



CNL Summit 2012

ABSTRACT PRESENTATIONS

January 20, 2012

CNL Summit

Hyatt Regency Tampa

Abstract Presentation Schedule- by Room

Friday, January 20, 2012

BUCCANEER A

3:00 p.m.

CNL Partnership for Improvement: Rapid Recovery Ambulation Program

LaDonna Adkins RN, MSN, CNL

Central Texas Veterans Health Care System

Temple, Texas

Email: LaDonna.Adkins@va.gov

3:30 p.m.

A New Approach to the Prevention of Central Line Associated Bloodstream Infections in Pediatric Intensive Care Unit

Kentlee Battick RN, BSN, CCRN, CNL Student

All Children's Hospital

Saint Petersburg, Florida

Email: Kentlee.Battick@allkids.org

4:00 p.m.

Using Environmental Scanning as a Strategic Approach to Improve Outcomes in Complex Health Care Systems

Patricia Bicknell, Ed D, APRN, ACNS-BC, CNL

La Salle University

Philadelphia, PA

Email: bicknell@lasalle.edu

4:30 p.m.

C-RISE: An Evidence Based Approach to Diabetes Compliance in Adolescence

Barnes, S., Bird, L., Brown, E., Kachman, A., Petree, K., Rapp, T., (MSN-CNL Students)

The University of Tennessee Health Science Center

Memphis, Tennessee

Email: ltarbox@uthsc.edu

BUCCANEER B

3:00 p.m.

Implementation of the CNL Role: An Innovative Approach

Debra Adornetto-Garcia, MSN, RN, AOCN, NEA-BC; Barbara L. Summers, PhD, RN, NEA-BC, FAAN; Ginny Bowman, MSN, RN, CNS-Onc, AOCNS, CORLN; Deborah Cline, MSN, RN, OCN

The University of Texas MD Anderson Cancer Center

Houston, TX

Email: dadornet@mdanderson.org

3:30 p.m.

Interdisciplinary Collaboration: the Role of the CNL

Miriam Bender MSN, RN, CNL
Sharp Healthcare
San Diego CA
Email: Miriam.bender@sharp.com

4:00 p.m.

Clinical Nurse Leader: Implementation of the role and the impact on nursing sensitive outcomes

Annamarie Chavarria, MSN, RN, Michele Wolf, MSN, RN, CNL, & Michelle Feil, MSN, RN
Abington Memorial Hospital
Abington, Pennsylvania
Email: achavarria@amh.org

4:30 p.m.

Evolution of the Clinical Nurse Leader: Inauguration to Influence

Lynn Drummond-Smith, MS, RN, CNL; David N. Alexandrou, MS, RN, CNL; Lorraine R. Kaack, MS, RN-BC, CNL; Hermes O. Vargas, MS, MBA, RN-BC, CCRN, CMC, CNL; Frances M. Zarella, MS, RN, CNL.
James A. Haley Veterans' Hospital
Tampa, FL.
Email: lynn.drummond-smith@va.gov

BUCCANEER C

3:00 p.m.

CNL Outcomes in the Pediatric Inpatient Unit

Kathryn Caiazzo, RN, MS, CNL
Maine Medical Center
Portland, Maine
Email: caiazk1@mmc.org

3:30 p.m.

Under Pressure: Decreasing Device-Related Pressure Ulcers in the ICU

Ann Deerhake, MS, RN, CNL, CCRN
St. Rita's Medical Center
Lima, OH
Email: adeerhake@gmail.com

4:00 p.m.

Improving Incentive Spirometry Performance among Children with Sickle Cell Disease in a Pediatric In-Patient Setting

Brittany Cardell, MSN, CNL; Leslie McKeon, PhD, CNL, NEA-BC; & Sherry Webb, DNSc, CNL, NEA-BC
LeBonheur and UTHSC
Memphis, TN
Email: cardellb@lebonheur.org

4:30 p.m.

Clinical Nurse Leader: Implements “The Daily Plan” at VA Connecticut to Improve Veteran Safety and Team Communication

Bonnie Haupt, MSN, RN, CNL-BC
VA Connecticut Healthcare System
West Haven, CT
Email: Bonnie.Haupt@VA.GOV

BUCCANEER D

3:00 p.m.

Clinical Nurse Leader: Role development, Implementation and Expansion

Kari Hamson-Kalis MSN, RN, CNL; Shannon Hulett MSN, RN, CNL
Gundersen Lutheran Medical Center
LaCrosse, Wisconsin
Email: kmhamson@gundluth.org

3:30 p.m.

Partnering: Ensuring a successful academic partnership

Deborah Cline, MSN, RN, OCN; Barbara L. Summers, PhD, RN, NEA-BC, FAAN; Debra Adornetto-Garcia, MSN, RN, AOCN, NEA-BC; Ginny Bowman, MSN, RN. CNS-Onc, AOCNS, CORLN
The University of Texas MD Anderson Cancer Center
Houston, TX
Email: dbcline@mdanderson.org

4:00 p.m

Evolution into Practice: A CNL Residency Program

Mary E. Mather, MSN, RN, CNL;
South Texas Veterans Healthcare System
San Antonio, Texas
Email: Mary.Mather@va.gov

4:30 p.m.

Facilitating Model C CNL Students Transition to Practice through a Better Understanding of the CNL Role

L. McKeon PhD, CNL; S. Webb, DNSc, CNL, NEA-BC; S. Strange-McClora, MSN, CNL; M. Elliott-Vizcarrondo, MSN, CNL; D. Pavlic, MSN DNPc, CNL; M. Gill, MSN, PhD
University of Tennessee Health Science Center, Memphis Veterans Administration Medical Center, University of San Francisco
Memphis, TN, San Francisco, CA
Email: lmckeon@uthsc.edu

YBOR ROOM

3:00 p.m.

Bringing Evidence-Based Practice on Delirium to a CLC unit

Brandi Fagner, MSN, RN, CNL

Central Texas Veterans Healthcare System-Waco VA Medical Center

Waco, Texas

Email: brandi.fagner@va.gov

3:30 p.m.

A Coronary Artery Bypass Grafting (CABG) and/or Valve Surgery Interdisciplinary Clinical Pathway; Achieving Improved Patient Outcomes through a Highly Functional Team

Jamie Gilliam, RN, MSN, CNL, CCRN

Malcom Randall VAMC, NF/SG VHS

Gainesville, FL

Email: Jamie.Gilliam@va.gov

4:00 p.m.

Improving Outcomes through Discharge Phone Calls

Karen Giovengo, MSN, RN, CNL / Heather Garrison, MSN, RN, CNL

St. Lucie Medical Center

Port St. Lucie, Florida

Email: karen.giovengo@hcahealthcare.com

4:30 p.m.

Leveraging Technology: Development and application of electronic tools to efficaciously manage care and decrease fragmentation

Kari Hamson-Kalis MSN, RN, CNL; Shannon Hulett MSN, RN, CNL

Gundersen Lutheran Medical Center

LaCrosse, Wisconsin

Email: kmhamson@gundluth.org

ESPLANADE 1

3:00 p.m.

Defining the CNL Role in the Emergency Department: The Nurse Manager and CNL Dyad

James Herrada MA, RN and Janine Decker MSN, RN, CNL

VA New Jersey Health Care System

East Orange, NJ 07848

Email: James.Herrada@va.gov

3:30 p.m.

The Impact of the Clinical Nurse Leader Role in Improving the Number Deaths Reported to the Facility's Organ and Tissue Procurement Agency

Linda Abercrombie, MSN, RN, CCF, Jackie R. Jacobson, MSN, RN, CNL; Francine Jamison, MSN, RN, CCF, Lynett King, MSN, RN, CNL; Christina McCullough, BSN, RN, CCF, Norma Patterson, MSN, RN, CCF

Tennessee Valley Healthcare System

Nashville, Tennessee

Email: Francine.jamison@va.gov

4:00 p.m.

Improving MRSA Nasal Screens

Paula Lavine-Smartt, MSN, RN, CNL
VA New Jersey Health Care System
East Orange, New Jersey
Email: paula.lavine-smartt@va.gov

4:30 p.m.

Enhancing Prelicensure CNL Problem Solving Skills: Use of the Fishbone Analysis

Lynn D Mohr MS APN PCNS-BC CPN
Rush University College of Nursing
Chicago, IL
Email: Lynn_Mohr@rush.edu

ESPLANADE 2

3:00 p.m.

Using WIKIS to facilitate group work on unfolding case studies for CNL students in an Accelerated Masters CNL program.

Kristine L'Ecuyer, RN, MSN, CCNS, CNL, Bobbi Shatto, MSN, RN, CNL, Geralyn Meyer, PhD, RN, CNL, and Rita Wunderlich, PhD, RN
Saint Louis University School of Nursing
St. Louis, MO
Email: Lecuyer@slu.edu

3:30 p.m.

Using Narratives to Illustrate Philosophy of Nursing Practice

Jean Logan, RN, PhD
Grand View University
Des Moines, Iowa
Email: jlogan@grandview.edu

4:00 p.m.

Maximizing the Clinical Immersion Experience and Project Development: Student, Preceptor, and Faculty Collaboration

Linda Roussel, DSN, RN, CNL; Cheryl Robinson, DNS, RN, CRNP
University of South Alabama College of Nursing
Mobile, AL
Email: lroussel@usouthal.edu

4:30 p.m.

CNL Student Projects: From Assessment Through Dissemination

Teri Moser Woo PhD, RN, CNL, CPNP
University of Portland School of Nursing
Portland, OR
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ESPLANADE 3

3:00 p.m.

Starting a Model C Program: Lessons Learned

Geralyn Meyer, PhD, RN, CNL, Kris L'Ecuyer, MSN, RN, CNL, Bobbi Shatto, MSN, RN, CNL

Saint Louis University School of Nursing

St. Louis, MO

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3:30 p.m.

Navigating the Model C Curriculum: Innovative Strategies for Individuals from Disadvantaged Backgrounds

Tommie L. Norris, DNS, RN; Patricia A. Cowan, PhD; Mona N. Wicks, PhD, RN, FAAN

Susan R. Jacob, PhD, RN; E. Erwin Story, MBA

The University of Tennessee Health Science Center (UTHSC)

Memphis, TN

Email: tnorris4@uthsc.edu

4:00 p.m.

Standing Up the VA Clinical Nurse Leader Implementation & Evaluation Service

Marjory D. Williams, PhD, RN

VHA Office of Nursing Services & Central Texas Veterans Health Care System

Temple, Texas

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4:30 p.m.

How Does an Organization Sustain the CNL Role? ... Sustain the CNL

Susan Wilkinson, MSN, RN, CNL

St. Vincent's East

Birmingham, AL

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REGENCY 2

3:00 p.m.

Transforming Care of the Patient by Caring for Our Own: A CNL Educational Initiative for Reducing Stress in New Perioperative Nurses

Daniel Nadeau, MSN, RN, CNL

UCLA Health System

Los Angeles, CA

Email: dnadeau@ucla.edu

3:30 p.m.

Clinical Nurse Leader (CNL) and a multi-pronged approach to improving care for the high risk, low volume patient

Sonja Orff RN, MS, CNL

Maine Medical Center

Portland, Maine

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4:00 p.m.

Changing Practice of Medication Documentation: A CNL approach to motivating accountability

Anne Marie Richmond MSN RN CNL, Carolyn Johnson MSN RN CNL CNRN, Elizabeth Triezenberg MSN RN CNL CNRN, Lauran Stuive-Bittinger MSN RN CNL CHPN, , Carrie Mull, BSN, RN, RN-BC (P-MH, GRN)

Saint Mary's Health Care

Grand Rapids, Michigan

Email: parkerrj@trinity-health.org

4:30 p.m.

Clinical Nurse Leader Impact On Methicillin-Resistant Staphylococcus Aureus Infection Rates

Jackie Rae Jacobson, RN, MSN, OCN, CNL, Lynett King, RN, MSN, CNL,

Norma Patterson, RN, MSN, Linda C. Abercrombie, RN MSN, Francine Jamison RN, MSN, Christina McCullough, RN, BSN, CCRN

Tennessee Valley Healthcare System

Nashville, Tennessee

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REGENCY 5-7

3:00 p.m.

The Impact of the Clinical Nurse Leader role on Quality Outcomes

Cynthia Pearsall MSN, NEA-BC, RN & Robin Sheets, MSN, APRN, CNL, RN

Fairfield Medical Center

Lancaster, OH

Email: Cynthiap@fmchealth.org

3:30 p.m.

Using Data to Determine Patient Rounding Strategies: A Unique Fall Prevention Program

Megan Rafferty MSN, RN-BC, CNL

Abington Memorial Hospital

Abington, PA

Email: mrafferty@amh.org

4:00 p.m.

The Diabetic Post Hospital Telephonic Health Follow-up Pilot Study

Veronica Rankin RN, MSN, CMSRN, CNL

Carolinas Healthcare System

Charlotte/ North Carolina

Email: vrankin99@yahoo.com

4:30 p.m.

Clinical Nurse Leader: The Strategic Advantage in Transforming Nursing Practice

Barbara L. Summers, PhD, RN, NEA-BC, FAAN; Debra Adornetto-Garcia, MSN, RN, AOCN, NEA-BC; Beverly Nelson, PhD, RN, NEA-BC; Ginny Bowman, MSN, RN, CNS-Onc, AOCNS, CORLN; Deborah Cline, MSN, RN, OCN

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Houston, Texas

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CNL Summit

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Abstract Presentation Schedule - By Session **Friday, January 20, 2012**

3 p.m.

Buccaneer A

CNL Partnership for Improvement: Rapid Recovery Ambulation Program

LaDonna Adkins RN, MSN, CNL

Central Texas Veterans Health Care System

Temple, Texas

Email: LaDonna.Adkins@va.gov

Buccaneer B

Implementation of the CNL Role: An Innovative Approach

Debra Adornetto-Garcia, MSN, RN, AOCN, NEA-BC; Barbara L. Summers, PhD, RN, NEA-BC, FAAN; Ginny Bowman, MSN, RN, CNS-Onc, AOCNS, CORLN; Deborah Cline, MSN, RN, OCN

The University of Texas MD Anderson Cancer Center

Houston, TX

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Buccaneer C

CNL Outcomes in the Pediatric Inpatient Unit

Kathryn Caiazzo, RN, MS, CNL

Maine Medical Center

Portland, Maine

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Buccaneer D

Clinical Nurse Leader: Role development, Implementation and Expansion

Kari Hamson-Kalis MSN, RN, CNL; Shannon Hulett MSN, RN, CNL

Gundersen Lutheran Medical Center

LaCrosse, Wisconsin

Email: kmhamson@gundluth.org

Ybor Room

Bringing Evidence-Based Practice on Delirium to a CLC unit

Brandi Fagner, MSN, RN, CNL

Central Texas Veterans Healthcare System-Waco VA Medical Center

Waco, Texas

Email: brandi.fagner@va.gov

Esplanade 1

Defining the CNL Role in the Emergency Department: The Nurse Manager and CNL Dyad

James Herrada MA, RN and Janine Decker MSN, RN, CNL

VA New Jersey Health Care System

East Orange, NJ 07848

Email: James.Herrada@va.gov

Esplanade 2

Using WIKIS to facilitate group work on unfolding case studies for CNL students in an Accelerated Masters CNL program.

Kristine L'Ecuyer, RN, MSN, CCNS, CNL, Bobbi Shatto, MSN, RN, CNL, Geralyn Meyer, PhD, RN, CNL, and Rita Wunderlich, PhD, RN

Saint Louis University School of Nursing

St. Louis, MO

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Esplanade 3

Starting a Model C Program: Lessons Learned

Geralyn Meyer, PhD, RN, CNL, Kris L'Ecuyer, MSN, RN, CNL, Bobbi Shatto, MSN, RN, CNL

Saint Louis University School of Nursing

St. Louis, MO

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Regency 2

Transforming Care of the Patient by Caring for Our Own: A CNL Educational Initiative for Reducing Stress in New Perioperative Nurses

Daniel Nadeau, MSN, RN, CNL

UCLA Health System

Los Angeles, CA

Email: dnadeau@ucla.edu

Regency 5-7

The Impact of the Clinical Nurse Leader role on Quality Outcomes

Cynthia Pearsall MSN, NEA-BC, RN & Robin Sheets, MSN, APRN, CNL, RN

Fairfield Medical Center

Lancaster, OH

Email: Cynthiap@fmchealth.org

Abstract title: CNL Partnership for Improvement: Rapid Recovery Ambulation Program
Authors/credentials: LaDonna Adkins RN, MSN, CNL
Institution: Central Texas Veterans Health Care System
City/State: Temple, Texas
Primary Contact Email: LaDonna.Adkins@va.gov

Background Information: Central Texas Veterans Health Care System (CTVHCS) is an integrated health care system providing inpatient and outpatient care to veterans across a large and diverse geographic area comprised of thirty-eight counties in the center of Texas. CTVHCS is a major provider of health care for combat veterans from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) with close proximity to Ft. Hood. One of the microsystems that is part of this integrated continuum of care is a 28-bed medical/surgical unit in the Temple hospital facility. The CNL role was implemented in this microsystem in April, 2009 and has been instrumental in improving patient outcomes on this floor. As part of an ongoing assessment of the microsystem, the CNL determined that surgeons and surgical residents had concerns regarding the ambulation of patients post operatively. A follow-up initial chart review showed insufficient and/or inconsistent nursing documentation, as well as orders that were not specific or lacking regarding ambulation/activity. A review of the literature substantiated that early and frequent ambulation/mobilization is essential to preventing venous thromboembolism and to reducing the occurrence of post-operative pneumonia.

Aim: After the identification of the problem in this microsystem, a team was brought together by the CNL to uncover issues within the steps of the process that interrupted or prevented the post-operative patients on this floor from being ambulated. The goal of this team was to have a specific ambulation/activity order on 100% of eligible post-operative patients, nursing documentation of ambulation/activity on 100% of eligible post-operative patients, and to decrease length of stay by 10% in 6 months.

Methods/Programs/Practices: Further information was obtained from a retrospective chart review showing that 85% of patients did not have a specific ambulation/activity order (ex: ad lib, as desired). Fifty percent of patients did not have documentation supporting ambulation on post-op day one. After examining the process of ambulation, several changes were made in the microsystem to ensure that patients were ambulated post-operatively. Changes included adjustments to the ambulation order set, obtaining additional ambulation equipment, partnering with Physical Therapy for staff training, focus on the critical role of the nursing assistant in promoting patient ambulation, development of an ambulation template, and floor markings for more accurate documentation.

Outcome Data Since the implementation of the Rapid Recovery Ambulation Program in this microsystem, ambulation equipment is more readily accessible. Staff have received positive comments from surgeons and surgical residents that see their patients more active. Nursing documentation has been more consistent and there is an overall increased awareness of the benefits of early ambulation and mobilization. There has been a shift with nursing assistants assuming more responsibility and ownership in the ambulation program. The nursing assistants take pride in their role in this improvement. The RNs and LVNs have more time for other duties with this shift in responsibilities. Monitors are currently in place to determine the impact of this program on length of stay and cost of care for this microsystem.

Conclusion: This CNL lead project originated from the assessment of the microsystem and identification of a problem. Through the partnership with key team members including the Nurse Manager, Assistant Nurse Manager, and nursing staff, practice on this floor was positively impacted through the development of a Rapid Recovery Ambulation Program. The team collaborated with Physical Therapy to obtain staff training to aid in this evidence-based practice project. The team anticipates improved patient outcomes with decreased post-operative complications and a decrease in length of stay by 10% in 6 months.

