TCAB 2 :
AONE Helps Hospitals Improve Care Through Second TCAB Effort

By Terese Hudson Thrall

AONE
The Voice of Nursing Leadership™

Overview

Transforming Care at the Bedside (TCAB) is a program that seeks to improve patient care and the work experience for nurses, providing a natural fit with AONE's goals to design future patient care delivery models and transform the culture of nursing units in ways that improve patient care. "Implementing programs such as TCAB fosters the development of nurse managers, who gain new skills through leading these initiatives. At the same time, these nurses are improving patient care and practice environments," said AONE CEO Pamela Thompson, RN, MS, CENP, FAAN.

After administrating a successful TCAB initiative with 67 hospitals, funded by a $1.5 million grant from the Robert Wood Johnson Foundation, AONE made the decision to continue working with new hospitals in a self-funded initiative beginning in August 2009. Units at 50 hospitals participated in the two-year initiative, in which they used TCAB processes to introduce care improvements.

Of the 50 hospitals, 32 participated in face-to-face meetings and monthly conference calls, while the remaining 18 participated "virtually" through conference calls and webinars. The webinars covered topics to help the units implement TCAB, including information on how to secure nurse manager engagement and how to spread TCAB to other areas of the hospital.

Webinar Topics

- Nurse Manager Engagement
- Transformational Leadership
- Negotiation and Conflict Resolution
- How to Build and Nurture a Successful TCAB Team
- Patient Safety and TCAB
- Spreading TCAB to Other Hospital Units

Advice from CNOs for making TCAB successful

- It's helpful if the hospital already has a staff participation model in place, such as shared governance. Then the TCAB model dovetails with the hospital's culture.
- Choose a unit with a manager ready to share leadership responsibilities and delegate significant TCAB duties to others.
- Choose a unit with an enthusiastic staff that has already demonstrated it has ideas for improvements.
- Publicize positive outcomes with hospital staff; recognize unit work through rewards and through opportunities to present TCAB innovations in venues outside the unit.

Source: Interviews with CNOs from Concord Hospital, Emory Healthcare and Hartford Hospital.

In the 16 months ending in December 2010, the 32 non-virtual participants tested more than 900 TCAB innovations, with the result of nearly 400 adoptions of innovations—everything from moving supplies to changing the patient care model.

Participants counted the number of instances that the innovations achieved the prime goals of TCAB: creating patient-centered care, increasing efficiency, improving safety, and creating a higher level of work life vitality and teamwork. (See TCAB Innovations chart on page 3.)

During the first year, hospitals in the initiative also reported the incidence of falls, falls with harm, and pressure ulcers. Many of the hospital units experienced a decrease in at least one of these areas, even though a number of the units already had a low incidence of falls or pressure ulcers. These data points are considered key indicators of patient-centered care, and were measured in previous TCAB initiatives led by the Institute for Healthcare Improvement and the Robert Wood Johnson Foundation.

