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Honor Society of Nursing Sigma Theta Tau International

EXCELLENCE in Clinical Practice

Third Quarter 2002 Volume 3, Number 3

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News Briefs

A battle in Britain over nurses' prescription powers
Health officials in the U.K. announced last month plans to increase prescribing rights for nurses in an effort to improve health care. But editors of *The Lancet*, leading medical journal, have expressed strong opposition to the plan, saying it could have serious consequences and pose unnecessary risks for patients.

Twenty-three thousand nurses are already prescribing drugs in the U.K., and officials would like the numbers to increase to 30,000 by 2004. Physicians have criticized the move, saying more training is needed and warning that nurses do not have the clinical knowledge they need to prescribe drugs. Officials counter that nurse prescribing means improved care.

Utah is short of nurses, but needs them less
The *Deseret News* reports that Utah is among the most severely affected by the nursing shortage, with fewer nurses per capita than only two other states. That's the bad news. The good news is Utah has a young and healthy population that simply doesn't need as many health-care services.

The state has one of the largest populations of young people, and one of the largest populations of elderly, especially those over 90. There is an acute need for long-term care nurses, but everywhere else the number of nurses is equal to the job, thanks in part to the full enrollment in the state's six public and two private universities and colleges with nursing programs.

New laws give nurses a boost
A new law in Florida called the Nursing Shortage Solution Act allows the Florida Department of Health to make loan repayments of up to $4,000 annually for four years for graduates of accredited nursing schools who work as a nurse in the state.

Evidence, ideas and actions:
New reports on the state of the shortage

Three new reports have been released that, when taken together, create a compelling structure for understanding and responding to the shortage of qualified nurses.

One study published by the *New England Journal of Medicine* represents some of the strongest evidence yet that lack of qualified nursing care results in an increase in adverse patient outcomes, including mortality. The other two—one funded by The Robert Wood Johnson Foundation and the other created by the American Hospital Association— propose specific solutions to the challenges of inadequate numbers of qualified nurses.

Each report has something valuable for the members of Sigma Theta Tau International, according to Nancy Dickenson-Hazard, Sigma Theta Tau International's chief executive officer.

"These are an extraordinary validation of what nurses already know. Patient care is suffering not just because there aren't enough nurses in hospitals, but because hospitals aren't bringing nurses fully into the process of creating policies and building cultures and models of care," says Dickenson-Hazard. "Perhaps now these essential issues can move higher on the national agenda."

From *The New England Journal of Medicine*: Clear Evidence

This report, ***Nurse-Staffing Levels and the Quality of Care in Hospitals***, was authored by Jack Needleman, PhD, an assistant professor of economics and health policy at the Harvard School of Public Health. Other authors on the report include Peter Buerhaus, RN, PhD, (a member of Sigma Theta Tau's Board of Directors), Soeren Mattke, MD, MPH, Maureen Stewart, BA, and Katya Zelevinsky.

This study used 1997 data for 799 hospitals in 11 states to examine the relation between the level of staffing by nurses and the quality of care. In all, 5,075,969 patient discharge records were examined, including 1,104,659 discharges of surgical patients. The investigators used regression analyses that controlled for patients' risk of adverse outcomes, differences in the nursing care needed for each hospital's patients, and other variables.

Needleman and his colleagues report that, in the United States, a higher proportion of hours of nursing care provided by registered nurses (registered-nurse–hours) and a greater number of registered-nurse–hours per day are associated with better outcomes for hospitalized patients.

Among medical patients, these outcomes were a shorter length of stay and lower rates of urinary tract infection and upper gastrointestinal bleeding. A higher proportion of registered-nurse–hours was also associated with lower rates of pneumonia, of shock or cardiac arrest, and of death from five causes considered together—pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis, or deep venous thrombosis. The findings for surgical patients were similar, although fewer significant associations were found.

The study found no evidence of an association between a greater number of hours of care per day provided by licensed practical nurses or hours of care per day provided by nurses' aides and better outcomes.

The study size in excess of 5 million patients represents an important response to a 1996 Institute of Medicine report that concluded higher levels of staffing by nurses in nursing homes were linked to higher-quality care, but that the overall data for hospitals were not good enough to "isolate a number-of-RNs effect."

