Frequently Asked Questions
Data and Expected Outcomes
Last Updated September 15, 2009

General Questions

What is the timeline for document submission after application?

Good news! There is no waiting list to submit your documents to the Magnet Recognition Program ®. The cycle dates for submission of written documentation are February 1, April 1, June 1, August 1 and October 1. You can submit your documents up to two years after application. You can apply at any time. As you are preparing to submit your application, it is a good idea to call the Magnet® Program Office, so we can work with you to identify dates for documentation submission that will meet your needs.

Should information on the Demographic Information Form (DIF) correspond to the 24 months prior to submission of documentation that we use for our document?

As much as possible, you should work to line up the data timelines. However, there is often a time lag in reports being disseminated, and there are also constraints on data collection timelines that the organization cannot control (for example, data submission is required on a certain date). Some organizations use different data collection processes and have different timetables for reports. The data submitted should be from the time period **closest** to document submission that is consistent with your organizations' data systems.

When collecting information about educational level of RNs, where do I count someone who has a bachelor of arts in nursing?

The category will read baccalaureate in nursing. If the RN holds a bachelor of science in nursing or a bachelor of arts in nursing, it should be counted in the baccalaureate category.

There is a definition of nurse leader on p. 4 of the green 2008 manual. Why are clinical nurse specialists not included in the data collection of nurse leader?

The definition of nurse leader has been clarified as a nurse who participates in decision-making bodies and/or has a leadership role. We are in the process of reprinting the manual with the correct definition. There is a separate data collection category for clinical nurse specialists on the DIF. The DIF is being changed so that information about advanced practice nurses and clinical nurse specialists have categories for data collection.

If a nurse manager has a master's degree in nursing but not a baccalaureate in nursing, will that meet the requirements that are outlined on p. 6 in the manual?

The criterion states that effective January 1, 2011, 75% of nurse managers must have **at least** a baccalaureate in nursing. If a manager has a higher degree in nursing, that will meet the requirement (a master's or doctorate in nursing), even if the baccalaureate degree is not in nursing.

In the section on "Notification of Events" why do organizations need to report sentinel events to the Magnet Program Office?

An "adverse event" describes any harm (i.e., undesirable clinical outcome) to a patient as a result of medical care. The term "sentinel event" denotes a serious occurrence that signals the need for immediate investigation and response. Research, policies, and action taken to reduce adverse or sentinel events often focus on mistakes and systemic problems with care.

The Centers for Medicare & Medicaid Services (CMS) indicates that reducing the incidence of adverse events in hospitals is a critical component of efforts to ensure patient safety and to provide quality health care.

Various federal and state government agencies and other entities are responsible for addressing adverse events in hospitals. Additionally, hospitals must track and analyze adverse events as a condition of participation in the Medicare and Medicaid programs. Reporting events and suspected causes can help hospitals improve practices to prevent adverse events and ensure accountability for poor care. Hospitals also use reported information to inform affected patients and families, which is thought to boost public trust, and to improve clinical decision-making compliance in treatment.

The Magnet Recognition Program ® goal is to provide patients with a benchmark to measure the quality of care that they can expect to receive by recognizing quality patient care, nursing excellence, and innovations in healthcare services. Therefore, the Magnet program must be cognizant of the current healthcare industry trends—emphasizing quality of care, lower error rates, and non-payment for many adverse and sentinel events. Magnet® designation is an indication to customers not only of a quality nursing program within a healthcare organization, but also a signal that they can expect quality care because of recognized nursing excellence within a designated facility. For those reasons, the Commission on Magnet should track and trend the situations of adverse or sentinel events of organizations that hold the Magnet designation credential.

The reports should remove any identifiable patient health information and names of healthcare professionals involved.

Questions about Nursing Sensitive Indicator Aggregate Data Collection and Benchmarking

Can you give some guidance about collecting data for Nurse Sensitive Indicators?