TCAB Innovations for 32 Hospitals

Count	Hospital	Total TCAB Innovations	Domain				Innova-tions Adopted	Innova-tions Abandoned
			Counts of Patient Centered	Counts of Efficiency	Counts of Safety	Counts of Vitality		
1	Abbott Northwestern Hospital	34	10	12	6	6	14	2
2	Abington Memorial Hospital	28	6	6	9	7	5	
3	Baptist Hospital of Miami	23	14	7	3		8	3
4	Bayhealth Medical Center	17	9	2		5	4	2
5	Carilion Roanoke Memorial Hospital	16	4	4	2	8	12	3
6	Carolinas Medical Center	22	11	3	2	6	8	3
7	Concord Hospital	11	14	12	5	2	10	3
8	Detroit Medical Center – Harper Hutzel Hospital	27	19	4	1	2	22	2
9	Elliott Health System	11	5	10	1	2	14	1
10	Emory University Hospital	35	3	5	22	4	6	1
11	Emory University Midtown	25	9	7	17	7	1	1
12	Exempla St. Joseph Hospital	56	27	21	5	2	38	3
13	Gillette Childrens Speciality	84	23	25	12	25	41	4
14	Holy Spirit Hospital	47	34	2	3	7	22	9
15	Integris Baptist Medical Center	25	18	3		2	5	5
16	Jennie Stuart Medical Center	29	14	10	3	4	18	1
17	Kadlec Regional Medical Center	74	19	23	11	14	26	4
18	Lawrence & Memorial Hospital	29	16	16	9	8	22	11
19	OSF Saint Anthony Medical Center	19	15	4			6	3
20	OSF St. Francis Medical Center	59	17	6	6	12	11	4
21	Parkview Hospital	26	8	4	4	5	15	1
22	Portland VA Medical Center	9	4	19	8	11	1	
23	Resurrection Medical Center	41	37	14	21	3	5	3
24	Saint Barnabas Medical Center	35	21	3	1	14	10	4
25	Santa Clara Valley Medical Center	22	13	3	3	3	13	1
26	St. Mary's Hospital	10	6	3	2	2	3	1
27	The Children's Hospital of Philadelphia	12	12		4		3	
28	The Christ Hospital	25	12	5	5	2	22	
29	The Nebraska Medical Center	34	15	11	2	5	5	
30	University Medical Center at Princeton	18	11	4	2	3	10	2
31	University of Alabama at Birmingham Hospital (UAB)	7	2	7	1	2	2	
32	Waterbury Hospital	16	10	4		2	5	
	Grand Total	**926**	**438**	**259**	**170**	**175**	**387**	**77**

Following are three case studies from hospital units that participated in the initiative. Among their results are reductions in overtime, falls, and pressure ulcers, reductions in the need for emergency interventions and increases in patient and staff satisfaction.

Building on the success of its TCAB dissemination programs, AONE has launched the Center for Care Innovation and Transformation which will oversee the Care Innovation and Transformation (CIT) initiative.

CIT will include additional tools to address nursing leader growth, culture change and health reform implementation. Forty-seven hospitals were participating in the CIT initiative by the end of 2011, and in 2012, more hospitals can apply to join a new cohort. Similar to the earlier TCAB initiatives, participating nursing teams at hospitals will be guided by face-to-face meetings, conference calls and webinars.

A TCAB Primer

TCAB, or Transforming Care at the Bedside, began in 2003 and was initially developed and led by the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement. The program sought to increase the nurse time at the bedside, improving working conditions for nurses through efficiency and improving care quality and the patient experience. This, in turn, was hoped to decrease voluntary nurse turnover and revitalize nurses' commitment to their profession.

While the decision to participate in TCAB is made by a hospital's leaders, it is the front line workers, nurses on the floor, who most often make the suggestions on ways to improve care. TCAB's four key goals direct the types of changes that are tested on units participating in the program. They are: safe and reliable care, vitality and teamwork, patient-centered care, and value-added processes (increasing efficiency).

After changes are suggested, units use a specific process to test them, employing four steps with the acronym (PDSA), or Plan, Do, Study and Act.

Plan: Plan the test, including a plan for data collection.

Do: Try the test on a small scale. This could be as small as one nurse on one shift.

Study: Analyze the results, and compare them to predictions.

Act: Determine if modifications to the change need to be made and prepare for a larger test, if warranted.

What started as a project in 2003 through RWJF and IHI, with three hospitals piloting the TCAB processes and ideas, has since spread to hundreds of hospitals.

A TCAB Primer draws information from Rutherford, P.; Moen, R.; Taylor, J. TCAB: The 'How' and the 'What'. *The American Journal of Nursing*, Nov. 2009.