The report has generated media coverage across the nation, including articles in *The New York Times*, *The Wall Street Journal, The Chicago Tribune and The Los Angeles Times*. National Public Radio has broadcast a feature that explored the study's conclusions. It's been news across the nation, but will it provide the

EVIDENCE, IDEAS AND ACTIONS... PAGE 4

Our Position. Our Role. Our Recommendations.

The Honor Society of Nursing Sigma Theta Tau International recognizes the nursing shortage as a major threat to the future of the world's health care system. We recommend several steps to reverse this trend now instead of later. Sigma Theta Tau recommends the following initiatives:

- Demonstrate to health-care leaders that nurses are the critical difference in America's health system.
- Reposition nursing as a highly versatile profession where young people can learn science and technology, customer service, critical thinking and decision-making.
- Construct practice environments that are interdisciplinary and build on relationships among nurses, physicians, other health-care professionals, patients and communities.
- Create patient care models that encourage professional nurse autonomy and clinical decision-making.
- Develop additional evaluation systems that measure the relationship of timely nursing interventions to patient outcomes.
- Establish additional standards and mechanisms for recognition of professional practice environments.
- Develop career enhancement incentives for nurses to pursue professional practice.
- Evaluate the effects of the nursing shortage on the preparation of the next generation of nurse educators, nurse administrators and nurse researchers and take strategic action.
- Implement and sustain a marketing effort that addresses the image of nursing and the recruitment of qualified students into nursing as a career.
- Promote nurses of all educational levels to pursue higher education.
- Develop and implement strategies to promote the retention of RNs and nurse educators in the workforce.

Family caregivers:
A critical resource in today's changing health-care climate

By Carol J. Farran

During the early 1980s, "family caregiver" was the term professionals began to use to describe family members who were caring for an elderly person in their family. Today the term has taken on more widespread meaning and may apply to any situation where informal and/or unpaid care is provided by relatives or close friends to persons who are dependent on others or require assistance to manage their daily lives or personal care (National Alliance for Caregiving and American Association of Retired Persons, 1997). In many cases, even some 20 years later, when family members are asked if they are the "family caregiver" they are not sure what the term means and reply by saying, "We are part of a family, and that's just what families do."

Family caregivers are moving to the forefront

Just as it is with nurses, family caregivers have come to the forefront for two major reasons: 1) increasing numbers of persons who live longer and have chronic illnesses for a longer period of time; and 2) changes in the health-care delivery system. Family caregivers essentially serve as the backbone of the long-term care system. It is estimated that nearly one-fourth of the households in the United States provide care to persons 50 years of age and older. The majority (75%) of family caregivers are female, generally wives, daughters/daughters-in-law, or other female relatives. Family caregivers provide an average of 18 hours of care per week, but these hours increase substantially if their care recipients have Alzheimer's disease or another related dementia (ADRD). Family caregivers, particularly younger ones, have additional responsibilities including childcare (41% have children under 18 years), and the majority of those under 64 years of age (66-77%) are employed outside the home (National Alliance for Caregiving and American Association of Retired Persons, 1997).

FAMILY CAREGIVERS... PAGE 2

A new kind of *Excellence* is taking shape

Our work as nurses is a continual effort to improve. We aim to deliver better care. We strive to be better managers, teachers and mentors. We have a passion for the better idea.

Improvement is at the core of our work in creating *Excellence* as well, and with next quarter's issue, you'll discover the next generation of this newsletter that is more informative, more interactive and more useful. In a word, better.

Excellence is migrating to the online environment. All the news and resources contained in the profiles and articles will be exclusively contained in a specially developed section of the Sigma Theta Tau International Web site, nursingsociety.org.

What you'll see there will be an ingenious evolution that embodies what members expect from *Excellence*: A lively, informed perspective on nursing, and expert voices that speak directly to you where you are now in your career. Yet, with this new generation of *Excellence*, you'll also be able to speak directly to us.

Dialogue and Investigation

In moving to an entirely online environment, *Excellence* will become a starting point for conversations between the articles' authors and you. Resources and background information that help to shape articles will emerge from the background and be made available to you for instant exploration. Back issues will be archived and searchable.

