



CNL Summit 2012

POSTER PRESENTATIONS

January 19-20, 2012

CNL Summit
Hyatt Regency Tampa

Poster Presentation Session
Thursday, January 19, 2012

During the reception on Thursday, January 19, posters will be presented within two different time slots, from 5:30-6:30 and from 6:30 to 7:30 pm. Poster presentations will be divided alphabetically into the two time slots as listed below. Posters will also be available for viewing on Friday, January 20, until 1:30 pm.

Posters A-J
5:30 to 6:30 PM

Innovation: Clinical Nurse Leader facilitates clinical implementation of the NICHE Program (Nurses Improving Care for Healthsystem Elders)

Authors/credentials: Pamela Abraham MSN, RN, CNL

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CNL Partnership for Improvement: Educational Poster Template

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The Clinical Nurse Leader: Shaping the New Health Care Environment

Authors/credentials: Kim S. Astroth, PhD, RN¹, Brenda Recchia Jeffers, PhD, RN²; Deb Stenger MSN, RN, CNL¹

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CNL's Practice: Begins with a story of the Clinical Microsystem

Authors/credentials: Patricia Baker, MSN, RN-BC, CNL

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Improving Fall Outcomes: A CNL's Collaborative Safety Initiative for In-Patient Geriatrics

Authors/credentials: Patricia Baker, MSN, RN-BC, CNL

Institution: Methodist Healthcare System

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The CNL Pain Plan Initiative: Developing an Educational Plan for Identifying and Managing Pain on a NICHE Senior Adult Medical and Intermediate Acute Care Unit

Authors/credentials: Dawn R. Borreson, MSN, RN, CNL, CWOCN, RN-BC

Lauren Stuiwe-Bittenger, MSN, RN, CNL

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Adaptation of Marks-Maran and Rose's reflective cycle in CNL student Journaling to demonstrate achievement of CNL core competencies

Authors/credentials: Sue Butz, MSN, RN, CCRN

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Preventing Hospital Acquired Pressure Ulcers in Hemodialysis Patients: A Nurse-led Quality Improvement Project

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The Evolution of a Nurse-Driven Mobility Initiative on a Certified Stroke Unit: Pioneering the CNL Role in a Magnet Recognized Medical Center

Authors/credentials: Gordana Dermody RN, BSN, MSN (CNL candidate)

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Prevention of Readmission within 30 Days among the Chronic Heart Failure Population: Implementation of the Clinical Nurse Leader Role

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Unit-Based Falls Team Fosters Awareness and Prevention of Inpatient Falls

Author: Catherine Edmonds MSN, RN, CNL; Pamela Abraham MSN, RN, CNL

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Hospital to Home: Patient as Partner in Delivering High Quality Transitional Care for Older Adults

Author: Helen Finley-Way, MSN, RN, CNL
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A New Practice Guideline Regarding Mobility of Patients with Left Atrial Catheters (LAC)

Authors/credentials: Jamie Gilliam, RN, MSN, CNL, CCRN
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CNL Impact on Intermediate Training for the Bedside Nurse

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The Structured CNL Practicum

Authors/credentials: Rebecca Greenwood, PhD, RN; Angela Jukkala, PhD, RN, CNL, CNE; Rebecca Miltner, PhD, RNC; Katherine D'Alessandro, MPH
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Joint Ventures for Patients and the Healthcare Team

Authors/credentials: Kim Hall MSN, RN, CNL, CM-VHA
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Clinical Nurse Leader: Implements "Quiet Hour" to reduce unit noise and improve patient satisfaction

Authors/credentials: Bonnie Haupt, MSN, RN, CNL-BC
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The CNL's Role in Initiating the Remote Medical Telemetry.

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Teaching Nurses An Effective Transition to Palliative and Hospice Care in an Inpatient Hospital Setting

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CNL Preceptor Teams

Authors/credentials: Lynnette Howington DNP, RNC, WHNP-BC, CNL & Penny Moore RN, Ph.D., CNL
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Patient and Family Nurse-Physician Rounding to Improve Communication: Effects on Length of Stay and Patient Satisfaction

Authors/credentials: Heather Huffman, RN MSN-CNL Student
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Abstract title: Using Medication Cards to Improve Patient Satisfaction

Authors/credentials: Jackson, Anita, RN, MSN, CNL; Wilkinson, Susan, RN, MSN, CNL; Williams, Keri, RN, MSN, CNL
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From “OW!” to “WOW!”: Improving CNL Certification Exam Pass Rates

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**Posters K-Z
6:30 to 7:30 PM**

Breathing Life into Dyspnea Relief: Educating Oncology Nurses about Alleviating Dyspnea During the End-of-Life

Authors/credentials: Sarah Kang, RN MSN
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The Scavenger Hunt; A Method for Enhancing Advanced Health Assessment Skills

Authors/credentials: Cynthia R. King, PhD, NP, MSN, RN, CNL, FAAN & Grace Buttriss, DNP, FNP-BC, RN.

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Hospital to Home Care Coordination

Authors/credentials: Paula Lavine-Smartt, MSN, RN, CNL

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Decreasing the 24 – Hour Urine Turnaround Time for Obstetric Patients

Authors/credentials: Leah Ledford, MSN, RN, CNL, SANE

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The CNL Impact on Quality Care: A Decrease in CLABSI

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Home Safety: Fixing Fractures Before They Fall

Authors/credentials: Mary E. Mather, MSN, RN, CNL & Nancy Burdine, RN, MSN

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Community Based Participatory Research: An Intervention Model for Homeless Women with Children Navigating the Health Care System

Authors/credentials: Virginia McCarthy, DNP, CPNP, RN

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The Influence of Patient Care Integrator's on the Reduction of Never Events: Hospital Acquired Pressure Ulcers (HAPU)

Authors/credentials: Kristen Meekins, RN, MS, CNL, PCI & Diana Glod, RN, MS, CNL, PCI

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Examining Rural Point of Care Nurse Leadership

Authors/credentials: Rebecca Miltner, PhD, RNC, Angela Jukkala, PhD, RN, CNL; CNE, Rebecca Greenwood, PhD, RN

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An Innovative CNL Endeavor: Promoting Evidenced-Based Practice Through Nursing Grand Rounds

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Improving Oncology Patient Outcomes through Expansion of the CNL Role

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Initiation and Development of a Fall Prevention Pilot Program: A Collaborative Effort

Dianne Ragno MSN, RNC, CNL; Jean Barry, MS, MSN, RN, CNL

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A Clinical Nurse Leader's Effort to Improve the Perception of Patient Privacy on an Acute Inpatient Medical-Surgical Unit.

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Improving Outcomes Through Staff Development

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A CNL in a non-CNL Role: Implementing a Palliative Care Bundle in an ICU to Reduce Moral Distress

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CNL Lead Interdisciplinary Pharmacy rounds at an acute care hospital enhance HCAHPS scores for the domains pain management and communication about medication.

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Restraint Free: A Quality Improvement Project

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Refining the Restraint Process in the PICU through Implementation of CNL Led Restraint Rounds

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Increasing Access to Medical Care through Case Assessment and Continuity

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Setting the Course: Intentionalizing a Clinical Nurse Leader Hiring and Retention Strategy that impacts Quality Outcomes

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Somewhere Over the Rainbow – Integrating Novice Nurses into the CNL Role

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Controlling Condom Catheter-Associated Infections (CCAI) while preventing indwelling urinary Catheter Associated Urinary Tract Infections (CAUTIs)

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Reaching Critical Mass: CNLs transforming Health Care in a Georgia Healthcare System

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A Voice with Courage is Measurable

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Using Evidence Based Practice at the Bedside to Improve Pain Management for Veterans with Cancer

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Poster Abstracts

Abstract title: Innovation: Clinical Nurse Leader facilitates clinical implementation of the NICHE Program (Nurses Improving Care for Healthsystem Elders)

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Background information

The number of Americans age 65 and older will reach 70 million by 2030, or 20% of the population. Healthcare spending will increase by 25% until 2030. Improving clinical and fiscal outcomes for the elder population is essential. Action was taken by the hospital in response to a letter from a patient's family indicating that specialized needs of the elder population should be a priority. A search was conducted; NICHE was the evidence-based program selected. NICHE is the only national geriatric nursing program that addresses the needs of hospitalized older adults and is a program of the Hartford Institute at the New York University College of Nursing. NICHE designation was achieved by the hospital in 2009. Three coordinators, working in an interdisciplinary approach, the Director of the Office on Aging, the Director of Staff Development and a Clinical Nurse Leader, were instrumental in planning and implementing the program. The NICHE program success has led to an increased engagement by critical team members including the unit Director and other CNL's, which is essential to continued sustainability.

According to the AACN White Paper 2007, the CNL takes primary responsibility for the design, coordination and management of healthcare across the lifespan. The CNL practices within a microsystem and assumes accountability for healthcare outcomes for a specific group of clients on a

unit through assimilation and application of research-based information to design, implement and evaluate client plans of care.

Aim

The NICHE program focuses on the geriatric population and has goals consistent with improving patient outcomes, the in-patient experience, increasing collegial networks, while promoting staff effectiveness and satisfaction. The intent was to provide optimal care for the hospitalized geriatric patient through successful facilitation of the NICHE program in the clinical setting. Recognizing that the NICHE program was consistent with CNL quality and safety measurable indicators, it was logical to direct the program. Coordinating, delegating and supervising the care provided by the frontline health care team by the CNL cultivated a climate of sensitivity, fostering ownership, and a desire to improve outcomes in the current geriatric population located on the unit.

Methods

The CNL and NICHE coordinator role combine to promote awareness of geriatric issues in the acute clinical care setting. In 2009, the Geriatric Institutional Assessment Profile survey revealed nurses' strengths and knowledge deficits. Organizational groups including NICHE coordinators and an advisory interdisciplinary team were formed to review survey results and plan systematic implementation of the NICHE program. Tapping into the team approach enables the focus to be on patient-centered care, emphasizing the value each discipline offers. The CNL recognized that educating RN's on geriatric issues promotes increased awareness resulting in positive patient outcomes. With CNL guidance, six nurses have received certificates of completion, identified a project of interest, prepared a poster and will be implementing their projects.

A NICHE volunteer program was identified as an opportunity to improve the geriatric in-patient experience. It began April 2010 with 3 volunteers who were interviewed and educated by the Director of Volunteer Services and the CNL. Orientation booklets, specialized NICHE badge, and patient activity cart was developed by the CNL.

To address current geriatric patient issues weekly Interdisciplinary Geriatric Rounds began on the pilot unit. CNL's assist staff RN's to identify and present geriatric issues using current patient case studies. A new safety initiative, a Falls team, was developed by CNL's in response to an increase in the falls rate.

Outcome Data

NICHE Volunteers maintain a link between the hospital and service community, acting as goodwill ambassadors, reducing staff workload, while providing personalized one to one interaction with each patient. Patient satisfaction scores reflected in Press-Ganey survey rose from 84% to 90% in an 8 month period after initiation.

Interdisciplinary "Geriatric Rounds" identifies current patient issues. Patients are recipients of team discussion, with care adjusted based on recommendations. The clinical pharmacy team provides collaborative practice by serving as resources, inclusion of Beers Criteria to the pharmacy data base and development of a list of contraindicated medications with alternatives, preventing potential adverse effects in the geriatric patient.

Six Geriatric Resource Nurses (GRN's) on the pilot unit completed the online course. Thirty nurses' hospital-wide will be receiving their certificate of completion and unit specific projects will be implemented.

Falls team created an increase in staff awareness, accountability and response to alarms. In 2009 there were 29 falls, 23 in 2010 and in 2011 there have been eight falls for the first nine months since implementation.

NICHE information is presented at monthly staff meetings and posted on a NICHE bulletin board. Due to the success of the program, a CNL and coordinator presented “Optimizing the Patient Experience through Volunteer Program” and “Interdisciplinary Geriatric Rounds Identifies Current Patient Issues” poster presentation at local and national NICHE conferences. A National Webinar was given by the CNL on May 16, 2011, “Expanding the CNL Role on Quality and Safety” which highlighted the implementation of the NICHE program.

