



CNL Summit 2011

POSTER PRESENTATIONS

January 20, 2011

CNL Summit

Miami Marriott Biscayne Bay

Poster Presentation Session **Thursday, January 20, 2011**

THE CLINICAL LEADERSHIP PROGRAM: SUPPORTING CNL CAREER TRANSITIONS AT THE JAMES J. PETERS VA MEDICAL CENTER

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IMPLEMENTATION OF BEDSIDE SHIFT REPORT: A PATIENT SAFETY INITIATIVE

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THE CNL DIFFERENCE: A COLLABORATIVE EFFORT TO IMPROVE PATIENT SATISFACTION

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CNLS LEVERAGE RESOURCES: A COMMUNITY COLLABORATIVE FOR QUALITY OUTCOMES

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IMPROVING CARE DELIVERY THROUGH EFFECTIVE IMPLEMENTATION & EVALUATION OF THE CLINICAL NURSE LEADER ROLE

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END-OF-PROGRAM COMPETENCIES AND CLINICAL EXPERIENCES FOR THE CNL
AT JESSE BROWN VA MEDICAL CENTER

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AN INNOVATIVE STRATEGY IN PURSUIT OF THE CLINICAL NURSE LEADER ROLE

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THE BEDSIDE PEDIATRIC EARLY WARNING SYSTEM: A CLINICAL NURSE
LEADER'S JOURNEY TO BEST PRACTICE FOR EVALUATING PATIENT ACUITY

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INTEGRATING INTERPROFESSIONAL EXPERIENCES INTO A CNL CURRICULUM

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CONTINUOUS RENAL REPLACEMENT THERAPY FOR ACUTE RENAL FAILURE IN
THE CRITICALLY ILL

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THE MINNEAPOLIS CNL EXPERIENCE

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DECREASING NAUSEA IN BARIATRIC POST-SURGICAL PATIENTS: A CLINICAL NURSE LEADER AND COMMUNITY HOSPITAL INTERDISCIPLINARY TEAM

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DEDICATED EDUCATION UNIT PATIENT OUTCOMES AND EXPERIENCES

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CLINICAL NURSE LEADER AS COORDINATOR OF MULTIDISCIPLINARY ROUNDS

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PREVENTION OF CATHETER ASSOCIATED URINARY TRACT INFECTIONS

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A DAY IN THE LIFE OF A CNL-PATIENT CARE INTEGRATOR

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QUALITY PAIN MANAGEMENT

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THE ROLE OF THE CLINICAL NURSE LEADER IN THE REDUCTION OF NOSOCOMIAL INFECTIONS

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TEACHING INTERDISCIPLINARY TEAM SKILLS TO CNL STUDENTS USING AN INTERACTIVE SYMPOSIUM

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COLLEGIAL COLLABORATION TO ENHANCE THE IMPACT OF THE CLINICAL NURSE LEADER

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IMPLEMENTING THE CNL ROLE IN DIVERSE CLINICAL SETTINGS

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CLINICAL NURSE LEADER IMPACT ON DOCUMENTATION OF PRN PAIN MEDICATION EFFECTIVENESS

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A CNL Initiative: IMPROVING STROKE CARE USING AN INTERDISCIPLINARY MODEL OF CARE DELIVERY

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Clinical Nurse Leader and Infection Prevention Collaboration Leading to Decreased Hospital Acquired Vancomycin Resistant Enterococcus (HA VRE) on a Medical-Specialty Unit

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EVALUATION THE ENTRY LEVEL CNL IN PRACTICE

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PATEINT EDUCATION TO PREVENT FALLS IN A PROGRESSIVE CARDIOLOGY UNIT

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IMPROVING URINARY CATHETER DISCHARGE EDUCATION

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INCREASING NURSE CONFIDENCE THROUGH NEROLOGIC ASSESSMENT EDUCATION

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EVIDENCE-BASED NURSE GROUP SHIFT REPORT

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EVIDENCE BASED PRACTICE CHANGE TO DECREASE SURGICAL SITE INFECTION

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CHALLENGES OF IMPLEMENTING THE CNL ROLE IN AN ACADEMIC MEDICAL CENTER

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IMPLEMENTATION OF THE CLINICAL NURSE LEADER ROLE COMBINED WITH
CLINICAL NURSE SPECIALIST COLLABORATION: AN INNOVATION DESIGNED TO
FACILITATE NURSING PRACTICE AND HEIGHTEN PATIENT CARE

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THE POWER OF PRECEPTING AND THE MAGIC OF MENTORING: THE
SECRET ROOTS OF PRECEPTING AND MENTORING

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DEVELOPMENT OF THE CNL: TRANSITION OF MODEL C TO PROFESSIONAL
PRACTICE

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IMPLEMENTING SKIN CARE ROUNDS IN CRITICAL CARE

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STEPS TO DEVELOPING A WORK SITE CNL PROGRAM

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IMPLEMENTING STANDARDIZED NURSING EDUCATION AND DOCUMENTATION
FOR PATIENT SWALLOW SCREENS

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A MULTIDIMENSIONAL APPROACH TO CURRICULAR MAPPING: CLINICAL NURSE
LEADER EDUCATION MODEL C PROGRAM

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ONE ROLE, MANY EXPECTATIONS: SUCCESSFUL CNL STUDENT EXPERIENCES IN
DIVERSE SETTINGS

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VALIDATION OF ROLE UTILITY FOR THE NEW CNL MODEL

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EVIDENCE PRACTICE CHANGE PROJECT: UTILIZING VOLUNTEERS IN A CLINICAL
MICROSYSTEM

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CONNECTING THE DOTS- CARE COORDINATION OF THE MENTAL HEALTH
PATIENT WITH A COMMUNITY PARTNER

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**VIDEOCONFERENCING ACADEMIC CNL PROGRAM AND SOLUTIONS FOR
MARKETING**

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DOUBLE CHECK: MEDICATION SAFETY IN THE PEDIATRIC INTENSIVE CARE UNIT

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**IMPLEMENTATION OF A FAST TRACK BOWEL PROGRAM AND THE IMPACT ON
LENGTH OF STAY**

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**IMPLEMENTING EVIDENCE BASED PRACTICE: USING A FALLS TYPOLOGY TO
PRESCRIBE NURSING INTERVENTIONS THAT PREVENT FALLS**

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IMPROVING PRN EFFECTIVENESS DOCUMENTATION

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EVALUATION OF THE USE OF HEALTH 2.0 TOOLS: IMPLICATIONS FOR CNL ROLE DEVELOPMENT

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REDUCING THE PERCENTAGE OF HEART FAILURE PATIENTS READMITTED TO THE HOSPITAL WITHIN 30 DAYS OF DISCHARGE: A SYSTEM REDESIGN PROJECT

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CLINICAL NURSE LEADER STUDENT PROJECTS: STEP-BY-STEP SUCCESS

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THE CLINICAL LEADERSHIP PROGRAM: SUPPORTING CNL CAREER TRANSITIONS
AT THE JAMES J. PETERS VA MEDICAL CENTER

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Background: In the summer of 2009 the Hunter-Bellevue School of Nursing (HBSON) and the James J. Peter's VA Medical Center (JJP VAMC) entered into an academic-service partnership to guide CNL role implementation efforts. Currently 12 RNs from the James J. Peters VAMC are enrolled in the HBSON's 42 credit post-baccalaureate master's degree CNL program. A unique feature of the HBSON-JJPVA CNL partnership is a facility-specific Clinical Leadership program that complements participants' experience in the masters' in nursing program at the HBSON. The goal of the JJPVA Clinical Leadership program is to promote the development of participant's role identity and career transition from that of a staff nurse to that of a CNL.

Program and Practices: The Associate Program Manager (APM) for the Center for Learning and Organizational Development designed and leads the Clinical Leadership program. Participants attend a monthly learning series to gain a broader perspective on the organizations' quality and performance improvement initiatives. The facility-specific learning modules include systems redesign, performance improvement, performance measures, NPSB standards and evidence based practice. In addition to building knowledge and skills to perform effectively in the CNL role at the JJPVA, the Associate Program Manager serves as a mentor to the program participants to identify and overcome challenges to successfully complete the graduate curriculum. For example, to address the competing demands and constraints on participants' time, a copy of the HBSON-CNL program course syllabi and required text books are on reserve at the JJPVA library enabling participants to work on assignments during breaks and before or after their work tours.

Outcomes: Program evaluation efforts are currently underway for both the HBSON CNL program and the JJPVAMC Clinical Leadership Program. The Clinical Leadership program modules have received high participant satisfaction ratings. We will have the opportunity to evaluate the extent to which the JJPVAMC clinical leadership program has influenced participant's perceived self efficacy in performing the CNL role competencies with CNL students not attending the program.

Recommendations: The Clinical Leadership program at the JJP VAMC serves as a realistic job preview for participants to deepen their understanding of the personal qualities and skills necessary to perform effectively in the CNL role. An additional benefit of this program for participants is the networking opportunities to build relationships with key program managers and leaders with whom many participants do not have direct access to in their current staff nurse role.

The CNL program at the Hunter-Bellevue School of Nursing is supported in part by funds from the Health Services Resource Administration: "Clinical Nurse Leader in Safety Net Settings" (DO9HP14819, Kathleen Nokes, P-I).

IMPLEMENTATION OF BEDSIDE SHIFT REPORT:
A PATIENT SAFETY INITIATIVE
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Shift report is a system of nurse-to-nurse communication between shift changes intended to transfer essential information for safe, holistic care of patients. Change of shift signifies a time of careful communication in order to promote patient safety and best practice. There is a risk that critical information may not be relayed during shift report, and often the person at the center of the communication, the patient, is not involved. The purpose of this project is to implement a patient safety strategy by initiating bedside nursing shift report using an evidence-based model. The Clinical Nurse Leader (CNL) provided the plan for change and implementation plan for the microsystem. In addition the CNL provided leadership and support during the change process.

Data collected during the comprehensive unit-based safety program (CUSP) project supports the need for better communication during shift change on the unit. The data confirms that there is an increase in admissions and nursing activities during shift change on the heart management unit. To increase patient safety healthcare organizations have transitioned from giving shift report at the nurse's stations to giving shift report at the patient's bedside.

Bedside shift report was put into practice using an evidence-based model, on the heart management unit and this project was lead by the Clinical Nurse Leader. This safety initiative has been implemented for 6 months. This project is being evaluated using surveys for both nurses and patients. The CNL distributed pre and post implementation surveys for nursing. A survey was also given to patients upon discharge and patient satisfactions scores are being used to evaluate the effectiveness of project. Nursing perception improved in 4 out of 5 areas. Patient's perceptions were overall positive. There was a change in nursing overtime from an average of 9.8 minutes pre-implementation to 5.2 post-implementation of bedside shift report.

The evidence-based project offers a model that can be replicated by healthcare institutions. Guidelines for this safety initiative have been identified and can be implemented at the microsystem level. The current guidelines are based upon successful bedside shift report projects already in existence. The role of the staff nurse, clinical manager, and clinical nurse leader are clearly defined. The current project gives health care organizations a plan for development and implementation of an evidence-based safety initiative.

THE CNL DIFFERENCE:
A COLLABORATIVE EFFORT TO IMPROVE PATIENT SATISFACTION
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Background information: It was brought to the attention of the Clinical Nurse Leaders (CNL) in February 2010 that patient satisfaction scores were below the organizations goal for a five month period. The CNL's took ownership of this issue and researched the National Research Corporation (NRC) Picker and Hospital Consumer Assessment of HealthCare Providers and Systems (HCAHPS) surveys for quality improvement behaviors identified as improving the patient's perspective on hospital care and improving the patient's experience. Starting in March 2010, the CNL's launched a campaign titled the CNL Difference to positively impact patient satisfaction scores for the unit.

Outcome Data: In a six month time frame patient satisfaction data was retrieved from the NRC Picker. After one month of implementing the CNL Difference, patient satisfaction scores improved by 20% from 64.0 in February 2010 to 80.0 in March 2010. These scores continue to improve from baseline scores that fell below benchmark for five months prior to initiating the CNL Difference; with the highest score being 88.46 in June 2010.

Methods: Discussions occurred amongst senior leadership and the CNL's regarding customer service issues and how the CNL's could impact the outcomes at the point of care. Unit summits took place and gave the CNL's the opportunity to address the problem with the staff, and introduce new initiatives to implement on the unit. Customer service initiatives focusing on positive outcomes were initiated on 6A Cardiac Progressive Care Unit (PCU). The three key components of communication, compassion, and caring were the primary focus and priority for our unit in order to achieve positive results. A review of literature was conducted to observe what impact CNL's were having with patient satisfaction. Personalized discharge cards, signs in patient's rooms, purposeful hourly rounding, snack rounds, bereavement cards, customer care cards, beside report/nurse introductions, etc...were just a few of initiatives implanted on 6A Cardiac PCU.

Summary recommendations and impact: Patient satisfaction scores did increase and improved morale on the unit. As a result of the CNL Difference campaign, our patient satisfaction scores have reached and surpassed the organizations benchmark score of 73.3 since May 2010. Our continued efforts of placing the patient and family first contribute to excellent customer service. The NRC Picker survey focuses on eight dimensions of patient-centered care. Research has shown that certain interventions are significant for patients to have a positive patient experience while in the hospital. Using this research and collaborating with the multidisciplinary team, we have a better understanding of what matters most to our patients in order to have them "definitely recommend" our facility as their hospital of choice.

CNLS LEVERAGE RESOURCES: A COMMUNITY COLLABORATIVE FOR QUALITY OUTCOMES

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Background: CNLs in practice and academia have a distinct opportunity to advance quality improvement in all health care settings. This action research project is a unique collaboration between a community program in an urban setting, delivering health promotion services to vulnerable populations with limited financial resources and access to health care, and its University partner. The two -year, two- phase project involves certified CNL faculty and graduate program CNL students working with the community organization members. In phase one, fall and spring 2009/2010, a Clinical Microsystems Analysis and Generative Star strategies produced the need for evidence-based outcomes of the non-profit breast cancer support program for African American women and their loved ones in the community of North West Philadelphia. The program assessments determined a need to implement outcomes research aimed at examining quality, satisfaction, efficiency and effectiveness of the Organization's support programs. Phase two, in fall and spring of 2010/2011, is on-target with data collection from the resultant outcomes study.

Purpose: The purpose of this study is to examine the effects of a community support program on quality of life for African American breast cancer survivors. An additional aim of the study is ongoing program assessment and documentation of outcome measures necessary to secure funding of cancer services for the underserved community of the program's locale.

