

Critical Care MANAGEMENT™

The essential monthly resource for critical care and intensive care managers and administration

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NOVEMBER
1998

VOL. 2, NO. 11
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Biomedical concerns get lost in high-tech world of critical care

ICUs need to apply death-and-dying principles in easing families' pain

After two decades of discussion, debate, and litigation, the principles of dealing with the difficult biomedical ethics issues posed by dying patients are well-established. Advance directives; surrogate decision makers; support for families dealing with loss, bereavement, and abandonment; and guidelines for use of life-support systems and “do not resuscitate” orders are all part of the medical culture.

The challenge remains, however, to ensure that the principles are applied in the everyday activities of the intensive care and palliative care units. With the ever-evolving capability of medical technology, there are few certainties. So the process has focused on making sure patients and families are actively involved in understanding the course of illness and decision making about treatment.

“It is important to go from written guidelines issued by elite groups and reach into the trenches with the professionals who care for dying people,” says **Bruce Jennings**, executive vice president at the Hastings Center, a medical think tank based in Hastings, NY.

Bioethics program acts as a support service for physicians

Jennings co-founded a program called Decisions Near the End of Life, which has been implemented in some 200 hospitals in 20 states and is designed to include the principles of bioethics as part of the normal course of treatment of seriously ill and dying patients. That process

EXECUTIVE SUMMARY

The goal of the Decisions Near the End of Life program is to include the principles of bioethics in the daily treatment routine of the doctors, nurses, social workers, and pastoral care workers who treat and care for critically and terminally ill patients. The program was co-founded by Bruce Jennings, executive vice president at the Hastings Center, a medical think tank based in Hastings, NY.

has worked its course at Deaconess Beth Israel Hospital in Boston.

For the past 20 months, Deaconess has operated an ethics support service that is available to all physicians attending to patient care on a 24-hour-a-day, seven-day-a-week basis. "In practice, it is no different from other support services in the institution. It's not a bioethics committee per se, but a support service. It is integrated into daily life around here," says **Marion Longo**, a psychiatric clinical nurse who runs the hospital program.

In addition, the hospital conducts seminars once a month among its palliative care issues group and monthly education seminars presented by ethicists for resident physicians. "It is built into the training program," Longo says.

The bioethics consultation process is initiated with a call to the service's in-hospital hotline, which is staffed by on-call bioethics advisors. That advisor will discuss the ethical issues that have arisen in the care of an individual patient and help develop a course of action.

In more complex situations, a formal ethics consultation will be arranged with a standing bioethics group. This group is formed from a roster of physicians, nurses, social workers, and lay people who convene to discuss in greater detail the ethical conflicts in a patient's care. This consultation group will make recommendations concerning individual ethical situations, "but the decision always remains with the attending physician," Longo says.

In addition, a group of ethicists, led by Longo, tour the hospital each week to review cases and attempt to anticipate issues that may arise.

Typical cases may involve determining who makes decisions when a family member is on life support and the attending physicians have concluded that life support should be withdrawn, making the transition from aggressive care to palliative care, removing information from medical records that could be damaging to patients or families, or dealing with chronically ill patients who want to be released from the hospital to commit suicide. "Do we let them go?" asks Longo.

How to keep patients involved in treatment

Strategies seek to achieve compatible outcome

As a result of its grand rounds program for residents in the surgical intensive care unit, the bioethics team at Deaconess Beth Israel Hospital in Boston identified seven key strategies to achieve an outcome compatible with a patient's wishes regarding treatment.

They are as follows:

1. Learn and understand the patient's wishes. The attending physician is the key person in initiating and continuing discussions with the family. However, there are no firm guidelines on when it is best to initiate those discussions; each family requires a different approach. However, in general, the sooner the discussions are initiated, the better the result.

2. Build an alliance with the patient and family members. It is important to maintain ongoing discussions with the patient, family members, and if necessary, surrogate decision makers, during the course of the patient's disease and treatment. A key issue is maintaining

effective communication with the family when the patient is incapacitated.

3. Document each communication with family members. Thorough documentation can be critical to resolving ethical issues by providing information on patients' stated wishes and knowledge of their critical status. Other documentation issues include health care proxy, treatment options and decisions, planning among caregivers, use of time-limited trials, and institution of comfort needs when aggressive treatment is no longer desired or justified.

4. Build teamwork among direct caregivers for planning and providing care. Conflicts between attending physicians and residents are common in the intensive care setting and a mechanism for addressing and resolving these conflicts is vital.

