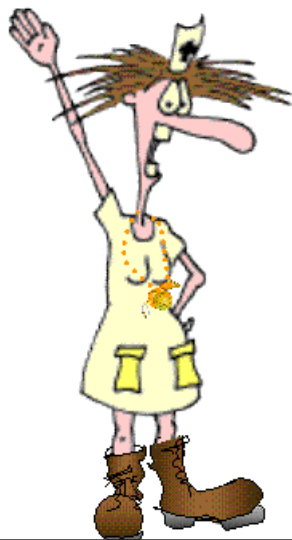


# The Nurse Manager Boot Camp E-zine...

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## FOLLOW-UP CHATS ON:

April 6, 2003 What is Safe Staffing?

3:00 - 4:00 PM EST

April 19, 2003 Nursing Care Models

3:00 - 4:00 PM EST

### Team Work Works!

Studies show that social cooperation is associated with rewarding experiences. In one study, participants who cooperated in a game experienced increased activity in their brains' reward regions, even when cooperating was not the best strategy for winning the game.

Cooperation based on reciprocal altruism has evolved in only a small number of species, yet it constitutes the core behavioral principle of human social life. In this study, the Prisoner's Dilemma Game was used to model this form of cooperation. The researchers used MRI to scan 36 women as they played an iterated Prisoner's Dilemma Game with another woman to investigate the neurobiological basis of cooperative social behavior. Mutual cooperation was associated with consistent activation in brain areas that have been linked with reward processing: nucleus accumbens, the caudate nucleus, ventromedial frontal/ orbitofrontal cortex, and rostral anterior cingulate cortex. The propose that activation of this neural network positively reinforces reciprocal altruism, thereby motivating subjects to resist the temptation to selfishly accept but not reciprocate favors.

**Conclusion:** Team work works; not just for delivering better care for patients but also for providing a personally rewarding work experience for staff. However, teams need to be built according to both skill level and personal 'fit'.

**Source:** Rilling J, Gutman D, Zeh T, Pagnoni G, Berns

## Excellent Caregiver Interaction Saves Lives

Sir William Osler, that great man of medicine in Canada and in the United States at the turn of the century, who saw the nurse as "taking a place beside the physician and priest and not inferior to either in her mission." He also noted that "In the gradual division of labor, by which civilization has emerged from barbarism, the doctor and the nurse have been evolved, as useful accessories in the incessant warfare in which man is engaged."

Now, there is a growing body of empirical data supporting the contention that each must collaborate with, and rely upon the other or patient care will suffer -- and patients may even die unnecessarily. "In 1986, one of the earliest studies associated with APACHE II, a severity adjustment and risk prediction system for critical care, identified collaboration as having an important positive impact on patient outcomes in intensive care units. In this study of thirteen hospitals, physicians and nurses independently reported their perceived level of collaboration with each other. The variation in mortality among the hospitals ranged from 41% below predicted to 58% higher than predicted, after adjustment for patient case mix and severity of illness."

"Shortell and colleagues examined data from 42 intensive care units in 40 hospitals, identifying those factors contributing to superior risk-adjusted outcomes. In these hospitals, there was again a wide variation in outcomes, ranging from 33% lower than predicted mortality to 26% higher than predicted mortality. Caregiver interaction (a concept including communication, coordination, and problem solving/conflict management) did not have a significant relationship with mortality in this study; however, the level of clinician interaction was significantly related to shorter, risk-adjusted, length of stay." Zimmerman *et. al.* recently used APACHE III to measure risk-adjusted outcomes of 359,715 patients from 108 intensive care units -- and, in addition to other factors, the best performing units were those in which experienced nurses interacted well with physicians -- and physicians readily developed protocols for nurses to follow. The best highest performing units were defined as those critical care units with a standard mortality ratio <1.0, (calculated by dividing mean actual mortality rate by the mean predicted mortality rate at hospital discharge) and the lowest actual to predicted ratios for ICU length of stay and hospital length of stay.