Abstract title: Implementation of the CNL Role: An Innovative Approach

Authors/credentials:

Debra Adornetto-Garcia, MSN, RN, AOCN, NEA-BC; Barbara L. Summers, PhD, RN, NEA-BC, FAAN; Ginny Bowman, MSN, RN, CNS-Onc, AOCNS, CORLN; Deborah Cline, MSN, RN, OCN

Institution: The University of Texas MD Anderson Cancer Center

City/State: Houston, TX

Primary Contact Email: dadornet@mdanderson.org

Background Information:

Delivering safe, quality care at the bedside while controlling costs has become increasingly challenging for nursing leadership. Nurses practicing at the bedside face an increasingly complex and fragmented health care system with gaps in communication, numerous handoffs between caregivers, expanding technology, and increasing patient acuity. The Institute of Medicine (IOM) report (1999): Building a Safer Health System highlighted the increase of medical errors and called on health systems to reorient their efforts to improve patient safety. In 2007, the American Association of Colleges of Nursing (AACN) responded with a proposed Clinical Nurse Leader (CNL) role, citing a need to focus education on preparation of nurses capable of addressing health care in the future. As a response, a comprehensive cancer center has developed a plan to implement the CNL role on the inpatient oncology units.

Aim:

The presentation describes the complex planning necessary for the institution-wide implementation of the CNL role. Because this change has a major impact on care delivery consistent, timely communication is key to the initial implementation of this role and program. The major components of planning and development will be described, including identification of key team members necessary to form an implementation team, facilitation and planning of regular meetings, establishing timelines and deliverables, appointment of focused sub-committees, and engagement of nursing staff and leadership.

Methods/Programs/Practices:

The first step on the journey to implementation of the CNL role was to establish an implementation team composed of members from nursing leadership, education, finance, and

human resources. The chair of the committee facilitates bi-monthly meetings. A timeline for the project was established and is updated periodically by members of the team. Four subcommittees were developed to address the multiple needs of the project including: education, communication, quality and outcomes, and role delineation. The education subcommittee developed an educational curriculum for the CNL candidates complementary to their Master's program. Competencies and an educational plan have also been developed for the unit-based teams focusing heavily on teamwork and communication. The quality and outcomes subcommittee's plan includes measurement of short term and long term outcomes, including process and direct patient care outcomes. Review and revision of position descriptions for the CNL, RN, nurse aide and assistant nurse manager has occurred in the role delineation subcommittee. A related activity has been evaluation of the nurse aide role for needed changes and enhancements to strengthen partnerships with nurses. The communication team is responsible for assuring that the institution's leadership and workforce receive timely and clear information regarding the project. A key to successful implementation is assuring leadership and staff are knowledgeable about the purpose and vision of the CNL role, are engaged in the planning stages, and understand their role in accountability for outcomes. Early engagement of both leadership and staff by frequent information about the plan and its phases is critical.

Outcome Data:

The first demonstration units will "go-live" in September 2012. The units will be organized into 12- 16 patient cohorts depending on the size of the unit with a CNL assigned to each. The initial outcomes to be evaluated will focus on team functioning and interdisciplinary communication. Baseline measurements will be obtained prior to implementation and repeated during and after implementation. Baseline patient clinical outcomes will be compared to subsequent measurements during and post-implementation, including indicators such as falls and pressure ulcers. An important process indicator that will be measured will be the successful communication to all stakeholders about the project by the implementation team within the established timeline.

Conclusion:

The organization has the opportunity to transform the way care is delivered and optimize patient outcomes for the future. The CNL is a key role that will focus on the microsystem in which patient care is delivered, assure knowledge transfer to staff, and provide clinical leadership and direction to the interdisciplinary team. Creating a culture of innovation and productivity focused on enhancing patient outcomes is the ultimate challenge and goal of the CNL. How this transformation is executed is key to the success of the implementation and change.

Abstract title: CNL Outcomes in the Pediatric Inpatient Unit

Authors/credentials: Kathryn Caiazzo, RN, MS, CNL

Institution: Maine Medical Center

City/State: Portland, Maine

Primary Contact Email: caiazk1@mmc.org

Background Information:

The Barbara Bush Children's Hospital (BBCH) inpatient unit is a thirty-three bed acute care facility within Maine Medical Center in Portland, Maine. The hospital offers over twenty sub specialty services to the children of northern New England. The Clinical Nurse Leader role has been in place at BBCH for four years.

This presentation is focused on positive patient outcomes and system improvement as a result of implementing the CNL role. System improvement that will be discussed include; development of an early warning system to detect patient deterioration, creation and enhancement of a tracheotomy team to increase parent education and decrease patient length of stay, development of a central line team and bundle to decrease central line infections, initiation of unit quality rounds, and formation of nursing huddles. Patient care stories and their outcomes will also be presented.

Aim:

The specific aim of this presentation is to showcase system-wide improvements, their outcomes, and to discuss positive patient care outcomes following implementation of the CNL role in a pediatric inpatient unit.

Methods/Programs/Practices:

- ✓ Initiation of The Bedside Pediatric Early Warning System (BPEWS), a decision support acuity system.
- ✓ Creation of a pediatric tracheotomy team with collaboration by the BBCH CNL, the pediatric intensive care unit CNL, physicians, respiratory therapists, and speech therapy.
- ✓ Formation of a central line team and bundle, partnership among inpatient CNL, physicians, pediatric intensive care unit CNL, educators and nursing directors.
- ✓ Assembly of unit quality rounding to monitor and provide monthly data of nursing sensitive quality indicators.
- ✓ Adoption of nursing unit huddles daily.

Outcome Data

There are significant improvements in patient care and systems at The Barbara Bush Children's Hospital since implementation of the Clinical Nurse Leader.

Initiation of The Bedside Pediatric Early Warning System (BPEWS) has over doubled our calls and the utilization of our rapid response team. The BPEWS facilitates appropriate patient placement and has enhanced our communication by offering a common language amongst providers. The BPEWS assists in patient placement to offer the patient the right resources at the right time in the right place. BBCH is proud to share that it has been over 12 months since a "code blue" has been called on the unit.

Initiation of the pediatric tracheotomy team has decreased the length of stay by up to 7 days. Formal tracheotomy rounding which is inclusive of "just in time education" has helped to standardize the system.

Formation of a central line team and bundle has dropped our catheter associated blood stream infection rates to 0 in 10 out of 12 months.

Nursing quality rounds were initiated to increase awareness of nursing sensitive indicators and create a culture of monitoring performance. With the data reported each month the unit is able to target areas for improvement. Most recently, documentation of patient education has been the target area for improvement.

Since initiation of nursing huddles communication amongst staff is more clear, precise, and accountable. Nursing staff express that the huddles have created a sense of “community” and that they have increased the morale on the nursing unit.

Conclusion:

As described in the literature, demonstrated across the country, and defined through outcome data, the Clinical Nurse Leader is essential to healthcare systems and the patient. The accomplishments, changes and impact the CNL role can have on healthcare are far reaching. This presentation scratches the surface of the impact a CNL can have on an acute inpatient unit.

Abstract title: Partnering: Ensuring a successful academic partnership

Authors/credentials:

Deborah Cline, MSN, RN, OCN; Barbara L. Summers, PhD, RN, NEA-BC, FAAN; Debra Adornetto-Garcia, MSN, RN, AOCN, NEA-BC; Ginny Bowman, MSN, RN. CNS-Onc, AOCNS, CORLN

Institution: The University of Texas MD Anderson Cancer Center

City/State: Houston, TX

Primary Contact Email: dbcline@mdanderson.org

Background Information:

As the Clinical Nurse Leader (CNL) degree continues to grow in popularity, many hospitals are evaluating how they might incorporate this masters-prepared nurse role into daily practice. At a large comprehensive cancer center, the decision was made to incorporate the CNL in a restructured care delivery model. To do so, a partnership between the hospital and a local university was developed, so the needs and vision of all parties could be realized.

Aim:

This presentation will provide an overview of the collaboration, teamwork, and communication experienced on the road to creating a successful hospital-academic partnership. Lessons learned will be shared including what worked well and potential pitfalls that could easily be avoided. Key to the relationship success is open, honest communication, and a heavy dose of reality on both sides.

Methods/Programs/Practices:

A hospital-university partnership is vital to the development and success of educating nurses to the CNL role, and implementing the role in a practice setting. Critical to that success is the need for initial face-to-face discussions between key faculty and hospital nursing leaders to establish common ground, the vision of each party has for the role, and determine if a partnership is desirable and possible for both parties. Additional meetings with key stakeholders are important to further discuss mutual expectations, timelines, critical accomplishments, and potential issues that can be averted.

A critical role to the success of the partnership is the identification of hospital and university liaisons. These individuals become the first contacts to discuss and determine how to address issues that occur. Channeling discussions through the liaisons keeps communication focused and reduces opportunities for multiple interpretations. These liaisons allow the hospital and university to raise student and program concerns or issues, that may lead to modifications in the program over time that best meet the needs of the hospital and university.

Ideally, curriculum development should be accomplished jointly, not independently. Although the university has the background and experience to independently develop curriculum, the hospital must be able to clearly articulate its needs, goals, and participate in the process. The partnership's goal is to prepare graduates for success in the CNL role in complex practice settings, and to do so may require modifications to the curriculum and core classes to reflect specific practice environments.

Outcomes:

Collaboration has grown since the initial meetings with a local university. Establishing non-tenured faculty appointments for designated nursing leaders has allowed participation in the education of the CNL candidates. Specific CNL classes will be developed and taught by a team of nurse leaders from the hospital and faculty from the school. New professional relationships have formed and a deeper understanding of the needs of the participants and limitations of both the hospital and the university has occurred. It is evident that the ultimate outcome of the hospital-university partnership has evolved in a positive direction; several potential barriers were identified along the way.

Potential pitfalls that can be avoided are related to difficulties in communication, application and registration delays, and failure to modify current curricula to meet the CNL candidates' objectives. Participants must be able to function as a cohesive team and share the responsibility of the CNL program. Failure to do so has grave implications for the partnership and for CNL graduates who may not be adequately prepared for the practice environment.

Conclusion:

A partnership that exists only on paper does not achieve goals of hospital or academic partners. Our experience has clearly shown that an active, collaborative partnership, which takes work on the part of all involved, is the only way to meeting the goals and needs of both partners. Successful partnerships support preparing CNL graduates to function effectively and add value to the settings in which they work, and to increase the desirability of the academic programs that prepare them.

Abstract title: Bringing Evidence-Based Practice on Delirium to a CLC unit

Authors/credentials: Brandi Fagner, MSN, RN, CNL

Institution: Central Texas Veterans Healthcare System-Waco VA Medical Center

City/State: Waco, Texas

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Background Information: Evidence-based practice is a standard that every microsystem should strive towards in today's healthcare system. Resident outcomes are related to several factors, one being the knowledge of the nursing staff providing 24-hour a day care. The patient cohort that was selected for a process improvement project was a 27-bed Community Living Center (CLC). The top primary diagnoses for the unit are dementia and schizophrenia. These residents also have multiple medical co-morbidities such as heart disease, diabetes and hypertension. Residents with dementia or schizophrenia can present with delirium but are misdiagnosed due to lack of firm assessment pathways. Assessment of delirium was brought forth as a particular problem associated with this cohort's microsystem. According to the 2008 Healthcare Cost and Utilization Project (HCUP) data, the mean length of stay for a person with delirium was 8.9 days and the mean cost was \$19, 693 (Agency for Healthcare Research and Quality, n.d.).

Aim: There was no clinical guideline established on the clinical unit to identify delirium. In the absence of a guideline, the nursing staff could not consistently differentiate the reasons for a resident's change in status. The goal was to develop and implement a clinical protocol for residents experiencing acute cognitive changes from a literature review of best practices. Differentiating delirium in residents with a known diagnosis of behavioral or mental disorders is often a daunting task for nurses. Recognition of the signs of delirium is imperative to early intervention.

Methods/Programs/Practices: Primary prevention in this project was targeted at averting this specific cohort of residents from experiencing delirium. This was accomplished through the education of the entire nursing staff on the predisposing factors related to delirium. The CNL student focused the attention of the staff to take a view of each resident in terms of their risk factors for developing delirium. The secondary mode of prevention of the project was intended to have the team promptly identify potential residents that need intervention by the early recognition of delirium. The Confusion Assessment Method (CAM) algorithm from evidence-based guidelines was chosen as the screening tool for timely detection of delirium. As a CNL student, permission was gained to use the copyrighted CAM algorithm for education and clinical purposes (Inouye, 1990). The staff was provided pocket cards that could be attached to their badges with the CAM tool visible. Finally, tertiary prevention was aimed at reducing the length of a delirium episode and preventing a decline in function of a resident with delirium. This mode of prevention was accomplished through educating the staff on nursing strategies to evaluate the effectiveness of treatment prescribed.

Outcome Data: A pre-test/post-test design was utilized to assess any change in knowledge of delirium. The process of measuring baseline data was collected by questionnaire in regards to the understanding of the identification of risk factors, symptoms and management approach to delirium. An overall picture of the results showed significant improvement in the objective responses as well as increase of staff confidence to the subjective questions. Specifically, merely 16.4% of the questions given at the initial implementation were answered correctly by 75% of the staff. Whereas 61% of the questions at one-month post implementation were answered correctly by 75% or more of the staff. Only 50% of the questions were answered correctly by at least 50% of the staff on the pre-questionnaire. In contrast, 89% of the questions were answered correctly by at least 50% of the staff on the post-questionnaire. Data is continuing to be gathered related to unit infection rates, transfers to acute care, and the use of "PRN" medication for behavioral management.

Conclusion: The improvement project is continuing to be implemented now by the certified CNL to potentiate further positive outcomes for the residents in the long-term care setting. There will be ongoing interdisciplinary collaboration to ensure effective holistic treatment care plans. A sustained effort to collect data, and evaluate the effectiveness of the protocol will continue to be the role of the CNL assigned to this microsystem.

Abstract title: Defining the CNL Role in the Emergency Department: The Nurse Manager and CNL Dyad

Authors/credentials: James Herrada MA, RN and Janine Decker MSN, RN, CNL

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Instructions: Please complete each of the following sections, when applicable. Each section should contain between 50 and 250 words.

Background Information:

The Clinical Nurse Leader program began in 2006 at the VA New Jersey Health Care System. The Emergency Department acquired their CNL in January 2009. The CNL works within the health care system as a lateral integrator at the point of care, improving patient outcomes. The CNL role has been defined to meet the needs of the department and the population of veterans we serve. Though this role has many similar functions as the inpatient CNL, there are clear delineations based on the number of patients and the unique environment of the Emergency Department.

Aim:

Define and articulate the CNL role in the ED and how it plays an important part in the operations of the department and patient care outcomes.

Distinguish the CNL from other members of the health care team.

Bringing to light the complimentary roles of the Nurse Manager and the CNL.

Methods/Programs/Practices:

During the CNL immersion period, the role was introduced to the staff through in services and meetings. The ED nurse manager clearly established the leadership position and function of the CNL within the context of the CNL's functional statement, in the delivery of quality care and improving patient throughput in the Emergency Department. The ED Chief fully supported the role which further defined the CNL function in interdisciplinary collaboration among the doctors and nurses in the department. The CNL leads the Interdisciplinary Team Huddles twice daily during walking rounds with the Lead Physician, primary physician, nurse, and psychiatrist on duty. Triage area modification, stream-lining of nursing documentation templates, and nursing protocols have all been established with the help of the CNL in stream-lining care. In addition, POC testing such as Troponin, lab accessioning, and other lab-related projects such as hemolyzed specimen rates which all contribute to reducing waste and length of stay, were maintained and initiated in part by the CNL. The introduction and transition into the use of our nationally-implemented ED tracking system (EDIS) was made easier by support of the CNL. The CNL has been an integral part in Joint Commission readiness while working with staff and adherence to the National Patient Safety Goals. The CNL leads continuous improvement projects such as the ED LEAN project. The CNL oversees the care of all patients with an emphasis on "at risk" populations such as the suicidal and indigent patients and provides direct care to critically ill veterans and those requiring transfer to another facility. She has been the leader in improving our health and safety process for behavioral health patients admitted to our psychiatric units.

Outcome Data

Baseline data for FY 2009 showed an average patient stay of greater than 6 hours to be 4.95% with a missed opportunities rate of 1.5%. Data collected for FY 2010 demonstrated 3.9% and 0.7% respectfully. FY 2011 data proved we are still below the VISN 3 excellence benchmark for both metrics with 4.2% and 2.1%.

Conclusion:

The CNL role has been defined in the Emergency Department based on the needs of the department and the National VA performance measures. The leader's work schedule fits the needs of the department and their peak times. The CNL reports to the Nurse Manager and works directly at the point of care. It has been a challenging journey in pioneering the first VISN 3 Emergency Department CNL. The role has been embraced by the entire interdisciplinary team of physicians, nurses, and other disciplines. Safe and efficient, patient-centered care is the primary focus of the CNL and Nurse Manager dyad. The CNL serves as a mentor to the staff and to 3 cohorts of CNL students from our academic partners. She serves as a resource person to the nursing staff and brings evidence-based practice to the bedside. The CNL has been instrumental in decreasing the department's length of stay and missed opportunities to the distinction of "Best in VISN 3" for FY 2010 and 11, through many of our improvement projects such as Interdisciplinary rounding and Triage modification. The CNL role in the VA New Jersey Health Care System Emergency Department is setting the standard for all other facilities to establish. Furthermore, the CNL role will be sustained in the ED as a change agent to improve care outcomes for our veterans.

Abstract title: Using WIKIS to facilitate group work on unfolding case studies for CNL students in an Accelerated Masters CNL program.

Authors/credentials: Kristine L'Ecuyer, RN, MSN, CCNS, CNL, Bobbi Shatto, MSN, RN, CNL, GERALYN MEYER, PhD, RN, CNL, and Rita Wunderlich, PhD, RN

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City/State: St. Louis, MO

Primary Contact Email: Lecuyerk@slu.edu

Background Information:

The use of case studies and problem based learning is a standard nursing education methodology. Additionally, unfolding case studies have been found to be beneficial for nursing students. Academic preparation for the CNL role should include group work methodologies to allow students to learn to work in group settings and practice leadership skills. We used WIKIS as an online supplement to a medical-surgical nursing course as a technological platform for group collaboration on unfolding case studies.

Methods/Programs/Practices:

The WIKIS were set up by the faculty, and included three sections. Each section was loaded separately during the week based on concurrent lecture content and in an attempt to create an unfolding case study. The first section was loaded prior to the upcoming lecture and included an introduction to the case study and discussion questions which served to guide students in their efforts to prepare for class. The second section revealed a continuation of the case study and additional discussion questions including a request for appropriate nursing diagnosis and nursing interventions, based on classroom teaching. The final section revealed the patient outcome and included discussion questions related to patient outcomes, as well as long-term planning. Each

week, there were 6 case studies, with 4 students working on each case. The groups were encouraged to divide up the work on the case study so that all students had equal responsibility. The faculty devised deadlines for completion of the discussion during the week. Throughout the week, the faculty had the ability to add notes and comments to the students work directly on the WIKI for the entire group to observe. Faculty often wrote these notes in RED font color to distinguish their notes from the student's comments. All students in the course had access to all WIKI case studies. At the end of the week, when time allowed, student groups gave short in-class reports of the highlights of their assigned case study. Class participation points were allotted for work on case studies. Students completed peer evaluations at the end of each case study, in an effort to ensure even distribution of workload.

Conclusion:

Using WIKIS was an effective method to facilitate group work on unfolding case studies for CNL students in an Accelerated Masters CNL program. The faculty liked the ability to cover numerous types of patients in the case studies for each topic area, and the ability to provide frequent feedback. The students appreciated the ability to work diligently on their assigned case study, in addition to learning from the other case studies completed by the other groups. The WIKIS facilitated group learning activities and leadership skills for beginning CNL students.