Hartford Hospital

Hartford, Connecticut
General Surgery Unit
42 beds
40 RNs

Improvements in numbers of falls, pressure ulcers, incidental overtime, length of stay

When one of Hartford Hospital's general surgery units began as a virtual participant in AONE's TCAB initiative, it had a particular problem it wanted to address: an inability to consistently meet an on-time 11 a.m. patient discharge. "The discharge time was a target goal, but a lot of things impacted that," said Susanne Yeakel, RN, MSN, nurse manager on the unit. "The factors were like pieces of a puzzle." While the obvious place to look for improvements involved the discharge rounding itself, the unit's staff found that the dietary and radiology departments could also contribute to delays.

To work on the 11 a.m. discharge, staff selected bariatric surgery patients as a group, and produced a process map starting with the time the discharge order was sent until the time the patient left, checking for trouble spots. One of the delays identified was the occurrence of diet changes for patients, who need to eat before they can leave. Yeakel explains that on a surgical floor, diets frequently change. "It can take up to two hours to get the correct tray for a patient," she said, "and that could delay discharge." To combat this delay, the unit worked with dietary to set up contingency carts for breakfast, lunch and dinner containing some of the frequently required meals. "Now if the patient has clear liquids sitting in front of her and she needs something else, the nurse can pick up the correct meal at the contingency cart," said Yeakel. Nursing also made sure bedside tables were cleared of equipment so trays delivered at 7:30 a.m. could be given immediately to patients.

Staffing for discharge

Another change that helped to improve the numbers of patients discharged was to add an especially assigned discharge nurse, which amounted to an extra half-position for the unit. That nurse starts her shift at 9 a.m. For six hours, she works on the tasks that lead to discharging patients, allowing other nurses to continue their duties. Nursing also created preprinted discharge instructions for bariatric patients--which spread to the unit's colorectal and urology patients-- to streamline and standardize the discharge teaching. The unit also worked with the radiology department to give pre-discharge patients priority, so patients were not waiting for imaging procedures.

The unit's data show an increase in the number of patients discharged by 11 a.m. rising from 14 percent to 22 percent, comparing data from November of 2009 with September 2010. The percentage for August 2011 was 25 percent. The unit also saw a slight percentage increase in the number of patients discharged earlier than the geometric mean length of stay set by Medicare.

As the unit staff worked on decreasing post-11 a.m. discharge, it found other ways to improve patient care. When the unit worked on a template for uniform discharge reports, it found it could also be used for bedside reporting, another innovation the unit wanted to implement. "We didn't want to create one more thing for nurses to do, we wanted to keep it in their daily practice, but improve the processes," said Yeakel.

Bedside reporting advantages

Yeakel noted that the key to getting staff on board with the bedside report was showing its advantage to staff—how it improved patient morale and safety, in addition to making staff more efficient.

Linda Spivack, RN, MS, and Hartford's former vice president of patient care services, who oversaw the initiative, agreed. "The individual nurse has to

see why the change will benefit her patients," she said. But TCAB processes, which involve soliciting solutions from staff, were also key. "If you try to impose change on people without involving them in making the change happen, it won't be sustained," said Spivack. "If you want a change to last for years, instead of days, nurses have to value it because they see the results--and they have to be able control and manage the evolution of the practice change. "

Bedside reporting is one change from which nurses have definitely seen value. The Hartford nursing unit credits this change with reducing falls, pressure ulcers and incidental overtime that occurred during shift changes. The chart below measures indicators from January through May of 2010, five months before bedside reporting was initiated, and September 2010 through January 2011, five months after bedside reporting was in place throughout the unit.

Hartford Hospital TCAB Outcomes

Outcomes	5 months pre-Bedside Report	5 months after all unit nurses using Bedside Report
Monthly average aumber of falls	1.4	0.8
Number of pressure ulcers per 1,000 patient days	2.2	2
Monthly average hours of incidental overtime	19.5	12

Bedside reporting has improved patient safety because a pair of fresh eyes is assessing the patient, and in several instances the insights of an observant nurse have resulted in immediate action. "One patient was suffering from internal bleeding, and because of bedside reports that patient was back in the OR in a half hour," noted Yeakel. Nurses also check that patients are positioned properly, have call lights and drinking water conveniently close, and that bed alarms are properly working. These checks contributed to the drop in pressure ulcers and falls, noted Claire Quaggin, RN, a veteran nurse who championed the unit's TCAB innovations.

