



CNL Summit 2010

POSTER PRESENTATIONS

January 21, 2010

CNL Summit

January 22, 2010

Town and Country Resort and Convention Center

Poster Presentation Session **Thursday, January 21, 2010**

The Journey of a CNL Educator: First Year Experience

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How Accurate are Neonatal Intensive Care Unit Based Charges?

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One Minute Messaging: The CNL Elevator Speech

Linda M Caldwell, DNSc, ANP, BC; Judy Dynan, RN, BS, OCN, CNL Student; Linda Raulinatis, RNC-OB, BS, CNL Student; Lucille Bousquet, RN, BSN, CNL Student; Denise McKenna, RN, BS, CNL Student; Ginny Williams, RN, BS, CNL Student; Susan Belton, RN, BS, CNL Student
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Alternative Strategies to Support the CNL Student Role in a Noneducation-Practice Partnership Model

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Evaluating PDA Use among Staff Nurses on a Dedicated Education Unit for CNL Education and Practice

Brittany Cardell, MSN, CNL, Sherry Webb, DNSc, CNL, Tommie Norris, DNS, Veronica Engle, PhD, Marie Gill, MSN, & Leslie McKeon, PhD, CNL
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Prevention of Post-OP Pneumonia Utilizing Pre-Operative Oral Care

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CNL Impact on Patients at Risk for Falls

Melinda Davis, MSN, RN, CNL; Bettye Glowacky, MSN, RN; Rae Jacobson, MSN, RN, CNL;
Lynett King, MSN, RN, CNL; Tiffany Latham, MSN, RN; Norma Patterson, MSN, RN; Ruth
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Nosocomial Ventriculitis: Utilizing the Eight P'S for Prevention

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Take the Pressure off Pressure Ulcers

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Application of the CNL Role in the Outpatient Clinical Setting

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NICU Nursing Research Journal Club: Bringing the Evidence to bedside practice

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An Exploratory Study of Emotional Intelligence and Clinical Nurses

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Nurse Rounding in an Emergency Department Observation Unit: Implementing an Evidence-Based Inpatient Practice into an Outpatient Service

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Project Assert: A Model for Professional Collaboration

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From Start to Finish: The CNL Job Description Roundtable

Jennifer Kareivis, MSN, RN, CNL and Judd Strauss, MSN, RN, CNL
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Model C Graduates: Clinical Expert- NO, Clinical Nurse Leader- YES!

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Electronic Documents the Smartworks Way

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CNL Stewardship of Environment with Proper Disposal of Pharmaceuticals

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Implementation of a New Nursing Role

Nicole Manchester, MS, RN, CCRN, CNL; Danielle Tabor, MS, RN, CNL; Nina Swan, MS, RN, CNL; Paulette Gallant, MS, RN, CNL; Lauri Wilson, MS, RN, CNL; Sonja Orff, MS, RN, CNL; Margaret Hiler, MS, RN, CNL; Darlene Rouleau, MS, RN, CNL
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Using a Scoring System to Activate Urgent Response System

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Therapeutic Group Proposal: A CNL Practice Innovation

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Aquapheresis Therapy in an Outpatient Setting: A Case Study

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The CNL'S Role in Empowering Staff to Improve Outcomes

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Clostridium Difficile: A CNLs Initiative to Improve Flow, Patient Outcomes, and the Environment for the Patient Being Ruled Out for Clostridium Difficile

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Implementation of Bedside Hand-Off in a Labor & Delivery Unit Utilizing a Standardized Tool

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Developing a Neutropenia Protocol

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Enhancing Heart Failure Core Measure Performance through Concurrent Review

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Collaboration: Implementation of the CNL Role across a Hospital System

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Cassandra Mathis, MSN, RN, CNL; Jocelyn Mueller, MSN, RN, CNL;
Joy Parchment, MSN, RN, NE-BC; Lari Quintero, MSN, RN, PCCN, CNL;
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Improving Patient-Centered Communication between Nursing Staff and Care Partners at Change of Shift

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How a CNL Empowers Staff RNS to Control Catheter Associated Urinary Tract Infection Rates via Improvements in Clinical Monitors and Nursing Documentation

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A CNL Initiative: A Mentoring Strategy Using a Care Group Approach J

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THE JOURNEY OF A CNL EDUCATOR: FIRST YEAR EXPERIENCE

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Development of the Clinical Nurse Leader (CNL) role addresses the need of this next generation of nurses to meet the healthcare needs in today's society. To educate the CNL, initial curriculum development can be a challenge for the nurse educator. The curriculum must be all inclusive at the microsystem level and capture the ten assumptions in the AACN White Paper on the education and role of the CNL (2007). Mennonite College of Nursing at Illinois State University has developed the CNL curriculum at the post BSN level and has just graduated the first cohort. There have been some bumps in the road as well as rewards received along the way for the CNL faculty educators.

Challenges in the creation of CNL curriculum for us included cost effectiveness, diversity, and limited resources. Limited resources are handled in a variety of ways. For example, CNL courses are shared with other master's level sequence courses such as advanced health assessment, pathophysiology, and advanced leadership concepts. Two specific courses for the CNL are offered which contain specific classroom and clinical components. Content experts from the faculty and the local hospitals teach selected aspects of the CNL courses, such as informatics, complexity science, quality resource management, and budgeting. Finding appropriate CNL preceptors was another resource challenge. Some nurse managers agreed to precept students, in close planning with the CNL certified faculty members. Meetings have been held throughout the semester to discuss immersion experiences and to identify others who could facilitate student experiences at the microsystem level.

The first cohort of CNL students was small (three), but with fairly diverse backgrounds. Two students were relatively new graduates (medical surgical and maternal health units) and the third was a nurse with over 20 years of varied experiences and already functioning in a role that was similar to what the CNL role would be in her hospital. How to keep the experienced nurse interested was a concern to faculty, while not minimizing the complexity of the role for the newer nurses. Many of the classes were presented in a seminar format, which allowed a lot of discussion and sharing of past experiences, which was helpful to the newer graduates. Since the clinical experiences for this group were in acute care, time was spent meeting a variety of health care team members and learning about their roles. The students were challenged through these meetings to explain the role of the CNL and discuss how the multiple disciplines could work together to facilitate better patient outcomes. Throughout the initial CNL course each student also developed resource files specific for her unit that would help the CNL be a lateral integrator of care. Additionally, because of the varied learning needs of the students and based on work completed during the initial CNL course, we implemented learning contracts for each student. This was done in collaboration with the clinical preceptors. Types of projects included in the contracts were based on individual student needs, such as development of a plan of care for the clinical microsystem or development of a CNL job description for the health care facility.

We received positive feedback from the first cohort of students on format of the class and use of learning contracts. Furthermore, clinical agencies were positive about the student projects.

HOW ACCURATE ARE NEONATAL INTENSIVE CARE UNIT BASED CHARGES?

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A review of standard setting documents from several organizations (American Academy of Pediatrics (AAP), Centers for Medicare & Medicaid Services (CMS) Guidance Document, Uniform Billing Editor 2008 and the McKesson InterQual Level of Care Criteria 2008), the

ONE MINUTE MESSAGING: THE CNL ELEVATOR SPEECH

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Because the Clinical Nurse Leader (CNL) is a relatively new role, many health care agencies are not familiar with it or may not appreciate the value added that the CNL could bring to the clinical setting.

Across the country, many health care agencies responded to current economic climate by eliminating new or unfilled positions or, in some cases, by implementing personnel lay-offs including nurses. Given this economic climate and the push for health care reform, it is essential that graduates of CNL programs are able to communicate clearly and succinctly what a CNL is, what a CNL does, and how health care agencies can benefit from their services. An “elevator speech”, or a one minute message, is one vehicle to elucidate the CNL role. An elevator speech is a focused message of less than 200 words conveyed in a conversational style which summarizes and highlights the unique aspects of a selected topic with a few well chosen sentences.

This presentation will describe the components of a one minute message as it relates to nursing and specifically to the CNL. The presenters will describe the essential components of the message for CNL’s, and demonstrate how the message will vary depending on the CNL’s clinical setting or the patient population. Several one minute messages describing the CNL in a variety of settings will be presented.