Methods: A mixed-methods data collection of quantitative survey data and qualitative data from focus groups is ongoing through early December 2010. The Quality of Life Instrument-breast cancer survivor version (Ferrell, Dow, & Grant, 1995) is being used to identify the four domains of quality of life including physical well being, psychological well being, social well being and spiritual well being. Query paths for the focus groups include questions aimed at understanding the effectiveness of the Organization's community programs.

Results: A Generative Star Mapping explained details of the supportive, collaborative relationship between the CNL, CNL students and the Organization's staff. Results from Phase 1 of the program assessment using the 5 Ps-Purpose, Patients, Professionals, Processes, and Patterns, identified the strengths, weaknesses, opportunities for, and threats to (SWOT) the Organization. Phase 2 analysis of the study's outcome data will be available late December 2010 at the completion of the data collection.

Discussion: Clinical Nurse Leader practice encompasses a broad continuum of care. This project represents the impact that a unique collaboration of practice partners can accomplish. CNL students, guided by CNL certified faculty, volunteer their expertise to improve the health of vulnerable populations and provide for expansion of quality community services. The return on investment is mutual.

IMPROVING CARE DELIVERY THROUGH EFFECTIVE IMPLEMENTATION & EVALUATION OF THE CLINICAL NURSE LEADER ROLE

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Background: Hospitals across the country have been developing and implementing various models to incorporate the role of the Clinical Nurse Leader (CNL) into the delivery of nursing care. At the same time, healthcare organizations must contend with demands for improvements in quality of care and safety in the face of declining reimbursement. This creates an ideal environment for nurse leaders to demonstrate the effectiveness of the CNL as a vital member of the new healthcare system.

Methods: This study was conducted on a 39-bed medical unit in a 927 bed magnet designated, academic medical center. To guide the selection on appropriate metrics to measure effectiveness, the project team met with hospital experts from infection control and quality and safety to review potential elements to track and determine baseline data. The team made a decision to focus on interventions that would impact both clinical quality and patient satisfaction. One of the unique aspects that was measured centered on infection prevention using a tool called MedMined. MedMined provides for the real time data mining of nosocomial infections which is a vast improvement over traditional infection surveillance which focuses on individual case identification. Additional metrics that were measured included patient satisfaction, fall rates, pneumovax vaccination rates for pneumonia patients, and discharge instructions for congestive heart failure patients.

Evaluation: Early results of the pilot have been promising and include a reduction in infection rates, earlier removal of urinary catheters, and improved hand hygiene with all care providers. However, it has been the unexpected results that have proven to be the most exciting. The CNLs on the pilot unit have: a) assessed and revised processes that interfered with the delivery of patient care, b) improved the transfer of deteriorating patients to the ICU, c) assumed the role of patient and staff advocate, and d) enhanced communication among all caregivers.

Impact: Data collection is still in process and will be completed prior to the presentation. Information gathered from this project will be valuable to the organization as they conduct a cost benefit analysis of the CNL role. In an environment of declining reimbursement, such an analysis can assist in determining if the CNL role needs further refinement and/or if it should be implemented on additional nursing units.

END-OF-PROGRAM COMPETENCIES AND CLINICAL EXPERIENCES FOR THE CNL AT JESSE BROWN VA MEDICAL CENTER

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Background Information: Jesse Brown VAMC has academic partnership with two universities which have CNL programs. The CNL curriculum framework is comprehensive in the inclusion of Nursing leadership, clinical outcomes management, and care environment management. The broad framework requires planning and forethought to accomplish the goals within the timeframe of the CNL residency. In anticipation of precepting CNL students from differing curriculum structures, and in order to provide a consistent, quality clinical experience for the CNL students, the three CNLs at JBVAMC developed a document based on AACN's End-of-Program Competencies and Clinical Experiences for the CNL Student. This document, with the addition of other facility specific resources have been compiled into a binder will serve as a guideline to customize a thorough and complete residency experience at JBVAMC.

Outcome Data: This project has recently been implemented with the first CNL student. It has been shared with our academic partners for feedback and revised according to their recommendations. There will be ongoing modification and improvement to the book based on identified needs as it is implemented. We plan to do a needs-assessment of past CNL students from both programs using a questionnaire format to assess how well the students felt their curriculum needs were met during their residency and to identify areas for improvement. This data will be incorporated into our project.

Description of methods, programs or practices: The document is based on the AACN's End-of-Program Competencies and Clinical Experiences for the CNL Student (2005). We identified potential clinical experiences that might achieve the specific required competencies. We obtained input from our two academic partners and compiled the document along with facility specific resources into a binder for each CNL. The facility specific resources include items such as the CNL Whitepaper, facility names and phone numbers, management hierarchy diagram, examples of a fishbone diagram, the facility Vision and Mission statements, maps, and the CNL Bibliography.

Summary Recommendations and Impact: The benefit of this project is that it provides a structured plan in preparation for the CNL student's residency. The students will benefit from additional guidance towards meeting required competencies and will assist the preceptors in their efforts and responsibilities to precept multiple students over time. Faculty feedback verified our initiative would be a valuable tool to enhance the student's immersion experiences. The ultimate impact will not be realized until it has been implemented with several students, however, we have the benefit now of being prepared for future students. A specific example of the benefit of preplanning is the barrier we encountered at our facility to CNL students participating in or observing a Root Cause Analysis. Because this was identified as part of the project planning we were able to locate other resources to use to meet that requirement. We anticipate this resource to be improved upon on an ongoing basis.

AN INNOVATIVE STRATEGY IN PURSUIT OF THE CLINICAL NURSE LEADER ROLE
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Background Information: The Clinical Nurse Leader (CNL) role is responsible for providing clinical leadership in a healthcare setting, responding to patient and family needs, and improving the foundation for patient-centered, evidence-based care. Our facility faced challenges in meeting the implementation goals of the CNL role. By using an evidence-based business planning process, nursing leadership accomplished the goal of obtaining senior leadership support and funding for the CNL role in our organization. However, finding a qualified applicant continued to be a struggle in the absence of a local CNL educational program. A subcommittee of the Nursing Leadership Council proposed hiring a Clinical Care Facilitator (CCF) as a precursor role for the CNL. CAVHS collaborated with the University of Central Arkansas (UCA) College of Nursing about the need for a CNL educational program. This innovative solution to a common problem has produced excellent results in nurse and patient satisfaction while enhancing the provision of patient-centered care.

Outcome Data: The National Database of Nursing Quality Indicators measures the nurse job satisfaction at our facility using a T-score. On the CCF unit, the T-score improved by 0.13 during the second quarter of FY10, while other units' T-scores decreased. Overall inpatient quality, measured by the Survey of Healthcare Experiences of Patients (SHEP) and completed by Veterans, increased from 57.9 to 77.4 during the first month the CCF was on the unit. Implementation of the CCF role at CAVHS influenced several processes throughout our facility. First, the CCF sets the standard for the quality of care provided on a unit. Through her educator role, the CCF developed teaching posters known as "MOUSE" (Managing Outcomes Using Scientific Evidence) that stimulate critical thinking on the part of nursing staff with direct application to the care provided to Veterans. The posters incorporate journal club articles, discussion on new technology, and evidence to support treatments. As a result of our collaboration with UCA, a CNL educational program was developed and implemented in the Fall 2010 semester. While preparing the business case for the CNL role, nursing leadership published *An Evidence-Based Business Planning Process* in JONA 39:511-513 December 2009.

Description of Methods, Programs or Practices: A subcommittee chose to modify the requirements for implementation of the role and create a new title in order to fulfill our goal of moving toward implementation of the CNL role. The title chosen to describe this innovative role was "Clinical Care Facilitator," intended to reflect the principle role of the CNL. The position was re-announced, accepting applicants who were actively participating in a CNL Program. The applicant selected had only one semester remaining in her CNL educational program. During this semester, one requirement was to complete a capstone project that integrated all the concepts developed during her educational process. Having the CCF position gave her access to a population in need of such a project and facilitated her success as both a professional and as a student. The selectee assumed the role in December 2009. The CCF was accepted as a benefit to the RNs, and the medical staff rely on her as a respected colleague.

Summary Recommendations and Impact: Developing the CCF role as a precursor to the CNL role was an integral part of being able to meet the challenge of implementing an evidence-based action to improve care to our Veterans. Because of the success of the CCF role, CAVHS plans to continue this approach for a smooth transition of staff into the CNL role.

THE BEDSIDE PEDIATRIC EARLY WARNING SYSTEM: A CLINICAL NURSE LEADER'S JOURNEY TO BEST PRACTICE FOR EVALUATING PATIENT ACUITY

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The Barbara Bush Children's Hospital at Maine Medical Center is a 49 bed inpatient pediatric unit located in Portland, Maine. In an internal review of emergent pediatric intensive care unit transfers from the Barbara Bush Children's Hospital over an 18 month period, the data revealed that 33 of these transfers could have been potentially identified earlier in their course of treatment. In an effort to address this issue and further improve patient care and safety, the clinical nurse leader was the catalyst, researcher, educator, and project lead in implementing the Bedside Pediatric Early Warning System (BPEWS).

The BPEWS was developed, implemented, and validated at the Toronto Hospital for Sick Children and nearby community hospitals. Versions of this scoring system have been adopted at institutions such as the University of Cincinnati Children's Hospital and at the University of Florida at Jacksonville. The Barbara Bush Children's Hospital has developed the first electronic version of the BPEWS. The purposes of this scoring system include a) determination of appropriate monitoring and nursing care for patients, b) assistance in the decision to call a rapid response team consult and c) potential reduction of "codes" on the inpatient unit.

The BPEWS is based on seven clinical measures monitored during routine patient care. The score has been used in children from 38 weeks gestational age to 18 years and has included children with cyanotic congenital heart disease. Based on the score obtained, there is a specific recommendation to aid clinicians, nurses and staff as to a) maintaining current care, b) increasing the degree of monitoring, c) requesting rapid response team evaluation or d) initiating transfer to the pediatric intensive care unit.

As part of the implementation of the BPEWS, the Barbara Bush Children's Hospital is part of a multicenter research endeavor to further validate the scoring system and to determine if use of the scoring system contributes to reduced patient mortality.

Outcome data is currently being collected and interpreted. Through observation and daily audits the Bedside Pediatric Early Warning System is changing and improving care for pediatric patients in our hospital. Patient transfer times to the intensive care unit have decreased and a common language surrounding acuity has been developed.

Best practices offer increased patient safety and improvement of patient care. It is the responsibility of the clinical nurse leader to research and seek out these practices. The BPEWS is an innovative decision support system which has demonstrated best practice in pediatric nursing.

INTEGRATING INTERPROFESSIONAL EXPERIENCES INTO A CNL CURRICULUM

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Healthcare providers need to work well together to provide quality care. Strong work relationships and mutual respect are also related to job satisfaction and lower turnover. As healthcare providers learn their clinical skills, they often are doing so only with others in their same discipline. Then, when they enter practice, they are expected to work with interdisciplinary teams, often with little knowledge of what their teammates potential contributions could be. Team manager is a competency expected of Clinical Nurse Leaders (CNL) and opportunity to practice team skills while students foster the development of this competency.

Since 2007, CNL students have been integrated into learning activities with students from other health science programs. The types of learning activities include simulations, systems thinking exercises, skills practice sessions and team-delivered services. Simulations may be done with mannequins or with live people acting a part. Nursing and medical students manage the care of the patient and participate jointly in debriefing. After the event, students write a reflection. In addition to psychomotor skills, clinical reasoning and priority setting, students across disciplines are asked to use and evaluate communication skills from the TeamSTEPPS® tools. Students in pharmacy, social work, physical therapy, physician assistant and hospital/health administration join the nursing and medical students in simulating living in poverty. The intent is to help students understand the challenges of clients with very limited resources and to familiarize them with resources they could offer. Specific skill sessions are built to capitalize on specific expertise for shared clinical issues. For example, physical therapy students lead a session on safe patient handling and ergonomic tips to prevent caregiver injury while pharmacy students lead an exercise focused on medication reconciliation. CNL students lead a flu clinic and teach medical students injection technique.

CNL students and students in other healthcare fields consistently rate the interprofessional learning experiences very favorably. Prior to interprofessional educational events, students are often anxious and unsure how they will be viewed by others. In addition to the designed activity, a great deal of serendipitous bonding occurs. Prior to interprofessional educational events, students are often anxious and unsure how they will be viewed by others. Once the students get into situations together, they realize they are all nervous and all there to learn. Students learn they have common foundational courses, shared interests, skills in common and unique contributions that are of great value to each other. CNL students state they are more confident in communicating with physicians and other professionals. In practice, students who have participated in interprofessional education are observed consulting one another and demonstrating TeamSTEPPS® skills.

Interprofessional education helps CNL lead and participate in teams. The breadth of activities has increased each year. Faculty lead some activities and a growing number are led by students. While scheduling logistics can be a challenge, the benefits of better patient outcomes and higher job satisfaction make it well worth the effort.

CONTINUOUS RENAL REPLACEMENT THERAPY FOR ACUTE RENAL FAILURE IN THE CRITICALLY ILL

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Up to 25 percent of critically ill patients admitted to the Intensive Care Unit develop Acute Renal Failure (ARF) (Ricci, et al, 2006). ARF has a significant impact on morbidity and represents an independent risk factor for mortality. Recent evidence suggests that utilizing the RIFLE criteria to risk stratify patients with early renal injury with subsequent initiation of intensive Continuous Renal Replacement Therapy (CRRT) is related to increased survival rates.

Do patients with acute renal failure have lower rates of chronic renal failure and mortality following acute events when intensive Continuous Renal Replacement Therapy (CRRT) is initiated early based on RIFLE criteria compared to a traditional approach to initiation and intensity? How does applying this new knowledge and building an organized evidenced based CRRT program impact patient outcomes?

The Iowa Model for Evidenced Based Practice was utilized to guide this project. Acute Renal Failure (ARF) carries a high incidence in the critically ill which elevates the need to manage it effectively through the application of sound evidence. This project relates to organizational priorities as it applies to safe and reliable patient centered systems of care that add value and positively impact patient outcomes. Additional application to organizational priorities include the reduction of redundancies in the processes in order to provide an organized and informed interdisciplinary approach to high risk activities

Initiation of this work was based on the purchase of new CRRT devices. This provided the opportunity to explore our current CRRT program and practices and critically look at potential gaps in the process and care standards. Extensive education both online and in classrooms sessions were held for providers, acute dialysis staff as well as adult and pediatric critical care staff. Based on the device upgrade and added options new order sets were developed, flowsheet documentation and practice standards were evaluated and changes as well as workflows investigated and transformed.

