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Network News

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Expert Perspectives

The Future of Nursing

On October 5, 2010, the Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) jointly released *The Future of Nursing: Leading Change, Advancing Health,* a blueprint for transforming both American health care and the nursing profession.

The report's second recommendation, "Expand opportunities for nurses to lead and diffuse collaborative improvement efforts," has special relevance for the ISRN, says Susan B. Hassmiller, RN, PhD, FAAN, who led the

"To lead and work collaboratively with other disciplines, nurses must educate themselves and continuously learn."

SUSAN B. HASSMILLER, RN, PHD, FAAN, SENIOR ADVISOR FOR NURSING, RWJF

Initiative on the Future of Nursing study at the IOM and who advises RWJF's president on nursing issues. Hassmiller is now directing the Future of Nursing: *Campaign for Action,* a

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Landmark Network Study to Begin in Spring 2011

The Improvement Science Research Network (ISRN) will launch the first of three national network studies in Spring 2011, says Darpan Patel, PhD, the ISRN's clinical research project manager at the network's Coordinating Center, University of Texas Health Science Center at San Antonio. "While there are some limitations on study participation, we are looking to be as inclusive as possible." Individual ISRN membership is required but institutional membership is not, Patel says.

Frontline clinicians are too often frustrated by small operational failures, such as broken equipment and missing supplies, that can adversely affect patient care. The first national multisite network study will test a low-tech, low-cost way to identify and resolve such problems.

The inaugural multisite network study, Small Troubles, Adaptive Responses (STAR-2), will, for the first time, involve a large sample of hospitals across the country in testing bedside clinicians' use of "pocket cards" to identify and report small operational failures—such as missing supplies, malfunctioning equipment, and poor communication—that waste time and can diminish care quality.

"There is often a gap between what management knows and what frontline workers know, and that gap can lead to disillusionment and cynicism for the front line," says Robert L. Wears, MD, MS, professor, Department of Emergency Medicine, University of Florida, and ISRN Steering Council member. "You don't think to tell an executive about a fax machine that routinely eats crucial paperwork, even when that problem has a significant impact on your ability to do your job. Something like the pocket card study is interesting because it addresses that information gap in a low-tech way without a big investment."

To learn more about the three network studies, visit www.isrn.net and select "Newsletter" (October 2010) and "Events" (October 26, 2010, Web Event). To express interest in pocket card study participation, use the "Contact Us" information on page 6, column 3.

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collaboration between RWJF and AARP to implement IOM report recommendations.

"The IOM report committee was keenly aware that nurses are in a prime position to lead quality improvement because they are there on the front lines, and they see the good patient outcomes and the bad patient outcomes," says Hassmiller.

"If nurses don't provide information and structure to quality improvement, the QI process will be imposed by others—such as regulators—who are far from the front lines."

"Though nurses are in a key position to speak up about needed improvements in the system and patient care, many are reluctant to do so," says Hassmiller. "That's where the ISRN is so valuable. It can be one part of the movement to advance health care reform."

Hassmiller notes that the IOM report defines educational progression and lifelong learning—in recommendations 3 through 7—as keys to successful leadership. "To lead and work collaboratively with other disciplines, nurses must educate themselves and continuously learn."

The Future of Nursing: *Campaign for Action* is now forming Regional Action Coalitions (RACs) to help implement report recommendations.

To access the IOM report and to learn more about the RACs, visit www.thefutureofnursing.org.

Care Coordination: A National Priority

Too many patients in America suffer from fragmented care, both while they are in the hospital and after they are discharged. Elderly people and those with chronic conditions are especially vulnerable, because they tend to see many providers, often with only themselves or a family member to remember and share with other providers details of the diagnoses, treatments, medications, and needed follow-up. Even within a single treatment setting, the potential for harm from poor coordination is great: many patients, for example, move three to six times during one hospital stay, say experts. Lack of proper care coordination results in waste and poor patient outcomes.

The ISRN has defined care coordination and transitions of care as a top priority for national research. This focus dovetails with a range of recent initiatives of the National Quality Forum (NQF).

To advance care coordination, NQF has released a set of endorsed practices and quality measures. It presents a set of preferred practices and performance measures divided into five domains: health care home, proactive plan of care and followup, communication, information systems, and transitions or handoffs.

Fragmented care is harmful to patients, wasteful of staff time, and very costly for U.S. health care. The ISRN has identified better care coordination, including effectively managed transitions in care, as one of its national research priorities.

at NQF. "A key aspect of care coordination is getting the patient's perspective and input." Kennedy argues for a health care home that is accountable for coordinating a patient's care, as well.

NQF also convenes the National Priorities Partnership (NPP), which has defined care coordination as one of eight national priorities. In October, NPP provided recommendations to the secretary of the Department of Health and Human Services for the development of a National Healthcare Quality Strategy and Plan. The national priorities will inform practices in private organizations as well as policymaking at the state and federal levels.