Abstract title: Starting a Model C Program: Lessons Learned

Authors/credentials: Geralyn Meyer, PhD, RN, CNL, Kris L'Ecuyer, MSN, RN, CNL, Bobbi Shatto, MSN, RN, CNL

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City/State: St. Louis, MO

Primary Contact Email: meyergera@slu.edu

Background Information:

Model C CNL programs are those created for non-nurses who hold baccalaureate degrees in other fields. These programs are offered in an accelerated time frame, usually 16 to 21 months. Saint Louis University School of Nursing (SLUSON), which began the first accelerated BSN program in the United States in 1971, began offering an Accelerated Generalist Master of Science in Nursing Program (AGMSN) in 2010. Although SLUSON had a long history of offering accelerated nursing education, the process of developing and implementing an accelerated master's program has had its challenges. The challenges faced and the change strategies used to overcome them will be discussed.

Methods/Programs/Practices:

The idea for the creation of an AGMSN program at Saint Louis University gained traction in the Spring of 2009, under the leadership of the Dean of the School of Nursing. Although the administrative support for the program was great, the process of developing and implementing the program was a change in the school's culture which required the skills of several change agents. The first hurdle was deciding on the length of the program and whether or not the AGMSN program should build on our existing accelerated BSN program or become a completely self-contained program of its own. Once those decisions were made, a curriculum had to be developed and the program had to be "sold" to our many stakeholders. First, the

AGMSN program had to be approved by both the Baccalaureate and Master's program committees at the School of Nursing even though, as a master's pre-licensure program, the AGMSN program did not readily seem to fit under the purview of either committee. Ironing out curricular concerns, selling the program to the university at large, the local health care community, the Missouri State Board of Nursing, and prospective students were all challenges that the implementation committee faced.

Conclusion:

Twenty four students were admitted to the newly created AGMSN program at SLUSON in August 2010 (a second cohort of 25 was admitted in August 2011). The anticipated graduation date of the first cohort is May 2012. The implementation of the program is on-going and bumps in the road are still being encountered and overcome. The CNL certified faculty members have been able to use and model the skills needed by a change agent, an essential CNL role. Lessons learned in SLUSON's creation and implementation of our Model C program may be helpful to others contemplating the development of programs of their own.

Abstract title: *Transforming Care of the Patient by Caring for Our Own: A CNL Educational Initiative for Reducing Stress in New Perioperative Nurses*

Authors/credentials: Daniel Nadeau, MSN, RN, CNL

Institution: UCLA Health System

City/State: Los Angeles, CA

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Background Information:

The Perioperative Training Program at the Ronald Reagan UCLA Medical Center (RRUCLA) is an eight-week program for recent nursing school graduates as well as experienced nurses. The program combines didactic education and clinical learning opportunities to refine nursing theories and processes related to the client undergoing surgical intervention. A willingness to return to the student role is an expectation of the program. As such, it is important to recognize student stressors in the clinical setting. Research demonstrates the importance of informing students about the stressors associated with their profession, and introducing interventions to reduce workplace stress. An analysis of a CNL project for the Perioperative Training Program at RRUCLA demonstrates the aims, methods, and outcomes of an educational initiative to address workplace stress in perioperative nursing.

Aim:

Research shows that approximately 35 to 65% of new nursing graduates will leave their work place within the first year of employment, and stress and burnout are likely contributing factors. Furthermore, the cost of orientating a new nurse to the perioperative role is estimated to be between \$50 and \$59 thousand. Clearly, stress-related nursing attrition can have significant staffing and financial implications. As an educator, team manager, and advocate for quality care and safety, the OR CNL is in a unique position to develop and deliver initiatives to reduce perioperative nursing stress.

The purpose of this CNL project is to improve the quality of nursing through the reduction of

stress in perioperative nurses in the OR at RRUCLA. Specific goals and objectives include the creation and demonstration of an interventional educational tool that addresses the causes of stress and burnout in the OR, recommendations for reducing stress in perioperative nurses, and the provision of resources available to nurses at RRUCLA for stress management.

Methods/Programs/Practices:

A PowerPoint (PPT) presentation serves as the interventional educational tool, and is supported by the provision of resources for stress management. This methodology was chosen due to time limitations, ease of use, and facile integration into the existing Perioperative Training Program curriculum. In addition, the PPT is an opportunity to provide sensitive information in a non-threatening format.

The project included a review of cogent peer-reviewed literature to identify important themes and relevant data for inclusion in the PPT. Data was synthesized and simplified to create a compelling narrative that was reinforced by thought-provoking stock photography.

Implementation of the CNL initiative consisted of a ten minute presentation to the Perioperative Training Program nurses and the OR Clinical Educator. In addition, a brochure from the UCLA Staff and Faculty Counseling Center, with information on the Center's stress management programs, was distributed to the nurses.

Outcome Data

Outcomes of the presentation included a 45-minute discussion of stress experienced by the Perioperative Training Program nurses and causative agents of stress in the OR. Mirroring results of studies of perioperative nurses' perception of stress in the workplace, participants noted that self-doubt, uncertainty regarding treatment, and receiving contradictory information contributed to stress in their new roles. The OR Clinical Educator stated that stress education would be a valuable addition to the program curriculum, and that she could envision a similar presentation for the entire OR nursing enterprise. Future use of the educational intervention will include a brief Likert Scale survey to provide measurable evaluation of the intervention.

Conclusion:

A subjective process evaluation based on responses of the nurses and OR Clinical Educator demonstrates that the project was successfully conceived, planned, and implemented, and that education regarding perioperative nursing stress is a valuable addition and a much needed adjunct to the curriculum. As an educational tool, the presentation provided the nurses with evidence-based knowledge of the risks of stress for perioperative nurses, as well as interventions to improve coping.

The literature reveals that nursing stress in the OR is unique, debilitating, and prevalent. This CNL project demonstrates that addressing stress concerns through an educational intervention for new perioperative nurses may help to increase retention and improve the health and safety of nurses and patients alike.

Abstract title: The Impact of the Clinical Nurse Leader role on Quality Outcomes

Authors/credentials: Cynthia Pearsall MSN, NEA-BC, RN & Robin Sheets, MSN, APRN, CNL, RN

Institution: Fairfield Medical Center

City/State: Lancaster, OH

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Background Information: This 220 bed community hospital was an early adaptor of the CNL role with the first CNL piloting the “12 Bed Unit” in December of 2008. Since then, four more nurses have graduated and passed the CNL certification exam while 13 more of our employed nurses are completing the CNL program over the next two years. The majority of these nurses are benefiting from an on-site, distance learning program with a university 140 miles away. This program was piloted at our institution three years ago and has been funded through a HRSA grant.

In January, 2011 nursing leadership decided to have the CNL students move into a pre-CNL role, which we call “Clinical Coordinators” and into a microsystem of their own. The nine Clinical Coordinators and two of the newly certified CNLs were implemented on our three medical/surgical units. Each unit was organized into three smaller, 12-16 bed care areas. These microsystems are modeled after Dartmouth Institutes call for smaller, easier to manage, areas. The new leaders participated in a 24 hour orientation designed to build a new team and find their strengths.

Aim: Nursing Leadership and the Clinical Coordinators/CNLs defined the foci for the first year as; bedside report/handoffs, reducing catheter associated UTI’s, patient and family centered care, physician and team collaboration, and Individualized Plan of Care. Each Clinical Coordinator/CNL takes ownership of their microsystem. The foci also include Core Measures related to their area of specialty; for example, SCIP on the surgery unit and CHF on the telemetry unit.

Methods/Programs/Practices: In 2010, prior to their new leadership role as a Clinical Coordinator, many of these students had been in charge nurse roles. At that time the CNO and Quality Outcomes nurses partnered to create a checklist for each of the 2010 Core Measures. The checklists are managed by the Clinical Coordinators/ CNLs who also managed them in their charge nurse roles. These checklists remain the highest priority in keeping our patients safe. The Clinical Coordinators/CNLs also formed several work groups that sustained two previous in-house projects; CAUTIs and Handoffs. Each of these was refined at the bedside. One work group completely revised the patient plan of care and rolled out an education plan, audits and data collection.

The CC/CNLs round with the patients’ primary physician daily. This is where communication gaps are closed. They discuss the plan of care, anticipated discharge date and Core Measures, among other things. Indwelling catheters are asked to be removed when they do not fit the CDC criteria. The CC/CNLs also participate in daily care rounds with the discharge planner and UR nurse. Care coordination and transitions in care are streamlined during this time.

Outcome Data The hospital’s aggregate data shows the CAUTI rates are significantly reduced. The total number of catheter days decreased from 9880 in 2010 to 4068 in 2011. The aggregate Catheter Associate UTI’s decreased from 2.94 UTIs/Number of catheter days in 2010 to 0.98 UTIs/catheter days in 2011. The total number of CAUTIs in 2010 was 29 and in 2011 it has only been five, year to date. Inpatient satisfaction, as measured by Press Ganey, has shown an overall upward trend since the implementation of these roles. Furthermore, our largest inpatient unit

participated in, and continues a project, developed by the IHI which has helped us reduce 30 day readmissions from 18.17% in 2010 to 15.05% in 2011. We continue to improve that rate each month with evidence based tools.

Conclusion: Improved communication between nurses and physicians can greatly reduce catheter days, catheter associated UTIs and 30 day readmissions, thereby minimizing further harm to patients. Implementing this role has been a significant component of the improvement in our inpatient satisfaction. Utilizing this data and other outcome data, as a business case for the CNL is easy to extrapolate the worth of the role, especially when Value Based Purchasing becomes part of the formula.

3:30 p.m.

Buccaneer A

A New Approach to the Prevention of Central Line Associated Bloodstream Infections in Pediatric Intensive Care Unit

Kentlee Battick RN, BSN, CCRN, CNL Student
All Children's Hospital
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Buccaneer B

Interdisciplinary Collaboration: the Role of the CNL

Miriam Bender MSN, RN, CNL
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Buccaneer C

Under Pressure: Decreasing Device-Related Pressure Ulcers in the ICU

Ann Deerhake, MS, RN, CNL, CCRN
St. Rita's Medical Center
Lima, OH
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Buccaneer D

Partnering: Ensuring a successful academic partnership

Deborah Cline, MSN, RN, OCN; Barbara L. Summers, PhD, RN, NEA-BC, FAAN; Debra Adornetto-Garcia, MSN, RN, AOCN, NEA-BC; Ginny Bowman, MSN, RN, CNS-Onc, AOCNS, CORLN
The University of Texas MD Anderson Cancer Center
Houston, TX
Email: dbcline@mdanderson.org

Ybor Room

3:30 p.m.

A Coronary Artery Bypass Grafting (CABG) and/or Valve Surgery Interdisciplinary Clinical Pathway; Achieving Improved Patient Outcomes through a Highly Functional Team

Jamie Gilliam, RN, MSN, CNL, CCRN
Malcom Randall VAMC, NF/SG VHS
Gainesville, FL
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Esplanade 1

The Impact of the Clinical Nurse Leader Role in Improving the Number Deaths Reported to the Facility's Organ and Tissue Procurement Agency

Linda Abercrombie, MSN, RN, CCF, Jackie R. Jacobson, MSN, RN, CNL; Francine Jamison, MSN, RN, CCF, Lynett King, MSN, RN, CNL; Christina McCullough, BSN, RN, CCF, Norma Patterson, MSN, RN, CCF

Tennessee Valley Healthcare System

Nashville, Tennessee

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Esplanade 2

Using Narratives to Illustrate Philosophy of Nursing Practice

Jean Logan, RN, PhD

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Des Moines, Iowa

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Esplanade 3

Navigating the Model C Curriculum: Innovative Strategies for Individuals from Disadvantaged Backgrounds

Tommie L. Norris, DNS, RN; Patricia A. Cowan, PhD; Mona N. Wicks, PhD, RN, FAAN

Susan R. Jacob, PhD, RN; E. Erwin Story, MBA

The University of Tennessee Health Science Center (UTHSC)

Memphis, TN

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Regency 2

Clinical Nurse Leader (CNL) and a multi-pronged approach to improving care for the high risk, low volume patient

Sonja Orff RN, MS, CNL

Maine Medical Center

Portland, Maine

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Regency 5-7

Using Data to Determine Patient Rounding Strategies: A Unique Fall Prevention Program

Megan Rafferty MSN, RN-BC, CNL

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Abstract title: A New Approach to the Prevention of Central Line Associated Bloodstream Infections in Pediatric Intensive Care Unit

Authors/credentials: Kentlee Battick RN, BSN, CCRN, CNL Student

Institution: All Children's Hospital

City/State: Saint Petersburg, Florida

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Background Information: An Increased incidence of Central Line Associated Bloodstream Infection's (CLABSI) was identified in the Pediatric Intensive Care Unit (PICU) over a two-month period. CLABSI's cost \$32,219 per infection and cause 30,000 deaths among patient's in intensive care units. Staff was surveyed on proper central line use and dressing change technique. Survey results were analyzed and an education program was created and completed with RN nursing staff. Education components included a computer a based module and a hands-on simulation based on unit specific needs.

Aim: The aim of this project is to eliminate CLABSI's in the PICU utilizing evidenced based practice and CDC recommendations. At the start of this project, the PICU was at 7.5 infections per 1000 line days. Initially our goal was to reduce the number of CLABSI's with the end goal to eliminate them altogether. The current PICU quality goal is to be below 2.5 infections per 1000 line days.

Methods/Programs/Practices: Identification of improvement areas was determined using improvement model plan, act, study, do. This revealed that staff required remediation in central line management. Tasks such as dressing care and proper central line access were common errors found. RN Nursing staff completed computer based module included review of central line care. Staff competence of central line management was increased through a multitude of educational methods including hands-on dressing changes observed on unit mannequin. A quiz was administered to all RN nursing staff with a requirement of 100% score. Central Line rounds and chart reviews were completed to ensure integrity of all central line dressings, and proper care. All staff competency was documented and saved in the department files.

Outcome Data: Staff survey revealed a great need for central line management. Education plan was created and completed by all nursing staff. Infection rate data showed a decrease from 5 infections to 2 infections two months following staff education plan. Outcome data will continue to be collected to support ongoing education plan implementation. Collaboration with hospital infection prevention department will also collect data in conjunction with PICU staff to support education implementation.

Conclusion: All staff successfully completed educational program and CLABSI's have been reduced in the PICU. Bedside education and chart review must be an ongoing process in order to reach our goal of completely eliminating CLABSI's in the PICU. Central line rounds have shown the need for continuing education to ensure proper line maintenance and observation of dressing changes.

Abstract title: Interdisciplinary Collaboration: the Role of the CNL

Authors/credentials: Miriam Bender MSN, RN, CNL

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City/State: San Diego CA

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Background Information: Fragmented patient care is associated with preventable adverse healthcare outcomes. Effective interdisciplinary collaboration decreases fragmentation and has

been shown to improve the quality and safety of patient care. Clinical nursing leadership will be necessary to drive collaborative change at the bedside, where the majority of decisions about care practices are made. Based on educational preparation, the CNL was recognized as being well positioned to provide leadership at the bedside to laterally integrate patient care across disciplines.

Aim: This study focused on the processes by which the CNL could positively impact the organizational and interactional determinants of interdisciplinary collaboration. Specific aims included:

- Develop a CNL role description using the empirical determinants interdisciplinary collaboration to direct workflow practice
- Integrate the CNL role into a progressive care unit care delivery microsystem
- Examine the role as tailored on organizational and interactional determinants of interdisciplinary collaboration on the unit.

Methods/Programs/Practices: A prospective descriptive design was used to explore the feasibility of the CNL role as an intervention to improve interdisciplinary communication and collaboration in an academic acute care microsystem. The CNL daily workflow was determined by: 1) Assessing the pre-CNL state of microsystem organizational and interactional determinants of interdisciplinary collaboration, and 2) Utilizing CNL core competencies of nursing leadership, care environment management and clinical outcomes management to develop new processes that promote or enhance specific determinants of interdisciplinary collaboration. Data was collected from RNs pre, 4-months, and 1-year post CNL implementation. Physicians provided data 1-year post implementation. CNLs provided descriptive evidence of collaboration with interdisciplinary staff as well as self-evaluation of role implementation. This qualitative approach was used to explore each discipline's perspective of the CNL role, and to ascertain whether/how each discipline found the CNL-integrated care delivery system a viable model for creating a collaborative environment.

Outcome Data: Initial findings from: 1) RNs, 2) physicians, 3) ancillary staff, and 4) CNL self evaluation of the role; provide support that integration of the CNL into an acute care microsystem can create and sustain an environment of interdisciplinary collaboration.

1) Nurses' self reports reflect meaningful changes in their satisfaction with the daily RN workflow on the unit: mean score pre-CNL was 2.53, and mean score 1-year post CNL was 3.53. For the item 'I am kept informed in a way that is meaningful to me all new policies/standards of care', scores increased from a mean of 2.33 (pre-CNL) to 3.57 (1-year post CNL). For the item 'I have the support I need to address all aspects of my patient's care needs', scores increased from a mean of 2.87 (pre-CNL) to 4.0 (1-year post CNL).

2) RN-physician communication and collaboration satisfaction surveys showed 89% of attending physicians felt the CNL role increased multidisciplinary collaboration on the unit compared to other units within the hospital, where there was no CNL. Seventy five percent of attending physicians responded this perceived increase in RN/physician collaboration regarding patient care resulted in better quality patient care.

3) Ancillary staff were happy to be included in a collaborative manner and provided a wealth of information that CNLs used to create information sheets and guide practice as needed.

Organization-wide changes that occurred because of this microsystem-based collaboration included: revising the electronic patient charting system to more easily reflect current patient status; creation of standardized care plans for patient populations with heart failure and specific cancer treatments; and better coordination between physical therapy, occupational therapy and the nursing staff on patient rehabilitation needs.

4) The CNL's main struggle throughout the study was creating a willingness to collaborate between nursing and medical staff. Interestingly, once CNLs secured the trust and respect of the administrative, nursing, ancillary, and medical staff, there was a synergistic effect in terms of

new staff entering the unit: they seemed to take other's trust and respect as a cue to feel secure enough to collaborate and communicate with the CNLs and other team members without reservation. Group cohesion was created, with a sense of interdisciplinary competence in each other, which new employees could immediately become a part of, and take part in by the end of the study.

Conclusion: Developing collaborative practice in a fragmented microsystem represents a considerable challenge to healthcare organizations. Effective collaboration involves interplay between teams of multi-disciplinary professionals, the organizational environment they practice in, and the underlying cultural expectations that presuppose the possibilities (or not) for collaboration. Framing CNL workflow around empirical factors necessary for interdisciplinary collaboration is an innovative approach to this complex healthcare problem. The results provide preliminary evidence that a CNL-integrated care delivery system can be an effective model to facilitate interdisciplinary communication and collaboration within a microsystem.

Abstract title: Under Pressure: Decreasing Device-Related Pressure Ulcers in the ICU

Authors/credentials: Ann Deerhake, MS, RN, CNL, CCRN

Institution: St. Rita's Medical Center

City/State: Lima, OH 45801

Primary Contact Email: adeerhake@gmail.com

Background Information: Critically ill medical-surgical Intensive Care Unit (ICU) patients possess multiple health issues including acute and chronic illness, mobility issues, moisture issues related to fecal incontinence, hemodynamic instability, vasopressor medication usage, edema, and poor nutrition, frequently leading to poor tissue perfusion, Multiple Organ Dysfunction Syndrome (MODS), skin failure and potential skin breakdown. Patients with medical devices are 2-4 times more likely to develop a pressure ulcer of any kind. Further, ICU patients require more monitoring and life-saving devices, making them prone to some of the highest rates of hospital-acquired device-related pressure ulcers (PU) within the acute care setting.