Conclusion

The NICHE program offered CNL’s an opportunity to be an integral part of a dynamic interdisciplinary team in planning, promotion and implementation of an innovative evidence-based program, NICHE, into the Healthcare System. Due to the success on the pilot unit, the NICHE Volunteer Program, interdisciplinary Geriatric Rounds and GRN’s have been initiated and implemented on all other nursing units within the hospital.

Support from key stakeholders including the Chief Executive Officer, Chief Nursing Officer, and Directors on inpatient units is essential to sustain this geriatric initiative.

Clinical Nurse Leaders have the opportunity to be proactive and motivational in their pursuit of safety and quality initiatives for the geriatric population and their families.

Anecdotally, the NICHE program provided geriatric-sensitive and exemplary care to *all* patients in the acute care setting.

Abstract title: CNL Partnership for Improvement: Educational Poster Template

Authors/credentials: LaDonna Adkins RN, MSN, CNL

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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. Within CTVHCS, one of the microsystems is a 28-bed medical/surgical floor. The CNL has been instrumental in improving patient outcomes on this floor in the two years the role has been in place in this microsystem. On this medical/surgical floor, there was a staff turnover rate of 25% from June 2010 to June 2011. The average length of staff retention on this unit was 17 months. In addition, 72% of the staff have been on this unit for less than a year and 63% of the RNs and LVNs coming to this unit are new graduates. The need for ongoing education in providing care for post-operative patients was evident in the microsystem assessment.

Aim: The CNL partnered with the Assistant Nurse Manager to develop a surgical nursing education series to educate new staff as well as to serve as an evidence-based resource for more experienced staff. The goal of the poster series is to provide evidence-based information that has

been approved by the corresponding surgeon as an educational tool for new staff orienting to the unit. Also, maintaining these posters on the medical/surgical unit provides an easily accessible tool for nurses to come back to as a quick reference and resource.

Methods/Programs/Practices: Each poster in the surgical nursing educational series was developed with evidence-based practice and surgeon input. For example: one poster focuses on the Total Knee Arthroplasty procedure. This poster highlights what the nurse should expect on arrival from PACU, post-op day 1, and post-op day 2 through discharge. This section is set up in a pathway format and helps the nurse anticipate how the patient should progress after surgery as well as focus on important performance measures such as discontinuing the foley catheter. There is a section on preventing and treating complications. The poster also includes discharge education and general information on the surgical procedure.

Outcome Data: Partnering with the surgeons to get feedback has been beneficial to strengthening the relationships that our medical/surgical floor has with the surgeons. Nursing staff utilize the posters often and they are used for teaching with new staff. Staff excitement and involvement due to the anticipation of which staff might be featured on the next poster in the series as exemplars of best practice adds to the engagement in this educational initiative. Staff pride and ownership of quality care is increasing and surgeon concerns regarding care have dramatically diminished. Although difficult to isolate as a causative intervention, the potential impact of enhanced staff knowledge and standardized care contributes to improving patient and system outcomes for surgical patients.

Conclusion: Educational needs were identified in this medical/surgical microsystem that led to a need for reusable, specific, evidence-based resources. The CNL partnered with the Assistant Nurse Manager and developed a surgical education poster template that was then used to create additional posters in the surgical nursing education series. These educational posters are used for new nurses on a floor with many new graduate nurses and a high turnover rate. The posters are also an excellent reminder and resource to our more experienced nurses and assist in keeping everyone informed and prepared to act.

Abstract title: The Clinical Nurse Leader: Shaping the New Health Care Environment

Authors/credentials: Kim S. Astroth, PhD, RN¹, Brenda Recchia Jeffers, PhD, RN²; Deb Stenger MSN, RN, CNL¹

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Background Information: Passage of the 2010 Patient Protection and Affordable Care Act will require change in health care systems. The Clinical Nurse Leader (CNL) must be prepared to lead and shape the changing environment to achieve maximum outcomes for patients and

families. Movement toward integrated care delivery across the care continuum, the transition of the Centers for Medicare and Medicaid Services (CMS) to a value-based funding model, and accountability for high quality cost effective care are just some of the drivers of this new integrated health care system. Reimbursement models that reward those health systems able to meet benchmark performance standards will result in major shifts in how health systems operate. Expertise in care coordination across the health care continuum is essential for maximum reimbursement. Integration of health services and patient-centered medical homes are two organizational models poised to provide patients the right health care at the right time in the right setting with the best outcome. Payment for value instead of volume delivered is a major reimbursement transition coming to the acute care setting, necessitating increased attention to mining data necessary to capture quality patient outcomes for maximum reimbursement. Quality outcomes such as decreased mortality, decreased readmission rates and lower infections will be tied to payments. Aging clients with multiple chronic illnesses will require more strategic coordination of care in and out of the hospital. Inter-professional health care teams must work together to assure health care needs are quickly identified, care is coordinated and a well-defined follow-up process is in place.

Aim: The goal of the integrated health care system is to assure that the patient receives the right treatment at the right time and in the right setting. The CNL is ideally suited to assist health care systems to meet this challenge. The purpose of this presentation will be to review these transitions including integrated health care systems, medical homes, accountable care organizations, and value-based reimbursement and discuss ways in which the CNL can be prepared to meet this challenge.

Methods/Programs/Practices: To meet these health care challenges the preparation of the CNL must build on the CNL core curriculum and include the elements of knowledge, skills, and attitudes as outlined by Quality and Safety Education for Nurses (QSEN). Further emphasis on building communication with inter-professional health care teams is needed more than ever. Curricular elements of nursing leadership, care environment, evidence-based care, and clinical outcomes management are key skills needed for the CNL to function within this integrated system of care delivery. While the microsystem is currently the focus of the CNL preparation and role function, there is a need for additional emphasis on understanding and analyzing the mesosystem of integrated care. Within an integrated health care system, the CNL must be prepared to analyze and evaluate the complex system alignments among the patient and each microsystem health care setting. Learning activities that include assessment of the mesosystem in a microsystem context and incorporation of the QSEN competencies are needed.

Outcome Data: NA

Conclusion: The 2001 Institute of Medicine (IOM) report, Crossing the Quality Chasm, stresses that the health care system as currently structured does not make the best use of its resources. All health care organizations and professional groups are called to promote health care that is safe, effective, client-centered, timely, efficient, and equitable. The recent IOM (2011) roundtable on the learning health system articulates that the use of high quality evidence is imperative to achieve value based care delivery within an improved health care system. The CNL is ideally suited to function within these integrated systems of the future. A strong foundation of the QSEN

competencies and expanded emphasis on communication and team building must be included with the CNL core curriculum for CNL students to be a leader in the future health care reform.

Abstract title: CNL's Practice: Begins with a story of the Clinical Microsystem

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Background Information:

The Clinical Nurse Leader (CNL), the newest professional nursing practice role, was designed for this practitioner to function at the microsystem level of a healthcare facility. The systems theory connects the Clinical Microsystems to the organizational meso-and macrosystem. The Clinical Microsystem is the smallest yet most powerful component of its organization, a place where clients receive and interprofessional teams deliver the highest quality care. To practice within a clinical microsystem, the CNL must acquire the highest level of knowledge, skill, and ability in nursing leadership (i.e., lateral integrator of care coordination, and skilled in interprofessional communication and collaboration); clinical outcomes management (i.e. cohort risk assessment, and implementation of evidence-based practice), and care environment management (i.e. elevated emphasis on team coordination, efficient utilization of resources and healthcare informatics, and quality improvement). Due to the complexity of a Clinical Microsystem, the CNL must begin with a story to gain a 40,000 foot global view.

Aim:

Display a story of a Clinical Microsystem, utilizing the "5Ps" conceptual framework. This methodology provides a wealth of knowledge of the uniqueness of this subsystem that is integral to system performance. The practicing CNL is charged with meeting the needs of complex patient cohorts, and ensuring that evidence-based practice care is provided that perpetuates positive outcomes. Through specific data collection and analysis, the CNL performs risk assessments and improves processes coordinated with a team collaborative approach.

Methods/Programs/Practices:

Retrospective data was collected, analyzed, and disseminated to various Emergency Department (ED) interdisciplinary team members creating the unit's story. Top priority opportunities were extrapolated, discussed, and acted upon utilizing the Plan-Do-Study-Act (PDSA) model for continuous monitoring. The focus was on the number one top diagnosis, chest pain, with greater than 10,000 12-Lead ECGs performed. Due to various nursing documentation formats, a ST-Elevated Myocardial Infarction (STEMI) note was designed, and developed to standardized documentation, and meet the required core/performance measures. The nursing staff received formal education on the new note, and the quality management staff along with the interdepartmental cardiac catheterization lab was introduced to the new note.

Outcome Data

Certain data sets were evaluated for opportunities of improvement. There was a marked improvement in compliance with utilizing the STEMI note by the nursing staff. Descriptive feedback from the quality management staff, ED Chief, Deputy Chief of Staff and the STEMI leadership committee members were positive (i.e., better documentation flow, accurate time stamps, and remarkable standardization).

Conclusion:

This story prompted a proposal submission to develop a standardized STEMI Note which was approved through the Performance Measure Committee and ultimately implemented by the Office of Health Informatics. Continuous monitoring of utilization of the new tool proves sustainability with 100% compliance. Of note, the use of the STEMI Note has been made a requirement through the ED Documentation Standard Of Practice (SOP). In addition, with the implementation of the STEMI Note, the ED staff has gained a heightened awareness of the core measure requirements and how they directly impact patient outcomes. The storyboard is referred to daily as a resource for ED staff members to introduce the unit to patients, ancillary staff, distinguished visitors, TJC, and new employees. Futuristically, the ED story board will be a tremendous asset as we begin to trend and compare previous year's data in preparation for future strategic planning sessions.

Abstract title: Improving Fall Outcomes: A CNL's Collaborative Safety Initiative for In-Patient Geriatrics

Authors/credentials: Patricia Baker, MSN, RN-BC, CNL

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Background Information:

During 1st Qtr 2010 and 2nd Qtr 2010, fall data for this faith based facility illustrated fall per 1000 patient days were 7.18 and 6.74 respectively and injury fall rate during the same time period were 0.94 and 1.18. National literature confirms that the population of elderly persons (age 65 and older) is growing rapidly corresponding with increased risk of injury from falling. This population is expected to increase from 31.0 million in 1990 to 68.1 million by 2040. In 2002, there were 31.7 million hospitalizations with 41% age 65 or older in the US. In 2000, health care cost equaled \$585 billion with 66% on older adults and \$120 billion on long term care. Falls are considered a potential hazard of hospitalization for the frail elderly individual. Annually, elderly persons fall three times higher in nursing homes and hospitals resulting in 10 to 25 percent injury rates, accounting for 6% of all medical expenditures and 2/3 of the deaths from unintentional injuries. Fall prevention strategies are supported by the National Clearinghouse Guideline on Fall Prevention in acute care setting, the National Center for Patient Safety (VA), and the American Geriatrics Society (AGS).

Aim:

The global aim of this collaborative initiative is to improve fall outcomes and decrease insufficient fall prevention processes. The specific aim is to decrease the number of total falls and falls with injury by 50% by end of 3rd Qtr 2010, targeting the NDNQI's 50th percentile.