According to NPP, making care coordination a national priority will diminish harm to patients by reducing medication errors and adverse events after discharge, improving minority patients' access to primary care, ensuring timely patient followup after discharge, and cutting waste by lowering the number of readmissions within six months.

"Care coordination requires rethinking the traditional models of care delivery. We need performance measures so we know whether we are making progress toward desired outcomes."

ROSEMARY KENNEDY, RN, MBA, FAAN, ASSOCIATE PROFESSOR, THOMAS JEFFERSON UNIVERSITY SCHOOL OF NURSING, AND MEMBER, ISRN STEERING COUNCIL

NQF's Steering Committee on Care Coordination is cochaired by Gerri Lamb, PhD, RN, University of Arizona, who has been defining and testing six nurse-sensitive performance measures that relate to care coordination, a project that many are watching with interest.

"Care coordination is critical for everyone across all venues of health care," says Rosemary Kennedy, RN, MBA, FAAN, associate professor, Thomas Jefferson University School of Nursing. Kennedy serves on the ISRN Steering Council and was formerly senior director of nursing and health care informatics

"Care coordination requires rethinking the traditional models of care delivery," says Kennedy. "We need performance measures so we know whether we are making progress toward desired outcomes. The ISRN has created an infrastructure for interprofessional collaboration that will allow studies to define and test specific process measures."

Featured Research: Addressing Systems Problems

Anita Tucker, DBA, associate professor, Harvard Business School, specializes in understanding the natural response of frontline providers to system breakdowns. She has found that nurses spend 7 percent of their day doing work-arounds, forcing them to stay later. "This represents a real loss in patient care activities they had wanted to do but didn't have time for," says Tucker.

Manager attitudes may keep problems in place, says Tucker. "When the manager's message is 'Don't bring me problems. Bring me solutions,' managers won't hear about problems that employees can't solve themselves." For example, if nurses are not getting medications in the form they need, that's a problem that the pharmacy needs to address. But no one will know about it if the nurses just work around the problem.

On the other hand, Tucker says that in some ways, frontline providers can derive satisfaction and a sense of competence from their ability to work around problems that come up in a day's work, again leaving systemic problems in place.

"Go to the unit that wants to work on the problem and give them resources and time."

ANITA L. TUCKER, DBA, ASSOCIATE PROFESSOR, HARVARD BUSINESS SCHOOL

Tucker offers insights into system improvement. Currently, to the detriment of system performance, she says, there is a tendency for each department to be measured and monitored as if it is its own system. Although this is easier than focusing on the whole system, it doesn't really work when you have system interdependencies.

Tucker argues that expanding improvement capabilities is crucial. "Go to the unit that wants to work on the problem and give them

resources and time. Have people practice improvement, create a culture and mind-set that says, 'We know how to make change as part of the daily work rather than something done on top of all the other work.'"

In an institution committed to improvement, the pocket card network study could be especially useful in addressing system problems, Tucker says, because it can alert frontline employees to how their workdays are shaped by many small problems that keep them away from patients (see "Landmark Study," p. 1, for more). Tucker will present at the February 16 web event described in column 3.

Research Resources: *Systems Change*

To learn more about Anita Tucker's research, consult the following references:

Tucker, Anita L., and Amy C. Edmondson. 2003. Why hospitals don't learn from failures: Organizational and psychological dynamics that inhibit system change. *California Management Review* 45 (2): 1–18.

Tucker, Anita L. 2004. The impact of operational failures on hospital nurses and their patients. *Journal of Operations Management* 22 (2): 151–69.

Tucker, Anita L., Sara J. Singer, Jennifer E. Hayes, and Alyson Falwell. 2008. Front-line staff perspectives on opportunities for improving the safety and efficiency of hospital work systems. *Health Services Research* 43 (5): 1807–29.

Web Events Update

Uniting Frontline and Leadership Capacities to Improve Patient Care
Wednesday, February 16, 2011 at 2:00 p.m. EST

Presenters will discuss how frontline clinicians and organizational leaders can collaborate to overcome patient care challenges. The web event will also review how these concepts apply to improvement science and the ISRN multisite network studies.

Quality Improvement through Team Performance
May 2011: More details soon

Learn about TeamSTEPPS, an evidence-based system designed to improve patient outcomes by fostering improvements in teamwork and communication skills among members of the health care team. The goal of the study is to understand TeamSTEPPS as an improvement science demonstration model by evaluating how teams work in real-world clinical settings.

If you missed our earlier web events, you can access them online as audio files or transcripts. Visit the ISRN web site for links.

For details, registration, and past events, visit the ISRN web site: www.isrn.net.

Improvement Science Summit Set for June 28–29, 2011

Following on the heels of the successful inaugural Improvement Science Summit, this year's event will again connect with the Summer Institute on Evidence-Based Practice, which has topped 500 attendees and is now heading into its 10th year.