ALTERNATIVE STRATEGIES TO SUPPORT THE CNL STUDENT ROLE IN A
NONEDUCATION-PRACTICE PARTNERSHIP MODEL

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Background Information

The CNL program at UMDNJ School of Nursing was initiated in 2006 with funding from a HRSA grant. Ninety percent of this first cohort was officially sponsored by their place of employment in an education-practice partnership (5 facilities) and the remaining 10% were indirectly supported by their employer. The immersion experience was completed in a 15 week term in accordance with the recommendation of the White Paper (July, 2007). Although the school maintains partnerships with several clinical practice sites, each subsequent cohort has had a decline in employer sponsorship and an increase in students seeking to complete the program independently without sponsorship from their employer. Non-sponsorship poses unique challenges to effective clinical experiences for both the student and instructor.

Outcome Data

This is a project in process.

Description of Practices

Students not in a formal education-practice partnership face a challenge in establishing a clinical practice environment to integrate knowledge and skills being acquired during the academic experience. Faculty advisors work closely with the students to explore clinical sites and preceptors that will enhance their academic experience. Facing an economic challenge, many of these students continue to work fulltime while simultaneously trying to meet the rigorous demands of the immersion experience. To date, all students have continued to have their clinical experiences in their place of employment but during non-work hours and often not on their clinical unit. Several students have voluntarily reduced their employment status to part time to meet the clinical hours of immersion. The current economic downturn of the economy has had a negative impact on local healthcare facilities and administrators are not supportive of introducing the CNL role into their table of organization. Only two of the original five education-practice partnerships remain and have maintained the CNL role in their facility.

Summary Recommendations and Impact

As academicians we support the AACN statement that “successful change in both the practice environment and nursing education requires committed and active partnerships between education and practice in nursing and with other health professions” (AACN, July 2007, p.27). We believe that the CNL role is a viable means to achieve successful outcomes but that an education-practice partnership may not be the only means to that end. Educators must consider alternative and creative measures for the student to meet the clinical requirements. Examples include external experiences with CNLs in other practice sites, ongoing meetings to develop the preceptor role and assist in identifying projects that will mutually benefit the clinical agency and the student, and a no-cost extension for the immersion clinical when necessary. This extension option would allow the student to spread their experience over 30 weeks and reduce the weekly obligation, thereby allowing them to continue fulltime employment. We believe that for the CNL role to be attractive to future students and for it to survive and grow, it is critical to explore other approaches to achieve the clinical experience while meeting the end of program competencies and requirements.

EVALUATING PDA USE AMONG STAFF NURSES ON A DEDICATED EDUCATION
UNIT FOR CNL EDUCATION AND PRACTICE

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Background: Clinical Nurse Leaders (CNLs) apply information technology in the delivery of client care, using data for evidence-based practice and to facilitate effective health teaching. The personal digital assistant (PDA) is an integral part of CNL practice, providing access to the best evidence at the point of care. Staff nurses also need to use information technology to communicate, manage knowledge, and support decision-making, but may not have access to or experience with PDAs. Informatics competency is particularly important for nurses involved in CNL professional entry clinical education. This study evaluates the impact of PDA use by staff nurses on their clinical practice as part of a CNL-led practice innovation for staff nurses serving as clinical teachers (CTs) on the University of Tennessee Health Science Center-Methodist Le Bonheur Children's Medical Center Dedicated Education Unit (UTHSC-Le Bonheur DEU).

The UTHSC-Le Bonheur DEUs are two of four DEUs developed through the University of Tennessee Health Sciences Center (UTHSC) and Methodist LeBonheur Healthcare partnership. The purpose of the DEUs is to create exemplar teaching-learning environments for CNL education and practice. Trained staff nurses serve as CTs under the direct guidance of UTHSC clinical faculty for our Master's Entry CNL students enrolled in professional entry specialty and leadership courses.

In June 2009, 12 staff nurses were educated as CTs for the 2 UTHSC-Le Bonheur DEUs. One DEU specializes in pediatric hematology and orthopedics and the other in pediatric neurology. CT training included assumptions of CNL education, AACN End-of-CNL competencies, principles of clinical teaching and adult learning, and use of PDA in clinical practice. PDAs (HpiAPAQ110) and clinical software were provided for all CTs by UTHSC through HRSA grant funds. Software included: Taber's Cyclopedic Medical Dictionary; Mosby's PDQ for RN; 2009 Mosby's Nursing Drug Reference; and Mosby's Diagnostic and Laboratory Test Reference. On-site training in the use of PDA, accessing software, and troubleshooting was conducted by the UTHSC College of Nursing Manager of IT Services.

Methods: This CNL-led practice innovation entails the education and initial evaluation of 12 staff nurse CTs in the use of the PDA in clinical practice during the UTHSC Leadership course scheduled over a 10-week period in Fall, 2009. The PDA Survey, an 8-item survey piloted earlier in 2009, will be used for the initial evaluation. The survey will be administered at the course end using SurveyMonkey. Questions focus on:

- PDA frequency of use in practice
- PDA utility in patient teaching, CNL student teaching and nurse precepting
- PDA impact on time spent hunting and gathering information
- Software usefulness
- Self-rated proficiency

Outcomes: Data collection will be completed by 12/09. Results, implications for staff nurse practice and CNL education, and recommendations for PDA training will be presented.

Funded: This project is supported in part by funds from the Division of Nursing (DN), Bureau of Health Professions (BHP), Health Resources and Services Administration (HRSA), Department

of Health and Human Services (DHHS) under grant number D09HP14828 Master's Entry CNL program for \$213,687.00. The information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by the Division of Nursing, BHP, DHHS or the U.S. Government.

PREVENTION OF POST-OP PNEUMONIA UTILIZING PRE-OPERATIVE ORAL CARE

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Hospital associated infections (HAI) are often an avoidable consequence of a hospital stay. With an incidence of 10% to 20%, VAP is associated with increased morbidity and mortality of ventilated ICU patients, as well as an increased length of stay, increased resource use, and increased costs. Prevention is the most effective method of decreasing the incidence of VAP.

Research has shown that aspiration around the endotracheal tube of oropharyngeal organisms and the subsequent development of infection is the most common mechanism of action in the development of VAP. Decreasing and/or removing the pathogenic microorganisms from the oral pharynx may decrease the incidence of infection. Chlorhexidine is an antimicrobial oral rinse that has shown positive results in the prevention of VAP. Since chlorhexidine products are effective in the prevention of VAP, the potential to prevent post operative pneumonias utilizing pre-operative oral care with a chlorhexidine product was hypothesized.

The Clinical Nurse Leader student, working in conjunction with the infection control team conducted a retrospective analysis of post-operative pneumonias seen in a specific patient population. The data revealed a total of 10 patients who developed a pneumonia following thoracic surgery. These cases were identified between March of 2008 and February of 2009. The team's research question hypothesized that by reducing the amount of flora in the oral cavity pre-operatively by routine oral care, a decrease in the number of post-operative pneumonias following intubation would be evident.

Preoperative mouth care instructions were provided to the patient in the physician's office. The patients were instructed to perform routine mouth care with toothpaste (Colgate Total was recommended) followed by a mouth rinse with Peridex (a chlorhexidine product). Mouth care was recommended three times per day until the day of surgery. The importance of oral care the morning of surgery was also stressed.

Post operative chest x-rays were monitored for signs of pneumonia. Changes noted on a patient's chest x-ray along with other indications of infection were utilized to determine the presence of pneumonia. These indicators included temperature elevation, increased white blood cell counts, changes in oxygen requirements and alterations in mental status (all indicators of pneumonia as indicated by the CDC).

The advent of the mouth care regime began in March 2009. Post thoracic surgery patients have been monitored through August 31, 2009. To date, one post-operative pneumonia has been identified in this specific patient population. Data will continue to be analyzed through October 2009 to accumulate eight months of data. Through the institution of a simple pre-operative procedure there appears to be the potential to reduce or eliminate the development of post-operative pneumonias in patients undergoing thoracic surgeries.

Objective:

Describe a process to decrease or eliminate the development of post operative pneumonias.

