Changes in reimbursement are bringing nurse-sensitive quality measures to the fore. Medicare will no longer pay for complications like retained foreign bodies and pressure ulcers. And Medicare’s administrator has proposed to Congress that part of DRG payments be based on meeting quality measures. That means nurses could be the new “rainmakers” for hospitals—a force driving reimbursement.

Yet nursing leadership is challenged. Turnover is high among chief nursing officers and other nurse managers. B.E. Smith, Inc, a health care recruiting firm in Lenexa, Kansas, estimates that at any given time, there are 800 open positions for nursing leaders across the country.

Nurse managers at all levels have seen their roles expand and expectations rise. Nurse leaders are looking over the horizon and wondering where the next generation of managers will come from. What steps are being taken to prepare new leaders?

OR Manager spoke with Lillee Gelinas, RN, MSN, FAAN, vice president and chief nursing officer of VHA Inc, the national health care alliance, which has 1,400 member not-for-profit hospitals.

What trends are you seeing in recruitment and retention of nurse leaders?

Gelinas: We have a serious problem. In the 7-state VHA Central Atlantic region alone from mid-2006 to mid-2007, about 50% of our members experienced CNO turnover in one of their facilities. That was a red flag to me. The reasons varied: A couple were promoted, some retired, and several left for philosophical reasons.

A new trend is global competition for nurse leaders. Many nurse executives are taking foreign assignments. I was just at one of our largest hospital systems and asked a group of nurse managers, “How many of you know somebody who has gone to Dubai, Thailand, or Singapore?” These areas have really built medical tourism into their national plans. A year ago, no hands would have gone up. In this group, 10 hands went up.

And they are going to Joint Commission-accredited hospitals overseas. If they choose a Joint Commission-accredited hospital, they know it has passed patient safety and clinical quality standards. The surgeons they work with are mostly American trained. [About 85 hospitals are accredited by the Joint Commission’s international division.]

Why are these foreign assignments attractive?

Gelinas: The number one reason I hear from nursing executives is, “We can’t take the work environment here in the United States anymore.” It is too highly stressed. No one is understanding the patient safety implications of what nurse managers are asked to do. Nurse managers say they keep hearing, “Do the best you can.” As I’ve said many times, “Sacrifice is not a staffing pattern.” But that’s a mandate unfortunately for many managers.

What issues do you see affecting retention of perioperative nurse managers?

Gelinas: We see many of the same issues. The one that worries me the
must is disruptive behavior. Alan Rosenstein, MD, and Michelle O’Daniel of VHA West Coast have published research showing that disruptive behavior is not only hard on morale, it’s a threat to patient safety. In a study they reported in 2006, 19% of respondents said they knew of a specific adverse event that happened as a direct result of disruptive behavior.

Q Medicare is placing more emphasis on paying for quality in hospitals. How do you think this will affect nursing?

Gelinas: This effort is ramping up. The CMS inpatient prospective payment rules for 2008 say Medicare will not pay for certain complications of care. Many of these are nurse sensitive, such as pressure ulcers and some aspects of preventing surgical site infections. CMS has proposed to Congress that part of DRG payments be based on meeting quality measures.

All of a sudden this is changing the conversation between chief nursing officers and chief financial officers. Good nursing care means there’s a greater chance these complications are not going to happen. That means nurses are now rainmakers. In the past, staff nurses have been seen as a cost. Now they are also being seen as revenue generators.

This is increasing the pressure on nurse leaders to improve care faster—rapid is the new normal. CFOs are coming into their offices and saying, “We’ve got to fix this because it’s really going to affect our reimbursement.”

It is a different day. The contribution of staff nurses to clinical quality has always been enormous—now it’s being recognized.

Q What initiatives is VHA undertaking to prepare nurse leaders for the future?

Gelinas: VHA has had a commitment to nursing and nursing leadership development for some time. We have had a nursing management development program for the past 7 years. Over 16,000 nurse managers have been through this program, either in live sessions or by viewing the TV series. OR and perianesthesia care managers are included.