Data from the international voluntary 2010 Hillrom Study showed that ICU PU rates were 9.5%. Also in 2010, St. Rita's Medical Center (SRMC), a Level 2 trauma center in northwestern Ohio, had an elevated pressure ulcer rate of 11.3% as compared to a rate of 7.7% in 2009, a 3.5% facility increase and 1.8% increase compared to other ICUs. At SRMC, 6 of 52 patients studied in quarterly performance improvement studies had PU; 100% of these PU were device-related, In contrast, the Hillrom data maintains that 26% of all ICU PU were device-related.

Aim: The goal is to reduce ICU-acquired PU to less than the 9.5% benchmark by maintaining current evidence-based practices that prevent non-device related skin breakdown, while further analyzing the occurrence of device-related PU and developing action plans for prevention. The stretch goal is to reduce ICU-acquired PU to less than the 2009 rate of 7.7% and ideally, to eliminate all ICU PU, device-related or otherwise.

Methods/Programs/Practices: The SRMC critical care CNL instituted twice weekly device checks in ICU to determine device-related PU risk and prevalence, as well as early prevention.

These continue to date, consisting of a bedside check of all devices applied to the patient, informal needs/benefits device assessment, current skin condition and PU-causing device evaluation. From this surveillance, as well as the quarterly performance improvement studies completed per the ostomy nurses and unit champions, it was determined that life-supporting respiratory devices were a main culprit of SRMC ICU's device-related PU.

An interdisciplinary task force lead by the respiratory care Clinical Manager and the critical care CNL was formed to further analyze respiratory device PU risk and develop action plans to remedy the situation. The committee consists of the CNL, respiratory care department and clinical managers, ICU nurse manager, ostomy nurse and dietician. At a later date, the trauma coordinator was also included in the meetings for specific trauma input.

Action plans were developed, including trialing, evaluating and instituting new endotracheal tube holders and cushioning pads for full-face Bipap masks. Education was given to physicians and nurses regarding timely removal of surgical tracheostomy sutures and the importance close observation of skin surrounding all respiratory devices, including nasal cannulas and sub-glottic suction tubing.

Outcome Data: Per the quarterly performance improvement studies completed per ostomy and unit champions, the first, second and third quarters have shown 0% PU in the SRMC ICU population. This is significant. Further, because of acuity, the ICU has had an increase in ventilator patients as well as ventilator days in the first two quarters of 2011, consequently making this outcome even more difficult to achieve. The CNL ICU device checks for the first six months of 2011 have shown that 145 patients studied had a total of 1055 devices, for an average of 7 devices per patient, an increase from the 6 the last two quarters of 2010 reported. No significance was noted in the ICU trauma population.

Conclusion: According to the National Pressure Ulcer Advisory Panel, an uncomplicated hospital-acquired PU can minimally cost \$43,000. In 2010, the SRMC ICU reported 6 PU during their performance improvement studies, equivalent to more than \$250,000 in increased expenses not reimbursed from Medicare. 2011 performance improvement studies have detected no PU, device-related or otherwise, in the SRMC ICU. With the institution of the CNL driven device checks and the ICU device-related PU task force with subsequent action plan development, the SRMC ICU stands to reduce costs significantly in 2011 and in years to come.

Abstract title: Clinical Nurse Leader: Role development, Implementation and Expansion
Authors/credentials: Kari Hamson-Kalis MSN, RN, CNL; Shannon Hulett MSN, RN, CNL
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Background Information:

A Clinical Nurse Leader (CNL) is a master's prepared nurse generalist, whose primary foci include nursing leadership at the bedside, managing patient outcomes, and managing the

care environment. CNLs manage achieve lateral integration of care at the microsystem level. They are not clinical managers, unit based educators, or clinical nurse specialist. The role was developed by the American Association of Colleges of Nursing (AACN) and other organizations in response to the landmark reports including *To Err is Human: Building a Safer Health System* and *Crossing the Quality Chasm*. Due to the complex status of the current healthcare environment, the need for advanced education, clinical expertise and leadership training at the bedside was recognized. Little is known about details of CNL role development, implementation, and expansion within an individual organization.

Aim:

Administration at Gundersen Lutheran recognized the need to transform the hospital care model on the medical/surgical units. As a Patient Family Centered Care (PFCC) initiative, the CNL role was developed in alignment with the AACN's white paper definition.

This presentation will:

1. Explore components in CNL role development, implementation, and expansion within an organization.
2. Identify staff, unit and organizational needs during CNL role development, implementation, and expansion.

Methods/Programs/Practices:

Gundersen Lutheran's journey consists of three phases.

- Phase 1 – Planning: four key factors
 - Structure: A steering committee scoped the work, set timelines, completed unit assessments, and solicited organizational support.
 - Role Development/Transition
 - Partnered established mid career and CNL student
 - MSN RN to CNL - previously unit based
 - BSN Bedside RN to CNL Fellow (CNL student) – evolved into “work is school and school is work”
 - Job Description designed with PFCC verbiage
 - Unit Task force: formulated over 200 role related questions encompassing philosophical/operational issues, developed guiding principles to steer decision making, instrumental in operationalizing CNL role on the Medical Oncology
 - Microsystem assessment(observations) provided insightful motivation for change
 - Office placed in central location on unit
 - Communication/education plans were developed, all levels of organization received varying degrees of PFCC, CNL and microsystem content
 - Metrics (quality, safety, satisfaction)were determined
- Phase 2 - Implementation on initial unit: Medical Oncology - July 26, 2010
 - Utilized Microsystems Process Improvement Methodology
 - Evolved from philosophical to operational to practical descriptions
 - Developed electronic tools
 - Learned to work collaboratively with unit Leadership Team
 - Continued discussion/evaluation of processes was recorded for next units
- Phase 3 - Expansion to other units (due to such positive outcomes, timeline sped up)
 - Go-lives tied with PFCC work
 - Refined planning and implementation was facilitated by CNL
 - ‘Leap frog’ approach
 - CNL transitioned to next unit to partner with new CNL fellow for

- implementation
- Subsequent units implement accordingly

Outcome Data

- Outcomes of the identified metrics have only been identified for the Medical/Oncology Unit and include the following:
 - Direct expense per discharge: 8% reduction
 - Hours per patient day: 15.5% reduction
 - Delays in discharges to SNFs: 26% reduction
 - Continuous observation hours: 48% reduction (Jan-May 2011)
 - Injury from falls: 66% reduction (Jan-Aug 2011)
 - Patient Satisfaction: 6% increase (4th quarter 2010)
 - Decreased internal diverts and holds
 - The only medical/surgical unit with increased staff engagement scores in 2011
 - Multiple anecdotal reports from interdisciplinary staff including physicians and residents indicating improvement in communication, satisfaction, and accountability

Conclusions

Early findings indicate the successful implementation of the CNL on the medical/surgical units. While refining the process we identified key elements for success including: staff engagement from CNL leadership and unit task force, pairing of CNL and CNL fellow, school is work and work is school framework, tool development, and extensive communication/education, and exceptional administrative support.

Abstract title: A Coronary Artery Bypass Grafting (CABG) and/or Valve Surgery Interdisciplinary Clinical Pathway; Achieving Improved Patient Outcomes through a Highly Functional Team

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Background Information:

At the Malcom Randall Veterans Administration Medical Center in Gainesville, Florida, the post-operative outcome trends and care practices of Coronary Artery Bypass Grafting (CABG) and/or valve replacement surgical patients were examined, and standardizing patient care with an interdisciplinary clinical pathway was deemed essential. Pre-implementation findings included an increased length of stay (LOS), prolonged intubation, delayed mobility due to invasive lines, and poor resource utilization and flow of patients to the appropriate level of care. An interdisciplinary team, led by the Clinical Nurse Leader (CNL), met weekly beginning in April of 2010. All care processes were examined, a review of literature was completed and current evidence based literature was analyzed. Based on current standards of care, an interdisciplinary clinical pathway was implemented in June 2010. This process improvement would promote a “6 day stay” for CABG and/or valve surgery patients.

Aim:

The clinical pathway employed multiple process improvement aims. One goal of the pathway was to improve resource utilization and impact the flow of patients through different levels of care to meet each patient's care needs. The pathway promoted a "6 day stay" consisting of 2 days in the cardiothoracic intensive care unit (CTICU) 2 days in the cardiothoracic step-down unit (CTSDU), and 2 days on the 5th floor medical/surgical unit. Other aims included early extubation within 4 to 6 hours postoperatively, early mobility and transferring the patient from the bed to a chair approximately 2 hours after extubation, advancing the patient's diet as tolerated, removing invasive lines on postoperative day (POD) 1, and early ambulation. The pathway supports early discharge teaching and planning to allow patients to be discharged home when appropriate and therefore decrease average length of stay (ALOS). The care plan, led by the CNL promotes a highly functional team leading to improved communication and planning.

Methods/Programs/Practices:

The interdisciplinary team included the Cardiothoracic (CT) surgery team, Chief Nurse of Surgery, Operating Room (OR) Nurse representative, CTICU, CTSDU and Medical/Surgical 5th Floor Nurse Managers, CNLs, Clinical Nurse Educators (CNEs) and Nursing representatives, Respiratory Therapists (RT), VA Nursing Academy (VANA) faculty, Pharmacists, and Dietitians. The team reviewed current professional literature, which revealed evidence that fast-tracking or rapid recovery processes for cardiac surgical patients were used in many facilities to emphasize outcomes of decreased LOS, improved quality of care and overall reduction in healthcare costs. Aspects of a rapid recovery process include: 1) early postoperative extubation; 2) a decrease in respiratory complications; 3) early ambulation; 4) early weaning of medications; 5) timely removal of invasive catheters and lines; 6) expedited transfer to a step-down unit; 7) and early discharge to home. All disciplines were present in order to design an interdisciplinary clinical pathway.

Ventilator weaning parameters and decreased narcotic use facilitated a goal of extubation within 4 to 6 hours post operatively. The Physicians and our electronic medical record (EMR) team worked with Nursing and RTs to change order sets and wean patients promptly. Education was provided by the CNLs and CNEs to all major stakeholders involved in this process change. Outcomes were measured from June 1, 2010 until November 2010. The CNL rounded with the CT team during the initial implementation to educate all staff at the point of care and encourage use of the tool.

Outcome Data:

The outcomes from the implementation of the CABG and/or valve surgery clinical pathway demonstrate measurable process improvements and improved patient driven outcomes. Patient care data was collected from June 2010 through November 2010. The average postoperative ventilation time decreased to 5.48 hours from 17.1 hours pre-implementation. The ALOS has decreased to 6.76 days from a pre-innovation ALOS range of 7.76 to 13.53 days. 43% of the total 92 CABG and/or valve surgery patients were assisted out of bed to a chair on the day of surgery. Before the pathway was initiated, patients were not assisted out of bed to a chair until POD 1. The decreased bed days of care (BDOC) and LOS for the initial 92 patients led to an approximated cost savings of \$528,076.32 to \$1,660,885.20. After displaying sustained, improved patient care outcomes since June 2010, the CNL continues to trend data and monitor the use of the clinical pathway.

Conclusion:

The interdisciplinary pathway continues to be utilized on all CABG and/or valve surgery patients and patient care outcomes continue to be evaluated to determine the need for further process improvements. The CNL and a highly functional interdisciplinary team designed this process change, which has led to measurably improved patient outcomes including decreased ventilation hours, decreased length of stay, improved communication, progressive mobility, and overall anecdotal satisfaction.

Nursing and ancillary staff, as well as the CT surgery team, continually verbalize satisfaction with the innovation based on improved communication processes and improved quality of patient care and outcomes. The CNL shares outcome data with staff monthly and praises the staff and entire interdisciplinary team for their performance improvement.

The Impact of the Clinical Nurse Leader Role in Improving the Number Deaths Reported to the Facility's Organ and Tissue Procurement Agency

Linda Abercrombie, MSN, RN, CCF, Jackie R. Jacobson, MSN, RN, CNL; Francine Jamison, MSN, RN, CCF, Lynett King, MSN, RN, CNL; Christina McCullough, BSN, RN, CCF, Norma Patterson, MSN, RN, CCF

Tennessee Valley Healthcare System
Nashville, Tennessee

The objective of this project was to increase the reporting of deaths at Tennessee Valley Healthcare System (TVHS) for the purpose of identifying possible organ, tissue and eye donors. In Tennessee greater than 2,000 people are awaiting lifesaving organ transplants. According to the Tennessee Donor Registry, on average only 200 Tennesseans became organ donors after their death in 2008. At that time TVHS was reporting few or no deaths to Tennessee Donor Service, the organ and tissue procurement agency for the facility. During the latter portion of 2009, the Clinical Nurse Leader/Clinical Care Facilitator (CNL/CCF) group spearheaded the endeavor to increase TVHS death reporting.

In an effort to have a greater impact throughout TVHS, we first identified the reasons for non-adherence to the Tennessee Uniform Anatomical Gift Act (TUAGA). Secondly, we established a relationship with the Hospital Service Coordinator from TDS. Once these actions were taken, we set a goal of 100% compliance throughout TVHS. With this objective in mind we collaborated with the Chief Nurse of Medicine, Nursing Officers of the Day (NOD) and Nurse Managers on the best way to accomplish this goal. The most effective practice implemented to establish the TUAGA program was determining who was responsible for reporting deaths to TDS. The CNL/CCF group created and disseminated education to nursing administration and bedside staff. We implemented the TDS Referral Guide into routine nursing practice on all patients who have expired. We developed a Death and Details notebook, which serves as a quick reference guide for staff. We then amended the TDS contract to include the Alvin C. York campus, revised the TVHS policy and created a Standard Operating Practice outlining responsibilities. After the implementation of the revised contract and policy, SOP, Death and Details notebook and education of all nurses, TVHS is now compliant with TUAGA and has greatly increased the number of reported deaths. In 2008 TVHS reported 0% of deaths to TDS. In 2009, 49% of deaths were reported. The percentage of death reporting has continued to

increase with 82% reported in 2010. As of August 2011, TVHS is reporting 94% of deaths with 24% of these being classified as potential donors.

In conclusion the CNL/CCF's efforts have proven to be successful and sustainable. We continue to update the policy, SOP and reference notebooks. There is on-going education of administrative and staff nurses. When outliers are found we investigate the circumstances and identify solutions. TVHS's compliance rate has steadily improved since the CNL/CCF group became involved in this project. We are dedicated to continue the quest for 100% compliance.

Using Narratives to Illustrate Philosophy of Nursing Practice

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Background Information:

The clinical nurse leader is a role model for nursing practice. One of the first classes taken by the students is titled Theoretical Context of Care. In this course students develop a personal philosophy that ultimately guides the practice of the CNL. "Philosophy sets forth the meaning of nursing phenomena through analysis, reasoning, and logical presentation" (Tomey & Alligood, 2010, p. 6).

Aim:

Students develop assertions using the five ways of knowing (empirical, ethical, personal, esthetic, socio-political) and their values and beliefs as a guide to create their personal philosophy of nursing. The four concepts of nursing, personhood, health and environment are included in each philosophy. Student create a concept map that connects the assertions and gels the philosophy.

Methods/Programs/Practices:

Nursing philosophy can be viewed as an abstract, somewhat boring topic. To make their personal philosophies applicable to nursing practice, students develop a narrative from their clinical practice and analyze it from the lens of their personal philosophies. Students can inductively develop the narrative first and then formally pull out the four concepts or develop their personal philosophy first and then deductively write the narrative from a clinical situation.

Students find that they used philosophy to guide their practice but did not recognize how to formalize it. Narratives are a powerful tool to facilitate philosophy in context. CNLs are in a position to use narratives as a teaching tool for other nurses, health professionals and patients.

Outcome Data Each of the CNL students will read their personal philosophies, followed by their narrative stories. All three of the students work with children. They will discuss their journey to formalizing their philosophy of nursing practice.

Conclusion:

Philosophy application in context makes a difference. Stories can make philosophy come alive. People remember stories more often than abstract, disconnected concepts. Health care institutions are increasingly formalizing their philosophies of nursing practice. The CNL has the tools to guide them through this important experience through narrative illustration.

Tomey, A.M. & Alligood, M.R. (2010). Nursing theorists and their work. (7th ed.) Elsevier. Maryland Heights, Missouri.

Abstract title: *Navigating the Model C Curriculum: Innovative Strategies for Individuals from Disadvantaged Backgrounds*

Authors/credentials:

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Background Information: The need for an increased nursing workforce and more diversity in nursing is supported by national data that clearly identifies a diversity gap. A lack of diverse faculty to serve as role models and mentors has been identified as a barrier to success for minority students. More nurses, a more diverse nursing workforce, and diversity training are needed to change the culture of health care. Using evidence-based student success strategies, an ongoing retention program to promote the success of individuals from disadvantaged backgrounds in a master's professional entry (pre-licensure second-degree) program was designed and implemented. Culturally inclusive curricula and instructions are lacking in many curricula. In addition, educational activities known to enhance nursing program retention success will be introduced to a pre-entry preparation cohort from disadvantaged backgrounds—thus providing a pipeline of applicants. The professional literature in all disciplines has identified strategies that are effective in building academic skills, building a positive image of the profession, and dispelling myths about the retention of minorities.

Aim: To integrate evidence-based student success strategies into the curriculum to increase nursing education opportunities for individuals from disadvantaged backgrounds. This will be achieved by providing an on-going retention program to promote the success of underrepresented minorities in a master's professional entry clinical nurse leaders (CNL) program, thereby meeting national goals to improve access to health care for underserved populations by increasing the proportion of minorities in nursing. Provide educational activities for individuals from disadvantaged backgrounds enrolled in or interested in CNL Model C Programs to improve

retention and graduation rates, as well as cultural competence. Innovative curriculum strategies will increase the number of underrepresented students from disadvantaged backgrounds who will graduate and enter the healthcare workforce.

Methods/Programs/Practices: Academic, financial, and social support services to promote retention and graduation of individuals from disadvantaged backgrounds enrolled in a CNL Model C program have been implemented. Strategies include implementing faculty and staff development courses on culture, diversity, and inclusiveness; administrative procedures to address diversity and inclusiveness; and cultural mapping of the curriculum to ensure incorporation of intercultural aspects into courses. Financial difficulty is a major deterrent to minority students who attend college; thus grant support was provided for scholarships and stipends. Stipends will help students pursue a degree so that holding a job and balancing family responsibilities are not barriers to success. A mentor will facilitate socialization, networking, and personal and professional development opportunities--key components of academic and professional success. Many minority students are academically under-prepared for college; a pre-entry immersion component will provide the foundation for success in a science rich curriculum: workshops to improve writing skills, evaluation of learning styles and strategies based on individual criteria, evaluation of critical thinking skills, and tutorials on test taking skills. Minority mentors have been, and continue to be, selected from professional and community partnerships, who serve as role models promoting a positive image of nursing. A course to improve cultural competence and language acquisition for Hispanic populations has been approved and will be implemented in Spring 2012, along with a Distinguished Visiting lectureship related to cultural competence.

Outcome Data: The majority (57%) of the students enrolled in the CNL Model C program in 2011 are minority students, and most received their high school educations in districts where free lunches were provided due to economic conditions. Focus groups provided evidence that individual and group tutoring provided academic support for success in the 3 “Ps”: pathophysiology, pharmacology, and physical diagnosis (health assessment). Strategies presented by an educational specialist related to test taking skills and techniques to reduce test anxiety (resulting in a 5-10 point increase in some test scores) have been implemented. Anecdotal information suggested that an expert on time management was found to be especially beneficial, due to competing demands on students’ time from balancing school and family.

Conclusion: In light of the changing demographics of our nation, it is imperative that nursing programs incorporate curricula and strategies to ensure success of individuals from underrepresented minorities and disadvantaged backgrounds into the nursing workforce. By increasing success of diverse nursing students, the end result will be a more diverse nursing workforce.