INTERVENTIONS FOR THE PREVENTION OF CENTRAL VENOUS CATHETER INFECTIONS IN A SURGICAL INTENSIVE CARE UNIT

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Background Information: Approximately 48% of critically ill patients have Central Venous Catheters (CVCs) which put them at high risk for developing CVC infections. CVC infections lead to higher rates of mortality and morbidity, increased length of stay, and higher hospital costs. The attributable mortality for CVC infections is approximately 18%. In addition, nosocomial bloodstream infections prolong hospitalization by a mean of 7 days. Estimates of the cost of a single bloodstream infection are between \$3,700 and \$29,000. Prevention of CVC infection was identified as a process improvement goal in the Surgical Intensive Care Unit (SICU) at Tennessee Valley Healthcare System subsequent to an increase in CVC infections in the SICU from a total of 2 incidences in Calendar Year (CY) 2007 with a rate of 0.97 infections per 1000 device days, to 6 incidences in CY 2008 with a rate of 2.6.

Description of Methods: Beginning in February, 2009 several interventions have been implemented with measurable success, including formation of a unit-based Infection Reduction Team (IRT) and applications of evidence-based interventions. Current practice was evaluated and revised based on guidelines and evidenced-based interventions. The ICT made rounds each shift using a walking monitor sheet that the Clinical Nurse Leader developed to evaluate compliance with standards of practice and perform real-time teaching and coaching to staff nurses. The sheets were monitored over time for improvements in compliance. The walking monitor included practice standards such as CVC dressing change, and tubing changes. Additionally, the CNL developed a service-wide CVC Dressing Change Standard of Practice and Competency Validation tool in collaboration with infection control and the Intravenous (IV) Therapy Team. The CNL included CVC dressing change as a station at the bi-annual Nursing Skills Fair. After reviewing the literature and CDC Infection Control Guidelines, the CNL set up a trial of a central line dressing impregnated with chlorhexidine gluconate that had been shown in the literature to reduce the incidence of CVC infections.

Outcomes Data: The number of CVC infections and infection rates were measured and benchmarked using the National Nosocomial Infection Surveillance (NNIS) method. Total number of CLI cases per calendar year decreased from 6 CLIs in the Calendar Year 2008 with an infection rate of 2.6, to 1 CLI in 2009 so far with an infection rate of 0.45.

Summary Recommendations: The results support continuation of the aforementioned interventions that have been effective in reducing CVC infection cases, continuing to seek out and use evidence-based literature to guide nursing practice, and to continue to monitor patient outcomes to evaluate effectiveness.

Impact: Several practice changes have been adopted since implementation of the process improvement initiative with measurable success including (a) continuation of ICT “spot checks”; (b) continuation of instruction and competency validation for CVC dressing changes at the bi-annual Nurse Skills Fair; (c) adoption of the chlorhexidine gluconate-impregnated CVC dressing as the dressing of choice for central lines.

NOSOCOMIAL VENTRICULITIS: UTILIZING THE EIGHT P’S FOR PREVENTION

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Infection is a potential complication for acute brain injury (ABI) patients with external ventricular drains (EVD) and intracranial pressure (ICP) monitoring devices. Located in Lima, Ohio, the Intensive Care Unit (ICU) at St. Rita’s Medical Center realized a significant increase in nosocomial ventriculitis from January 2008 to June 2009. The 5 P framework, plus an additional 3 Ps, was utilized to assess the ICU microsystem and develop an action plan to remedy the situation. After analyzing processes regarding ABI patients with EVD/ICP devices, patterns emerged. No protocol existed for EVD/ICP dressing changes. Furthermore, there was nursing concern regarding lack of EVD/ICP care direction. A literature search showed little study regarding nursing dressing care of these devices, but did discuss significant implications of nosocomial ventriculitis in the EVD/ICP device population. Following development and implementation of a dressing change protocol, a retrospective/prospective experimental study was initiated. Retrospective data collected from 13 patients significantly revealed that 54% had positive cerebrospinal fluid (CSF) cultures and that 77% had received 3 dressing changes or less throughout their ICU course. Average length of stay (LOS) was 34 days, with EVD/ICP devices in place for 14 days. Prospective data collection and intervention evaluation is ongoing.

TAKE THE PRESSURE OFF PRESSURE ULCERS

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The incidence of hospital acquired pressure ulcers in the intensive care units at Tufts Medical Center is above seven percent. In an effort to achieve pressure ulcer reduction, Tufts is utilizing the CNL candidate to assess the current practices, prevalence data and interventions in place in order to improve upon these practices and make further recommendations to improve outcomes. The goal is to reduce the occurrence of pressure ulcers in the intensive care units. The CNL in collaboration with the Director of Performance Improvement, are utilizing the Six Sigma process to effectively reduce the number of pressure ulcers. Six Sigma is a data-driven methodology to solve issues, eliminate waste and improve processes. Lean/Six Sigma is an integrated set of tools that produce breakthrough performance improvements. Six Sigma has not created new tools; it has simply organized a variety of existing tools to create flow. The premise of Lean/Six Sigma is continuous quality improvement.

The project includes assessing the current practices including reviewing the following: staffing patterns, patient acuity, wound data, as well as contributing factors related to pressure ulcers in the intensive care unit. The objectives are a work in progress and will be measured by utilizing evidence based practices to reduce the number of pressure ulcers in the intensive care units.

APPLICATION OF THE CNL ROLE IN THE OUTPATIENT CLINICAL SETTING

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The Clinical Nurse Leader (CNL) role as a Master's prepared nurse generalist has broad application to multiple care settings. The literature is sparse on application of the CNL in the outpatient setting, with case studies, examples and comments most often referring to the role in the acute care setting. However, according to the Kaiser Family Foundation (2009), only 31% of total health care spending (\$2.2 trillion) in 2007 was for hospital-based care. Economic factors and changing reimbursement structure will likely further increase the amount of care provided in outpatient settings.

The American Association of Colleges of Nursing (2007) states the CNL role not only applies to acute care, but can provide leadership in all aspects of the health care system. CNL educational preparation provides a broad base of knowledge to draw upon when functioning in the outpatient setting, which may include program development and administration or population-specific application such as an oncology nurse navigator.

This presentation will focus on how the CNL can effectively and efficiently function in the outpatient setting, which often requires one to multitask duties and responsibilities. Application of the American Association of Colleges of Nursing CNL core competencies and the Health Professions Core Competencies identified by the Institute of Medicine, which include patient-centered care, interdisciplinary teams, evidence-based practice, quality improvement and informatics, will be discussed (Finkelman & Kenner, 2009). The ability of the CNL to respond to increased and changing demands of the outpatient clinical setting, including issues being faced in today's environment, will be addressed. The presentation will include examples from work in a multidisciplinary breast center and a nursing college-based breast and cervical cancer screening program, and provide suggestions on application of the CNL role in other outpatient settings.

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**NICU NURSING RESEARCH JOURNAL CLUB:
BRINGING THE EVIDENCE TO BEDSIDE PRACTICE
KATHY FABER MSN, RN, CNL
ST. JOSEPH'S REGIONAL MEDICAL CENTER
PATERSON, NEW JERSEY**

Introduction: An important part of our professional nursing practice is the ongoing development of knowledge. We consistently strive to provide “Best Practice” for our patients and families, and know that these practices must be determined by sound research rather than by clinician preferences or traditions. Current research findings can help solve clinical problems, improve outcomes, introduce new technology, support cost-effective changes, and understand patient perspectives. The NICU Nursing Research Journal Club seeks to provide nurses with an opportunity to regularly participate in literature review enabling nurses to develop skills in evidence-based practice and primary nursing research.

Background: The nursing journal club was initiated by the Clinical Nurse Leader and featured articles chosen by the CNL and NICU Council monthly, hard copies were posted in the nursing staff lounge three weeks prior to review.

Discussion Groups/Article Review Outlines/Establishment of the PICO Question/Possible Future Research Proposal evolved into developing focus groups in the following area: Discharging of the Preterm Infant, Reduction in BSI, Developmental & Early Intervention Care, Hypothermia and Evidenced-Based Plans of Care. From May 2008 to August 2009 participants equaled 296.