Methods/Programs/Practices:

Data collection consisted of five days of randomly selected data on unit based patients at high fall risk from nursing fall risk assessments. The results revealed an average of 60% to 80% of patients were at high fall risk and an age of 67.5 years old. This project focused on implementation of an innovative collaborative initiative on fall prevention which included the system's leadership and key stakeholders, unit nurse director, nursing staff, unlicensed assistive personnel, clerical, housekeeping, physical & respiratory therapists, case managers, central supply, patients and their families, fall committee members, pharmacists, quality and risk management, purchasing, and nursing education. Review of the facility's current policies revealed a standardized fall risk indicator tool, fall assessment (performed on admission, every shift, and post fall), and electronic incident reporting. A new debriefing tool is being developed. Heightened awareness to staff at the point-of-care on the facility's provision of evidence-based practice fall prevention interventions such as patient educational brochure (English and Spanish), yellow fall risk wrist band, yellow non-skid slippers, bed alarm devices, and interdisciplinary communication on high risk fall patient were implemented daily during comprehensive fall rounding by the CNL. The policies are incrementally reviewed and reiterated in staff meetings and one-on-one coaching.

Outcome Data

Results: Comparative data for 2nd Qtr 2010 with 3rd Qtr 2010 results were demonstrable of improved fall outcomes as evidenced by falls per 1000 patient days from 6.78 to 2.98 (NDNQI's 50th percentile); total falls drop from 23 to 9; injury falls per 1000 patient days improved from 1.18 to 0.32; and total injury falls from 4 to 1 respectively. The unit celebrated this success.

Conclusion:

Implementation of an innovative collaborative initiative that is evidence-based best practice is highly recommended for success. Fall prevention is complex, best managed by multidisciplinary team approach, and falls are multifactorial. This faith-based facility is committed to continuously monitor fall prevention strategies through system level and facility level fall committee innovative initiatives.

Abstract title: The CNL Pain Plan Initiative: Developing an Educational Plan for Identifying and Managing Pain on a NICHE Senior Adult Medical and Intermediate Acute Care Unit

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Background Information:

Assessing and managing pain in the Senior Adult poses a great challenge for the health care team in the acute care setting. Senior Adults are at risk for poor pain control because identifying and treating different types of pain is not well understood by caregivers. Senior Adults units care for patients with diverse medical conditions causing complex issues including cancer pain, acute surgical pain, chronic pain and pain paired with psychiatric illness. Additionally challenging is assessing pain in patients with dementia and identifying medications that can cause acute delirium. Unmanaged pain can lead to functional decline, emotional and physical stress, and dissatisfied patients and families.

Aim:

To improve patient satisfaction related to pain by the implementing the CNL pain initiative to a 32 bed Senior Adult Medical and Intermediate Acute Care Unit.

Methods/Programs/Practices:

Patient satisfaction scores related to pain were suboptimal on a 32 bed Senior Adult Medical and Intermediate Acute Care unit. It was a priority for the leadership team to improve patient pain scores. The Clinical Nurse Leaders (CNLs) on the Senior Adult Unit collaborated with the Palliative Care CNL to develop a unit based plan to mentor the health care team in the moment at the bedside. The focus of this approach is teaching staff at the point of care on how to recognize pain, choose the right tools for intervention and act proactively on patient's pain. During daily interdisciplinary rounds, the CNLs address each patient's pain and plan as well as initiate Pain Service consults for patients with uncontrolled pain. Intentional hourly rounding with scripting to address pain control has also been implemented.

Outcome Data

Patient satisfaction scores are as follows to these questions: "Pain well controlled during stay". Results: 52% in May, 45% in June, 78% in July, and 35 % in August. "Staff did everything to help control my pain". Results: 64% in May, 45% in June, 72% in July, and 95% in August. Pain interventions have begun with outcomes to be determined via future patient satisfaction scores.

Conclusion:

Managing pain in the Senior Adult acute care hospital setting is an important aspect of total patient care and patient satisfaction. CNL initiated collaboration across departments to develop a comprehensive pain intervention plan has been implemented. Continued assessment is required to determine the full impact of this education.

Abstract title: Adaptation of Marks-Maran and Rose's reflective cycle in CNL student Journaling to demonstrate achievement of CNL core competencies

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Background Information:

During the CNL immersion experience, the CNL students will be practicing in an intensive clinical experience in a microsystem chosen by the student, in collaboration with the CNL course faculty. Students will experience the role of a clinical leader while under the guidance of a preceptor working directly in the clinical setting. Journaling is one aspect of analysis of the student's performance and experiences

Aim:

The purpose of journaling is to provide an opportunity for personal reflection and analysis of observations and experiences in the clinical setting. This process contributes to the development of critical thinking and analytic skills required of the clinical nurse leader, enhancing the personal and professional development of the students.

Methods/Programs/Practices:

The CNL students keep weekly journals of the clinical microsystem immersion experience. The Marks-Maran and Rose's reflective cycle (1997) is the model used to direct the reflective process in journaling. The reflective cycle includes description of incident/experience, reflective observations, related theory, and future action. These concepts are supported by the following theories: Theory of Appreciative Inquiry, Chaos and Complexity theories, Leadership Theories, Emotional Intelligence Theory and others. Included in each weeks' journals are reflections on the unit microsystem, a self-leadership assessment, self-reflection on CNL core competencies, and progression of microsystem unit projects.

Outcome Data

Using a grading rubric, points are distributed in the categories: content knowledge, analysis, clarity, relevance, conciseness, and formatting. Validity of the grading rubric will be established by review from a panel of experts in pedagogy and the CNL role. The grading rubric will be checked for inter-rater reliability. Qualitative methods, using a focus group of CNL students, will be utilized to describe use of journaling for self-reflection and self-analysis. Results from the quantitative and qualitative analyses will be used in revising the reflection component and grading rubric in the CNL immersion course.

Conclusion:

Conclusions will be determined from the outcome data described above. Initial analysis support that students believe the journaling aided them in incorporating the CNL role and moved them toward application of core concepts and planning for practice.

Abstract title: Preventing Hospital Acquired Pressure Ulcers in Hemodialysis Patients: A Nurse-led Quality Improvement Project

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Background Information: Among all United States healthcare institutions an average of 2.5 million patients develop pressure ulcers, leading to prolonged hospital stays and increased risk for infection. On the medical-surgical unit of an urban Northwest hospital, the baseline rate of hospital-acquired pressure ulcers (HA-PU) was 9.5%. The benchmark set by the National Database for Nursing Quality Indicators for HA-PU is 6.84%. Baseline assessment found 40% of hospital-acquired pressure ulcers on the medical-surgical unit occurred in patients with a diagnosis of end-stage renal disease receiving inpatient hemodialysis. End-stage renal disease increases patients' risk of developing pressure ulcers due to average age of onset, immobility during hemodialysis, malnutrition, and common co-morbidities.

Aim: The quality improvement project investigated the use of staff education and enhanced unit-to-unit communication to decrease hospital-acquired pressure ulcers among end-stage renal disease patients receiving inpatient hemodialysis.

Methods: The Clinical Nurse Leader student-led quality improvement project involved two interventions to decrease pressure ulcers in hospitalized end-stage renal disease hemodialysis patients. First staff attended an educational in-service focusing on general pressure ulcer risk factors and how end-stage renal disease increases the occurrence of these factors, thus resulting in a higher risk for pressure ulcer development. A pressure ulcer risk check box was then added to the hospitals' unit-to-unit communication tool. Evaluation consisted of pressure ulcer point prevalence audits and staff satisfaction surveys, assessing staff's perceptions of the importance of pressure ulcer prevention and the unit-to-unit and shift-to-shift communication.

Outcome Data: An independent t-test and Chi-squared test evaluated the statistical significance of the interventions. Hospital-acquired pressure ulcer rates decreased significantly from 8.8% to 0.0% ($p < .05$). No significant change occurred in staff perception of pressure ulcer prevention and communication.

Conclusion: Evidence supports the use of education and communication of pressure ulcer risks and prevention strategies to decrease hospital-acquired pressure ulcer prevalence. By developing an improved communication tool and increasing nurses' awareness of risk factors and prevention strategies the CNL can impact the quality of care delivered, thus decreasing the rate of hospital-acquired pressure ulcers for this vulnerable population.

Abstract title: The Evolution of a Nurse-Driven Mobility Initiative on a Certified Stroke Unit: Pioneering the CNL Role in a Magnet Recognized Medical Center

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Background Information:

With 137,000 deaths per year, stroke has been reported as the third leading cause of death in the United States (National Stroke Association, 2010). Approximately 795,000 individuals suffered a stroke last year. Subsequently, surviving stroke victims will face various short-and long-term health consequences. Nursing-driven, early, and frequent mobility activities for patients with stroke diagnosis are imperative to maintain and increase patient strength, decrease pain, and increase general well-being. In addition, nursing initiated mobility activities may decrease potential complications such as skin break-down, joint stiffening and muscle atrophy, aspiration pneumonia, urinary tract infections, and falls (National Stroke Association, 2010).

However, due to the chaotic and hectic nature in today's acute-care units the need for basic, evidence-based, and time-tested nursing interventions may be undervalued and forgotten—pushed behind technologically advanced equipment, electronic medical record keeping, and limited interdisciplinary collaboration. A micro-system analysis revealed that nursing staff initiated early, and frequent mobility activities for patients affected by stroke, on a certified stroke unit at Saint Anthony Medical Center (SAMC) did not meet clinical practice guideline standards for stroke patients.

SAMC is a 254-bed tertiary care center located in Rockford, IL on a 100 acre campus about 80 miles north-west of Chicago. SAMC has achieved credentials to be a level one trauma center, regional heart institute, Illinois neurosciences institute, center for cancer care, diabetes center, and center for sports medicine and health. In 2005, SAMC achieved the prestigious American Nurses Credentialing Center (ANCC) Magnet certification and obtained re-certification in 2009 (OSF Health Care).

The CNL role is new to Saint Anthony Medical Center SAMC and the region, and has not yet been operationalized in the region.

Aim:

The purpose of this CNL student project was to promote early, and frequent nursing staff initiated physical mobility interventions such as ambulation, active/passive range-of-motion, and sitting in the chair for meals on a certified inpatient stroke unit.

Due to economic constraints, mobility activities for patients with a stroke diagnosis can no longer only be administered by physical therapists or therapists aides, but must also include the active participation of the nursing staff on the unit (Bernardt, Dewey, & Donnan, 2004; Skarin, Bernardt, Sjöholm, Nilsson, & Linden, 2011).

This mobility project has contributed to the microsystem goals by providing the nursing staff clear guidelines and understanding on initiating early mobility activities by utilizing the SAMC safe movement and repositioning team (S.M.A.R.T.). Furthermore, increasing the amount of

mobility activities patients receive may enhance functional status in stroke patients, decrease complications, improve health outcomes, and possibly decrease length of stay, re-admission rates, and change discharge disposition to outpatient rehabilitation programs.

Methods/Programs/Practices:

Complexity change theory was used with an evidence-based practice approach to initiate change. Strong collaboration between the unit manager, a geriatric Clinical Nurse Specialist and the CNL student practicum existed, which was instrumental to unit-based and house-wide interdisciplinary collaboration.

The project was implemented over 18 weeks in three phases: 1) education, 2) intervention implementation, 3) evaluation and sustainability. Unit nurses and nurse assistants were invited to participate in the change process during each phase. Nursing staff education and training was provided over 8 weeks. The educational components included increasing awareness of the far-reaching effects of early and frequent mobility activities for patients with stroke or stroke related diagnosis. In addition, hands-on refresher training for active/passive range-of-motion (ROM), ambulation, and gait-belt use was provided during the annual nurse, and nurse assistant skills check off. Implementation interventions were developed based on the collaborative efforts of the unit nursing staff, manager, and CNS.

Interventions include a new bed-side rounding hand-off process and tool; pocket guidelines for nurses and nurse assistants for the new hand-off process; education to increase utilization of the communication board by nurses, and nurse assistants; family, and patient education in the form of brochure and handouts; mobility resource manual for nursing staff; mobility education board depicting the change process and far-reaching benefits of nurse-driven mobility activities; increase of the scope of documentation for nurse assistants in the electronic medical record; basic mobility activity training for nursing staff including active/passive ROM, using the gait-belt and lift equipment for transfers, and ambulation with the gait-belt; initiating the process for single-use gait-belts to become a chargeable patient item, readily dispensable for use at the bed-side and later at the patients home if needed.

