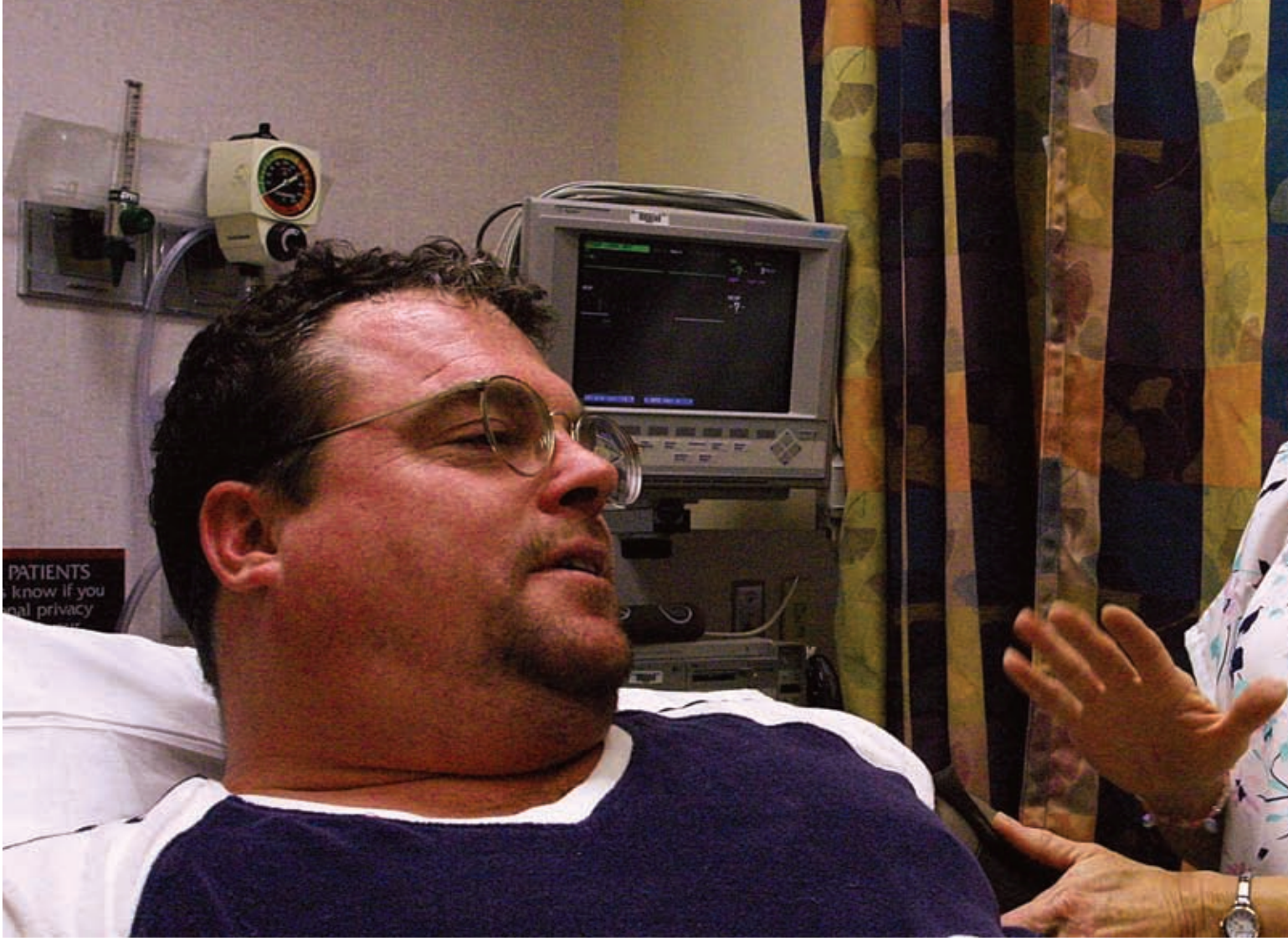

CE Home Study Course

Scripting and Rounding
Impact of the Corporate Care Model on RN Autonomy and Patient Advocacy

This home study CE is part two of a two-part series. The first installment appeared in the October 2010 issue of *National Nurse* and is required reading for successful completion of this home study course.