You will see a big initiative this year called ReturnRN to Care that will emphasize better practices and proven results in increasing the time RNs have to spend directly with patients.

Unfortunately, with high turnover among nurse managers, it is like swimming upstream, but we all need to do our part.

Q What could help address the turnover of managers?

Gelinas: VHA has used evidence in the Institute of Medicine (IOM) 2004 report, Keeping Patients Safe: Transforming the Work Environment of Nurses, which found the typical work environment of nurses poses serious threats to patient safety. One threat is management, including changes in the way care delivery is organized. The IOM says many of these changes have focused mainly on increasing efficiency and have damaged trust between nursing staff and management.

The IOM suggests 5 management practices that seem to make for a safer care environment. These are evidence-based management practices—they aren’t from the latest best seller.

Tell us a little about these 5 practices.

Gelinas: The first practice is creating and sustaining trust. I’m amazed by how many staff don’t trust their manager. They say things like, “Oh, they’re in management—they’ve gone to the dark side.” Creating and sustaining trust is essential. The IOM says the staff’s trust in leadership often reflects how committed leaders are to the values of nursing and medicine.

Second is actively managing change. Nurse managers need to know how to manage change. That includes using the Institute for Healthcare Improvement’s Transforming Care at the Bedside project, which outlines approaches for creating a safer patient environment.

The third practice is involving the staff in work design and workflow. Evidence indicates that old bureaucratic structures aren’t appropriate in health care today. Instead,
decision making needs to be more flexible and take place closer to the staff level. The staff at the frontlines are the ones who know how to get the work done.

Fourth is creating a learning organization. A lot has been published about learning organizations. High-performing organizations know how to bring in knowledge and use it to improve their practices. This means nurse leaders take advantage of new knowledge and are able to transfer it quickly and effectively to the staff.

The fifth tenet is balancing efficiency and reliability. The IOM notes that efficiency can be at odds with safety. Organizations need to be able to balance safety with production efficiency. Look at the auto industry and how defects per car in American-built cars have gone down dramatically because of world competition. Look at aviation. When there is a plane crash, the NTSB investigates to see if changes are needed. In health care, we are making improvements. Now we need to follow other industries and learn how to sustain these improvements.

The more we can help nurse managers understand evidence-based practices, the more we will be leading them in the right direction.

This sounds good. But managers say they’re over-whelmed with the duties they already have.

Gelinas: The number one question I’m asked when I’m with a group of nurse managers is, “I don’t know how I can work on that because I’m so burdened now with everything else I have to do.”

One strategy is to leave and go to an organization where the senior management “gets it”—they understand the role and focus needed to do the job well. You do find organizations that are dedicated to nurse manager development. A second approach is to really understand what nurse managers do today and help them create a “stop-doing-it” list.

What could they stop doing?

Gelinas: Some of our hospitals have had nurse managers do a time image of their day. They keep track of their activities for 30 to 45 days. Then they can see how they are spending their time. This is one of the best skills we can teach our experienced managers. The majority of nurse managers find they spend about 60% of their time in meetings.

Then you make those findings visible to the organization. You say to the leaders, “You hired this manager to oversee care and the staff. But they are spending 60% of their time in meetings. Is that what you want them to be doing?”

What have managers found they could give up?

Gelinas: The classic example is exit interviews. That is a dinosaur tactic. People are not going to be honest with you when they leave. If I saw a nurse manager had spent 2 to 4 hours on exit interviews in a 2-month period, I would say, “scratch that.”

We have seen some hospitals eliminating employee evaluations—you talk about delighting people. They haven’t eliminated performance reviews. Instead, they use more of a scorecard for the hospital so everyone from the staff to the CEO is vested in the same corporate goals so everyone understands his or her contribution in a concrete way.

In developing new managers, this is one of the strategies we have to look at—how are you spending your time, and is that why the hospital hired you? I’m excited about the emphasis on developing and keeping great managers. It’s a win for the hospital, for nurses, and for patients.

References
Bad behavior in OR threatens patient safety, stresses teams. OR Manager. 2006 (10):1, 19, 21, 25.
www.nap.edu/catalog/10851.html