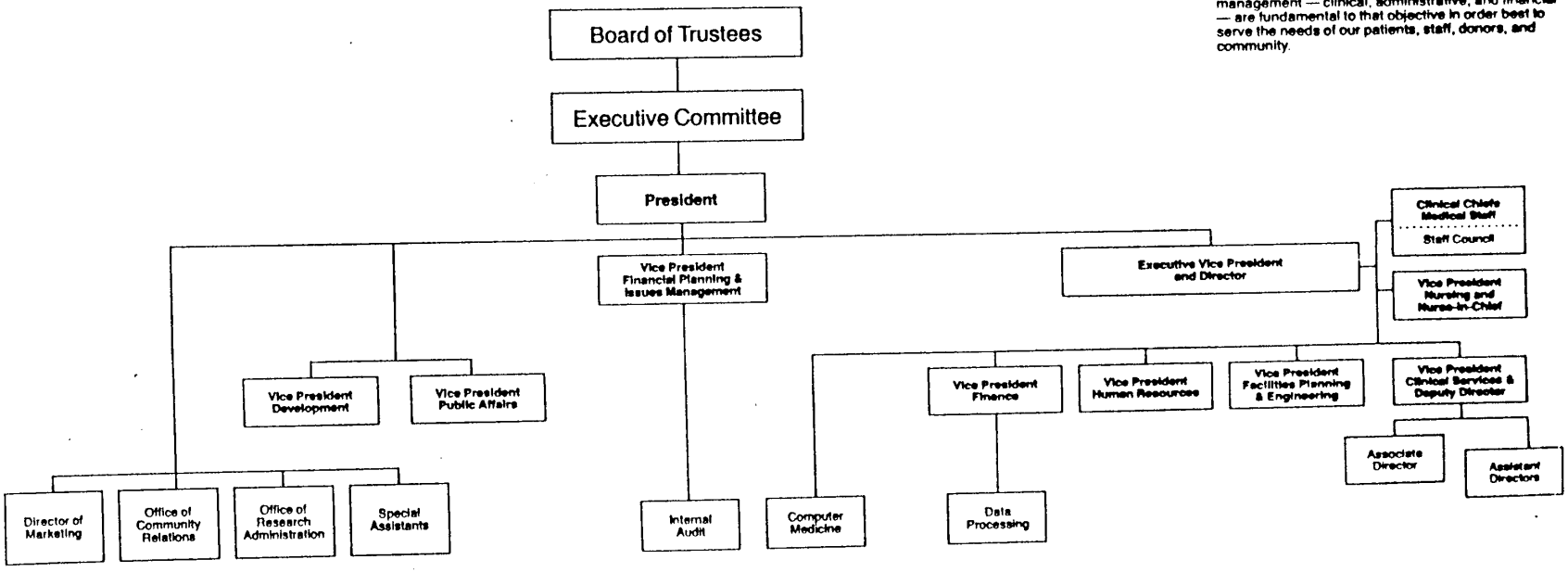
Beth Israel Hospital Boston

Beth Israel Hospital Corporate Organization Chart

Boston's Beth Israel Hospital provides health care services from simple clinical procedures to the most critical life-sustaining systems, all in a warm and personal setting where the patient is the primary focus.

As a major teaching hospital of Harvard Medical School, Beth Israel advances medical science through research and teaching to provide its own staff and the nation with leading-edge medical knowledge and technology.

The hospital's objective is national leadership in health care, both in service and scholarship. Sound management — clinical, administrative, and financial — are fundamental to that objective in order best to serve the needs of our patients, staff, donors, and community.

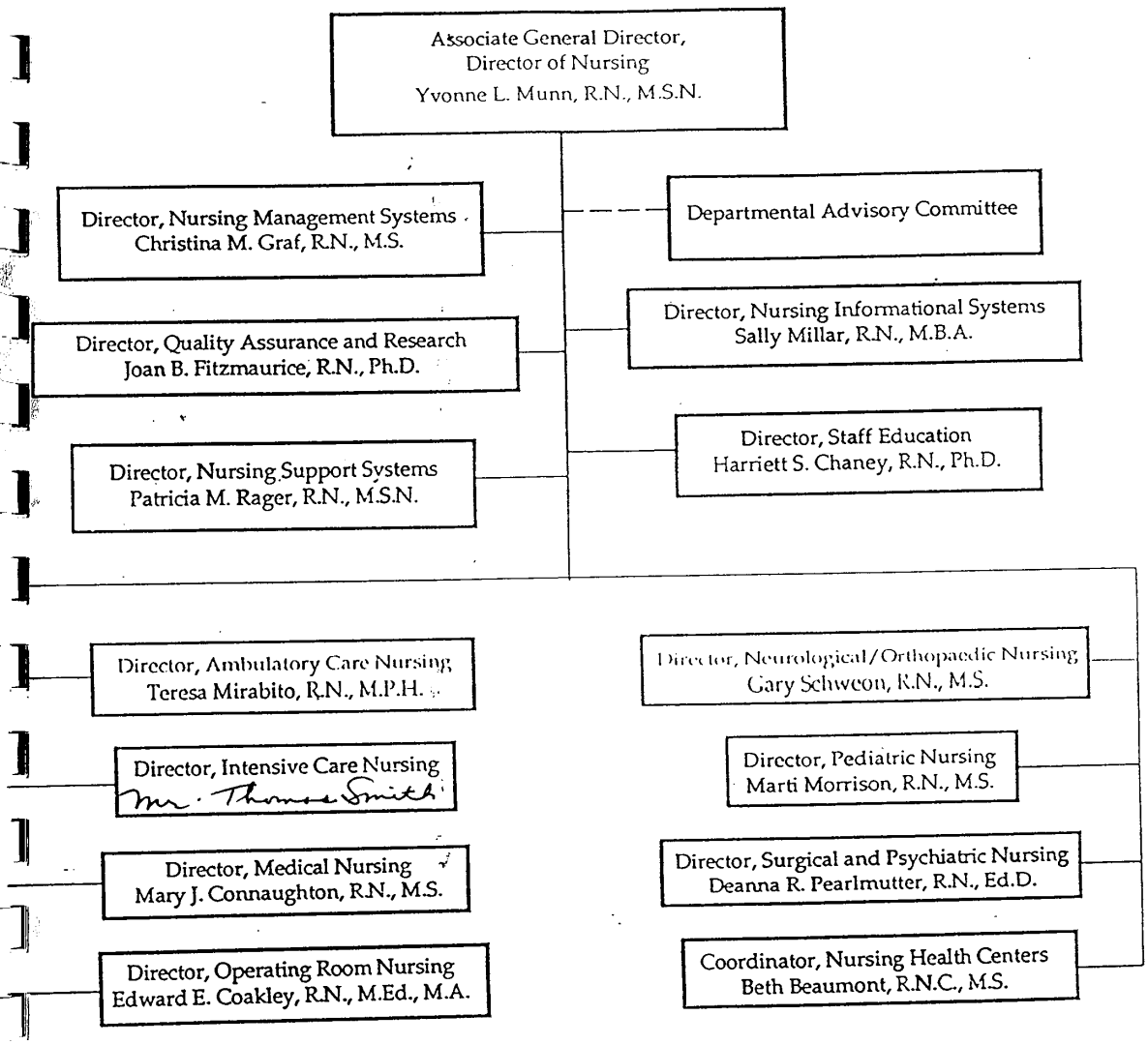


APPENDIX A

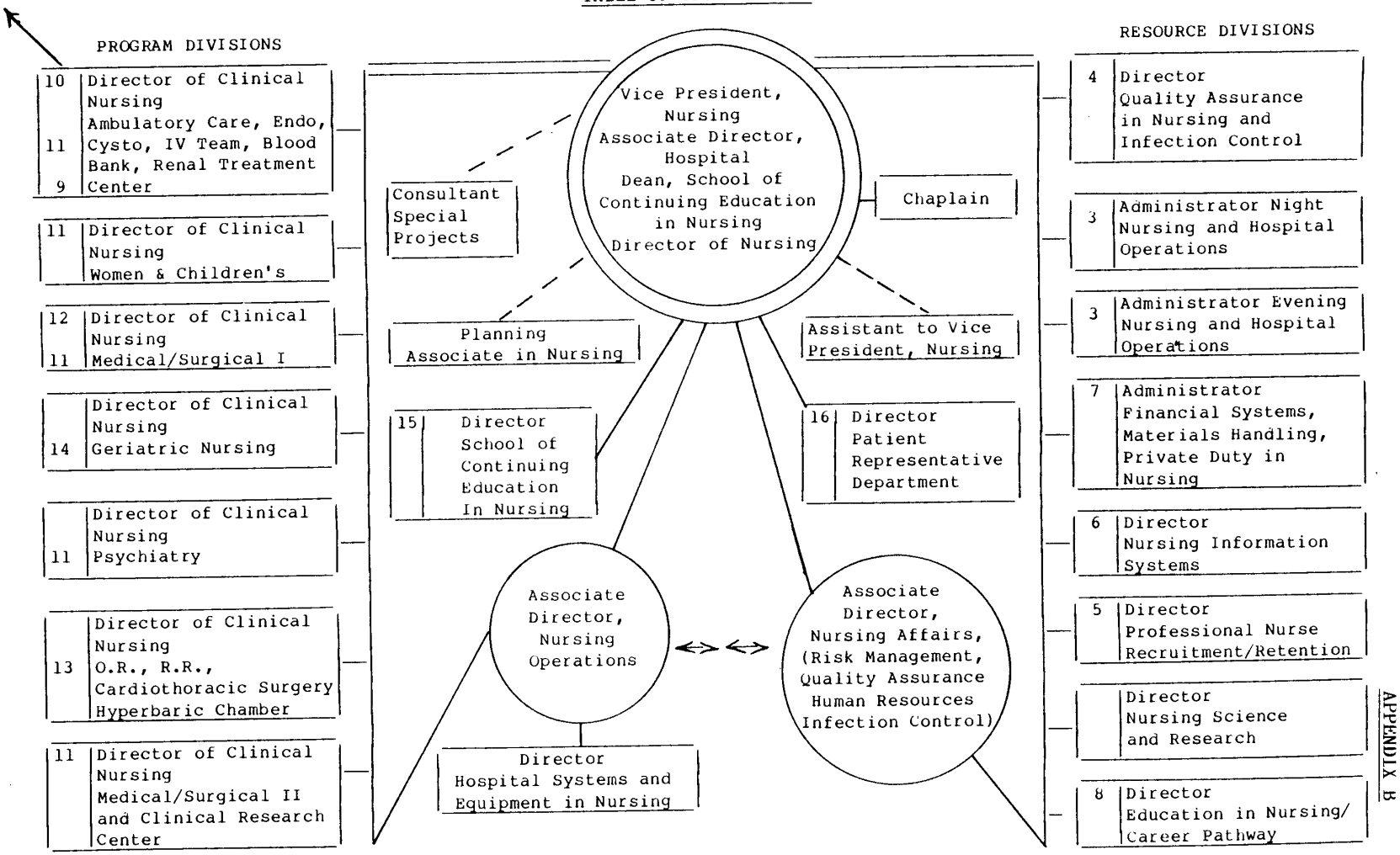
6/87

MASSACHUSETTS GENERAL HOSPITAL
Department of Nursing

ORGANIZATIONAL CHART



THE MOUNT SINAI MEDICAL CENTER
THE MOUNT SINAI HOSPITAL
DEPARTMENT OF NURSING
TABLE OF ORGANIZATION



APPENDIX B

N.B. Legend is on Page 2.

June 1988

LEGEND

The following indicates relationships and organizational structure that are used in the various organizational charts.

Relationships

 = Program Resource Consulting Relationship:

The Mount Sinai Medical Center organizational structure is a program-resource concept, and is a form of matrix organization. This concept's design provides for the collegial, participating decision-making structure for directing health professionals. Simultaneously, it provides the hierarchical centralized decision-making structure for managing employees. Inherent within this organizational concept are the program and consulting relationships. These relationships provide for the development of plans to achieve programs, the need for which has been defined in institutional and departmental objectives.

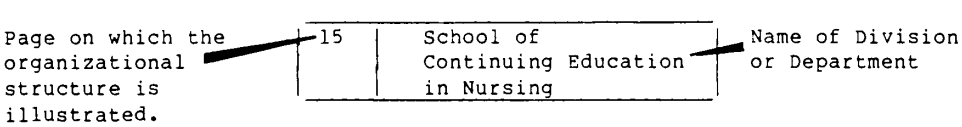
 = Lines: The lines structure, consisting of direct relationships, connects the positions with the Vice President, Nursing for policy development, program definition and resource control.

 = Line: The line structure, consisting of the direct (vertical) relationships, connects the positions and tasks of each level with those above and below it.

 = Staff: Advises, counsels and performs delegated functional duties affecting the whole system.

 = Responsible to the Program Chairman.

Organizational Structure



* = Where Applicable

BETH ISRAEL HOSPITAL
Nursing Services

APPENDIX C

TITLE: ~~Head~~ Nurse - Manager

General Summary

The head nurse position in the Beth Israel Hospital, Boston is recognized as a key management/leadership position within the hospital organization. The Head Nurse assumes the broad responsibility of translating the objectives, policies and procedures of the hospital and Nursing Services into effective action. Maintains the standards of nursing care and practice of the Nursing Services on the designated patient care unit. Responsibility is centralized in three major ares: patient care management, personnel management, and unit management. Has delegated authority to make decisions in these areas specific to the patient care unit the head nurse manages.

Role Responsibilities

1. Responsible for patient care management of designated patient care unit.

   . Maintains own current knowledge of nursing care requirements for all patients on the unit:

     - appropriate assignment of personnel is accomplished according to patient needs.

     - assessment of the patient and family response to nursing care and services.

     - coordination of plans for total services including planning for optimal utilization of staff for the delivery of nursing services throughout a twenty-four period to meet patient care needs.

   . Develops systems which allow for consistent evaluation of nursing care provided in relation to the nursing requirements of patients.

   . Maintains constant interventions and interaction with primary nurse/staff nurse for purpose of assessing the care provided and the development of the nurse's capability to render care in changing circumstances.

   . Administers direct nursing care to select patients as deemed appropriate to maintain own clinical competence and/or to assess particular patient requirements.

   . Consults with patients and families through primary nurse request, direct family request and/or direct assessment of patient/family response to hospitalization.

   . Utilizes appropriate resources within the institution and within the Nursing Services to provide consultation, education, technical or informational services as needed to self, staff or patients.

   . Supports and participates in on-going educational and research programs of the Nursing Services and hospital.

   . Works closely with own staff and peers in developing improved nursing care programs and nursing practices and, where appropriate, makes recommendations for change to the Director of Nursing for the clinical service.

2. Responsible for the personnel management on a designated patient care unit.

   - Recommends to the Director of Nursing long term staffing pattern and personnel complement needs for the patient care unit and submits accompanying data and rationale to support these recommendations.
   - Interviews, selects and hires all nursing personnel for the patient unit.
   - Assists new staff members in the adjustment process and facilitates the development of an appropriate orientation program for the new employee.
   - Monitors the activities of all nursing personnel assigned to the unit for educational, service or observational purposes to insure adherence to standards of the unit and the Nursing Services.
   - Evaluates the individual capabilities of each member of the staff and takes appropriate action if discrepancy is recognized between capability and performance requirement. Identifies problem, provides appropriate counseling, instruction or experience as needed. Is authorized to take disciplinary action when indicated including termination if required.
   - Plans for, directs and/or participates in regularly scheduled meetings and conferences with staff.
   - Works closely with the Assistant to the Vice President for Nursing for Budget and Staffing to develop and maintain the master staffing pattern as well as the short term and daily scheduling time pattern for the patient unit.
   - Determines the utilization of unit staff.
   - Responsible for all nursing personnel assigned to the unit. As manager, provides supervision to others who come onto the unit to provide services, visit or learn.
   - Authorizes hours worked, including overtime, for all unit nursing personnel.
   - Is the primary clinical nursing resource for own nursing staff and for other areas where her expertise may be required.

