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Transforming Care At The Bedside Lessons from Phase II

Executive Summary

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Transforming Care At The Bedside: Lessons from Phase II: Executive Summary

Transforming Care At The Bedside Lessons from Phase II EXECUTIVE SUMMARY

Transforming Care at the Bedside (TCAB) is a joint effort between the Robert Wood Johnson Foundation (RWJF) and the Institute for Healthcare Improvement (IHI) that aims to improve the hospital work environment to attract and retain high-quality nursing staff, with the ultimate goal of improving patient care and outcomes on hospital medical/surgical units. TCAB unit efforts are built around improvement in four domains: Care Team Vitality, Safety and Reliability, Patient-Centeredness, and Increased Value.

The key strategy to accomplish TCAB goals is to engage and empower front line unit staff and managers. TCAB puts them at the center of efforts to identify the areas for change and potential strategies, test them, and decide whether they should be maintained. TCAB unit staff and managers are provided support for this work within the hospital and externally via a quality collaborative. This has led to a wide range of changes being tested, sustained, and spread in participating hospitals and has also led to a change in the culture on the participating units and the hospitals as a whole.

Thirteen hospitals participated in Phase II of TCAB, which ran from June 2004 to May 2006. This report discusses key lessons from Phase II and the implications for hospitals, hospital systems and other organizations that wish to conduct or sponsor initiatives like Transforming Care at the Bedside, based upon observations and analysis conducted by the UCLA/RAND Evaluation Team.

A. OVERVIEW OF TCAB AND ACTIVITIES UNDERTAKEN

Thirteen hospitals participated in a quality improvement (QI) collaborative to facilitate the development, testing, and spreading of effective strategies and processes on medical-surgical units. As part of this collaborative, all hospitals designated one or two initial TCAB units and organized TCAB teams, with almost all organizing a unit-based team and most a hospital-level leadership team. The teams identified areas for change, developed and tested strategies for improvement, and implemented changes that were judged effective. As part of this work, hospitals were also expected to implement and report a set of core outcome measures. Over the course of the two years, several participating hospitals spread either proven innovations or TCAB unit processes or both to other units.

While there were a wide range of changes being tested, sustained, and spread in participating hospitals, participants repeatedly emphasized that the change in unit culture and engagement of frontline staff in improvement activities were central to their TCAB experience. Creating this change has involved not just change at the unit level but complementary changes in the culture and style of QI and leadership at the hospital level.

Nurse managers, hospital leadership, and QI staff must be committed to building commitment, skills, and unit process ownership by unit staff if a primary goal is to transition from working around problems to solving them.

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B. DOING THE WORK OF TCAB

1. TCAB at the hospital level

While the goal is for TCAB spread throughout the hospital, participating hospitals initially chose one or two units to start, “TCAB units.” The expectation was that the process would be piloted on these units and as these units identified valuable innovations, the innovations would be spread to other hospitals. The initial group of hospitals differed in their expectation of whether the innovation process itself would be spread, with some initially identifying this as their goal and other expecting that they would have a small number of innovation units, and only spread best practices. Most of the hospitals with the latter view have reconsidered it, and now believe that spreading the TCAB culture of process improvement is important.

Leadership involvement and support has been crucial in TCAB. When absent, TCAB has not taken root in the hospital as a whole. One of the ways many of the hospitals sought to balance the need for accountability and unit autonomy was to create hospital leadership teams which involved the Chief Nursing Officer (CNO) with other leaders. Other hospitals made reporting on TCAB activities and progress a standing agenda item on hospital leadership, quality council, and/or nursing council meetings.

Given the importance of leadership commitment, we believe it important to critically assess the willingness to support TCAB processes and front line staff involvement in change.

2. The Role of Hospital Quality Improvement/Performance Improvement Departments

Most of the TCAB units had a member of the hospital quality improvement or quality assurance unit on their TCAB team. However, the level of involvement of this member varied. On ten of the seventeen units in Phase II, TCAB activities were led by the nursing unit, with the role of the QI department ranging from minimal to active participation. In one hospital, we judged the leadership of the TCAB unit activities to be equally and jointly the responsibility of the unit manager and a staff member from the quality improvement. In four of the TCAB hospitals, with six units, staff from the quality improvement/performance improvement department rather than unit staff led the TCAB effort. None of these hospitals reported increases in unit vitality on the TCAB unit in the first year of TCAB. Based upon both the experience with testing innovations and changes in vitality, we would discourage hospitals from organizing TCAB with the quality improvement/process improvement staff as the lead.