Outcomes to be explored are utilization of CRRT(patient days), initiation practices compared to traditional standard, intensity of the CRRT initiated (recommended 35 mL/kg/hr), mortality changes, as well as transition of patients to end stage renal disease compared to reversal of ARF due to CRRT. Process outcomes will include turnaround times from pharmacy based on custom mixes versus premixed bags, optimization of supplies to meet the demand and effectiveness of practice changes to streamline documentation accuracy and patient care.

THE MINNEAPOLIS CNL EXPERIENCE

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Healthcare is subject to a chaotic and frenzied level of change. In order to improve health care delivery, redesign must occur at the Microsystems level where the real transformation occurs. To address the redesign needed, the Minneapolis Veterans Affairs Health Care System (MVAHCS) partnered with the University of Minnesota School of Nursing (UMSON) to begin implementation of the Clinical Nurse Leader (CNL) role. In 2005, a CNL candidate began working on an inpatient medical/telemetry unit and in 2006 a CNL candidate was established on the inpatient polytrauma unit.

Although both Clinical Nurse Leaders work on many similar projects, they also have demonstrated positive impacts on their unit and throughout the hospital. Together, the two CNLs and a Nurse Manager co-chair the Nurse Practice Council at MVAHCS. They also serve on several other committees and evidence based practice projects together. The CNL on the medicine unit led the implementation of hourly rounding throughout the facility and helped initiate the discharge call program. The CNL on the polytrauma unit led an interdisciplinary group to develop *The Rehabilitation Guide Book* that all patients and families receive on admission to the polytrauma unit and implemented a primary nursing care delivery model to improve patient and nurse satisfaction.

There have been several positive outcomes on both units in which the CNLs work. There is a noticeable difference in length of stay (LOS) between the two non-differentiated medical floors. In 2006 both floors had a similar length of stay at approximately four days. In 2010, the LOS decreased on the CNL unit to 3.3 days, while the unit without a CNL has a LOS of 6.5 days. The CNL on medicine is also co-chair of the Fall Prevention Committee. There has been a decrease in falls throughout the hospital and on the medical unit with the CNL. This CNL has also positively impacted the organization's Performance Measure for discharging patients with heart failure. The hospital began with a compliance rate of 7% prior to the CNL education of the four medical and surgical units. The current compliance rate is close to 100%.

The stand alone polytrauma rehabilitation unit was newly opened in 2006; the CNL has demonstrated a positive impact related to emerging practice and process implementation. She developed therapeutic pass and off station outing policies and procedures and developed policy and procedures for use of the transitional living apartment located on the nursing unit. In addition, the CNL has developed a collaborative relationship with the inpatient TBI/polytrauma Medical Director. Together they lead and facilitate a monthly action oriented work group that is charged with establishing, assessing, planning and evaluating rehabilitation standards.

Both CNL's serve on National VA committees developed by Office of Nursing Services to disseminate nursing competencies, guidelines and clinical best practices to the field. The medical CNL serves on the evidence-based practice goal group and the polytrauma CNL is a member of the Polytrauma rehabilitation Field Advisory Committee.

DECREASING NAUSEA IN BARIATRIC POST-SURGICAL PATIENTS: A CLINICAL NURSE LEADER AND COMMUNITY HOSPITAL INTERDISCIPLINARY TEAM

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Gastric bypass surgery and other procedures to assist obese patients have been found to be successful in meeting the overall goal of weight loss (Kligman, et.al., 2008). Post-operative symptom management is a challenge for most bariatric teams, however. Nausea is common in the post-operative bariatric population and the reported average in many facilities is 60% or higher. Lengths of stay are increased and the costs of additional anti-nausea medications are significant in these patients (Tyler and Pugh, 2009). The interdisciplinary team at this rural Bariatric Surgical Center sought to decrease the nausea rate to below this reported percentage to 30% or lower. The clinical nurse leader (CNL), as a joint appointed faculty member, affiliated with the team to provide evidence and research-based support in decreasing patient nausea.

Prior to the interventions the nausea was reported to be 60%. The team began review of records and found many different anesthesia, post-anesthesia (PACU) and nursing unit care interventions. The interventions included educational programs for nursing staff, a randomized control group study comparing fluids post-operative, and anesthesia standardized protocols. The educational projects were found to be ineffective although there were significant differences between nursing practice in post anesthesia recovery room ($P=0.004$) (alcohol swab under nose, ice chips, washcloth to neck and to wet lips, and nausea assessment). The nausea medication protocols differed significantly between anesthesiologists ($P=0.000$). One anesthesiologist had a nausea level as high as 84% and another, as low as 30%. Medications given in surgery and in PACU differed significantly, also.

Anesthesiologist members of the interdisciplinary team voted in favor of standardized orders to enhance control of nausea for the post-operative patient. Once changes were made in protocols, post operative nausea rates decreased to 30% for the highest nausea anesthesiologist on staff in the rural hospital. The anesthesiologist with the lower rates initially found that the nausea rates were increasing with his patients. The team continued to follow the issues at hand and recommended that the standardized protocols needed further definition and further research. Issues were identified with the consistency of data collection times for documenting the presence of nausea post-operative. The team of nurses, physicians, administrators, admission personnel, pharmacists, psychologists and anesthesiologists hope that nausea rates will be decreased so that identified outcomes are met, patient costs are decreased, and patient discomfort from nausea will diminish.

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DEDICATED EDUCATION UNIT PATIENT OUTCOMES AND EXPERIENCES
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BACKGROUND: CNL students are educated to evaluate microsystems for quality and safety using extant microsystem outcome and process data. However, students may have challenges obtaining outcome data in a timely manner. We present our experience obtaining and evaluating microsystem data from our Dedicated Education Unit (DEU) used for BSN and CNL clinical education. Our experience is an exemplar for: a) documenting the impact of DEU clinical teaching on nurse-sensitive patient outcomes and patient experiences, and b) identifying issues that CNL faculty may need to address when designing CNL student quality and safety projects.

We partnered with Methodist LeBonheur Healthcare for a new model of clinical education, the DEU, in our 2-year accelerated Master's-entry CNL program. Our DEU is a high-functioning 44-bed inpatient unit (microsystem) developed as an exemplar clinical teaching-learning environment. Nursing faculty co-teach with DEU staff nurses who complete a clinical teaching workshop and work with 2 students concurrently.

METHODS: We evaluated baseline data for the 3-month quarter before implementing the DEU and follow-up data for the quarter after implementing the DEU for clinical teaching. Data were obtained from existing electronic records. We developed our variable list in consultation with hospital nurse executives for nurse-sensitive patient outcomes. It took ~ 6 - 9 months of ongoing effort to obtain partial data. Usable patient outcome data were retrieved for nine variables (pressure ulcers; urinary catheter and surgical site infections; blood clot after hip/knee surgery; all and with harm falls; all, near miss, and with harm medication errors). We retrieved additional nurse-sensitive patient experience data for twelve variables (recommend and choose hospital again; feel safe; quality of care; staff compassion and problem resolution; day and night shift nurse attention; preparation for discharge; information for and participation in decisions; pain management). Independent samples t-tests were used for analysis of unmatched patient data.

OUTCOMES: There were no statistically significant ($p \leq .05$) differences for all nine patient outcome and for all twelve patient experience variables. We found that extensive electronic DEU microsystem data were collected regularly. Although the environment was data rich, data were often collected and archived in a manner that limited the type, quality, and accessibility of data. This may constrain the design of CNL students' quality improvement and safety projects.

RECOMMENDATIONS: The DEU did not adversely impact nurse-sensitive patient outcomes and patient experiences although DEU staff nurses were intensively involved in clinical teaching. The DEU should be continued for clinical teaching. Microsystem outcome evaluation data for CNL quality improvement and safety projects, however, was not readily available. Faculty may need to: a) use microsystem *process* data for student projects, and b) conduct pilot *outcome* evaluation studies to evaluate data acquisition feasibility issues.

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CLINICAL NURSE LEADER AS COORDINATOR OF MULTIDISCIPLINARY ROUNDS

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Background Information: As the lateral integrator of care, the CNL coordinates all health care disciplines to achieve optimal client care outcomes. In the provision of patient-centered care, the health care team must discuss each patient and agree on common goals based on individual problems. MDRs provide the process for coordination of all team members, including the patient, to communicate effectively with each other and to reach common goals for patient care. This initiative describes the role of the CNL as coordinator of routine unit based MDRs, which are an evidence based process for improving communication and collaboration among members of the healthcare team, achieving better patient outcomes and facilitating access to care by decreasing acute care length of stay.

Outcome Data: MDRs had been implemented by the CNL on the Medicine/Oncology Unit and have been expanded to include all acute care units at the JBVAMC. Rounds are now conducted daily, hospital-wide, at the patient's bedside. Early qualitative data suggests improved job satisfaction among nurses, improved team collaboration, and improved understanding of the treatment goals by the patients. Quantitative data includes decreased days on remote telemetry which saves nursing time and prevents days of diversion for the hospital, increased number of Palliative Care consults which improves quality of care and decreases hospital readmissions, and earlier consults to our Community Living Center which decreases acute care length of stay.

Description of Methods: JBVAMC has 3 acute care units served by eight medical teams including Attendings, Residents, and Medical Students from two medical schools. The eight teams cycle through the units daily and report to the ward clerk. The teams are given an updated list of their patients on each unit, including the assigned nurse's name and phone number. The core team includes the Patient, Nurse, Medical Team and Social Worker. The CNL and Assistant Nurse Manager attend rounds as needed depending on the workload of the bedside nurse. Rounds are conducted in the patient's room. Other members of the team may include Dietary, Pharmacy, Physical Therapy and Respiratory Therapy.

Summary Recommendations: MDRs are a financially efficient mechanism, in that they do not require additional resources for implementation, to reduce fragmented care. MDRs contribute to higher levels of safe patient care while having a positive impact on patient satisfaction and collaboration among the healthcare team. By assuming oversight for MDRs, the CNL provides ongoing evaluation and improvement of the process.

PREVENTION OF CATHETER ASSOCIATED URINARY TRACT INFECTIONS

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Background: Urinary tract infections (UTI) are the most common preventable hospital acquired infections with approximately 19,000 deaths per year. The daily risk of developing a catheter related UTI is 3%-7% in the acute care setting.

Problem: A standard urinary catheter consists of three items that require aseptic technique while assembling prior to insertion. The possibility exists of contamination of urinary catheter during assembly at the point of insertion and possible transmission of patient body fluids in the inserter's eyes or on skin.

This quality improvement project eliminated potential body fluid transmission and promoted best practice for prevention of UTI through implementing a one-piece continuous urinary catheter with a sample port and drainage bag.

Method: A literature review was performed to evaluate best practice guidelines for reducing urinary tract infections and eliminating potential body fluid transfer to the practitioner. A cost analysis was performed comparing a continuous foley catheter system with a silver coated tip compared to the three part system on the unit. The cost analysis revealed the continuous system to be comparable in cost to the three part system, even with the addition of the silver coated expense. A pilot project was initiated in the operating room using a checklist to monitor urinary catheters inserted in the operating room and identifying whether they were secured prior to transfer to the PACU.

Results: Since implementation, urinary tract infections attributable to foley catheters initiated in the operating room were reduced and securing catheters prior to transfer increased. Currently, staff has been using the evidence-based practice of a continuous silver coated urinary catheter for two years. The pilot project initiated in the operating room is now moving forward to include the acute care units and implementation of the CDC Catheter Associated Urinary Tract Infection (CAUTI) initiative.

Summary recommendations: A performance improvement project using a continuous urinary catheter is evidenced to reduce urinary tract infections. Securing the urinary catheter is often an overlooked prevention strategy for urinary tract infection. Staff participation in quality improvement projects at the unit level promotes evidence-based practice change at the bedside and provides an exemplar for critical thinking among nurses for improvement projects.

A DAY IN THE LIFE OF A CNL-PATIENT CARE INTEGRATOR
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Background Information: Contemporary healthcare systems require innovative nursing roles that focus on improving the quality of patient care and the overall patient experience. In response to this mandate, the Clinical Nurse Leader role was developed with the goal to provide care coordination influenced by evidence based practice. Recognizing the need for this role, nursing leaders at Sinai Hospital of Baltimore created the Patient Care Integrator (PCI) position as part of the Sinai Hospital Integrated Care Model for a high-volume, 36-bed high acuity Intermediate Care Unit. **Outcome Data:** Metrics have been identified to measure the multiple domains of the CNL-inspired PCI role. Outcome measurements reflect the primary foci of the role which include patient throughput, increased compliance with core measures, elimination of never events, and improved patient safety. Specifically, throughput is measured by Emergency Department diversion times (red and yellow alert), and the amount of time lapsing between “bed request for IMC” and “patient arrival to IMC”. Patient satisfaction is being measured by nurse sensitive items on the Press Ganey survey including but not limited to, patients’ perceptions of readiness for discharge, and patients’ perception of IMC nurses’ skills. Additionally, outcomes related to CLABSI, CAUTI, HAPU, and falls are being collected. Data analysis for this presentation will occur in December 2010 (the role has been in place for only two quarters).

Description of Practice: There are two Patient Care Integrators on the Intermediate Care Unit. In an effort to ensure continuity of care, the PCIs work Monday – Friday with overlapping hours to provide coverage from 0700 to 1900 (if needed). The PCI’s are not counted in staffing. On a daily basis, the PCIs use independent judgment combined with a set of clinical criteria to determine which patients they will follow for the day. Each PCI is assigned no more than 12 patients. During the course of their day, the PCIs work closely with direct care nurses, case managers, clinical nurse specialists, ancillary specialists, and physicians as they plan patient care through lateral integration. Each morning the PCIs, along with the charge nurses from day and night shift as well as the service-line hospitalist meet in the IMC to discuss the history and plan for each patient. Part of the meeting includes the opportunity to assess whether or not IMC patients continue to meet admission criteria for the unit. High-risk rounds are held twice weekly. The purpose of these special rounds is to discuss the plan of care for patients with a length of stay greater than three days. After reviewing clinical data, disposition is made and patients are educated on their plan for transfer or discharge. In addition, the PCIs work closely with direct care nurses and physicians to determine the need for central lines, and Foley catheters in an effort to help decrease infections from these sources. Impacting practice on a more global basis is also a vital part of the PCI’s responsibility. For example, the PCIs have participated in revising the Admission/Transfer/Discharge criteria for the IMC. This ensures only appropriate patients who meet appropriate criteria are admitted to the unit. **Summary Recommendations and Impact:** There is a public mandate for the US healthcare system to become more efficient while remaining patient-centered. The CNL-inspired Patient Care Integrator role is one mechanism by which that mandate is being addressed. Through the PCI role, Sinai Hospital of Baltimore hopes to enhance communication between the multidisciplinary healthcare team, decrease fragmentation, reduce costs, and improve patient outcomes.

