

**Betty Irene Moore Speaker Series**  
**Martha Norton Hill in conversation with Diana Russell**  
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**Chapter 1: Patient-Centered Care...It's a Team Approach**

Diana

You mentioned patient centered care along with outcomes based practice. I think that we as nurses often describe ourselves as patient activists. We hold that role as a very prominent role of what we do but sometimes I think obstacles get in our way. We don't fully embrace the full aspects of patient centered care. Why do you think we get distracted by some of the issues in the hospitals and more importantly, what can we do to address it?

Dr. Hill

I think there are several factors that we need to recognize and acknowledge. The one that to me is the most serious is the increasing complexity of the care environment. The increasing complexity of the technology and of the illness of patients and of the economic factors that are driving throughput. Just recognizing just how complex it is, is a first step. It decreases some of the notion that I as an individual, or that nurses as a single professional group alone are going to be able to make that much difference. I was at a conference a couple of weeks ago on nursing education and quality and safety. I listened for a while, and I said you know, you can teach nurses everything they need to know, they can get a 100 on every test, whether it is a simulation, or whether it is a rehearsal on a disaster response exercise or its any practice implementation. But nurses alone cannot save the day. Save the patient, save the hospital. It's got to be people who are working together, because we don't practice alone. So I don't think we should be taking on the professional responsibility and say we are going to fix it. I think we have to recognize that all of us are in this together and we need to welcome and embrace working. We are not going to solve the medication error problem without working with the pharmacy or pharmacist and the physicians at least. We are not going to solve some of the difficulties we have with finding the right equipment or finding the right supplies if we are not working with the administration. So I think it calls for an embracing and a commitment and the behavior that says this has to be about a team approach, it has to be about patient centered care. Then you behave differently when you accept that as the reality. The other thing is that we have to take on responsibilities as a professional group for lifelong learning. We have got to recognize that half of what we learned ten years ago is obsolete, probably half of what we learned five years ago is obsolete and we've got to be willing to do continuous education, go back to school and keep our skills up because the rest of the world is changing very very fast. If we don't do that, we are going to be left behind. That becomes another professional obligation and responsibility.

## **Chapter 2: The Importance of Asking “Why?”**

Diana

As nurse leaders in organizations looking at evidence based practice, I think sometimes the research aspect of it can be pretty daunting for a staff nurse. What have you done at Johns Hopkins to help your community hospitals in this area and help the nursing staff embrace research and evidence based practice.

Dr. Hill

There are two things we have done. One is to ask the nurses to listen to themselves. Take note of the questions they are asking that are frustrating in practice. So if it's, for example, why are these patients continually being readmitted? Let's take the heart failure patients. Why are they continually being readmitted? We tune them up, we reconcile the medication orders, we send them home, why do they keep coming back. It is the why questions. Listen to yourself, then ask others have you noticed this, do you see this? Do you agree that this isn't the right thing going on? Can we share a sense of responsibility for addressing these questions? Sometimes just getting the question asked and getting it discussed is in fact a contribution. But then say I'd like to be a part of the discussions of the questions that are going on at this hospital, or in this department to resolve some of these challenges. I'd like to be a part of it. And maybe then you bring your own clinical experience. For those of you who are students, and I hope that you all are in some way, whether you are in a formal program or not, but knowing how to do a literature review and volunteering and saying before the next staff meeting on this issue, I'll do a lit review. Or I'll get some articles about what other places have done. Or I'm going to call up Diana and say, "help me know some other magnet hospitals that I could call and see what they are doing about this". Participating and trying to figure out how we are going to answer the question. Reviewing questionnaires, offering to be a part, your unit, to be part of a pilot study. Getting involved is one way that really helps. We listen to the staff nurses and we will say what are your challenges, what are your problems. What is it you would like to address? We got our students involved by taking the undergraduate students that were involved in the utilization course, and we asked for clinical nurses in the hospital to volunteer to work with the group of five or six students. The staff nurses job was to find the why questions in practice. Then the students would do the lit reviews, the students would read the procedure manual, and they would look "is this evidence based practice, is there evidence to support this practice or the policy". And then they would do a report back to the unit. My favorite example... The why question... Why are we taking vital signs every fifteen minutes when blood is running? Students reviewed the literature, they got very upset and they were really anxious. I said what's the matter? They said can't find anything in the literature that supports why. They were sure that they had not looked in the right places, that they had not looked far enough. I said, "No don't make that assumption at all". I said, get on the phone, you call NB Anderson, you call Hutchinson, call Dana Farber, you know... call around and ask for the unit where they do run the blood on the