The second Improvement Science Summit will feature expert plenary presentations, short presentations followed by panel reactions, and concurrent sessions to accommodate formation of the multisite network studies. Each session will encourage audience questions.

Invited experts include John Ovretveit, PhD, Stockholm, improvement research expert; Kara L. Hall, PhD, National Cancer Institute, team science expert; and Virginia Moyer, MD, MPH, Baylor College of Medicine, quality expert.

The inaugural Summit's 266 attendees from 30 states gave strong evaluations to the event. For a detailed overview of major conference sessions, visit www.isrn.net and download *Network News* vol. 1, no. 2.

The cost of the second Summit will be $300 per attendee plus travel-related expenses. Continuing Education (CE) credits for nursing are being sought. If CE credits are granted for nursing, other health professionals may request CE credits from their own accrediting bodies.

See www.isrn.net soon for details and a registration link or to submit an abstract for the Summit.

Expert Perspectives

Urgent Patient Safety Problems

"Patient safety as a field has lost some steam. In focusing on interventions that can lead to immediate impact, patient safety research often ignores deeper fundamental issues."

ROBERT L. WEARS, MD, MS, PROFESSOR OF EMERGENCY MEDICINE, UNIVERSITY OF FLORIDA HEALTH SCIENCE CENTER, AND MEMBER, ISRN STEERING COUNCIL

"Patient safety as a field has lost some steam," says Robert L. Wears, MD, MS, professor of emergency medicine, University of Florida Health Science Center, and member, ISRN Steering Council. "In focusing on interventions that can lead to immediate impact, patient safety research often ignores deeper fundamental issues. This may happen because people tend to choose problems that are easy to work on and don't threaten the established order."

Wears argues that the methods used most often to study human error in complex systems—for example, methods from psychology, engineering, and sociology—aren't common on campuses of academic medical centers and are seldom evident in discussions. Yet these excluded disciplines are equipped to address fundamental issues that medical researchers can miss.

Developing a cross-disciplinary approach to patient safety would be helpful, particularly in light of the complexity of problems facing health care and threatening patient safety. Wears offers two examples.

There is too often a mismatch between demand for care and capacity to provide care, Wears says. When demand exceeds resources, care providers get overloaded with work, and they cut corners, work faster, and don't document as well. "These adaptations allow work to continue, but with inattention and degradations in quality. For example, sometimes, when an overly busy nurse has hung the wrong blood, the nurse looked at the patient's armband, but did not register the mismatch and hung the blood anyway." Human factors engineering could make the right choice nearly unavoidable.

Another urgent issue relates to health information technology (HIT). "Many systems used in health care were originally engineered for business systems, in contexts where the stakes were low if problems occurred," says Wears. "They were not engineered with safety in mind." Ideally, HIT should be engineered so that system failures will still be safe for patients.

Wears challenges improvement science to look at its own methods through the interdisciplinary lens. He notes, for example, that health care lionizes the randomized controlled trial though it is impractically expensive and ignores local context. "Improvement science is well positioned to answer the question, what leads to biases and problems?"

RWJF Award Announcement

Robert L. Wears, MD, MS, University of Florida Health Science Center, and coinvestigator Kathleen M. Sutcliffe, PhD, University of Michigan Ross School of Business, recently received a grant through the prestigious Investigator Awards in Health Policy Research program of the RWJF.

Their project, titled Medicalizing Patient Safety, will document and account for the ways discussions of quality and patient safety have become less cross-disciplinary in the past 20 years. The researchers will also explore ways of building the capacity that will lead to more—and more effective—collaborations across disciplines to improve patient safety.

ISRN Member Spotlight

KATHLEEN R. STEVENS, EdD, MS, RN, ANEF, FAAN, ISRN PRINCIPAL INVESTIGATOR

Note FROM THE DIRECTOR

Members are the lifeblood of the ISRN, and I am delighted to announce that the network now has almost 200 individual members and its first institutional member, Palmetto Health Richland. To bring you member news and views, *Network News 3* inaugurates the "ISRN Member Spotlight." This first Spotlight focuses on what members see as the advantages of ISRN membership and on the synergies between ISRN activities and education and academia. For more on member services and benefits, see page 6.

"The ISRN offers resources, rich opportunities for access to research populations, and data banks that can take us to another level in our professional work."