Outcome Data

The project will officially conclude at the end of October of 2011. Preliminary patient chart and bedside communication board audits show that the specific, measurable goal setting for mobility activities has increased from 6% to 48% with a goal of 50%. In addition, patients and families have reported increased satisfaction with being involved in their care, and increased feelings of well-being. Future Press Ganey results, chart audits, and staff surveys will include final outcome data.

Conclusion:

The negative health consequences due to immobility are far-reaching. With close to 800,000 stroke patients per year, individuals with stroke are a highly vulnerable population in need of early and frequent nurse-driven mobility interventions to prevent complications, make care more efficient, and decrease cost due to preventable adverse health outcomes. In conclusion, this CNL student project shows that the CNL role can be valuable in private hospitals by bridging administrative efforts of increased health care efficiency and patient satisfaction to the chaotic

nature of the bedside by forming strong collaborative relationships with the unit manager and clinical nurse specialist. This triadic relationship was the catalyst for dynamic change of nursing practice at the microsystem level, as evidenced by the increased mobility goal attainment.

Abstract title: Prevention of Readmission Within 30 Days Among the Chronic Heart Failure Population: Implementation of the Clinical Nurse Leader Role

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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: In our ever changing and evolving world of healthcare one thing must remain true amidst the worries of financial reimbursement, budgeting and legality; a consistent dedication to improving patient care and outcomes. The newly introduced role of the Clinical Nurse Leader (CNL) can assist the healthcare system in doing just that. There is no doubt that the chronically ill populations have become the biggest burden on the healthcare and Medicare system. For example, the ever increasing population of heart failure patients that currently exists. This population consisted of 5, 800,000 patients nationally in 2006 with an estimated healthcare cost of 39.2 billion dollars in 2010 as reported by the Center for Disease Control (2010). Without question this is a population that cannot be ignored in relation to improving patient care and outcomes and therefore reducing the cost of healthcare.

In relation to heart failure and the care of this population, education and the need for self management at home is evident. Numerous studies and research articles have shown the need for both education at the bedside and continued care and follow up at home. In an article written by Brock and Jnecks (2008) justification in relation to the need for this care is given and suggests the use of an RN as a “coach” for these heart failure patients. The “coach” presented in this model can be compared to the role of the CNL and for that reason the components of this article have been adapted to the role of the CNL as well as its suggestions for implementation. The model used in this article is one that is will be attempted to replicate within the microsystem served here as a quality improvement project for the Congestive Heart Failure Service (CHF).

Aim:

- Decrease rate of patient readmission within 30 days of last discharge.
- Increase patient education during inpatient stay.
- Increase medication education and compliance prior to discharge.
- Increase communication between inpatient practitioners and outpatient CHF clinic practitioners.

Methods/Programs/Practices:

Existing Protocols

- Biweekly CHF inpatient discharge education class and monthly outpatient class.
- Bedside patient education encouraged to be done by staff RN during inpatient stay.
- Patient CHF handbook given to all CHF patients upon admission.

- Strong encouragement for patient to have scheduled appointment with CHF NP or MD within 7 days of discharge.

Interventions

- Clinical follow up phone calls completed by acting CNL obtained within 72 hours of discharge with nursing communication note completed and sent to follow up physician within CHF outpatient clinic.
- Encourage all patients to attend CHF discharge education class while inpatient, if class is not completed during inpatient stay this will be communicated to follow up practitioner so that patient can be scheduled for outpatient class.
- Monthly medication record completed prior to discharge for patient use at home either by acting CNL or staff RN. Encouragement by acting CNL for staff RN's to make this common practice.

Implementation

- Project began in early May 2010 and ran for approximately 14 weeks allowing for examination of 30 day readmission within contacted patient population
- 49 patients were included in this project, 33 were successfully contacted by phone
- 75% of 49 patients attended the CHF education class
- 100% of all patients received the CHF handbook
- Low rate of compliance among monthly medication sheets

Outcomes:

- CHF readmission rates within 30 days for fiscal year 2009 were 27.3%, 2010 showed improvement with a rate of 20%.
- From the 49 patients seen within this project 11 readmissions occurred with 7 of those readmissions being heart transplant patients who were most likely not admitted with a CHF primary diagnosis.
- Including heart transplant patients overall readmission rate was 22%, however without these patients the rate of readmission was only 8%.
- Most interestingly, of the patients that were contacted successfully there was only a 15% readmission rate including heart transplant patients which is an improvement from fiscal year 2010. There were also 3 documented expirations within this time period.
- The extent to which patients felt the nurse kept them informed improved with scores from April 2010 being 88% to June 2010 scores of 91.7%.
- Discharge instruction improved ranking at 88% in April 2010 to 94% in June 2010.
- Overall patient satisfaction in regards to nursing improved from 90% in April 2010 to 93% in June of 2010.

Conclusion:

- Because this project was only done during formal clinical hours, *time* was a barrier to being able to reach all patients as well as spend adequate time educating or reaching by phone.
- *Patient participation* was also a barrier, as stated earlier of the 49 patients included in this project only 33 were successfully reached by phone. Many contributing factors were seen here; incorrect contact information, inability to leave a message because the CNL did not have a business phone number or voicemail for patients to attempt a call back and again clinical time.
- *Staff involvement* was not mandatory and therefore some staff RN's may have chosen not to complete the monthly medication record at discharge when the CNL was not present.
- Recommendation is for the construction of a full time CNL role within the CHF service and patient population
 - Allowing more appropriate assessment, intervention and follow up

- Construction of lateral integration and collaborating relationships
- Increased continuity of care
- Visible force for staff and unit
- 24 hour accountability
- Champion for staff RN

Unit-Based Falls Team Fosters Awareness and Prevention of Inpatient Falls

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Background Information

Falls are a growing health concern. Millions of adults fall each year in the U.S. Inpatient falls occur due to multiple factors, including a change in familiar surroundings, change in medications, multiple co-morbidities, and complications of specific disease processes. A unit-based Falls Team can raise staff awareness of the significance of inpatient falls, as well as promote a safer environment for hospitalized patients.

Aim

Falls are the most common reason for injury and admission to the hospital, costing billions of dollars each year. Hospitalized patients who fall have an increased length of stay and incur almost double the medical expenses than those who do not fall. Hospitals are not reimbursed for these expenses. The aim of the Falls Team is to decrease the total number of falls on one intermediate care unit.

Methods

On the pilot unit, staff identified the need to raise awareness of the impact of inpatient falls, as well as educate staff about the unique circumstances that led to each fall. Based on this need, a unit-based Falls Team was created in April 2010. The Falls Team consists of Clinical Nurse Leaders, staff nurses, patient care assistants, and the unit director. Interventions that have emerged from the monthly Falls Team meetings include ongoing education of falls prevention and protocol (which include signs on the doorways and wristbands to alert staff of at-risk patients), “Call, Don’t Fall” posters in each room, evaluation of the risk assessment tool, and the creation of a Falls Bulletin. The bulletin describes the circumstances leading to each fall, and is distributed to every staff member to elicit feedback. Staff is encouraged to make suggestions based on the previous falls in an effort to prevent future falls.

Outcome Data

In 2009 there were 28 falls on the unit. There were 23 falls in 2010; 11 were in the first quarter, prior to the Falls Team. There have been eight falls for the first nine months of 2011, which is on track to decrease the total number of falls by half since the implementation of the Falls Team. During that time, the unit also had 75 days without a fall, which is a record for that

unit. The total number of falls has decreased, as well as the percentage of unassisted and preventable falls. Staff has also shown more accountability for initiating falls precautions and answering bed and chair alarms promptly. Preventing falls has truly become a team effort since the Falls Team was created.

Implications for Practice (Conclusion)

The Falls Team, with the help of the Clinical Nurse Leaders, has been shown to be an effective way to educate and involve staff in the prevention of falls. The Bulletin has made staff more aware that bedrest is a factor in inpatient falls. Therefore, the next goal for the Falls Team and the Clinical Nurse Leaders is a collaborative “mobility program” with the Physical Therapy department to identify and mobilize appropriate patients sooner. The Clinical Nurse Leaders have also been collaborating with the leaders on other units to help foster the implementation of a Falls Team on those units as well.

Abstract title: Hospital to Home: Patient as Partner in Delivering High Quality Transitional Care for Older Adults

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Background Information:

According to Bixby et al, older adults hospitalized for a newly diagnosed acute condition or an exacerbation of a chronic condition are at heightened risk of re-hospitalization due to poorly managed transitions from hospital to home or other care setting. The “hand-off” period for older patients with multiple chronic conditions takes on even greater importance. It is during these transitions between settings, the hospitalized older adult is extremely susceptible to problems due to care fragmentation.

Approximately twenty-five to thirty percent of these patients are re-hospitalized due to preventable complications. This evidence-based practice approach addresses needed hospital discharge assessment that should be completed by registered nurses or advanced practice nurse managing the complex care of hospitalized older adults. The available evidence suggests that interdisciplinary team collaboration plays a pivotal role in ensuring that successful care transitions occur. Transitional care is one of the most critical health issues for older adults.

At the Veterans Administration New Jersey Health Care Systems it was identified that 90% of surgical patients are living with at least one chronic illness (e.g., CHF, CAD, DM, and HTN.). Another 65% of patients complained they were not involved in the discharge planning process and did not know their treatment plan. Readmission rates following a first admission for heart failure have not improved, and remained at 18.87% during 2010-2011.

Aim:

This collaborative care model is aimed at providing a framework wherein nurses, physicians and the entire interdisciplinary team focus on, eliminating preventable hospital acquired conditions while improving the care and transitions of the hospitalized older adult.

To reduce unplanned 30-day readmissions among patients discharged with HF from 18.87% to 12% within four months and to improve these patients' experience of care at discharge as measured by satisfied or highly satisfied from 68% to 90% or more.

Methods/Programs/Practices:

Interdisciplinary bedside rounding was initiated in June 2011. The rounding team is comprised of Physicians, Clinical Nurse Leader, Social Worker, Dietitian and Staff Nurse. A discussion of the treatment plan takes place at the patient's bedside focusing on reaching the patient's goals of care. The whiteboard in patient's room is used to share daily goals of care and expected discharge date.

Truth point technology using real-time data is used to drive improvement of pain management, patient education and shared decision making. This initiative was piloted on the surgical unit and was successful in improving outcomes in two additional inpatient units.

Every patient with a past medical history of DM, CHF, HTN, and CAD receives a follow up appointment with PPG provider within seven days of discharge.

Outcome Data

The average length of stay (LOS) decreased from 9.04 in 2Q FY2011 to 7.8 days in 3QFY2011 for orthopedic patients and from 8.4 in 2QFY2011 to 5.06 in 3QFY2011 for surgical patients. Shared decision-making improved from 60% to 100%, Patient-Nurse communication improved 19%, Patient education improved 25%, Pain management improved from 76% to 100% and Inpatient injury and functional decline decreased by 20%.

Conclusion:

The Hospital to Home model promotes team collaboration to improve the quality of transitional care for older adults while promoting patient-centered care. By having a vision of the same goal, nurses and physicians can enhance safe hospitalization, cohesive transitional care, and optimal organizational performance. Enhanced patient education, actively involving patients in decision-making, better coordination of care and follow up helps mitigate the effects of discontinuity and bridges the gap between hospital & home for patients with complex or multiple health problems.

Abstract title: A New Practice Guideline Regarding Mobility of Patients with Left Atrial Catheters (LAC)

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Background Information:

In May 2010, outcomes were collected on average length of stay (LOS), ventilation hours, and early patient mobilization. After comparing these outcomes to national benchmark data, an interdisciplinary team was formed to standardize the care of a particular cohort of patients, in order to improve outcomes. After consulting the professional literature, a Coronary Artery Bypass Graft (CABG) and/or valve surgery interdisciplinary clinical pathway was developed to standardize the care in this cohort of patients with the overall goal of improved clinical outcomes.