Title: QUALITY PAIN MANGEMENT

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Background Information: Southern Arizona Veterans Association Health Care System (SAVACHS) has struggled in the past to be compliant with the Joint Commission and Center for Medicare Standards in pain management, documentation, and timely administration of PRN effectiveness. A committee was formed hospital-wide in March of this year to improve compliance of pain quality indicators and for appropriate pain documentation. Facility-wide compliance overall is greater than 90%. One of the guidelines involved is timeliness of PRN medication, and numeric pain scale. The facility had an Inspector General visit which indicated that our pain management documentation did not address quality of pain. The Community Living Center CNLs looked at our current practice and methods to improve the assessment and documentation of pain.

Outcome Data: The CNLs brainstormed and decided to go back to basic Nursing 101(Phillips, 2007). We implemented the PQRST mnemonic for pain assessment and documentation. Weekly, we have CNL meetings that address compliance of staff in pain documentation. We are in the process of collecting outcome data to exceed the expectation of Joint Commission, Inspector General and Center for Medicare Standards surveyors. The outcome data from our improved audit tool shows that we are currently at 80% compliant with these new indicators with our benchmark set at 90% or higher. These numbers are only from June 2010. The overall pain documentation however continues to be 95-100% since March 2010.

Methods: Findings from the surveys have been discussed at the CNL meetings and the Professional Practice Council for nursing of SAVACHS. A workgroup was formed to implement a new way to document pain and PRN effectiveness. All staff where in-serviced on the PQRST assessment. A laminated 3x2 card was given to all staff and was placed on each medication cart for easy reference. The CNL's are currently in charge of auditing pain assessment and documentation with the new tool. The CNL's are also responsible for 1 on 1 education for any staff who struggle with the change.

Summary /Recommendations/Impact:

The Community Living Center (CLC) will continue weekly Pain audits, simplify the pain documentation process for an easy to learn patient assessment tool, and continue to education staff, float pool, and agency nursing staff. This will ensure better pain management for patients, and a better understanding of patient's pain issues. The expectation is to exceed the Joint Commission, Inspector General, and Center of Medicare Standards within the next fiscal year.

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THE ROLE OF THE CLINICAL NURSE LEADER IN THE REDUCTION OF NOSOCOMIAL INFECTIONS

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The Clinical Nurse Leader is emerging as a crucial role in the health care delivery model and has proven to be a vital component of the healthcare team, specifically in the area of quality and family-centered patient care. Trends in healthcare reimbursement dictate that care be at a certain level of quality and that a patient does not incur any additional costs related to the lack of quality care. A pilot of the CNL role was conducted to evaluate the impact of the role on quality patient care on a 39 bed acute medical floor. One of the major focus areas for the CNL role was the reduction of nosocomial infection markers (NIMs), subsequently reducing the risk of loss of reimbursement. The CNL role has specifically been beneficial in the reduction of NIMs through decreasing the number of indwelling device days. This has been accomplished by focusing on collaboration with the multidisciplinary healthcare team, patient-family centered care, and evidence based nursing practice.

A research of the literature provided the framework for the initiative and the emphasis was placed on reducing the number of foley catheters and central lines placed and retained by patients on the unit. Often, foley catheters were ordered due to immobility, incontinence, the need for urine collection for strict output and urines studies, and regards for the maintenance of skin integrity. The CNLs developed a comprehensive, patient-family centered approach that included educating the patient, family, and nursing staff on collection of output, bladder training, and hygiene. The CNLs simultaneously maintained collaboration with the healthcare team (nurses, nursing assistants, physicians, and physical and occupational therapists) to prepare the patient for and determine readiness for foley catheter removal. Central venous lines are often placed due to the need for IV medications and frequent lab draws. The CNLs utilized a multidisciplinary approach involving nurses, nursing assistants, physicians, and speech therapists to encourage transitions from intravenous to oral medication and established a timed lab draws protocol to reduce the number of individual labs collected, thereby eliminating the need for central venous lines in most cases.

A review of the data available at this time has shown a reduction in indwelling device days by 8% which has correlated closely with a 50% reduction in NIMs. This reduction in indwelling device days and NIMs has been consistent over the past 3 months and provides justification for the presence of the role from both a reimbursement and quality standpoint. The data gathered from this pilot will be used to determine other units in the hospital that could benefit from the CNL role.

TEACHING INTERDISCIPLINARY TEAM SKILLS TO CNL STUDENTS USING AN INTERACTIVE SYMPOSIUM

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In the past, healthcare professionals from diverse disciplines failed to consistently communicate across disciplinary lines regarding the plan of care for clients, often resulting in fragmented care. Such fragmentation highlighted the need for an interdisciplinary healthcare team approach. As the lateral integrator of care and the healthcare team member with the most comprehensive knowledge of the client, the Clinical Nurse Leader (CNL) is responsible for coordinating the efforts of the interdisciplinary healthcare team. In order to prepare CNLs to fulfill the role of healthcare team coordinator, learning opportunities must be provided in which CNL students work closely with physicians, healthcare administrators, social workers, occupational therapists, and other members of the healthcare team. A crucial component of CNL education is teaching CNL students how to effectively establish relationships and communicate with other interdisciplinary team members. The purpose of this presentation is to share one teaching strategy, an interactive symposium, developed to expose CNL students to an interdisciplinary approach. Students representing five healthcare disciplines including health services administration, nursing (CNL students), occupational therapy, psychology, and social work participated. Prior to the symposium, students were assigned a common reading regarding the team approach to clients with complex healthcare needs as well as additional readings that were discipline specific. A didactic presentation by a nationally known speaker, case studies based on real life scenarios provided by community leaders, and small group work were used to teach interdisciplinary team skills. Following the presentation, students were assigned to a team that reviewed a case study of a client with complex healthcare needs and developed a plan of care. Assignment to case study groups ensured representation from each discipline. Interdisciplinary group discussions were facilitated by a faculty member and a community partner with expertise in the case. Lively discussions occurred as members presented thoughts regarding client care from their disciplinary perspectives. Throughout the discussions, students expressed an appreciation for the holistic perspective provided by interdisciplinary team collaboration rather than the narrow perspective generated by a singular disciplinary view. Providing an annual venue for CNL students to participate as a member of an interdisciplinary team affords the opportunity for students to gain skills in establishing relationships with, collaborating and communicating with, and appreciating the contributions of all healthcare team members in developing shared goals that impact client care.

Collegial Collaboration to Enhance the Impact of the Clinical Nurse Leader

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In October 2008 the University of Pittsburgh School of Nursing moved the CNL curriculum to an area of concentration leading to a Master of Science in Nursing. In addition to creating this new program path, the SON was also awarded the distinction of becoming one of only two pilot programs within the University to deliver graduate programs totally online. This created a challenge for faculty who were not familiar with the technology or course delivery strategies.

Although CNLs have been educated and certified since 2003, the role is new in the Western Pennsylvania. When the curriculum was changed to an area of concentration, there were five students currently enrolled in the program. One of the key requirements during their immersion experience was the creation, development and evaluation of a microsystem project. This proved to be challenging since the project description was new plus there are very limited practicing CNLs in Western Pennsylvania.

One of the best ways to encourage collaboration and sharing of ideas is to network with other professionals who have a similar understanding and idea. Therefore, practicing certified CNLs from across the country were asked to share microsystem projects and immersion experiences with the five students. Working collaborating with the instructional design teams from the University and sites from around the country, several live 1-2 hour video sessions were held. One of the objectives for each class session was discussion related to developing and conducting each student's microsystem project. Additional topics of discussion included incorporating the CNL in various health care settings, educating staff and professionals on the CNL role and future directions once the students graduate and incorporate the CNL role in their respective healthcare settings.

Qualitative data obtained from students related to three themes: (1) improving networking skills with other CNLs, (2) enriching current and future microsystem projects that highlight the CNL role and (3) promoting the CNL role within a variety of healthcare settings. Feedback obtained from certified CNLs guest speakers included (1) continuing growth in their professional knowledge, (2) sharing strategies for success with future CNLs and (3) recognizing educational and interprofessional collaboration opportunities.

As additional students are educated in the role of the CNL and conduct microsystem projects that highlight improved patient outcomes and satisfaction, it is important to share strategies for success with other certified CNLs. Using technology as a teaching strategy helps to lessen the distance between students and certified CNLs and encourages networking.

IMPLEMENTING THE CNL ROLE IN DIVERSE CLINICAL SETTINGS

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Summary of Initiative (Abstract): In 2008 the VAMC DC decided to integrate the Clinical Nurse Leader role into the Nursing Service. The Nursing Service Team reviewed the AACN models of education and decided that the post-master's certificate model would allow the pilot to hire nurses who had already proven the necessary requirements of academic and clinical expertise at the level of a master's trained nurse. The team formed a collaborative relationship with Oakland University School of Nursing to develop a distance learning program which would allow students to continue to work full time while completing the program. CNL candidates were assigned to medical, surgical, neurology, and renal units within the facility while they completed the immersion program. With the mentorship of Nursing Leadership, this pilot group developed projects that impacted their individual units and the entire Medical Center. Their academic success during the 18 month experience ensured that the program was accepted formally into the Oakland University curriculum and approved by the AACN as a CNL Certification Program which will allow VA's and healthcare facilities nationally to have access to cost-effective CNL education within their own locality.

CLINICAL NURSE LEADER IMPACT ON DOCUMENTATION OF PRN PAIN MEDICATION EFFECTIVENESS

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The Joint Commission emphasizes the need that every patient has a right to have his or her pain assessed and treated. Poor pain management persists in health care. Nursing staff assumes the primary responsibility for assessment of patients in pain. They are also responsible for giving pain medications, providing other interventions and documenting relief of pain.

To improve the management of pain medication effectiveness for our veterans at TVHS, the Clinical Nurse Leaders (CNLs) and Clinical Arms (CAs) collaborated to track prn effectiveness documented within four hours. (A CA is a BSN or MSN-prepared nurse that is designated to fulfill some of the duties of a CNL on specified wards). The goal was that when a pain medication was given, the patient would be assessed on a numeric rating scale of 0-10 and results would be documented within 4 hours. If a patient's pain was not relieved adequately (remained greater than 3 or greater than the patient's comfort goal) or was difficult to control, the primary team would be notified and the pain medication increased or changed.

In a striving to meet the pain management needs of veterans, the CNLs and CAs embraced the Institute of Health's (IHI) idea of a "team huddle" to address clinical issues. The "team huddle" meets on a daily basis to report status and update information. The idea of transferring this operational concept to the clinical arena has been explored by the Clinical Nurse Leaders at the VA Tennessee Valley Health Care system since March 2008. CNLs/CAs from inpatient nursing units formed a daily 12 noon clinical team huddle. One of the goals of the clinical team huddle was to increase the timeliness of documentation of prn medication effectiveness to four hours or less. The daily clinical team huddle of CNLs tracked all inpatient prn effectiveness documentation deficiencies from the daily prn effectiveness report submitted to each unit by their Automated Data Package Application Coordinator (ADPAC). The CNLs identified educational needs for staff nurses. They developed and provided education to front line care givers regarding the requirement to document effectiveness of prn medications within four hours in order to start immediate implementation in the acute care setting. They also provided pain management education including a review of pain management principles, review of facility documentation requirements, and use of the Numeric Rating Scale and alternative pain scales for patients unable to report their pain. The CNLs tracked the compliance of each nurse in their unit and recognized those with 100% compliance of timely documentation of effectiveness of prn medications on a monthly basis. Increasing awareness of the need for documentation resulted in improvements in compliance from FY 2009 to FY 2010 in units that have a CNL or CA as follows: 1A – 80% to 91%, 2G – 90% to 92%, 2N – 91% to 93%, 3N – 78% to 89%, 4B – 90% to 94%, MCCU 93% to 97%, and SICU – 87% to 94%.

The CNLs continue the daily huddles to analyze, identify trends, identify training deficiencies and develop/ implement strategies for improvement. They have become active participants in the Pain Management Committee and are now focusing their efforts on improving pain management outcomes.

A CNL Initiative: IMPROVING STROKE CARE USING AN INTERDISCIPLINARY
MODEL OF CARE DELIVERY

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Background: Stroke is the third leading cause of death in the United States as well as the state of Georgia. Specific performance measures were designed based on the Brain Attack Coalition's Recommendations and guidelines developed by the AHA/ASA and equivalent evidence-based guidelines for facilities certified as a Primary Stroke Center. Recognizing the importance of making efforts to foster better outcomes for stroke patient care, this Primary Stroke Center set a goal of being in the 90th percentile or higher for stroke evidence based measures. A review of evidence based measure data identified gaps in practice, which led to development of staff education and an interdisciplinary approach to care delivery. The purpose of this project was to utilize the CNL role to assist with achieving 90th percentile performance with stroke evidence based measures.

Methods: Staff on the stroke unit was educated via bulletin boards and classes on the role of the CNL, identification and assessment of stroke patients and evidence based measures. The retrospective data was collected for each individual patient and reviewed monthly by an interdisciplinary team with implementation of changes based on trends. This team was co-led by the CNL student and a physician champion. The membership consisted of physicians, nurses, administration, pharmacist, diagnostic areas, rehab services, care coordination, data support and others as needed. There were communication methods established for routine dissemination of the data to clinical and non-clinical staff. Concurrent rounding of CNL student, pharmacist and nursing on patients admitted with a diagnosis of stroke. We also implemented daily Interdisciplinary conferences. These conferences were attended by staff nurses, leadership, respiratory and rehab therapist, pharmacy, care coordination and CNL student. The conferences allowed the group to individualize and identify barriers to each patient's care plan. The CNL student served as the link between physicians and other members of the team. **Outcomes:** Overall the interventions had a significant impact on enhancing our stroke care. When we originally started the project, none of the measures were benchmarked in the 90th percentile. Within five months of method implementation, we had five measures that were consistently benchmarked at or above goal with marked improvements in the others. In conjunction with other hospital initiatives we also had a decrease in our length of stay for our ischemic stroke population and a readmission index below our peer groups. A significant change in unit culture has been noted as members of the interdisciplinary team are able to verbalize the measures, rationales and take accountability for their part in its success.

Conclusions: The improvement of patient care requires interdisciplinary collaboration occur at the patient care delivery level. This will in turn promote optimal outcomes for our patients and our healthcare facilities.

Implications for Practice: The Clinical Nurse Leader can be instrumental in leading initiatives that will improve outcomes, decrease cost and event recurrence by using the latest evidence, an outcomes management approach and facilitating the lateral integration of care.