The intent is to collect data that is applicable and *value-added* for the particular unit or facility. If a national database is available, it should be used. But an organization can choose another appropriate way to benchmark for clinical areas/subjects not covered by a national database. An organization can choose another benchmarking measure or database as long as the facility can justify the reason for choosing that measure or database. Benchmarking should be done at the highest level possible to have a meaning and value. Appraisers will ask: Why are you using it? What did you use to determine measure? What else did you look at?

Example: Many specialty pediatric hospitals across the country formed a cohort and benchmarked against each other.

What advice can you give me about choosing a benchmarking database?

There is no Magnet-required process for approving databases or benchmarking choices. Organizations have the latitude to choose the tools that are most beneficial to them. The guidance is to choose the highest quality tool that is statistically significant, at the broadest level nationally available, with the largest cohort to get the greatest comparative value. In addition, review of the requirements in the Organizational Overview will provide applicants with the data elements that they need to make sure they are collecting, and also requires that some data be displayed at the unit level.

Are the outcomes weighted more in re-designation than in the original application?

The requirements for redesignation require that all of the outcomes Sources of Evidence delineated in the manual as EO (Empirical Outcome) are addressed. Since there are fewer overall Sources of Evidence to address in re-designation (64), and all of the outcome sources (19) need to be addressed, the “weight” of the outcomes sources will be emphasized in redesignation.

In the organizational overview, does nurse (RN) satisfaction data need to be provided at the unit level?

Yes, you need to submit unit-based nationally benchmarked data.

Can you explain more about the Nurse Sensitive Indicator data requested in EP32EO?

Individual units should have four indicators. When applicable, indicators are collected in these areas: falls (required where applicable); hospital-acquired pressure ulcers (required where applicable); and two of the following:

- blood stream infections
- urinary tract infections

- ventilator-associated pneumonia
- pediatric IV infiltrations or
- restraints
- other specialty-specific nationally benchmarked indicators

In areas where these “other” indicators are not applicable or collected, a minimum of two indicators is required. No area is required to submit more than four indicators at this time.

Exceptions:

- **Obstetric areas** present a unique situation related to nursing sensitive indicators. Hospital-acquired pressure ulcers and pediatric IV infiltrates do not apply and OB patients rarely have blood stream infections, urinary tract infections, ventilator-associated pneumonia, or restraints. It would be appropriate for them to choose two of the “other specialty specific indicators.”

- **In ambulatory care areas**, hospital-acquired pressure ulcers and pediatric IV infiltrates may not apply, nor do blood stream infections, urinary tract infections, ventilator-associated pneumonia, or restraints, in most situations. It would be appropriate for them to choose two of the “other specialty specific indicators.”

- **In any areas where the number of RNs is small, with only one or two RNs**, one indicator may be appropriate and reasonable, as organizations attempt to balance productivity with performance improvement. Just be sure to explain why an area does not have two indicators, as the expectation is that nurses are critically examining their practice for opportunities for improvement wherever they practice.

Is it required that we collect and benchmark falls and pressure ulcers in *all* areas?

It is required to collect falls and pressure ulcers on the units where this is an applicable data indicator, *plus* two other indicators from the list provided on page 21 of the 2008 Magnet Manual. If your unit does not have falls or pressure ulcers as an applicable indicator, then you only need to collect two of the indicators on the list. As a result, some units may be collecting two, three or four indicators to meet the intent of this requirement. As a minimum, each unit must collect at least two indicators, but no more than four are required.

We currently collect BSI and VAP data in two areas only. We do not benchmark these. Is it a problem that we aren’t benchmarking them?

BSI and VAP data can and must be benchmarked to address Magnet Sources of Evidence. We suggest you participate in a comparative database (such as those that are publicly available on the Center for Disease Control’s National Healthcare Safety Network data set) to benchmark these indicators. If a national database is available, it should be used. But an organization can choose another appropriate way to benchmark for clinical areas/subjects *not covered* by a national database. An organization can choose another benchmarking measure as long as the facility can justify the reason for choosing that measure or database. Benchmarking should be done at the highest level possible to have meaning and value. Appraisers will ask: Why are you using it? What did you use to determine the measure? What else did you look at?