In June 2011, the Clinical Nurse Leader (CNL) implemented this pathway, which included a plan to discontinue invasive lines early in the recovery period, if the patient was hemodynamically stable. Patients were still expected to be mobilized, even if invasive lines and catheters remained indwelling, within two hours after extubation.

One of the invasive catheters utilized by our cardiothoracic surgeons included a Left Atrial Catheter (LAC). The initiation of this pathway included a substantial change in practice related to the mobility of patients with invasive lines and catheters. Historically, care of the patient with a LAC has been very cautious. Patients with LACs would not be mobilized for fear of dislodging or accidental removal of the LAC. Our CABG and/or valve patients were not assisted out of bed until the LAC was discontinued by the surgeon on post-operative day (POD) 1 or 2 before the pathway was implemented. The change in culture and practice by the nursing staff was a lengthy investigational and educational process.

Aim:

The overall aim of this evidenced-based project was to improve outcomes in CABG and/or valve surgery patients in our intensive care unit (ICU). Two initial goals included: 1) extubation within four to six hours of arrival, and 2) advancing the post-operative cardiac surgery patient's activity level to out of bed to a chair approximately two hours after extubation, if hemodynamically stable.

Methods/Programs/Practices:

To ensure patient safety, a lengthy review of literature (ROL) related to the nursing care and maintenance of LACs was conducted prior to implementation. Current hospital policies, procedures, and standards of care related to the nursing care and maintenance of LACs were reviewed. The 2011 American Association of Critical Care Nurses (AACN) Procedure Manual for Critical Care does not provide any evidence-based information or guidelines regarding mobility for the patient with an LAC³. Critical care textbooks were reviewed to evaluate care practices related to patients with invasive hemodynamic lines and catheters. Furthermore, a large

tertiary care hospital in the southeast was queried regarding their practice of mobilizing patients with LACs. The facility did not mobilize these patients, but their practice was not evidence-based.

The results of the ROL discovered scarce empirical evidence and research related to LACs. No information was found regarding guidelines or recommendations on the mobility of the patient with a LAC. The nursing staff were educated as to the standards of care related to the care of patients with LACs and their potential complications. The cardiothoracic surgeons participated in education and support of the nursing staff as patients were mobilized with LACs.

Outcome Data:

Data was collected on a daily basis from June 1, 2010 through November 1, 2010. 43% of the total 92 CABG and/or valve surgery patients initiated on the pathway were assisted out of bed to a chair with LACs in place. As of July 2011, 233 CABG and/or valve surgery patients were initiated on the pathway on arrival to the ICU. Those patients with LACs were mobilized once extubated and hemodynamically stable. There have been no incidences of complications such as accidental dislodgement or removal, air embolism, bleeding, partially retained catheters leading to embolization or infection, thrombus formation, or cardiac tamponade on any of the patients mobilized on POD 0 or POD 1. Unit data is now collected on a quarterly basis due to improved outcomes and absence of complications related to mobilizing patients with LACs.

Conclusion:

Care of the patient with a LAC has changed over the past few decades. The change in culture and practice by the nursing staff was a lengthy investigational and educational process. The nurses were understandably resistant to the change based on the current practices and past education. This change in practice has shown that patients with LACs may be mobilized in a standardized manner, without complications. There is a need to examine the current practice of bed rest for patients with LACs in place, and for further investigation to determine best practices as it relates to the care and maintenance of patients with LACs.

Abstract title: CNL Impact on Intermediate Training for the Bedside Nurse

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Background Information:

In February of 2011 our hospital opened a 32 bed acuity adaptable senior adult unit (3 Lacks). Staff was hired for the unit that had a passion for working with the senior adult. The majority of staff that was hired was competent in med surg nursing but didn't have any intermediate experience. In fact, less than 12% of staff were intermediate competent. CNL's, along with unit's

CNS, teamed together to develop and execute RN intermediate education in order to provide professional development, education, and the coaching required to ensure safe and excellent patient care.

Aim:

Develop a plan to educate and mentor the bedside nurse to be competent in caring for the senior adult patient that requires an intermediate level of care.

Methods/Programs/Practices:

The first objective was to determine the minimum competencies for an RN to be considered intermediate trained. The criteria were as follows:

- All RNs will be ACLS certified within one year of opening
- RNs must understand, verbalize, and demonstrate the use, effects, and monitoring requirements for the vasoactive drips used on our unit
- RNs will understand, verbalize, and demonstrate the use of hemodynamic monitoring
- RNs will recognize signs/symptoms of and care for the patient with respiratory and cardiac failure
- RNs will understand, verbalize, and demonstrate continuing assessment and re-assessment of the intermediate patient
- RNs will verbalize and demonstrate knowledge and ability to access additional resources during their shift (i.e. rapid responder, e library, unit literature, CNLs and CNS)
- Completion of 3 Lacks specific intermediate competency checklist
- All non-intermediate RNs had telemetry/EKG classes and 4 hrs of didactic intermediate training

The CNLs, in conjunction with the CNS, developed a unit specific intermediate competency tool that was to be completed at the end of training. This served as a record of completion of intermediate training. Charge nurses were the priority group to receive intermediate training. All RNs were paired with a CNL or the CNS for three 8 hour shifts. We worked one on one at the bedside to ensure education and monitor progress. The CNLs and CNS worked the schedule of nurse, whether it was days or nights. After 3 shifts of education, the RN and/or the CNL and CNS could determine need for continued education. Training would continue if the RN required additional education. Intermediate education binders were also placed on unit as a resource for staff.

Outcome Data

When we began our training and mentoring only 11.76% of our RN staff was intermediate trained. Currently 76% of our RN staff is intermediate trained. The CNLs and CNS continue to mentor staff and provide intermediate education with the goal of 100% completion by December 2011. We have increased the trust between staff and CNLs/CNS. RNs that have completed intermediate training verbalize that they feel empowered to teach new RNs on the unit intermediate skills.

By training our staff to care for the intermediate patient, we have prevented transfers to a higher level of care. This has prohibited unnecessary handoffs. Handoffs to RNs on a higher level of care were decreased by 32%.

The financial impact of training the nurses was minimal. Besides classroom time spent training the RNs, 1:1 training and mentoring with the CNL or CNS came at no additional cost to the unit. We paired with staff on their already budgeted shifts and therefore incurred no cost to train them.

Conclusion:

The CNLs on 3 Lacks played an instrumental role in the mentoring and training of intermediate RNs for the new unit. Through the use of collaboration, education, evidence based practice for seniors, and application of clinical skills the CNLs impacted patient safety on the unit and helped to ensure a higher standard for the level of care expected. Working closely with the RNs fostered the growth of knowledge and skills for the bedside nurse. Handoffs between RNs on different units were decreased. This was all accomplished with a minimal financial impact to the unit.

Abstract title: The Structured CNL Practicum

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Background Information: In 2008, the University of Alabama at Birmingham admitted the first cohort of Model C CNL students to the School of Nursing. At that time, little was known about CNL education and the CNL role in the Birmingham area hospitals. Further, there were no practicing CNLs to serve as preceptors. Faculty recruited preceptors from other Master's prepared nursing groups who possessed the skills to mentor CNL students, primarily Clinical Nurse Specialists, Nurse Managers, and Nurse Educators. Kolb's Experiential Learning Theory was used as the guiding framework for the program. A conceptual model was developed to help students and preceptors consider the relationship of the CNL to other healthcare team members. The clinical practicum was designed using the AACN White Paper, the AACN end-of-program competencies, and the Microsystem Assessment Framework. Students and preceptors were oriented to the course and provided with course and reference materials. Faculty visited the preceptor/student pairs three or more times during the semester to assess the student's progress and give support and advice to the pair. Despite this level of support, CNL students and preceptors reported that they felt unsure of what activities were appropriate for the practicum experience.

Aim: The aim of this project was to improve the quality of the practicum experiences of the CNL students at the University of Alabama at Birmingham. After the experience with the first cohort of students, faculty realized that Model C students needed more direction than had been provided. First-time preceptors for CNL students also needed more assistance in planning

meaningful practicum experiences that would enhance the application of the theoretical components of the curriculum.

Methods/Programs/Practices: To assist CNL students and preceptors plan practicum experiences that would facilitate a microsystem assessment and achieve the AACN end-of-program competencies, faculty developed a detailed list of healthcare team members with whom the CNL student should interact, along with an accompanying list of suggested activities the student might complete while engaged with each team member. Guidance was given on the amount of time that the student should spend with each person/position. Students and preceptors were required to submit an “Initial Clinical Contract” of the planned activities for faculty review and comment. When needed, faculty met with the student and preceptor to revise the plan. Each “Initial Clinical Contract” was individualized to the needs of the CNL student and the assessment required of the unique microsystem.

Outcome Data: Preceptors and students in the second cohort reported satisfaction with the new practicum planning procedure. Both preceptors and students felt organized and deliberate in the activities that were planned for the practicum. Students were able to prepare in advance for each practicum experience, as they knew with whom they would be working and in what activities they would be engaged. Preceptors felt more confident that they were providing a meaningful practicum experience that helped the student progress towards achievement of the end-of-program competencies. Faculty noted that the quality of the microsystem assessments completed by students improved as the students interacted with the organization using a more comprehensive method.

Conclusion: Providing a structured plan for the practicum experiences of CNL students at our school has been helpful to both students and preceptors. The structured practicum is particularly helpful to Model C students who have not yet had the opportunity to acquire healthcare work experience, as well as new preceptors in the program.

Abstract title: Joint Ventures for Patients and the Healthcare Team

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Background Information: Scientific evidence indicates patient education on pain management preoperatively to improve outcomes of total knee arthroplasty (TKA) is highly recommended. According to research there is a positive correlation between preoperative anxiety and postoperative pain.

Aim: The aim of this project is to determine if veterans with TKA replacement surgery that received pain management education prior to surgery reported lower levels of pain than those who did not receive pain management education?

Methods/Programs/Practices: Provide effective patient centered pain management through developing a pre operative pain management education class to include an interdisciplinary approach including: pain management, diet, exercise and deep vein thrombosis prevention. National Association of Orthopaedic Nurses (NAON) patient education series for Total Knee Replacement and Krames on demand patient education including understanding of chronic pain, communicating about pain and managing post operative pain. Staff nurses on the post operative unit received education on pain assessment. Pain will be assessed by current computerized patient record system (CPRS) template on thorough Pain assessment and reassessment to attain patient's goal of managing pain to an acceptable level, and evidence of relief of pain. Care coordination, disease prevention, health promotion are all utilized to optimize pain management.

Outcome Data: Formative evaluation of this project indicates that patients who received pain management education compared to those who did not had shorter lengths of stay by 1.5 days on average, and reported unacceptable pain level prior to reaching a higher level of pain, as well as consistent lower levels of pain. Pain documentation monitoring reports indicate unit compliance rate of 99% since the initiation of the pain education class

Conclusion: Patient and staff education classes on pain with an interdisciplinary approach are recommended to optimize pain management, care coordination, disease prevention and health promotion.

Abstract title: Clinical Nurse Leader: Implements “Quiet Hour” to reduce unit noise and improve patient satisfaction

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Background Information/Aim: On the VA's journey to Patient-Centered care our unit is evaluating innovative ways to provide an optimum healing environment. The Clinical Nurse Leader identified and evaluated unit noise. Noise is defined by the Environmental Protection Agency UK as “Any sound that may produce an undesired physiological or psychological effect in an individual or group” (2011). Mosby's Medical Dictionary defines noise pollution as an unwanted noise level in the environment, causing discomfort and possibly threatening health (2009). Multiple patient bed rooms, hospital equipment, environment design, intercom systems, and patient acuity are a number of factors that influence daily unit noise in healthcare facilities. Studies have shown these unit noises have negative psychological as well as physical effects on patients during their stays. A Johns Hopkins University Hospital study showed that noise levels can increase blood pressure, decrease oxygen saturations, disrupt sleep and decrease wound healing rates (2005). The University of Michigan's study supports the finding that overall noise levels can affect blood pressure levels too (2005). Florence Nightingale wrote in her 1859 book

“Unnecessary noise is the most cruel abuse of care which can be inflicted on either the sick or the well” (Notes on Nursing).