With patients well-being, perhaps even their lives hanging in the balance, what is to be done? Certainly, decency and courtesy are essential components that must be used by nurses who will start today-not next year, not tomorrow-to: (1) speak up: a keen mind cannot be discovered unless its owner learns to open up; (2) keep a sense of humor and perspective and remember that only a minority of physicians have no appreciation of nursing's contribution to health care; (3) enhance academic preparation through taking responsibility for their own education; (4) document what was done and observed and be prepared to subject it to the scrutiny of peers who include physicians; (5) exercise the patient advocacy role that has been made explicit in formal position statements of some professional associations,57 by speaking for patients and intervening if necessary; (6) keep an open mind and a short memory by never holding a grudge about incidents that take place in the heat of difficult moments; and (7) ensure that diplomacy prevails in accordance with the diplomatic craftsmanship that is a hallmark of nursing skills. McGuire believes that when nurses learn to use these resources that are available, problems with the nurse-physician relationship will be solved.

## A Case Study on Staffing: On the Horns of a Dilemma...

You are the nursing supervisor responsible for staffing the next shift. You have one less ICU nurse than required. The ICU ratio is supposed to be 1:2. There are 5 patients in the ICU, thus you should have 3 RNs on duty. However, two of the patients in ICU are being held there only because there were no beds available in the telemetry unit. You have called every qualified registered nurse, and no one will/can come in to cover the Unit. You notify the ICU nurse manager, who says she cannot come in either, and instructs you to do “whatever.” As you see it, your options are: 1) to pull one of the RNs from a med-surg unit, thus leaving that unit short -- and leaving a 1:9 ratios of RNs to patients, or 2) to leave the ICU short one nurse (given that 2 of the ICU patients could be transferred out if there was a bed available in the telemetry unit). Either way, you are in trouble -- especially if one more patient is admitted through the ED.

None of the agencies in town have RNs with ICU experience available, and in fact, most of them do not have any RNs available to work on such short notice. Your hospital does not have a ‘contingency or float’ pool. Most of the RNs won’t even answer the phone when the hospital calls (caller ID!), and if you do manage to get one she/e refuses to come in because the hospital eliminated the night differential in a cost-saving move. What is your personal legal liability if you do pull a med-surg nurse, and the med-surg unit experiences an incident with negative patient outcomes related to low staffing? Or if a patient comes in through the ED and is admitted to ICU? Or how do you handle it if the staff nurse on the med-surg unit refuses the assignment because she/he does not feel competent to work in ICU? And you force the issue and she/he makes a mistake? Or you do not pull a nurse and a patient goes bad in ICU?

### Commentary: On Getting Pragmatic Fast....

To put the matter in a nutshell, What I would do were I that supervisor, would be:

1. to visit ICU personally and assess the situation,
2. to ask the ICU nurses for their assessment of their situation
3. If necessity demanded, I would then personally visit the nursing units to ascertain which was the least stressed unit —
4. Ask the charge nurse on the least stressed unit for her/his assessment of the situation
5. Make a decision about whether and whom to pull based on these assessments. And making a decision about putting the hospital on ‘divert’ based on these assessments.
6. If there is no ‘least stressed unit’ and the Administrator-on-call will not put the hospital on divert, I would consider holding the patient in the ED until the day shift comes in, or sending any new patient to PACU where there is always supposed to be nurses on call, and the patient could be cared for there...If none of this can help, I would either go to ICU personally to help with the least critical patients, or pull a more competent nurse from a stressed unit — and go to that unit to help on that med-surg unit until end-of-shift (presumably other units etc. can still page me at will!!)
7. Talk to administration about 1) starting an ICU internship program for staff who may be interested in working ICU full or part time, thus creating a pool of persons who could safely be pulled to ICU. 2) starting an ICU internship for new graduates to begin dealing with chronic shortages in ICU
8. Talk to administration about the advisability of re-instituting a night differential as an incentive.

While one must be prepared for contingencies, it usually is extremely stressful as well as unproductive to anticipate disaster on every shift. All RNs, including nursing supervisors, are accountable (i.e., liable) for the professional decisions they make. If, in the circumstances in which you find yourself, you make a staffing decision - one that your reasonable and prudent peers would agree is an appropriate decision -- you will be about as ‘safe’ from litigation as it is possible to be. As for ‘forcing’ any RN who believes he/she is incompetent to accept -- NO: that is neither reasonable or prudent!. We have a professional duty to handle the problems associated with the roles we have accepted -- and part of that duty is to respect the persons -- patients and personnel -- of all involved.