Clinical Nurse Leader and Infection Prevention Collaboration Leading to Decreased Hospital Acquired Vancomycin Resistant Enterococcus (HA VRE) on a Medical-Specialty Unit
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Background: Hunterdon Medical Center employs 3 Clinical Nurse Leaders on 3 West, a 48-bedded Medical-Specialty Unit. The efficacy of the Clinical Nurse Leader is based upon measurable indicators formulated by the Chief Nursing Officer and are unique to each unit's population. One of these indicators is Healthcare Acquired Vancomycin Resistant Enterococcus (HA VRE). 3 West screens all patients on admission for MRSA and VRE in order to find community acquired cases.

Objective: Our aim is to illustrate the correlation between the collaboration of the Clinical Nurse Leaders and the Infection Prevention Department and the decrease in the rate of HA VRE at Hunterdon Medical Center.

Methods: In the beginning of 2010, 3 West noted an increase in the rate of healthcare acquired VRE. The Clinical Nurse Leaders had already been collaborating with Infection Prevention Department regarding means of decreasing infection rates on the unit. A committee was formed on the unit to involve staff nurses, housekeeping, patient care assistants, the infection prevention department, the Director and Assistant Director of 3 West, along with the CNLs, in the process of improving the rates of HA VRE. Observations were conducted to evaluate the nursing staff compliance with hand hygiene, cleaning of equipment, use of equipment in isolation rooms, and wearing of personal protective equipment in isolation rooms. Review of the patients' record is conducted after a HA VRE is discovered. The CNL and the Infection Prevention Department assess if the patient was in a room next to a patient with a known positive VRE, if they were on telemetry or if they were utilizing a bedside commode during their stay. In conjunction with Infection Prevention, an educational program was developed for the nursing staff and given by the Director of the Infection Prevention Department. During the education sessions, the staff was informed of the increased rate of hospital acquired VRE and data from observations was shared. The education session focused on hand hygiene before and after patient contact and wiping of equipment before and after patient use. Other topics for discussion included education for the staff directly and indirectly involved in hands-on patient care, as well as for the patients that screen positive for VRE while hospitalized.

Results/Conclusion: The overall rate of healthcare acquired VRE decreased on 3 West Medical-Specialty Unit from February 2010 to September 2010. The Clinical Nurse Leader cannot effect changes such as decreasing Healthcare Acquired Vancomycin Resistant Enterococcus (HA VRE) without collaboration with other departments such as the Infection Prevention Department.

Evaluating the Entry Level CNL in Practice
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The Clinical Nurse Leader (CNL) is a new role, developed by the American Association of Colleges of Nursing (AACN) in 2000 to address this problem, (AACN, 2007). The Clinical Nurse Leader is a master's prepared generalist, accountable for patient outcomes through ensuring evidence-based design, implementation and evaluation of individual patient care, clinical populations and communities (AACN, 2007).

Schools of nursing have developed entry level masters' (ELM) programs for students with non-nursing Bachelor's degrees, to complete entry into practice requirements through accelerated programs. These programs are highly competitive and have a high level of rigor. Accelerated programs are offering the CNL track as entry into practice. Presently the first few cohorts have graduated and are practicing as nurses.

It is unknown whether such graduates are able to implement the end of program CNL competencies as novice nurses in practice. This project evaluated entry level CNL graduates with the CNL end of program competencies to determine whether these entry level master's CNL graduates are able to continue developing their end of program CNL competencies at the same time that they are working as novice nurses.

The Entry Level CNL Survey was developed and reviewed by two experienced researchers for survey validation. The Entry Level CNL Survey included 6 Likert style questions that were developed to elicit perceptions of practice using the AACN CNL End of Program Competencies (AACN, 2007). Themes were grouped around the ability to provide Nursing Leadership, Care Environment Management and Clinical Outcomes Management. In addition respondents were asked open ended question about the ability to apply the elements of the CNL role in their daily practice. The link was sent to all graduates of the ELM-CNL programs from two institutions and was accessible online. IRB approval was obtained from USF.

The survey was sent to 163 graduates of 2 nursing programs providing ELM-CNL graduates. The response rate was 35%, with not all respondents answering every question. No graduates are in CNL positions, however 40% (n= 20) reported that they had been asked to be in charge or leadership positions. Ninety-two percent are in staff nurse positions. Thirty six percent believe to be valued because of their CNL competencies. Twenty-four percent are applying to clinical advancement positions within their organization, while another 25% reported no such clinical ladders available. More than half believe that they are able to use their CNL competencies in their current role as staff nurses. More than half are participating in hospital based committees and 67% are using evidenced based research to improve their units' outcomes. Qualitative themes were analyzed and responded to the feeling of "new nurse", manager and healthcare resistance, and yet an underlying potential of hope for change when these nurses gain more experience.

Implications for nursing practice include helping new graduates identify and articulate the role competencies as well as education of nurse managers in ways to integrate and utilize the skills and competencies of novice nurses that are CNL's. Specific orientation pathways need to be developed to allow ELM CNL's to continue honing their CNL competencies as they become proficient as staff nurses.

AACN (2007). *White Paper on the Education and Role of the Clinical Nurse Leader*

Abstract
PATIENT EDUCATION TO PREVENT FALLS IN A PROGRESSIVE CARDIOLOGY
UNIT

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Background: Despite numerous prevention efforts, inpatient falls remain a significant problem in most health care institutions. In-hospital falls that cause injury are commonly associated with increased length of hospitalization, increased costs of hospitalization, and prolonged recovery.

Purpose/Goals: The purpose of this EBP change was to decrease patient fall rates through patient education and to improve nurses' perceptions of falls and safety.

The following goals for this project were:

- 1) Providing education to patients (defined as patients and any support persons) identified as high risk for falls on a progressive cardiology unit would decrease the rate of falls by at least 50%.
- 2) After patient education on falls, accuracy of nursing staff perception of fall rates would improve by 10%.
- 3) After patient education on falls, staff perceptions related to use of and impact of education would increase by 10%.

Design: Using interventions based in the current state of science, this project was conducted as an EBP change project.

Measurements: Pre and post surveys regarding the perception of falls and safety of all patients were administered to the nursing staff on the progressive cardiology unit. These surveys had four to six open ended and yes no questions that focused on the perception of the nurses on patient falls and whether the appropriate preventative measures were in place.

Procedures: Once a patient has been identified high risk for falls, verbal education as well as a patient educational sheet was provided.

Results: After the implementation of patient and family education on fall prevention, the fall rate decreased by 80%, the accuracy of the nursing staff's perception improved by 10%, and there was a 22% increase in the nursing staff's perception that education impacts fall rates.

Implications for Nursing: Patient and family education continues to be a valuable aspect in falls prevention. Reducing the number falls improved the perception of the nursing staff and how they view patient safety and greatly impacted the awareness of this initiative. The expense of patient education is minimal when compared to cost savings for hospitals. Most importantly, it improves patient safety and outcomes.

IMPROVING URINARY CATHETER DISCHARGE EDUCATION

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Discharge education resources for patients with urinary catheters (UCs) at a public hospital in the Northern California area are lengthy, and difficult to comprehend. Also, patients with UCs are unknowledgeable about the risks associated with UCs. Therefore, hospitalized patients with UCs, and those discharged with UCs (“leg bags”) are not receiving optimal discharge and UC education and thereby, possibly contributing to urinary tract infection rates and costs associated with catheter associated infections. A cohort was interviewed regarding their knowledge and awareness of UCs. Patients discharged with a UC were followed for UC complications. Revision of leg bag discharge information was designed based on current evidence-based practice. Results show that majority of patients are unable to state why they have a UC, verbalize signs or symptoms of a urinary tract infection (UTI), nor identify ways to prevent a UTI. One out of two patients discharged with a leg bag reported a UTI. Practice recommendations include implementation of a UC-need decision making algorithm, continued staff education to empower patients to actively participate in their UC care, a systemic method to log suspected urinary catheter associated UTIs, and multilingual patient care plans, and discharge information. For more information, please contact: Sherrie Ladegast- email: sladegast@gmail.com

Increasing Nurse Confidence through Neurologic Assessment Education

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Confidence with standardized neurologic tools will improve effectiveness of communication with physicians and ultimately lead to better patient satisfaction. Constructed as a microsystems assessment with gap analysis, including a logic model, and integration into Unit Based Shared Governance and key leader goals, a *Primer on Advanced Neurologic Assessment* is offered as a nursing education intervention focused on short-term outcomes of developing staff competence and confidence related to use of standardized neurologic assessment tools, specifically National Institutes of Health (NIH) Stroke Scale and Confusion Assessment Method (CAM), along with focused cranial nerve assessment. Using a Clinical Nurse Leader approach to satisfy the requirements of a CNL[®]-oriented masters degree, this is a microsystem-level intervention aimed at sustainability and bedside effectiveness, which offers collaborative support for the existing work and teaching of the Clinical Nurse Specialist, Stroke Coordinator, and emerging unit leaders.

The theoretical basis is grounded in improving nurse-physician communication as pre-requisite for excellence. Short-term outcomes include increased knowledge and confidence with the tools. Using the Student t-test (n = 20, or 36% of nursing staff), pre-/post-test significance was found at the following levels: Confusion Assessment Method, p = 0.002; NIH Stroke Scale, p = 0.003; focused cranial nerve assessment, p = 0.007.

Projected long-term outcomes, beyond the scope of this intervention, include higher nurse satisfaction leading to higher patient satisfaction as measured by Press-Ganey scores. Primary limitations are the amount of time to implement and effectively evaluate, and the limited sample size; both of which decrease penetration of intervention and subsequent impact.

EVIDENCE-BASED NURSE GROUP SHIFT REPORT

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ABSTRACT

Background: Shift report was not standardized on 9B, a high-risk OB unit (OBHR). A big complaint on the unit was that the charge nurse did not know what was going on with all of the patients, but was legally responsible for all of them. The PCL was unable to get a full report on each patient, update the primary nurses on the patients, or correct misinformation communicated during report. This could have affected the quality and safety of care provided.

Objectives: 1) To increase nursing satisfaction on the OBHR unit at Carolinas Medical Center by changing shift report for one month. 2) To decrease overtime on the OBHR unit at Carolinas Medical Center by changing shift report for one month.

Design: Using interventions based on the current state of science, this project was conducted as an evidence-based practice change project.

Setting: The setting was the OBHR unit (9B) at Carolinas Medical Center in Charlotte, North Carolina. This is a 14-bed unit.

Participants: All of the 20 nurses that worked on the OBHR unit during June, July, and August 2010 participated in the practice change, and were asked to participate in the pre- and post-surveys.

Methods: The investigator conducted pretest observations during May 2010 and distributed an anonymous survey that assessed nursing satisfaction with the current method for shift report. During June and July 2010, group shift report was implemented for six weeks. Posttest observations and a post-survey were conducted during July and August 2010.

Results: There was a 95 percent response rate to the pre-survey, and a 75 percent response rate to the post-survey. Group report did save overtime. Group report averaged about nine minutes less than one-on-one report. Nurses felt they received a more standardized and complete report using group shift report; however, overall nursing satisfaction with this change was low.

Conclusions: There are several factors that may have contributed to the lack of nursing satisfaction with this intervention: First, some individuals were resistant to change. Second, there was not one separate question on nursing satisfaction with report on the survey.

Based on the lack of nursing satisfaction, reinforcement or slight changes should be made to group shift report. Report needs to be standardized with guidelines to ensure patient safety and quality of care. The actual method of shift report is not nearly as important as making sure that whatever method is used is standardized, comprehensive, efficient, and improves nursing satisfaction.

EVIDENCE BASED PRACTICE CHANGE TO DECREASE SURGICAL SITE INFECTION

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Introduction: Surgical site infections have been defined as wound infections that occur within thirty days post-operatively. In an age where hospitals are no longer getting reimbursed for hospital acquired infections, it is of dire importance to find ways to decrease costs and it is of greater importance to examine the means to save more lives. In surgical patients, such as the ones on the orthopedic unit, surgical site infections are the most common hospital acquired infection. As a result hospital stays for individuals in the postoperative period may increase anywhere from seven to ten days.

Purpose: of this evidence based practice (EBP) change at Carolinas Medical Center (CMC) Orthopedic unit in Charlotte North Carolina was to decrease readmission rates due to post operative infections, thus, decreasing any surgical site infections. The objectives of this project were for adult patients admitted to 11T for scheduled orthopedic surgeries that includes scheduled hip, knee, shoulder, and elbow surgeries between June 1st 2010 and July 31 2010 .And to specifically to:

1. Decrease hospital readmission rates by 25%.
2. Decrease surgical site infection rates by 25%.
3. Increase patient self reported preparedness for managing surgical site care upon discharge by 50%.

Intervention: based on current evidence, this project was conducted as an (EBP) change. The sample and practice change included all adult patients admitted to the 36-bed orthopedic unit (11T) for scheduled orthopedic surgeries that included scheduled hip, knee, shoulder, and elbow surgeries between June 1st 2010 and July 31 2010. The three variables measured for this project were a) hospital readmission rates within 30 days post operatively, b) surgical site infection rates, and c) patient self reported preparedness for managing surgical site care upon discharge. Each of the variables was measured before and after the practice change. Patient self reported preparedness was measured via an anonymous survey. The month of June displays pre change data. Education to nursing staff and patients was done prior to July post change data.

Results: for the patient preparedness surveys were found to be positive as seen with some of the results that follow. Concerning the question on whether nurse's teaching on incision care began on the first day in the hospital; the increase from pre-change in June to post-change in July was improved by 41%. Concerning the question on whether the patient met with a nurse on more than one occasion, the increase from pre-change to post-change was 41.76%. Most notably was the increase from pre-change to post-change on teaching signs and symptoms of infection, found to increase by 62%. There was a 40% increase with nursing education on other patient health concerns. A 15% increase was seen both with patients understanding all teaching given to them and being adequately prepared for the hospital. The data for June on readmission rates and surgical site infections will be received this week. In the next month, the data for July will follow. I will then be able to compare the months' readmission rates and surgical site infections.

Nursing Implications: It is imperative for patient outcomes, patient safety, and quality of care that continued updates and education for staff on the most current evidenced based practice be done. One area in which CNLs can take the lead is in decreasing infections and readmission rates in orthopedic patients who have undergone surgery.

CHALLENGES OF IMPLEMENTING THE CNL ROLE
IN AN ACADEMIC MEDICAL CENTER

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Background: The clinical nurse leader (CNL) is being utilized throughout the country in an attempt to improve patient outcomes and facilitate the defragmentation of care. This is often accomplished by integrating the role into current care delivery models. When the CNL is fully integrated into the role, he/she functions as a facilitator of communication within the interdisciplinary team, and as a single, consistent source of patient information. However, there are several challenges when to integrating the role in a large academic medical center.