Aim: The main goal was to create a restful, peaceful and healing environment. First and foremost education of Veterans, families and staff in “Quiet Hour” was ongoing at admission and during Veteran hospital stay on our unit.

Methods/Programs/Practices: Nursing team member’s participation and input was invaluable and essential before the implementation of “Quiet Hour.” Team members collaborated at staff meeting and daily huddles during the process. A Patient-Centered care approach focusing on physical environment, rest, and mind-body connection model was followed during development and implementation. The project initially was viewed as possibly affecting staff workload. Some staff comments included; “We still have to get our work done,” “What times are we going to do this, what if I have medications to pass,” and “We just can’t stop patient care or procedures.” Team members were concerned as to how house staff and other employees would feel about being asked to speak softer and accomplish their patient care activities in a quieter fashion during these times. 4 guidelines were designed for “Quiet Hour.” Our team chose the hours between 1 and 2 pm to begin “Quiet Hour,” this would allow Veterans to rest after lunch. A daily announcement prior to “Quiet Hour” would inform Veterans, families and staff of our intention during this time frame. The hallway lights would be dimmed during this time, and team members would be vigilant in answering phones and call lights promptly with no overhead paging. Buy in was received from our support staff teams as well.

Outcome Data Post-noise results indicated that; 93% of participants recorded there was a decrease in staff noise, 98% of participants recorded there was a decrease in unit, 73% of participants recorded a decrease in stress level, 91% of participants recorded being able to rest and relax, and 41% of participants recorded a decrease in pain level during “Quiet Hour.” (Figure 2) Quotes from Veterans stated “Awesome, what a difference,” “I took a 20 minute nap,” I never heard it so quiet.”

Conclusion: The “Quiet Hour” initiative has promoted a culture change on our journey to Patient-Centered care. Due to the positive feedback and satisfaction outcomes received our team continues long-term implementation of “Quiet Hour” on a daily basis on our unit and has expanded to our CLC unit. An increased awareness of noise levels in our hospital environment was created by the project. Veterans, visitors and healthcare team members are excited and encouraged with its outcomes. “Quiet Hour” has brought about changes in practice by inter-professional team members across the care spectrum. Having a direct effect on the patient care environment and improving patient noise satisfaction during “Quiet Hour” times. Collaboration of inter-professional team members to ensure “Quiet Hour” is encouraged and supported. Staff and visitors have developed an increased awareness and understanding of noise and it’s affect on Veteran-Centered care and the healing environment. Recently, notification was received that a manuscript submission to a double blind peer review journal about the successes of “Quiet Hour” was accepted for publication.

Abstract title: The CNL's role in Initiating the Remote medical Telemetry.

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Background Information: Heart disease is the number one killer among the American population, so the need for treating and monitoring patients with cardiac conditions continues to skyrocket. Telemetry provides early warning of cardiac changes and lethal dysrhythmias which signal deterioration in the patient's condition. Today, telemetry is used in most hospitals for medical-surgical patients to detect life-threatening dysrhythmias. Early intervention improves patient outcome for cardiac patients. There is a long list of patients who require telemetry monitoring ranging from electrolyte imbalances to cardiac procedures and conditions.

“The hospital loses about \$4,000/bed day when a MICU patient is transferred to another hospital within our network for telemetry services. An additional \$600-1,000 transportation cost for ambulance services are also incurred by the transferring hospital” “Although the average cost per bed day for a general medical ward bed is about \$1600, but telemetry monitoring capabilities are lost when the patient moves to the medical wards”. Due to the lack of other options, currently otherwise stable patients must remain in the PCU/MICU delaying appropriate patient flow in and out of the emergency room and PCU/MICU. The number of patients who need telemetry monitoring increases each day so does the need for additional telemetry beds. Increasing the number PCU or MICU beds is very expensive, so other options must be explored.

Aim:

Currently, the hospital has the capability to provide 4 medicine telemetry beds in our Step- down Progressive Care Unit (PCU) which spill over to the Medical Intensive Care Units (MICU) beds, if needed. The monitor technician (MT) views the telemetry screens of 4 PCU patients in addition to the MICU patients who require telemetry from a central monitoring station located in MICU. If the PCU and MICU beds are occupied and a patient is admitted who needs telemetry, the three options currently available are to outsource the patient to another hospital, move the most stable patient to a medical ward or allow the patient to remain in the emergency room. Initiation of remote medical telemetry provides a tremendous cost saving for the medical center.

Methods/Programs/Practices:

The Remote Medical telemetry program has been in existence for two year and was developed by the Clinical Nurse Leader. Telemetry nursing is a specialty and requires additional education for the medical ward's nursing staff. A basic EKG Interpretation and 12-Lead EKG class will be given by hospital staff and any equipment needed for the classes will be provided by the hospital. The Licensed Practical Nurses (LPN) will receive specialized education to become the additional monitor technicians. Each nurse (RN and LPN) will be required to show proficiency by passing an annual telemetry monitoring test and competency. Most remote telemetry patients are stable but their conditions can change rapidly, so the nurse must be able to recognize dysrhythmias. Transceiver and monitor training is provided by the Phillips Company and is

already factored into the equipment cost. Remote telemetry allows the nurse to monitor the patient without direct line of sight; therefore, increasing the amount of time the nurse has for other activities.

Outcome Data Providing telemetry on the medical ward (remote telemetry) would be a substantial cost saver to the hospital of about \$2400/per bed day over the cost of keeping the patient in the PCU/MICU bed. Over 400 patients have been cared for in medical remote telemetry.

Conclusion:

The challenges to initiating and sustaining remote medical telemetry have been many. Careful planning and strong interdisciplinary collaboration was the key to successful implementation of remote medical telemetry.

Abstract title: Teaching Nurses An Effective Transition to Palliative and Hospice Care in an Inpatient Hospital Setting

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Background Information:

With the known benefits of palliative and hospice care, the question arises how to create a transition of care that is effective for the healthcare delivery team, patient, and family. Nursing provides the majority of patient contact hours in an inpatient hospital setting. Nurses evaluate the changes in vital signs, the signs and symptoms of discomfort, and provide an active listening and caring role to patients' needs. While this places nurses in a position to advocate for palliative and hospice care, many nurses lack the knowledge and resources to communicate this effectively. While the American Association of Colleges of Nursing (AACN) identifies the role of competent end-of-life care, there is a lack of teaching the subject in nursing school curriculum and textbooks (Betcher, 2010). A recent article by the American Nurses Association (ANA) details the subject of ethical decision making and nurses need for end-of-life education (ANA, 2010). A review of the research literature with regards to nursing, palliative, and hospice care identifies the clinical problem of ineffective communication and lack of knowledge of end-of-life care.

Aim:

The purpose of this evidence-based practice project was to identify the barriers of nursing assisting in the implementation of palliative/hospice care and propose a strategy to enhance effective transition of care in an inpatient hospital setting. This project offered nurses on a 36-bed neurosurgical unit a teaching program on palliative and hospice care with the theoretical background of Jean Watson's theory of human caring. Goals for the teaching included increased knowledge, understanding, and confidence for nurses to be involved in palliative/hospice plans of care. The effectiveness of this project was measured by pre versus post-intervention scores on

a survey administered to nurses who participate in the educational intervention. The objectives of this evidence-based practice project were to enhance nurses understanding of hospice and palliative care, identify the ten caritas factors of the theory of human caring, and ease the transition of patients to hospice or palliative care

Methods/Programs/Practices:

A teaching intervention was implemented with an expected result of differences in pre-intervention and post-intervention survey scores. The type of intervention was educational, in this case the education of nurses in palliative and hospice care. Caroline Hosseini, the MSN student, conducted the teaching. A convenience sample of nurses (n=26) on an inpatient neurosurgical unit was used. This number represents male and female RNs and LPNs employed on the unit. Prior to the intervention, nurses took the Caring Efficacy Scale (CES) to demonstrate their level of caring. Teaching included a packet containing handouts from the hospital's palliative care team and information on Jean Watson's theory of human caring. A bulletin board presentation was presented twice at shift change, to both day and night shift nurses on the unit. Each participating nurse received an educational packet containing the ten caritas processes from the theory of human caring and guide to the hospital's palliative and hospice care services. The bulletin board was posted for one month in the break room, as a resource to the unit. After one month, the participants retook the CES. The controls were nurses on the same unit, same education given, and use of the same survey administered. The difference was measured by a change in caring attitudes as represented by pre and post-intervention scores. Permission for the evidence-based project was gained from the hospital and university level Institutional Review Boards.

Outcome Data

A paired t-test statistical analysis of pre-intervention and post-intervention survey answers, revealed a small increase in caring and understanding patient needs in respect to hospice and palliative care. The p-values for a comparison of pre versus post-intervention answers identified two questions to have p-values less than 0.05, showing statistical significance. Question 9 of the CES asked participants if they feel able to create a presence of serenity and calmness when entering a patient's room. Nurses moderately agreed (-2) with this statement and had an increase in caring from pre-intervention 34%, moderately agreeing, to 50% post-intervention (p-value= 0.048). Participants also showed a significant increase in caring when answering question 30 of the CES, strongly disagreeing (-3) that they do not use creative ways to express caring. Pre-intervention, 42% of participants scored this answer as strongly disagreeing versus 50% post-intervention (p-value= 0.047).

Conclusion:

Numerous studies have been conducted to gain better understanding of the transition process of patients to palliative and hospice care. Indicators of quality patient palliative/hospice care show that effective communication techniques enhance how nurses, doctors, and other members of a healthcare team provide care. The healthcare system involved in this evidence-based practice project provided Hospice care for over 3,000 patients in 2010 (CHS, 2011). By identifying caring attitudes of nurses on an inpatient unit and offering palliative/hospice care education, a bridge to an effective transition of care is possible.

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Abstract title: CNL Preceptor Teams

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Background Information:

The Clinical Nurse Leader (CNL) Role is the first new nursing role in over 40 years (AACN, 2007). Implementing a new role into an established system can be difficult. Preparing the way for these new people seems key to their satisfaction and success (Wiggins, 2006).

The 2011 CNL clinical cohort at Texas Christian University consists of 17 students. These students are located in almost ten different facilities throughout the Dallas/Fort Worth region. Since there is an absence of CNLs in several of our current hospital systems to serve as preceptors to CNL students, interdisciplinary preceptor teams have been developed. These teams are unique to each student depending upon their practice location. This seems most appropriate since one of the major roles of the CNL is lateral integration of care which involves pulling together multiprofessional teams to address patient care issues.

Aim:

The primary aim of the preceptor team approach is to share the planning, implementation, and evaluation of the CNL student using preceptor teams. Conversely, the CNL student routinely collaborates with the preceptor team and the faculty member to create a clinical project that incorporates quality improvement and financial outcomes. The secondary aim is that the preceptor team approach enhances the visibility of the CNL in the hospital microsystem and gives the CNL student opportunities to educate hospital departments about the CNL role.

Methods/Programs/Practices:

Preceptor teams are formed by the CNL faculty person with input from the student and the practice partner CNL facilitator. The primary preceptor must be an RN with at least a master's in nursing education. The other team members are individuals important to the student's microsystem and the student's expected project needs. This is frequently a case manager, social worker, information systems person, and others to create a 3-6 person team. The inclusion of

persons from outside nursing is encouraged such as persons in finance, nutrition, and in some cases, physicians. The preceptor team may change slightly after the capstone project is selected. Each member of the preceptor team signs an agreement with the university and communicates regularly with the faculty member.

This plan brings a multiprofessional team together providing students the opportunity to lead such teams and disseminate information about the CNL role throughout the facility. Additionally, it allows students to further understand the impact of various hospital departments on the CNLs microsystem.