Description

THIS HOME STUDY COURSE examines the impact of scripting and rounding on the autonomous practice of registered nurses that interferes with their critical role as patient advocates. Scripting and rounding schemes are being aggressively marketed, incentivized, and implemented in a variety of acute-care and outpatient settings using deceptively reassuring terms on embracing change, transforming care at the bedside, and increasing customer satisfaction designed to create and influence the public's "perception" of quality.

It describes a new restructuring model for nursing, which is aimed at deskilling and automating RN interactions with patients. Under these new schemes, patient outcomes are secondary to patient satisfaction scores based on customer service and hospitality as practiced by companies such as Disney and five-star hotels. These schemes are being mandated by hospital policy over the objections of direct-care RNs despite the fact that there is a dearth of evidence linking patient satisfaction to positive clinical healthcare outcomes.

Objectives

UPON COMPLETION OF THIS home study RNs will be able to:

Articulate their major advocacy role in the delivery of safe, therapeutic, and effective patient care where the patients' individual

healthcare needs, interests, and wishes are respected and protected.

Explain the potential of protocols and patient interaction scripts for replacing individualized human interaction in the delivery of healthcare.

Describe how rounding, scripts, and rigid protocols can supplant critical thinking and override the independent professional clinical judgment of registered nurses.

State why safe staffing with specific, numerical RN-to-patient ratios, and the requirement that hospitals staff up from the minimum based on individual patient acuity, is an evidence-based practice that improves patient outcomes, results in cost-savings, and increases both patient and nurse satisfaction that allows direct-care RNs to be in control of the nursing process.

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Provider Approved by the California Board of Registered Nursing, Provider #00754 for 2.0 contact hours (cehs). Recognized by all states with the exception of Arkansas, Delaware, Massachusetts, Minnesota, Montana, North Carolina, and South Carolina.

What's It All About, All "P's"?

THE ESSENTIALS OF rounding and scripting (The 3 P's) are as follows:

The RN is directed to enter each patient room once every one or two hours.

The RN is directed and scripted to ask three questions of the patient regarding:

1. **Pain:** The RN is to ask about the patient's pain level.
2. **Potty:** The RN is to ask about the patient's toileting needs.
3. **Position:** The RN is to ask if the patient wants repositioning help.

(Note: Some scripting schemes add a 4th 'P')

4. **Possessions:** The RN is to ask if the patient's possessions are within reach.

Another common rounding scheme refers to "the Four Rs"

1. **Rx:** Provide any needed medication.
2. **Reach:** Are the patients' belongings within easy reach?
3. **Respond to questions:** Ask if there is anything else the patient needs.
4. **Reassure:** Express care and concern. Let the patient know at what time the next rounding visit will occur.

Some hospitals are using acronyms to help the RNs remember their scripts. One example is A.I.D.E.T.* (*Studer Group). The tool is marketed as reinforcing "important key words" and is also known as the "Five Fundamentals of Service" to help build customer loyalty. Managers are instructed to coach their staff using A.I.D.E.T* as a "communication framework" to improve patients' perceptions of care provided by the staff.

A stands for **Acknowledge** the patient. "Hello, Mrs. Jones."

I stands for **Introduce** yourself. And state your certifications/experience

D stands for **Duration;** "Your test results won't be back until tomorrow."

E stands for **Explanation;** "This is part of the excellent care we provide here."

T stands for **Thank You;** "Thank you for choosing our hospital, Mrs. Jones."

Many RNs who have been introduced to these schemes are aghast at the patronizing assumptions behind the introduction of these schemes, i.e. that RNs do not already acknowledge and introduce themselves to the patient or explain procedures to the patient.

On the face of it, these seem like very obvious interventions for an RN to perform. Where the danger lies in this scheme is that the RN becomes over-scripted and is pressured to adhere to a script and so ceases using critical thinking skills and focusing on the individual needs of each patient.

The usual initial question asked of this scheme by RNs is, "Why is this necessary?" After all, RNs are educated and experienced in meeting all of their patients' needs as well as providing first-class patient care using the nursing process. One answer to that question is a familiar one in the corporate model of healthcare: money!