patients and talk to head nurse and ask them what they do and ask them to fax you their policy. We found policies all over this country that not one was alike anything else. Everything from we do vital signs before we start the blood and never do them again to we do them every 5 minutes, we were doing it every fifteen minutes, some were every hour. The point was, there was no evidence, the point was the practice was not standardized. There was no evidence based practice. That then led to the nurse who'd asked the question in the first place. With working with faculty, and then recruiting some physicians and got permission and got through the IRB to do a clinical trial. Where they randomized patients, the vitals signs every 15 minutes or the vital signs before the blood started running. And that led to a study, then they did a larger trial, that had more power and they presented it to ONS and the American Cancer Society and it changed policy, not only at our hospital, but it has an impact on changing policy across the country. And that came from one nurse listening to herself, asking the why question. But having students help getting that preliminary work done. I love that kind of model for how do you get academia and the teaching function paired up with practice so that it becomes a real win win. We look for those opportunities all the time. So some of the studies are ones the staff nurses are interested in doing. Some of them are taking what the faculty are interested in doing and getting them together and pairing it in a way that it becomes the win win.

### **Chapter 3: Defining yourself as a Learner**

Diana

I'd like to change just a little bit now and ask you about inter-disciplinary collaboration. I think many of us feel that things are changing but changing rather slowly and that we as nurse leaders need to be the drivers, at least to some extent to change within our own organization so that there is more inter-disciplinary collaboration between professionals. I know that you have worked hard at Johns Hopkins to setup a model of collaboration between the nursing, the medicine and public health sections. Can you tell us a little bit about that. The success that you have had.

Dr. Hill

Sure. It began actually on the units. When I was even a student, and we had rounds, and the physicians would do rounds and the students and nurses were expected to go on the rounds. It is interesting to me that if you have read the recent literature on ICUs they have rediscovered rounds? That is the teaching opportunity for people to share information and to listen, to learn from each other. That is the basic concept. It is to listen to others and it is to share what you know that is a contribution to improving their knowledge of this patient of a particular condition or of a practice on the unit or something that is not going right where you need a chorus of voices to try to understand what is the root cause analysis and what is going to be done about it.

Because patching is only patching. And if you really have not peeled it back, what is the fundamental contributing factors, you don't fix it. You're just patching. I think having that respect for other people and having a desire to understand their world view is absolutely fundamental. In an academic or teaching hospital it's much easier because I think the culture is already set for that. I think in a community hospital where there are different drivers, or different environmental factors it's much harder. That is to say it is different and it calls for different approaches. I don't think there is any doubt that people who come into the health professions are altruistic. They do want to do good, they do want to make a difference and so sometimes just asking somebody... I know that my colleagues who work in the community hospitals... the whole phenomenon of the Attending, when they are in and when they're out and how little that they are there and how do you catch them... But asking, just asking them, "Is there anything I can do for you? Is there anything you'd like me to do to help your patients?" Or try the plural pronoun... "is there anything WE can do to help OUR patients?" ...is a way of opening up some communication. I think that volunteering to serve on hospital committees is a way to learn what is going on. Get the data from the administrators about what they are dealing with. The morbidity and mortality conferences, nurses are typically not involved in those at all. Showing up is a very powerful statement for saying I am just here to listen and to learn. I'd like to know what's happening. I would like to know what I could do and what my colleagues can do so that we as a team and we as a hospital can do a better job. Going back to school, I keep stressing this, when you go back, for example, and go get your masters degree, for those who have a masters and go get your doctorate, when you become a student, you have a different persona. People will take an interest in you as student. They will give you time and attention. That you don't get in your professional role. My mentoring of people is to say take that attention and time and use it. Use it to learn and participate. You will get mentorship because you are a student. And that changes the whole dynamic. The next thing you know, you will become a colleague and you become a "co...", co-worker, co-investigator, co-caregiver in a way that you weren't before. Some people say it's like taking three steps back, and I said yes in order to get 10 steps ahead. It is redefining yourself as a learner in a way that other people see you differently because you have declared that you want to change your knowledge and change your competencies. That is the single most powerful strategy.