3. TCAB at the unit level

a. TCAB Unit Selection and Orientation

The bulk of the work of TCAB happens at the nursing unit level. We observed that units in the same hospital or system could be dramatically different with respect to their participation

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in, and reported results from, TCAB. Thus, success appeared to depend not only on the hospital leadership. Rather, specific features of the unit, its manager, and staff appear to be the strongest predictors of the ability of a unit to derive benefit from TCAB. The units that we observed moving most aggressively were those that were viewed as strong units prior to TCAB or had a strong, experienced nurse manager with excellent staff rapport.

The TCAB unit managers cultivated staff leadership in a variety of ways. A management style which delegated authority to their staff to develop new skills and a greater sense of autonomy was mentioned as a particular area of management growth by some unit managers. Unit staff must be trained in TCAB processes and their commitment sought. Hospitals need to anticipate that significant training and support will be needed to orient and engage staff. A broad range of orientation materials, including videos, story boards, posters, classes, and meetings are needed.

b. Formation of TCAB Unit Teams

Composition of the teams varied across hospitals. Nearly all included staff nurses and nursing assistants/ nursing assistants, and many included physicians and other unit assigned staff (e.g. social work, pharmacy, dietary, housekeeping), as well as current or former patients or their families. Regular team meetings have been essential to sustaining TCAB. **Units with irregular meetings conducted fewer tests of change.**

c. Selection of Ideas to be Tested

Over 400 innovations were tested by the TCAB units during Phase II. The ideas tested came from a wide range of sources including: an initial unit brainstorming session, suggestions by staff, and other hospitals. Learning and Innovation Collaborative meetings, road trips and site visits offered formal processes such as IHI presentations and unit storyboards as well as informal discussions as sources of ideas. Requests for ideas were also made on the TCAB list serve.

We found that one of the factors building initial enthusiasm for TCAB on the unit among staff was that a significant portion of the initial ideas tested come from the unit. Beyond participating in generating ideas, frontline nurses often participated in the decisions of what was to be tested. **Units where someone other than the staff nurses decided which tests of change to conduct appeared to have lower nurse engagement.**

d. Conducting Tests of Change

A standard QI testing strategy, PDSA (plan, do, study, act) cycles, was used to test innovations. When objective metrics did not exist, there was a tendency to adapt or modify innovations based on perceptions of impact rather than formal measures, and refinement through further testing was not consistently done. Some units found that a daily huddle of 10-15 minutes among staff involved in current tests was beneficial.

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e. Building Staff Commitment and Expertise

In addition to involving staff in the idea generation process and, in some sites, the choice of changes to test, most hospitals reported employing additional incentives to build staff participation in TCAB. These were generally administered at the unit level, although some were hospital-wide programs or required hospital-level resources. They included identifying tangible benefit to nurses of the changes made, giving nurses choices in which changes to test and assuring nurses' ideas are actually implemented. Unit managers addressed the challenge of resistance via candid one-on-one conversations and posting TCAB activities and results. Most hospitals made some accommodation for the initial time demands of TCAB.

4. Measurement of Impact

Unit and hospital engagement in measurement has been viewed as essential by IHI and RWJF but has met with mixed support from the hospitals. Among the challenges to effective use of measurement of impact were: undeveloped measures, lack of unit staff orientation and training in measurement, resistance to collecting additional data because of the staff time or cost required, and the perception of value for external assessment rather than internal use.

5. Spreading TCAB beyond the Initial Unit

While spread to other units was not a primary activity, a number of hospitals and systems began dissemination of TCAB innovations and methods. Some innovations had such high perceived value, they were spread quickly as new standard practices beyond the initial hospital. Processes were slower to be disseminated, with most hospitals identifying one or a few units for a second wave of implementation.

C. CONSIDERATIONS FOR SPONSORS

While the work of TCAB is conducted by the hospitals and their participating units, external resources supported this work in critical ways. Face to face meetings have been appreciated and we would encourage any sponsor of a TCAB-like program to provide such opportunities. However, in a less resource intense environment, there are likely to be fewer such meetings. Additionally, there is a need to develop training materials and methods that reach staff who don't attend such meetings. With fewer resources available from the sponsoring organization, there will be a need for more intra-hospital consultation and problem solving.

We would encourage a sponsor to consider the following:

- Require hospital leadership involvement
- Create written and audio-visual materials describing TCAB processes
- Provide training for hospital and unit staff
- Disseminate training materials
- Focus on unit-manager and front-line staff engagement
- Encourage QI staff to work with front line staff and support front line activities
- Support development of a virtual community of hospitals.