Patient satisfaction scores rather than patient outcomes have become a major driver of the corporate healthcare agenda. The Centers for Medicare and Medicaid Services (CMS) is now using patient satisfaction scores as a measure of quality care and reimbursing hospitals accordingly. Press Ganey, an independent for-profit company, has marketed itself to the hospital industry as the "go-to consultant "on how hospitals can improve their patient satisfaction scores to meet the requirements of the new CMS criteria. In its marketing messages to the hospital industry, Press Ganey makes the following

statement: "…those institutions that react quickly and comprehensively can turn higher patient satisfaction into a clear competitive advantage in the marketplace."

The new CMS criteria along with aggressive marketing from companies such as the Studer group and Press Ganey have resulted in hospitals experiencing "market anxiety," leading to a clamoring for new ways of improving patient satisfaction. This "market anxiety" leads to less-than-critical thinking on the part of the hospital administrators and so-called nurse leaders, whereby they become easy prey for outside consulting groups to come into their facilities to "train" their staff on these new schemes. Since their pay and personnel evaluations are often conditional on successful implementation of these schemes, management has a vested, personal self-interest in promoting adoption and could be biased toward reporting positive outcomes, which makes the data and its interpretation highly suspect and unreliable.

Of course these rounding schemes are endorsed and promoted by the same corporations and hospitals that stubbornly fight against improving nurse-to-patient ratios or attempt to replace RNs with lesser-skilled healthcare workers. According to Dr. Christopher Guadagnino, in a December 2003 article he wrote for *Physician's Digest News*, "variation in measurement tools is an obstacle to making patient satisfaction a reliable part of the quality equation. Even if redundancy and variation of patient satisfaction measurement can be minimized to permit meaningful comparison across providers, questions remain…whether it is even appropriate to consider patient satisfaction as a valid clinical quality indicator."

A recent Institute of Medicine report outlined six characteristics of quality healthcare: safe, equitable, evidence-based, timely, efficient, and patient centered. Lack of comparability of patient satisfaction data remains an obstacle to its expanded use. Measured by different entities, for different purposes, using different instruments, patient satisfaction data is far from uniform. In a December 2003 interview also reported in *Physician's News Digest*, Carey Vinson, medical quality director for Blue Cross-Blue Shield, said, "Patient perception data about clinical processes and outcomes may lack validity, and not many tools currently exist to measure what is going on inside a hospital or a physician's office."

According to Dr. Marshall Webster, MD, president of the University of Pittsburgh Medical Center's Physician Services Division, and president of UPMC's physician services, "measurements (surveys) are best kept to the quality of service side rather than become integrated with the quality of care issues. I don't think the Press Ganey survey is the kind of instrument that is helpful for us in looking at very objective measurements of quality of care. We want specific, objective, measurable things that attest to the quality of care that we are providing—for example, one year survival after liver transplants."

One obvious method of improving patient satisfaction as well as patient outcomes would be to improve nurse-to-patient ratios. According to a study published in the *New England Journal of Medicine*, American patients generally express a higher satisfaction with their hospital stays when cared for and treated in facilities with a higher ratio of nurses to patients. They rated their experience with their hospital stays more positively than patients admitted to hospitals with poor staffing and higher nurse workloads.

A recently published study in *Health Services Research* (2010) titled "Implications of the California Nurse Staffing Mandate for Other States," (Aiken, L.H., Sloane, D.M., Cimiotti, J.P., Clarke, S.P., Flynn, L., Seago, J.A., Spetz, J., & Smith, H.L.), reveals that improving nurse-to-patient ratios has demonstrated significant positive outcomes:

- New Jersey hospitals would have 14 percent fewer patient deaths and Pennsylvania 11 percent fewer deaths if they matched California's 1:5 ratios in surgical units.
- California RNs have far more time to spend with patients, and more of their hospitals have enough RNs on staff to provide quality patient care.
- Fewer California RNs miss changes in patient conditions because of their workload than New Jersey or Pennsylvania RNs.
- In California hospitals with better compliance with the ratios, RNs cite fewer complaints from patients and families and the nurses have more confidence that patients can manage their own care after discharge.
- California RNs are far more likely to stay at the bedside, and less likely to report burnout than nurses in New Jersey or Pennsylvania.