Outcome Data

To date there is only qualitative outcome data. Feedback from students and preceptors has been positive and there is evidence of increased awareness of the CNL role. The CNL certification exam pass rate is currently 100%.

Conclusion:

Within our facilities where the CNL role is just beginning there are no CNLs to serve as preceptors. In our facilities where there is a CNL able to function as a primary preceptor, there are several significant reasons to use a team approach. First, students benefit from learning how to manage a multidisciplinary team. Second, both students and members from other departments recognize the purpose and value of each role to the microsystem. Finally, the facility has an increased awareness of the purpose of the CNL to the microsystem. Relationships formed from this team approach have facilitated collaboration on projects benefiting the microsystem after the student graduates from the CNL program. This shows that establishing the preceptor teams during the clinical experience establishes a solid foundation for future cooperative efforts. Texas Christian University's approach to the CNL students clinical experience has been successful and well accepted by students and practice partners.

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Abstract title: Patient and Family Nurse-Physician Rounding to Improve Communication: Effects on Length of Stay and Patient Satisfaction

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Background Information:

This is a pre/post intervention study completed on a 10 bed observation unit identified as having an average length of stay of 1.5 days and decreased patient satisfaction scores in categories involving communication. Improving communication has been established as an essential part of providing safe and effective patient care; miscommunication between health care professionals and patients, or among health care professionals, can lead to medical errors or adverse events (Hughes et al.2005) (Forster 2005) (Woolf 2004) (Bartlett et. al, 2008) (O’Leary et al., 2008). Communication from providers to patients regarding their plan of care helps patients and families prepare for discharge, which can reduce discharge delays, decrease length of stay, and improve satisfaction (Ahrens et. al, 2003) (Webber-Maybank and Luton, 2009) (Lees, 2008) (Shiu et al., 2004) (Clark, 2006) (Dutton et al, 2003). Patient satisfaction is an important consideration because it demonstrates an organizations’ commitment to quality care and is one of the main factors consumers consider when choosing a healthcare facility (Stavins, 2006). A statistically significant and sizable relationship between providers’ communication behaviors and overall patient satisfaction has been consistently shown in nursing research (Clever et al, 2008). Patient satisfaction increases when communication is clear, understandable and respectful (Beach et al. 2005) (Wanzer et al. 2004). Nursing literature has shown a decrease in length of stay and improved patient satisfaction after implementation of nurse-physician rounding. (Vazirani, 2005) (Gittell et al, 2000) (Chapman, 2009) (Pronovost et al, 2003) (Narasimhan et al, 2006) (Phipps & Thomas, 2007) (TJC, 2007).

Aim:

The purpose of this study, currently in progress on this 10 bed observation unit, is to determine if daily patient and family rounding completed in tandem with nurses and physicians will improve communication as demonstrated with increased patient satisfaction and a decrease in patients’ length of stay

Methods/Programs/Practices:

Initial data on patient satisfaction was collected by the student Clinical Nurse Leader prior to the intervention through the use of patient satisfaction surveys. Participants (n=30) were asked to respond to questions using yes/no and a 5 point Likert scale. Chart reviews were completed to collect data on length of stay for patients admitted to the unit prior to the initiation of nurse-physician rounding. Staff education on nurse-physician rounding followed the collection of pre intervention data. Patient and family centered nurse-physician rounding was then implemented. This intervention includes the use of a daily rounding tool and inclusion of the patient and family during daily rounds performed in tandem by nurse and physician. Following the intervention, data will be collected on patient satisfaction and length of stay in the same manner as the pre intervention data. Compliance with nurse-physician rounding is also being collected by the student Clinical Nurse Leader by review of the completed daily rounding tool and through direct observation. A Chi Square analysis will be completed on rounding compliance data and each yes/no question; a t-test will be used for each Likert-type question of the patient surveys. A t-test will be used to analyze length of stay data. Length of stay data was collected for 6 week period prior to the intervention and will be collected during the 6 week period following implementation.

Outcome Data

Analysis of pre and post intervention data will be used to determine statistically significant increases in patient satisfaction and decreases in length of stay. Results pending completion of project.

Conclusion:

Potential benefits of this study include an increase in patient and family involvement in plan of care and increased communication from care provider to patients resulting in increased satisfaction. Patient and families will have the opportunity to be more prepared for discharge which may potentially decrease length of stay. Nurse-physician communication will be enhanced regarding discharge planning, thereby increasing efficiency and patient safety.

Abstract title: Using Medication Cards to Improve Patient Satisfaction

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Background Information:

Hospitals are becoming more concerned regarding patient satisfaction with their facilities, staff, and services. Many hospitals use the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) Survey to poll patients regarding their satisfaction with care received while hospitalized. Satisfaction data are available to the public so that consumers can compare hospitals and make informed decisions about which hospitals they choose for health care services. In the very competitive market of healthcare, there is motivation to achieve and maintain high scores to attract patients, physicians, and payers (Institute for Healthcare Improvement, 2011). Additionally, there are financial incentives to maintain high patient satisfaction scores. Hospitals are now required to participate in the HCAHPS Survey or risk a 2% reduction in payment from Centers for Medicare and Medicaid Services (Kutney-Lee, et al., 2009).

Another area of concern facing the healthcare industry is finding innovative means of decreasing medication errors and keeping patients safe from adverse medication errors, even after discharge. One way to achieve this goal is through simple, easy to read, printed education materials about medications (Maniaci, Heckman, & Dawson, 2008; Coulter and Ellins, 2007; Oyekan, et al. 2009).

Using HCAHPS data, St. Vincent's East identified that there existed an opportunity to improve patient satisfaction regarding communication about patient's medications. Furthermore, of the HCAHPS scores that nursing could control, communication regarding medications consistently received the lowest score.

Aim:

The aim of this improvement project is to increase patient satisfaction scores for the 6 West population regarding communication and education about newly prescribed medications. This goal will be accomplished through the design and implementation of a medication card protocol. The baseline for measurement will be the HCAHPS Survey scores for 6 West patients for the time period of October 1, 2010 through December 31, 2010, which reflects that of the

50% of patients who received a medication they had not taken before, only 67% said they were “always” told what the medicine was for, and only 60% were “always” told of possible side effects. The aggregate score for these two questions was 63%. The desired goal of the project is to increase this aggregate score over the next quarter to 72%, slightly above the national benchmark of 70.42%.

Methods/Programs/Practices:

To determine which medications would be included, a list of the most frequently administered medications throughout the hospital, and the most commonly prescribed medications nationwide was compiled. A comparison of these two lists was performed, and a master list developed that was presented to key personnel. Once the medication list was narrowed down to 250 medications, the medications were grouped into 29 classifications. Each medication was cross-referenced within its classification for common side effects using Micromedex[®].

Medication cards were then modeled after cards used at Trinity Hospital in Birmingham, Alabama. The cards are 4”x5½” and printed on color-coded cardstock. A black size 12 Arial font was used, and text was bolded for critical information. Information on the cards was written at a 6th-7th grade reading level. The information on the cards addresses the questions on the HCAHPS Survey, which ask the reason for taking the medication and possible side effects. Also included on the cards are drug classification, important warnings, lab work, if applicable, and trade and generic names of the medication.

Medication cards, along with verbal education, are provided to patients upon receipt of any new medication. The cards are left with the patient and referred to during subsequent administration.

Outcome Data

At the time of this abstract, available HCAHPS data shows patient satisfaction with medication communication at 100% since implementation date of July 5, 2011. HCAHPS scores are continuing to be monitored and reviewed, and end of quarter scores will be compared to the baseline goal to see if improvement has occurred, and if the goal of 72% has been achieved.

Conclusion:

Thus far, the implementation of the medication card protocol is showing success in improving patient satisfaction about medication communication as evidenced by HCAHPS data. The medication cards have been received well with patients, staff, and administration. Since the implementation of the medication cards on 6 West, the hospital has adopted and implemented the use of medication cards throughout all patient care units.

From “OW!” to “WOW!?”: Improving CNL Certification Exam Pass Rates

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Background: Professional certification provides external validation that an individual has knowledge and skill needed to fulfill a role. CNL certification assures patients, families and potential employers that graduates of master’s and post-master’s Clinical Nurse Leader programs have demonstrated accepted standards of practice and has the knowledge and skill needed to fully function in the 9 roles of the beginning CNL. While individual CNL certification pass rates reflect upon the ability of an individual, aggregate pass rates reflect upon academic programs. Aggregate pass rates are commonly used by accrediting bodies, leadership, and potential students as an overall measure of program quality.

Setting: The University of Alabama at Birmingham School of Nursing began preparation for the first cohort of CNL students in 2008. Curriculum was designed and implemented based on AACN White Paper guidelines to include all required curricular components, clinical experiences, and overarching end-of-program competencies. UAB faculty were additionally challenged to create a curriculum that would be equally effective in preparing CNL students regardless of the educational model (Model A, B, C, D or E).

Outcomes: Faculty felt confident that the curriculum would prepare graduates to sit for the AACN CNL Certification Exam, however Cohort 1 had an overall pass rate of 37.5% (3 of 8) much lower than the national average of 78%.

Response: Information obtained from graduates, AACN exam feedback, and a comprehensive review of the curriculum was used to guide revision of the curriculum to address identified areas of weakness. In addition, an expert consultant was asked to review the curriculum following revision. Our multifaceted approach included an early program intensive, creating and implementing structured practicum guidelines, participation in the IHI open school, and a 2 day student led CNL test preparation course.

Outcomes: The second cohort achieved a 100% pass rate on the multiple choice portion of the exam and an 88% pass rate on the simulation portion of the exam. While faculty are very pleased with these outcomes, we still seek to improve the curriculum and achieve better programmatic outcomes. Student and AACN CNL certification exam feedback are being used to further refine the curriculum.

Abstract title: Breathing Life into Dyspnea Relief: Educating Oncology Nurses about Alleviating Dyspnea During the End-of-Life

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Background Information:

Refractory dyspnea is the uncomfortable and subjective sensation of discomfort while breathing wherein the underlying cause cannot be reversed (Thomas, 2009). The sensation is described as breathlessness, air hunger, or shortness of breath and is not necessarily associated with hypercapnia or hypoxemia (Thomas, 2009). Refractory dyspnea is especially frequent and distressing for terminally ill adults with advanced cancer at the end-of-life. The hematology-oncology floor of the Cedars-Sinai Medical Center (CSMC) 4SW is a unit that cares for seriously ill patients with advanced cancer, including many near death. While CSMC has no protocol for recording and measuring dyspnea, the estimates for dyspnea during the end-of-life for cancer patients is greater than 60 and 70% (Mercadante et al., 2009; Reuben and Mor, 1986 as cited by Shumway, Wilson, Howard, Parker, and Eliasson, 2007). Dyspnea is also consistently the primary or secondary indication for patients to receive palliative care (Maltoni et al., 2009; Rietjiens et al., 2008). Despite its prevalence, dyspnea is poorly identified and assessed by both physicians and nurses (O'Mahony et al., 2010; Shumway et al., 2008). Additionally, the widespread treatment of dyspnea through narcotics has been a source of distress for family and health care providers due to fears of hastening death (Thomas, 2009). Since dyspnea is a nursing sensitive outcome, an educational program was designed targeting the nurses of Cedars Sinai 4SW with the goal of improving their awareness of dyspnea and the evidence based interventions designed to alleviate physical and emotional distress for the patients and families.

Aim: The goals of the program included educating nurses on the pervasive and distressing nature of dyspnea, recommended assessment, evidence-based interventions, and current research.