And for those of you who appreciate the ability to take *Excellence* anywhere and read it away from your desk, you will be able to print the entire newsletter in a format that's easy to carry and to read.

Keep watching (both) your mailboxes

Excellence will be entirely and exclusively online with the next issue, but we'll let you know when it's posted and ready for your eyes. Next quarter, a postcard announcing the new issue and highlighting some of the top articles will arrive in members' postal mailboxes. Members who have shared their e-mail addresses with Sigma Theta Tau International will receive an e-mail with immediate links to the new issue.

Future issues will be announced from the society's Web site and through e-mail to members. Which brings up a good question: Do we have your e-mail address?

By registering an e-mail address with Sigma Theta Tau International, you'll be among the first to know when a new *Excellence* is available and what's waiting there for you to explore. It's important to note that this is not an invitation to flood your inbox. The Sigma Theta Tau International policy on spam is very clear and can be viewed at www.nursingsociety.org/new/privacy.html. While you're there, click over to www.nursingsociety.org/publications/excellence.html to enter your name and e-mail.

Excellence is changing to reflect the way nurses and nursing careers are changing. We're becoming more responsive, informed and connected. It's going to be an exciting transition, and we invite you to share it with us.

FAMILY CAREGIVERS... FROM PAGE 1

A long list of needs. A wide range of care.

Care may include *Anticipating* what their family members need in the next several minutes, several days, or coming year. Other aspects of care involve *Preventing* complications. One wife family caregiver said proudly, "I cared for my husband for 17 years and he never had a bedsore." Unfortunately when he was hospitalized, he developed three decubitus ulcers in one week. For more dependent family members, family caregivers assume responsibilities for *Protective Care*. Protective care for persons who have dementia may involve "child-proofing" the house, such as making sure the care recipient can't use the stove, get out of the house unattended, or drive the car.

With increasing care recipient dependency, caregivers also assume more responsibilities for *Instrumental and Personal Activities of Daily Living*. Usual responsibilities that were assumed by the ill person in the past may include paying bills, shopping, and car maintenance. One 85-year-old wife caregiver said, "I never worried about changing the oil in the car until now. John always did that." With increasing impairment of individuals, family caregivers also assume more responsibility for providing personal care such as bathing and toileting.

When the care recipient is cognitively intact, part of the caregiver's responsibilities may involve *Education*—showing the person how to give his/her own insulin or calculating daily calories. When persons are ill and dependent on others for care they also need more *Emotional Support*. For the care recipient who is depressed, s/he may need support to get daily chores done or additional support to even leave the house. Oftentimes providing care for a dependent family member cannot be done alone and requires that the family caregiver have other persons come into the home. In this case the caregiver must take on *Supervisory* responsibilities. Family members have often remarked, "Now I have to interview, hire, supervise and even fire in-home workers."

As care receivers remain at home in increasingly more complex situations, the family caregiver may also have to assume *Technological* aspects of care. Here family members assume responsibilities that we typically thought were only the prerogative of professional caregivers. Because of this broad range of responsibilities assumed by family caregivers, some have commented, "I'm passing as a nurse."

Family in the care of ADRD patients

The majority of research concerning family caregivers has focused on those who provide care for persons who have ADRD. The major challenges faced by these family caregivers emerge because of the care recipient's cognitive impairment, behavioral responses, and increasing dependency in activities of daily living. During initial phases of dementia, caregiver responsibilities include "being there, keeping an eye out, and providing gentle supervision." As the care recipient becomes more impaired, caregiver responsibilities increase, particularly in providing for the care recipient's bathing and toileting needs. When the caregiver "invades the care recipient's personal space" during bathing or toileting, the care recipient is more likely to exhibit agitation and aggression. As the dementia progresses, the impaired family member becomes increasingly more dependent on the family caregiver for all aspects of care.

Transitions in responsibilities, attitudes and challenges

Family caregiving generally takes place over a period of time and may involve transitions for the caregiver. *Home care* is often only the first step in a longer process. Providing care in the home may have an insidious beginning where the family caregiver gradually begins to assume more responsibilities for the impaired family member, almost without notice. Some wives say about their husbands, "Well, he never helped around the house anyway, so I hardly noticed it at first." During this time caregivers may find themselves doing a "balancing act" of attending to caregiving responsibilities, work, and other family issues.