The standardized bedside report, using an SBAR format, (Situation, Background, Assessment, Recommendations) made it possible for a nurse completing a shift to finish updating the oncoming nurse in less time. This, in turn, reduced incidental overtime.

Patient morale also improved with bedside reporting, during which time patients meet the oncoming nurse. "Before bedside reporting, during shift changes patients felt alone. Now they see a face and have a number to call," said Sara Hickey, RN, BSN, a floor nurse who piloted bedside reporting. In the morning bedside report, patients receive a plan for their day, which might include getting out of bed with the help of a physical therapist, or learning how to use a glucometer. This gives patients something to look forward to, said Yeakel, and also helps patients become more involved in their healing.

Countering resistance

However, some nurses resisted converting to bedside reporting. "The pushback from some nurses involved the fear of HIPAA violations," said Hickey, but those fears were unfounded. After the hospital's legal department researched the topic, the unit found that the content of bedside reports wouldn't violate HIPAA restrictions. Other nurses were uncomfortable talking in front of the patient. One remedy: Hartford nurses ask patients for the permission to report at the bedside. Once nurses saw that the bedside reports weren't a surprise for the patient, they became more comfortable. "We are not giving patients awful news or test results," noted Hickey. "We are explaining all their tubes and lines. It's not anything out of the ordinary."

To make the change, some nurses practiced in the hall before reciting at the bedside, and peer pressure played a role. "The champions went to the bedside and wouldn't come out until other nurses came in," said Yeakel.

Another change--which Yeakel credits with lowering the number of falls and improving operations—was the introduction of "huddles," short meetings for the unit staff that occur at 8 a.m., 4 p.m. and midnight. The meeting gives the staff information about which patients are at risk for falling, and the numbers of patients being discharged or being transferred from the ICU, and how many nurses are on staff. In a large unit in which nurses do not circulate to all areas, noted Yeakel, the huddle can create a team atmosphere. When nurses are walking down the hall, they put their eyes on the room of the patient who's at risk for falling or nurses may offer to help a nurse who has a very ill patient. Patient care assistants and unit secretaries are included in these meetings, making them aware of conditions for the unit's operation that shift. Staff see a real value in the huddle and make it a priority, said Yeakel.

Bedside reporting is spreading hospital wide and should be completed by April 2012. Yeakel notes that her staff has presented information about bedside reporting to other regional hospitals that are interested in introducing the practice. Other units at Hartford are using the standardized discharge instructions, staff unit huddles and one unit has added a discharge nurse.

Spivack noted that the most important success is the commitment nurses now have to their performance improvement activities. "They feel personally invested in improving the care they are delivering. They will inspire other staff," she said. "They want to go to every other unit in Hartford Hospital and show nurses how they can make these changes work in their units."

Concord Hospital

Concord, New Hampshire
Telemetry Unit
26 beds
35 RNs

Improvements in patient satisfaction, missing medications, staff satisfaction, injuries from falls

At Concord Hospital, a lot of small changes have created a big difference for nurses. When nurses at a telemetry unit generated ideas to improve operations, they went to work on the irritating and inconvenient issues that confronted them daily.

The first innovation, and one that convinced nurses that TCAB had leadership support, was an interior design change. The unit is laid out in a square shape with an exterior hallway going around the circumference, with a counter running through the middle. Nurses on one side of the counter had trouble reaching patients that were in rooms on the other side. "A bed alarm would go off and a nurse would have to go all around the unit. The staff thought it was a safety concern," said Wendy Burke, RN, BSN, unit manager.The nurses suggested a cut in the center of the counter, so that nurses could walk through the middle of the unit, creating a short cut to get to the patient rooms. The design change was completed in just two weeks, which impressed upon nurses that their suggestions would be heard and executed.