3. Responsible for unit management of designated patient care unit.

   - Utilizes the Administrative Assistant as a resource and to delegate authority for taking initiative in carrying out the daily operational activities required for overall effectiveness in unit functioning.
   - Maintains control of the approved personnel and supplies and expense budgets for the designated patient care unit.

- Maintains a safe environment for patients and staff; one conducive to positive health teaching and comfort.

- Has close working relationship with other managers whose departments provide support services to the patient unit. Initiates appropriate communications and planning to insure a consistently high level of service to the unit and to effectively meet any special needs of the patients or the unit.

- Active participation in the budget process of the Nursing Service. Makes recommendations to the Director for new programs and/or program changes with supporting data justifying the need.

- Establishes appropriate communication mechanism for providing information to clinical advisors covering unit during the absence of head nurse on off shifts.

- Provides unit-based orientation to new house staff and other unit-based non-nursing personnel regarding structure and operation of the unit and the role of the primary nurse in patient care management.

- Participates as requested by the Director, in departmental orientations for non-nursing personnel.

4. Attends head nurse meetings and disseminates the appropriate information to staff.

5. Contributes and represents department or Nursing Service through committees.

6. Utilizes the Director for consultation, support and guidance in program planning for the unit, in professional self-development, and in seeking appropriate resources.

7. Develops goals and objectives for unit programs on an annual basis and submits annual written report of program evaluation to the Director.

8. Identifies goals for professional self-development and seeks continuing education opportunities to attain these goals.

Reporting Relationships

Accountable to the Director of Nursing of the designated area.

Knowledge, Skills and Abilities Required

1. Current nursing registration in the Commonwealth of Massachusetts.

2. B.S.N. required, M.S.N. desirable.

3. Must have demonstrated clinical competence in area of nursing practice and demonstrated ability and potential managerial competency. Evidence of this should include: effective communication skills, ability to deal well with people, ability to problem solve, ability to approatiately confront issues, ability to motivate others as individuals and as a group, ability to plan, organize and direct the activities of others.

BETH ISRAEL HOSPITAL
Nursing Services

APPENDIX D

TITLE: Clinical Nurse

General Summary

Utilizes nursing process as the frame of reference for practice as a professional registered nurse in the role of primary and/or associate nurse and provides direct nursing care as appropriate. As primary nurse, assumes full responsibility for the nursing plan of care, has the authority to make and is held accountable for patient care management decisions specific to assessment, planning, implementation and evaluation of the plan. As associate nurse, assumes responsibility with the primary nurse for the implementation of the nursing care plan formulated by the primary nurse and may alter plan of care only in an emergency situation. Changes in the plan other than to meet an emergency, must be validated with the primary nurse whenever possible and if not possible, with the head nurse.

Principal Duties and Responsibilities

1. Responsible for systematically assessing the health care needs of individuals or groups and for the formulation of a care plan, its implementation, and evaluation of care.

   - Observes patients in a systematic way for both overt and covert signs and symptoms.
   - Interviews in a purposeful, goal directed fashion encouraging the patient or family to express ideas, feelings, and facts that help identify his need and goals.
   - Compiles a nursing history utilizing direct and indirect sources of data.
   - Formulates a nursing diagnosis through the identification of the patient's nursing problems and expresses this verbally and in documentation.
   - Assesses interest, coping patterns and learning abilities of patient and families relative to care during hospitalization and after discharge.
   - Identifies learning needs of patients and families.
   - Develops and/or implements appropriate teaching plans and utilizes incidental teaching as opportunities arise.
   - Ranks patient's needs in an order of priority to establish a preferential order for delivery of nursing care.
   - Involves patient and/or family in the plan of care.
   - Develops individualized nursing care plans and revises appropriately to reflect current and changing status of patient.
   - Evaluates and revises nursing care plans appropriately to reflect current and changing status of patient.
   - Identifies realistic short and long term goals related to patient's physiological and psychosocial needs.
   - Identifies need for and participates in nursing conferences/or multidisciplinary team conferences.

- Initiates referrals and utilizes available resources within and outside the institution for the purpose of comprehensive care to patients and families.
- Participates as an integral member of the health team in formal and informal shift rounds, medical rounds, and/or Grand Rounds.
- Organizes care considering each patient's needs and preferences and in relation to the unit's activities and needs as well as own commitments.
- Assesses the patient's progress toward health goals and offers additional or alternative plans of care.
- Offers suggestions or engages in activities which could enhance quantity and quality of care given to patients. Shares ideas and seeks assistance in experimenting with new ideas.
- Assesses and incorporates suggestions of staff associates in planning care.
- Throughout hospitalization, incorporates discharge planning in the nursing plan of care and records a discharge summary in the patient's record at the time of discharge.

2. Provides direct care to patients and makes substantial nursing judgments.

- Has knowledge of patient's health status, treatment, care and progress of assigned patients.
- Recognizes changes in physical and mental condition and takes appropriate actions.
- Alters patient care in accordance with new needs and observations made of physical and mental changes.
- Responds appropriately in emergency situations.
- Integrates knowledge and skills in delivery of care to patients.
- Adapts nursing procedures to meet individual needs of patients. Assists in maintaining a safe environment for patients and staff.
- Understands and uses equipment properly, considering the maintenance, safety and availability.
- Seeks guidance from appropriate resources when necessary.
- Accepts responsibility for own actions.
- Validates decisions and actions taken.
- Administers medications safely.

3. Works in a collegial and collaborative relationship with other health professionals to determine health care needs and assumes responsibility for quality nursing care.

- Recognizes and responds to verbal and non-verbal communications of patients and families.
- Recognizes and responds to verbal and non-verbal communications of staff members.
- Defends and preserves the rights of patients relative to all aspects of their care, knowledge and privacy.
- Defends and supports appropriate decisions and actions of other staff members. Investigates questionable activities and discusses such with the person involved and/or manager.
- Asserts self with tact and determination when dealing with other members of the health team.
- Resolves issues and/or refers them appropriately to others.
- Interested, caring, and willing to involve self on behalf of patients and staff.
- Relates information in clear, concise manner.
- Relates complete and pertinent information in verbal and written communications.
- Knows of current changes, protocols and implements the changes. Informs other staff members as opportunities arise. Utilizes opportunities to clarify questions relative to new changes and/or discusses additional dimensions related to the subject.
- Documents appropriate information promptly, clearly, and completely.
- Offers suggestions/or constructive criticism for improvement of patient care or staff development.
- Conducts activities in calm, controlled, and purposeful fashion.

4. Responsible for maintaining competencies and participating in those activities that contribute to the on-going development of self, profession, and other health professions.

- Accepts responsibility for own practice and development.
- Identifies learning needs and seeks assistance from more experienced staff members, manager, NEAR-staff, etc.
- Participates in activities which further develop professional growth.
- Guides and assists other staff members in their growth.
- Recognizes professional responsibility as extending beyond own group of patients to include goals established for unit and Nursing Department.
- Sets realistic goals for own development based on assessment of own strengths and learning needs.

- Seeks learning experiences that will strengthen areas requiring development.
- Demonstrates interest in continuing education through committees, research activities, etc. offered by agency or outside sources.

5. Coordinates the care of patients and directs a variety of personnel who possess diverse backgrounds in education, experience, ability and motivation.

- Establishes appropriate priorities when organizing work.
- Recognizes problems, evaluates facts, and reaches sound conclusions.
- Problem solves with an understanding of short term and long term goals.
- Demonstrates flexibility in responding to change.
- Maintains confidentiality in matters relating to patients/or staff.
- Influences others through knowledge, attitude, and interest.
- Motivated and self-directed taking the initiative to act independently/or with appropriate others.
- Displays appropriate degree of confidence in self.
- Willing to share and assist others.
- Offers and values constructive criticism.
- Objectively listens to all sides of an issue before making a judgment.
- Finalizes plans, seeks answers to questions or needs. Assumes responsibility for seeing things through to completion and for informing others of outcomes.
- Recognizes and utilizes talents and strengths of personnel to improve care of patients and staff members.
- Initiates change by utilizing appropriate channels.
- Maintains purposeful activity and order in usual and emergency situations.
- Maintains open communications with all health team members.
- Utilizes inter and intra departmental resources in planning patient care.
- Functions without supervision in a manner appropriate for experience.

5. Has a professional commitment to patient and nursing staff.

- Flexible to unit needs in relation to patient assignment, shift assignment or work schedule.
- Demonstrates a commitment to unit by extanding self when unusual needs arise.

- Reports for duty punctually.
- Gives adequate notice of absenteeism or tardiness.

Reporting Relationships

Accountable to the patient and family for care provided and to the Head Nurse for the totality or work performance.

Knowledge, Skills and Abilities Required

1. Graduate from an accredited school of nursing.
2. Current registration in the Commonwealth of Massachusetts as a registered nurse.
3. Must have a sound understanding of biological, social and behavioral theory normally acquired through the completion of a B.S.N. degree.

Approvals

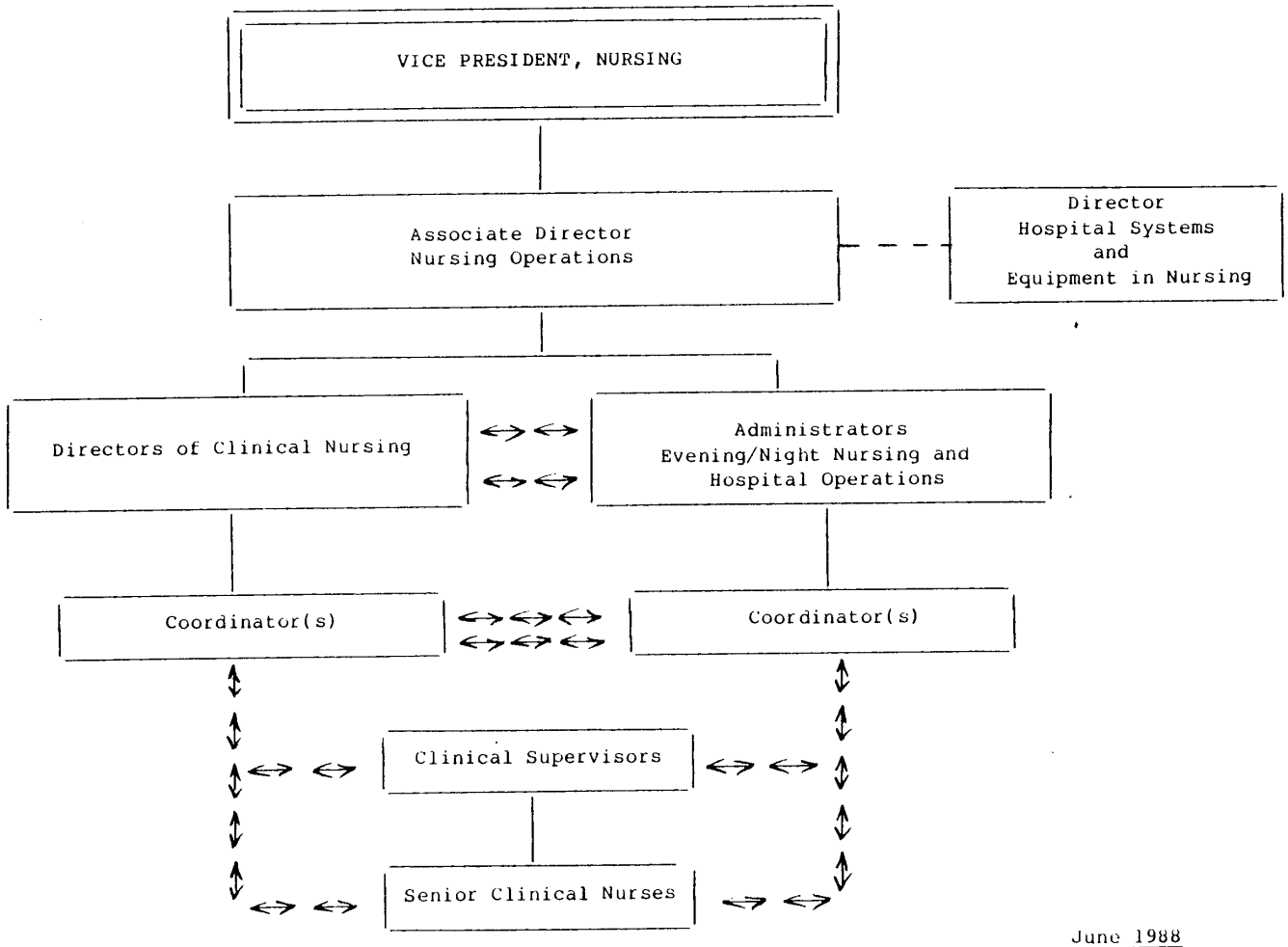
Name	Title	Date
Name	Title	Date
Name	Title	Date

The above statements are intended to describe the general nature and level of work being performed by people assigned to this classification. They are not intended to be construed as an exhaustive list of all responsibilities, duties, and skills required of personnel so classified.

ksp
5/83

THE MOUNT SINAI MEDICAL CENTER
THE MOUNT SINAI HOSPITAL
DEPARTMENT OF NURSING

NURSING AND HOSPITAL OPERATIONS ADMINISTRATION

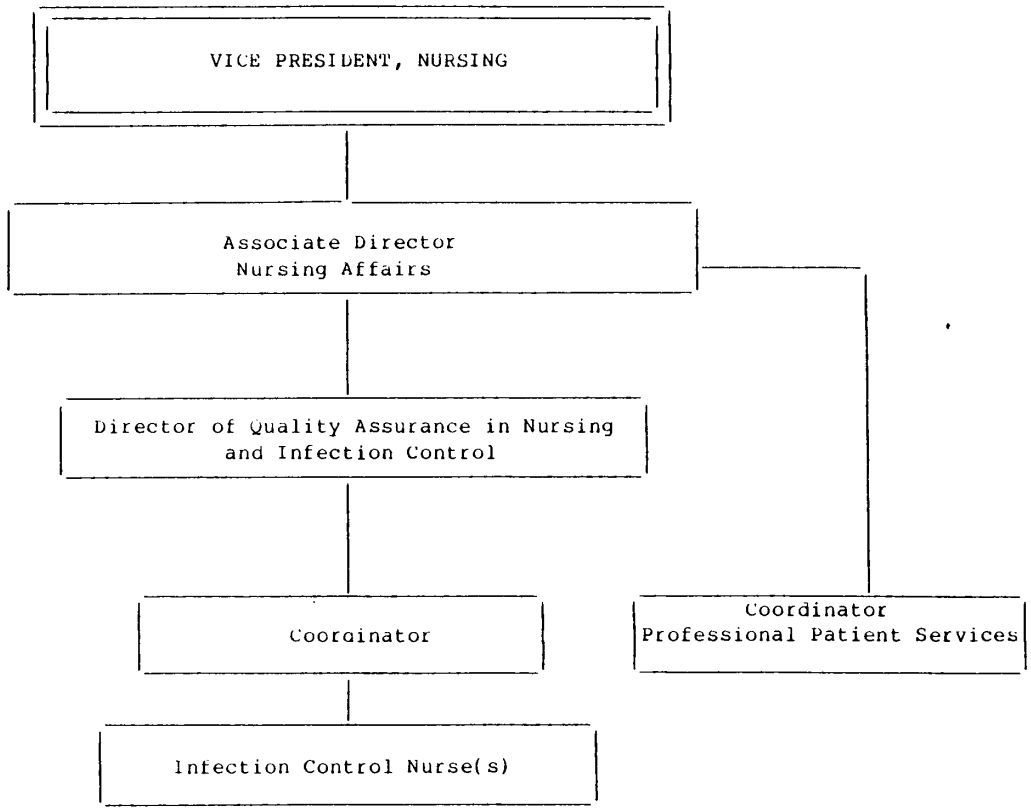


APPENDIX E

June 1988

THE MOUNT SINAI MEDICAL CENTER
THE MOUNT SINAI HOSPITAL
DEPARTMENT OF NURSING

NURSING AFFAIRS; RISK MANAGEMENT, QUALITY ASSURANCE, HUMAN RESOURCES IN NURSING AND INFECTION CONTROL



June 1988

APPENDIX F

NURSING DEPARTMENT POLICIES		
Distribution: General	VISION STATEMENT FOR NURSING THE MOUNT SINAI MEDICAL CENTER NEW YORK, NEW YORK	No. 45A Page 1 of 1

Original Date of Issue 07-15-88

Reviewed:							
Revised:							

Gail Kuhn Weissman, R.N., Vice President, Nursing — Date 7/88

Mount Sinai Nursing will continue to play a major role in enhancing the reputation, effectiveness, and success of The Mount Sinai Medical Center by providing our patients with compassionate, safe, competent nursing care and our staff with a well-managed nursing service. We believe all individuals are unique and deserving of dignity and worth. Therefore, Nursing will foster the mutual respect for all members of the Mount Sinai community and opportunities for all individuals to be the best they can be.