5. Address family members' fears of abandonment.

6. Use time-limited trials to evaluate treatment alternatives for dying patients.

7. Implement "comfort measures only" orders when appropriate. Effective use of the policy resulted in significant reduction in the length of stay in the intensive care unit for dying patients at Deaconess. ■

The goal of the project was to take the developing consensus on bioethical issues — the result of a variety of factors from court decisions to guidelines developed by professional societies — and implement it into the daily routine of doctors, nurses, social workers, and pastoral care workers who care for critically and terminally ill patients, says Jennings.

By the late 1980s, health care and professional groups, as well as the courts, were issuing guidelines, consensus statements, and other policy documents on decision making on life-sustaining treatment and other ethical issues in the care of dying patients.

There was widespread agreement on the basic form of the decision-making process, the kinds of questions that doctors and families should be asking about the course of dying, Jennings says. “There might be disagreement about life support, but at least everyone was asking the same questions and following the same procedures, such as honoring living wills and advance directives,” he adds.

“We felt it was important to go from written

guidelines issued by elite groups and reach into the trenches with a continuing education program for professionals who care for dying people,” he says. “We wanted to extend to them the awareness and critical reflection about emerging ethical and legal consensus about end-of-life decision making.”

The founders also wanted the program to involve interdisciplinary teams, not just doctors and nurses, and to be based on-site rather than off-site. “We wanted this program to be more than just informational; we wanted it to be a program of institutional change,” Jennings says. “The key question was, ‘How do we go from talking about things to changing the practice and the way patients are cared for?’”

Reducing hospital costs or reducing utilization of services were not the goals of the program, he stresses. “Our goal was that we don’t care about the outcome as long as the decision-making process is one that listens to the patient and the family, that is patient-centered, and that respects the patient’s and the family’s values,” he adds.

“That meant talking to patients and family

LOS decreases after ethics program begun

A study conducted on the effects of the four-year-old ethics grand rounds program at Boston’s Deaconess Beth Israel Hospital found that for patients who died, length of stay in the surgical intensive care unit (SICU) declined 46% in 1994 compared with 1990. The results also indicated that the severity of illness did not vary significantly over the four years.

After operating the program for four years, Deaconess researchers designed a study to determine if the program had any measurable effect on patient care management in the hospital. The outcomes measures of interest were documentation of patient and family contacts in the medical record and length of stay trends. These outcomes were assessed for all patients in the SICU during the years from 1990 to 1993.

Overall, the total number of days for 64 dying patients was 1,003 in 1993, compared with a total of 2,028 days for 73 dying patients in 1990. At an average cost of \$1,763 per day, the savings exceeded \$1.75 million (though

researchers stressed that cost containment was not a goal of the ethics grand rounds program).

There was also evidence that for patients who spent more than 30 days in the SICU, communication with patients and family was occurring more frequently and earlier in the patient’s course of treatment. “During this time, the SICU culture changed for the better,” Deaconess researchers wrote in the journal *Surgery* in August 1995.

“Patients and families become more involved along with surgical staff in patient/family meetings and in critical, ethical decisions. We conclude that our educational intervention met its objective, which was to integrate practical ethical issues into surgical resident clinical practices resulting in better patient care that was cost-effective.”

Begun in 1990, the ethics grand rounds program at Deaconess Beth Israel Hospital included every resident physician in the SICU attending four 60-minute discussion groups. Led by attending physicians and nursing directors, the groups discussed and debated case histories based on recent patient profiles from the hospital’s SICU. ■

earlier rather than later about issues of dying patients. It meant honoring advance directives and listening to family members," he says. "This was a reflection of the growing consensus that was not in favor of physicians making decisions behind closed doors then paternalistically leading families into decisions."

The program was piloted at 10 institutions, and then offered to interested institutions which paid part of the costs. Though funding has ended, the program is still available with more than 200 hospitals participating or completing the program, Jennings says.

The program typically requires about a year to complete and involves these components:

- a leadership training seminar for team leaders from the hospital;
- a survey questionnaire to hospital staff who care for dying patients to determine current policies and issues within the hospital;
- a series of grand rounds sessions and smaller seminars at which legal and ethical issues and hypothetical cases are discussed.

Typically, these interdisciplinary seminars focus on events that have caused problems in the hospital, glitches, and practices or policies that need to be changed. Finally, working groups are established to review institutional policies and propose changes.

The hypothetical cases, which are structured for increased complexity, may include:

- a competent patient who is dying and wants to refuse life support;
- a competent patient who is dying and who has provided an advance directive;
- a dying patient who has lost the capacity to make decisions and has left no advance directive;
- a dying patient who has left an advance directive with which family members do not agree;
- a case in which doctors want to stop treatment but family members insist that everything be done to prolong the patient's life.