Evaluation and Outcomes: Lead by the CNL, the care teams developed were able to validate their results with data. The length of stay was reduced from 19.23 in 2007 to 17.42 (YTD 2009) as a result of bi-weekly multidisciplinary rounds and incorporating Parents As Partners. The Central Line infections in the low birth weight class, (400-1500 grams), were reduced from 9.1 per 1000 device days in 2008 to 3.9 (YTD 2009), due to the adoption of daily antibiotic rounds and a BSI Bundle Book. Introduction of the Trans-thermal mattress reduced the number of infants with hypothermia on admission from 45.5% in 2007 to 24% (YTD 2009) and referrals increased in Early Intervention Initiatives, (PT, OT, EIP, and Feeding & Swallowing), from 24% in 2007 to 39% (YTD 2009), as a result of an algorithm to facilitate the consult and referral process during multidisciplinary rounds. Evidence-Based Plans of Care resulted from 56 literature reviews of which yielded new research for the development of 32 Evidence-Based Plans of Care for the NICU.

Implication for nursing practice: Based on the outcomes, the implication for nursing practice will be to continue nursing journal clubs and monitor staff participation, while triggering the cycle of inquiry promoting evidence-based practice at the bedside.

Future: Roll out for the entire nursing department is expected in the spring of 2010 and access online via the hospital's intranet. Continuing Education (CE) attainment for online journal club will also available by spring 2010.

AN EXPLORATORY STUDY OF EMOTIONAL INTELLIGENCE AND CLINICAL NURSES

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Purpose. The purpose of this study was to explore the relationships between the emotional intelligence of clinical nurses and situational antecedents including age, gender, years of education, years of total work experience, years of work experience as a nurse and nursing sub-specialty in a large, public health system in the Midwest.

Background. It is unresolved how emotional intelligence is manifested in clinical nursing and patient care. Past research has not provided due diligence examining the relationships between emotional intelligence and clinical nurses.

Design. This study used a quantitative, descriptive survey approach as the dominant design and a qualitative, interpretive approach as the less-dominant design.

Method. Analyses included backward regressions, ANOVAs and descriptive statistics. The Mayer, Salovey, and Caruso Emotional Intelligence Test was used to measure emotional intelligence. A questionnaire collected the situational variables. Five nurses with high emotional intelligence scores were interviewed.

Results. The sample included 142 clinical nurses. Nursing sub-specialties included medical/surgical, surgical services, women's health, critical care and intermediate care. No significant correlation was attributed to situational variables including nurses' age and years of education (all $p \geq 0.16$). Emotional intelligence was not correlated to nursing sub-specialties (all $p \geq 0.63$). Interviews provided little agreement on situational or dispositional antecedents to emotional intelligence.

Conclusions. No situational antecedents were related to emotional intelligence. There were no significant differences among the five nursing sub-specialties. Scores from the current study were compared with four studies that measured the emotional intelligence of other occupational groups. Findings suggested that nurses in the current study had higher emotional intelligence scores than the other occupations.

Summary Recommendations. Although this study did not yield statistically significant findings, there are several practical implications for nursing and human resource development professionals. These include the further exploration of the antecedents to EI in nurses; EI and its relationship with nursing performance; using EI for nurse selection; using the MSCEIT for nursing sub-specialty selection; and occupational comparisons of EI abilities using the MSCEIT.

NURSE ROUNDING IN AN EMERGENCY DEPARTMENT OBSERVATION UNIT:
IMPLEMENTING AN EVIDENCE-BASED INPATIENT PRACTICE INTO AN
OUTPATIENT SERVICE

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In the first quarter of fiscal year (FY) 2010, the Emergency Department (ED) at PVAMC will implement a dedicated 3-bed, 23 hour and 59 minute Observation (OBS) Unit. The goals of the OBS unit are to: 1) care for ED patients who need care for a diagnosed medical condition for more than six hours but less than 24 hours; 2) provide a positive patient experience; and 3) improve efficiency in the ED and inpatient wards. Observation ends when a determination can be made either to discharge a patient home or admit to inpatient status. The OBS Unit is located on the first floor of the facility about 50 feet from the ED. Patients admitted to the OBS Unit must be: 1) at low risk for a major event; 2) behaviorally stable; and 3) independent with activities of daily living (ADLs). Per facility policy, nurse staffing is 1:4; a nurse or certified nursing assistant (CNA) is not assigned to remain in the 3-bed OBS Unit 24 hours a day. During orientation, observation patients are informed that nurses will "check on them often" and that "police monitor the hallway at all times." Patients admitted for chest pain are monitored 24/7 from the ED Nurses' Station via wireless cardiac telemetry. A camera placed above the door to the OBS Unit provides unrestricted view of the OBS hallway without disturbing patients' in-room privacy. To ensure that patients' clinical and personal needs are met within the requisite 24 hours, the CNL developed operational and clinical flowcharts for each approved medical condition. The CNL introduced nurse rounding to ensure that OBS patients are assessed visually at regular intervals. ED RNs always stay close to their patients and do not need to round. The benefits of hourly nurse rounding for inpatients are well-documented. A few researchers extended rounding to outpatient observation patients; none found described rounding when a nurse is not present at all times. In addition, low risk, stable patients do not welcome being awakened often. Observation protocols usually specify nursing care at 4-hour intervals. Hourly rounding was deemed unnecessary. After several "what if" discussions, RNs agreed to coincide routine rounding with patient care at 4 hour intervals. Additional rounding is performed to re-assess pain and to ensure patients' needs are met. Documentation is kept simple and follows a "2S" approach:

- Status = Patient's vital signs, notes about the patient's progress, and any other care required by the protocol.
- Safety = Ensure the patient is safe and feels safe while in the OBS Unit.

Rounding on patients represents a behavioral and cultural change for ED RNs. Challenges include careful selection of potential OBS patients, and using clinical judgment to terminate observation before expected to maintain the safety and care of both ED and OBS patients. On the positive side, regular rounding has improved RN morale by showing that low risk patients can be cared for in a different location; and patients report feeling satisfied with this "unexpected" level of care. The rounding practice is sustainable as RNs want to do the best for their patients.

PROJECT ASSERT: A MODEL FOR PROFESSIONAL COLLABORATION

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Project ASSERT, a support service to facilitate patient access to primary care, clinical preventive services, and, when needed, to the drug and alcohol treatment network, is based in the Emergency Department (ED) at Boston Medical Center (BMC), the largest safety net hospital in MA and one of the busiest EDs in New England. Originally funded as a federal grant project fifteen years ago, Project ASSERT has become an invaluable service to the safety net hospital's ED and a budgeted department of the hospital.

Staffed by six Health Promotion Advocates (HPA) licensed by the state as drug and alcohol counselors and managed by an RN, Project ASSERT has serviced approximately 60,000 adult and pediatric ED patients to date. Partnered with the BNI-ART (Brief Negotiating Interview-Active Referral to Treatment) Institute at the Boston University School of Public Health, Project ASSERT has trained over 2,000 health providers nationwide in the brief negotiating interview (BNI) model.

In close collaboration with ED nursing and physician staff the HPAs of Project ASSERT screen, intervene, and facilitate patients, ensuring appropriate patient centered discharge planning. The Health Promotion Advocates document their assessments in the patient's ED electronic medical record in collaboration with nursing and physician staff. On a monthly basis outcome data is gathered and reviewed by Project ASSERT's staff to identify trends and possible reasons for the trends. A monthly case study is often reviewed.

The current initiative is the partnering with the Boston Public Health Commission in a harm reduction model of education and distribution of nasal naran to opiate users and their significant others. Currently one Health Promotion Advocate has been trained and after instruction and return demonstration distributes a kit. Future plan is to have the entire staff of HPAs trained in this intervention.

Nursing's role has been instrumental in managing the care team. As the Clinical Nurse Leader role evolves in this setting, the teamwork and collaboration needed to sustain the program will support further initiatives furthering the education of HPAs, collection of ongoing data, continued evaluation of the program and will assist in the delivery of the model.

FROM START TO FINISH: THE CNL JOB DESCRIPTION ROUNDTABLE

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Background: During the Clinical Nurse Leader clinical experience at Hunterdon Medical Center, the need was present to create a job description, as there were upcoming graduates without an existing role in the hospital setting. After review of the CNL White Paper, the CNL students collaborated with the Chief Nursing Officer in order to facilitate the development of a job description and role responsibilities. After further drafts and revisions, a formal job description was developed for the current and future CNLs at Hunterdon.