Purpose: This presentation will describe how one 927 bed academic medical center implemented a pilot of the CNL role on a 39-bed medical unit that operates with five rotating medical teams. Each team consists of an attending, a resident, two interns and two medical students, with rotations occurring at least monthly. The challenges to implementing the CNL role in this environment included frequently re-establishing trust and relationships, as well as re-orienting physicians to the CNL role. These challenges were addressed by creating a standardized plan for orientation, clarification, and adaptation of the role.

Methods: The CNLs participated in monthly physician orientation for the unit giving an overview of what the role was meant to accomplish. Handouts were provided in a CNL-physician huddle to outline unit initiatives and goals. CNLs rounded with each team daily to address nursing and patient needs and also participated in a multi-disciplinary discharge meeting. The CNLs closely monitored the needs for role clarity and provided this clarity as needed through huddles and at individual physician requests.

Outcome: The CNLs provided nursing staff with a survey that indicated that the CNL role positively impacted the bedside nurses' ability to contact physicians and stay informed of the plan of care. Physicians were also provided with a survey regarding the physicians' understanding and perceived efficacy of the role. Feedback indicated a positive response to the role in regards to facilitating nurse-physician communication and collaboration, and physicians that rotated on to the service prior to implementation of the CNL role indicated a marked perceived difference in their overall experience on the unit.

Summary: As the organization plans to implement the CNL role on other units, the experiences and lessons learned from the pilot unit will be used facilitate success for future CNLs.

**IMPLEMENTATION OF THE CLINICAL NURSE LEADER ROLE COMBINED WITH
CLINICAL NURSE SPECIALIST COLLABORATION: AN INNOVATION DESIGNED
TO FACILITATE NURSING PRACTICE AND HEIGHTEN PATIENT CARE**

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In response to critical issues facing healthcare, the Portland Veterans Affairs Medical Center (PVAMC) has implemented numerous practices, including the adoption of the Clinical Nurse Leader (CNL), an innovation designed to facilitate nursing practice and heighten patient care. Implementation of this role was facilitated by PVAMC's strong academic partnership with the University of Portland. In accordance with the vision held by PVAMC nursing leadership, the CNLs have customized their role based on the specific needs of the various microsystems within the facility, an important component of sustaining this innovation. To further integrate and sustain the innovation, the CNLs have initiated a collaborative network with PVAMC's Clinical Nurse Specialists (CNSs), in order to better saturate both macrosystem and microsystem facets of nursing practice and patient care. Use of the CNL and concomitant collaboration with the CNSs have yielded positive outcomes in several patient and nursing arenas. With further integration of the CNL role, along with continued collaboration between CNLs and CNSs, it is projected that evidence-based nursing practice will continue to be elevated, patient safety increased, and that outcomes will continue to improve.

**THE POWER OF PRECEPTING AND THE MAGIC OF MENTORING:
THE SECRET ROOTS OF PRECEPTING AND MENTORING**

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Problem: Ambivalence in new role acquisition creates enormous expectations from the organization, peer level, as well as personal perspectives. These expectations may lead to stress levels which are beyond the level of endurance.

Evidence: It is reported that 83% of influential nurses in the US have been mentored. Mentoring is an important mechanism to ensure success in career development.

Strategy: Effective preparation for graduate nursing students in the Clinical Nurse Leader (CNL) program was designed using Benner's Novice to Expert Theory, resulting in the transition from staff nurse to MSN level graduate using self discovery and growing to complete confidence in the new role.

Practice Change: The practice change was accomplished by integrating the competencies of the CNL curriculum into the clinical setting. The formal preceptorship was tailored across semesters throughout graduate studies, including immersion and capstone completion.

Evaluation: The path to success was ultimately measured in successful graduation and certification attainment as a CNL. The process was realized over time through self performance monitoring, seeking validation of findings, increased use of intuition all of which culminated in peer trust.

Results: The continuity of having one preceptor accelerated the relationship into a trusting and respected one for role clarity. Successful assimilation into the CNL role was optimal due to the building of mutual trust and respect during the course of studies. Professional activity resulted in dissemination of CNL work: national presentations, peer reviewed publications, national consultation, etc.

Recommendations: Utilization of one preceptor across the clinical curriculum in a CNL program affords the ongoing development of relationship building and formalization of relationships from preceptorship to mentorship.

Lessons Learned: Trust is the mechanism through which relationships are built and maintained. Trust is difficult to build, yet once attained, catapults professional development beyond any planned timeline of traditional growth trajectories.

Development of the CNL: Transition of Model C to Professional Practice

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Background: The CNL role was developed in an effort to meet the demands of an increasingly complex healthcare system and evolving patient population. The University of Maryland School of Nursing (UMSON) developed their Clinical Nurse Leader (CNL) Program through adapting the Model C master's entry program established by the AACN. The Model C program is designed for individuals with a baccalaureate degree in another discipline. Upon completion of the Model C program, the individual receives a generalist master's degree and is eligible for both RN and CNL licensure. Through the development of the Integrated Care Model, Sinai Hospital of Baltimore has embraced the CNL credential and placed it at the center of the Patient Care Integrator (PCI) role. **Outcome Data:** Sinai Hospital of Baltimore implemented the Integrated Care Model in June 2010 and has fully integrated two PCI positions in the model with a focus on lateral integration of care for acutely ill patients in an Intermediate Care Unit. Outcome data for the role are currently being collected and will be analyzed at the end of FY11 second quarter (December 2010). **Description of program:** The University of Maryland School of Nursing provides CNL nursing students with a unique educational experience including master's level credits in research for the advanced practice nurse, systems and populations in healthcare and gerontology. Additionally, coursework in leadership and evidence based practice is at the center of its curriculum. Skills and competencies gleaned in the CNL academic program were leveraged in the creation and development of the CNL-inspired Patient Care Integrator role of the Sinai Hospital Integrated Care Model. Alignment between academic preparation and professional practice for the PCI at Sinai are evident in many ways. For example, during the program, a health agency assessment project was required. During the assessment project individuals were given the opportunity to meet with the admissions coordinator as well as a representative from the budget department of the University Specialty Hospital - a long term care facility. This allowed students to learn about healthcare across the continuum as well as healthcare costs. Lessons learned through this experience translate into professional practice. At Sinai Hospital of Baltimore, the PCIs are deeply involved in the transition of care for patients between the acute and long term care settings. Understanding the basic concepts of budget and finance have helped the PCIs better understand the impact that issues like length of stay and denied days have on the nursing unit bottom line. In addition, education tailored for the advanced generalist role prepares nurses to improve practice through critical thinkin, effective communication and providing patient care in complex situations. The PCIs use these skills on a daily basis through service as a unit-based resource nurse and lateral integrator of care across all disciplines. **Summary/Impact:** Model C graduates from the University of Maryland School of Nursing are educated to function as strong nursing leaders. The PCI role at Sinai Hospital of Baltimore leverages the educational preparation of CNL nurses in efforts to bridge the gap in care that is so common in contemporary hospitals. This role influences practice in many positive ways by decreasing length of stay, improving patient outcomes, and providing less fragmented care. The PCI serves as the lateral integrator of care across disciplines and assumes accountability for achieving targeted outcomes. The PCI demonstrates safe and effective navigation of patients and families through the complex healthcare system.

IMPLEMENTING SKIN CARE ROUNDS IN CRITICAL CARE
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During 2008-2009 pressure ulcer rates were 44% higher than the national average for hospitals 400-499 beds in a critical care step-down unit at a community hospital in Southern California. Increasingly high prevalence rates of hospital-acquired pressure ulcers derived from quarterly prevalence studies have triggered the initiation of weekly nursing skin care rounds by the wound care nurse, unit manager and CNL graduate student to increase awareness for nurses caring for patients at risk for skin breakdown. The goals include increasing staff awareness and institution of best practices for pressure ulcer prevention. During weekly rounding, four patients with the lowest Braden scores are selected for review. The nurse caring for each selected patient presents the patient from a skin care perspective. Nurses are given education regarding product usage for prevention and treatment as well as reminders on utilizing the Braden Score correctly. Fifty-nine patients with an average Braden Score of 12.45 were reviewed in five months. Following the implementation of rounds the pressure ulcer prevalence rate fell to 3.33%. Monthly internal prevalence studies are also completed. In five months, only two stage II ulcers discovered and no stage III, IV or "unable to stage" ulcers were discovered. Nurses are taking a more active role in protecting patient's skin upon admission.

Steps to Developing a Work Site CNL Program

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The Clinical nurse leader (CNL) is the first new nursing role in 40 years. The CNL is a position developed by the American Association of Colleges of Nursing (AACN) in 2003. As a CNL, I was asked to design a work site curriculum for a major university. Designing a CNL curriculum differs from other nursing specialties because AACN and practicing partners contribute to the dimensions of this role. In addition to gaining support from the university, commitment from a practicing health care partner is essential before proceeding with this initiative. The first step in creating the curriculum design is to determine the community's readiness and need for this type of program. In this paper I will outline the steps taken to develop a work site CNL program. The CNL graduate needs to meet the requirements of the AACN and pass a certification exam after completing the program. A capstone project and clinical immersion hours must be met prior to sitting for this exam.

My experience as a CNL as well as my personal education in graduate school influenced the curriculum design. The curriculum for this work site program was tailored to meet the specific requirements of a large university with multiple healthcare affiliations.

CNL-LED COLLABORATION AND INNOVATION

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Providence Health System has created a strategic vision to provide a connected care experience for patients that is based on clinical excellence. The goal of this experience is answer each patient's desire that providers "know me, care for me, and ease my way." The contribution of the Clinical Nurse Leader (CNL) role exemplifies this vision of connected care. This abstract will describe how a unit based CNL contributes to improved patient care through innovative practice, collaboration, and coordination of care.

The CNL role was implemented on the Orthopedic (8N) and Neuroscience (8S) units at Providence Portland Medical Center in 2009. These two units include 48 private rooms and are staffed by nearly 60 registered nurses and 10 certified nursing aides. The architecture of the unit was designed to support patient centered care, with nurses at the bedside. The population of patients includes elective surgeries such as joint replacement and back surgery as well as unplanned orthopedic surgery, stroke, and other neurological ailments.

An early CNL led innovation within these units was the organization and facilitation of an interdisciplinary partnership council (IPC). The mission of the CNL led 8N/8S IPC is to foster shared meaning and purpose in the work of all disciplines that participate in patient care. Members of the IPC include representatives from nursing (RNs and CNAs), physical (PT), occupational (OT) and speech therapy (ST), clinical education, food services, chaplain services, and medicine. The IPC reviews data including patient satisfaction survey information, nurse sensitive indicators, and informal information gathered from all members of the staff. Based on this gathered information, members of the IPC agreed that many patients and family members did not feel adequately informed and had unclear expectations about their care. Discharge was also delayed when patients were unprepared for the therapies (PT, OT, ST).

In order to provide improve communication about care provided on 8N and 8S, the IPC worked collaboratively to develop a welcome video for patients and families. Each discipline contributed content that was specific to their area of expertise, while the CNL edited the language to meet everyone's needs. This collaborative effort resulted in a product that is shown to patients and/or their families upon admission, before transfer to 8N/8S from other units, and even as families wait for their loved one to arrive from surgery. The video includes information about what to expect during the patient's stay, descriptions of all the members of the health care team, how to communicate with nursing staff, how nursing care is delivered, comfort promotion, therapy procedures for PT, OT, and ST, ordering meals, and discharge planning.

The CNL on 8N/8S has been successful in fostering an environment of collaboration and coordinated care through the implementation and facilitation of the IPC. The development and production of the educational welcome video has provided patients and their families with important information and clearer expectations of care. As a result of the CNL and the IPC, the 8th floor health care team is better able to care for and ease the way for their patients.

IMPLEMENTING STANDARDIZED NURSING EDUCATION AND DOCUMENTATION
FOR PATIENT SWALLOW SCREENS

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Background: The evaluation of a patient's ability to swallow following the diagnosis of Stroke or Transient Ischemic Attack (TIA) is a preliminary step in determining a plan of treatment. **Purpose:** Describe how the Neurological Trauma Care Unit (NTCU) significantly improved the number of staff nurses credentialed in swallow screening, and increased documentation of the patient swallow screen in the nursing notes. **Design:** A Time Series Design using retrospective chart audits was employed to evaluate nursing documentation of the patient swallow screen before and after implementing the improved education process. **Patients:** Eligible patients admitted to the NTCU at risk for failure to swallow were included in the study. **Intervention:** Staff nurses were educated on swallow screening and documentation in relation to the screen. Eligible patients at risk for failure to swallow were evaluated. **Results:** The percentage of nursing staff credentialed in swallow screening on the NTCU increased from 67% to 90% as a result of the improved education process for screening. Following the education for swallow screen chart documentation of the patient screening increased from 54% to 72%. **Limitations:** A small sample size, non-randomized design. **Conclusion:** An increase in nursing staff credentialed for swallow screen was achieved. Staff nurse education led to a marked improvement for completion of swallow screen documentation for the eligible patients.

A MULTIDIMENSIONAL APPROACH TO CURRICULAR MAPPING: CLINICAL NURSE
LEADER EDUCATION MODEL C PROGRAM

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Background: As faculty strive to map courses/content to the BSN Essentials, MSN Essentials, STEEEP principles, QSEN competencies, and Clinical Nurse Leader (CNL) End of Program Competencies for the CNL Education Model C curriculum, it seems to be a daunting task. The faculty at the University of Tennessee Health Science Center (UTHSC) have approached this innovative curriculum review by finding key commonalities among all of these competencies. The STEEEP principles: Safe, Timely, Effective, Efficient, Equitable, and Patient-Centered care were the first to be used to guide curricular development and revision and therefore the first to be mapped.

Method: The faculty of the professional entry into practice program collaborated to develop a template for the course coordinators to map learning outcomes, learning activities (theory and clinical), and evaluations (activities, quizzes, group projects etc.). The template was then customized to capture each of elements of the essentials. The major threads for the CNL curriculum that are required to be integrated throughout the curriculum were then mapped. Faculty participated in an annual retreat to present courses and how the different essentials were integrated into their courses.

Outcome: The curriculum for the Clinical Nurse Leader Education Model C can be viewed multi-dimensionally but revolves around the axis of the IOM's STEEP principles. This curricular schema aids faculty in preventing "curriculum slide" and helps ensure graduates who are prepared to practice as a CNL in dynamic complex work environments.

Recommendations/impact: The curricular mapping and course blueprints provide a guide for faculty who are developing and/or revising courses. Standardized exams and practice certification exams will continue to aide in refining content placement and review of evaluation practices.