Note: This presentation is supported in part by funds from the Division of Nursing (DN), Bureau of Health Professions (BHP), Health Resources and Services Administration (HRSA), Department of Health and Human Services, under Grant No. D19HP22229, Nursing Workforce Diversity Grant, 7/01/2011 – 6/30/2014.

Abstract title: Clinical Nurse Leader (CNL) and a multi-pronged approach to improving care for the high risk, low volume patient

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- **Background:** In June 2010, health care providers were experiencing increased stress and discomfort when caring for pediatric patients with a tracheostomy. This uneasiness amplified when the patient transitioned from the critical care setting to the general care setting to the patient's home. The health care providers identified multiple variations in the standard of care, in department responsibilities within units, in communication and documentation, in education provided to patients and families, and in their own comfort level in providing care. They consulted the CNL to help them assume accountability for the health care of this specific patient population who was deemed high risk, low volume.
- **Methodology:** The SCU CNL, with support from leadership, identified key stakeholders and invited them to attend an interdisciplinary meeting regarding the patient flow across the care continuum. The SCU CNL directed the attendees to identify and create a problem list in which a shared vision for change was developed. Through weekly rounding, the team identified gaps in practice, hand-off, supplies, and processes in which the team could work on in an effort to improve staff satisfaction. By effectively managing the team, the CNL coordinated the tasks that needed to be in place to improve consistency and safety in care for the pediatric trached patient. A manager of the Physician Hospital Organization (PHO) partners with the CNL to co-lead the team. The team holds monthly meetings. Members of the team include: critical care pediatric physician, pediatric surgeon, general floor pediatric attending, physical and occupational therapist, respiratory therapist (RT), basic life support (BLS) instructors, department based educators, and a general floor pediatric CNL. Through increased communication, team building, revision of policy, the development of a consistent care environment, and a direct line of communication with the PHO, the team has been able to provide and maintain a high level of safety.
- **Programs and Practices:** The team has:
 - Developed the Pediatric Tracheostomy Team
 - Created a non-emergent contact resource for staff: Pedi_trach@mmc.org
 - Revised the Pediatric Trach Policy to reflect standardization in practice
 - Created handout, "What is a Trach" to be given to families for informed decision making
 - Devised an educational resource guide for staff and families (with family input)
 - Collaborated with Informatics Services and developed an electronic order set and flow sheet to improve hand-off communication
 - Reviewed and formalized trach stock at bedside and in distribution
 - Formed a team in collaboration with local ambulance services that educates families on CPR prior to discharge
 - Developed a formal basic airway anatomy airway test for families/home care takers to assess readiness to discharge
 - Hosted two Interdisciplinary Pediatric Airway Conferences at facility, Spring/Summer 2011 (offered to community resources as well)

- Connected and collaborated with community resources: home health agencies, equipment supplies, schools, and rescue
- **Outcomes:** Listed below:
 - Experienced zero bounce backs from pediatric general floor to ICU June 2010 to current
 - Experienced zero return admissions of pediatric trached patient for complications regarding airway care and maintenance June 2010 to current
 - Experienced zero fatalities or sentinel events June 2010 to current
 - Increased CNL- to- CNL collaboration regarding hand-off of the pediatric trached patient
 - Increased health care provider to pediatric surgeon direct line of communication
- **Conclusion:** Working within a system that supports CNL led initiatives and allows health care teams the opportunity to voice their concerns has created a process in which patient care and staff satisfaction can improve. The SCU CNL led a project in which standardization of care was improved for a very high risk population. Through team building, increased collaboration, direct lines of communication, the development of tools, and the identification of a shared vision, this team has maintained a high level of quality and safety for a specific patient population.

The team which includes our PHO partners has a continuous focus on education. We are planning our third interdisciplinary pediatric airway lecture. The team also promotes real time interdisciplinary education at the bedside. The team remains connected with our community resources in an effort to streamline the discharge process. They have joined our team in educational offerings to endorse the use of consistent language and education for patients and families.

The team is standardizing competencies for the interdisciplinary health care team. The team continues to seek input from families on how to improve processes and provide adequate resources and education in an effort to keep them well informed and prepared for safe discharge. A survey is being designed to measure the health care team's level of satisfaction regarding changes made. Most recently, our neonatal colleagues joined the team in an effort to improve their resources, level of safety, hand-off, and continuum of care.

Abstract title: Using Data to Determine Patient Rounding Strategies: A Unique Fall Prevention Program

Authors/credentials: Megan Rafferty MSN, RN-BC, CNL

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Background Information:

Falls are the leading cause of accidental injury for the hospitalized patient. Just being in the hospital increases your risk for falls even if you have never fallen at home. Approximately 30% of inpatient falls result in injury with 4% to 6% resulting in serious injury which includes fractures, subdural hematomas, excessive bleeding and even death (Hitcho, 2004). One study found 90% of hip fractures occur from falls and 50% of those patients will die within one year of the fall (Sobel, 2009). As if these numbers are not staggering enough, The Centers for Medicare and Medicaid no longer reimburse organizations for specific injuries such as fractures and dislocations occurring as an inpatient. These injuries are often related complications of falls (Tzeng, 2010). The Centers for Medicare and Medicaid are not the only governing institutions that are making patient falls a priority. The Joint Commission (TJC) also made falls prevention a patient safety goal for 2010. TJC commented that surgical patients may be at higher risk for falls due to changes to the patients' physical ability for movement, anesthesia, and pain medications ("Fall prevention," 2009).

Hourly rounding has been found to decrease the rate of patient falls. An initial attempt to adapt this practice failed. In discussion with staff they voiced difficulty fitting hourly rounds into their workflow and they reported that they often forgot to round on the hour.

Aim:

The overall aim of this project had three distinct foci. First, was to decrease falls on an orthopedic/overflow trauma unit in an acute care community hospital in suburban Philadelphia, PA. Second, was to improve awareness of patient safety and fall prevention techniques, and lastly was to explore strategies that would remind staff to initiate rounding.

Methods/Programs/Practices:

The original method trialed was to have the charge nurse hold a beeper that was set to go off at designated times. The times were identified after an unit data analysis of all falls in FY10. When the beeper alarmed (an auditory cue) the nurse then flicks the lights (a visual cue) to prompt the staff to round on their patients. Staff round on patients and ask the three P's (Potty, Pain, and Positioning).

After trailing this for one week, new technology became available. The new technology, allowed all staff to be prompted through their wireless phone at the designated times and allowed them to receive an automated message reminding them to round on their patients.

Outcome Data

The initial falls rate per 1000 patient days in FY09, prior to this project, was 3.32. In FY10, the falls rate fell to 2.54 and in FY11, the falls rate has dropped to 2.11. There has been a steady decrease in the falls rate for this orthopedic unit since the launching of this project. In addition, at the beginning of this initiative, the unit went 100 days without a fall, which is the longest this unit has ever gone without a fall in its history.

Conclusion:

The project resulted in the orthopedic unit going 98 days without a fall. This is the longest time frame this unit has ever gone without a fall. The success of this project led to implementation

hospital wide. This project rekindled interest in fall prevention techniques and the need for patient rounding. Hourly Rounding is being instituted throughout this hospital and since the staff has become accustomed to rounding at designated intervals it is hoped this will ease the units transition to this safety practice. Furthermore, this practice improved the staff's awareness of fall prevention, the need to implement unique strategies, and the successes that come from such efforts.

4 p.m.

Buccaneer A

Using Environmental Scanning as a Strategic Approach to Improve Outcomes in Complex Health Care Systems

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Buccaneer B

Clinical Nurse Leader: Implementation of the role and the impact on nursing sensitive outcomes

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Buccaneer C

Improving Incentive Spirometry Performance among Children with Sickle Cell Disease in a Pediatric In-Patient Setting

Brittany Cardell, MSN, CNL; Leslie McKeon, PhD, CNL, NEA-BC; & Sherry Webb, DNSc, CNL, NEA-BC
LeBonheur and UTHSC
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Buccaneer D

Evolution into Practice: A CNL Residency Program

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Ybor Room

Improving Outcomes through Discharge Phone Calls

Karen Giovengo, MSN, RN, CNL / Heather Garrison, MSN, RN, CNL
St. Lucie Medical Center
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Esplanade 1

Improving MRSA Nasal Screens

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Esplanade 2

Maximizing the Clinical Immersion Experience and Project Development: Student, Preceptor, and Faculty Collaboration

Linda Roussel, DSN, RN, CNL; Cheryl Robinson, DNS, RN, CRNP
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Esplanade 3

Standing Up the VA Clinical Nurse Leader Implementation & Evaluation Service

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Regency 2

Changing Practice of Medication Documentation: A CNL approach to motivating accountability

Rebecca Parker MSN RN CNL ONC ; Anne Marie Richmond MSN RN CNL, Carolyn Johnson MSN RN CNL CNRN, Elizabeth Triezenberg MSN RN CNL CNRN, Lauran Stuiwe-Bittinger MSN RN CNL CHPN , Carrie Mull, BSN, RN, RN-BC (P-MH, GRN)
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Regency 5-7

The Diabetic Post Hospital Telephonic Health Follow-up Pilot Study

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Abstract title: Using *Environmental Scanning* as a Strategic Approach to Improve Outcomes in Complex Health Care Systems

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Background Information:

Complexity Science, the study of evolving and adaptive systems, is critical to the practice of the Clinical Nurse Leader. The CNL is responsible not only for improved outcomes for cohorts of at-risk patients but also for executing change in concert with the broader mission and vision of multifaceted health care delivery systems. Using complexity science knowledge is vital to improving and sustaining change in health care organizations and is important for all levels of providers especially the Clinical Nurse Leader. Environmental Scanning is a technique used in business and industry to prospectively examine the complex influences, both internal and external, on the organization.

Aim:

The purpose of this presentation is to provide an exemplar of how using *Environmental Scanning* as a strategy to better understand both the internal and external influences on the clinical microsystem can improve the identification of outcome indicators.

Methods/Programs/Practices:

The presentation will employ a case and commentary method and offer a tool that can be used by CNL faculty and clinicians to better understand the clinical microsystem in the context of a broader network of data and client perspectives. Developing a method to examine (scan) the literature and other information sources from an interprofessional perspective is urgent. Identifying information from community sources, such as newsletters and blogs, to inform practice and provide for efficient and effective care is essential.

Outcome Data

Comparisons of microsystem outcome indicators before and after the use of the Environment Scan demonstrate the usefulness of the process.

Conclusion:

Skills in assessing the clinical microsystem have been a strength of CNL practice. Increasingly as patient-centered care becomes more complex and integrated with other community systems, new models for assessments are needed. Skills in *Environmental Scanning* can be used to assist the CNL to identify barriers and opportunities for improved care not only from the internal but from the external environment as well. This information gathering, decision making strategy is not a simple task. An illustration of this process can serve as a strategic approach to assist CNLs in new endeavors towards care coordination and lateral leadership.

Abstract title: Clinical Nurse Leader: Implementation of the role and the impact on nursing sensitive outcomes.

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Background Information:

Improving patient safety and quality has been the driving force for many changes in healthcare over the last decade. In an effort to improve outcomes at the point of care the Clinical Nurse Leader (CNL) role was developed in 2004 by the American Colleges of Nursing with support from the American Organization of Nurse Executives and is now recognized by the American Nurses Credentialing Center. The CNL is the first new role in nursing in over 35 years. The CNL is a master's prepared advanced generalist serving as a lateral integrator for the health care team who facilitates, coordinates, and oversees care within the microsystem level and in collaboration with the macrosystem...A CNL is designed to practice at the microsystem level, following a cohort of patients with a focus on evidence based practice, safety, quality, risk reduction and cost containment (AACN).

The Chief Nursing Officer (CNO) at Abington Memorial Hospital foresaw the value of this role and envisioned its positive impact on patient safety and outcomes. The CNO created a partnership with a local university and several Abington registered nurses were enrolled in one of the first Pennsylvania CNL programs. After several years of careful planning the CNL role was implemented in October of 2009. Abington Memorial Hospital currently has 8 masters prepared nurses working in this role, one assigned to the Neonatal Intensive Care Nursery (NICU) and seven assigned to the Medical-Surgical Units (MSU).

Aim:

The aim of instituting the new CNL role at Abington Memorial Hospital was to improve patient safety and quality by directly impacting patients and nurses at the point of care. Nurse sensitive indicators were tracked and measured to evaluate the impact of the CNL role.

Methods/Programs/Practices:

The CNLs assumed responsibility for the nurse sensitive outcomes on their respective units. Each CNL, using their training in safety and quality, implemented evidenced based practice initiatives in an attempt to improve outcomes. The following nurse sensitive outcomes were measured to evaluate the effectiveness of the CNL role:

- Falls
- Falls with injury
- Catheter- Associated Urinary Tract Infection (CAUTI)
- Catheter Utilization rate
- Central-Line Associated Bloodstream Infections (CLASBI)
- Nosocomial Pressure Ulcer Incidence
- Hand Hygiene
- Daily Nursing Unit Safety Briefing Compliance
- Ventilator Associated Pneumonia - NICU only

Outcome Data:

The 9 MSUs with CNLs were able to demonstrate the following overall improvements:

- 43% improvement in hand hygiene
- 58% improvement in daily unit safety briefing compliance
- 68% improvement in central line associated bloodstream infections
- 7% improvement in fall rate
- 93% improvement in fall with moderate or severe injury rate
- 84% improvement in nosocomial pressure ulcer incidence (stage II or greater)

- 13% improvement in catheter associated urinary tract infection rates
- 6 of the 9 MSUs were able to reduce catheter device days by an average of 17%, the remaining 3 had increased catheter device days which continues to be investigated and addressed.

The NICU had a 52% reduction in ventilator-associated pneumonia rate.

Conclusion:

Patient care continues to increase in complexity as the patient population ages and healthcare reform drives precipitous change. Many aspects of healthcare reform are forcing hospitals to improve outcomes or lose revenue. As healthcare institutions strive to meet the new demands for improvements in safety and quality innovative solutions are sought. Implementing the CNL role is a unique way to directly improve outcomes and reduce costs. In this institution, after careful planning and with continuous tracking of nurse sensitive data, the role of the CNL has shown improved outcomes on all units in which the role was implemented. Based on initial findings, we would expect that the expansion of the CNL to other settings would yield similar improvements in safety and quality.

Abstract title: Improving Incentive Spirometry Performance among Children with Sickle Cell Disease in a Pediatric In-Patient Setting

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Background Information:

Preventing respiratory complications among children in sickle cell disease (SCD) crisis is critically important. Mutations from SCD affect the smooth motion needed for effective oxygenation and deoxygenation, causing intense pain and leading to Acute Chest Syndrome (ACS). Incentive spirometry (IS) is recommended to modify severe chest wall pain that can cause atelectasis and require ICU care. Patients receiving IS have significantly less pulmonary complications compared to patients who do not.

In 2010, 36% of patients admitted to the Orthopedic/Hematology unit at a Mid-South children's hospital had a diagnosis of SCD. To prevent ACS, standard protocol includes IS with 10 maximal inspirations every 1-2 hours while awake administered by either nursing or respiratory therapy (RT). However, medical staff shared concerns that children were not receiving IS at the recommended frequency. Subsequently, for their quality improvement project, four 2nd year CNL students were charged with measuring baseline IS performance for SCD patients, age 5 years and older, during a 5-day period mid-March, 2011. Data were obtained from the electronic medical record, staff interview, patient/family report, and through observation during typical patient waking hours. Six SCD patients were observed; findings suggested inconsistent IS initiation, delays in IS patient/family education, significantly fewer IS treatments than prescribed, and documentation decline over the patient's course of stay. Students presented the results to staff, along with the following recommendations: 1) develop standard orders for IS

education; 2) define responsibility for IS education to one discipline; and 3) engage patients and families in performing and documenting IS care.

Aim:

The aims of this project are twofold: 1) revise the process for IS care based on the proposed improvement recommendations, including assigning full accountability to nursing for in-patient IS education and treatment; and 2) evaluate IS education and treatment by nursing staff.

Methods/Programs/Practices:

A pilot project was conducted on the 24-bed inpatient Orthopedic/Hematology unit to improve IS adherence. First, the nursing team met with unit respiratory therapists and agreed that nursing would manually change orders for *RT Incentive Spirometry Education to Incentive Spirometry-Nursing* in the electronic medical record. Second, the team created a process map starting with IS education, followed by goal determination (estimated inspiratory capacity) and ending with IS activity initiation to identify potential problems associated with the change in accountability. Third, the team developed a *Caregiver Progress Record* for patients/families to document their progress and performance with IS activity in the absence of the nursing staff. Fourth, the team developed a *Caregiver Education Sheet* as an additional resource for the patient/family as the nurse provides the IS education with return demonstration. Fifth, nurses agreed to an IS standard of care which included initiation of IS education and treatment within 1-2 hours of the physician IS order and nursing follow-up of patient/family IS activity a minimum of every 2 hours while patient is awake.

The group decided to implement the revisions in stages. Stage 1 entailed transferring accountability of IS care exclusively to nursing. Stage 2 entailed implementation of patient/family documentation after Stage 1 was successfully hardwired in the microsystem.

Stage 1 commenced in August, 2011 with nurses receiving education for the revised IS protocol. Following staff education, IS performance data for newly admitted SCD patients, age five years and older were collected by the team during the following month.

Outcome Data

Six patients with SCD were admitted in September, 2011 for a three-day average length of stay. Five patients received IS education & 1st treatment by a RN; one patient was treated by a RT who had forgotten about the pilot. The mean time between IS education & 1st treatment and initial physician order was 1 hour and 45 minutes compared to a mean baseline performance of 5 hours and 45 minutes. Nursing documentation of IS care on patient days 1, 2, and 3 was 75%, 76% and 81% respectively compared to a baseline documentation performance of 40%, 25%, and 10% for days 1 through 3. Outcome data three (3) months after implementation will be collected by CNL students and presented.

Conclusion:

Results point toward a significant improvement in IS adherence as a result of one-discipline accountability. The team plans to go through several more PDSA cycles before implementing Stage 2, patient/family engagement in IS documentation, and rolling out the revised protocol to all in-patient units. Nevertheless, initial findings suggest that simplifying processes through the systematic use of quality improvement methods improves timeliness of IS care. Assigning exclusive accountability to one discipline reduces the risk of delays, and in combination with patient and family-centered documentation, may prevent of serious respiratory complications among SCD children.

Abstract title: Evolution into Practice: A CNL Residency Program

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Background Information: The mission of the Veterans Health Administration is to provide exceptional health care that promotes veterans' health and well-being with a vision toward patient-centered, integrated health care. A new nursing role has emerged that impacts professional nursing practice and creates value for the organization: the Clinical Nurse Leader (CNL). The CNL is a master's prepared nurse who uses evidence-based practices to facilitate and coordinate care for a group of patients and provide direct patient care in complex situations, engaging other nurses to affect positive patient outcomes. The CNL graduate may come from many different levels of experience such as: Model C graduates who are new RNs as well as new CNLs, seasoned RNs who are new CNLs, and post master's certificate graduates who are new CNLs. The VHA Office of Nursing Services (ONS) has launched a portfolio of multi-year activities to support full implementation of the CNL role at all points of care across the system. Development and implementation of a VHA CNL Residency Program is one of the activities in the ONS portfolio. This presentation describes the synergistic group process employed to develop the VHA CNL Residency Program.

Aim: A core work group was brought together to guide the development of the VHA CNL Residency. Four CNLs were selected as domain leaders to provide subject matter expertise and experience across different entry into practice models and different areas of CNL practice. The group facilitator was selected for experience in CNL program management as well as formal training in systems and education. Although the group had never worked together, the common passion for the role and shared value of transition to practice support provided for rapid development of synergy within the group. The eight competencies in the nursing synergy model are: clinical judgment, advocacy and moral agency, caring practices, facilitation of learning, collaboration, systems thinking for resources, response to diversity and clinical inquiry. These competencies were manifest in the efforts of this core group toward the designation of CNL residency learning domains, learning module content within each domain, learning module format, and program evaluation strategies.