At Deaconess, participation in the Decisions Near the End of Life project evolved into a program to train resident physicians in the surgical intensive care unit (SICU). Program developers found that, while medical and surgical residents are among the most likely to encounter complex ethical issues in hospitals, they are among the least likely to have received ethics education and training. The hospitals developed a grand rounds program that included a series of four 60-minute group discussions led by an attending physician

and the nursing director.

The discussions centered on hypothetical cases very similar to actual surgical intensive care patient issues, with an emphasis on incorporating ethical principles into problem solving in the SICU.

Out of that program came a series of guiding principles for responding to and resolving ethical issues. A study of the impact of the program found that length of stay in the SICU for dying patients was significantly reduced. (See related story, p. 123.) ■

Organ donor debate tied to Medicare contracts

Feds put Medicare at stake over donor efforts

Hospital critical care units can play a vital role in resolving the serious shortage problem of transplantable human organs in the United States. But they are allowing a precious natural resource to slip through their fingers by literally ignoring opportunities for organ procurement at the most appropriate time.

That's the view of a growing number of organ procurement officials who see hospitals as a vital missing link in an increasingly noisy debate between the federal government — particularly the U.S. Department of Health and Human Services (HHS) in Washington, DC —

EXECUTIVE SUMMARY

Federal officials are attempting to bring fairness to the organ donation system by creating one national donor list. But the effort has sparked debate. Opponents say the change will result in longer delays and fewer successful transplants. Meanwhile, organ donor groups are looking to hospitals for help. But here, too, critics say:

- Hospitals are adding to the problem by not responding to nationwide demand for organs.
- Critical care staff need training in working with potential donors' families.
- Requesting organs for donation requires tact, skill, and persuasion.
- Many hospital personnel, including physicians, are personally opposed to asking.

Survey Results: Comparison of Responses from Physicians and Nurses

Survey topic	Percentage of		Chi-square	P
	Physicians (N=226)	Nurses (N=675)		
Attitudes (% agreeing/strongly agreeing)				
I support the donation of organs for transplantation	96.9	92.9	4.62	.032*
I would consider donating my own organs	89.7	83.0	5.57	.018*
I would consider donating my family member's organs	85.4	78.9	4.27	.039*
Knowledge (% answering correctly)				
Greater than 75% of U.S. population approves of organ donation	22.0	12.3	12.41	.000*
Greater than 75% of kidney recipients have successful one-year graft survival	68.7	38.4	55.62	.000*
More than 20,000 are on waiting list to receive an organ	63.7	55.9	4.15	.042*
Brain death (% agreeing)				
Brain death is a valid determination of death	98.6	95.9	3.75	.053
Medical and clinical criteria for determining brain death are well established	87.4	82.9	2.51	.113
Appropriate time to introduce donation is after brain death is determined (decoupling item)	25.8	30.6	1.71	.191
Training (% who have received training)				
Have received training in family grief counseling	22.6	20.4	0.46	.498
Have received training in explaining brain death to the family	37.2	21.5	21.98	.000*
Have received training in how to request donation	29.2	32.6	0.90	.343
Policies and practices (% agreeing)				
I find the protocols for dealing with a potential donor to be time consuming and burdensome	51.4	48.9	0.40	.528
Participating in a successful donor situation is a rewarding part of my job	38.3	56.2	20.28	.000*
Our hospital has guidelines for declaring brain death	91.8	96.2	6.27	.012*
Uncomfortable with how our hospital handles donation	39.1	39.6	0.01	.906
Comfortable calling organ-procurement organization to come to hospital before brain death declaration and family approach	72.0	72.8	0.05	.825

* Statistically significant result; $P \leq 0.05$

Source: *American Journal of Critical Care* 1998; 7:9.

and nonprofit organ donation interests.

Essentially, the debate centers on how long a terminally or critically ill patient will have to wait to get a badly needed heart, kidney, or lung, who that lucky patient will be, and which state or region will be the one chosen over others.

HHS issued new rules earlier this year that would create a single, national donor list that rations available organs to the neediest individuals first. The rules effectively replace the present system of doling out organs through a network of 63 organ procurement organizations (OPOs) that act as regional centers. Each center essentially sets up its own criteria in determining which patients are first to get available organs.

The single donor list replaces the current patchwork quilt of lists, priorities, and eligibility standards for organ recipients with one set of criteria. The government, however, left the decision of how patients will be selected and added to the list up to the medical community.