#### **Chapter 4: Bedside Nurses are Battlefield Commanders**

Diana

I read one article that you wrote and you described the bed side nurse as the battlefield commander. I think that many days we feel like that and we are in a lot of struggles, it does spotlight the leadership role that nurses play and the significance and impact that they have.

Dr. Hill

Yes, the battlefield commander is on the front line. There is no question about it, I once heard... this was the president of the university giving an alumni gathering talk in Philadelphia and the president of Johns Hopkins, and he was talking about how the physician is the captain of the ship. This went on for a while and just could not stand it any longer. When it came time for questions and answers, I said respectfully I would like to suggest an alteration on the metaphor, that the physician is the captain of the ship, if the ship is the patient unit, I am going to suggest that the captain of the ship is the nurse in charge. And the physician usually is the admiral of the fleet. Which is to say, back at headquarters. There is a chain of command, and there is a hierarchy of credentials and presumably of competencies and skills and authority and so forth, but let's face it, but most of the time on the patient care units the captain of the ship is supposed to be on the ship, right? Recognizing the reality and being respectful of who is there independent of title and degree. Who's got the responsibility is a way to shift the dialog, and I think that's been one of the issues where when I think historically what's happened you know we used to have patient care units, now we have cost centers. We used to have head nurses, now we have nurse managers. If you think about what's changed, it is the shift of the business model in delivering health care and they talk about too many lawyers, well we can talk about too many MBAs or too many administrators. That is where nursing has got to catch up fast with our own competency and knowledge of administration today. If you don't know budgeting, and if you don't know systems level change, then you can't be at the table for most of the discussions, never mind being at the head of the table chairing the meeting. That is why I think this whole notion about evidence based practice, competency, performance is our opportunity and we should be deliberately and intentionally looking for ways that we can participate meaningfully. Not out of entitlement, but out of competence and contribution.

## **Chapter 5: Effective Collaboration between Education and Service**

Diana

Speaking of working together, another area we have been focusing on in the bay area is a stronger collaboration between education and service. I know that at Johns Hopkins you have two programs, the spring and the leadership fellowship program. Can you tell us a little bit about that and how that has improved the collaboration between service and education?

The spring program was set up as an orientation for new graduates and it is a nine to ten month long orientation. Not two weeks, not six weeks because what we learned was that it takes a whole lot longer. You've got to provide that mentorship and the preceptorship. If you do it right, if you invest in your new graduates, your new hires, then your retention rates are dramatically higher. It is that old "You get what you paid for" story. So why would you keep hiring people that you are going to lose because you are not giving them what they need to stay. So it is matter on the service side so that not only knowing the reality, but thinking in a constructive way about

how to make it different. This spring program at Hopkins has been pretty well publicized, written up, and it is something that is... and if you go on the Johns Hopkins web site you can find some data about it. What we did recently was that we hired the person who founded and led the spring program to come on over to faculty. She still has an appointment in the hospital, but it is to help us better know and understand those competencies and the attitudes and ways that we can get the students even more engaged in the hospitals, which allows the hospitals to select and pick and mentor the best and brightest students at the least expensive recruitment and the highest retention. So it is this win, win. Now the full leadership program is where we, in watching what is happening at the hospital and you are always trying to look for the new wave. It was the quality, safety, innovation movement. How do we take that movement and bring the content into the school, in the curriculum? So the students are aware of this movement and they become early change agents themselves and we are educating them to look at system level change, to understand data on falls, data on medication errors. To learn how to do a root cause analysis, and they get put on project teams on the hospitals if they are a full scholar. They have to apply, they have to be interviewed, and they get a five thousand dollar scholarship, if they come in this program, they come to extra classes and they, on extra time, get involved in a project in the hospital which might be a unit based project for preventing falls or finding clean sheets or whatever it is that needs to happen. And they join those teams as the student. And remember about what I said earlier about the benefits a student. So you get that halo around you and people gravitate around you to help mentor you. Then they trained how to do a lit review, so that the product at the end is at least an abstract that can go to a profession meeting so that the other people they are working with, the administration interns and the physicians and whoever is part of the team they all get on the abstract, they shop it around to different professional meetings and even write some manuscripts on preliminary projects or pilot projects. It has become it a real win win for the service unit as well as something and honorific for the students.