Sometimes other family members are very involved and supportive of care that is provided by the primary caregiver. Other times, old family conflicts "rear their heads" and these family members simply disappear and have no further contact with the caregiver.

Seeking and using outside help often occur simultaneously with the delivery of home care, but may be a key transition point for some families. Research suggests that family caregivers only use an average of 1.4 outside services. For some, but not all caregivers, realizing that they can't and shouldn't provide care without help requires a major shift in their thinking. They may feel they have failed, that they are inadequate, and they may feel guilty. Once caregivers become accustomed to having outside help, they may find that they have more time to do things they used to enjoy and can once again begin to develop their own lives. Adult day care, chore workers, home health care, and other respite services are amongst the services that families find very helpful.

Hospitalization of the ill family member constitutes another transition for some family members. The major precipitating events involve changes in the ill person's medical or mental status. For elderly persons this may include medical complications due to existing illnesses, surgery, stroke, hip fractures, pneumonia, or urinary tract infections. Psychiatric hospitalizations of elderly persons generally result from unremitting depression or behavioral changes. Hospitalization is generally an unexpected and uninvited event where the caregiver feels s/he "loses control" and where, particularly an elderly family member, s/he may "lose ground." For persons who have dementia, 50-60% of those who are hospitalized are discharged to a nursing home (Aneshensel, et al. 1995; Zarit and Whitlatch, 1992). Post-hospitalization caregivers must often learn new skills, modify their home environment, and once again, change their role.

Nursing home placement is a transition that may be most difficult for family caregivers. One wife caregiver said, when commenting about the day her husband was placed in the nursing home, "It would have been easier if it was his funeral." Nursing home placement may be experienced as a personal failure or the inability to keep an earlier promise to the spouse "to never place him/her in a nursing home." For persons who have dementia, nursing home placement occurs most frequently due to changes in behavior (30%), caregiver depletion (28%), incontinence (12%), insufficient help (12%), care receiver physical illness (11%), or failure of the care receiver to recognize the caregiver (6%) (Aneshensel, et al. 1995). Nursing home placement generally means that the focus of caregiving shifts. Where the caregiver may have once single-handedly provided in-home care, s/he must now relinquish these responsibilities to others.

For many caregivers, the financial concern of nursing home placement always remains. After awhile many caregivers find that they have more time available for themselves, feel increased freedom and space, and may note improvements in their own sleep and eating habits. Overall though, nursing home placement takes an emotional toll. Caregivers often report feeling guilty, sad, and depressed.

In a recent study where caregivers who were asked to "paint a picture" about how they were experiencing the nursing home placement of their relative, a wife caregiver said, "It's not a happy picture. I'm not in the picture. My sons are putting up a bird feeder outside my husband's window. He has a nice room. There is a lady in her bathrobe sitting in a cluttered room. On the wall is a clock with only the second hand ticking" (Johnson, 2002).

Studies have shown that the stress experienced by family caregivers while providing care in their homes may continue after nursing home placement. Caregiver guilt may be expressed as hostility toward the nursing home staff; and caregiver strain, how the care recipient adjusts, and other nursing home stressors may affect caregiver adjustment, caregiver depressive symptoms, and satisfaction (Whitlatch et al., 1999). For some caregivers, satisfaction with nursing home placement is a result of positive adaptation to this change, while for other caregivers, it is a result of lowered expectations and decreased involvement (Gaugler et al., 2000).

What can nursing home staff do for family caregivers?

It is important that staff understand what the nursing home placement means to a particular family—is it a relief, cause for grief and loss, or cause for feelings of failure? Nursing home staff members are in key positions to offer a listening ear and support the family caregiver. It is also vital that staff members establish trust with the family caregiver and provide quality care. Oftentimes, nursing home staff becomes like "family" or an extended community for the caregiver. Nursing home staff can promote partnerships with the family by involving them in care planning, providing information, and encouraging collaborative activities and community building (Murphy et al., 2000).