Critics of the HHS plan, for example, the Richmond, VA-based United Network for Organ

Sharing (UNOS), declare that the new regulations will increase the average waiting period for an organ transplant by years due chiefly to the number of individuals on the national list. It also will reduce survival rates in the overall population by nearly 10%.

The current average waiting time varies from region to region depending on demand and availability of needed organs, say donation officials. UNOS is the principal government contractor charged with managing the nation's organ procurement system.

Critics also claim that patients who are most in need

but have a poor survival outlook may not make the best transplant candidates. And they claim the new rules do not take into account whether children or the aged should take precedence in selections.

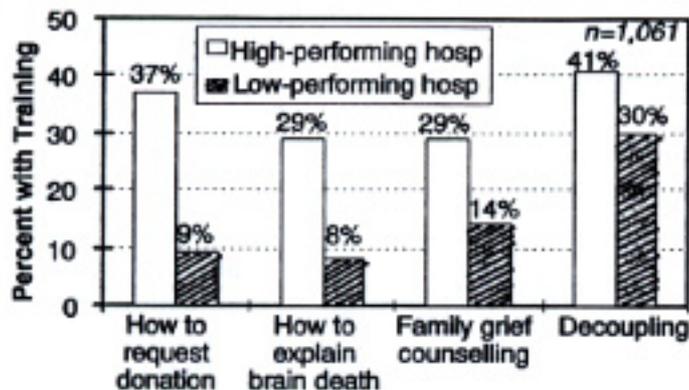
Partly for this reason, a Louisiana federal judge imposed a temporary injunction on the HHS plan in September pending an Oct. 14 hearing on a lawsuit, which was filed against the agency by the state's attorney general.

Fairness of the donation system

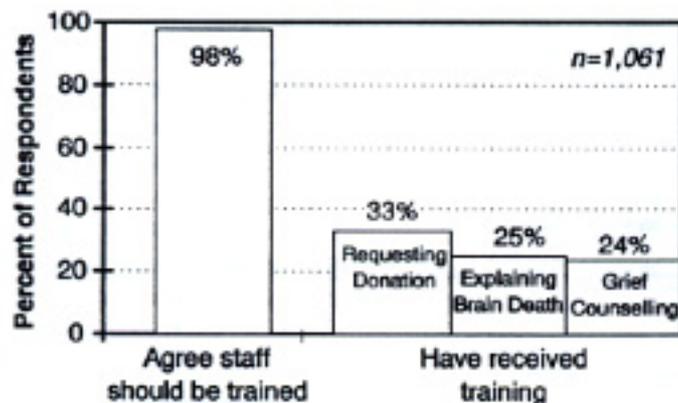
The debate, itself, doesn't directly concern hospitals or their ICUs. It has more to do with how fair and efficient is the system of patient selection and organ distribution. But the debate does raise questions about why there continues to be an alarming shortage of organs available for donation. And some critics are pointing their fingers at hospitals' levels of interest and commitment to the process.

Many critics, including UNOS, say that there

Hospital Staff Readiness and Performance



Importance of Staff Training



Source for both graphs: *Clinical Transplants* 1997; 21:224.

would be no inequity in the system if human organs were more plentiful. Everyone in need of an organ transplant would have one. Critics inevitably place part of the blame on hospitals.

At least one-fourth of all potential organ donation opportunities are missed annually by hospital personnel who simply overlook asking families of terminally ill patients to donate their relative's organs. Most of the oversight is due to poor training and a relative lack of commitment by the hospital community to organ donation.

"Hospitals aren't responding in an organized way," says Carol L. Beasley, MPM, managing director with The Partnership for Organ Donation. The Boston-based nonprofit research and advocacy group is studying ways to improve the nation's organ procurement system. "Even transplant centers, which are on the front lines of the organ donation process, are doing no better than anybody else."

The federal government is determined to get

hospitals more actively involved in the organ donation system. Earlier this year, the Health Care Financing Administration in Baltimore issued a set of directives essentially requiring that hospitals meet certain requirements for procuring and donating human organs as a condition of participation in the Medicare program. About one in five hospitals routinely donate organs. Some 300 facilities regularly perform organ transplantation.

The directives are fairly straightforward and focus on two key mandates:

1. **Hospitals are required to notify a local OPO of all deaths that occur in the hospital.** The aim is to increase an OPO's opportunity to determine the suitability of every potential organ donor. The reporting also will enable OPO officials to gather data on death rates at an individual hospital in order to concentrate on certain facilities with high donor potential and work with families of potential donors. The regulation affects all 5,200 U.S. hospitals. There are about 2.1 million hospital deaths reported annually.