There is a direct correlation between nurse satisfaction and patient satisfaction reported in the scientific, peer-reviewed literature, a study titled, "Nurse Burnout and Patient Satisfaction", *Vahey, D.C., Aiken, L.H., Sloane, D.M., Clarke, S.P., & Vargas, D. (2004),* published in the journal, *Medical Care*. The authors reported the following:

Results of the survey showed: Patients cared for on units that nurses characterized as having adequate staff, good administrative support for nursing care, and good relations between doctors and nurses were more than twice likely as other patients to report high satisfaction with their care, and their nurses reported significantly lower burnout. The overall level of nurse burnout on hospital units also affected patient satisfaction.

Conclusions of the survey were: Improvements in nurses' work environments in hospitals have the potential to simultaneously reduce nurses' high levels of job burnout and risk of turnover, and increase patients' satisfaction with their care.

More recently, in a 2008 article published in the *New England Journal of Medicine* titled, "Patients' Perception of Hospital Care in the United States," authors Jha, Orav, Zhen, and Epstein reported the following:

Results: As compared with hospitals in the bottom quartile of the ratio of nurses to patient-days, those in the top-quartile had a somewhat better performance on the HCAHPS survey (e.g., 65 percent versus 70.2 percent of patients responded that they "would definitely recommend" the hospital; $P<0.001$). For example, those in the top quartile of HCAHPS rating performed better than those in the bottom quartile with respect to the care that patients received for acute myocardial infarction (actions taken to provide appropriate care as a proportion of all opportunities for providing such actions) and for pneumonia in unadjusted analysis.

Conclusions: This portrait of patients' experiences in U.S. hospitals offers insights into areas that need improvement, suggests that the same characteristics of hospitals that lead to high nurse-staffing levels may be associated with better experiences for patients, and offers evidence that hospitals can provide both a high quality of clinical care and a good experience for the patient.

Investigators have linked the HCAHPS data to the American

Hospital Association's annual survey which provided information about nurse staffing levels, profit status, number of beds, teaching status, and rural or urban location. According to their study, the biggest satisfaction differences between hospitals with higher versus lower nurse-to-patient ratios showed up in the specific areas related to nursing services: discharge instructions, communication with nurses, and communication about medications.

Of interest, researchers also found that patients in nonprofit hospitals ranked their satisfaction higher than patients in proprietary hospitals; something the authors suspected might be related to patient expectations. There was no difference in satisfaction between teaching and non-teaching hospitals. Patient satisfaction was associated with quality of clinical care on indicators for the conditions assessed: acute myocardial infarction, congestive heart failure, pneumonia, and surgery.

Rounding and other similar patient satisfaction schemes do nothing to improve actual therapeutic patient outcomes. They are short sighted and are aimed at manipulating the perception among patients and visitors that staffing is adequate. These "creative" management schemes depersonalize the relationship between RNs and patients. Ultimately they interfere with the Nursing Process, the RN's professional judgment and control of their ability to prioritize, assess, plan, individualize, implement, and evaluate the care they provide. Such interference leads to nurse dissatisfaction and burnout, poor patient outcomes, and lower patient satisfaction.

Rounding schemes are not required by CMS for the purpose of obtaining increased reimbursement incentives. These schemes never discuss the ratio of RNs to patients even though the CMS guideline states:

> "The nursing service must ensure that patient needs are met by ongoing assessments of patients' needs and provides nursing staff to meet those needs. There must be sufficient numbers, types and qualifications of supervisory and staff nursing personnel to respond to the appropriate nursing needs and care of the patient population of each department or nursing unit.
>
> There must be a RN physically present on the premises and on duty at all times. Every inpatient unit/department/location within the hospital-wide nursing service must have adequate numbers of RNs physically present at each location to ensure the immediate availability of a RN for the bedside care of any patient."

By tying reimbursement to patient satisfaction using rounding schemes, CMS would be in violation of its own guidelines. Rounding schemes appear to come from the same philosophical place as computerized charting, charting by exception, overuse of technologies, speed up and fragmentation – all driven by the depersonalization of healthcare. Rather than stress individual care, the new paradigm is population-based care, i.e. fitting patients into a statistical mean. This also corresponds with attempts to deskill the health professions to both save on labor costs and eliminate the voice of professional advocacy.

Experienced bedside RNs are reacting to the introduction of these scripts in their facilities. Here are just a few of the comments made about such scripts:

"Most nurses are 'people persons,' and we know instinctively that we can save ourselves a lot of time and give the best care by anticipating our patients' needs. It's so much easier to invest a few minutes of time at the beginning of the shift to learn who your patients are and what they need, and assure them that you will do your best to meet those needs. No one has to tell us how to do this; it comes naturally."