Outcome Data: The original CNL job description was developed in July 2007 and is currently used at HMC for yearly job performance evaluations.

Methods: The CNL students and CNO performed a review of the CNL White Paper and End-of-Program competencies. Responsibilities were adapted to need of the healthcare system to prevent duty overlap with other disciplines. A final job description was published.

Summary: The HMC CNL job description has been shared with CNL students from other healthcare and educational institutions to aide in their process of creating a formal job description. In addition, there has been frequent discussion on the CNL List-serve regarding this topic and questions relating to implementation of a job description at other facilities. This roundtable discussion is meant to provide an example of a job description to current CNLs, students, and hospital administrators in order to assist in the development of their own individualized CNL Job Description.

MODEL C GRADUATES: CLINICAL EXPERT- NO, CLINICAL NURSE LEADER- YES!

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One of the major challenges and causes of resistance to the Clinical Nurse Leader role for Model C students is the perception that as novice RNs, these graduates cannot be leaders. Students often voice the same concern, knowing that they will be clinical novices. As CNL educators, our task is to integrate leadership into the curriculum and socialize students to a leadership role. Are we successful? My observations of Model C graduates from our program have reinforced my conviction that as new graduates, they may not be clinical experts in their first jobs, but, they are demonstrating clinical leadership as delineated in the White Paper on the Education and Role of the Clinical Nurse leader (AACN, 2007) which states that the fundamental aspects of the role include:

- Leadership in the care of the sick in and across all environments;
- Design and provision of health promotion and risk reduction services for diverse populations;
- Provision of evidence-based practice;
- Population-appropriate health care to individuals, clinical groups/units, and communities;
- Clinical decision-making;
- Design and implementation of plans of care;
- Risk anticipation;
- Participation in identification and collection of care outcomes (p.10)

Recently, I was able to observe eight CNLs, Model C graduates, in their role as Staff Nurses in a public acute care facility. Most Model C students in our state are finding employment as Staff Nurses. Five of these students were graduates from the Fall, 2008 semester (8 months experience), two were from Summer semester, 2008 (12 months experience), and one had graduated in Fall, 2007(20 months experience). Each one was involved in special projects, nursing committees, and, as a group, they had formed a journal club to review evidenced based practice. Two were able to serve as preceptors for a new group of CNL students during their internship. As supervising faculty, I observed a definite difference in the progress of the students when they were teamed with a CNL graduate. The committees they serve on include the Medical- Surgical Council, a Leadership in Practice committee, and involvement in the Transforming Care at the Bedside (TCAB) collaborative team. Special projects included: developing a CNL job description for the facility, working on decreasing the incidence of urinary tract infections (UTIs), falls, and pressure sores.

Because of my observations, I was curious about our other graduates. I decided to survey the available Model C CNL graduates of our program currently working as nurses. I have created a questionnaire using Survey Monkey that will provide specific data on their job related activities both in patient care where they are gaining clinical experience, and their involvement in leadership activities. I will be able to quantify the number of new graduates who are nurse leaders.

This presentation will focus on the results of this survey and attempt to correlate the specific aspects of the leadership role with their work activities.

ELECTRONIC DOCUMENTS "THE SMARTWORKS WAY"

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CNL's have been challenged with providing quality care to patients while maintaining high levels of safety and fiscal responsibility. CNL's must be innovative and implement programs that ensure these standards. The top two national patient safety goals are accurate patient identification and effective communication among caregivers. The Joint Commission states "No adverse event should ever occur anywhere in the world if the knowledge exists to prevent it from happening." The use of electronic documentation helps increase accurate identification of patients and communication among caregivers by providing easily accessible information between points of entry into a health care system. The Agency for Healthcare Research and Quality is providing many grant initiatives to help with the implementation of electronic records. Many states are also initiating policies and giving tax incentives to promote electronic health record systems. Standard Registry has designed a software program called Smartworks Clinical Enterprise System that uses scanning equipment to scan patient photographs into electronic record and documents such as insurance cards. They have also formed a library of documents that can hold valuable patient education and patient care information such as consent forms, discharge teaching, and vaccination information. Health care providers can access this information from clinics, outpatient offices, and inpatient clinical areas. The system can also provide electronic capturing of patient and providers signatures. Clarity of forms, access from multiple care areas, and ease of printing to regular printers will help providers improve health care efficiency and safety. The CNL role is to review programs, present the potential safety and financial benefits to the institutions, and implement the program. Lastly the CNL would include the evaluation of the success of the program by improved outcomes such as improved workflow processes, decreased readmissions with clear discharge teaching, and organizing care delivery. This project is currently in the beginning phases. I have reviewed the program and prepared a presentation for the VIP committee at Tufts Medical Center. I have the support of the Nurse Informatics Director as well as the Smartworks Program representative from Standard Register. Money has also been earmarked to support this program in the 2010 hospital budget. After the presentation to the VIP committee I will meet with the clinical computer support staff to build the interface from the core operating system of the hospital to the new program. Then I will meet with several representatives from the nurse and physician groups to determine which forms to place in the library. Then the hospital staff will need to be educated about the program and how to use it. This is a perfect example of a project that a CNL can implement to improve patient quality and safety

CNL STEWARDSHIP OF ENVIRONMENT WITH PROPER DISPOSAL OF PHARMACEUTICALS

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Purpose/Objective: To determine if education is significant in changing a community's behavior, and to advocate for a community using Clinical Nurse Leader competencies.

Background: U.S. Geological Survey and various studies found 80% of waterways tested had measurable concentrations of prescription and nonprescription drugs including steroids and reproductive hormones.

Methods: Qualitative Analysis. To determine how individuals of this microsystem dispose of their expired or unused medications. A tool that surveyed the residents of this complex was developed and administered.

Overview of project: As a holistic nurse, I am concerned about how we as individuals contribute to the demise of our environment. In our immediate past, healthcare providers myself included have utilized the lavatory as a means of disposing of outdated or unused prescription drugs. Until recently this was the acceptable method of disposal. The long-term health effects of a contaminated water supply are unknown. We, as healthcare professionals must act prudently to minimize the contamination and subsequent impact to the environment.

Information systems and various other resources were utilized to conduct extensive research in determining how best to construct a survey that would yield useful information. The current research related to these environmental issues justified the need for this project. They were further substantiated by field interviews and the marine life that has been affected.

Conclusions: Based on the collection results of this project, it is apparent educating communities on proper medication disposal is a critical component of behavioral change. Further research is needed to support the claim education isn't enough to change behavior.

Abstract:

Medication is hazardous to the environment if not properly disposed of. More than 4,600 tons of pharmaceuticals enter the waste stream each year, a result of disposing them down the lavatory or sink, which were previously acceptable methods. Recent studies have shown that many of these substances are surviving water treatment facilities and make their way into our drinking water. Improper disposal into landfills also has the potential to contaminate the water we consume by allowing the chemicals to seep back into our soil.

The purpose of this project was to determine if education would significantly change the medication disposal practices in a community to safeguard the water. Current disposal methods of a select population were assessed and resulted in modification intervention. Agencies collaborating included the police department, the solid waste management district, the public broadcast station, faith-based communities, the North Township Trustee, the chamber of commerce and the local newspaper. This project demonstrates the role of a Clinical Nurse Leader as advocate, change agent and steward of the environment

THE IMPLEMENTATION OF A NEW NURSING ROLE: FACILITATING INNOVATIVE PRACTICES, IMPROVED OUTCOMES, AND COST SAVINGS WITH CLINICAL NURSE LEADERS

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The role of the Clinical Nurse Leader is to advocate for patients, families, and bedside clinicians in order to increase both quality of care and satisfaction while also decreasing costs. This presentation describes the successful operationalization of the role for eight Clinical Nurse Leaders in one institution over the past two years.