One Role, Many Expressions: Successful CNL Student Experiences in Diverse Settings
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Health care reform initiatives, coupled with the needs of the aging population, call for increased need for focused and effective health care delivery within the outpatient and community sectors. Nursing's voice and expertise in health promotion, disease prevention, and chronic disease management are essential for improved national health outcomes. Quality and safety related to healthcare must include patient, family, and community engagement, calling for greater expertise in collaboration and continuity of care delivery within and across diverse healthcare delivery settings. The CNL skill set is ideally suited to provide the necessary leadership for optimizing effective health care outcomes in acute care systems as well as outpatient and community venues.

Successful student clinical experiences will be shared including long term care, residential care, home health care, the medical home model, public health, prenatal care for uninsured migrant workers, faith community nursing, Veteran's Administration outpatient women's health care, and outpatient services for underinsured/uninsured. The congruence of the CNL competencies will be discussed as well as the variations of expression of those competencies within diverse healthcare delivery systems. Facilitators and barriers in operationalizing the role within these settings will be reviewed, as well as lessons learned.

VALIDATION OF ROLE UTILITY FOR THE NEW CNL MODEL

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In March, 2007, to ensure that the customer service scores improved and that performance measures were met at the Cincinnati VAMC, a patient education pilot began on the 6th floor following the 4 medical resident teams. Discharge phone calls and patient education focused on primary diagnoses of the patients. The goal was to improve patient and family education and the implementation of discharge planning. The length of stay decreased and the SHEP scores improved during the 2nd quarter in which the pilot was implemented. The outcome in the 3rd quarter of 2007 showed a positive impact on the customer satisfaction scores. The Congestive Heart Failure performance measure was met due to the patient education focus of the CNLs and the staff nurses at the bedside.

The CNLs role was soon compromised while remaining assigned to the medical resident teams. There was a lack of focus on the medical / surgical units of the hospital and quality indicators suffered from the lack of attention and coordination of care. The complex cases lacked the management needed for discharge follow-through and the amount of time the CNLs spent at the bedside was depleted by various projects and performance measures that were not directly related to nursing or patient care. A re-evaluation of the role occurred in 2008 with recommendations made to have the CNLs assigned to each of the three Medical / Surgical units.

The Clinical Nurse Leaders are currently assigned to each of the three Medical/Surgical units instead of the Medical Resident Teams and a refocus on the patients and their care plans, education and discharge planning has occurred. They focus on nursing quality indicators at the unit level that gives them the opportunity to tailor interventions to the specific units.

The new model of the CNLs will direct their attention to the elevation of the nurses' practice by their involvement in evidence based practice. The CNLs will be mentors and clinical resources for the implementation of change in nursing care at the bedside, documentation changes, patient education and staff education. The microsystem development model will be used to refer the most complex cases to the CNLs for review and the discharge planning associated with the complexities will increase the customer satisfaction and the care received by the Veterans after discharge. Collaboration efforts with the nurse manager and assistant nurse managers on each of the units will enhance both nursing practice and staff satisfaction, decreasing turn-over rates.

The CNL model will be outcome driven using quality and safety measures to affect the staff nurse practice in each of the units with currently assigned CNLs. CNLs will be integrated into Primary Care and the CLC, with additional CNLs placed in the MICU and SICU by 2012. Education for the facility about the CNL role will be done through posters highlighting the results produced by the CNLs on each of the units. A cohesive group of CNLs will meet regularly with the Project Manager and the Chief Nurse to delegate various improvement projects to be implemented throughout the facility based on evidence based practice. The new model of the CNL role will provide a support system for the nursing staff dictating improved nursing performance and patient care through exceeding sustainable targeted quality indicators.

EVIDENCE PRACTICE CHANGE PROJECT: UTILIZING VOLUNTEERS IN A CLINICAL MICROSYSTEM

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Background Information: It was found most staff working on 9B, an Obstetrical High-Risk Unit at Carolinas Medical Center, was dissatisfied primarily with feeling over-worked, the staffing matrix and lack of time to complete assignments during their shift. This unit is unique in that it has tasks that could be completed by non-nursing staff (e.g., by volunteers). Three concepts were measured while enacting this clinical change project in this microsystem. The purpose of this evidence based initiative was to improve nursing productivity, nursing satisfaction and response time/promptness to patient's needs. The three major goals were:

1. The use of volunteers on 9B will increase nursing satisfaction by 10%.
2. The use of volunteers on 9B will increase nursing productivity by 10%.
3. The use of volunteers on 9B will increase the response time/promptness to patient's needs by having 80% of patient's surveyed respond with "excellent."

Methods: Using innovations based in the current state of the science, this project was conducted as an evidence-based practice change project. The pre-volunteer survey was administered before the implementation of the innovation (use of volunteers) and the post-volunteer survey four weeks after. Professional Research Consultants (PRC) recorded the results of the patient telephone survey for response time/promptness in meeting patient's needs pre-volunteers in May and the first month of utilizing the volunteers in June.

Outcomes Data: The results of the surveys and PRC score provided positive feedback that the volunteer program provided benefits for the OB High Risk Unit. Both the pre and post scores of the survey proved staff felt volunteers helped them successfully do their job, although it was not possible to measure the increase due to the wording of the questions. For nursing productivity, the average score for the Pre-Survey was 2.889 compared to the Post-Survey of 3.188, resulting in a 10.35% increase. This achieved the goal of having a 10% increase. The PRC scores from the question, "How would you rate the nurses': Promptness in Responding to (Your/Your Family Member's) Calls? Would you say:" were measured in both May and June. The only result recorded is if the patient responded "excellent." In May, 36.4% of the surveyed patients rated us as "excellent." In June, 76.9% of the surveyed patients rated us as "excellent" for the same question. The implementation of the volunteer program created 111 % increase from May to June in patients' rating the promptness in responding to their calls as excellent.

Summary Recommendations and Impact: This project provides strong evidence for the implementation of a change project utilizing volunteers on an inpatient unit. Even though only three items were measured for the purpose of this research project, many other benefits were seen during the duration of the volunteer implementation. Overall, from the results of this study and other studies it appears that utilizing volunteers can have positive implications for nursing care on an obstetrical high-risk unit. Implementing a volunteer program can be beneficial and rewarding.

Abstract

CONNECTING THE DOTS- CARE COORDINATION OF THE MENTAL HEALTH PATIENT WITH A COMMUNITY PARTNER

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The care of the mental health patient can be challenging due to complex psychosocial needs and physical complications. Inpatient and outpatient services are available for those needing treatment. Due to environment of care safety standards for all inpatient mental health units, the psychiatric unit in the West Palm Beach Veterans Affairs Medical Center (WPB VAMC) was scheduled to close temporarily from February 2010 to June 2010 to allow the completion of the renovations necessary to meet these standards. A contract was established with a community mental health center (CMHC) allowing any veterans requiring inpatient stabilization to be transferred to this facility for services. However, the WPB VAMC was responsible for coordination and provision of outpatient services post discharge. A liaison team consisting of two social workers and a psychiatrist was formed to coordinate these services. This would ensure the same level of care for our veterans during this interim period. For my capstone project I was assigned to work with this liaison team. The following plan was developed to coordinate these services:

- The transfer office staff was charged with handling the flow of information to the CMHC when the veteran is accepted for admission.
- The physician assistant will complete a complete history and physical on each veteran prior to transfer to ensure the veteran is medically stable.
- The liaison team was to follow treatment and progress of veterans transferred to the CMHC on a daily basis to facilitate care post discharge.
- Medications prescribed upon discharge would be filled by pharmacy at the WPB VAMC and delivered to the CMHC prior to the patients discharge.

The use of Deming's PDSA cycle was utilized to evaluate process improvement. A workflow analysis identified several critical issues requiring immediate attention.

- Duplication of work, poor communication among team members resulting in fragmented care, and missed opportunities.
- No process to complete mandatory suicide risk assessments for veterans.
- No process in place to obtain demographics data which is crucial to post discharge care.

A multidisciplinary team meeting was held; roles were clarified and new processes were introduced. This resulted in eliminating duplication of work and improving communication within the team; connecting the dots and coordinating services required to ensure the provision of the quality of care our veterans deserve. In addition were the following improvements:

- An improvement of 73.5% was noted for completion of suicide risk assessments. Pre implementation the rate was 24%, post implementation rate for completion was 97.5%.
- An improvement of data collection for demographic information. Post implementation was 97.5%, pre implementation there was no documentation of data collected.
- A computerized alert system was developed to notify pharmacists of pending discharges.

The addition of a CNL to any team caring for a cohort of patients is recommended. They bring with them a specific skill set, improving communication and coordinating care among providers working in silos, improving outcomes and quality of care.

On Boarding the Clinical Nurse Leader
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As a masters prepared generalist it is common for a Clinical Nurse Leader candidate to be not only a new employee of the unit but also new to a health care entity. Implementing the Clinical Nurse Leader role within any facility requires a structured orientation which allows the candidate to be oriented to the entity and the role. Texas Health Resources has oriented ten Patient Care Facilitators/Clinical Nurse Leaders to not only the unit which they work but also to the system. With plans to double the number of PCF's/CNL's in the coming year, lessons learned from both failed and successful orientations have shown a structured orientation enhances the success of the role on any unit. This presentation is designed to discuss the general orientation needs of the clinical nurse leader and demonstrate successful integration of the role despite variances related to entity size. Key topics that will be addressed are things the clinical nurse leader needs to know before entering the role; planning the key personnel the clinical nurse leader needs to meet and spend time with, and crucial tasks for On Boarding the clinical nurse leader when they arrive on the unit.

VIDEOCONFERENCING ACADEMIC CNL PROGRAM AND SOLUTIONS FOR MARKETING

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Background: Xavier University, School of Nursing was awarded \$1,488,825.00 in 2009 from Health Resources and Services Administration to establish a graduate program in rural areas throughout Ohio for the purpose of preparing nurses with advanced degrees in the role of the Clinical Nurse Leader (CNL) through video-conferencing. To date, five rural sites have video-conferencing equipment deployed to their hospital or long term care facility. The video-conferencing equipment is installed in board rooms, conference areas or classrooms for the rural nurses to attend classes taught live at Xavier. Real-time/faculty-time allows these nurses to interact with the faculty during the class and with each other at the distant sites as well as the nurses located on-site at Xavier. Unexpected problems include the installation of videoconferencing technology that runs flawlessly and the need for on-going aggressive marketing of the program to individuals located in distant areas where Xavier does not have personnel located. The needs to deploy the appropriate equipment that matches site capabilities and to establish a sustainable long-distance aggressive marketing plan are explored. Outcome Data: Distinction between hi-definition and standard definition equipment and which works best in various settings is identified. Band width and bridges are required to make systems work flawlessly. An undergraduate business marketing class project was established in the business college in a partnership with the nursing school videoconferencing project to address distant marketing solutions. Initial publication costs, information sessions, and travel costs total over \$25,000.00 for a yield of 35 students of whom none are from minority populations. Student satisfaction varies with the quality of the audio-video equipment. The marketing plan is designed to create an innovative way to reach out to nurses in distant sites in a way that is meaningful to them. The goals of the plan are to inform rural areas of the program and the role of the CNL, increase enrollment to at least five students each year at each site, increase student satisfaction, increase diversity of students and improve communications and networking with different sites. Description of Methods: Consultation from various groups to identify problems with the videoconferencing equipment. A state-wide E-tech center provided valuable insight to the use of bridge systems. The marketing faculty requires for class projects the development of a marketing plan for a non-profit organization. Debbie Davis presented the videoconferencing project to the fall 2010 marketing class. Students are guided by their marketing professor, Dr. Thomas Hayes, to apply marketing concepts to the plan they develop and students meet regularly with D. Davis. The final plan will be presented in January at the CNL conference. Impact: Universities throughout the nation are struggling with the preparation of and marketing of the CNL role. Challenges are largely driven by the fact that the role is new to health care and requires a transformation of delivery services to establish the role in healthcare settings. A parallel effort needs to be made in which schools prepare a critical mass of qualified CNL nurses to be available for employment across the nation in all geographic areas. Establishment of videoconferencing methodology will be shared. Insight of a marketing strategy established by a new generation of marketing students may be an excellent example for others to follow.

Double Check: Medication Safety in the Pediatric Intensive Care Unit

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Background Information

In a report by The Institute of Medicine (IOM) in 2000, entitled *To Err is Human: Building a Safer Health System*, they estimated that medication errors alone account for 6,000 – 7,000 patient deaths annually (IOM). Although there is little data on medication safety in pediatric populations, one study found that medication errors and adverse drug events (ADEs), both actual and potential, in this population were very common (Kaushal et al. 2001). Complex pediatric calculations like weight-based dosing and dilution of many standard concentrations contribute to the risk of ADEs (Kaushal et al. 2001). In the intensive care setting, these errors are of increasing importance, because they are not only more likely, but are often more dangerous and more costly (Kaushal et al. 2007). Nurses play an important role in double-checking safe dosing and calculations before administering the medication to the patient.

The first goal of this project, implemented with new graduate RNs in the pediatric intensive care unit (PICU) at the Ronald Reagan UCLA Medical Center, was to provide education to new graduate nurses on the importance of medication safety from an ethical and financial perspective. The second goal was to provide new graduate nurses with a resource they could use on a daily basis to assist them with safe calculations: a medication safety badge card with standard pediatric dosing formulas and safe dosage ranges of post-resuscitation maintenance medications. The clinical nurse leader (CNL) role that was utilized for this project was that of the educator, a role in which the CNL provides teaching on current evidence and appropriate materials to facilitate learning.

Outcome Data

Of the new graduate participants (n = 7), 100% completed a pre-project survey and 72% completed a post-project survey. On the pre-project survey, 100% of the seven new grads surveyed either agreed or strongly agreed that the education session was helpful. On the post-project survey, respondents either agreed or strongly agreed that the medication card was helpful to them in ensuring accurate calculations. On the pre-project survey only one new graduate nurse indicated she strongly agreed she was very comfortable with pediatric drug calculations. On the post-project survey, this number increased to two.

Description of Methods

This project utilized the Rosswurm and Larrabee model for evidence-based practice to guide the methodology. After determining the needs of the unit through assessment, the next steps were to link the problem with potential solutions, synthesize the available evidence, plan and implement the project, evaluate its effectiveness, and integrate it into practice (Rosswurm & Larrabee, 1999).

Summary of Recommendations and Impact

The data results point to the potential positive impact of this kind of resource for new graduate nurses in the PICU setting. In the future, this project could be implemented with a larger sample size of new graduates from the PICU and other pediatric areas for better outcome measurement. Medication safety interventions like this one may also be broadened to include nurses of vary levels of experience and better measurement of their effect on patient safety outcomes.