"It's the idea of the 'script' that sticks in my craw. Nurses are *professionals*; it's insulting to all concerned to demand that we utter a canned, pat phrase like 'Is-there-anything-else-I-can-do-for-you-I-have-the-time.' It sounds insincere and forced, and most patients know it."

"If hourly rounding and scripting is supposed to be so fundamental in a customer service focus, but if everyone is doing this latest management craze then I don't see how it will help these institutions stand out. And now the big trend for managers is being taught the lean, mean 'Toyota Way' or the 'Disney Way'; and they have another new thing called a 'Power Minute' where a manager comes along and tells you something new, then you have to sign and say you agree with it or you learned it. I'm about to go ballistic! Who are these people and why should we listen to them? It's like, they're not even nurses."

"Our hourly rounding logs hanging on the patient doors say at the bottom, 'Always remember to ask: Is there anything else I can do for you, I have time?' Sure, I have time as my hospital-issued cell phone is ringing off the hook, and the pager connected to my patient's monitor is beeping. Instead of calling in more staff to answer the call lights, they want us to fill out another form and they write us up if we have to stay overtime to finish our charting."

"We have the same exact script at our hospital. In critical care you almost never leave the patient's room anyway, but to be told what to say and to have to initial and check a piece of paper to show I was in the room is insulting. If the patient's in a coma they want us to have the family bring in a picture and dialogue with the patient about their picture."

"Why don't they just look at my charting and read it if they want to know what I've done for my patients? The initialed rounding log isn't part of the patient record anyway; it's for our boss. If you don't fill it out you get counseled and if you get more than three counselings, you are suspended and they threaten to terminate you. I didn't know that R.N. stood for Robot Nurse."

"At my hospital we formed an informational picket to alert the public about our employer's failure to correct several safety issues brought forward by the staff nurses. We developed our own acronyms and a rather colorful chant about the phony 'AIDET' scripts our boss was pushing: 'A is for Asinine, Abhorrent, and Abominable; I is for Insulting, Intrusive, and Idiotic; D is for Demoralizing, Deskilling, and Dumb; E is for Egregious, Erroneous, and Excrement; T is for Thoughtless, Terrifying, and Trespassing on our rights as nurses."

Compare and Contrast: Nursing Practice and Patient Advocacy Standards vs. Commercial Interests and Corporate Profits

THE CNA/NNOC/NNU PROFESSIONAL PRACTICE and patient advocacy model definition of "quality" in nursing practice is as follows:

> Competent, safe, therapeutic, and effective care provided in the exclusive interest of the patient.

This model ensures that the RN always acts in the patient's best interests. This is not only the moral obligation of the nurse, inherent within the social contract between the public and the profession of nursing, but it is also a duty and a right. As direct-care nurses, we have a vested interest, on behalf of our patients and our profession,

to be accountable for the provision of care according to the true art and science of nursing as described by Florence Nightingale.

Evidence-based practice can be defined as the conscientious integration of best research evidence with clinical expertise and patient values and needs in the delivery of healthcare. The best research evidence is produced by the conduct and synthesis of numerous, high-quality studies. Improved staffing has a significant and positive correlation with improved patient outcomes; research has shown quality of care is improved when staffing is adequate (Tourangeau, Cranley, and Jeffs, 2006).

There is a dearth of valid and reliable empirical studies which demonstrate a correlation between scripting and rounding schemes, patient satisfaction surveys, and improved health outcomes. Scripting and rounding schemes, when taken together with the mandated implementation and coercive enforcement of them in lieu of, or as a substitute for, increasing nurse-to-patient ratios creates a hostile work environment for RNs and an unsafe care environment for patients. In the field of patient safety, management tactics of fear, intimidation, and threat of retaliation have long been recognized as detrimental to safe practice.

Scripting and rounding schemes are a creation of for-profit commercial interests whose priority is to reap the economic incentives of corporate healthcare. Such schemes provide continuing cover for the commodification of healthcare and the failed health policies that continue to pose a significant barrier to the RNs' ability to control the practice of nursing and RNs' efforts to winning a single-payer

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healthcare system with a single standard of excellent care for all based on medical need.