Another constant irritation was missing medications. The problem, explained Burke, is that medication carts would be changed at 11 a.m. If patients were off the floor, they would not receive their medications. When nurses used medications from the new cart, they were taking medications that were slated for later shifts, so the nurse on the next morning shift would open a medication drawer to find that she was short the needed dosages. The unit staff, along with pharmacy staff, brainstormed solutions. At first, the unit tried leaving reminder cards for pharmacy staff to tell them to leave the medications in the drawers, which did have an impact, but ultimately, the pharmacy agreed to change the time that replacement carts were brought to the unit to 2 a.m., which cut the number of missing medicines in half.

Reduction in Missing Medications

- August 2009 – 9.6 medications per day missing
- December 2009 – 8.1 medication per day missing
- October 2010 – 4.6 medications per day missing

Working on efficiency, safety and the patient environment

Two other changes to aid in efficiency were moving patient education materials and insulin, which were both out of the way for nursing in normal traffic patterns. The insulin was kept in a refrigerator in a locked room. After researching the problem, the unit staff learned that the insulin didn't need refrigeration, opening the way to a more convenient location. "Having supplies closer to where nurses are working cuts down on my travel time," said Janet Harmon, RN. "It makes my day go better and I am spending more time at the bedside."

Another change that helped nurses better serve patients was the purchase of larger white boards. Before, the boards contained only enough room to see the names of the shift's nurse and nursing assistant. Now that board contains information such as patient goals for the day, how the patient ambulates, and if the patient has glasses. This helped ease staff shift changes and helped oncoming nurses quickly see what patients would need that day.

To decrease falls, the unit trialed low beds, which can be raised for nursing care and lowered to one foot from the floor. The unit also used "regrouping," a 10:30 a.m. meeting, for unit staff to communicate which patients are at risk for falls. Burke attributes these changes, among others, for dropping the unit's injuries from falls from 12 in 2009 to 5 in 2010.

Concord Hospital Patient Satisfaction and Team Vitality Outcomes

TCAB Healthcare Team Vitality Instrument Survey results for RN's 2010 – 2011*		
Questions done on a likert scale of 1 – 5	**2010**	**2011**
I have easy access to the supplies and equipment I need to do my work on this unit	3.5	3.9
The work environment on this unit promotes patient safety	4.0	4.5
Nurses physicians and other staff on this unit work as a high-functioning team	4.2	4.5
I speak up if I have a patient safety concern	4.7	4.9
Important care information is exchanged during shift changes	4.2	4.5
Care professionals communicate complete patient information during handoffs	4.1	4.5

*In 2010, 22 nurses responded to the survey. In 2011, 18 nurses responded to the survey.

Press Ganey HCAHPS 12-month average, 2010 – 2011			
	July '09-June '10	**July '10-June '11**	**Percentile Rank**
Would you recommend this hospital to your friends and family?	77%	84%	97%
How often did the nurses treat you with courtesy and respect?	88%	91%	98%
How often did the nurses listen carefully to you?	73%	82%	96%
Before giving you a new medication, how often did staff tell you what the medication was for?	69%	82%	97%

The unit also made a number of enhancements to the patient's environment. For instance, the unit installed a wider ceiling track for the curtains that encircle beds so that patients have more room to have a commode next to their beds. The unit placed signs outside patient rooms to remind staff to knock on patients' doors before entering, allowing them to prepare for a visitor if they are uncovered. Burke attributes an uptick in both patient and staff satisfaction to such improvements in the working environment.

Bedside reporting—a long introduction

But not all the changes went smoothly. The unit tried to start bedside reporting in 2009, but had resistance from staff. The previous method of nurse shift change reporting was through audiotaped notes that the oncoming nurse listened to in a conference room, away from patients. While some of the nurses had privacy concerns due to the unit's semi-private rooms, Burke believes most of the pushback was due simply to the difficulty of adapting to change. "When we tried to introduce it the first time, we had to back off," she said.