Understanding caregiver stress

Caring for a person with ADRD has often been labeled as a chronic stressor because of the length of time spent and the unrelenting responsibilities of providing care. Relationships between stress and depression are well established in both the general population and in caregivers of persons with ADRD (Kiecolt-Glaser & Glaser, 1995). Study findings suggest that anywhere from 14-81% of family caregivers may be at risk for developing depressive disorders. ▶

The knowledge momentum continues:

Young bike riders are safer wearing a helmet

By wearing a helmet when riding a bike, children and adolescents can prevent serious head injuries. But that simple and powerful fact has yet to create a large-scale change on the sidewalks, streets and driveways of the world, according to a review of helmet use and legislation recently published on Sigma Theta Tau International's *The Online Journal of Knowledge Synthesis for Nursing*.

The review of current research, entitled "Promotion of Safety Helmets for Child Bicyclists: 2002 Update," was conducted by Sherrilyn Coffman, DNS, APN, CPN.

In the review, Coffman has aggregated the current research that continues to show that bicycle helmets prevent serious injury and death in cyclists of all ages. The purpose of the review was to update information on the use and protective effect of bicycle helmets for child cyclists. Not surprisingly, trauma center data reveals that most seriously injured victims of bicycle collisions are non-helmeted riders.

The review also includes a survey of legislative and community education programs that either require or stress helmet use among children and adolescents, including an interesting and unexpected connection between mandatory helmet laws and a decrease in overall bike ridership among children.

Adding the informed voices of nurses

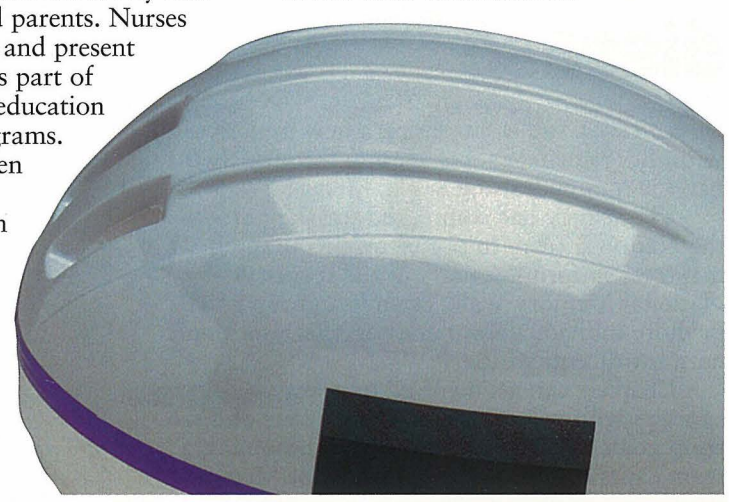
The implications for nurses are many. They are often in advantageous positions to encourage helmet use by educating children and parents. Nurses can add credibility and present medical evidence as part of community-based education and advocacy programs.

Nurses can even help add to the knowledge base on this timely issue.

Nurse researchers can initiate studies that examine factors such as parental rules and adolescent risk-taking—two less understood factors in this very preventable injury.

Summer is here. The issue is hot.

With this new review as further evidence, nurses can be confident in stressing helmet use among their patients and within their communities.



FAMILY CAREGIVERS... FROM PAGE 2

Generally, a family caregiver who is actively involved in providing care will not be clinically depressed, as a person with clinical depression has difficulty attending to his/her own needs. But nonetheless, caregivers tend to suffer from depressive symptoms—fatigue, difficulty sleeping, changes in eating habits, and mood changes. Increasingly more research also suggests that caregivers experience changes in physical health. This may involve changes in health behaviors (e.g., increased smoking or alcohol use, changes in eating habits, decreased exercise), greater medication use, and a more negative perception of their physical health (Schulz, O'Brien, Bookwala, & Fleissner, 1995). Over time and when caregivers were strained, higher mortality rates have also been reported (Schulz & Beach, 1999). Hence, if caregiver stress, depressive symptoms, and changes in health behaviors and physical health are not addressed, family caregiving may result in two patients—one who has a diagnosed illness and the family caregiver.