Today's health care system has become complex and mired in the science and technology of many specialized disciplines. Nationally, hospitals are faced with increased costs and reduced revenue which has forced cuts to meet financial needs. Care can be task-oriented, fragmented and lacking continuity. It may not adequately reflect the needs, values and concerns of the patient. By questioning fundamental assumptions, engaging in multi-disciplinary collaboration and problem solving with creativity, the CNL's have been given the opportunity to redefine their roles as nurses in a healthcare system that is in crisis. They have mastered many aspects of the role such as: systems analyst, risk anticipator, educator, and team manager. Quantifiable outcomes have been achieved through their initiatives with the adult tracheostomy population, ventilator acquired pneumonia, pressure ulcers, and vaccination rates among our patients. They have extended care to the community with follow-up phone calls post-discharge, visits with patients to their primary care physicians, and educational offerings at elder care facilities. As primary and co-investigators in hospital wide research, they have made innovative changes in practice which have improved patient outcomes. They have been able to realize significant cost savings while improving outcomes and also while following the most complicated patients. They have successfully changed the focus from discipline-centered to patient centered care. In doing so, they have modeled a role to which all nurses can aspire. Nurses in this role can affect changes that dramatically impact the future of nursing and of healthcare delivery.

USING A SCORING SYSTEM TO ACTIVATE THE URGENT RESPONSE SYSTEM

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Background:

Early recognition of patients with declining conditions is significant in patient safety and has the potential to save lives. Research has shown that patients experience deterioration in clinical symptoms four to eight hours prior to cardiopulmonary arrest. Improving recognition and response to a patient's declining status is a Joint Commission National Patient Safety Goal. The Institute for Healthcare Improvement also recommends an organized system when responding to patients at risk for respiratory and cardiac arrest.

To prevent a critical patient event from occurring, hospitals must have a process in place that will assist bedside clinicians in recognizing early warning signs of deterioration in patient condition. Rapid response teams and urgent response systems have been implemented in institutions across the United States. Common practice includes using various physiological trigger criteria to activate the system. Yet, there is limited information or recommendations on the severity or number of adverse parameters that should be present before requesting activation.

Quality Improvement Plan:

The objective of this project is to determine whether using a scoring system to implement various steps in the urgent response system improves patient outcomes and improves response time in recognizing a critical situation. This is currently a project in progress. The plan is to implement a quality improvement project that uses a scoring system to develop guidelines, with several tiers, for the bedside clinicians to activate when there is a decline in patient condition. This would provide a more systematic approach and support for the bedside provider during a potential stressful and life-threatening situation. Using an early warning scoring system has shown to improve patient outcomes and reduce the incidence of mortality.

Method:

Guidelines using a modified early warning scoring system will be developed and implemented on two medical-surgical units at a community hospital in Southern Massachusetts in adjunct to the current urgent response system. Prior to implementation, education will be disseminated by the Clinical Nurse Leader. An awareness campaign consisting of educational sessions, informational posters, and visual reminders will provide education to staff members. Patients will be assessed on admission, daily, and with any change of condition using the early modified early warning scoring system. Outcomes and recommendations will be available at the conclusion of this project.

THERAPEUTIC GROUP PROPOSAL: A CNL PRACTICE INNOVATION

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Background information:

To meet competencies clinical nurse leaders must be able to facilitate groups. There is a lack of CNL literature to provide strategies necessary for teaching group facilitation to enable CNL students to originate, propose, and implement a group idea. Psychiatric Nurse managers require nurse leaders who can facilitate groups for patients. Group implementation process has a broad application for patients in every setting.

Outcome data:

Antidotal reports including patient feedback and staff facilitators' evaluation indicated that after effective instructions, CNL students are able to effect positive group outcomes.

Description of practice:

After learning about group design and implementation, a cohort of eight masters level CNL students successfully led a group based on their own design. Groups were comprised of psychiatric patients who were hospitalized in a short-stay twenty bed adult psychiatric unit, within a general hospital. The group module included an introduction of the group concept, background, including grounding theorists, expected outcomes, techniques for implementation, and a patient evaluation tool.

Summary recommendations and impact:

CNL students must be able to identify the need for and successfully establish groups within a variety of patient settings. Effective group function is instrumental in identifying and changing group microsystems problems. CNL education preparation must include didactic and practical applications of group process.

AQUAPHERESIS THERAPY IN AN OUTPATIENT SETTING: A CASE STUDY
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Aquapheresis is a mechanical therapy used to remove excess water and sodium from fluid-overloaded patients who have failed diuretic therapy. Patients with renal insufficiency, right-sided heart failure, and those with greater than 20 pounds of excess fluid can benefit from this therapy. Signs of fluid overload include peripheral edema, ascites, and dyspnea. The goals of therapy are to remove the excess fluid on a regular basis in order to manage symptoms for the patient, to achieve euvolemia, and to improve their quality of life.

Prior to the pilot project in June 2009 at the University of Maryland Medical System (UMMS) in Baltimore, MD, aquapheresis therapy was done in an inpatient setting for both acute and non-acute patients. In an effort to maximize inpatient bed availability for acutely ill or higher acuity patients in the Cardiac Surgery ICU, the opportunity was identified to evaluate the development of an outpatient treatment program. This was projected to have the added benefit of improving patient care outcomes and patient satisfaction by providing a scheduled service to accommodate patient lifestyles.

A team of nurses explored the options for organizing an outpatient aquapheresis treatment center at UMMS starting in March 2009. The first patient began therapy in June 2009. Currently two patients are receiving weekly therapy with several more on a waiting list. The start-up committee explored facility needs, equipment, supplies, training, nursing support, documentation, registration process, and billing.

Our first patient, BR, entered the program at the beginning of June at 260 pounds, 40 pounds over his dry weight from a few months before. He is a 54 year old black male with Diabetes, hypothyroidism, ischemic/restrictive cardiomyopathy, a pacemaker, a junctional rhythm, and congestive heart failure. He is currently a status 1B on the heart transplant list. BR has been receiving therapy twice a week for four months now. He keeps central line access, (a subclavian double lumen) and is on a Dobutamine drip at home. He receives home health care once a week as well.

BR's therapy has been a success. He has lost over 43 pounds and has considerable improvement in his symptoms. He drives himself to the hospital twice a week for 8 hours of treatment in the Ambulatory Surgery Care Unit. We typically remove about 4 liters or 5 pounds of fluid per session. He initially had used a scooter for ambulation and now is able to walk short distances without dyspnea. His ascites has resolved and his lower extremity ulcers have healed. He is still waiting for a new heart but his satisfaction with our service and care is evident in that he is now enthusiastic about his future. He is able to perform his own ADLs now, has restarted his hobbies and has even taken short day trips out of his home with his family. His quality of life has improved while receiving life-saving therapy for his CHF on an outpatient basis, enabling him to remain in the comfort of his home while waiting for his new heart.

THE CNL'S ROLE IN EMPOWERING STAFF TO IMPROVE OUTCOMES

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Central Texas Veterans Health Care System (CTVHCS) is part of the VA Heart of Texas Health Network, which also includes VA North Texas Health Care System and South Texas Veterans Health Care System. CTVHCS contains one of the newest VA inpatient medical/surgical hospitals, one of the largest inpatient psychiatric facilities, and one of the few Blind Rehabilitation Centers in the country. CTVHCS is a major provider of health care for combat veterans from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). CTVHCS serves veterans in thirty-eight surrounding counties.

Within CTVHCS, a collection of microsystems share familiar broad goals of meeting the health care needs of veterans, delivering quality care, and ensuring best practice. Two of these microsystems are a 32-bed acute medical/surgical/telemetry unit and a 32-bed acute medical/surgical unit. Clinical Nurse Leader (CNL) positions have been implemented on each of these units. These roles have been instrumental in identifying the need to empower staff to improve outcomes. This presentation focuses on two initiatives that evolved from the microsystem assessment conducted as part of CNL role implementation on these units.

Microsystem assessment indicated critical opportunities for improvements related to the care of patients admitted with chest pain after administrative hours and to the care of patients post hemicolectomy. Risk for less than optimal patient outcomes was associated with timeliness and appropriateness of orders. Risk for less than optimal system outcomes was associated with patient admission to appropriate levels of care being impacted by physician satisfaction and confidence in nursing practice.