We seek the advancement of the profession of nursing by fostering and supporting professional autonomy and interdependence as members of collegial health care teams. Mount Sinai Nursing will participate with the nursing profession in hastening the establishment and valuing of the contribution of nursing to the health care outcomes of its patients.

Mount Sinai Nursing will foster and support: collegiality in professional practice with physicians and other health care providers; effective nurse-consumer relations; the growth of nurse leaders in an environment of limited and scarce resources and consumer demand for quality nursing care; insurance reimbursement for registered professional nurses; joint endeavors between nursing service and education; and nursing as a challenging and meaningful professional career for the 21st century.

5091P/js

NURSING DEPARTMENT POLICIES

Distribution: General	DESCRIPTION OF THE ORGANIZATION	No. 45B Page 1 of 2

Original Date of Issue 04-15-83

Reviewed:							
Revised:	06-01-84	06-01-87	07-01-88				

G Kuhn Weissman RN — Gail Kuhn Weissman, R.N., Vice President, Nursing

7/88 — Date

POLICY: The Department of Nursing is a professional department directed by the Vice President, Nursing of The Mount Sinai Medical Center/the Director of Nursing/Associate Director of The Mount Sinai Hospital. The Department of Nursing is appropriately integrated with the medical staff and with other hospital staff that provide and contribute to patient care. The Department of Nursing is responsible for collaborating with the medical staff, other departments and services that provide and contribute to care, in the planning of programs and resources for the patients at The Mount Sinai Hospital. The Department of Nursing is organized to assure that the following are effectively fulfilled.

A. Meeting the nursing care needs of patients.

B. Establishing and maintaining standards of nursing care and for evaluating such care.

C. Establishing and maintaining standards of nursing practice and evaluating practice.

D. Implementing the approved policies of the department.

E. Appointments to the professional staff of qualified registered professional nurses and, developing methodologies which will ensure quality practice.

F. Reviewing and approving policies and procedures that relate to the qualifications and employment of members of the staff.

G. Appointing committees to conduct departmental functions and encouraging staff to participate in staff education and attend required meetings.

H. Accounting for professional and administrative nursing staff activities.

Distribution: General	DESCRIPTION OF THE ORGANIZATION	No. 45B Page 2 of 2

IMPLEMENTATION:

The Department of Nursing is composed of the following clinical divisions: Medical/Surgical I & II; Psychiatry; Women & Children's; Ambulatory Care including IV Team, Renal Treatment Center, Endoscopy and Cystoscopy; Operating/Recovery Rooms including Hyperbaric Chamber and Cardiothoracic Surgery, Geriatric Nursing, Evening and Night Nursing and Hospital Operations Administration, and the following resource divisions: Education in Nursing/Career Pathway; Quality Assurance in Nursing and Infection Control; Professional Nurse Recruitment and Retention; Information Systems in Nursing; Financial Systems, Materiels Handling, and Private Duty in Nursing; Nursing Science and Research; and The School of Continuing Education on Nursing.

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NURSING DEPARTMENT POLICIES

Distribution: General	PHILOSOPHY, GOALS, AND OBJECTIVES DEPARTMENT OF NURSING	No. 45C (Formerly #44) Page 1 of 6

Original Date of Issue 3/4/80

Reviewed:	8/1/80	4/6/82	4/15/83	1/28/85	9/86	7/1/88	
Revised:							

G Kuhn Weissman RN — Gail Kuhn Weissman, R.N., Vice President, Nursing

7/88 — Date

I. PHILOSOPHY:

The philosophy of the Department of Nursing is based upon the belief that the practice of nursing makes an essential contribution to the overall mission of the institution. Nursing is a caring process which encompasses those elements necessary for promoting, conserving and/or restoring health and when necessary fostering attitudes and conditions that will lead to a dignified death.

Based on this philosophy we believe that:

A. Each individual has dignity and worth, deserves respect and recognition of their uniqueness and the right to quality health care service.

B. The Department of Nursing is committed to providing optimal, achievable nursing care.

C. All members of the Department of Nursing have the right to directly influence, and actively participate in, decisions affecting their practice.

D. All members of the Department of Nursing have a commitment to maintain competence and to continuously update and expand the body of knowledge upon which practice is based.

E. All members of the Department of Nursing demonstrate commitment to the concept of collegiality among health professionals.

F. All members of the Department of Nursing incorporate ethical decision making as an integral part of professional practice and conduct.

G. All members of the Department of Nursing participate in establishing and maintaining a work environment conducive to the delivery of optimal, achievable nursing care.

PHILOSOPHY (continued)

H. The practice of professional nursing utilizes the nursing process which is based upon a specialized body of scientific knowledge and nursing theory.

I. Nursing requires effective use of specialized knowledge and high technology in the planning, management, provision and evaluation of health care.

J. Nursing in a high technology environment requires the fostering and demonstration of a humanistic, kind, and caring attitude in the delivery of health care.

K. Nursing requires the use of political and social skills in order to enhance the recognition, advancement and autonomy of the profession.

L. The professional nurse is accountable to and includes the patient in the process of determining health care goals.

M. The professional nurse promotes collaboration and coordination among health care disciplines, resources, and services to provide the care which is most advantageous to the patient.

N. The professional nurse will participate in, promote, disseminate and utilize, nursing research in the delivery of nursing care.

O. The professional nurse consistently strives to protect the patient's rights.

P. The professional nurse participates in the profession's effort to protect the public from misrepresentation and to maintain the integrity of professional nursing.

Q. Nursing administration involves the effective management of systems, technology and personnel through the use of interpersonal, political and leadership skills.

II. GOALS

A. To maintain an environment which recognizes the dignity and worth of each patient at all times.

B. To provide 24-hour nursing care to the patient population served at The Mount Sinai Hospital.

C. To collaborate and coordinate resources and services of health care disciplines to provide optimal and achievable care for the patient.

D. To ensure that departmentally approved standards for professional practice are defined, implemented, evaluated and monitored. We will be responsive to the standards of nursing practice stated by recognized professional nursing organizations and comply with standards mandated by regulatory agencies.

E. To effect a system of organizational management which places responsibility and accountability for the nursing care of patients with qualified professional nurses.

F. To effect a system of organizational management which reflects sound fiscal principles and practices.

G. To maintain a process of staff development and formal education appropriate to the needs of members of the Department of Nursing, which contributes to their professional practice and ethical conduct as defined by Department of Nursing standards, identified in position descriptions and evaluated in periodic performance appraisal.

H. To plan, implement, support and evaluate a variety of new programs in nursing practice, education, research and management.

I. To plan, design and implement management systems that utilize resources and finances required for cost-effective and competent nursing services.

J. To develop operational planning programs that are responsive to the strategic plan of the Mount Sinai Medical Center.

GOALS (continued)

K. To be responsive to the needs of all members of the Department of Nursing to participate in establishing and maintaining a work environment conducive to the delivery of optimal, achievable nursing care.

L. To recognize the need of the professional nurse to use political and social skills to enhance the recognition, advancement and autonomy of the profession.

M. To provide opportunity for patients to participate in decisions affecting their health according to each patient's capabilities and circumstances.

III. OBJECTIVES

A. To promote a humanistic, kind and caring attitude in the delivery of health care.

B. To provide and implement a dynamic organizational plan for the Department of Nursing which clearly delineates lines of authority, accountability and communication.

C. To define and implement policies and procedures based on departmentally approved standards which assure the delivery of optimal achievable patient care, professional competency, and ethical conduct in professional practice.

D. To evaluate staffing requirements in the Department of Nursing, using current methodologies to assure the appropriate staff-patient ratio for delivery of optimal, achievable nursing care.

E. To recruit qualified personnel to support the goals of the Department of Nursing.

F. To retain qualified personnel through efforts to identify, implement and evaluate measures to enhance the quality of work life.

G. To maintain an organized Quality Assurance Program which identifies issues, implements resolutions, evaluates outcomes through continuous monitoring systems.

OBJECTIVES (continued)

H. To utilize a criterion-based appraisal system based on the standards of the Department of Nursing and the position descriptions, to evaluate the job performance of the members of the staff of the Department of Nursing.

I. To develop, implement and evaluate appropriate programs of staff development and continuing education which provide planned learning experiences to assist personnel in the achievement of expected job competencies through a process of learning needs analysis, program development and program appraisal.

J. To participate in research for the purpose of testing theory, solving clinical and administrative problems and expanding the scientific basis for nursing practice.

K. To design, implement and evaluate systems of documentation which substantiate the delivery of optimal, achievable patient care.

L. To maintain primary nursing as the model for the delivery of nursing care, in which a professional nurse is responsible and accountable for assessing, planning, implementing and evaluating care for a specific patient case load.

M. To foster interdisciplinary collegial relationships through a decentralized organizational structure.

N. To ensure achievement of the annual fiscal objectives of The Mount Sinai Hospital.

O. To plan, design and implement Nursing Department Management Plan projects and to provide necessary management support for other Hospital Department Management Plan projects.

P. To plan, design and implement computerized information systems in nursing to ensure timeliness in transmission of information and documentation.

Q. To participate in the planning process and implementation phases related to the building of the new Medical Center facilities.

OBJECTIVES (continued)

R. To ensure that departmental management systems are responsive to the philosophy, goals, and objectives for the Department of Nursing and are effective and efficient.

S. To promote the positive image of professional nursing in the Medical Center and the local and world communities, by implementing programs which acknowledge and recognize nursing as a profession of worth.

T. To collaborate with educational and service institutions and agencies for the purpose of enhancing the contribution of professional nursing to patient care in the local and world communities.

U. To establish a milieu which is continually cognizant of the role of the individual health care worker in furthering a positive image of health care delivery in the Medical Center, and the lay and professional community.

V. To promote nursing as a viable professional career to elementary, junior and senior high school students, their parents and guidance counselors.

W. To promote nursing as a viable second career for adults.

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Case management in nursing

The following is excerpted from the American Nurses Association (ANA) publication "Case Management in Nursing". Copies of the entire document are available through the ANA at 2420 Pershing Road, Kansas City, Missouri, 64108. For members, the price is $10.00; for non-members, $15.00.

LHW, editor

The concept

Case management is a system with many elements:

- health assessment,
- planning,
- procurement, delivery, coordination of services and
- monitoring to assure that the multiple service needs of the client are met.

Case management optimizes the client's self-care capability, promotes efficient use of resources and stimulates the creation of new services. The nurse case manager may assume responsibility for all the elements listed above, which would include providing nursing care to the client, or may carry out the remaining aspects of case management while arranging for other nurses to provide the necessary nursing care.

The goals of case management are the provision of quality health care along a continuum, decreased fragmentation of care across many settings, enhancement of the client's quality of life and cost containment. These goals are often achieved through preventing inappropriate institutionalization or delaying institutionalization in acute and long-term care settings. Case management promotes the provision of quality care in the least restrictive environment. Other terms for case management are service management, care coordination and care management.

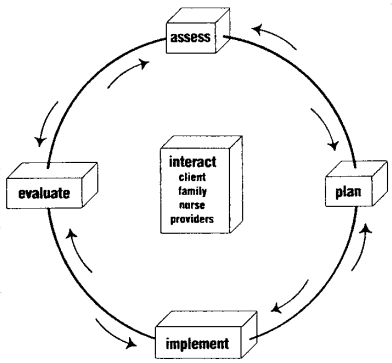
The target population is persons designated at high risk for problems associated with complex healthcare needs. Clients who need case management come from all population groups at all points on the healthcare continuum. Case management may be an intermittent or continuous process, depending upon the needs of the individual. It is not limited to the community setting; it is also used in hospitals, managed care practices, rehabilitation institutions and other settings. Case management is the best method to assure long-term community care.

Nurses—with their theoretical background in the biological and social sciences and the humanities, their knowledge of health maintenance, disease processes and medications and their experience in collaboration—are uniquely equipped to become case managers.

Nursing case management can encompass the conceptual framework of individual practitioners and facilitate personal practice model development. Case management has the potential to increase the nurse's level of satisfaction and sense of authority as a healthcare provider.

Core components

The specific activities of the case manager blend with the stages of the nursing process to form a framework for nursing care management. The components of nursing care management—whereby individuals interact, assess, plan, implement and evaluate—are illustrated below.



Nursing case management model

Interact

The interaction essential to case management requires the development of relationships among the nurse case manager, client, family members and other service providers. The interaction component of nursing care management involves the tasks of case-finding and screening. The main purpose of the initial screening is to outline the problem, determine the need for case management services and determine the client's eligibility for services. If the client is not eligible for case management according to pre-established guidelines, he or she is referred for assistance as appropriate.

Assess

Through the assessment component of case management, a comprehensive evaluation is made of the client's physical health status, functional capability, mental status, personal and community support systems, financial resources and environmental conditions. Standardized assessment instruments are often used by an interdisciplinary team consisting of a nurse, a social worker and at times other professionals.

The multiplicity of problems and the complexity of services for high-risk clients such as the elderly, premature infants and the developmentally disabled make providing case management for them a challenge. An assessment interview in the client's home environment to determine strengths and areas for concern is preferred.