Evidence-Based Nursing Practice Points

WITH THE PROSPECT OF INCREASED reimbursements to healthcare providers and organizations being linked with higher patient satisfaction scores, administrators and managers might well consider the findings of a study of nurse staffing models, nursing hours, and patient safety outcomes conducted by McGillis, Hall, Doran, and Pink (2004). The authors demonstrated that increased RN-to-patient ratios were positively correlated with increased patient satisfaction with the care they'd received.

Decisions about nurse staffing levels should be based on sound evidence and health policy science to reduce the risk of preventable complications and ensure optimum patient outcomes. The strength of the empirical, peer-reviewed research findings of Dr. Linda Aiken and her colleagues' 2010 study supports the immediate implementation of California's landmark RN-to-patient ratio law as a benchmark on a national scale in order to protect the public and reverse the nursing shortage. The evidence is clear and convincing that minimum RN-to-patient ratios, with staffing up based on the patient's acuity and severity of illness, is the most important and cost-effective safety measure for ensuring therapeutic and effective patient outcomes.

Conclusions

BECAUSE DIRECT-CARE RNS take a dim view of expensive and insulting scripting and rounding schemes, frequently reporting that they are strong work-life dissatisfiers, hospitals should reconsider the imposition of them on staff RNs because such schemes may have the unintended consequence of increasing the turnover rates of experienced RNs. Hospital nursing turnover has been correlated with a higher adjusted mortality index and severity-adjusted average length of stay, as well as a higher cost per discharge. A stable nursing workforce with experience at the facility as well as with specific patient populations, combined with collegiality with physicians, leads to higher quality. Several respectable studies published in peer-reviewed journals have concluded that nurse satisfaction leads to staff stability, which leads to improved clinical and financial outcomes.

Rather than decreasing the number of RNs, hospitals should increase the ratios of RNs to patients, because RNs' higher level of knowledge and experience has been shown to reduce patient mortality and reduce the overall costs of care (Aiken, et al., 2002; Eastabrooks, Midodzi, and Cummings, et al., 2005; Needleman, 2006; Dall, Chen, and Seifert, et al., 2009).

From a hospital and business perspective, improved RN-to-patient ratios have a synergistic and demonstrated economic value for hospitals in terms of lower liability and improved reputation by reducing adverse outcomes such as decreased blood-borne infection rates, patient falls, decubitus ulcers, ventilator-acquired pneumonia, and medication errors. In instances where there is not a clear business case for increased nurse-to-patient ratios, there is a compelling social case that can be made due to reduced adverse outcomes and avoided additional hospital days.

From a patient and social advocacy perspective, improved RN-to-patient ratios have economic and non-economic benefits for patients and their families in terms of decreased pain and suffering from preventable complications, decreased length of stay, lost days from work, and increased patient satisfaction. Increasing nurse staffing is associated with fewer in-hospital deaths under all options. Needleman (2006) and his colleagues concluded that 70,000 deaths could be avoided by raising the hospital nurse staffing threshold to the 75th percentile overall.

Rather than weakening or lowering safe staffing standards, a more appropriate strategy would be for government and other payers to increase reimbursement rates to hospitals that comply with the standards, instead of tying reimbursement to unproven customer satisfaction surveys. Under current reimbursement systems, the incentive and financial reality for hospitals is for them to staff at levels below where the benefit to society equals the cost to employ the additional nurses (Dall, 2009).

A strong reason for employers to change nursing care delivery models and practices is to encourage the development of behaviors and skills that reflect business strategy and organizational design. Salary and pay-for-performance schemes are designed to communicate these messages of strategy and control to generate compliance with organizational policies. Rounding and patient satisfaction schemes are methods by which healthcare organizations can substitute industry-aligned, performance-based competencies as a substitute for professional clinical nurses' skill, expertise, and practice-based competencies.

Nurse administrators are responsible for allocating nursing staff to meet professional quality-of-care standards and unfortunately, many have aligned themselves with the business interests of their employers. The CNA/NNOC/NNU definition of quality is safe, therapeutic, and effective care, competently delivered, that allows the patient to reach his or her optimum level of health and well-being. Direct-care registered nurses are responsible for ensuring that the care they provide is in the exclusive interests of the patient they care for, even when the provision of patient care is in conflict with the financial interests, policies, or orders of the employer.