2. **Hospital ICUs are expected to designate an individual or team to work directly with families of terminally ill patients** in obtaining permission to allocate the deceased's organ to the national donor list. But the stipulation also requires that providers undertake formal training for the designated donor specialist or team.

"This is where the rubber meets the road for ICUs in all this talk about organ donations," says Beasley. "All this yackety-yak may cross the radar screen or may not. But conditions of participation in Medicare make the issue fairly clear for hospitals." Staff training and communication with OPOs make a difference in the rate of successful donations, Beasley adds. (See bar graphs, above left.)

But some hospitals respond to claims they aren't doing enough by saying that the organ donor issue is too complex to describe in simple either-or terms. "People don't understand this issue. There is a lack of knowledge not only from the public but among local elected officials and even physicians," says Jane Keihm Hooker, RN, associate director of patient care services at the University of Maryland (UM) Medical System in Baltimore.

Speaking to families about organ donation spills over into someone's personal beliefs, convictions, and biases either for or against a donation, says Hooker. "The medical profession isn't geared for end-of-life decisions. We find it hard to

Establish an Internal Organ Procurement Program

- ✓ Adopt the best practices and procedures related to organ procurement and donation.
- ✓ Designate a donor specialist or advocate at the hospital charged with all donor activities.
- ✓ Form a small group of individuals composed of nurses, social workers, and pastoral workers to assist the donor advocate in disseminating information and working with families.
- ✓ Plan outreach activities that include discussions with community groups.
- ✓ Recognize that organ procurement and transplantation are not everyday occurrences but are special events.
- ✓ Fully assess your internal donation system: strengths, weaknesses, levels of participation, accountability, communication, and quality of information known and disseminated.
- ✓ Communicate regularly with local legislators, organ procurement organizations, and other hospitals regarding donor opportunities and support favorable legislation.
- ✓ Work with the hospital's counsel on the legal aspects of donor procurement.
- ✓ Get the full support of management and the local community through information.

Editor's note: The Partnership for Organ Donation and other groups can offer advice on nationally accepted best practices and procedures. (See box, at right, for contact information.)

approach families to say, 'We give up. There's nothing more we can do for your son or daughter. So how about donating their organs to help someone else's son or daughter.' It's not something we as health professionals have been trained to do," Hooker adds. (See **survey of physicians' and nurses' responses to organ donation, p. 125.**)

Although Hooker acknowledges that hospitals generally have done a poor job of supporting organ donor programs, she also notes that institutions can be successful at implementing internal programs that achieve results. In 1997, UM launched an education program to encourage families and physicians to be more involved in organ donation.

Working with the local OPO and neighboring Johns Hopkins Hospital, UM officials began an educational outreach effort to teach the community and potential donors' families about the

donation process. Included were religious and philosophical factors underlying the decision and medical conditions that would bar a patient from donating, including a history of drug or alcohol abuse or HIV infection.

The program also works with critical care physicians and nurses regarding what to consider when approaching families, how these decisions will affect those relatives and their religious convictions, and the emotional factors underlying the death of a loved one and organ donation.

The program has shown early signs of success, according to Hooker. The number of families that gave a yes response to a donation request has climbed to 34% over 24 months from 13% before any formal effort was started. Officials are now studying how the donor advocates got families to agree and eventually will investigate shortcomings that led other families to refuse.

"Working with the families is crucial to the process," Hooker says. "You only get one chance to get either a yes or no from them. You have to know what you're doing," she concludes. ■

SOURCES

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To succeed at doing evals, try a positive approach

Wisconsin ICU uses encouragement to get results

Nurse managers continue to struggle with one of the most elusive areas of their responsibilities, staff evaluations. But some nurse educators say they are coming closer to a solution that may also bode well for lowering high turnover and improving job satisfaction in the ICU.

"There isn't a nurse manager in the country who likes to do performance evaluations. It's very hard for people to give accurate assessments, especially in a busy environment like the ICU," says **Colleen M. O'Brien**, RN, a nurse educator with the cardiac care center at Bellin

Hospital in Green Bay, WI.

Traditionally, hospitals have not done a good job of defining sound objective measures of individual job performance. And the problem has been particularly acute in the ICU, where nurses are expected to work as a closely knit team despite high staff turnover, which has repeatedly undermined efforts to maintain performance goals.

The problem isn't due to a lack of objective measures. "If [a behavior exists], it can be measured," says O'Brien, who works in a large, 14-bed cardiac critical care unit staffed by 45 nurses and 20 technicians. The challenge is to develop a dependable tool that can accurately measure your staff's performance.