Plan

The next phase of the case management process is developing the service care plan with client participation. Essential components of this phase include setting mutually agreed-upon goals with measurable objectives, determining action steps toward goal achievement and enumerating and selecting essential resources and services through collaboration among healthcare professionals, the client and family or significant others. By the conclusion of this phase, the nurse case manager, other professionals, client and family have developed a care plan designating the needs to be addressed through informal support systems and those for which formal services will be required.

Implement

Implementation aims to provide for the delivery of care by linking the client with appropriate service providers. The case manager coordinates the care so the client and healthcare providers clearly understand and fulfill their part in the service care plan.

During the implementation phase, the case manager is frequently called upon to advocate on behalf of the client. Client advocacy often involves providing additional information and education to prevent denial of services or denial of financing for services for which the client is eligible, extension of services already in place and conflict resolution. The case manager also identifies gaps in the service continuum and advocates the change in the community.

Finally, the case manager must provide for education of the client, the family and significant others concerning the importance of self-care by the client. Self-care at the highest level of functioning is essential to the client's sense of autonomy and self-determination.

Evaluate

The final phase of the case management process is monitoring and evaluation. During this phase, the nurse case manager maintains contact with the client's

informal support systems and direct service providers in order to continually evaluate the client's responses to interventions and progress toward attainment of the pre-established goals.

Ongoing care coordination is necessary until outcomes are achieved. The client may be discharged or assigned to inactive status as appropriate. The outcomes, both expected and unexpected, must be evaluated. In addition, there must be a quality assurance program for ongoing systematic monitoring and evaluation of the case management program. The services delivered by providers and subcontractors as a result of case management activities must also be evaluated through a quality assurance program. ●

Thoughts on case management

Adrian Harper, RN
clinical supervisor, KCC 5S

"Almost a year ago, I started what I called a 'group management' model on my unit. My motivation was to save my sanity and the stability and morale of my staff in the face of diminishing human resources. I only recently discovered that what we are doing is very close to case management.

"I divided my unit into three groups, primarily determined by spacial arrangements. In case management, groups are divided according to diagnosis, but the use of nurse managers and plans for treating patients efficiently are similar in both models.

"After several months, our group management model has produced more human resources and less waiting time for patients, a shared knowledge of patient needs and care plans, a reduction in the isolation of staff and patients, an increase in group spirit and better and more consistent use of nursing attendants.

"The primary problems we've found—which have solutions—are the fragmentation of care due to communication breakdowns among group members, primary nurses feeling overwhelmed until they learn how to delegate responsibilities and the integration into the group of people who have difficulty working closely with others. All of these can be corrected with fine-tuning, communication skills and education.

"The experience continues to convince me that we nurses can—and must—solve the problems caused by resource shortages and the changes in health care for ourselves. If we don't, someone else will find less effective solutions for us.

"Nursing is one of the largest professional groups in this country. Our leadership is capable of transforming ideas into realities. Our time to propose and implement innovations—like case management—is now."

Pearl Bryant, RN
staff nurse, KCC 5S

"As a group leader on KCC 5S, I've become familiar with every patient in my group. Their nurses give me updates, which means I can answer questions or step in when a patient's primary nurse is unavailable.

"The most important thing I've learned as a nurse manager is how to manage patients and my time. Learning how to prioritize is essential. I've grown professionally in the process."

Joyce Schweiger, RN
clinical director, Clinical Resources/
Clinical Career Pathways

"Case management would be a benefit at Mount Sinai, especially in managing patients with both psychiatric and medical problems who spend a period of time in the hospital.

"There are several advantages. For nurses, it's an opportunity for true collaboration with physicians. The format is similar to what we called a multidisciplinary team—with one important difference. In case management, a professional nurse is in charge of pulling the team together as a cohesive group and making it function as a unit. That in itself demands collegiality.

"For patients, case management assures a specifically identified primary nurse from the day they enter the hospital until release—even if the patient is transferred from one unit to another. In a hospital this size, patients wouldn't get lost in the shuffle.

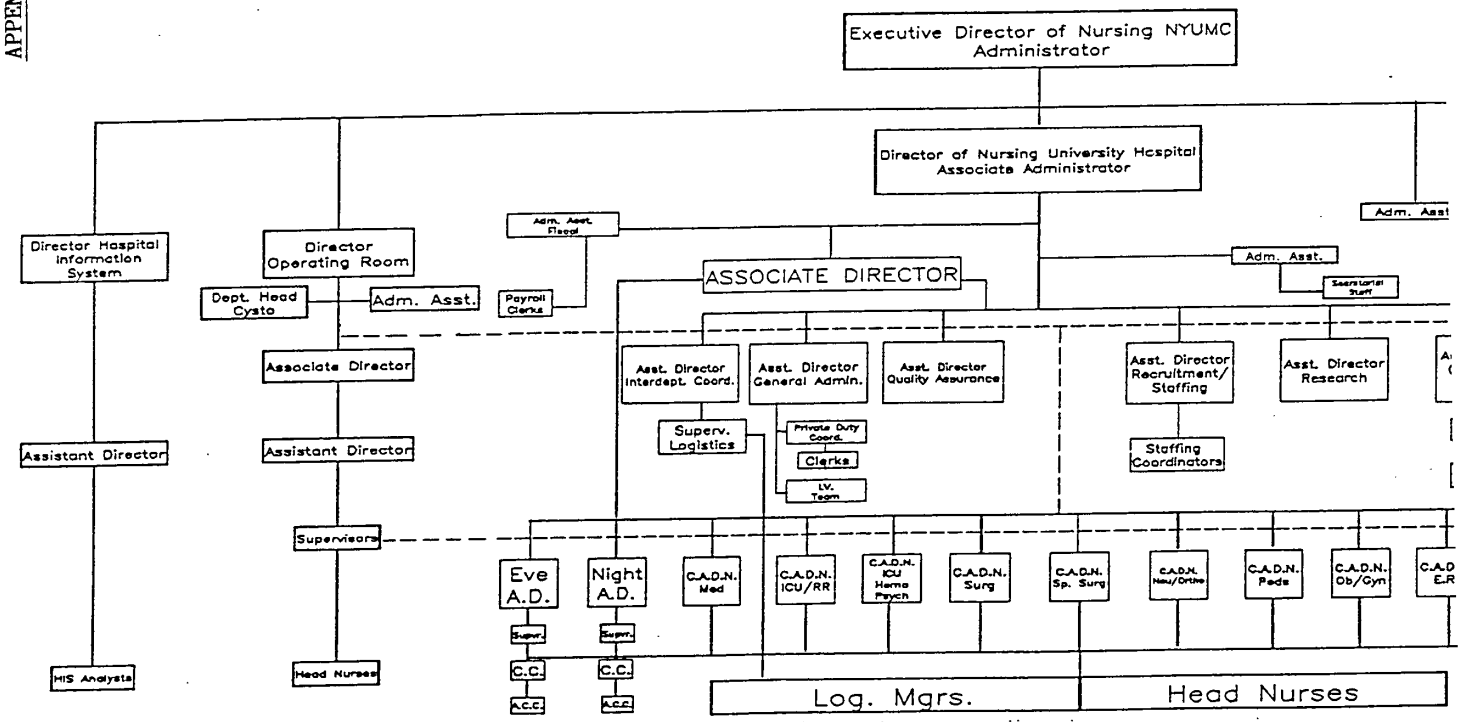
"It's also cost effective. Because one person carefully monitors each patient's progress, the expensive minutia that results from many monitors is eliminated.

"There would be problems, of course; but most of them could be resolved through identified pilot projects. For example, we would have to identify primary nurses who are ready to be primary nurse case managers. In addition, we would have to be certain that every individual involved—physicians, social workers and nutritionists included—understood the case management process. Pilot case management units would provide the opportunity to learn specific required skills and the best way of educating everyone involved.

"Instituting case management would take time and energy—particularly in a huge hospital like Mount Sinai. But even with that, the pluses would far outweigh the minuses. The effort required would be realized many times over in benefits to patients, nurses, physicians and the hospital in general." ●

APPENDIX H

NEW YORK UNIVERSITY MEDICAL CENTER
NURSING AND RELATED DEPARTMENTS
ORGANIZATIONAL CHART



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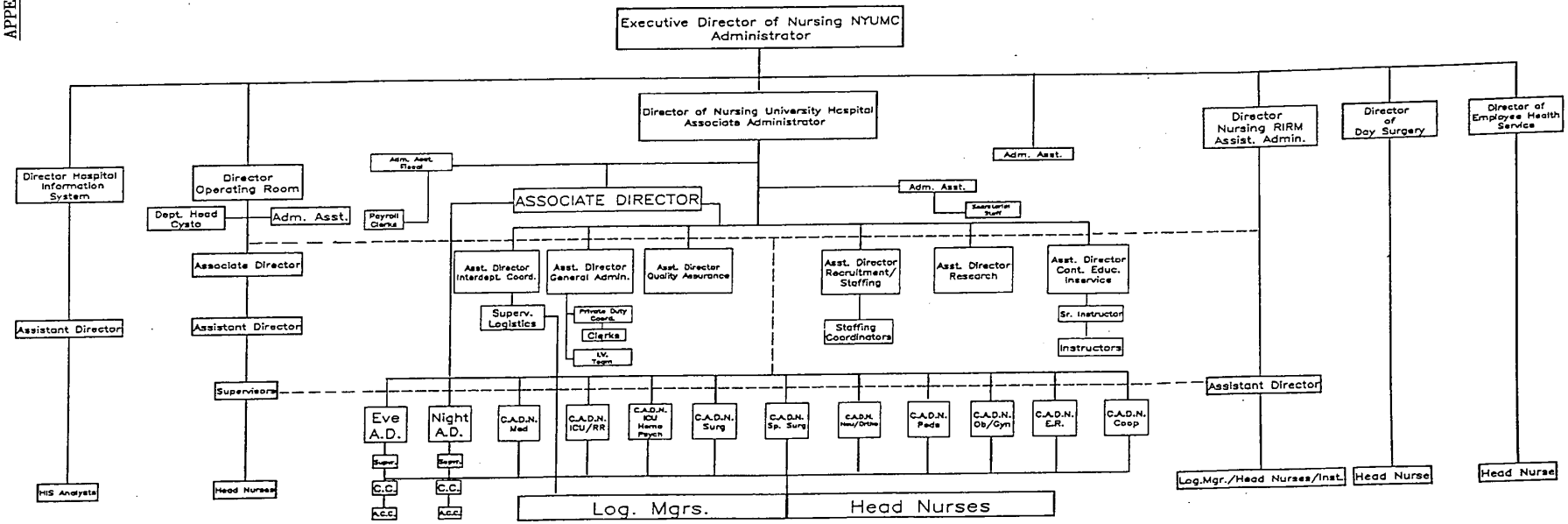

NEW YORK UNIVERSITY MEDICAL CENTER

NURSING DEPARTMENT

STAFF NURSE

OVERVIEW OF POSITION:

The Staff Nurse is a registered nurse who, in a first level professional position, carries out care for an assigned group of patients under supervision.

The criteria for assignments and level of responsibility recognize the staff nurse's need to concentrate on organizing and synthesizing basic knowledge of disease processes, effects of treatment and operative measures, interpersonal therapeutic skills and procedure standard of patient care.

ORGANIZATIONAL STRUCTURE:

Accountable to Head Nurse.

QUALIFICATIONS:

1. Currently registered license or limited practice permit in the State of New York.
2. Membership in professional organizations is encouraged.
3. Has had only limited graduate experience in the chosen area of clinical practice prior to joining University Hospital staff.

SENIOR STAFF NURSE

OVERVIEW OF POSITION:

The Senior Staff Nurse is a registered nurse who, in a second level professional position carries out patient care responsibilities with emphasis on nursing judgments to assist the patient attain his optimum level of wellness.

Beginning specialization is recognized at this level and opportunities for further development in a specialty will be provided as well as in expertness of general practice.

ORGANIZATIONAL STRUCTURE:

Accountable to Head Nurse.

QUALIFICATIONS:

1. General

   A professional nurse who has demonstrated the ability to solve problems, and is able to work in a group setting to plan and implement nursing care of patients seeking assistance and guidance as needed.

2. Professional

   A. Current license in New York State.

   B. B.S.N. preferred.

   C. Membership in professional organizations is encouraged.

   D. a. or b.:

NURSE CLINICIAN

OVERVIEW OF POSITION:

The Nurse Clinician is a registered nurse who, in a third level professional position, carries out patient responsibilities with emphasis on increasing independence for designing standards of patient care and intermediate leadership of personnel in planning, organizing, implementing, and evaluating nursing activities.

Progressive specialization is expected at this level and opportunities for continued development in a specialty will be provided as well as in expertness of general practice.

ORGANIZATIONAL STRUCTURE:

Accountable to Head Nurse.

QUALIFICATIONS:

1. General

   A professional nurse who can exercise judgment to plan, execute and evaluate a program of actions to achieve stated goals -- one who can implement nursing care by means of team direction with the assistance and guidance of the Head Nurse.

2. Professional

   A. Current license in New York State.

   B. B.S.N. preferred.

   C. Membership in professional organizations is encouraged.

SENIOR NURSE CLINICIAN

OVERVIEW OF POSITION:

The Senior Nurse Clinician is a registered nurse who, in a fourth level professional position, carries out patient care responsibilities with emphasis on independent decision making related to the steps in the nursing process and demonstrates the ability to provide consistent direction for all nursing personnel in planning, organizing, implementing and evaluating nursing activities.

Clinical expertise and commitment to continued professional development is expected.

ORGANIZATIONAL STRUCTURE:

Accountable to Head Nurse.

QUALIFICATIONS:

1. General

   A professional nurse who can provide clinically specialized expertise in direct patient care responsibilities, application of the nursing process and team direction with the assistance and guidance of the Head Nurse.

2. Professional

   A. Current license in New York State.

   B. B.S.N. required.

   C. Active membership in a professional organization

APPENDIX I

STAFF NURSE

SENIOR STAFF NURSE

a. At least nine months or more graduate experience prior to joining University Hospital that is relevant to chosen clinical field, and satisfactory references.

b. A staff nurse evaluated after six months and recommended for promotion by nursing management.

NURSE CLINICIAN

D. Minimum of 18 months documented progressive effectiveness in clinical practice.

E. Minimum of 15 hours of documented annual attendance at educational offerings. Up to 10 hours of the 15 hours can be proof of attendance in a course(s) in a nursing degree-granting program.

SENIOR NURSE CLINICIAN

D. Minimum of 3 years clinical experience.

*E. Documented clinical expertise as evidenced by certification through a national professional organization.

F. Minimum of 20 hours of documented annual attendance at educational offerings. Up to 12 hours can be proof of attendance in a course(s) for a nursing degree granting program.

*Optional.

FUNCTIONS AND RESPONSIBILITIES:

1. Provides direct total care for a specific group of patients in compliance with the U.H. Standards of Nursing Practice.
2. Demonstrates the ability to utilize the nursing process to identify patient care priorities in the development, implementation and on-going evaluation of the plan for care.
3. Demonstrates the ability to accept responsibility and be held accountable for patient care provided.
4. Performs beginning nursing skills in accordance with U.H. Nursing Department's policies and procedures.
5. Organizes patient care activities in a manner that demonstrates ability to set priorities and use time effectively.