Recommendations and Social Advocacy Action Plan for RNs

THE EVIDENCE EVALUATED HERE suggests that patient satisfaction, nurse satisfaction, and optimal patient outcomes are influenced by ensuring that there are an effective number of direct-care registered nurses to meet the needs of patients who require nursing care. Effective RN-to-patient ratios, not creative and illusory rounding and scripting schemes, are required for prevention, care planning, initial and ongoing assessment and evaluation of the treatment plan, patient education, and restoration to the optimal level of health and well-being attainable in the exclusive interests of the patient.

The social good and public benefit of increasing RN-to-patient ratios compels nurses and other social advocates to demand healthy social policy and financial accountability when it comes to solving our current crisis in healthcare. This is congruent with our vision of advocacy for a single-payer national health program, with a single standard of excellent care for all.

Standards for Evaluating Whether Scripting and Rounding Schemes Are in the Interests of Direct-Care RNs and Their Patients

STATE NURSING PRACTICE ACTS and registered nursing board implementing regulations, practice standards, and professional license guidelines generally impose a "fiduciary responsibility" on registered

nurses who accept assignment of a direct-care RN-to-patient relationship in which nursing care is provided. The fiduciary obligation infers a duty of loyalty to the patient to provide care in the exclusive interests of the patient without compromise or surrender to interests of health facility employers, physician practice groups, healthcare systems, managed care organizations, or health insurers/HMOs.

The fiduciary relationship and related professional fiduciary duties of direct-care registered nurses to assigned patients are fundamental public health and safety regulations created to protect patient safety.

The CNA/NNOC/NNU Code of RN Professional Responsibility

THE CODE OF RN PRACTICE includes the following standards:

1. The nurse assumes responsibility and accountability for competent and appropriate performance of the RN Duty of Patient Advocacy, acting in the exclusive interests of the patient, as the patient's advocate, by initiating action to improve healthcare or to change decisions or activities which are against the interests or wishes of the patient, as circumstances may require, and by disclosing information and providing patient education as necessary for informed patient decisions about healthcare before care is provided to the patient.
2. The nurse recognizes the importance of collective patient advocacy to the public health and the integrity of professional nursing standards of care, and participates in necessary and appropriate actions and exercises of collective patient advocacy to protect the public health and safe patient care standards against erosion, restructuring, degradation, deregulation, and abolition by the large healthcare corporations, hospital chains, HMOs, insurance companies, pharmaceutical corporations, and other powerful economic institutions and interests which today seek to control the availability, access, and quality of healthcare services for purposes of profit and surplus revenue generation against the interests of patients and healthcare consumers.

Necessary Conditions for Safe, Therapeutic, Effective, and Competent Registered Nursing Practice in the Interests of Patients

PROTECTION OF PRACTICE and working conditions for direct-care RNs that are essential for safe, therapeutic, effective, and competent care:

1. An RN-to-patient relationship which allows for competent performance of all aspects of the nursing process, enforced by objective minimum standards for safe patient care (i.e., specific, numeric unit-based RN-to-patient staffing ratios, with additional staffing up based upon the severity of illness/acuity of the patient).
2. The right and practical ability to exercise independent professional responsibility and judgment to determine and implement nursing care in the exclusive interests of patients, uncompromised by and without interference arising from the conflicting commercial and revenue-generating interests and demands of healthcare industry restructuring schemes.

Hospital direct-care registered nursing practice today is severely burdened by excessive patient assignment loads, mandatory extended work hours, unsafe patient handling practices, and routine exposure to risks of professional license discipline and/or malpractice liability inherent in the working and practice conditions created, implemented, and enforced by hospital administrators whose interests are aligned with the bottom line of the employer.

Rounding and scripting schemes are a marketing gimmick used to promote a false appearance of superior hospital nursing practices and "quality" patient outcomes. They are a strategy used to gain market advantage for public and private reimbursement for hospital nursing services. These schemes promote a deceptive redesign of direct-care practice standards intended to restrain independent judgment and action by direct-care RNs, obstruct patient advocacy, and subvert the nursing process with a mandate to serve commercial enterprise interests over patient interests.

What Then Shall We Do?