In addition to changes in caregiver mental and physical health, family caregiving can affect all other aspects of one's life. *Family life* can be affected when an elderly family member moves into the home or the family caregiver frequently must check on a dependent person who is still living by him/herself. *Leisure time* is also affected as the family caregiver juggles care-related responsibilities with other demands. When asked how they spend their leisure time, many caregivers respond by saying "what leisure time?" *Work life* for family caregivers can also be affected as caregivers juggle caregiving and work responsibilities, reduce their work hours, retire early, or stop working entirely. *Personal finances* are also affected, as the majority of family caregiving costs are out-of-pocket. Medicaid and Medicare do not pay for the costs of providing in-home care to a family member.

Clinical interventions to reduce stress

While intervention studies conducted with dementia family caregivers suggest that there are minimal decreases in family caregiver distress (Knight, Lutzky, & Macofsky-Urban, 1993), family caregivers, nonetheless, report that they are helped by the following:

- Participating in information and support groups.
- Contacting and using information provided by the Alzheimer's Association (1-800-272-3900 or at www.alz.org).
- Developing skills in providing personal care and dealing with difficult behaviors associated with dementia.
- Finding and using support services such as personal chore workers, adult day care and other respite care.
- Finding ways to "make sense" of what is happening to them and creatively dealing with their responsibilities of and responses to caregiving.

What appears to be an understudied and under-developed area for family caregiver interventions is a greater focus on:

- Developing a "two-track" life where one track focuses on caregiving responsibilities and the other focuses on self-care.
- Dealing with caregiver health behaviors such as getting enough sleep, maintaining healthy nutrition, getting enough exercise, and other health behaviors.
- Maintaining caregiver mental, physical, and spiritual health.

Our role as nurses

Nurses can play a major role in working not only with the care recipient, but also in identifying family caregivers. Oftentimes nurses are the persons who are talking with family caregivers by telephone or seeing them in other health-care settings. The simple question "How are you doing?" provides family caregivers the opportunity not only to ventilate but also to share some of the issues they are facing.

Nurses are particularly equipped to assess caregivers' level of stress concerning their caregiving responsibilities; to identify caregivers' feelings of distress such as burden, loss/grief, and depressive symptoms; and to determine what toll family caregiving may be taking on the caregiver's health. Treating the caregiver/care recipient dyad is a comprehensive way of addressing health-care needs and is vital to protecting the family caregiver as a critical resource in today's changing health-care climate.

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Sigma Theta Tau walks against Alzheimer's disease

Sigma Theta Tau is launching a new initiative with the Alzheimer's Association through their nationwide fundraising event, Memory Walk.

The society has committed to take part in the National Team Initiative by encouraging members to form Memory Walk Teams. A National Memory Walk Team is a group of 10 or more individuals walking together as a single nationwide entity.

Chapters can get involved by selecting a team captain, who will recruit team members and set team goals. If you are interested in becoming a team captain or have questions about Memory Walk, contact Lauren Hickel, National Team Recruitment, Memory Walk at 800.272.3900.

Nurses for a Healthier Tomorrow campaign recognized with a top national award

Nurses for a Healthier Tomorrow, a coalition of leading nursing and health-care organizations, including Sigma Theta Tau International, has been awarded the Public Relations Society of America's 2002 Silver Anvil Award, which honors the best in strategic public relations planning and implementation.

It's a significant achievement, on par with journalism's Pulitzer Prize and Broadway's Tony Award.

The award in based on the campaign's research, planning, execution and results over a sustained campaign. There were 603 entrants in this year's Silver Anvil competition and only 47 winners. Nurses for a Healthier Tomorrow won in the public service category, besting strong campaigns from McDonald's and Gould Electronics.

"As a Silver Anvil Award winner, Nurses for a Healthier Tomorrow has been recognized by its industry peers to have met the highest standards of performance in the public relations profession," said Gerard F. Corbett, chairman of the 2002 Silver Anvil Awards and vice president of Hitachi America Ltd. "We congratulate them on the exemplary research, planning, execution and results they delivered in this program."

EVIDENCE, IDEAS AND ACTIONS... FROM PAGE 1

necessary leverage to give nurses the voice needed to affect change? "It can," according to Dickenson-Hazard, "*if* we have the capacity to create long-term, effective solutions and the strength to put them in action."