FUNCTIONS AND RESPONSIBILITIES:

1. Provides direct total care for a specific group of patients in compliance with the U.H. Standards of Nursing Practice.
2. Utilizes an individualized patient centered approach in planning, implementation, evaluation, and any needed modification of care plans.
3. Is able to coordinate the care delivered by a nursing team.
4. Interprets and adheres to lines of authority and is accountable for delegated work responsibilities.
5. Identifies the rationale underlying the nursing care skill performed in accordance with the Nursing Department's policies and procedures.

FUNCTIONS AND RESPONSIBILITIES:

1. Provides direct total care for a specific group of patients in compliance with the U.H. Standards of Nursing Practice.
2. Demonstrates independent nursing decisions in the development, implementation, evaluation and any needed modification of the individualized plan of care for each assigned patient.
3. Carries out innovative nursing interventions that reflect an ability to make discriminating assessments for complex patient needs.
4. Is able to direct and supervise Nursing Staff in caring for a group of patients.
5. Readily accepts responsibility and is accountable for own and delegated activities.

FUNCTIONS AND RESPONSIBILITIES:

1. Provides direct total care for a specific group of patients in compliance with the U.H. Standards of Nursing Practice.
2. Demonstrates independent decision making.
3. Develops and implements innovative nursing interventions that reflect an ability to make discriminating assessments for complex patient needs.
4. Directs, supervises and contributes to the development of Nursing Staff caring for an assigned group of patients.
5. Is accountable for own and delegated activities.
6. Insures continuity of patient care through a holistic approach to health team collaboration.

STAFF NURSE

6. Demonstrates ability to work well with nursing staff, other members of the health team and the patient and his family.

7. Communicates patient's needs and/or responses through appropriate verbal and written channels.

8. Participates in formal self-evaluation of nursing practice seeking guidance and supervision when appropriate, and accepts criticism and correction constructively, if needed.

9. Utilizes available opportunities for increasing own competence and scope of experience.

10. Identifies patient learning needs based upon the clinical situations and participates in the teaching plan of care.

SENIOR STAFF NURSE

6. Demonstrates ability to coordinate and collaborate with patient, family and other members of the health team for continuity of patient care.

7. Is able to set priorities in planning and carrying out patient care that reflects effective time management.

8. Is a resource person for the nursing staff both informally and through initiation of clinical presentations.

9. Actively participates in work related activities.

10. Demonstrates accurate and complete charting, reporting and recording keeping following standard policies and procedures of the Nursing Department and U.N. when carrying out inter-departmental functions.

11. Seeks formal self-evaluation, accepts constructive criticism and demonstrates recommended change(s) in nursing practice.

12. Contributes to nursing quality assurance and research activities by assisting in identification of recurrent nursing problems and cooperation in the data collection.

13. Demonstrates motivation for own professional growth by documented participation in in-service and continuing education offerings/ programs.

14. Identifies patient learning needs based upon the clinical situations and initiates the teaching plan of care.

NURSE CLINICIAN

6. Actively seeks the participation of patient, family and other members of the health team for continuity of patient care.

7. Is able to facilitate Nursing Staff's need for knowledge, skills and experience they may require to perform patient care activities in changing situations.

8. Participates in the formal orientation program and on-going staff development offerings to aid the staff in meeting patients' needs.

9. Assists in the development/ revision of Nuring Standards to facilitate care and treatment goals for patients.

10. Promotes effective verbal and written communications inter and intra departmentally in the planning and implementation of the patients' therapeutic regimen.

11. Initiates self evaluation in conform'ty with the work expectations, periodically evaluates progress with Nursing Leadership and institutes modifications for practice as needed.

12. Collaborates in quality assurance and nursing research projects and utilizes the findings to propose change and/ or modify clinical nursing practice.

13. Designs and persues written plan developed for professional growth.

14. Assesses patient learning needs and develops the teaching plan based upon the clinical situation and expected outcomes

SENIOR NURSE CLINICIAN

7. Initiates those experiences necessary to provide nursing staff with the knowledge and skills they may require to perform patient care activities in changing situations.

8. Participates in the planning, implementation, on-going evaluation, and needed alterations of the orientation program.

9. Initiates changes as needed in Standards of practice through appropriate channels.

10. Communicates effectively with all members of the health team through initiation of collaboration and/or teaching.

11. Initiates self-evaluation in conformity with the work expectations, periodically evaluates progress with nursing Leadership and institutes modifications for practice as needed.

12. Participates in quality assurance and nursing research projects and initiates need for same as it compacts on clinical practice.

13. Demonstrates a commitment to continued professional development by establishing and achieving personal goals.

14. Insures implementation and evaluation of comprehensive teaching plan.

APPENDIX J
PATIENT CARE WORKSHEET

KELLY TEST 1704SC
4213456 00068 03/03/50 37 F
MARKS CLEMENT MD KELLY TEST

ADMIT DATE 01/28/88

DIAGNOSIS:

ADMIT DX:SICK
OPERATIONS/PROCEDURES:CUTDOWN DONE ON 01/01
OPERATIONS/PROCEDURES:HYPERBARIC CHAMBER DONE ON 04/04
FINAL DIAGNOSIS:--FFFFFFFFFFFFFFF
CONDITION:GD

ALLERGIES:
IODINE,REACTION:RASH/HIVES

VITAL SIGNS:
01/29 VITAL SIGNS....T-P-R OD, (JBKA)

DIET AND FLUID BALANCE:
01/29 DIET....MECHANICAL SOFT, (D194)
02/10 NUTRITIONIST CONSULT FOR ALOC NEEDS, (JBKA)

IV'S:
01/29 14. ARAMINE DRIP - DOUBLE STRENGTH: D5/W,250CC W/ ARAMINE 200MG, RATE: TITRATE, TO KEEP SYSTOLIC ABOVE 90, X24 HR.... NOTIFY MD FOR SYST BP <60 MMHG, (D194)
02/17 29. PERIPHERAL LINE #1....START D5/W,1000CC; KCL 20MEQ, RATE: 125CC/HR, X3 BAGS, (NR).
04/06 43. CHEMO INFUSION....START D5/W,500CC; ADRIAMYCIN 10MG, RATE: 200CC/HR, X1 BAG TO START ON 04/07, (TR).

EPIDURAL MEDICATION:FOR USE BY ANESTHESIA ONLY
01/28 INSTITUTE CONTINUOUS EPIDURAL INFUSION PROTOCOL FOR: FENTANYL 10 MCG IN 10ML NORMAL SALINE, EPIDURAL INFUSION, VIA HARVARD PUMP, STARTED AT 11:30AM, (JBKA)
01/28 CONTINUOUS INFUSION OF 10ML/HR EQUALS 10 MCG/HR, (JBKA)
01/28 PATIENT CONTROLLED ANALGESIA SET AT 10ML PER DOSE EQUALS 10 MCG PER DOSE WITH DELAY TIME OF 10 MINUTES BETWEEN DOSES, (JBKA)
01/28 MAXIMUM DOSE PER HR. OF CONTINUOUS INFUSION PLUS PATIENT CONTROLLED ANALGESIA EQUALS 10ML EQUALS 10 MCG, (JBKA)
01/28 CHECK RESPIRATORY RATE @ 15MIN X 4, & THEN @1H UNTIL 3 HRS AFTER INFUSION IS COMPLETED, (JBKA)
01/28 NOTIFY ANESTHESIOLOGIST FOR RESP RATE OF 10 OR LESS, CHANGE IN MENTAL STATUS, PRURITUS, NAUSEA, VOMITING, OR URINARY RETENTION, (JBKA)

CONTINUED

KELLY TEST 17D4SC
4213456 00068 03/03/50 37 F
MARKS CLEMENT MD KELLY TEST

ADMIT DATE 01/28/88

DIAGNOSIS:

ADMIT DX:SICK
OPERATIONS/PROCEDURES:CUTDOWN DONE ON 01/01
OPERATIONS/PROCEDURES:HYPERBARIC CHAMBER DONE ON 04/04
FINAL DIAGNOSIS:--FFFFFFFFFFFFFF
CONDITION:GD

ALLERGIES:
IODINE,REACTION:RASH/HIVES

VITAL SIGNS:
01/29 VITAL SIGNS....T-P-R OD, (JBKA)

DIET AND FLUID BALANCE:
01/29 DIET....MECHANICAL SOFT, (D194)
02/10 NUTRITIONIST CONSULT FOR ALOC NEEDS, (JBKA)

IV'S:
01/29 14. ARAMINE DRIP - DOUBLE STRENGTH: D5/W,250CC W/ ARAMINE 200MG, RATE: TITRATE, TO KEEP SYSTOLIC ABOVE 90, X24 HR.... NOTIFY MD FOR SYST BP <60 MMHG, (D194)
02/17 29. PERIPHERAL LINE #1....START D5/W,1000CC; KCL 20MEQ, RATE: 125CC/HR, X3 BAGS, (NR).
04/06 43. CHEMO INFUSION....START D5/W,500CC; ADRIAMYCIN 10MG, RATE: 200CC/HR, X1 BAG TO START ON 04/07, (TR).

EPIDURAL MEDICATION:FOR USE BY ANESTHESIA ONLY
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01/28 MAXIMUM DOSE PER HR. OF CONTINUOUS INFUSION PLUS PATIENT CONTROLLED ANALGESIA EQUALS 10ML EQUALS 10 MCG, (JBKA)
01/28 CHECK RESPIRATORY RATE Q 15MIN X 4, & THEN Q1H UNTIL 3 HRS AFTER INFUSION IS COMPLETED, (JBKA)
01/28 NOTIFY ANESTHESIOLOGIST FOR RESP RATE OF 10 OR LESS, CHANGE IN MENTAL STATUS, PRURITUS, NAUSEA, VOMITING, OR URINARY RETENTION, (JBKA)

CONTINUED

Nursing Process

DEMO DEBBY 1725
4000588 00052 04/05/48 39 F
FIELDS STEVEN

DEMO DEBBY

PRIMARY DIAGNOSIS: --CORONARY ARTERY DIEEASE...

NURSING DIAGNOSIS				
10/11	POTENTIAL FOR ACCIDENTAL INJURY R/T- QUADRIPLEGIA/PARESIS			RNGN
EXPECTED OUTCOMES		R/P	R/D	
10/11	ABSENCE OF INJURY	QS	10/15	RNGN
NURSING ORDERS				
10/11	DISCUSS SAFETY PRECAUTIONS WITH PT. RECORD UNDERSTANDING & COMPLIANCE			RNGN
10/11	OOB WITH ASSISTANCE ONLY			RNGN
10/11	PROVIDE HAND BELL			RNGN
10/11	BOTH SIDERAILS UP WHEN IN BED			RNGN
10/11	FAMILIARIZE WITH ENVIRONMENT			RNGN
NURSING DIAGNOSIS				
10/11	DECREASED ABILITY TO PARTICIPATE IN ADL R/T....PAIN			RNGN
EXPECTED OUTCOMES		R/P	R/D	
10/11	PT WILL PARTICIPATE IN ADL	QS	10/13	RNGN
NURSING ORDERS				
10/11	DESIGN PAIN CONTROL PROGRAM			RNGN
10/11	CLOSE CURTAIN AROUND BED			RNGN
10/11	USE OWN PILLOW FROM HOME			RNGN
10/11	ADMINISTER PAIN MEDICATION 1/2HR PRIOR TO -- GETTING TO OOB			RNGN
NURSING DIAGNOSIS				
03/18	INADEQUATE REST, SLEEP R/T....ENVIRONMENTAL STIMULI			JBKA
EXPECTED OUTCOMES		R/P	R/D	
03/18	PT ABLE TO SLEEP 6HR W/OUT DISRUPTION	QNITE	3/21	JBKA
NURSING ORDERS				
03/18	W/PT ASSESS USUAL SLEEP PATTERN:; SLEEP AIDS USED AT HOME; PT'S PERCEPTION OF WHAT ACTIVITIES, PROCEDURES, ETC. ARE MOST DISRUPTIVE TO SLEEP			JBKA
03/18	INCORPORATE ASSESSMENT & ESTABLISH PLAN W/ PT TO SCHEDULE NECESSARY ASSESSMENTS & INTERVENTION TO PROVIDE LONGEST POSSIBLE UNINTERRUPTED PERIODS			JBKA
03/18	COMPLETE LATE PM/EARLY AM ASSESSMENT AT 11: OOPM			JBKA
03/18	PROVIDE SLEEP AIDS & COMFORT MEASURES DURING LAST PM ASSESSMENT AT 11:OOPM, BACKRUB, WARM MILK			JBKA
03/18	TURN ON NIGHT LIGHT			JBKA
03/18	PLACE CALL LIGHT, H2O PITCHER, BEDPAN, ETC W/IN PT'S REACH			JBKA
03/18	AVOID USE OF FLASHLIGHT DIRECTLY ON PT			JBKA

CONTINUED

Nursing Process

DEMO DERBY 1725
4000588 00052 04/05/48 39 F
FIELDS STEVEN

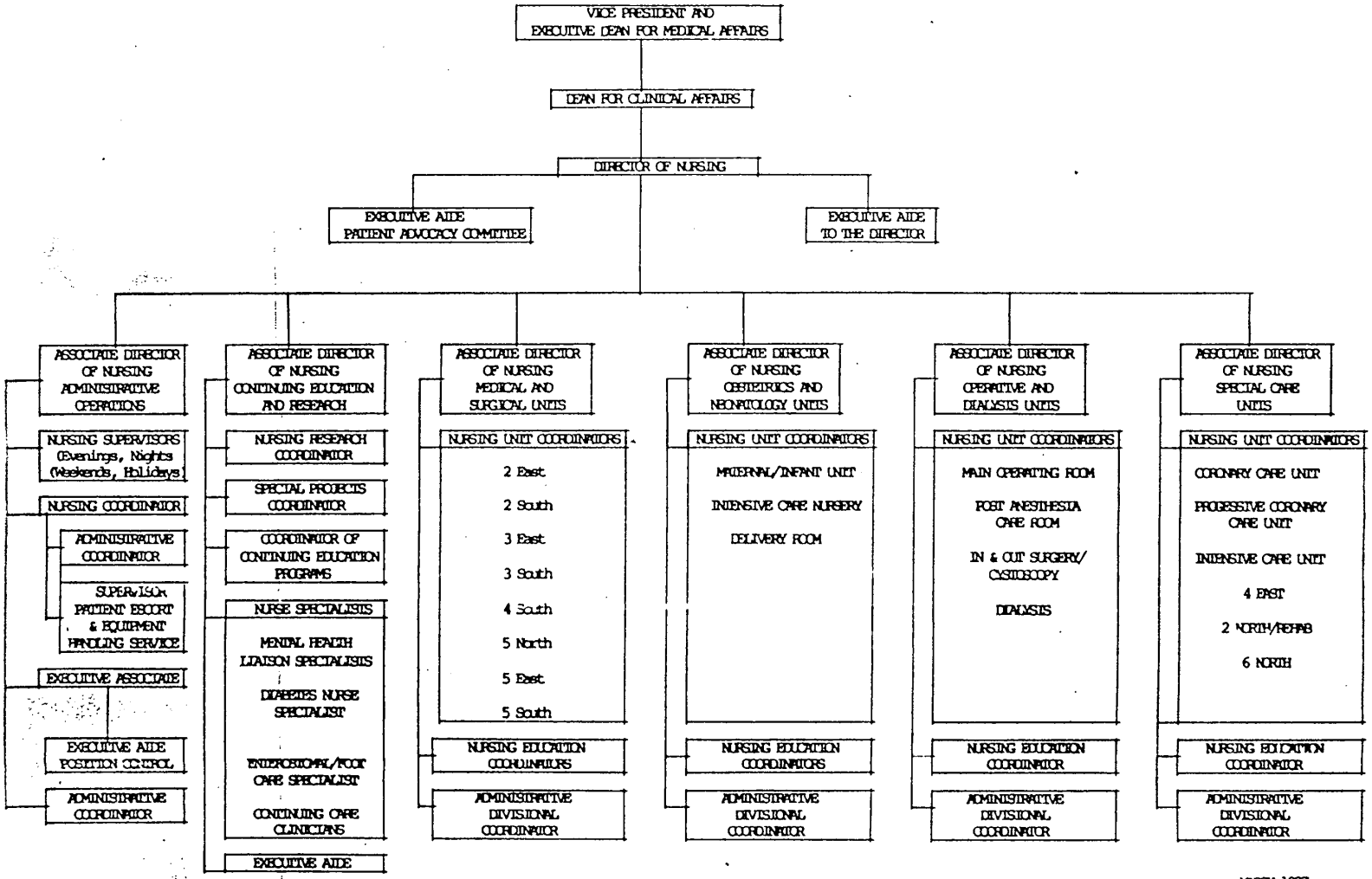
DEMO DERBY

PRIMARY DIAGNOSIS: --CORONARY ARTERY DIEEASE...