CONSISTENT WITH THE ESSENTIAL PURPOSES of CNA/NNOC/NNU as the voice for direct-care RNs and the Code of Professional RN Practice adopted in the CNA/NNOC Bylaws, our position must be one of categorical rejection of scripting and rounding schemes that override the critical thinking and independent professional clinical judgment of the direct-care RN. The responsibility to act as a patient advocate in the exclusive interest of the patient, and the affirmative obligations of collective patient advocacy offers no opportunity for concession of that duty.

Staff nurses must oppose any and all schemes that:

Directly or indirectly interfere with or compromised direct-care RN professional responsibilities to provide care in the exclusive interests of patients and take all necessary and appropriate actions to ensure patient safety.

Purport to replace or in effect operate to replace governmental regulation of hospital services for the public health and safety.

Directly or indirectly coerce, intimidate, induce, or encourage frontline caregivers to accept assignments, duties, and responsibilities which require enterprise loyalty and/or apparent assumption of managerial or supervisory authority that would disqualify them from collective bargaining representation.

Deceive and confuse direct-care RNs with Total Quality Management/Shared Governance/Rounding, Scripting, and Patient Satisfaction schemes, including pay-for-performance incentives to engage support for and suppress direct-care RN resistance to benchmarking schemes that redefine disease, treatment, and outcomes.

Promote cutbacks that deprive patients of access to safe, therapeutic, effective, and competent direct-care nursing services through reductions in staff and nursing service budgets, prioritization of surplus revenue generation, and other anti-patient care practices under the cover of "gold standard" redesign and elimination of professional RN patient care standards.

Fail to establish or allow for an objective, transparent process for working and practice conditions demonstrated to improve quality of the RN-patient therapeutic relationship, reduce errors and adverse outcomes, and improve RN recruitment and retention.

Establish, sanction, or otherwise permit different standards of nursing service performance or patient care outcomes which allow for substandard or different classes of competent care in derogation of the universal health principle of a single standard of excellent care with equitable access to all.

Continuing Education Test

Scripting and Rounding

For continuing education credit of 2.0 hours, please complete the following test, including the registration form at the bottom, and return to: CNA/Nursing Practice, 2000 Franklin St., Oakland, CA 94612. We must receive the completed home study no later than February 28, 2011 in order for you to receive your continuing education credit.

1. Because hospitals can always be trusted to provide excellent care, patient satisfaction is the most important issue for nurses and management alike.
❑ True ❑ False

2. In analyzing the safe, therapeutic, and effective values of any new protocol or script, RNs must explore the potential of protocols and patient interaction scripts replacing individualized human interaction in the delivery of healthcare and explore the potential of protocols and patient interaction scripts causing the supplanting of critical thinking and independent clinical judgment with rigid protocols and/or scripts.
❑ True ❑ False

3. One obvious method of improving patient satisfaction as well as patient outcomes would be to improve nurse-to-patient ratios. Patient satisfaction with their hospital stays are more positive at hospitals with fewer patients per RN than patients admitted to hospitals with poor staffing and higher nurse workloads.
❑ True ❑ False

4. Registered nurses must take all necessary and appropriate actions to ensure patient safety, even if such actions conflict with employer interests, policies, or orders.
❑ True ❑ False

5. Rounding and scripting depersonalize the relationship between RNs and patients. Ultimately they interfere with the Nursing Process, RNs' professional judgment, and control of their ability to prioritize, assess, plan, individualize, implement, and evaluate the care they provide.
❑ True ❑ False

6. The CNA/NNOC/NNU Professional Practice & Patient Advocacy Model is to provide safe, effective, therapeutic, competent care in the exclusive interest of the patient. The RN has the duty and must exercise the right to advocate in the interest of each individual patient.
❑ True ❑ False

7. The economic interests of the healthcare industry as presently constituted, the interests of patients, and the rights and obligations of direct-care registered nurses are the same.
❑ True ❑ False

8. The responsibility of the nurse is to represent the hospital. Scripts help the nurse better communicate with patients.
❑ True ❑ False

9. The three "P's" and four "'R's" are not so bad. There just isn't enough staff to care for patients without this streamlining.
❑ True ❑ False

10. There is no need for ongoing patient assessments so long as the RN asks if the patient is in pain, ensures the patient is positioned comfortably, and asks whether he or she needs to go potty.
❑ True ❑ False

Name:_____

Address: _____

City:_____ State:_____ Zip: _____

Day phone with message machine: _____ Email: _____

RN license #: _____Job Classification: _____