In areas where VAP isn't appropriate to collect, is the assumption that we should be collecting and benchmarking other data such as BSI, UTI, etc.?

It is required to collect falls and pressure ulcer data on the units where applicable, *plus* two other indicators from the list provided on page 21 of the 2008 Magnet Manual. If your unit does not have falls or pressure ulcers as an applicable indicator, then you only need to collect two of the indicators on the list.

How should I present my organizational aggregate or unit level Nursing Sensitive Indicator data?

Include a graphic display of the data that clearly identifies benchmarks.

Organizational aggregate data should include falls, pressure ulcers, and two other indicators from the list noted in the manual EP32EO: blood stream infections, urinary tract infections, ventilator-associated pneumonia, pediatric IV infiltrations or restraints. The data sets for these four indicators would include only those areas within the facility that is collecting them.

For example:

- Falls data aggregated at the organizational level should include all areas except exempt areas where this is not an applicable indicator.
- Hospital-acquired pressure ulcer data aggregated at the organizational level should include all areas except exempt areas where this is not an applicable indicator.
- Ventilator-associated pneumonia data aggregated at the organizational level should include applicable areas in which patients receive ventilator care, but would exclude areas in which patients do not receive ventilator care.

Questions about RN Satisfaction, Patient Satisfaction and Clinical Outcome Measures data collection (EP3EO, EP32EO, EP35EO)

Can you explain more about the requirement to have data submitted that outperforms the mean and is above the midpoint of the national database used?

In the new 2008 manual, the Magnet Recognition Program ® has evolved to include outcome measures as Sources of Evidence. There is awareness that there is variation in units, over time, for each of the indicators for patient satisfaction, RN satisfaction and clinical indicators.
If you find that you are not currently collecting information to meet the requirements outlined in EP3EO, EP32EO, or EP35EO, **get started,** as 2009 is a transition year. The intent of the requirement for submitting data and the required outcome Sources of Evidence is to show that your organization is in the top half of nationally representative benchmarked organizations, either for the total organization or at the unit level.

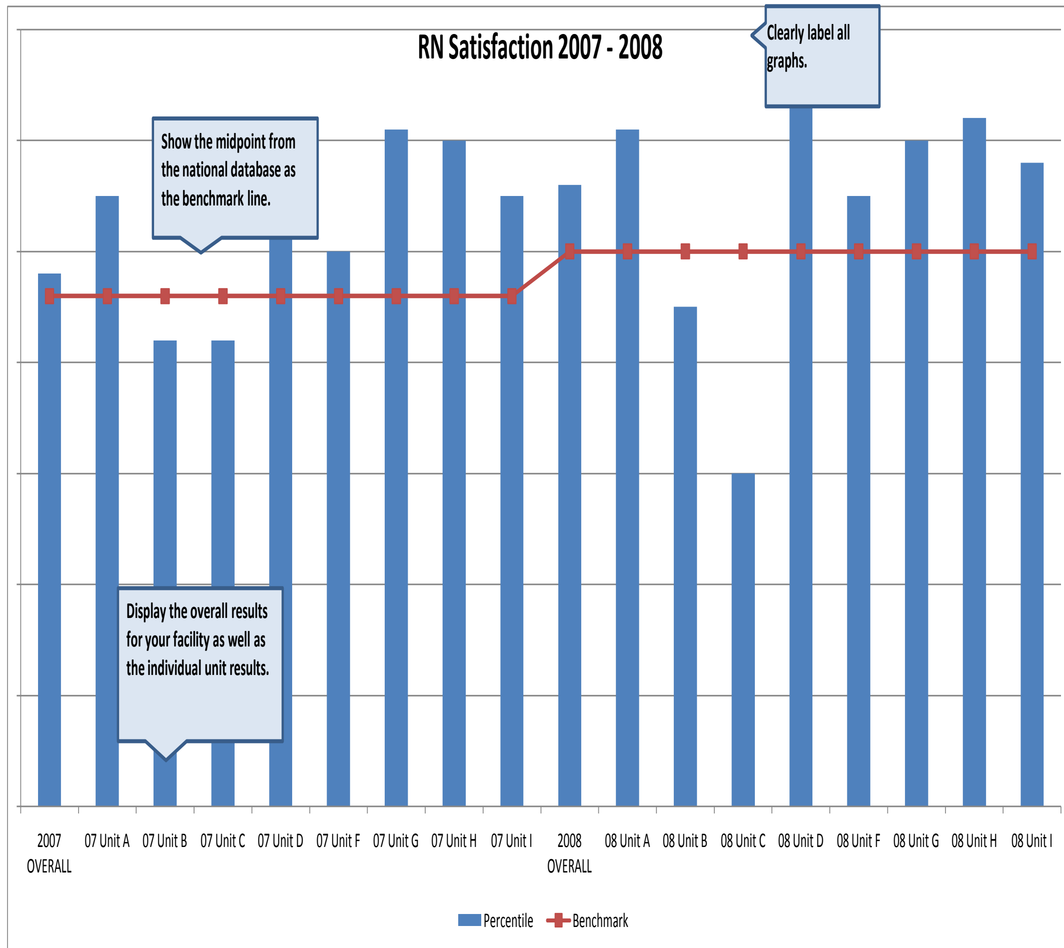
If unit-level data is presented, the guidance is that at least the majority of the units be in the top half of the national benchmark (or whichever half is better) for the majority of the indicators selected to measure at least half of the time. Over time, this threshold will be increased as Magnet hospitals continue to improve performance.