IMPLEMENTATION OF A FAST TRACK BOWEL PROGRAM AND
THE IMPACT ON LENGTH OF STAY
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A fast track bowel program is used to guide an elective non-emergent colorectal surgical patient's care. Fast-track bowel pathways provide standardized orders that all of the participating physicians follow. Nursing plays a vital role in the patient's recovery. The purpose of this student Clinical Nurse Leader study, currently in progress, is to examine if focused education for the nursing staff regarding the fast-track bowel pathway impacts length of stay and respective associated costs for patients undergoing elective bowel surgery. IRB approval for this intervention study utilizing retrospective review of charts has been received. The student Clinical Nurse Leader using a fast track bowel program data collection tool reviewed thirty charts of patients who had an elective bowel surgery in 2009. Once the order sets were completed in collaboration with the physicians, the student Clinical Nurse Leader held focused education sessions on the fast track bowel program including the essential nursing factors which have the potential to reduce the patient's length of stay. These nursing factors include implementation and documentation of: incentive spirometry, ambulation, and foley catheter days. After discharge, the study participant's chart will be reviewed and data will be collected using the data collection tool. Once thirty patient charts have been analyzed, the information will be compared to the data analysis from 2009 charts to determine if focused nursing education regarding a fast-track bowel program decreased the length of stay for patients undergoing an elective bowel surgery. Frequency statistics will be employed to report demographic data. Interval or ratio data will be reported with means and standard deviations. Chi square statistics will be used for comparison regarding incentive spirometry use, activity, and foley catheter use before and after the clinical nurse leader facilitated intervention. A two way ANOVA will be used to examine impact of incentive spirometry use, activity, and foley catheter use on length of stay for the pre and post data groups. Findings from this study will yield insights regarding whether or not the length of stay and respective cost avoidance for elective bowel surgery patients is impacted by Clinical Nurse Leader implementation of focused nurse education.

MONITORED HOURLY ROUNDING

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Purpose: The purpose of this project was to improve the hourly rounding process on a medical unit at Carolinas Medical Center in North Carolina. Hourly rounding was currently practiced on the medical unit (3T) and nursing presence was documented on a paper log at each patient's bedside. The proposed intervention included a way to monitor nursing presence using an existing feature of the current call light system.

Background/Rationale: On a medical unit (3T) at Carolinas Medical Center the 2009 data for falls per 1000 patient days indicated an average of 8 falls per month. The Professional Research Consultants (PRC) 2009 data specific to 3T indicated overall quality of nursing care rated as 58% excellent, pain management by staff rated 39.6% excellent, and overall safety rated 53% excellent. These results indicated a decrease in patient safety and satisfaction related to nursing presence. Patient safety and satisfaction depends largely on the patient's perception of nursing presence which consequently affects fall rates, patient satisfaction, and frequency of call light use. Hourly rounding performed by nursing staff is a common intervention used today to meet patients' comfort, safety, quality, and environmental needs.

Description of the Practice Change: The proposed intervention provided education for the nursing staff on the importance of consistent hourly rounding and included a way to monitor nursing presence. The hourly rounding process was monitored with a presence indicator and an hourly reminder was sent to the nursing staff's handheld phone if nursing presence was not identified each hour. The intercom piece of the call light system located on the wall behind each patient's bed has punch buttons available to indicate nursing presence. When touched one time a light comes on and nursing presence is indicated; when touched again the light turns off indicating departure. Touching the button in this manner does not trigger the call bell at the nursing station, but nursing presence was recorded within the system and transferred onto the call light report log. If nursing presence was not identified each hour an hourly reminder alert was sent to the RN responsible for the patient via their handheld phone. The reminder alert was also recorded within the system and transferred onto the call light report log for further review.

Outcome Results: From May 2010 to July 2010 fall rates, patient satisfaction, and call light frequency were all improved. Fall rates reduced 39%, call light frequency reduced 35%, and patient satisfaction scores related to all three areas of concern increased. Overall quality of nursing care increased 14%, pain management by staff increased 15.9%, and overall level of safety increased 14.3%.

Conclusions: Monitoring the hourly rounding process can assist nursing staff by providing reminder alerts when necessary to ensure ongoing safety and security. The use of monitored hourly rounding on this medical unit decreased fall rates, increased patient satisfaction, and decreased the frequency of call light use. Based on these results, recommendations have been made to standardize this practice change throughout the entire hospital to improve patient safety and satisfaction.

Clinical Relevance: Safety practices like monitored hourly rounding can result in positive patient outcomes. Through interventions such as monitored hourly rounding nursing staff can decrease patients' anxiety and improve patients' perception of nursing care evidenced by the outcome results.

**IMPLEMENTING EVIDENCE BASED PRACTICE: USING A FALLS TYPOLOGY TO
PRESCRIBE NURSING INTERVENTIONS THAT PREVENT FALLS**

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Background: Patient falls remain among the most commonly reported incidents in hospital settings, with approximately four falls occurring per 1,000 patient bed days. There is strong evidence that proper assessment and nurse-led interventions improve patient fall rates.

Clinical observation and expert consultation noted that falls assessments were completed when falls occur and that fall prevention interventions were deployed. Post-fall huddles and analyses of data about the falls were also completed for falls, but the match of proper intervention to specific fall type was not being carried out. This quality improvement project helped staff implement evidence by matching patient fall typology to an evidence-based intervention.

Falls typology is drawn from a nursing assessment combining the items in the Morse Falls Scale, the patient's history, diagnoses, and the environment to elicit three types of falls: accidental, anticipated physiological, and unanticipated physiological. Each fall type has evidence-based specific nursing interventions that can be implemented and further tailored to the particular patient population and hospital setting.

Outcome data: Pre-intervention, only 24% of patient falls were categorized on Post Fall Huddle/After Action Reports and of the 24%, only half were categorized correctly. After intervention, 80% of patient falls have been categorized correctly and staff is now aware of the most common types of falls currently occurring on their unit.

Method: A comprehensive review of patient fall reports on the cardiac-telemetry unit over a ten-month span classified the reports according to specific fall type. This unit-specific data was shared with staff who then were presented with the evidence about the typology system and its implementation. Post-education quizzes, role playing, case studies, and rewards for proper assessment when an actual incident occurred were teaching-learning methods used to present the evidence. Literature was reviewed to identify and "package" clinical practices to avoid the most common types of falls.

Summary recommendations and impact: Currently, staff is evaluating the most effective evidence-based interventions to implement for their most common patient populations and most common types of falls. Once further evaluation is complete and proper interventions are utilized, fall rates will be examined to validate typology as a predictor of effective patient falls prevention interventions.

IMPROVING PRN EFFECTIVENESS DOCUMENTATION
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Purpose and Discussion

PRN medications are routinely prescribed to patients for pain, nausea, constipation, etc. Because these medications are given on an as needed basis, the documentation of their effectiveness is one of the most crucial aspects of patient care. Although prescribed by Physicians, it is the responsibility of the Nurse to ensure that PRN medications are effective in treating the conditions for which they were prescribed. This can be done by periodic and timely follow-up assessment and documentation of the PRN medication effectiveness.

At the Charlie Norwood VAMC, timely documentation is defined as within two hours of administration for pain medications and within 24 hours of administration for all other medications. The documentation of PRN effectiveness provides the provider with the information needed to make informed patient care decisions.

Methods and Findings

An initial evaluation of PRN effectiveness in August 2009, by this CNL found a low compliance rate of PRN effectiveness documentation at 5% on one unit. A fact finding investigation was initiated to assess from staff the reasons for decreased compliance with documentation. The responses ranged from nurses being too busy to document PRN effectiveness to the process being too cumbersome and time-consuming. The CNL discussed the problem further with Nurse Managers and a decision was made by the Nurse Managers for the CNL to create an awareness education campaign for all units. This involved an in-service being conducted with nursing staff on the involved units. The nurses were provided with best practice information explaining the reason for and importance of timely documentation of PRN effectiveness. Use of the Limited Access feature in BCMA was also reviewed for documentation of PRN effectiveness allowing staff to use any computer terminal. Reminder posters were posted on all units and a flyer displaying the steps in documenting PRN effectiveness was created for nursing staff. Nurse Managers, working with the CNLs, implemented a Microsystem process change to have the unit Charge Nurse on each shift print a PRN effectiveness report every two hours and to follow-up with staff to ensure that proper documentation was completed. Weekly reports were compiled by CNLs and displayed in an Excel spreadsheet/chart, sent to unit Nurse Managers. Staffs were kept informed of their progress by posting outcomes on the units detailing their improvements in documentation.

Although progress in the beginning was slow, documentation improved 80% for the initial lowest reporting unit to up to 100% for others. This change in practice brought the facility's compliance average up to 90%. Additional reminders have been posted on units, and when necessary, individual staff members were provided personal guidance by the Nurse Managers and/or CNLs. Progress continues to be made and CNLs continue to periodically monitor compliance and provide education when needed.

Evaluation of the Use of Health 2.0 Tools: Implications for CNL Role Development

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As the use of information technology in healthcare environments increases, the Clinical Nurse Leader (CNL) will be expected to utilize Health 2.0 tools to provide patient care and promote evidence-based practice. For this study, Health 2.0 was defined as the participatory healthcare environment that is enabled with software, technology, and the Internet. Educating colleagues and patients about best practices and treatments can lead to improved patient outcomes. One of the fundamental aspects of the CNL role is “management and use of client-care and information technology” (AACN, 2007). Reports from the literature suggest the interactive web empowers the healthcare consumer and provides just-in-time information for both. It is essential that the CNL effectively and efficiently manage information relative to clinical decision making. One of the assumptions for the preparation of the CNL is that communication technology will facilitate the continuity and comprehensiveness of care.

There is little data about how healthcare providers and consumers are using Health 2.0 tools for healthcare purposes. However, there is current evidence that suggests the internet and the use of technology enhances healthcare delivery and patient outcomes. Healthcare providers will increasingly be expected to use electronic medical records and technology for communication purposes with patients and other health care providers. Thus, the CNL must be proficient in utilizing a variety of Health 2.0 tools in overseeing the care of a cohort of patients. The purpose of this study was to assess how healthcare providers are using Health 2.0 in their everyday practice. This research project is part of a larger, multi-site study being coordinated by colleagues at several other universities. The following research questions guided the study:

1. What Health 2.0 tools do healthcare consumers and healthcare workers use for personal use?
2. What Health 2.0 tools do healthcare consumers and healthcare workers use for healthcare?
3. How do healthcare consumers and healthcare workers utilize Health 2.0 tools for personal use?
4. How do healthcare consumers and healthcare workers utilize Health 2.0 tools for healthcare?

A commercial survey platform was used to collect data from participants. Surveys were distributed via an electronic link (using the institution’s intranet) to all employees at a 282 bed regional nonprofit acute care hospital in Northwest Georgia. The survey instrument contained 33 items addressing use of Health 2.0. Approximately 350 surveys were completed by the participants. Data analysis is in process and will be completed by the time of the presentation. The findings from this study should help identify the level of use and knowledge of Health 2.0 tools among healthcare providers and consumers. These findings should help guide the design of appropriate educational and other interventions using Health 2.0 tools. Health care outcomes should be enhanced with the use of Health 2.0 tools that are geared to the health and computer literacy levels of consumers. The ways that CNLs incorporate the use of Health 2.0 tools into traditional healthcare systems will influence service delivery and patient/provider relationships as they now exist. The CNL must be prepared to act as a leader within the organization by modeling proficiency in technology and sharing this information with the interdisciplinary team.

REDUCING THE PERCENTAGE OF HEART FAILURE PATIENTS READMITTED TO
THE HOSPITAL WITHIN 30 DAYS OF DISCHARGE: A SYSTEM REDESIGN PROJECT

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The VA provides care for approximately 240,000 veterans with heart failure and in 2005 over 42,000 of these veterans were hospitalized with a primary diagnosis of heart failure. The goal of this system redesign team was to reduce the percentage of these patients who are readmitted within 30 days of their discharge. This system redesign team is a multidisciplinary team formed to review the current practices for heart failure patients, review the process for areas of weakness and propose solutions to ensure proper treatment and follow up for heart failure patients. The core of the system redesign team consists of nine members including a hospitalist, RN's from Primary Care, Home Based Primary Care, Care Coordination, Quality Management and Clinical Nurse Leaders (CNL's); additional input is drawn from Cardiology and Primary Care Physicians. Particular areas that were identified as disruptions in a patient's continuum of care were in-house education and timely follow up care. Several changes were made in the care, education and follow up for heart failure patients, including evidence based order sets, education for all heart failure exacerbation patients provided by CNL's, the addition of an outpatient heart failure SIGMA (Scheduled In Group Medical Appointment), and post-discharge appointments with a PCRM (Patient Care Resource Manager) and PCP (Primary Care Provider) made prior to discharge. These changes were implemented in FY2009 Q4 and have resulted in a drop in 30-day all-cause readmission rates for patients originally admitted for a heart failure exacerbation from 31.39% in FY2009 Q3 to 18.38% in FY2010 Q3. Through this system redesign team, various departments serving the heart failure population are now working together to ensure continuity of patient care from inpatient admission through outpatient follow-up.

Clinical Nurse Leader Student Projects: Step-by-step success
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The American Association of Colleges of Nursing provides clear End-of-Program competencies for the education of CNL and faculty are tasked with developing learning experiences to meet the competencies. University of Portland School of Nursing has developed a process of students conducting a quality improvement project during their 3 semester, 500 hours of clinical experiences to meet multiple CNL competencies. The project is designed to facilitate evidence-based organizational change identified through a systematic assessment of the microsystem. Projects integrate best practices, principles of effective leadership and negotiation skills, use of information systems to evaluate patient outcomes, and theories of organizational behavior in the design of their project. Examples of student projects may include evaluating and/or modifying current practice standards, increasing clinical application of evidence-based interventions, or adapting or designing a research based intervention. Student projects culminate in both a oral presentation and a scholarly paper written using the SQUIRE Guidelines for quality improvement reporting.

This presentation will discuss the step-by-step process of how to guide students through their clinical projects. Success stories and “speed bumps” that slow students down will be discussed. University of Portland CNL students have conducted a wide variety of projects. In the Inpatient setting projects include but are limited to: Falls, CAUTIs, pressure ulcer prevention, pain (post op and pain in dementia patients), early sepsis identification, medication safety projects, implementing a CIWA scale, bedside rounding, and sternal precaution education. Community –based projects include: hypertension care in Veterans and in Vietnamese population, providing evidence-based patient education materials in the Community Health Department.

Four cohorts of students (N= 40) have completed the 500 hours of clinical and their quality improvement projects. The feedback from students is consistently positive at the end of the process. University of Portland has a 95% first-time pass rate on the CNL exam, with 100% participation by our graduates, who are a mix of Model A and Model C students. The feedback from our clinical practice partners is equally positive.