NURSING DIAGNOSIS				
10/11	POTENTIAL FOR ACCIDENTAL INJUR, R/T- QUADRIPLEGIA/PARESIS			RNGN
EXPECTED OUTCOMES		R/P	R/D	
10/11	ABSENCE OF INJURY	QS	10/15	RNGN
NURSING ORDERS				
10/11	DISCUSS SAFETY PRECAUTIONS WITH PT. RECORD UNDERSTANDING & COMPLIANCE			RNGN
10/11	OOB WITH ASSISTANCE ONLY			RNGN
10/11	PROVIDE HAND BELL			RNGN
10/11	BOTH SIDERAILS UP WHEN IN BED			RNGN
10/11	FAMILIARIZE WITH ENVIRONMENT			RNGN
NURSING DIAGNOSIS				
10/11	DECREASED ABILITY TO PARTICIPATE IN ADL R/T....PAIN			RNGN
EXPECTED OUTCOMES		R/P	R/D	
10/11	PT WILL PARTICIPATE IN ADL	QS	10/13	RNGN
NURSING ORDERS				
10/11	DESIGN PAIN CONTROL PROGRAM			RNGN
10/11	CLOSE CURTAIN AROUND BED			RNGN
10/11	USE OWN PILLOW FROM HOME			RNGN
10/11	ADMINISTER PAIN MEDICATION 1/2HR PRIOR TO -- GETTING TO OOB			RNGN
NURSING DIAGNOSIS				
03/18	INADEQUATE REST, SLEEP R/T....ENVIRONMENTAL STIMULI			JBKA
EXPECTED OUTCOMES		R/P	R/D	
03/18	PT ABLE TO SLEEP 6HR W/OUT DISRUPTION	QNITE	3/21	JBKA
NURSING ORDERS				
03/18	W/PT ASSESS USUAL SLEEP PATTERN:; SLEEP AIDS USED AT HOME; PT'S PERCEPTION OF WHAT ACTIVITIES, PROCEDURES, ETC. ARE MOST DISRUPTIVE TO SLEEP			JBKA
03/18	INCORPORATE ASSESSMENT & ESTABLISH PLAN W/ PT TO SCHEDULE NECESSARY ASSESSMENTS & INTERVENTION TO PROVIDE LONGEST POSSIBLE UNINTERRUPTED PERIODS			JBKA
03/18	COMPLETE LATE PM/EARLY AM ASSESSMENT AT 11: OOPM			JBKA
03/18	PROVIDE SLEEP AIDS & COMFORT MEASURES DURING LAST PM ASSESSMENT AT 11:OOPM, BACKRUB, WARM MILK			JBKA
03/18	TURN ON NIGHT LIGHT			JBKA
03/18	PLACE CALL LIGHT, H2O PITCHER, BEDPAN, ETC W/IN PT'S REACH			JBKA
03/18	AVOID USE OF FLASHLIGHT DIRECTLY ON PT			JBKA

CONTINUED

DEPARTMENT OF NURSING



MARCH 1987

APPENDIX K

GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

DEPARTMENT OF NURSING

PHILOSOPHY OF NURSING

As professional nurses in a university hospital which offers a wide range of acute services, we are committed to providing comprehensive care to patients who require diversified levels of personal attention and technical expertise. Depending on the needs of the patient, the goals of our care include sustaining life, providing comfort, enhancing recovery from illness or injury, promoting health, and facilitating reintegration into the community. In the event that death is the inevitable outcome, our care is directed towards alleviating suffering and supporting the patient and his family in facing this reality.

We believe that:

Each patient is a unique person with individual needs. The patient, family, and nurse share responsibility for identifying those concerns, needs, and health care goals which fall within the scope of nursing practice. The patient and family should become actively involved in the planning and implementation of his care within the limits of their capabilities.

We are accountable for our nursing practice which is based on knowledge, skills, and established standards. The provision of nursing care is accomplished through the use of assessment, planning, intervention, documentation, evaluation, and revision (the nursing process).

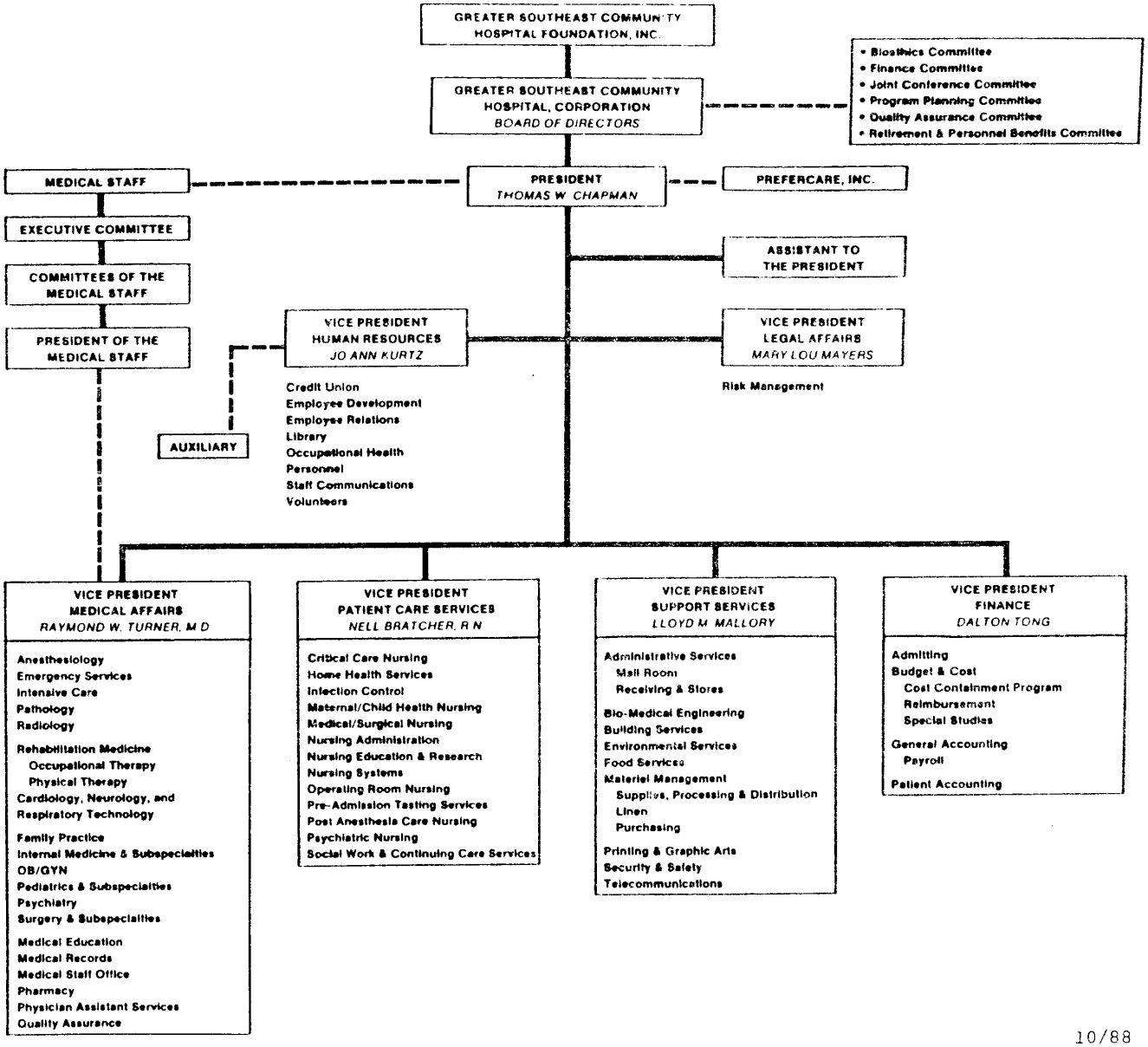
The nurse collaborates to facilitate continuity of care through open communication with other health care disciplines.

The nurse is accountable for implementing those portions of the medical regime that are within the scope of nursing practice.

The care we provide our patients is enhanced by our support of and participation in the decision-making processes within the Department of Nursing as well as within the institution.

Participation in continuing education is an essential activity which enables every professional nurse to expand her knowledge and practice.

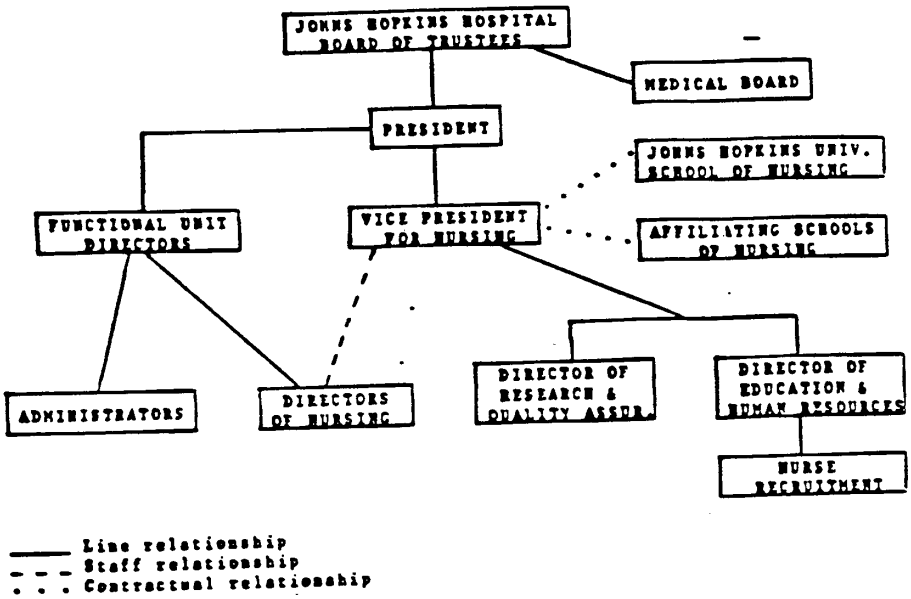
Nursing research provides the rationale for validating or changing current nursing practices or instituting new ones.



10/88

APPENDIX M
ATTACHMENT 4

Figure 2.
The Johns Hopkins Hospital
Chart of Organization
Nursing Service



Hospital President — Robert Heyssel, MD

Vice President for Nursing & Patient Services — Linda Arenth, MS, RN

Departmental Administrators

Dept.	Nursing Director	Functional Unit Director
Emerg. Med.	Barbara Mlynczak	Dr. Keith Sivertson
Gyn/Ob	Diann Snyder	Dr. Edward Wallach
Medicine	Chris Evans	Dr. Stobo
Neurosciences	Shirley Sohmer	Dr. Guy McKhann
Oncology	Sharon Krumm	Dr. Donald Coffey
Ophthalmology	Dawn Henninger	Dr. Arnold Patz
Pediatrics	Lisa Phifer	Dr. Frank Oski
Psychiatry	Shirley Sohmer	Dr. Paul McHugh
Radiology		Dr. Martin Donner
Surgery	Jo Walrath	Dr. John Cameron

The Johns Hopkins Hospital
Department of Nursing
State of Philosophy

The Department of Nursing supports the philosophical tenets which govern the institution. We believe nurses play an integral role in fulfilling the hospital's mission to promote clinical practice, education and research. We hold ourselves accountable to our patients for safe, responsible, quality care rendered in cost effective manner; to the profession for establishing and maintaining high standards of care and to the community for the improvement of health, education and health care delivery systems.

We acknowledge the uniqueness of each patient as an individual, a family and community member. In collaboration with other health disciplines, we strive to provide holistic care in order to meet the patient's biopsychosocial needs. We contend that each patient has a right to be informed of and participate in decisions regarding his/her care. In circumstances where the patient is unable to attain his/her level of optimal health, the nurse is responsible for assisting the patient and family in adapting to alterations in life style or death. We strongly advocate preventive health care and support the efforts of health care professionals to provide education to individuals in the hospital setting and the community.

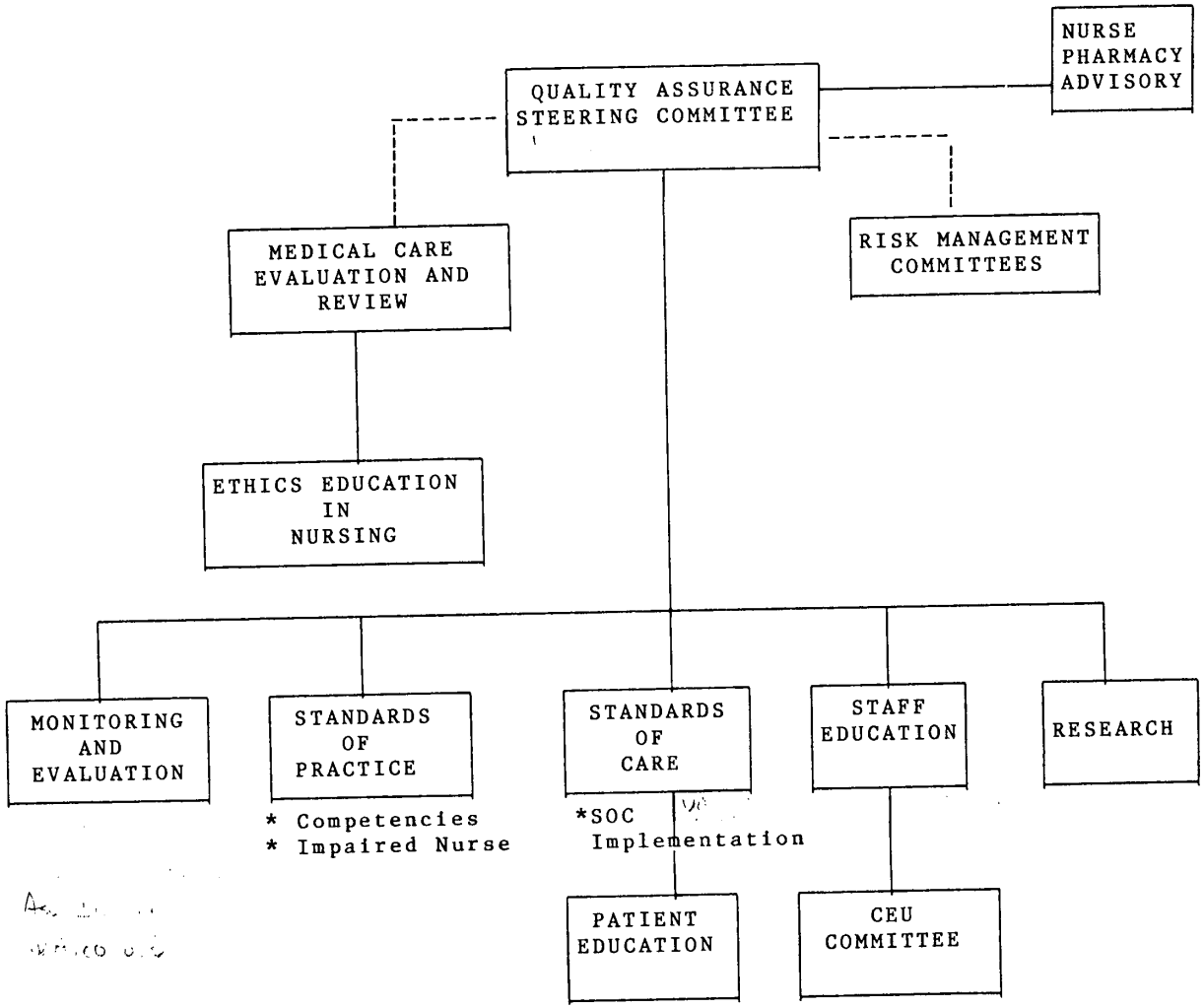
We believe that every nurse is responsible for utilizing the nursing process to assist the patient in restoring and maintaining his/her optimum health status. This is best achieved by organizing our practice based on biophysical and behavioral health parameters as defined by the Nursing Intensity Index.