Two years later, in September 2011, Burke's unit converted to bedside reporting, but only after a number of steps allowed staff to adapt to the change. For instance, as an interim step, the unit used bedside handoffs. Instead of a full report, both nurses went to the bedside, introduced the oncoming nurse and checked on the patient.

Nurses also role played the bedside report, with a nurse playing the patient. "We included issues nurses were sensitive about, such as using a situation in which the patient was recovering from alcohol abuse," said Burke. Unit nurses watched a bedside report and then each was able to role play, giving a report. Unit staff also visited another hospital to watch actual bedside reports given in semi-private rooms, similar to the situation they would face. The Concord nurses addressed privacy concerns by asking visitors to leave the room for bedside report. If patients want the person to stay, they can request that, but nurses don't want patients left with the responsibility of asking their loved ones to leave.

Then the unit developed a standardized report used for either audiotape or bedside use. This created a situation in which some nurses wanted to do it at the bedside, no longer wanting to tape the reports, and others did not want to tape some reports and perform others at the bedside.

Data on time savings also drove change. Under the old system nurses were taping their report and then doing bedside handoffs; the new system combines the report and handoff, resulting in a nearly 50 percent reduction for nurse time spent on this activity. The old system used 19 minutes per patient; the new one, 10 minutes. This drops the nurse time needed for this task—for a nurse who has normal load of four patients--from 76 to 40 minutes. If a nurse has been off-duty for only 12 hours, the 40 minute figure can drop even lower, noted Burke.

The time savings for nurses has translated into a budget bonus. When the unit director compared monthly end-of-shift overtime in October 2010 and October 2011, she saw a 39 percent reduction. With the unit's average RN wage of $30 an hour, that computes to a $1,011 a month savings, more than $12,000 annually.

In the end, none of the nurses' fears were realized—that patients would dislike bedside reports, or that the reporting process would be lengthy and inefficient.

"The patients absolutely love it," said Burke, who noted that one patient was so well informed about his condition that he also could give a bedside report.

In the fall of 2011, the Concord unit began spreading TCAB to other hospital units, teaching them how to brainstorm and the Plan, Do, Study, Act method that TCAB employs. The hospital plans to link TCAB ideas and LEAN training to create improvements hospital wide, said Diane Allen, RN, MS, NEA-BC, vice president of operations and CNO of Concord Hospital.

"What's important is the sense of ownership that TCAB participants develop," said Allen. "Through these methods, everyone has a chance to participate and improve the quality of care delivered on the unit."

Emory University Hospital Midtown

Atlanta, Georgia
Renal services unit
48 beds
50 RNs

Improvements in codes blue, patient satisfaction

For Emory Healthcare, joining the TCAB project dovetailed with other initiatives the system was undertaking. "We were already using a care model that used staff participation and we thought TCAB would give those efforts more energy," said Susan M. Grant, RN, MS, FAAN, NEA-BC, CNO of Emory Healthcare, the parent organization for Emory University Hospital Midtown. Units at two of the system's hospitals participated in the project. Robert A. Vautier II, RN, MSN, director of the service line that includes two units that care for renal patients, was part of that effort. The combination of changes on his two units has improved metrics for patient satisfaction and safety.

One way to improve care was to increase patient and family involvement in care delivery and healing. Toward that end, the service line created a brochure to orient patients to the unit. The brochure, produced with input from staff and patients, stresses that the two units' priority is the physical and emotional healing of the patient, and that the units seek to exceed patients' expectations. To make good on these goals, the brochure asks patients to contact the unit director immediately if their needs have not been met.