From The Robert Wood Johnson Foundation: Re-Envisioning Nursing

In a report entitled "*Health Care's Human Crisis: The American Nursing Shortage*" authors Bobbi Kimball, RN, MBA, and Edward O'Neail, PhD, MPA, of Health Workforce Solutions conclude that the complex and enduring nature of the current nursing shortage requires bold new solutions.

The study and report were funded by The Robert Wood Johnson Foundation and calls on the philanthropic sector to provide the crucial leadership and resources to help create and fund new solutions.

The authors' central solution is the formation of an independent body of nursing and health-care stakeholders to address the shortage and the reasons behind it. They call for the creation of a National Forum to Advance Nursing. This new organization would, as envisioned in the report, build upon the vast numbers of activities that are already underway, acknowledge their value and, ultimately, help nurses and nursing by further advancing the profession.

The proposed National Forum would focus on four strategic areas:

- Create new nursing models that address both the current shortage and broader health and social issues.
- Reinvent nursing education and work environments to align with a new generation of nurses.
- Establish a national workforce measurement and data collection system.
- Create a clearinghouse of effective strategies to advance cultural change within the nursing profession.

According to the report, "If lessons from the nursing shortage are any guide, addressing a systemic problem requires the input of all of those who have a stake in that system. The National Forum to Advance Nursing would provide the necessary structure to bring together all stakeholders in a collective effort to develop meaningful, lasting solutions to the American nursing shortage."

"Sigma Theta Tau will be at that table," responds Dickenson-Hazard. "This organization is already actively engaged—at an international level—addressing the nursing shortage and the issues behind it. We look forward to adding the voices of nurse leaders, scholars, educators and researchers."

From the American Hospital Association: Challenging Leaders to Change

The Commission of Workforce, a multi-disciplinary task force of the American Hospital Association (AHA), has recently published a detailed set of recommendations for hospital leadership entitled "*IN OUR HANDS: How Hospital Leaders Can Build A Thriving Workforce.*"

The report places nurses at the center of several of its clear and comprehensive recommendations saying "While technology, market share, financial performance, physician recruitment and facilities management are all important to a hospital's success, they fail to include an important truth: health care is always about people caring for people."

The report recommends that hospital workers, with nurses at the center, must be included in a human resource strategy based on continual input and a partnership model.

According to Dickenson-Hazard, "This report—aimed at hospital directors and administrators—is unequivocal in its language that so many current programs are not working. Clearly, a new model of care is required that lets nurses do what they do best, and it's encouraging to see administrators reading what nursing has been saying for years."

The AHA task force report makes five broad recommendations then balances each with the significant challenges that stand in the way. Concrete strategic and tactical recommendations are attached to each recommendation, supported by existing background data (when available) and profiles of hospitals (including individual administrators, complete with contact information) that succeeded in implementing tactics that have made measurable differences in care or positive contributions to the hospital's culture.

The categories forming the cores of the strategic and tactical recommendations are:

- Foster meaningful work
- Improve workplace partnerships
- Broaden the base of workers
- Collaborate with other hospitals
- Build societal support

This report calls for immediate and sustained action by hospitals, associations, schools and universities, foundations, and others—but identifies hospital leaders as the keys to making changes to address the current shortage and prevent a long-term crisis. In words of the report, "The changes are not easy...but they are necessary."

Nurse-Staffing Levels and the Quality of Care in Hospitals
By Jack Needleman, PhD, Peter Buerhaus, RN, PhD, Soeren Mattke, MD, MPH, Maureen Stewart, BA, and Katya Zelevinsky.
Published by *The New England Journal of Medicine*
www.content.nejm.org

Health Care's Human Crisis: The American Nursing Shortage
By Bobbi Kimball, RN, MBA, and Edward O'Neail, PhD, MPA, of Health Workforce Solutions
Funded by The Robert Wood Johnson Foundation
www.rwjf.org

IN OUR HANDS: How Hospital Leaders Can Build A Thriving Workforce
By the Commission of Workforce, a multi-disciplinary task force of the American Hospital Association (AHA)
www.aha.org

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