We believe that professional nursing is an independent and interdependent discipline. Nurses must assume responsiblity and accountability for their practice. We believe that professional practice can best be accomplished through Primary Nursing as the care delivery system. Key components of the delivery system are participative decision making, peer review and collaborative practice. We support that entry into practice is at the baccalaureate level and commit ourselves to recruiting and maintaining competent professional practitioners.

We believe nursing practice at JHH is best accomplished through a decentralized management system. We believe that the office of the Vice President for Nursing Services must assume a pivotal position in facilitating all functional departments to accomplish the goal of quality patient care. In order to assure excellence in the quality of patient care at JHH, this office will monitor compliance to standards of care and change practice based on collected data; incorporate the advancement of technology and automation into practice; maintain a human resource division which focuses on the development of competent professional staff; and promote scientific inquiry which quantifies or qualifies nursing practice and establishes the foundation of future trends in health care.

2/79
Rev. 8/83, Rev. 12/85

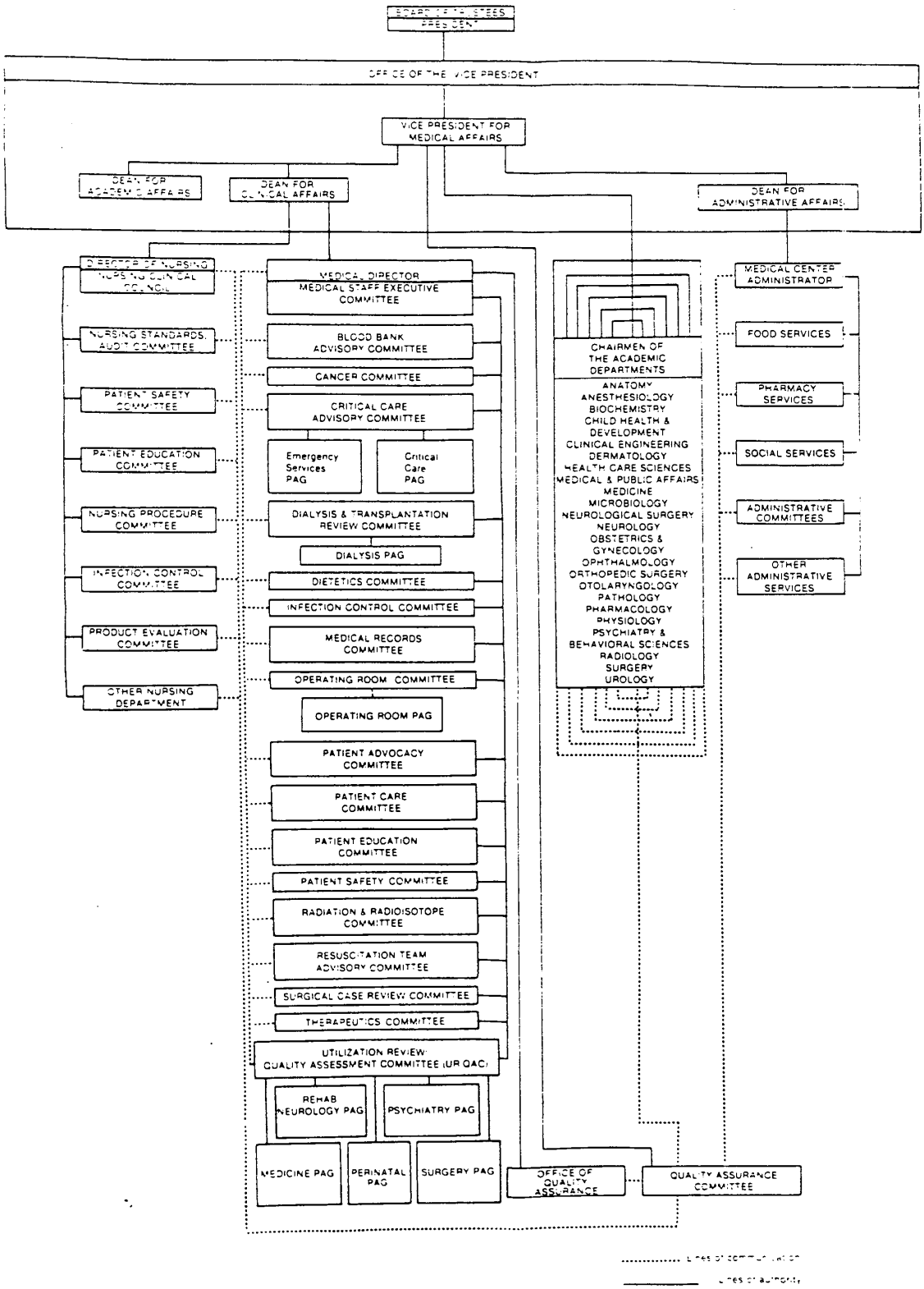
FY 89



*Task Force

QUALITY ASSURANCE PROGRAM

APPENDIX P



MASSACHUSETTS GENERAL HOSPITAL
DEPARTMENT OF NURSING

PHILOSOPHY

We believe that the essence of nursing practice is caring
caring which is a science and an art
is deliverable
teachable
researchable
is accomplished with wisdom, knowledge,
compassion and competence.

We believe that the clinical practice of nursing is built on
a scientific base
that evaluation of nursing practice is
a professional responsibility
that critical thinking and scientific inquiry are
essential to the improvement of practice.

We believe that we have the responsibility to educate ourselves and to educate others
to expand our knowledge and expertise
to share this growing body of knowledge
to provide such opportunities to the greater
health care community.

PHILOSOPHY OF PATIENT CARE SERVICES

We believe in the mission of Greater Southeast Community Hospital -- to provide high quality care to our community.

We recognize the interdependent parts of the health care system of Greater Southeast Community Hospital and Patient Care Services, and dedicate ourselves to work collaboratively with all departments for the mutual goal of high quality patient care.

We believe that:

Man is an individual whose physiological, psychosocial, and spiritual components interrelate for smooth functioning of the whole.

Health is optimum wellness as defined by values, norms, and constraints of the individual, family and, society.

The Environment is recognized as those supports and constraints that influence Man in maintaining wellness.

We recognize and believe Man, Health, and Environment are interrelated components which make up the health care system.

NURSING PHILOSOPHY

We believe in and support an intradependenent, interdependent, independent nursing system with practice derived from client needs and implemented by the nursing process.

We believe that nursing acts to enhance the functioning of Man by supplementing man's available strengths, will and knowledge to achieve his goal of health or peaceful death.

We believe that nurses function as collaborative partners with patients, families, and other members of the health care system.

We believe nursing is practiced in three distinct, yet interdependent roles at Greater Southeast Community Hospital. The three roles, Clinical Practice, Education, and Management, integrate and coordinate to promote and provide high quality patient care. Each role is unique yet integrated by the common goal of quality patient care through the use of the nursing process.

Nursing Practice

We, as nurse clinical practitioners, believe in high quality patient care based on patients' needs.

We believe the nursing process offers a framework for decision making and recognize its importance in nursing planning and communication.

We believe in the concept of primary nursing where an individual nurse practitioner is responsible and accountable for the development and implementation of an individualized plan of care, based on the patient's needs.

We believe the primary nurse must coordinate the patient's care with other members of the health team, in order to provide the best quality patient care.

We believe Man to be an active participant in determining his health goals and thus respect his dignity, worth, and right to make informed decisions.

We believe nurses have a duty and responsibility to actively participate in quality assurance, research, education, nursing committees, and professional activities.

Nursing Education and Research

We recognize the educational and research process as dynamic functions that are an integral part of nursing practice. Utilizing nursing standards, activities are directed toward maintaining a competent nursing staff.

We believe in adult learning theory and its application to educational activities.

We recognize that nursing education supports nursing practice and management by needs assessment, curriculum development, teaching, research, and program evaluation.

We also recognize the importance of free communication and encourage participation during all phases of the educational process.

We believe that nursing education at Greater Southeast Community Hospital must work collaboratively with other health care providers and the community to recognize and respond to identified needs so that resources can be utilized effectively.

Nursing Management

We, as managers at Greater Southeast Community Hospital, believe in the mission of the hospital system with nursing as an integral component.

We recognize the managerial process as dynamic functions based on standards which are accomplished by decentralized decision making at all levels of practice.

We believe in participative management as an important element of response to the constantly changing needs of the health care system -- clients, staff, and agency.

We support the educational and research process which functions to develop nurses and expand nursing knowledge toward improvement of health care.

We recognize the formal and informal communication process as a unifying concept that flows vertically and horizontally to maintain an open system.

We believe the nursing management at Greater Southeast Community Hospital must work collaboratively with the community and other health care providers to recognize and respond to the influences of the environment, the resources, values, social and political forces.

The three roles of nursing within Patient Care Services are integrated, yet independent. All three, clinical practice, management, and nursing education and research, recognize Man as the focus of the health care delivery system.

Each nursing role utilizes a decision-making process with clearly defined subfunctions that, when integrated, provide the individual employee and patient a progressive environment where change, growth, and opportunity are present.

Information for Employees on Beth Israel Hospital's Patient Care Assessment Program

A new Hospital-wide Patient Care Assessment Program has been established to replace and expand the Hospital's existing quality assurance and risk management programs. The goal of this new program is to help assure the delivery of optimal patient care through the establishment of ongoing patient care review mechanisims. The program is designed to comply with the recently issued requirements of the Massachusetts Board of Registration in Medicine and encompasses all clinical departments, services, and committees involved in the provision of patient care.

The Patient Care Assessment Committee

A major component of this program is the appointment of a governing board committee, the Patient Care Assessment Committee. This joint committee of the Hospital and the medical staff has overall responsibility for coordinating and integrating the responsibilities of the Patient Care Assessment Program. Its directives are accomplished through the Director of Quality Assurance and Risk Management (Patient Care Assessment Coordinator) and through the operation of departmental and service-specific quality assurance mechanisms.

Specific Responsibilities of Employees

Incident Reporting: An essential component of the Patient Care Assessment Program is the early identification and reporting of patient care-related incidents and injuries. All employees involved in patient care are required to report patient-related incidents and injuries, including, but not limited to, slips and falls, equipment malfunctions, and burns, in writing, to the Director of Quality Assurance and Risk Management. An Incident Report form must be completed for any incident or occurrence which is not consistent with the expectations arising from the routine care of the patient or the routine operation of the Hospital. Employees should let their supervisor know about any incident. If you have any questions on the incident reporting system, speak to your supervisor.

Risk Management: Risk Management is also a function of quality assurance. A major component of risk management is the reporting of events which may represent potential liability. Staff involved in patient care should report promptly to the Director of Quality Assurance and Risk Management (x2624) and their supervisor the following:

a) Any unexpected occurrence or medical event where there appears to be the possibility of patient or visitor injury, or where a claim against the Hospital or member of the professional staff could result

b) any request for information or medical records data by a patient's attorney or other external source

c) any notice or threat of legal action or demand for compensation

Patients' Rights

Beth Israel Hospital was the first hospital in the country to issue a statement on patients' rights. This statement is given to each patient upon admission to Beth Israel. At Beth Israel we have no ombudspersons because all employees are expected to act as patient advocates. Employees are to act on patient concerns and complaints promptly or direct them to their supervisor for proper action. Complaints relative to patient care are to be reported to your supervisor and the Director of Quality Assurance and Risk Management.

It is the responsibility of every employee to follow these guidelines as an expectation of their employment to the Hospital.

March 1988

APPENDIX U

Unit:_____

DEPARTMENT OF NURSING

SURVEY OF RECENTLY HIRED STAFF NURSES

1. How (where, when) did you first hear about (or learn about) GWU Hospital?

2. Why did you chose to interview here?

3. What influenced your decision to accept the offer of an appointment here?

4. During the application or interview process, what was your most

   a) positive experience

   b) frustrating experience

5. If you could make one suggestion for how the Department could improve or increase recruitment, what would it be?

Question 5: If you could make one suggestion for how the Department could improve or increase recruitment, what would it be?

Response That Were Related to Retention:

°Decrease Per Diem Salary/Increase Regular Staff Salary	3
° Increase Salary	3
° Better Staffing	3
° Increase Orientation To Unit Speciality	2
° Offer Bonus For Longevity	2
° Maintain Good Standards	2
° Live Up To Promises	1
° 12 Hour Shifts	2
° Permanent Shifts	1
° 4-10° Shifts	1
° Increase Flexible Hours	1
° No Wait For Parking	1
° Increase Retention Focus	1
° Improve Inservice Department	1
° Improve Respiratory Department	1
° Put Bathrooms in Rooms	1

Question 5: If you could make one suggestion for how the Department could improve or increase recruitment, what would it be?

Response That Were Related To Recruitment:

° Recruitment at Colleges	5
° Send Staff Nurses to Recruit	2
° New Grads to Recruit	2
° Attend Career Days	1
° Respond To Inquires ASAP	2
° Follow-up After Offer	1
° Increase Access to Nurse Recruiter	1
° Put Everything In One Building	1
° Make Applicant Feel Welcome	1
° Improve Paperflow	1
° Give Tour Of Hospital	2
° Free Parking	2
° Advertise More	1
° Advertise Tuition More	1
° Offer More Student Experiences	1
° Continue High Salary	1
° Offer Flexible Hours	1
° Pay Relocation Fee	1
° Offer Bounty For Hire	1
° NUC Should Not Act Desperate	1

Question 3: What influenced your decision to accept the offer of an appointment here?