Patients on the units are introduced to bedside reporting and hourly rounding through the brochure, and it tells patients that they should have daily recovery goals. Because of the brochure, patients are more likely to ask questions and talk to their nurses, said Simone Jackson, RN, a mid-career nurse on the unit. "I had a patient tell me that 'I feel like I belong here. I have all these [phone] numbers, I have people I can talk to.'" The brochure also helps patients after they leave the hospital, explaining the role of the renal transition manager, who coordinates care during the hospital stay and checks on patients at home after discharge.

The changes that have taken place during TCAB have made Jackson feel more connected to her patients. Data from the units' patient satisfaction survey bears this out. Rankings improved for the statement "the nurse kept you informed", rising from 66.7 to 90 percent from August of 2009 to the quarter ending January 2011.

Another area that Vautier's units sought to address was increased efficiency and standardization for nurses giving discharge instruction. A special projects team assembled packets containing a list of patient exercises and necessary items. Previously, staff would have to create the "teaching bundle" each time, with nurses spending time scanning for items in supply areas.

Changing the Rules for calling a 'Code MET'

Perhaps a change that was more noticeable to patients was a more inclusive set of rules governing who could summon the unit's rapid response team, called the Medical Emergency Team. In the past, only nurses could request this team to evaluate a patient. Now, nursing assistants, housekeeping and family members can call for the team. The rapid response team includes an ICU nurse and respiratory therapist, who evaluate the patient and can start interventions to resolve patient conditions that could become life threatening. The MET brings assistance immediately to the bedside, instead of delaying action until a physician can assess the patient.

"The family members often can see very subtle changes in a patient's condition before vital signs or other indicators change," noted Vautier. But this rule change engendered a culture shift. "We needed to institute a 'no retribution' policy if a staff member called the team and the patient didn't have life-threatening issues," said Vautier. "The attitude has to

be, 'We'd rather have 30 false calls than miss a call that was needed.'" The patient brochure includes instructions for the family on how to call the Medical Emergency Team.

More staff accepted this change—and the perceived inconvenience that the increased number of calls entailed—when they saw the difference early intervention could make. For instance, noted Vautier, a patient with high blood pressure whose condition is recognized and treated could spend a couple of days in the ICU, come back to the renal services unit and be discharged. Untreated, this same patient could have a stroke, spend several weeks in the ICU and be discharged with permanent damage. "Some of the staff who were reluctant to call the team, have become our biggest champions," he added. The program has also caused a drop in the instances of "code blue," in which an emergency team is called when a patient is not breathing or has no pulse.

Another change involved using intentional rounding. While the units already used hourly rounding before the TCAB initiative took effect, nurse leaders wanted to change the way in which it was performed. The difference is a specific set of questions for a patient, including whether the patient's pain medications are adequate and whether the patient needs a visit to the restroom. Vautier noted that many falls are due to patients trying to get to the bathroom alone. After such a fall, staff will ask a patient why she didn't turn on a call light to get assistance. "Patients will often reply, 'The nurses looked so busy, I didn't want to impose on them,'" said Vautier. "We need the ability to help patients when they need help."

As the renal service line's changes have proven successful, some of the changes have spread, such as the intentional rounding and the rule changes for calling a Code MET, both of which went system wide. Other units at Emory Midtown have developed their own orientation brochures.

The renal service line nurses also have been recognized for their efforts, with hospital leaders rounding on their units, and staff presenting to nurse leadership. "It shows the unit staff that others at the hospital are aware of their accomplishments," said Grant, "and are just as invested in it as they are."

More than any of the service line's initiatives, Grant values the change in staff attitude that the TCAB initiative engendered. At Vautier's units, staff members and nurses are eager to know about the clinical outcomes associated with their innovations, and their patient satisfaction scores. "I've never seen anything like it. So many nurses were so motivated and improved outcomes," said Grant. "Unit leaders were able to get people to step up to the plate, and that is a real testament to the commitment to TCAB."

Terese Hudson Thrall has written about health care issues for 20 years, and served as a senior editor and a senior writer on **Hospitals & Health Networks**, *the flagship publication of the American Hospital Association.*