Unique environments

ICUs are uniquely different from other patient-care departments due to the highly charged emotional air and life-or-death patient acuity levels that consistently affect both patients and the clinical staff. Nurse burnout is a constant problem.

So it isn't surprising that administrators are under intense pressure to evaluate their nurses objectively while not alienating and, possibly, accelerating an individual's decline, says **Neva Rogers**, MSN, MBA, a performance appraisal expert with Development Dimensions International (DDI), a global human resources consulting firm based in Bridgeville, PA.

Earlier this year, clinicians at Bellin Hospital instituted a formal evaluation program targeted at new nursing hires to help them adapt to the demands of their departments. The program affects all departments throughout the facility. (*Editor's note: Critical Care Management will revisit Bellin in six months to assess the results of its assessment program.*)

The tool, which the hospital is using with new hires, can easily be adapted for annual performance reviews because most of the elements apply or can be modified for use with veteran staff, O'Brien says. And if properly executed, the approach can serve as an opportunity for improving on-the-job performance and morale. Here's how it works:

- **Tool offers specific details for assessment.**

The tool employs a customized evaluation instrument called "The Maximizing Performance Tool" adapted to Bellin's needs from concepts produced by DDI.

The approach emphasizes evaluating personnel in several key performance areas, which are

broken down to specific skills or duties such as hemodynamic monitoring or timeliness of making rounds rather than in broad strokes.

But unlike many appraisals, the evaluation is conducted periodically rather than at the end of a review period. Instead of a cumulative evaluation, employees get micro-assessments each week, month, or quarter. Management determines the time interval for each assessment. The smaller the interval, the more data there are available for the review.

- **Data on specific performance categories are formally recorded and kept.**

The information is recorded at regular intervals on a progress form and kept by a charge nurse, or someone working close to the subject. At Bellin, the individual responsible is called a preceptor. The form allows the preceptor to document daily or weekly anecdotal observations. (**See a sample copy of this form, inserted in this issue.**) The unit also uses a set of clinical pathways that chart the progress of each nurse over a 12-week period that isn't integral in appraising veteran nurses.

- **The performance ratings are nonthreatening and nonjudgmental.**

A key component of the system uses a non-threatening, nonjudgmental, and nonquantitative set of values represented in letter-grade ratings to measure performance. In contrast to using numerical values such as a 1 for excellent and 2 for good, the letter-grade approach encourages improvement while it assesses competency levels without risk of bias, O'Brien says. Therefore, the letter grades go as follows: E — Exceeds (instead of excellent), M — Meets, P — Progressing, and NI — Needs Improvement.

- **Letter-grade method focuses on intangibles.**

Another key to the appraisal tool emphasizes performance areas that usually defy measurable evaluation. These are employee characteristics that

SOURCES

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O'Brien calls "soft skills," which are extremely important in critical care but are frequently overlooked or downplayed by appraisers because they are so difficult to assess.

Soft skills are more or less important in other inpatient departments, but they are essential to a smooth-running ICU, Rogers observes. They include people skills such as the level of commitment to a job, critical thinking skills, customer service orientation, integrity, and trust.

On the progress form, the preceptor places a letter grade in each box for each soft skill being evaluated during the appraisal period. For example, if the nurse meets the ICU's standards for decisiveness or teamwork, the preceptor is likely to place a letter M in the corresponding boxes on the progress form. Implied in the grade in each case is whether in the preceptor's view the subject met the standard more than 50% of the time, says Rogers.

• **Technical skills are identified as specific objective.**

Technical competency is usually easier to recognize than soft skills, says O'Brien. A nurse either meets ACLS (advanced life cardiac support) standards or does not. A checklist that covers most of the ICU's technical requirements forms part of the evaluation process. But the challenge lies in accurately assessing how well those technical skills are displayed on the job.

Again, to a great extent the evaluation is subjective. But nevertheless, preceptors can play a big role in observing a nurse and offering constructive criticism in discreet terms. "You did this task very well," a preceptor would say during a feedback discussion, says Roger, "but how would you do it better?"

Davis advises managers to think in terms of "critical success factors." These are specific areas in which the nurse must perform well in order to succeed as a team member. These include: clinical competence, customer service, cost consciousness, teamwork, and professionalism, using the letter-grade and anecdotal assessment tool.

Equally important for managers is to "quantify the variables." This means placing the assessed behavior in a particular time frame. Doing so enables you to compare time periods and observe improvements. It also permits managers to assess the validity of their own expectations.