Responses:

° Salary	16
° Benefits	13
° Tuition Benefits	11
° Location	11
° Metro Proximity	5
° Unit Speciality Available	12
° NUC	9
° Friendly People	5
° Meeting Unit Staff	4
° Schedule	5
° Teaching Hospital	3
° Hospital Reputation	2
° Roommate Got Offer Also	2
° Comfortable With Environment	1
° Low Unit Turnover	1
° Orientation Program	1
° Prompt Offer	1
° Unit Reputation	1
° Type of Position Offered	1
° Unit RN Support Group	1
° GWU Acceptance of Indigent Patients	1

Question 4: During the application or interview process, what was your most

a.) Positive Experience?

Responses:

° Nurse Recruiters (J. Bahm, T. Everhart)	13
° Interview With NUC	12
° Being Able To Have Two Interviews On One Day	2
° Meeting Staff	10
° Relaxed, Friendly Atmosphere	6
° Nice People	3
° Prompt Offer	5
° None	4
° Unit Tour	2
° Made to Feel Capable	1
° Unit Speciality Available	1
° Work Schedule	1

Question 4: During the application or interview process, what was your most

b.) Negative Experience?

Responses:

° No Negative Experience	18
° Parking	4
° Setting Up Interviews	3
° Interview	3
° Lack of Information	2
° Unable to Meet NUC	1
° Resume Lost	1
° Applicant's Lack of Interview Skills	1
° Never Received Brochure	1
° Unable to Get Hospital Tour	1
° Providing Proof of Citizenship	1
° Setting Appoint For Physical	1
° Finding Buildings	1
° Waiting For Paperwork	1

Question 1: How (where, when) did you first hear about (or learn) about GWU Hospital?

Responses:

° Friend/Relative	18
° Newspaper Ads (Washington Post 6 including one Open House ad)	10
° Nursing Journal Ads (AJN 1, Nursing '87 1)	5
° College Clinical Experience (Catholic U. 3, Marymount U. 1)	5
° Area Native	5
° College Career Days	4
° Job Fairs	3
° Rehire	2
° GWU Reputation	1
° Investigated All Area Hospitals	1
° Peterson's Guide to Hospitals	1
° Traveling Nurse Corps	1

Question 2: Why did you choose to interview here?

Responses:

° Location	13
° Metro Proximity	3
° Teaching Hospital	15
° Unit Speciality Available	11
° Benefits	3
° Tuitition Benefits	6
° Hospital Reputation	6
° Positive Comments From Friends	6
° Interviewed In Several Area Hospitals	6
° Salary	4
° College Clinical Experience	3
° Worked here as SNA	2
° Marymount BSN Tuition	1
° Knew NUC	1
° Open House Visit	1
° Unit Reputation	1
° Schedule Available	1
° Information From Personnel	1
° To Practice Interviewing	1
° Size of Hospital	1

DEPARTMENT OF NURSING

Report of the Survey of Newly Hired Staff Nurses

Purpose & Methodology

A survey of newly hired nurses was conducted in December 1987 to collect information useful in planning recruitment activities. The data was collected by the Nursing Supervisors who identified staff on duty from a list of 141 nurses hired between January 1987 and December 1987. Each nurse was given a questionnaire and it was collected at the end of the shift.

The Questionnaire

(Attached)

Findings

48 questionnaires were completed. Although the questions were open-ended, many responses were similar and were therefore grouped together. A list of the responses to each question is attached to this report.

Conclusions

* Promotion of the Hospital by our employees influenced nurses to apply here.

* Advertising in the Washington Post and Nursing Journals influenced applicants.

* Promotion of our Department at Schools of Nursing (through career offices and student clinical experiences) influenced applicants.

* Common reasons for choosing to interview and accept a position here included: the hospital's location and reputation, the fact we are a teaching facility, the preferred clinical specialty was available, the educational benefits and salaries.

* Many nurses who responded made reference to having been positively influenced by the interviews with nursing recruiters and with Nursing Unit Coordinators. Although we do not know if a negative interview experience results in declining a position, it is evident that positive interview experience makes a good impression.

* The most frequently cited negative experience for applicants was trying to park their cars.

* The most frequently listed suggestion for improving recruitment was to have our own staff nurses attend career days and visit schools of nursing.

* Responses to Questions 4 and 5 indicate a need for us to facilitate efficient processing through the application process, including:

    -prompt responses to inquiries/applicants
    -prompt arrangement of an interview
    -prompt responses of the results of the interview
    -timely generation of the NOA letter.

UNIT:_____

DPEARTMENT OF NURSING

SURVEY OF RECENTLY HIRED STAFF NURSES

1. How (where, when,) did you first hear about (or learn about) GWU Hospital?

2. Why did you choose to interview here?

3. What influenced your decision to accept the offer of an appointment here?

4. During the application or interview process, what was your most

   A)positive experience?

   B)frustrating experience?

5. If you could make one suggestion for how the Department could improve or increase recruitment, what would it be?

APPENDIX V

MASSACHUSETTS NURSES ASSOCIATION

MASSACHUSETTS NURSES ASSOCIATION
376 BOYLSTON STREET
BOSTON, MA 02116
(617)4825465

OFFICE USE ONLY
MNA #_____
SFS/INDIVIDUAL
CHECK AMT $_____
POSTMARKED_____

****

APPLICATION FOR APPROVAL OF CONTINUING EDUCATION CREDIT
SINGLE OFFERING

Sponsoring Agency_____ Contact Person_____

_____ _____

_____ _____

Address_____ (If Different)_____

_____ Zip_____ _____ Zip_____

Telephone_____ (If Different)_____

Submit: 1. Two (2) typed copies to Staff Development Services
2. Materials at least 45 days prior to offering.
3. OFFERING OUTLINE - must be on the enclosed "grid"

OFFERING TITLE_____

District_____ Location_____

Contact Hours Requested: _____ Granted: _____

Announce this Offering in THE MASS NURSE No_____Yes_____ If yes, answer the following: Telephone Contact:_____Offering Fee:_____

I/We state that the information submitted is complete and accurate and meets the definition of C.E.

_____

Signature Title Date

2/77 REV 8/87
MASSACHUSETTS NURSES ASSOCIATION

CRITERIA	SUBMITTED
A. **Resources**	**A. Resources**
1. A person is identified to be administratively responsible for planning and producing the offering	1. Administrative Bio Sketch Attached_____
2. A minimum of two R.N.'s (one with a minimum of a B.S.N) are involved in the planning process	2.Bio Sketches Attached_____
B. **Target Audience and Needs Assessment**	**B Target Audience/Needs Assessment**
1. The target audience is identified	1. Describe:
2. The offering is developed based on a documented need of the potential participants in relation to topic, scheduling and location.	2.Describe how the need for this offering assessed and how learner input was considered in the planning process: _____Expressed needs (written/verbal) _____Recommendations from Q.A. Studies _____Recommendations from Nsg Mgt. _____Recommendations from Ed. Com. _____Program Evaluations _____Survey re:location/schedule _____Other (specify):
C. **Objectives**	**C Objectives**
1. Objectives for the offering are stated in operational/ behavioral terms that define the expected outcomes for the learner.	1. ADDRESS CRITERIA "C-F" ON REQUIRED "GRID"(enclosed) Submitted on "Grid" _____
D.**Content/ Time Frame**	**D Content/Time Frame**
1. Offering content is related to and consistent with objectives. Each objective has corresponding content.	1. Submitted on "Grid" _____
2. Content is described in the form of a content outline with corresponding time .	
3. Time alloted for the offering is consistent with objectives and is appropriate for the content being presented.	

CRITERIA	SUBMITTED
E. Faculty	**E Faculty**
1.Faculty /presenters take an active part in planning and evaluating their presentations.	1. Describe how faculty participate in planning/evaluating: See "Grid"_____
2. Faculty/presenters present content in an area in which they have knowledge and expertise.	2. Faculty Bio Sketch Attached _____
F. Teaching Methods:	**F. Teaching Methods**
1. Methods are congruent with the offering obejctives and content presented.	1. Identified on "Grid"
2.Reflect the knowledge of adult learning principles.	2. Explain how adult learning principles are utilized:
G. Physical Facilities	**G. Physical Facilities**
1. The site for the offering will accomodate teaching methods employed, environmental comfort and target audience accessibility.	1. State Room Capacity _____ 2. Number of learners to attend_____ 3. Identify room set up: _____Classroom _____Theater _____Breakouts _____Conference _____Other:
H. Coprovidership	**H. Coprovidership**
If the offering is to be Coprovided, a written agreement exists between your agency and the Coproviders which identifies YOUR agency's responsiblity for: 1. Administration of the budget 2. Determination of objectives and content 3. Selection of faculty/presenters 4. Awarding of contact hours 5. Record keeping for the offering 6. Evaluation	Coprovided? _____Yes _____NO If yes, written agreement attached _____

CRITERIA	SUBMITTED
I Evaluation	**I Evaluation**
There is a clearly defined method for evaluation of the following: 1. Learner's achievement of each offering objective 2. Teaching effectiveness of each faculty/presenter 3. Relevance of content to objectives 4. Effectiveness of teaching methods 5. Appropriateness of physical facility 6. Achievement of personal objectives by the learner	1.Evaluation by: _____Test _____Rating Scale _____Other: 2. Copy of Tool(s) attached _____

NOTE: **Submit attendance only to Staff Development Services**
J-K will be done by Staff Development Services

J. Verification of Attendance	**J. Verification of Attendance**
Participants will receive written verification of the following: 1. Attendane at the offering 2. Number of contact hours awarded 3. Provider of the offering 4. Title, date and location of the offering . 5. Appropriate statement of approval which indicates the organization that has approved the offering for contact hour credit.	1. Sample Certificate attached _____
K. Record Keeping	**K. Record Keeping**
1. Records are kept for the offering that include the following essential information: a. Title b. Name/Title of administratively responsible person. c. Names/Titles of planning committee members d. Name/Title/Bio Sketch for each faculty/presenter e. Starting and ending dates f. Name/address of facility where offering held g. Objectives/content/time frame/ teaching methods and evaluation h. Description of the target audience i. Method used to determine the need for this offering j. Participant names etc. k. Contact hours awarded to each participant l. Summary of evaluations m. Coprovidership agreement (if applicable)	1. I/ We agree to maintain the following records/ information for a 5 year period in a secure area, available only to authorized personnel, for retrieval of essential information: _____A copy of the MNA application _____A roster of all participants _____ Record of contact hours awarded to each participant _____A summary of evaluations _____Coprovidership agreement (if applicable)
2. A system exists for storage of records which allows for retrieval of essential information.	2. Identify personnel authorized to access C.E. records: (by category/title)
3. Records are kept for 5 years and are available only to authorized individuals.	

Study Results

The participants generated 438 training topics. It should be noted that some topics were reduntant across services. The topics receiving the highest mean within each service were as follows:

Pediatrics

Bedside emergencies
Ethical issues in pediatrics
Death & dying in pediatrics
Infectious diseases
AIDS & pediatrics
Working with families

OR Services

Types & expected outcomes in day surgery anesthesia
New anesthetic agents
New relaxants in anesthesia
New preop medication & reversal drugs
AIDS update

Critical Care

Ethical dilemnas in CC nursing
Legal aspects of CC nursing
CPR drugs, new AHA standards
New Drugs
Retention activities at MGH

Clinical Teacher

Implementation of PBDS
Developing self directed packets
Becoming computer literate
Improving alternative learning statagies

Ortho/Neuro

Suctioning techniques
AIDS
Bedside emergencies
Trauma

Surgery

Bedside emergencies
EKG interpretation & arrhythmias
New cardiac medications
AIDS
Coping with the nursing shortage

Medicine

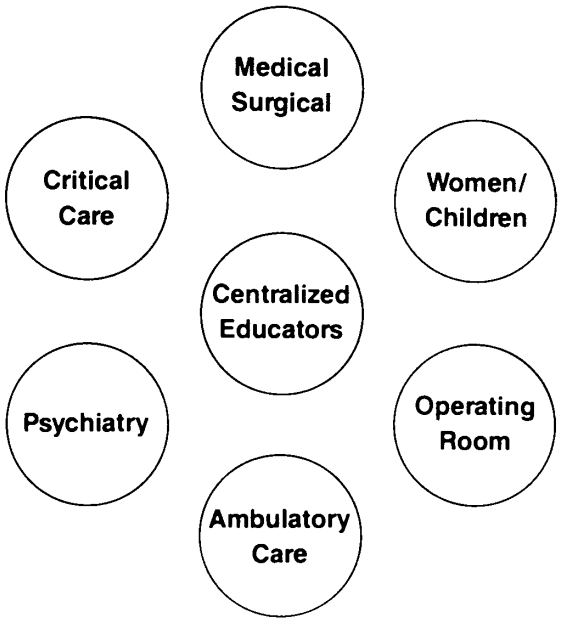
Care of the resporatory patient, COPD, failure
Bedside emergencies
AIDS
EKG interpertations
Current drug therapies

The 1988 training programs will address the revealed needs through the cooperative activities of the Staff Development Service personnel, the Clinical Teachers, CNS and other clinical service personnel.

CLINICAL EDUCATOR MODEL

Excellence Through Education

Clinical Resource Division
Clinical Career Pathway
Mount Sinai Hospital
Department of Nursing
New York City



CENTRALIZED ROLE:

- Orientation
- Staff Development
- JCAH Programs
- Critical Care Program
- Leadership Workshop
- Liaison With Units
- Quality Monitoring
- Hospital Committees

DECENTRALIZED ROLE:

- Orientation
- Staff Development
- JCAH Programs
- Individual Learning Assessment
- Preceptor Development
- Contract Time for Centralized Programs
- Quality Monitoring
- Hospital Committees

ALTERNATIVE TEACHING STRATEGIES:

- Assessment Center
- Learning Lab
- Self Directed Learning Modules
- Learning Agreements
- Professional Update
- Clinical Update
- Travenol PBDS

THE MOUNT SINAI HOSPITAL
DEPARTMENT OF NURSING
CLINICAL RESOURCE DIVISION
CLINICAL CAREER PATHWAY

Clinical Educator Model

The Clinical Resource Division/Clinical Career Pathway (CRD/CCP) provides all levels of nursing personnel with learning opportunities for competent job performance in the delivery of quality patient care. The division also assists the Department of Nursing to maintain and advance the standards of nursing practice through quality monitoring and other evaluative systems that help assess the functioning of the organization. Two important departmental committees, Clinical Guidelines and the Nursing Documentation Review Committee are the responsibility of the division.

The Clinical Educator Model is a proposal to meet the needs of the Department of Nursing with both a centralized and decentralized focus. With the rapid, increase in health care technology, the increase in the acuity of patients coupled with the current nursing shortage, a unit based staff development/education model becomes imperative. Simultaneously, the need for centralized educational programs becomes necessary to comply with standards set forth by accrediting agencies, to reflect changes in nursing practice, and to market educational programs to the outside nursing community.

Thus, the CRD/CCP developed the Clinical Educator Model, which emphasizes both centralized and decentralized roles for the staff development instructors. Each role involves clear and distinct responsibilities This operational model provides orientation and staff development programs that are consistent with the patient needs, unit/staff needs and philosophy of the Department of Nursing.

Within our 1200 bed facility, the Clinical Educator Model requires 22 instructors: 18 are decentralized; 4 are centralized. Coupled with this Model is the Travenol Competency Based Instruction Program (PBDS) which emphasizes self-directed learning modules as well as competency based education principles.

It is this unique combination of the educator's role and teaching strategies which can better meet both the practice and educational needs for the development of nursing staff.