Methods/Programs/Practices: Group synergy was harnessed through facilitated group processes and dynamics. Activities included open discussion, brainstorming, reflection around actual experience, attention to wholism, active listening to one another, consensus development, evaluation and re-examination of ideas within evolving context, and purposeful grounding of abstract concepts in shared theoretical and practical understanding. Group members fully engaged with each other and drew upon each other's perspective, knowledge, and experience to expand and enhance individual ideas.

Outcome Data: Group synergy around shared passion and values informed the process of developing the framework of learning domains for a series of self-paced preceptor-guided educational modules with clinical activities, tools, and resources that will assist new CNLs transitioning to practice in the VHA. Within the five learning domains of role differentiation, clinical outcomes management, care environment management, data management, and developing evidence based practice, content will promote development of proficiency in professional communication, professional practice, care coordination, patient centered care, data driven process, and health promotion and disease prevention. The focus of this program is to provide the CNL with a skill set that is based on academic and practice standards, is grounded in

the Ten Assumptions from the CNL White Paper, is driven by client outcomes in assigned microsystems, and supports strategic priorities of the VHA and ONS.

Conclusion: Residency training has proven effective to transition graduates into practice with skills and in depth training. Through facilitated group process the synergy of the collective knowledge and experience of the workgroup brought together to guide the development and implementation of the VHA CNL Residency Program resulted in a solid foundation for this important VHA initiative.

Abstract title: Improving Outcomes through Discharge Phone Calls

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Background: The administrative team at St Lucie Medical Center, a 229 bed for-profit community hospital in Port St Lucie, FL, challenged The Clinical Nurse Leaders to improve patient satisfaction in early 2009. One initiative developed was a process to contact patients after discharge- the discharge phone call.

AIM: The purpose of this presentation is to show the impact the discharge phone call process can make.

Methods/Practices: Beginning in early 2009, the Clinical Nurse Leaders and case managers began making discharge phone calls. Initially, the discharge phone calls occurred on a limited basis reaching only a small number of discharged patients. During the first year approximately 40% of discharged patients received a phone call. Over the course of time, the Clinical Nurse Leaders realized the impact of the discharge phone call far exceeded improving patient satisfaction. Consequently, the team revised the discharge phone call process to increase the number of discharged patients contacted. In 2011, approximately 96% of discharged patients receive a phone call. During the presentation we will review past and current practices as well as the impact made by the Clinical Nurse Leader acting as a lateral integrator beyond the walls of the hospital.

Below is an example from a Clinical Nurse Leader journal entry of a discharge phone call:

During my discharge phone calls, the son of a recently discharged patient explained to me that the patient had a UTI while in the hospital. She received one dose of Cipro and was discharged from the hospital the next day. Unfortunately, the patient was not sent home on antibiotics. The son shared with me that in the past she had an untreated UTI which led to numerous complications. I reviewed the record and collaborated with our hospitalist's office. The covering hospitalist called a prescription into the pharmacy for the former patient. I reviewed the same with the caregiver. The son was very appreciative for my assistance and follow through.

Outcomes/Conclusion: Through the years of speaking with patients after discharge the Clinical Nurse Leaders began to understand the struggles endured by the patient after discharge from the hospital. The Clinical Nurse Leaders identified trends such as forgotten prescriptions, poor follow up by home health companies, lack of understanding of the discharge instructions as well as failure to fill prescriptions and make follow up appointments. During the discharge phone call the Clinical Nurse Leader assesses the patients understanding and compliance with the discharge instructions and has a unique opportunity to intervene. Such Clinical Nurse Leader interventions have decreased our readmission rates while increasing our patient satisfaction from the fourth quartile to the top quartile over the past two years.

Abstract title: Improving MRSA Nasal Screens
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Background Information: The VANJHCS implemented a standardized *Methicillin-Resistant Staphylococcus aureus* (MRSA) Initiative in an effort to interrupt MRSA transmission thereby, reducing the number of patients at risk for infection. The MRSA bundle includes active surveillance, contact precautions, and hand hygiene. MRSA nasal swabbing is required for patients upon admission, transfer-in, discharge, and death. Data collection and trending of MRSA surveillance for June 2011, showed a total of eight MRSA nasal screens not completed upon patients' admission/transfer-in to the unit according to the protocol. The unit just minimally met the performance goal of 90%. This is the lowest MRSA swabbing compliance rate reported for FY2011 as compared to 93% -97% in previous months. Retrospective chart review revealed incorrectly labeled specimens i.e., date and time of specimen collection not indicated and late submission of specimens to the laboratory beyond the 24 hour timeframe within admission per VHA guideline.

Aim:

- To reduce the number of MRSA nasal screens not completed upon admission/transfer-in to the unit
- To increase the number of compliant MRSA nasal screens
- To reduce the number of patients at risk for MRSA infection
- To satisfactorily meet and sustain MRSA nasal swabbing compliance rate above 90%.

Methods/Programs/Practices: Interventions implemented following CNL collaboration with the MRSA Prevention Coordinator included the following:

- Reinforcement of performance of MRSA swabbing within 24 hour time frame within patient's admission/transfer-in and discharge.
- Label specimen including time and date of collection
- Signage posted as a reminder to take the specimen to the lab immediately after collection
- Specimen collection basket with reminder signage was moved to a more visible location in the dirty utility room

- MRSA Initiative refresher training/in-services were conducted for the staff
- Random spot checks of collected MRSA specimens were conducted to ensure labeling compliance
- Rotate/assign responsibility to the staff to check collected specimens prior to be taken to the laboratory

Outcome Data: As a result of the interventions implemented, the MRSA admission swabbing compliance rate increased from 90% to 96% and the discharge compliance rate increased from 95% to 100% within 2 months.

Conclusion: CNL collaboration and partnership with the MRSA Prevention Coordinator resulted in an improved swabbing compliance rate, an increase in the number of compliant MRSA nasal screens, and a reduction in the number of patients' at risk for infection. The improved MRSA swabbing performance outcome supports the value of teamwork and communication, and adherence to the VHA guidelines.

Abstract title: Maximizing the Clinical Immersion Experience and Project Development: Student, Preceptor, and Faculty Collaboration

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Background Information:

Based on the curriculum standards set forth by AACN, the CNL student completes a Clinical Immersion Experience of 300 hours. Maximizing learning outcomes for the immersion hours requires specific activities on the part of the CNL student, the CNL preceptor, and the CNL faculty. The CNL as a master's prepared advanced generalist provides clinical leadership for a specific group of clients within a clinical microsystem. Working through a faculty-student-preceptor triad, The CNL assimilates and applies research-based evidence in the planning, design, intervening and evaluation of patient and nursing sensitive outcomes. *A collaborative framework* provides the underpinnings of a dynamic immersion experience, outlining specific activities and assignments. Exemplars considered are the CNL's management of clinical outcomes such as blood sugar control for diabetics, reducing restraint use of patients on ventilation support, improving advocacy and client navigation through community outreach for the homeless, decreasing length of stay for hospitalized patients, engaging patients through coaching, and self-management skills for persons with heart failure. The CNL is mentored through the process, provided with care delivery models for impacting professional development and engaging frontline staff. Fostering a healthy work environment has been noted to improve quality of work life, increasing autonomy of nursing decisions, and decreasing nurse turnover. The CNL student is pivotal to patient and staff engagement. The Clinical Immersion experience begins with a deep analysis and understanding of a microsystem, in a variety of clinical and community settings, including hospital units, outpatient clinics, hospice programs, long-term care and a homeless center.

Aim:

Collaboration involves a group of people working together to achieve a specific goal. For the CNL Clinical Immersion Experience to accomplish the goal of preparing the CNL for certification and practice, a collaborative relationship must exist between the faculty, the preceptor, and the student to design an outstanding clinical immersion experience. The aim of this presentation is to outline the individual roles/activities faculty, preceptors, and students must assume to optimize the immersion experience. Using a *collaborative framework*, faculty, students, and preceptor roles and responsibilities will be identified, and integrated as a road map for a successful clinical immersion experience. This experience culminates with a scholarly project that links need, interventions, and outcomes with impact.

Practices and Outcome Data:

Practices incorporated into the *collaborative framework* include the roles and responsibilities of faculty, preceptors and students. The collaborative framework guides the planning, development, analysis and evaluation of the Clinical Immersion Experience, culminating with a scholarly project.

Faculty must be cognizant of the need to design foundational assignments highlighting leadership, team building, motivation, professionalism and communication – all critical skill sets for the practicing CNL. Students have exposure to the current and up-to-date information and evidence from the Institute of Medicine (IOM), Agency of Healthcare Research Quality (AHRQ), Institute of Healthcare Improvement (IHI), National Committee on Quality Assurance (NCQA) and other reports that provide the background for a deeper understanding of their microsystems and needs that emerge from this work. Doing work in real time with real patients and staff, faculty guides the student through a Needs Assessment, Workflow and Gap Analysis and development of an evidence-based quality improvement project. Reflection exercises on emotional intelligence and leadership offer students the opportunity to understand their influence in the process and how they are able to be persuasive in improving the environment of care delivery. Faculty is responsible for assuring that student comes prepared and equipped to take on the challenge, ready and confident to engage and work with the patient and interdisciplinary teams. Standards must be understood, allowing the student opportunities to directly apply knowledge to specific cases.

Preceptors are integral to the process affording opportunities for the CNL student to assume accountability for client care outcomes. As part of the CNL student's role adjustment in the unit, the preceptor must help the student to identify role priorities and potential role conflicts as well as assist the CNL student in the navigation of unit "politics". The Preceptor must be willing to assume a coaching/mentoring role, thus allowing the CNL student an opportunity to apply new knowledge, attempt the application of new strategies, and create opportunities for innovative expression. Preceptors often appreciate the evidence-based research that can be use to determine how the microsystem "stacks up" to best science. The appreciation of each one's contribution promotes authentic communication and collaboration.

Students must be willing to design, implement, and evaluate plans of care for a group of patients based on evidence based practice. The didactic content and clinical immersion experience go hand in glove, providing the foundation for the student to develop the confidence to engage in this creative work. Faculty facilitates the active learning of the CNL student, thus preparing them

to “take on,” the challenges in each microsystem. Fundamental concepts of leadership, change, quality, emotional intelligence, motivational interviewing, and readying the environment for improvement are cornerstone to the CNL student’s understanding of their microsystem, be it a hospital unit, hospice, outpatient clinic or a homeless center. CNL students becoming dynamic partners in their microsystem, serving as role models, change agents, and part of the solution to care improvement and innovation. A well thought out, and executed Clinical Immersion Experience goes far to prepare stakeholders to appreciate this value-added clinical leadership role.

Conclusion:

A *collaborative framework* provides the underpinning for maximizing the Clinical Immersion Experience and Project Development. Describing the work of the CNL student in real time with real patients and staff, guided by their faculty and preceptor will be presented. Using a variety of tools, such as a Needs Assessment, Workflow and Gap Analysis and development of an evidence-based quality improvement project are integrated into this framework. Reflection exercises on emotional intelligence and leadership offer students the opportunity to understand their influence in the process and in the environment of care delivery. Exemplars of work accomplished through the Clinical Immersion Experience, and how faculty, preceptor, and student engage in the work will be outlined.

Abstract title: Standing Up the VA Clinical Nurse Leader Implementation & Evaluation Service

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Background Information: The Veterans Health Administration (VHA) Office of Nursing Services (ONS) Clinical Nurse Leader (CNL) Spread Plan is a portfolio of multi-year activities guided by a systems redesign flow improvement approach to promote and facilitate full implementation of the CNL role across the VA system. One of the activities designated in this portfolio is the CNL Implementation and Evaluation Service that is being established as collaboration between the ONS and the Central Texas Veterans Health Care System (CTVHCS). This service will provide consultation and assistance to VA Medical Centers, academic affiliates offering a CNL curriculum, and individual CNL students and preceptors.

Aim: The overall objective of the CNL Implementation & Evaluation Service is to support and integrate with the other activities in the ONS CNL Spread Plan portfolio for the purposes of overcoming barriers to implementation and sustainment of the CNL role, to employ and fully integrate the CNL role into patient care models, to embed quality, safety, and efficiency into patient care delivery, and to enhance collaborative partnerships with academia and among inter-professional teams.

Methods/Programs/Practices: Field-based infrastructure at CTVHCS will provide services to other VA Medical Centers that include assistance in fostering clinical and academic partnerships, readying environments for CNL role implementation and sustainment, developing CNL preceptors, guiding development and analysis of metrics, outcomes, and expectations related to the impact of the CNL role, collaboration on dissemination of findings/activities, and compiling summary reports for ONS initiatives involving CNL role implementation. Consultation services are multi-faceted and will provide flexible options to VA Medical Centers based on identified need and phase of CNL program implementation.

Outcome Data: Anticipated outcomes included in the evaluation framework for the CNL Implementation & Evaluation Service are measures evidencing expanded implementation of the CNL role in the VA, standardized core outcome metrics of the impact of the CNL role in patient care delivery in the VA, and indicators of value of the service to the various stakeholders across the VA system.

Conclusion: The VHA Office of Nursing Services launched a multi-year portfolio of activities to support full implementation of the CNL role at all points of care in the VA by the year 2016. This presentation describes the CNL Implementation and Evaluation Service being established as one portfolio activity in collaboration with the Central Texas Veterans Health Care System. This consultative service is expected to integrate with other portfolio activities in the ONS CNL Spread Plan to facilitate both implementation and evaluation of the CNL role and the fulfillment of the ONS strategic initiative.

Abstract title: Changing Practice of Medication Documentation: A CNL approach to motivating accountability

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Background Information:

Saint Mary's Health Care had a significant problem with nursing staff failing to document narcotic medication delivered by Patient Controlled Analgesia pumps (PCA) and Patient Controlled Epidural Analgesia pumps (PCEA). An audit completed in October 2010 indicated that less than 50% of patients with PCAs/PCEAs had complete documentation of medication administered. Staff was unable to accurately determine how much medication a patient had received by PCA/PCEA. Critical patient safety issues occurred and over 31 incident reports were filed.

A Failure-Mode-Effect-Analysis (FMEA) process was initiated by a multi-disciplinary group to address the problem. The team included Pharmacists, Clinical Nurse Specialists, Educators, and Quality Department representatives. Several interventions including changing the policy, changing the documentation form, computerizing the documentation, staff education,

creation of order sets and staff awareness campaigns were implemented. Despite multiple approaches, practice did not change and documentation remained at less than 50%.

In July of 2010, Saint Mary's implemented the Clinical Nurse Leader (CNL) role and placed 17 CNLs in 11 different Microsystems. After unit assessments were completed, the group decided to tackle the issue of PCA/PCEA documentation. Patient safety issues (over-sedation, poor pain control), patient satisfaction (pain management), and provider satisfaction (physician frustration with lack of critical information) influenced this choice. Utilizing a LEAN process and implementing change strategy at the bedside through the CNL role resulted in documentation increasing to 90% - 100% throughout the hospital.

Aim:

The goal of the project is for 100% of patients with PCAs/PCEAs to have total medication dose delivered documented with each change of caregiver per hospital policy. Root cause analysis identified equipment issues, complex documentation and lack of accountability as key reasons staff were not changing practice.

Methods/Programs/Practices:

A proactive coalition was built and buy-in was sought from the quality department, nurse managers, clinical pharmacists, and all levels of leadership including nursing directors, advance practice nurses, charge nurses, and staff leaders of nursing shared governance. Primary stakeholder support was sought from the Pain and Palliative Care Team.

A process map was created identifying the steps necessary to clear and document PCA/PCEA pump medication administration. Staff quickly identified one barrier as lack of keys necessary to clear the pump. Additional keys were ordered per unit management.

The complexity of the documentation form was analyzed by staff users. PCA/PCEA documentation was the only technology that required an extra form and wasn't found on the Medication Administration Record like all other medications in the hospital. There was no built in alert system in the EMR if staff did not document medication administered. There was no audit process or reporting if staff did not document this important medication. Change of the EMR at the local level was not an option. CNLs created an SBAR communication requesting revision of the EMR and this is being worked on at the national level of Trinity Health.

It was not an option to wait for the EMR to be revised and CNLs looked deeper to see what could be done now to impact practice change. Staff reported that nothing happened when they didn't document medication administered. The difficult issue of lack of staff being held accountable was identified as the true root cause of the problem. Awareness of accountability was influenced by multiple simultaneous change processes that were occurring on every hospital unit – leading to some “initiative fatigue”.

An “accountability ladder” specific to PCA/PCEA documentation was created with members of a multidisciplinary team. Ladder steps included: re-education of the staff and clarity of expectations, coaching and mentoring at the point of care, rewarding practice change and formal counseling if practice did not change. Following initial education and communication of charting expectations, CNLs completed daily chart audits. A reward SBAR email was sent for proper documentation. When incomplete documentation was found, CNLs held a coaching conversation “at the bedside” and sent a follow-up email to the nurse and manager reminding them of the importance of practice change. When documentation was incomplete a second time, a Red Flag Alert was sent to the nurse and manager. In response, counseling action and development of a formal performance plan was initiated. All CNLs and managers used the same tools and messaging which helped motivate practice change across the organization.

Outcome Data

Documentation of total dose delivered from PCAs/PCEAs increased on every inpatient unit of the hospital. A strong partnership with the manager created better compliance outcomes. CNL/manager partnerships made it easier to discuss accountability issues and support one another through coaching and counseling of nursing staff.

Every staff member on high use units had at least one individual discussion with the unit CNL. An average of 85% of staff received a reward SBAR email. Staff reported they valued being recognized for a job well done, which helped to change practice. An email format with visuals was used to provide immediate feedback. This “in the moment” approach was appreciated by staff and most sustained practice change from a bedside conversation and a reward email for safe patient care.

An average of 45% of staff received coaching SBAR emails for failing to document a second time - heightening their awareness of the expectation and giving the message that staff would be held accountable for this practice change. 90% of staff changed practice after this second email. Less than 10% of staff received counseling SBAR emails for failing to document a third time. This small group was primarily composed of staff already in counseling for other practice issues. An additional tool that was found helpful included weekly visual posters celebrating practice change results.

Conclusion:

Many attempts had been made to improve documentation of PCA/PCEA pump medication, but utilizing continuous quality improvement processes at the point of care with CNLs leading the effort made change in practice successful. LEAN principles including a deep root cause analysis helped focus the project to what the real barriers were to change. Positive reinforcement was a powerful motivator to influence staff. CNL coaching “elbow to elbow” at the bedside was critical to the success of the plan. CNLs learned how to stay committed to a long range change process, build staff relationships, utilize continuous rewards, harness the power of multi-media, assume goodness in intentions as a core value, build coalitions between CNLs and nurse managers, and make project success a collaborative experience. Education and appropriate tools were partnered with an accountability process to truly change practice. Future challenges include sustaining change on low incidence units and sustaining change over time in the face of multiple new initiatives.

Abstract title: The Diabetic Post Hospital Telephonic Health Follow-up Pilot Study

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Background Information: Diabetes is one of many chronic diseases that potentiate numerous hospital readmissions. Frequently patients suffering from diabetes are admitted into the hospital for short periods of time to address immediate life-threatening and non life-threatening conditions. Once stable, these patients are given discharge instructions that include a medication review, diet restrictions, follow-up appointments, and any other self management teaching that is needed. Regardless of how distracted and preoccupied the patient may be, the

discharge instructions are given as an intermediary bridge to sustain patients until their follow-up appointment with their primary care physician. Most problems arise after discharge when patients are expected to follow the physician-prescribed new lifestyle that was explained by a nurse within the last few minutes to hours before discharge. Without proper preparation and continued contact, patients return home and revert to the routine they had prior to their hospitalization, forgetting about the instructions they were given. Patient-centered health care interventions are needed to transition patients from the hospital to home, while retaining the aspect of continuity of care. Interventions such as these have no choice but to improve health, facilitate disease management, and decrease hospital readmissions.