"If most of your nurses come in too low in your expectations range, maybe you need to lower the bar slightly," Rogers concludes. ■

Open-door ICUs can help patients but are mixed bag

How accessible should you make your critical care unit? Some nurse managers and physicians are beginning to question whether keeping the ICU out of the reach of patients' families and their personal physicians is a good idea. Others aren't certain.

The answer seems to rest on certain factors, including the physical size of the unit and the level of commitment of the medical and nursing staff to unrestricted access, says **Dianne Y. Daniels, RN**, a nurse educator at the University of North Carolina's College of Nursing in Charlotte.

The debate over open-door policies in the ICU has received attention mostly in discussions and seminars but hasn't moved much beyond the speculation stage. Hospitals have toyed with the possibility of giving greater access to families of ICU patients in the belief that the longer contact could help improve outcomes and stabilize volatile medical conditions.

Is an open-door policy dangerous?

Most ICUs do allow restricted family visits on a selective basis. But in many cases, patients have been too ill for visits and 24-hour visiting policies have rarely, if ever, been considered practical in the ICU. Making a unit accessible to outsiders, even noncritical care physicians, 24 hours a day is regarded by most ICU managers as meddling and possibly even dangerous to other critically ill patients.

But the open-model concept doesn't stop at family visitations. In an unrelated approach, hospitals have long maintained an open organizational

EXECUTIVE SUMMARY

Supporters of open-model ICUs say that quality patient care and cost containment can be achieved by maximizing the use of ancillary "human" resources, such as family members and their physicians, in critical care setting. Conditions necessary for a successful open model ICU include:

- an appropriate physical infrastructure;
- an early adoption experience;
- a supportive nursing staff.

structure as a medical-care option. Under this model, ICUs routinely admit critically ill patients without formal triage. They also give unfettered access to the patient's primary care physician.

According to researchers, several hospitals currently use an open organizational model in their ICUs. These same researchers advocate a closed setting as more cost efficient.¹

Together, these two approaches to ICU care have been criticized because they tend to shift too much focus away from traditional critical care medical practices and place too much emphasis on "soft" ancillary resources. But they persist, mostly as a result of critical care medicine's evolution toward more patient-centered strategies.

Supporters of open visitation are relatively few. But they're rooted in the belief that "patients and their families can benefit from wider access in the ICU," says Daniels. She has written about open-visit policies and says they can work at hospitals with relatively small ICUs and where charge nurses and other staff are adequately trained and highly customer service-oriented.

But if conditions are right, even unconscious terminally ill cases that are on ventilators and in the last throes of life could benefit from having families regularly at their bedsides, advocates say. In fact, these are patients and families who stand to benefit most in the last moments of life, proponents of open-door policies argue.

Nevertheless, administrators have drawn the line when it comes to such unrestricted policies.

Considering the human component

Underlying the discussion, however, supporters of open-model ICUs believe that quality patient care and cost containment can be achieved by maximizing the use of ancillary "human" resources such as family members and their physicians in critical care settings. Making allies of these noncritical care personnel can help lower the cost of ICU medicine while potentially improving outcomes, they say.

According to researchers at Long Island Jewish Medical Center in New Hyde Park, NY, lowering the cost of critical care has led to experimentation with different operating models. While ICUs generally account for only 5% to 10% of inpatient beds, they eat up about 34% of most hospital budgets. In 1990, the latest year in which figures were available, the cost of ICU care stood at \$62 billion or 1% of the nation's gross domestic product.

The aim has been to lower costs through various patient-care strategies. But ICUs are the one place in which cost-cutting options may be limited due to the intensity and duration of expensive resource utilization, according to one study of closed ICU models conducted by Jewish Medical Center earlier this year.¹

But while cost-cutting is certainly important, open visitation policies are more focused on improving the quality of patient care in the ICU, not necessarily on achieving direct cost savings, observes **Eileen Speed**, RN, a staff nurse in the critical care unit of Presbyterian Hospital in Matthews, NC.

In 1994, Presbyterian took the unusual step of instituting an unrestricted 24-hour family visitation policy in its critical care unit. The policy allows family members the right to remain with relatives around the clock "as long as their presence doesn't interfere with the patient's stability or condition," Speed says.

The unit does set limits on certain occasions, particularly those involving cases of recent myocardial infarction or patients who are subject to volatility in their conditions. But these cases are in the minority. Most patients, especially the elderly, appear to do better when they are close to family members, Speed notes. The majority of patient cases in the ICU involves recent heart attack victims and serious orthopedic injuries. About 60% of patients in the six-bed unit are age 60 and older.