On both of these units, the CNL's recognized a need for intervention and through application of evidence based practice constructed clinical pathways that fit each individual microsystem. Clinical pathways are used as methods to reduce variation in care, improve resource utilization and guideline compliance, and advance quality of care. Pathways promote organized and efficient patient care based on evidence-based practice.

The clinical pathways clearly define the timing sequence of critical interventions for chest pain and hemicolectomy patients from the time they are admitted until discharge home or, if need be, transferred to a higher level of care. Interventions include activity level, diagnostic tests, diet, medications, frequency of vital signs, patient education, discharge planning, and consults. The pathways are multidisciplinary and should facilitate more effective collaboration and efficient communication between nurses and physicians to ensure that appropriate interventions are implemented for patients. Modifications can be made to the pathways based on individual patient needs.

Initial evaluation indicates improved communication and confidence among nursing staff, as well as improved relationships between nursing staff and physicians. Anticipated additional outcomes include decreased lengths of stay, decreased costs, increased patient satisfaction, greater standardization of care, as well as increased nursing autonomy and confidence.

CLOSTRIDIUM DIFFICILE: A CLINICAL NURSE LEADERS INITIATIVE TO IMPROVE FLOW, PATIENT OUTCOMES, AND THE ENVIRONMENT FOR THE PATIENT BEING RULED OUT FOR CLOSTRIDIUM DIFFICILE

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Background: In January 2008, an interdisciplinary team that focuses on patient flow within the hospital noted that with increased census there was also a high number of patients on precautions blocking beds. As a member of this team, one CNL took the initiative to assess one of these precaution groups and noted that 11-15 patients a day were being ruled out for Clostridium Difficile (C-Diff). Of this patient population, many had a delay in specimen collection of greater than five days. This delay prolonged the need for isolation precautions and in many cases inhibited patient flow. Notably, several patients were also not appropriately placed on or off contact precautions.

Method: The CNL assessed this patient population through random chart audits within the institution.

Programs and Practices: The CNL formed a team with representation from epidemiology, information services, and performance improvement to review the audit data which revealed delays and inconsistency in the rule out process. The team strategized ways to facilitate the ordering and discontinuation of contact precautions. Under the leadership of the CNL, the team developed a new order set and a decision tree for Clostridium Difficile associated diarrhea (CDAD) precautions. The goal of the order set was: to early identify the patients positive with C. Diff facilitating prompt treatment and better patient outcomes; to facilitate the appropriate rule out process of C. Diff (3 stool specimens); to decrease unnecessary time spent on contact precautions; to ensure that all patients being ruled out had contact precaution order entered to decrease risk of transmission to other patients. The goal of the Decision Tree was to provide: a communication and educational tool for staff and to decrease unnecessary testing. As a result of this practice change there is a decrease in variability in the process and a continued decrease in Clostridium Difficile rates.

Outcomes:

- Streamlined the C. Diff ordering process
- Improved SCM ordering screen
- Developed new order pathway
- Increased the compliance of the contact precaution order to 96-98%
- Electronic Decision Tree (for all healthcare workers)
- Decrease in Clostridium Difficile rates

Summary Recommendations and Impact: The CNL disseminated the order set changes and use of the decision tree via presentations, e-mails, handouts, and one-on-one education. Through continued data collection and analysis of the C. Diff patient, the CNL is able to target both individual healthcare providers and units for additional education or support in caring for the patient ruling out for Clostridium Difficile. The goal is to continue to decrease the financial burden for the patient and the facility by: eliminating unnecessary testing, decreasing precaution days, making better use of resources, and decreasing the number of blocked beds.

IMPLEMENTATION OF BEDSIDE HAND-OFF IN A LABOR&DELIVERY UNIT
UTILIZING A STANDARDIZED TOOL

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The Institute of Medicine report, *To Err is Human* documented wide scale patient safety and quality problems in the Nation's Healthcare System. Furthermore, the Joint Commission identified communication issues among team members as the single most important factor in root cause analyses. Communication among nursing professionals occurs throughout the day but most importantly during hand-off. . Hand-off has been defined as the transfer of responsibility and /or accountability for patient care from one provider or team of providers to another. Hand-offs of patients to other caregivers is increasingly recognized as a time when patient safety can be jeopardized. The Joint Commission now requires a standardized approach to hand-off communication including an opportunity to ask and respond to questions which can aid in promoting patient safety. The implementation of nurse to nurse hand-off at the bedside is one measure to improve the quality of the hand-off, while allowing for the opportunity to ask and respond to questions. This method of hand-off has been shown to engage and improve the patient's and family's experience of care and improve staff satisfaction as well.

Labor and delivery units are high-risk, high-cost, rapid response environments in which decisions, mistakes, and delays can have tragic consequences. This abstract describes a pilot project conducted in a tertiary-level academic center serving a diverse urban and suburban population. The center is the predominant referral center within a 100- mile radius for high risk perinatal care, delivering close to 10,000 neonates a year. Staff nurses on the unit were dissatisfied with the hand-off process currently utilized on the unit. The Clinical Nurse Leader student in conjunction with a group of nurse champions participated in a process improvement project to standardize the hand-off process utilizing the SBARR format. SBARR stands for the following elements, Situation-Background-Recommendation-Response and provides a framework for communication about a patient's condition between healthcare members.

Kotter's 8 stage process to create major change was the theoretical framework for this project. This presentation will discuss the change process, tool development, implementation process, usefulness and staff satisfaction. Goals of the project include changing the culture of the unit to promote patient safety, improved nurse communication and an increase in staff/patient satisfaction.

DEVELOPING A NEUTROPENIA PROTOCOL

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Neutropenia is an oncologic emergency and potentially life threatening side effect for patients undergoing chemotherapy. Many nurses and physicians who are not familiar with oncology patients tend to be uncomfortable with managing the care of the neutropenia patients. Delays in care have been shown to result in longer lengths of stays, increased costs, and poor patient outcomes. Clinical pathways and protocols plan a chronological plan of care that leads to desired outcomes. By definition, a clinical pathway integrates medical treatment protocols, nurse care plans, and the activities of associated health professionals into a single plan that clearly defines the expected progress of a patient through the hospital system within an agreed timeframe. Clinical pathways provide a means for variance analysis, dictate timely interventions, and increase patient satisfaction. This presentation describes efforts toward the development and implementation of a neutropenia protocol in one clinical oncology setting and highlights the clinical immersion experience and role of the CNL. Anticipated outcomes will be to improve patient outcomes and quality of care for the neutropenia patients, decrease length of stay therefore decreasing costs, and increasing patient and staff satisfaction. Staff collaboration, teamwork, and use of nursing autonomy and judgment will also be utilized and improved. Specific outcomes for after immersion include: all inpatient units and the emergency room will have guidelines to follow for the care and management of the neutropenia patient by following the clinical pathway; provide consistent, coordinated care; decrease length of stay; improve patient outcomes; employ nurses to use their skills; and decrease cost to the facility.

ENHANCING HEART FAILURE CORE MEASURE PERFORMANCE THROUGH
CONCURRENT REVIEW

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Background: Public reporting of core measure data was initiated in 2004. Concurrent chart review at OU Medical Center began the third quarter of 2008. At the onset of this project it was determined that discharge instructions were the area that needed the most improvement. Our greatest opportunity was the patient discharge medication list.

Outcome Data: Ongoing data collection. The second quarter 2009 we began to see a significant increase in discharge instructions completion. The discharge instruction measure increased 9.3% from third quarter 2008 when project began. OU Medical Center heart failure core measure performance in the second quarter of 2009 was in the top 10% of hospitals nationwide. The preliminary third quarter 2009 results are also in the top 10%.

Methods: Clinical Nurse Leader (CNL) was appointed to an assignment for quality improvement to assist healthcare providers with improving patient outcomes by using evidence-based interventions. Through concurrent analysis immediate interventions can be made to meet best practice standards before the patient leaves the hospital. When an opportunity for intervention is identified the Clinical Nurse Leader works with the appropriate care provider to adjust care to meet evidence-based standards.

Practices: CNL partnered with the quality department to develop a concurrent review process. Information systems at OU Medical center created a daily report that list all patients with a primary or secondary diagnosis of heart failure or a history of heart failure. CNL assesses patients on daily report for core measure compliance. CNL places a heart failure core measure checklist in the medical record that defines each measure. This serves as a guide for nursing and physicians. CNL is called by the nursing staff with all heart failure discharges before the patient leaves to ensure that all measures are addressed and that patient has received appropriate home care education.