Aim: The aim of this evidence based project, The Diabetic Post-Hospital Telephonic Health Follow-up Pilot DPTHFP Study, was to improve patient outcomes by affording a process and tool for nurses to provide more creative diabetic teaching for patients. This was accomplished with the follow-up phone calls and the use of a medical diary. Another aim was to allow the opportunity for nurses to reassess and reinforce the understanding of the provided teaching post discharge, while evaluating a patient's health progress. A final aim of this patient centered project was to demonstrate the level of care the nurse has for the wellbeing of the patient and the primary goal of the nurse to advance the health and self-efficacy of the patient population served.

In order to quantify and measure success of the aims for this project goals were constructed. The main goal of this project was to decrease the readmission rate of this project sample to less than two within the one month timeframe of the project. Another goal of this project was to decrease the averaged blood glucose levels prior to the patient's discharge from the hospital by 10%. Two supporting goals were that the patients would have at least a 60% follow-up appointment attendance rate and that at least 50% of the participants would report that the project was beneficial during the follow-up phone call.

Methods/Programs/Practices:

This project consisted of periodic phone calls from the Clinical Nurse Leader Student (CNLS) to a consented sample of patients discharged home from the hospital that met certain inclusion criteria. After obtaining IRB approval, consented patients were given a medical diary and the CNLS' contact information. The medical diary is a journal given to patients in order to log their hospital course that includes such detailed information as: unit information, healthcare provider's names, new medications and purposes of those medications, abnormal lab work, tests, blood glucose readings, etc. This book was started by the CNLS and given to the patient to continue to log in even after discharge. During the follow-up phone calls the CNLS asked the patient to refer to the book to report recent blood glucose readings.

The first phone call was made within two days post discharge and the second phone call within two weeks post discharge. During the calls the CNLS assessed such outcome variables as readmissions, blood glucose levels, follow-up appointment attendance, the diagnosis time length, medical diary and project benefit, and the patient's knowledge base concerning abnormal blood glucose levels. This knowledge base was tested in the form of a hypoglycemic and a hyperglycemic scenario question. Follow-up teaching concerning diabetes management were then reiterated according to the survival skills education packet given during their hospitalization. Patients were also reminded of the follow-up appointment date and informed about their blood sugar control progress. All patient reported data was documented on a datasheet.

Outcome Data

This project produced the evidence to support the concept that maintaining contact with patients post hospital discharge can have a positive effect on diabetes management as evident by better blood glucose control. While hospitalized, the CNLS calculated an averaged blood glucose reading of 158.7 mg/dL from the medical records of the sample group. This reading increased between the date of discharge and the first follow-up phone call to 170.6 mg/dL. Interestingly, a drop of this averaged reading was calculated by the second phone call to be 135.6 mg/dL. This number was lower and closer to the American Diabetes Association's recommendations for blood glucose control than when the patients were hospitalized. Forty five percent of the sample population completed the study, while four patients were readmitted prior to receiving their first phone call.

All of the goals except one were met for this project. The readmission rate goal was not met because there were three more readmissions than projected. The goal to decrease the averaged blood glucose level prior to discharging from the hospital was met and exceeded with a value of 135.6 mg/DL. A decrease of 10% would have necessitated a value of 142.83 mg/DL. The supporting goal that the patients would have at least a 60% follow-up attendance rate was exceeded because these patients had an 80% attendance rate. Lastly the goal that at least 50% of the participants will report that the project was beneficial was met and exceeded by 100% of the participants reporting favorably.

Conclusion:

The Diabetic Post-Hospital Telephonic Health Follow-up Pilot Study was a great intervention that aided in diabetes disease management, facilitated the transition of care from the hospital to home, and maintained a supporting relationship between the medical team and the patient. This project may serve as a foundation for future initiatives and projects focused at maintaining communication and education dissemination between health care providers and the patient population after discharge. Structured by the social cognitive theory and Kurt Lewin's change theory, this project has proven that continuity of care and contact is a remedy for patients at risk of experiencing reversion of unhealthy habits once transitioned home. The project met goals of decreasing blood glucose levels, positively impacting follow-up appointment attendance, and patient reports of the benefit. This project provides more creative teaching with assessment and repeated reassessments of that teaching and serves as a resource that can affect future action plans and initiatives aimed at improving patient outcomes hospital-wide. Most importantly future studies and initiatives that relate to this project may demonstrate the level of care the nursing community has for the population of patients served and our continued efforts to improve patient outcomes.

4:30 p.m.

Buccaneer A

C-RISE: An Evidence Based Approach to Diabetes Compliance in Adolescence

Barnes, S., Bird, L., Brown, E., Kachman, A., Petree, K., Rapp, T., (MSN-CNL Students)

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Buccaneer B

Evolution of the Clinical Nurse Leader: Inauguration to Influence

Lynn Drummond-Smith, MS, RN, CNL; David N. Alexandrou, MS, RN, CNL; Lorraine R.

Kaack, MS, RN-BC, CNL; Hermes O. Vargas, MS, MBA, RN-BC, CCRN, CMC, CNL;

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Buccaneer C

Clinical Nurse Leader: Implements "The Daily Plan" at VA Connecticut to Improve Veteran Safety and Team Communication

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Buccaneer D

Facilitating Model C CNL Students Transition to Practice through a Better Understanding of the CNL Role

L. McKeon PhD, CNL; S. Webb, DNSc, CNL, NEA-BC; S. Strange-McClora, MSN, CNL; M.

Elliott-Vizcarrondo, MSN, CNL; D. Pavlic, MSN DNPc, CNL; M. Gill, MSN, PhDc

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Ybor Room

Leveraging Technology: Development and application of electronic tools to efficaciously manage care and decrease fragmentation

Kari Hamson-Kalis MSN, RN, CNL; Shannon Hulett MSN, RN, CNL

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Esplanade 1

Enhancing Prelicensure CNL Problem Solving Skills: Use of the Fishbone Analysis

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Esplanade 2

CNL Student Projects: From Assessment Through Dissemination

Teri Moser Woo PhD, RN, CNL, CPNP
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Esplanade 3

How Does an Organization Sustain the CNL Role? ... Sustain the CNL

Susan Wilkinson, MSN, RN, CNL
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Regency 2

Clinical Nurse Leader Impact On Methicillin-Resistant Staphylococcus Aureus Infection Rates

Jackie Rae Jacobson, RN, MSN, OCN, CNL, Lynett King, RN, MSN, CNL,
Norma Patterson, RN, MSN, Linda C. Abercrombie, RN MSN, Francine Jamison RN, MSN,
Christina McCullough, RN, BSN, CCRN
Tennessee Valley Healthcare System
Nashville, Tennessee
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Regency 5-7

Clinical Nurse Leader: The Strategic Advantage in Transforming Nursing Practice

Barbara L. Summers, PhD, RN, NEA-BC, FAAN; Debra Adornetto-Garcia, MSN, RN, AOCN,
NEA-BC; Beverly Nelson, PhD, RN, NEA-BC; Ginny Bowman, MSN, RN, CNS-Onc, AOCNS,
CORLN; Deborah Cline, MSN, RN, OCN
University of Texas, MD Anderson Cancer Center
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C-RISE: AN EVIDENCE BASED APPROACH TO DIABETES COMPLIANCE IN ADOLESCENCE

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Memphis, Tennessee

Background: As part of an Evidence-Based Practice class, student groups were provided scenarios to address as a CNL team. This team's scenario focused on a pediatric unit that cares for adolescents with diabetes. This unit reported one of the primary causes of readmission was uncontrolled diabetes, specifically high HbA1c. Our group was charged with finding an evidence-based solution for reducing recidivism and helping adolescents gain control of HbA1c.

Aim: In creating our program, our goal was to integrate evidence-based approaches to increase adolescent compliance with diabetes management.

Methods/Programs/Practices: In order to address noncompliance in adolescents with diabetes, we created the C-Rise program. C-RISE is Compliance through Reminders, Incentives, and Social Encouragement. The program strives to address those barriers to compliance that are common with the adolescent population. These barriers are largely social in nature and include concern with fitting in with other teens, social eating habits, and teen inclination towards impulsivity. The C-RISE program also attempts to address the issues of "diabetes burnout", shifted responsibility from parents to teens, and subsequent family strain. Evidence has shown that adolescents with insulin pumps were more likely to maintain glycemic control; therefore, our initial pilot program was designed for teens using insulin pumps (Johns, Faulkner, & Quinn, 2008). The program is designed to incorporate the Medtronic MiniMed Paradigm REAL-Time Revel System, which includes an insulin pump, glucose monitoring, and CareLink Therapy Management Software. Use of this software allows the teen's glucose level and insulin administration to be monitored through a computer system. The system uses an algorithm that will send automated texts to the teen to "eat carbs" if BG <60mg/dl or "check ketones" if BG >250. Each teen participating in the C-RISE program should have a phone with texting abilities to enable these interactions with a member of our healthcare team (Carroll, DiMeglio, Stein, & Marrero, 2010). Furthermore, the system will notify the nurse if the teen's blood glucose levels are not being controlled so that he or she may intervene. Studies suggest that adolescents lack the appropriate level of knowledge and responsibility to independently manage their diabetes, as youths with lower collaborative involvement have consistently poorer outcomes (Wysoki et al, 2008). This system incorporates a nurse-patient-parent contract, which enables parents to give teens more freedom and provides them assurance that they will be contacted if potentially emergent situations arise. To further entice adolescents to be compliant with their diabetes regimen, the system rewards teens with points when they are compliant, as evidence suggests that small financial incentives and written reminders encourage greater control of HbA1c levels (Austin & Wolfe, 2011). Once the teen accumulates a predetermined number of points, he or she can choose a gift certificate to a popular venue. The program also provides the teen with social encouragement by providing the teen opportunities to interact with other teens and young adults with diabetes.

Outcome Data: Based on the review of related study outcomes, our expected outcomes are decreased HbA1c, increased compliance as evidenced by decreased recidivism, avoidance of long-term health problems associated with poorer glycemic control, and increased and appropriate independence with diabetic management. By comparing pre-intervention HbA1cs and subsequent cost of care to HbA1cs and C-RISE implementation costs at the completion of a

six-month trial period on the pediatric unit, we will be able to evaluate effectiveness of the program. Analyzing adolescent and parent feedback will provide additional information on program effectiveness.

Conclusion: Rather than focusing on a single approach, our program allows for the synergy of multiple evidence-based practices in order to maximize client outcomes. This exercise taught us how to incorporate multiple evidenced-based interventions to meet the needs of a specific population. This project highlighted the value of employing evidence-based interventions in clinical practice as CNL students.

Abstract title: Facilitating Model C CNL Students Transition to Practice through a Better Understanding of the CNL Role

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Background Information:

Model C CNL students require more than a basic understanding of the CNL role to successfully transition into the role after graduation. Standard practice calls for CNL-precepted experiences to learn the CNL role, though unfortunately, there are insufficient practicing CNLs® to accommodate large student cohorts. The AACN Whitepaper is helpful in defining competencies required for CNL practice, however, role expectations are typically aimed at the experienced nurse, thereby making it difficult for novice nurses to understand *what CNL practice is*. For example, CNL competencies, such as interprofessional team supervision, typically take five years of nursing practice to acquire. Publications about CNL practice are also helpful in role understanding, however, most describe outcomes expert nurses rather than those of the novice or advanced beginner.

In 2010, 48 students in a Model C program were enrolled in the *CNL Practicum*, a 315-hour immersion experience in the CNL role. There was only one local practicing CNL® who worked in an institution with a lengthy student credentialing process. Subsequently, considerable barriers needed to be overcome to provide 48 students with an authentic CNL experience. In addition, introducing students to Model C graduates who transitioned to the CNL role also seemed like an insurmountable task until we attended the 2010 CNL Summit. Two bright, energetic, and deeply committed CNLs® presented their story of assuming a CNL role while an advanced beginner nurse. After the presentation, we immediately contracted with the CNLs® to share their journey and impressive outcomes with our students, faculty and practice partners.

Aim:

The aim of this presentation is to share how we collaborated with three CNLs® to facilitate second-year Model C students' understanding of the CNL role during the final term of their program. Information about the development, implementation, and evaluation is provided for two clinically-focused activities: *Day in the Life of an Expert CNL®* and *Lessons Learned by Advanced Beginner CNLs®*.

Methods/Programs/Practices:

The first step in developing the *Day in the Life of an Expert CNL* was to negotiate an abridged student credentialing process because the traditional process took more than four weeks to complete. Because students were not providing direct care during this clinical activity, a new process to assure patient confidentiality was developed that entailed completion of a 30-minute on-line credentialing program. The next step involved collaboration between faculty and the CNL® to develop a reflective journaling format based on the eight CNL role functions described in the CNL Whitepaper. The final step involved assigning students in pairs over a 3-month period for a 1-day CNL observational experience.

The two CNLs® began *Lessons Learned by Advanced Beginner CNLs®* by sharing their first impressions as novice nurses—shifts beset with dysfunctional processes, unsafe work-arounds, and little time to learn about their patients, a hallmark of CNL practice. They discussed how they convinced their manager to implement the CNL role (budget neutral) and how they systematically met with staff to understand their concerns and identify what staff perceived as barriers to safe nursing practice. The CNLs® explained how they measured problematic core processes and collaborated with the interprofessional team to create better systems that improved core measures, reduced costs, increased revenue, and provided more time for nurses to spend with patients and families. The CNLs® encouraged faculty to emphasize relationship building, systems engineering methods, and cost-analysis and presented a cost-benefit analysis for implementing the CNL role to leaders from the practice partnership.

Outcome Data

Student journal entries for the *Day in the Life of an Expert CNL®* suggested that they each had multiple opportunities to observe CNL practice. Examples included:

- The CNL® worked with the patient care team to develop a process that would assure timely transport of patients at discharge and reduce ED patient boarding time.
- The CNL® lead a patient care team in the development of a computer system template for intravenous line insertion and maintenance.
- The CNL® implemented a rounding tool which identifies high risk patients for c-difficile infection to reduce risk of patient cross contamination and expedite treatment.

Many students reported that *Lessons Learned by Advanced Beginner CNLs®* provided them with a better understanding of the CNL role since most of the improvement examples focused on systems engineering rather than advanced clinical practice. This distinction was important for the Model C students because in general, they had greater confidence in their previous work and newly acquired systems improvement skills than their general nursing skills. Several students shared concerns over inflated and unrealistic expectations of *master's-level CNL practice* by nurses with many years of experience. However, as a result of this presentation, students had a better understanding how leveraging their specialized quality and safety skills could help them transition to a CNL role. In addition, after the presentation, faculty planned adding more communication content to enhance student relationship building skills, and nursing practice leaders committed to drafting a CNL job description in collaboration with core CNL faculty.

Conclusion:

Facilitating Model C CNL student understanding of CNL role requires innovative, creative, and collaborative approaches because of the few CNLs® in practice. With better role understanding by students, faculty, and practice leaders, it is hoped that Model C graduates will transition into CNL roles early in their career, leveraging their prior work experience and new nursing and systems knowledge to transform the practice environment for safer and better quality care.

Abstract title: CNL Student Projects: From Assessment Through Dissemination

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Guiding students through the process of designing and implementing quality improvement projects is a major role of the Clinical Nurse Leader (CNL) faculty. The quality improvement project provides the opportunity for CNL students to gain experience with multiple skills within the CNL role expectations that build toward meeting the AACN CNL End-of – Program Competencies. This presentation will discuss the process used at University of Portland to guide students through their quality improvement (QI) projects from the assessment of the microsystem to the dissemination of their findings in a public presentation.

The University of Portland CNL clinical projects evolve out of the assessment of the clinical microsystem the students conducts when they start their clinical hours. Students are taught a systematic approach to microsystem assessment based on the 4 P’s approach of assessing patients, professionals, processes and patterns (Nelson, Batalden & Godfrey, 2007). The assessment allows students to operationalize content they were taught in courses such as informatics, communication and resource management into the clinical setting. At the completion of the assessment, there are usually one or more areas of quality and/or safety that emerge and the decision on which issue to address during the QI project is guided by the faculty and preceptor.

The planning and implementation of the QI project require the student to build more skills toward meeting the End-of-Program Competencies. For example, CNL students are pressed to use their communication skills within multidisciplinary teams to implement their projects. Most QI projects involve educating providers, patients or both and require students to utilize teaching/learning principles and strategies to strengthen their educator role. Implementation of the project also teaches the student the challenges of creating change in a complex system.

The evaluation and dissemination phase of the QI project provide the student with additional learning and competency building. Students use skills learned in their statistics and applied research courses to evaluate the outcomes of their project. Whether the student has a statistically or clinically significant outcome from the project or not, the process of evaluation is critical for students to understand how to assess outcomes in the microsystem. Additionally the process of writing and speaking about the outcomes of the CNL student QI project develop dissemination skills that are critical to masters prepared nurses and to gaining a wider acceptance of the CNL role in the healthcare setting.

The end result of the CNL QI project is that University of Portland CNL graduates are comfortable with the process of guiding change in the microsystem and speaking publically about the role the CNL can have in improving the quality of patient care.

Abstract title: Evolution of the Clinical Nurse Leader: Inauguration to Influence.

Authors/credentials: Lynn Drummond-Smith, MS, RN, CNL; David N. Alexandrou, MS, RN, CNL; Lorraine R. Kaack, MS, RN-BC, CNL; Hermes O. Vargas, MS, MBA, RN-BC, CCRN, CMC, CNL; Frances M. Zarella, MS, RN, CNL.

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Background Information:

Since mid-2006 the James A. Haley Veterans' Hospital has been a leader in implementation and development of the Clinical Nurse Leader (CNL). The Tampa VA has the distinction of implementing one of the first CNLs in the state of Florida and has since increased that number to 11 certified CNLs. Ongoing physical presence of academic partner faculty during and after graduation from the CNL program provided mentorship in the CNL role. The facility CNLs have led efficiency improvement projects, developed hospital policies and procedures and ultimately developed a CNL forum. The CNL forum enjoys hospital-wide influence with all services and systems within the James A. Haley Veterans' Hospital. Concurrently CNLs serve in several elected leadership positions within the shared governance organization of nursing service.

Aim: This presentation will demonstrate the process of enhancing the bedside point-of-care CNL role with strategic steps that influence hospital-wide planning and operations, primarily through interprofessional collaboration and systems redesign.

Methods/Programs/Practices: Lecture and discussion will demonstrate the journey of the CNL from novice to leader at the James A. Haley Veterans' Hospital. Outlines of the methods utilized by CNLs at this facility include: committee leadership, implementation and interpretation of tests of change, aligning frontline staff work with the organizational strategic plan and hands-on patient care focused on mentorship.

Outcome Data This presentation will include outcome data from test of change including:

Establishing Multidisciplinary Patient Goals

Expanded Patient Information Database

Designing and implementing several order sets; i.e., Ventilator Associated Pneumonia Prevention and heart failure.

Establishment of a system to identify a patient's falls risk

Developed a Transforming Care at the Bedside Toolkit

Leadership roles in Shared Governance: Practice, Quality and Advocacy Councils

Rapid Process Improvement Workshop: Improving discharge medication delivery

Establishing the CNL Forum to provide formal clinical leadership within the nursing service shared governance.