For each indicator displayed, there needs to be at least two data points from the same survey tool or clinical measurement.

So, for example, for unit level data presentation, if an organization had nine patient care units, at least five of them have to be performing above the mid-point more than half the time.

How often do we need to do the RN satisfaction survey?

The nursing satisfaction surveys do not need to be done annually, but you do need to show at least two comparisons over time. Whether that is an annual survey or every two years is up to your organization. A bar-line graph is often an effective way to display the data. Organizations frequently need more than one year to demonstrate improvement in the scores. For each measure, there needs to be at least two data points from the same survey tool. Below is an example of a bar-line graph that displays RN satisfaction over time.



During the off years, we do a house-wide employee engagement survey for the entire health system, from which we can isolate results specific to the RN. Would this be acceptable?

One thing to consider is the comparability of the indicator set. You must have two data points from the same survey tool to compare results. You must assure that it is benchmarked as part of a nationally representative sample. In addition, data needs to be available for RNs by unit, even in the house-wide survey. As long as those conditions are met, you may use whatever survey instrument you wish.

If special circumstances prevent your organization from comparing two data points from the same survey tool, a detailed explanation must be included in the written documents. Every effort needs to be made to compare results between similar concepts for nurse satisfaction over time.

The 2008 Magnet Manual says that beginning in 2010 we need to submit unit-level data on all indicators listed. We won't be able to have the data by then.

The Magnet program is moving the requirement to 2012 because of the lag in reporting benchmarking data. This should give organizations time to catch up. The requirement will be to submit data on all indicators, so you should be *collecting now* in order to have two years' worth of data to submit by 2012.

For restraint use, what specific data is being requested? In-house restraints in use, or injuries related to restraints?

It depends on the database being used and how restraints are defined. Submit the restraint indicators that have benchmark data.

We have 20 hospitals in one state. Would we qualify as large enough to be a comparison benchmark against ourselves?

The requirement is to benchmark against a nationally representative sample. The larger the comparative cohort, the more valuable the data set on which to base your improvement efforts. While it is always helpful to compare yourself to other hospitals in your state, 20 hospitals in one state would not qualify as a nationally representative sample for comparison benchmark for Magnet. If you have questions, or are unsure, it is always a good idea to call the Magnet Program Office and talk to your analyst.