However, the hospital isn't certain whether patients do better as a result of the open policy or if it only seems that way. Most of the perceptible

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gains with patients have been anecdotal, Speed acknowledges. But factual or not, the payoff has been visible to nurses by seeing quieter, more stable patients and fewer worried family members.

"The system saves us a lot of time making phone calls and having to explain things to anxious relatives," Speed says, which frees up nursing time and manpower. At first, physicians and some nurses resisted the idea. But after four years, most nurses have been sufficiently trained to carefully manage the visitations without seeming obtrusive and have accepted the policy as part of the medical care rendered in the unit.

But even Speed and Daniels acknowledge that conditions have to be right for these policies to flourish. These include:

□ **An appropriate physical infrastructure.**

The ICU at Presbyterian is very small. At only six beds, it also has a relatively high nurse to patient staffing ratio (each shift has two full-time nurses in the unit), which helps in managing patients and families when they are together. The unit also has separate rooms for each patient, which makes around-the-clock visitations possible without interfering with other patients.

□ **An early adoption experience.**

Hospital administration supported the ICU's efforts early when the unit was established in 1994. Getting in at the outset has helped because administration officials had no history to fall back on as an indication that the plan would fail. They were also intent on making the unit work by trying innovative strategies, according to Daniels.

□ **A supportive nursing staff.**

While they received no formal training, staff nurses saw the benefits of working with families and became receptive to the idea of focusing on patients' emotional well-being in the ICU, Speed recalls. Without a unified, supportive nursing staff, the system would encounter mixed results, she adds.

But while Presbyterian's efforts are noteworthy, are they effective? A different school of thought advocates that ICUs should not be open to outside influences. They should be closed models of medical care. Allowing limited family visitations is one thing, but permitting outsiders to play a significant role in influencing critical care outcomes and decision-making is another.

A recent study of closed ICU models didn't go so far as to say so, but researchers found that closed settings tended to be more efficient from a patient utilization standpoint. They had lowered lengths of stays in both the ICU and in the hospital overall

(6.1 ICU days in the closed setting compared to 9.3 days in open models and 22.2 overall hospital days vs. 31.2 days respectively).

Patients on ventilation support also had shorter periods of mechanical ventilation (3.3 days in the closed setting vs. 6.4 days in the open model). In calculating the differences for this part of the study, researchers looked at one hospital before and after it closed its ICU. Patient mortality was affected depending on the open or closed model, but the variability was considered small.

A closed ICU, according to the researchers, was defined as one in which the patient is transferred to the care of an intensivist and patients are accepted in the unit only after a complete clinical evaluation.¹

One of the reasons cited for improved utilization was the possibility that in the closed ICU, most patients were transferred from the hospital's emergency department after formal triage. This could have accounted for better, more targeted resource utilization.

Critical Care Management (ISSN 1070-4523) is published monthly by American Health Consultants[®], 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Critical Care Management**, P.O. Box 740059, Atlanta, GA 30374.

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(Required by 39 U.S.C. 3685)

1. Publication Title Critical Care Management		2. Publication No. 1 0 7 0 - 4 5 2 3		3. Filing Date 9/25/98	
4. Issue Frequency Monthly		5. No. of Issues Published Annually 12		6. Annual Subscription Price \$249.00	
7. Complete Mailing Address of Known Office of Publication (Street, City, County, State, and ZIP+4) (Not Printer) 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, Fulton County, GA 30305				Contact Name Willie Redmond	
8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not Printer) 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305				Telephone Number 404/262-5448	
9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor (Do Not Leave Blank)					
Publisher (Name and Complete Mailing Address) Brenda Mooney, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305					
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15. Extent and Nature of Circulation		Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
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In both cases, proponents of closed or open ICUs indicate that there are several variables in either case that account for eventual results. Nurse managers should consider them as options. But they should also investigate their suitability with knowledge and caution.

Reference

1. Multz AS, Chalfin DB, Samson IM, et al. A "closed" medical intensive care unit (MICU) improves resource utilization when compared with an "open" MICU. *Am J Respir Crit Care Med* 1998; 157:1,468-1,473. ■

CE objectives

After reading this issue of *Critical Care Management*, participants in the continuing education program should be able to:

- describe the ethics support service that is available to all physicians at Deaconess Beth Israel Hospital.
- explain the difference between skills and characteristics in performance appraisals.
- cite the two biggest complaints against the government's new organ donation policy.
- describe the difference between an open and closed ICU from a triage point of view. ■