JULIE COWAN NOVAK, DNSC, RN, CPNP, FAANP, ASSOCIATE DEAN, PRACTICE AND ENGAGEMENT, JOSEPH AND THELMA CROW ENDOWED PROFESSORSHIP, UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER SCHOOL OF NURSING, DIRECTOR, UTHSCSA STUDENT HEALTH CENTER, EMPLOYEE HEALTH AND WELLNESS CLINIC, AND UT NURSING CLINICAL ENTERPRISE

Julie Cowan Novak develops university- and community-based clinics managed by advanced practice nursing faculty. Graduate nursing students serve on the front lines of quality improvement. "Health care reform is expected to bring at least 31 million uninsured or underinsured people into the health care system," says Novak. "We need to focus on cost-effective prevention and early intervention in a multidisciplinary, integrated mosaic of primary health care support, including mental health, dentistry, physical therapy, pharmacy, and audiology. To do this effectively, we need the best possible evidence base for care. The ISRN offers resources, rich opportunities for access to research populations, and data banks that can take us to another level in our professional work."

"Our ISRN membership will allow us to learn, move forward, and make an impact on care quickly because we won't have to reinvent the research wheel."

FORREST FORTIER, RN, BSN, MSTD, DIRECTOR OF NURSING EDUCATION AND RESEARCH, PALMETTO HEALTH RICHLAND

Palmetto Health Richland (Columbia, South Carolina), the first institutional member of the ISRN, is a busy institution that plays a vital role in its region. For example, its 1,528 registered nurses support 79,488 emergency room visits and 40,230 inpatient admissions a year. "While research and quality improvement are already part of the culture at Palmetto Health Richland, becoming an institutional ISRN member will allow us to integrate nurse-driven research projects on a larger scale," says Forrest Fortier. "Our ISRN membership will allow us to learn, move forward, and make an impact on care quickly because we won't have to reinvent the research wheel. In addition, participation in a network study will allow our nursing staff to contribute to the body of nursing knowledge without taking them away from patients' bedsides."

"I see the ISRN as a place where people can have conversations about how change gets made."

KATHERINE JONES, PT, PHD, ASSISTANT PROFESSOR, DEPARTMENT OF PHYSICAL THERAPY EDUCATION, SCHOOL OF ALLIED HEALTH, UNIVERSITY OF NEBRASKA MEDICAL CENTER

Katherine Jones considers herself a bit of an odd duck. She practiced as a physical therapist for 20 years, teaches in a physical therapy program, and does patient safety and quality work for small rural hospitals in her state. But it's a combination of interests that makes sense, she says. "By 2020, physical therapists will be preferred providers for musculoskeletal disorders, and they will take on increasing importance in rural settings."

For Jones, the ISRN is the answer to a couple of key questions: "How do you become a researcher when you have few resources? And how do you become a learning organization if you don't have researchers? The ISRN offers a wealth of resources to support research, including technical help, training, an infrastructure for data collection and sharing, and more," she says.

"The ability to link what you have done in your practice with a theoretical framework is what moves practice forward," says Jones.

Survey Informs ISRN Member Services

"To get a refined look at things that we knew would be common member needs," says ISRN principal investigator Kathleen Stevens, "the ISRN surveyed 2,777 individuals with roles relevant to the ISRN mission" (February 2010). Highlights of several key findings and ISRN responses follow.

The most frequently cited need was help with funding and funding sources. In response, the ISRN is providing seed money to network study sites and assembling a comprehensive web resource with links to potential funding sources.

Other highly desired services included project management assistance with IRBs and communities of practice, access to databases and research methods, more information on improvement science research studies, strong communications mechanisms, and statistical support.

To address these needs, the ISRN is using its Coordinating Center to provide wide-ranging technical assistance, has hired a statistician to provide support to network study sites, has launched a variety of communication venues (e.g., www.isrn.net, web events, the annual Improvement Science Summit, and *Network News*), and is creating annotated bibliographies, a compendium of research instruments, and an improvement science taxonomy.

"This is an ongoing story," says Stevens. "The ISRN will continue to survey and respond, and we encourage *Network News* readers to communicate service suggestions at any time, using the 'Contact us' information" (see column 3, bottom of this page).

Joining the Network

Become a member of the ISRN, the first national collaboration of clinical and academic leaders devoted to accelerating improvement science in a systems context across multiple hospital sites. Membership in the ISRN is open to individuals who are health care researchers, academicians, clinicians, or administrators with a specific interest in patient safety and improvement research in the acute care setting. Benefits of membership include the following:

- Opportunities to participate in multisite collaborations on patient safety and quality improvement research initiatives;
- Access to members-only ISRN online resources;
- Leverage of a national test bed for evaluating improvement strategies;
- Training resources such as IRB training;
- Expert guidance in conducting research;
- Technology infrastructure for participating in multisite studies;
- Access to the ISRN web portal, which provides secure communication, storage, and sharing of documents and data;
- A technical support system that provides access to expert guidance in conducting research and using statistics; and
- Recognition as an ISRN member and use of the ISRN logo on presentations and publications.

To become a member of the ISRN, visit www.isrn.net/members and select the "Join Now" button. For additional information about ISRN membership, contact ImprovementScienceResearch@isrn.net.

JOIN

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