Research assistant in multiple studies including; Augmented Communication Networking Network (CAN), Greenfield Innovation: Brain Interface Speller.

Conclusion: Implementing CNL knowledge and skills in an organization occurred in stages in this VA hospital. From one CNL in June, 2006 to, now, 11 CNLs in the organization, there was a progression of spheres of influence from individual CNLs trying to implement the role on a specific unit, to coalescing as a group of CNLs to share concerns and strategies, and presently to the establishment of a formal organizational element in nursing service's shared governance: the CNL Forum. The progression of spheres of CNL influence have affected the hospital

organizational structure by attaining CNL membership in: nursing strategic planning, hospital strategic planning, nursing practice council, nursing quality council, and coordinating council. The interprofessional work of CNLs have been rewarded with a Veterans Health Administration Office of Nursing Service innovation award, external funding for projects and other achievements. Factors that influenced the progression of CNL influence in the hospital will be discussed. These factors are felt to be: 1) a unique partnership between the academic unit and the hospital; 2) organizational support, first within nursing leadership and then among physician and other clinician leadership; 3) intersection with NON-clinical departments and sections who heretofore had not always had positive relationships with clinical groups; 4) actively seeking to join councils and be elected to chair positions within the organization.”

Abstract title: Leveraging Technology: Development and application of electronic tools to efficaciously manage care and decrease fragmentation

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Background Information:

While facing the multiple demands of a complex healthcare environment, Clinical Nurse Leaders (CNLs) are responsible for managing and coordinating care that results in safe, high quality, cost effective, patient/family centered care. By leveraging technological resources of an electronic medical record (EMR), healthcare professionals can efficaciously identify, prioritize, respond to, communicate and track the ever-changing needs of patients and families, ultimately leading to decreased fragmentation across the continuum of care.

Aim:

The CNLs at Gundersen Lutheran recognized the need to utilize informatics to improve coordination and management of patient care throughout the stay and upon discharge. Leveraging this resource, the CNLs with support from Information Systems designed electronic tools to provide point in time reports of patient status allowing interdisciplinary staff, guided by CNLs, to efficaciously manage the needs of a 29 bed medical/surgical unit. Our goal is to promote/support Patient and Family Centered Care that will consistently culminate in safe, efficient discharge.

This presentation will:

- 1) Identify key components of CNL designed electronic tools.
- 2) Promote an understanding of how the electronic tools are utilized to improve coordination and management of patient care throughout hospitalization, including discharge.

Methods/Programs/Practices:

Electronic reports were developed:

- 1) The Interdisciplinary Planning Navigator: Initiated on admission, partially auto-populated, continuously updated from EMR, checklist and communication tool. Viewed and updated by

multiple disciplines, this tool tracks patient/family needs/progress and communicates patient/family's plan for the day and plan for the stay (discharge plan).

- 2) The Nurse Report: Auto-populated/continuously updated from interdisciplinary documentation in the EMR. Communicates important information to community healthcare agencies (i.e. Skilled Nursing Facilities (SNFs), Home health Agencies) for referral and handoff to promote safe, efficient discharge
- 3) CNL Tracking Report and My List: Two reports, auto-populated/continuously updated from EMR. Provides point in time update of prioritized/critical information of every patient on 29 bed medical/surgical unit. Allows CNL to insert patient specific tracking notes. Allows CNLs to efficaciously identify areas of risk or "hotspots" and track progress.

These tools extend our eyes and ears and give us direction as we collaborate with interdisciplinary staff. The tools provide a consistent, efficient method of tracking and communicating patient needs and progress.

Outcome Data

Reported measurements include:

- 1) Direct expense per discharge: 8% reduction
- 2) Hours per patient day: 15.5% reduction
- 3) Delays in discharges to SNFs: 26% reduction
- 4) Continuous observation hours: 48% reduction (Jan-May 2011)
- 5) Injury from falls: 66% reduction (Jan-Aug 2011)
- 6) Patient Satisfaction: 6% increase (4th quarter 2010)
- 7) Decreased internal diverts and holds
- 8) Only medical/surgical unit with increased staff engagement scores
- 9) Multiple anecdotal reports from interdisciplinary staff including physicians and residents indicating improvement in communication, satisfaction, and accountability

Conclusion

Technology is a valuable healthcare resource and can be utilized to enhance the work of CNLs and interdisciplinary staff. Application of electronic tools on the medical/surgical unit resulted in cost savings, decreased delays, smooth transitions of care and increased safety while at the same time promoted staff engagement and patient satisfaction. These tools are necessary for CNLs to efficaciously coordinate and manage the care of multiple patients in demanding healthcare environments.

How Does an Organization Sustain the CNL Role? ... Sustain the CNL

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In 2007, the American Association of Colleges of Nursing (AACN) published the White Paper on the Education and Role of the Clinical Nurse Leader. Yet, to date, many of the nurses who have achieved CNL certification are not practicing in that capacity. Year after year, conferences are being held with the express purpose of teaching nursing educators, administrators, and students how to recite an "elevator speech" about the CNL and the value this role has to the

health care industry. So, why, four years later, are we still trying to define, articulate, defend and promote the role? Is it that the role isn't needed, or maybe, is it because the longevity of a CNL is short-lived, and thus viewed as a transient misstep?

The role has substantiated effects. Pick up any nursing journal, read a book written by James Harris or Linda Roussel, attend a conference where Marjorie Godfrey is the guest speaker, or Joan Stanley can dance a dance, and even the uninitiated soul could articulate the value of this role. Quality indicators have improved; patient satisfaction has improved; compliance with core measure has improved; all measurable patient outcomes have had a positive effect because of implementing the CNL.

As a CNL with only one year of experience under the belt, the few CNLs this author has had the pleasure of meeting and working under the tutelage of, have either left the role, taken a job as a nurse manager, or abandoned the role altogether, leaving this author scratching her head and wondering why. However, when examined closely and compared, the plight of these CNLs to my own reveals that I have had the incredible support from my chief nurse officer, director of nursing, nurse manager, and clinical instructor from the school of nursing.

Nurses who enter this role, especially nurses who have worked as a staff nurse or charge nurse, find themselves in a world all alone. They are no longer part of the "floor," nor are they nurse "managers." Whom do CNLs eat lunch with? Whom do CNLs bounce ideas off of? It is highly unlikely that a second CNL is employed within the organization. Who defines the CNL goals, their purpose? Who measures their success? Who can even accurately articulate a job description or annual competencies? How will CNLs survive and thrive?

Strong support from nurse leaders, knowledge of the role and the positive outcomes it can generate, and consistent meetings to remove barriers to ensure success, has proven to be key in successful implementation and sustainability of the role at this author's organization. The past year as a CNL has been the most rewarding and provided the most professional growth of this author's lifetime. The expected goal, net savings, and/or cost avoidance for the first year was \$53,000. The actual savings/cost avoidance was a little over \$3 million. How did that occur? Was it the genius extraordinaire of the CNL, or was it the combined efforts of nurse leaders with a vision for the future who helped bring about the success?

What is necessary to sustain the role? Defining and establishing attainable metrics and consistent meetings with key players who have the authority and power to remove barriers the CNL may incur are critical to the success of the role. Providing names, contacts, and being copied on emails to guarantee attainability of goals also ensures success. Guiding the CNL to look at the scope of nursing from a financial standpoint, or encouraging the CNL to become actively involved with clinical partners and affiliations helps to ground the CNL. Nurse managers who are open to new ideas and concepts, without feeling threatened or intimidated can make the CNL flourish. Fostering an environment for the CNL to voice thoughts, ideas, and opinions (groupthink) is critical.

The role of the CNL was not just needed in 2007, but is also needed today. Consistent meetings, removing barriers, and establishing collaborative relations and partnerships, will not only sustain the CNL, but will also cause the CNL to thrive. The positive effects that the CNL has had on the American health care system, has not only improved relations with nursing, physicians, administration, and patient care outcomes, but has also improved the financial bottom line of the hospitals that have utilized the role.

Abstract title: Clinical Nurse Leader: Implements “The Daily Plan” at VA Connecticut to Improve Veteran Safety and Team Communication

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Background Information: Healthcare institutions are continually researching improved performance measures to improve patient safety. Joint Commission National Patient Safety Goal, “Encourage patients’ active involvement in their own care as a patient safety strategy.” The Institute of Medicine’s report “Crossing the Quality Chasm” has recommended for patients to be viewed as active and involved members of the healthcare team. The Daily Plan was developed by the VA National Center for Patient Safety Department to reduce the disparities in safety and communication in healthcare between the Veteran and VA healthcare team.

Aim: The goal in implementation of the Daily Plan at our facility was to improve Veteran participation, communication and understanding of their healthcare plan. Focusing on patient safety and education with a Patient-Centered care approach; to improve collaboration with the Veteran and Inter-professional team members.

Methods/Programs/Practices: The Daily Plan was piloted on a 30 bed medical/surgical unit. Inter-professional team members were identified prior to implementation with the CNL as the identified team leader. Patient criteria and distribution were developed with team member input. Pre and Post Questionnaires with a focus on Veteran satisfaction were developed. Veterans were given the Daily Plan every morning by the CNL, along with an information booklet and journal. Veteran healthcare was discussed at the initial contact and follow was required to address any other concerns relating to a variety of identifiers examples included but were not limited to; medication, allergies, diet, procedures, demographic and NOK information.

Outcome Data: Pre satisfaction questionnaires were taken in regards to Veteran participation, communication, and understanding in their healthcare plan. The Data revealed that 66% of Veteran did not feel they participated, communicated or understood their healthcare plan. Post satisfaction questionnaires after implementation of the Daily Plan noted by Veterans 90-100% felt they actively communicated, participated, understood and were encouraged to ask questions in regards to their healthcare plan and would recommend utilizing the Daily Plan.

Conclusion: In conclusion the phase 1 pilot of the Daily Plan was successful. VA Connecticut will be participating in phase 2 trial of the Daily Plan. After completion of phase 2 trial the goal is to implement the Daily Plan across all units in our facility. Incorporation of the Daily has led to discovery of near-miss events with medications, allergy, demographics, NOK, and diet documentation/orders. It has also increased Veteran satisfaction, communication and dialogue among CNL, Veterans, families and other members of the inter-professional teams.

Abstract title: *Enhancing Prelicensure CNL Problem Solving Skills: Use of the Fishbone Analysis*

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Background Information:

The Clinical Nurse Leader (CNL) role emerged as a way to engage highly skilled clinicians in outcomes-based practice and quality improvement (AANC, 2005). For the CNL prelicensure nursing student, possessing the ability to think critically about system process issues is central to their ability to translate evidenced based practice into the provision of quality nursing care. The graduating Rush CNL nursing student is required complete a Capstone project, which gives students the opportunity to integrate the knowledge and skills acquired throughout the advanced generalist nursing program. The focus of the capstone project is the development of an evidence-based plan to improve healthcare outcomes for a patient cohort/population. Part of the project is a problem statement and analysis. Historically, problems statements and analysis were narrow focused and required much faculty assistance. Two of the capstone faculty had previously attended a Quality and Safety Education in Nursing (QSEN) Training session. The goal of QSEN is to prepare health professionals to lead the continual improvement of quality, safety and value of healthcare (QSEN, 2010). During the Quality Improvement session attendees engaged in an exercise focused on the use of fishbone diagramming with patient case scenarios. One faculty had extensive experience utilizing this tool in the clinical practice setting. Both faculty agreed that this exercise could offer the CNL nursing students an opportunity to engage in developing the ability to critically think about system process issues related to their proposed targeted Capstone problem and enhance their problem solving skill set lifelong in the provision of quality nursing care.

Aim:

The aim of this innovation in teaching is to provide the graduating CNL nursing student the opportunity to engage in developing the ability to critically think about system process issues related to their proposed targeted Capstone problem and enhance their problem solving skill set lifelong in the provision of quality nursing.

Methods/Programs/Practices:

Core to the role of the CNL is the ability to critically think in order to provide outcomes-based practice and improve the quality of care at the point of care. For the prelicensure CNL student, faculty noted that problem identification was the most difficult part in problem analysis. To gain practical experience in using problem solving techniques in a group, an exercise known as the “Fishbone” was initiated. This exercise was incorporated into the initial week of coursework in the last term. The time allotment was 3 hours.

CNL nursing students were self divided into groups of no more than 6 students. Using two faculty (both of whom had attended the QSEN training; one had extensive experience with Fishbone diagramming in clinical practice) served as facilitators for the exercise. Student groups self selected patient case scenarios numbered from 1-4, a copy of a fishbone diagram for use, and post it notes. Students were given 30 minutes to complete their group’s fishbone analysis.

During this work group time, the facilitating faculty rounded on groups to clarify questions and provide feedback on group process of problem analysis. At the end of the group exercise, the facilitating faculty reviewed each group's fishbone analysis with the remaining student groups.

Outcome Data

Upon completion of this exercise, CNL students reported that they were able to complete the problem identification process with greater ease and understanding for their Capstone project. Students further reported that this exercise made the didactic portion of the CNL prelicensure program "come alive". Several faculty who served in an advisory role for student capstones had no knowledge of the initiation of this exercise. Upon review of CNL prelicensure students Capstone problem identification, these faculty commented on how much clearer the proposed interventions were because the problem identified was more defined and specific to the agency/unit where the CNL prelicensure students completed their Capstone. Faculty further identified that these students required much less prompting in problem identification. Another outcome was the ability of the CNL prelicensure students to model and teach the process of problem identification using the Fishbone analysis with other member of the interdisciplinary healthcare team at multiple points of care delivery.

Conclusion:

Based upon faculty and CNL nursing student feedback, it was determined that this fun exercise offers the CNL nursing students an opportunity to engage in developing the ability to critically think about system process issues related to their proposed targeted Capstone problem and enhances their problem solving skill set lifelong in the provision of quality nursing care.

CLINICAL NURSE LEADER IMPACT ON METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS INFECTION RATES

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Background

In 2007, a national initiative by the Veterans Association (VA) was introduced to reduce the spread of Methicillin-resistant Staphylococcus Aureus (MRSA) in all VA facilities. In 2006, Tennessee Valley Healthcare System (TVHS) had a total number of 43 healthcare associated infections, with an approximate cost of 1.7 million dollars. With the introduction of the "MRSA bundle", MRSA testing of all patients who were admitted, transferred and discharged consistently got their nares swabbed. As MRSA rates continued to rise, the initiative hoped to see a decrease in the number of healthcare associated infections.

AIM

The multidisciplinary team including the clinical nurse leaders (CNL), clinical care facilitators (CCF) and the MRSA co-ordinators, collaborate to decrease the number of MRSA infections. The teams recognize the importance of getting patient and staff participation for this initiative to meet the nasal swab rate compliance. Education focuses on nasal swab rates, hand hygiene and proper isolation precautions.

Methods

The initiative started with education on MRSA: what MRSA is, colonization versus infection, high risk patient populations, mode of transmission and environmental awareness. MRSA champions on each unit provided one on one staff education on the “MRSA bundle” and swab techniques. Information on MRSA was added to the admission packet, educating both patient and family members on what is MRSA, the precautions to be made and the screening process. Increased awareness of hand hygiene compliance includes ongoing monitoring and posting unit progress reports for staff awareness. Engaging patients in proper hand hygiene, empowers patients to be an active member of their care team. Contact isolation precautions are initiated with any positive MRSA culture. Medical records are automatically flagged MRSA POSITIVE for twelve months, so on readmission, staff are aware that the patient has had a positive MRSA culture.

Outcomes

TVHS has made great strides in reducing the spread of MRSA with the MRSA initiative. From 2006 to 2011, we have decreased the healthcare associated infections from 43 to 9. This is a 79% reduction for TVHS. Nationwide the VA saw a 60% reduction of infections in just three years (U.S. Medicine, May 2011). Hospital-wide swab compliance rates are above 90% for admission, transfers and discharge. Nursing hand hygiene continues to improve with 86% compliance for 2011. Adherence of healthcare workers with hand-hygiene procedures has been poor, with an overall average of 40% (CDC, MMWR, October 2002). With the flagging of the medical records, appropriate isolation precautions are immediately initiated with all readmissions, decreasing the potential exposure of others.

Conclusions

The CNL/CCF team continues to be diligent with staff education on proper hand hygiene, isolation precautions and nasal swabbing of our patients. Hand hygiene is an opportunity for improvement with staff. The implementation of the MRSA initiative has shown to decrease infection rates. Continued monitoring and on-going education will help TVHS continue to meet the initiative goal and change the culture at TVHS.

Abstract title: Clinical Nurse Leader: The Strategic Advantage in Transforming Nursing Practice

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Background Information:

Nurses are uniquely positioned to realize their full potential to shape the future of health care delivery. This potential is particularly compelling in the setting of a hospital-based, comprehensive cancer center.

The ever-present demands to increase “value” in health care delivery have highlighted the deficiencies of acute, hospital-based health care. The very structures and processes of nursing and hospital care which previously offered promises of improvement can now be viewed as driving forces for fundamental change:

- Patients in hospital settings today are often subjected to fragmentation in care delivery in the context of multi-specialty, multidisciplinary care;
- Compressed nursing work schedules lead to lack of continuity both in clinical nursing care and in handoffs among members of the nursing and medical team;
- Payers are focusing on outcomes of care that are within the practice realm of nurses; and
- Wages and salaries for registered professional nurses have, and will continue to rise, as demand exceeds supply; at the same time, personnel expenses in health care are a frequent focus for cost savings

Nothing short of a transformational model of nursing care delivery will be sufficient to insure the future role of nurses in this care setting. The CNL role provides the essential functions and expertise to support continued improvements in care quality at lower costs.

Aim:

This presentation will address the rationale, key components, and strategic goals underpinning a model designed to use the Clinical Nurse Leader (CNL) as a strategic advantage in transforming nursing practice and care delivery. The new model is designed to develop, implement and sustain a group practice culture of nursing care in which members of each nursing team, led by the CNL, are collectively accountable and responsible for the outcomes of care delivered to patients in the group practice.

Methods/Programs/Practices:

Implementation of the Clinical Nurse Leader (CNL) role in the absence of an organizing framework for practice presents several risks. While the role has intrinsic value, in order for the CNL to be sustainable, the role must be hard-wired into care delivery in a manner that is linked to quantifiable improvements resulting from CNL practice. The Primary Team Nursing Model© was developed to provide the practice context and framework for the CNL to influence improvements in clinical, financial and human resource outcomes. Creation of the Primary Team Nursing Model© and the role of the CNL within this model has been a multi-year process, with implementation of demonstration projects projected to occur within the next 12 months. Under the direction of the Chief Nursing Officer, a team was charged with developing, implementing and evaluating plans to embed the CNL within the Primary Team Nursing Model©. Planning for this transformation has included work to delineate nursing roles for the CNL as well as all the other members of the nursing team; setting budgetary targets; developing plans for resource allocation to support program planning; employee and team-based development; building effective partnerships with colleagues in academic nursing programs to build CNL curricula; and creating a cascading communication and change management plan.

Outcome Data

The presentation will include review of the proposed outcome measures to be incorporated in program evaluation. The planning team has identified foci for outcome evaluation including

clinical outcomes (rates of readmission, post-discharge visits to the emergency room, mortality); nurse sensitive outcomes (falls, pressure ulcers, CLABSI, etc.); financial outcomes (costs per patient episode of care; total nursing salary costs, etc); patient satisfaction outcomes; and nursing professional practice outcomes (autonomy and control over practice). The presentation will summarize progress to date in the development and implementation of this transformational nursing care delivery model.

Conclusion:

A transformational nursing care delivery model predicated upon the role of the CNL offers a vision for the future that has the power to remedy the chaos plaguing hospital-based acute care. The vision of a preferred future must be married to a well-defined business case and to dedicated structures in order to secure the CNL role and the place of professional nursing in health care delivery.