Summary: Waiting until the patient is discharged before reviewing the chart may highlight missed opportunities. Prospective and concurrent patient management is a valuable method to provide every patient the appropriate care every time. In addition to the concurrent review process OU Medical Center initiated electronic medication reconciliation and discharge instructions in the summer of 2009 to assist care givers with discharge instructions. It has yet to be determined if this initiative will enhance congestive heart failure core measure results.

COLLABORATION: IMPLEMENTATION OF THE CLINICAL NURSE LEADER
ROLE ACROSS A HOSPITAL SYSTEM

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Background information: It was approximately ten years ago that the American Association of Colleges of Nursing (AACN) formed a taskforce consisting of educators and nursing leaders to identify and solve critical concerns on a national level with quality outcomes, safe, effective patient care, and the impending nursing shortage. The advanced generalist, master's prepared role called the Clinical Nurse Leader (CNL) was created to engage highly skilled nurses in outcomes based practice and quality improvement initiatives at the point of care. Nursing leaders at Orlando Health saw this new role as a means to have master's prepared nurses directing and leading the care of patients at the bedside.

Methods: In 2006, a joint partnership with the University of Central Florida (UCF) and Orlando Health, a seven hospital organization, serving the Central Florida area was started. The goal was to implement the CNL role in the organization and measure the impact that the CNL role would have on our patient populations. Even though many masters' prepared nurses and Advanced Practice Nurses (APN) were employed in various capacities throughout the hospital system, the CNL was not.

Programs: To get this role to the bedside, nursing leaders targeted specific high volume, high acuity patient units, and extremely competent experienced nurses who were willing to expand their academic preparation. Orlando Health offered an incentive program that provided flexibility to quickly complete rigorous course work in exchange for an agreement to work in this new role at any of our hospitals upon graduation. Orlando Health overcame the challenge of integrating the CNL role by working collaboratively with our academic partner, CNL scholars, APNs and nursing leaders at Orlando Health. This steering team developed processes to ensure the successful enculturation of the new role into our existing patient care delivery model.

Outcomes: With this targeted approach for the recruitment, immersion, and implementation of the CNL role, the number of CNLs at Orlando Health has grown from zero to nine from 2006 to 2009. As a result of this collaborative effort, by May of 2010, it is predicted that we will have a total of eleven master's prepared advanced generalists at the point of care. Orlando Health is the first hospital system in our tri-county area to utilize the CNL at the point of care.

Summary/recommendations: We are half way through a two year nursing research study with our nursing research scientist to determine the effect of the CNL on patient safety and quality of care in our patient populations, final results will be available in August 2010. Key trends include an increase in effective communication, physician and patient satisfaction, and compliance with core measure documentation. Decreased in length of stay, and improved pain management. We believe this model to recruit, immerse and implement the CNL role could be successfully implemented in any hospital system through similar academic partnerships.

IMPROVING PATIENT-CENTERED COMMUNICATION BETWEEN NURSING STAFF
AND CARE PARTNERS AT CHANGE OF SHIFT

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The purpose of this student clinical nurse leadership project was to improve the method of patient-specific information communicated from one caregiver to another. In the 31-bed Orthopedic Unit, patients did not receive requested care during shift change because the limited information in the Kardex provided to care partners was not sufficient for them to provide safe care. Staff nurses, administrators and care partners were surveyed by the CNL student to create a form that would provide better patient-specific information. Currently this form is completed by the charge nurse during rounds and includes the following categories: patient name, diagnosis, precautions, activity, and diet. This form, which was adopted by the unit, is now used to inform the arriving care partners during RN shift report and enables them to provide continuous safe care.

HOW A CLINICAL NURSE LEADER EMPOWERS STAFF RNS TO CONTROL
CATHETER ASSOCIATED URINARY TRACT INFECTION RATES VIA
IMPROVEMENTS IN CLINICAL MONITORS AND NURSING DOCUMENTATION

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Non-indicated and extended use of indwelling urinary catheters (IUC), a frequent cause of hospital-acquired infections, can be directly attributed to nursing care practices. Therefore, it is imperative that nurses are aware of the impact their care has on controlling catheter-associated urinary tract infection (CAUTI). A multi-faceted nursing educational intervention on an acute care medical unit was implemented by a Clinical Nurse Leader (CNL) as a quality improvement (QI) project. The outcomes of the educational intervention were measured in terms of: a) Number of in-dwelling catheter days, b) Nursing documentation practices, and c) Presence of physician orders for IUCs. The final goal of the unit level QI project is to decrease CAUTI rates. The outcomes of the educational intervention were measured through chart reviews performed during pre- and post-intervention phases.

Chart reviews to develop baseline measures were followed by the implementation of an intensive nursing education, including; nursing in-services, introduction of a decision making algorithm for indwelling catheters, display of an informational poster, emails to staff with reminders of key in-service topics, “just in time” teaching, a checklist designed for daily query, graphical outcome data updates, and finally, the development of a staff RN champion task force assigned to maintain the project’s momentum. This project used a Plan, Do, Study, Act (PDSA) QI method to gauge the progress of the educational intervention, and further gain nursing staff and management support. Progressive graphical chart review findings comparing pre- and post-intervention nursing performance were posted and celebrated on the unit throughout the QI project implementation.

Since the inception of this QI intervention, March 2009 till the present, there has been a 35% increase in nursing documentation compliance noting the indication for a patient’s IUC and a 27% increase in the number of IUCs with physician orders. Currently working in collaboration with infection control clinical nurse specialists, direct impact on UTI rates is under study with results available soon. Ultimately, this project aims to establish an evidence-based link between aggressive nurse monitoring of IUC days and CAUTI rates.

The CNL role proved necessary for the success of this project. Staff education, unit presence and support of clinical development established mutual trust and respect. Responsible, professional and ethical accountability of nursing practice via innovative CNL leadership has improved nursing practice and will likely improve patient outcomes. Methods used and results from this quality improvement project are applicable to other nurse-sensitive outcomes.

Abstract

A CNL Initiative: A MENTORING STRATEGY USING A CARE GROUP APPROACH

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Background Information

The transition from a new graduate nurse to a practicing nurse can be particularly stressful during the first year of employment. Innovative ways to meet the supportive needs of the new graduate nurses are through care group meetings. Care groups can be used as a cost effective mentoring strategy to support new graduate nurses during their first year of employment, leading to increased retention rates for the hospital facility and ultimately improved patient outcomes.

Description of Program

The WellStar Health System offers a formal orientation during the first 3 months of employment for a new graduate, which include care group meetings that provide a small group experience in a caring atmosphere for new graduates to openly discuss their transition into practice. Care groups provide a consistent, experienced mentor to support the new graduate's development. The purpose of this pilot program is to continue the care group sessions throughout the first year of employment. Recognizing the need for continuing support of new graduates, a team of CNL students will employ the competencies of advocate, educator, and team leader related to facilitating group and other health professionals learning and professional development.

Methods

At the pilot site, WellStar Cobb Hospital, care group meetings will be implemented as a form of mentoring after the new graduates' formal orientation has ended. With the success of the initiative at the pilot site it will be presented for all 5 Wellstar Hospitals. The care group meetings will be held quarterly throughout the first year of employment. Care group meetings will consist of peer group discussions between new graduate nurses and mentors. Predetermined topics of discussion such as death, bereavement, conflict resolution, leadership, etc. will be included in the discussion as well as topics and experiences selected by participants.

Future Data Collection:

Collection of data will be performed in 2 methods. First, a comparison of new graduate retention rates pre and post implementation of the care group program will be made in order to determine the effects care groups have on new graduate nurse retention past the one year mark. Secondly, data will be collected through surveys by participants at 6 month and 1 year intervals to gain feedback on the program and needs for improvement.

Summary

The care group will be designed to build onto an existing orientation process to provide support to new graduate nurses during their first year of employment. The desired outcome for the program is to increase retention rates of new graduate nurses past the 1 year mark, resulting in increased financial benefits for the hospital institution.