Methods/Programs/Practices:

A literature review was conducted on the nature of dyspnea in dying cancer patients, best evidence-based practices including the Oncology Nursing Society (ONS) "Putting evidence into practice series," and on current research (DiSalvo, Joyce, Tyson, Culkin & Mackay, 2008). While opioids are considered the gold standard for treatment, many evidence-based interventions center on decreasing anxiety through medication and non-medication means. Additionally, recent research has provided more support for the efficacy of benzodiazepines alone or in combination with opioids (Edwards, 2005; Mercadante et al., 2009; Navigante et al., 2006). Review of seven recent studies strongly suggest that increasingly high doses of opioids and benzodiazepines, even to the point of palliative sedation, may not hasten death and may even prolong life (Clemens and Klaschik, 2007a and 2007b; Edwards, 2005; Maltoni et al., 2009; Mercadante et al., 2009; Navigante et al., 2006; Rietjiens et al., 2008).

The program included an educational in-service and informational flier, a pre and post-test, and a poster. The material was presented at the huddle on two days in order to reach rotating shifts of nurses. Pre-tests were given prior to education and post-tests were given afterwards while the

poster was placed on the hallway. Outcomes of the project were evaluated through the pre and post-test responses to the definition of dyspnea, causes of dyspnea, listing five evidence-based interventions, the percent of cancer patients experiencing dyspnea during the end-of-life, and the potential effects of providing increasingly high doses of opioids and benzodiazepines.

Outcome Data

Responses on a four question pre- and post-test were used to evaluate the effectiveness of the project. The educational intervention sought to evaluate post-tests for responses that included neural as well as mechanical causes of dyspnea, correctly identified five evidence-based interventions, correctly listed the percent of cancer patients experiencing dyspnea during end-of-life, and the positive effects of opioids and benzodiazepines such as comfort and prolonging life rather than simply negative ones.

During two huddles, 15 pre-tests and 14 post-tests were returned. No change was seen in the definition of dyspnea, which was correctly defined by all responders. In the responses for the causes of dyspnea, one person named neural causes in the pre test while two did so in the post-test. Only six of the pre-test responses correctly identified five evidence-based interventions and ten correctly named the percent of cancer patients with dyspnea during end-of-life. Of the post-test responders, 13 correctly identified five evidence-based interventions and 14 correctly identified the percent of cancer pts with dyspnea. Pre-test responses to the potential effect of providing increasingly high doses of opioids during the end-of-life included decreased respirations (9), death (2), agitation (1), and sedation (1). However, post-test responses included alleviation of dyspnea or comfort (11) and respiratory depression (3). Also, only five of the pretests listed interventions decreasing anxiety while 11 did so in the post-test. These responses demonstrate that education had a positive impact on the nurses' knowledge of dyspnea in cancer patients during end-of-life, and therefore on their practice.

Conclusion: Examination of post test responses confirm that the educational program “Breathing Life into Dyspnea Relief” positively impacted the knowledge of the nurses on Cedars-Sinai 4SW on the nature of dyspnea and dyspnea relief. While no systematic method of measuring and recording dyspnea for palliative patients currently exists at CSMC, nurse feedback and anecdotal responses suggest that the educational project has also positively impacted patients experiencing dyspnea as well.

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Abstract title: The Scavenger Hunt; A Method for Enhancing Advanced Health

Assessment Skills

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Background Information: One of the goals of a Clinical Nurse Leader Program is to increase the student's health assessment skills through ongoing practice. Some of the most common methods include: clinical hours with a nurse practitioner preceptor, use of simulation labs or simulation mannequins, and health assessment videos. The difficulty for educators is to develop creative methods to increase and practice health assessment skills. The scavenger hunt is one novel method utilized to practice and increase health assessment skills.

Aim: The purpose or aim of the Scavenger Hunt is to have a supplementary creative, innovative method for Clinical Nurse Leader students to use during the Advanced Health Assessment Class to increase and practice their health assessment skills.

Methods/Programs/Practices: The new method introduced is called the Scavenger Hunt. This was designed to highlight key regional assessments: 1) Neurological, 2) HEENT (head, eye, ears, nose, throat), 3) Cardiovascular, 4) Respiratory, 5) Gastrointestinal and Genitourinary, 6.) and Dermatologic. During this presentation we will describe how the student must inspect, palpate, percuss and auscultate these systems. Moreover, the students submit a log with all normal or abnormal findings along with the education provided and their recommendations.

Outcome Data: This presentation will describe the outcomes of using the Scavenger Hunt for the first time in an Advanced Health Assessment Class for Clinical Nurse Leaders. Furthermore, the presentation will discuss the benefits and challenges in using the Scavenger Hunt in the current form.

Conclusion: Clinical Nurse Leader Programs as well as all nursing programs need to learn new and creative methods to increase knowledge and skills. One new method to increase knowledge and skills related to Advanced Health Assessment is the Scavenger Hunt. The instructions for this method will be described, while the benefits and challenges will also be discussed.

Abstract title: Hospital to Home Care Coordination

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Background Information: Interdisciplinary discharge planning should be initiated at the time of admission and throughout the hospital stay. Interdisciplinary discharge planning should be coordinated to facilitate an effective and efficient discharge plan. In August 2011, patient satisfaction with being included in their discharge planning was 67% and 23% for an excellent rating for including family members/significant others in discussions about their care. In an effort to decrease gaps in communication among interdisciplinary team members, patient and family member/significant other partnership should be achieved to ensure a seamless transition from hospital to home and to improve patient satisfaction with discharge planning.

Aim:

- To decrease gaps in the collaboration for discharge planning
- To promote interdisciplinary cohesion
- To achieve a partnership with the patient/family/significant other in discharge planning
- To achieve a seamless transition from hospital to home

Methods/Programs/Practices: The following interventions were implemented to ensure post discharge, comprehensive care coordination:

- Providing reminders to the team members for multi-disciplinary discharge planning meetings
- Providing an alternate day and time for interdisciplinary discharge planning meetings
- Increased attendance at the bedside rounding with the Medical teams
- Including the patient/family/significant others in discharge planning discussions
- Utilization of an electronic, pilot, MAS (Medical Administration Service) request for transportation
- Discharge planning huddles, as appropriate
- Daily review of the Truth Point Inpatient reporting results
- Collaboration with ancillary services
 - Pharmacist
 - Physical Therapy
 - Dietitian
 - Wound and Ostomy practitioners
 - Palliative care team members
 - MAS (transportation) service

Outcome Data: As a result of the implemented interventions, within 30 days, there was a 10% increase in patient satisfaction for being included their discharge planning and a 27% increase in an excellent rating for family members being included in discussions about their care.

Conclusion: The data to date demonstrates effective and efficient collaboration to ensure patient and family members/significant other satisfaction with partnering in the collaboration of post discharge, comprehensive care, as well as ensuring a seamless transition from hospital to home, and ongoing collaboration among multi-disciplinary team members.

Abstract title: Decreasing the 24 – Hour Urine Turnaround Time for Obstetric Patients

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Background Information:

According to Gilbert (2011), pre-eclampsia is described as the “development of hypertension and proteinuria in previously normotensive patient after 20 weeks of gestation or in early postpartum period; in presence of trophoblastic disease, it can develop before 20 weeks of gestation.” Pre-eclampsia, a leading cause of morbidity and mortality in mothers and neonates, occurs in about 80 percent of all pregnancies complicated by hypertension, which is about five percent of all pregnancies (Gilbert, 2011).

Generally, the hospital lab runs the 24-hour urine tests at the end of the day, because the total protein has to be manually entered, which is time consuming. Also, the 24-hour urine test is

not considered urgent in non-pregnant patients. The average turn-around time was 399.8 minutes for all obstetric patients, and 203.9 minutes for inpatient obstetric patients.

Aim:

The aim of this project was to decrease the turnaround time of 24-hour urine results, due to their impact on the patients' plans of care.

Due to the lengthy turnaround time, the patient often had an unnecessarily increased length of stay. This ties into the secondary aim, which was to decrease patients' lengths of stay (this information is currently being collected), and thereby improving patient and provider satisfaction, although this data was not collected.

Methods/Programs/Practices:

The CNL realized this lengthy turnaround time as a problem. She took the problem to the director of the lab, and they sat down and brainstormed ideas on how to improve the turnaround time. Together they came up with a plan: Get brightly colored stickers made that say "High Risk OB Patient – Please Rush" and attach the stickers to the lab requisition forms and the actual 24-hour urine jugs so they stood out. The staff on the high-risk antepartum unit, labor and delivery, and the high-risk postpartum unit were all educated about the new process by the obstetrics Clinical Nurse Leader. The lab staff were educated on the new process by the lab director. The lab was educated that when a 24-hour urine jug was dropped off for an obstetrics patient, it was to be done right then and not held until the end of the day.

Outcome Data

The new process was started June 6, 2011. The pre-data showed a baseline of an average turn-around time of 399.8 minutes for all obstetric patients, and 203.9 minutes for inpatient obstetric patients. The average turnaround time for inpatient obstetric patients for June 2011, after June 5, was 102.82 minutes. This is a 74.29 percent decrease for all patients, and a 49.57 percent decrease for inpatient obstetric patients. The average turnaround time for inpatient obstetric patients for July 2011 was 97.94 minutes. This is a 75.5 percent decrease for all obstetric patients, and a 51.97 percent decrease for all inpatient obstetric patients.

Conclusion:

A simple process change can greatly improve patient outcomes. This is an ongoing project, and the Clinical Nurse Leader believes it will continue to have a decreased turnaround time. As staff—both clinical and lab, are educated and become more familiar with the new process, the turnaround time should decrease even more. Making significant improvements in patients' plans of care can be as simple as knowing what the problem is, what the goal is, and who should be on your team. Working with an interdisciplinary team, especially on an interdisciplinary problem, is key.

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Abstract title: The CNL Impact on Quality Care: A Decrease in CLABSI

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Background Information:

Central lines are a necessity for the critically ill patient. Central line related bloodstream infections result in a significant increase in mortality and morbidity of the critically ill patient. There is a national call for the collective reduction of incidence of central line infection, by which public reporting has supported. These infections are cost consumptive in the current health care atmosphere that is already strained for resources. The Clinical Nurse Leader plays a key role in the reduction of central line infection, through the use of evidence-based practice.

The incidence of central line infections is so broad that the United States Institute for Healthcare Improvement: Five Million Lives Campaign has listed central line infection as one of the twelve patient care improvement initiatives. Healthcare organizations are feeling the pressure to reduce the number of nosocomial infections from regulatory agencies; this includes the incidence of catheter associated bloodstream infections. The push for collection of data and public reporting of performance for individual hospitals are also increasing the drive to implement and utilize evidence-based practice for improved patient outcomes.

The Intermediate Critical Care Unit (ICCU) at Orlando Regional Medical Center (ORMC) is a 22 bed multi-system medical floor that uses central lines to care for the very complex patients that are received on the unit. The ongoing effort to eliminate central line associated bloodstream infections (CLABSI) began in May 2008. A Clinical Nurse Leader student held a part-time position as a nurse clinician on ICCU until graduation in May 2010, then was employed as a full-time CNL.

Specific Aims:

Eliminate central line blood stream infections in the Intermediate Critical Care Unit.

Aims:

Perform literature search to determine current evidence based practice.

Identify gaps in care practices.

Develop care bundles based on evidence based practice.

On-going team member education.

Daily CNL rounding on each patient in geographical region.

Analyze each CLABSI for root cause.

Methods/Programs/Practices:

A substantial review the literature was completed, it was determined that data must be collected on how many patients have central lines daily to provide internal benchmarking and comparative analysis to external benchmarking. May 2008 thru the present, numerous interventions have been put into place in effort reduce the CLABSI in the ICCU. Interventions such as, a central line

insertion bundle, placing the Biopatch in the clean utility for ease of availability, adding SAGE bath cloths to reduce the bioburden, implementing disposable EKG leads for all patients, and ongoing nursing education regarding central line care. Upon graduation in May 2010, the full-time Clinical Nurse Leader rounds five days a week on the patients her geographical area. Most recently in April 2011, the Clinical Nurse Leader in conjunction with the Renal Collaborative Council led hospital wide policy change to the dialysis access dressing.

Outcome Data:

The outcome data for the CLABSI on ICC is from May 2008 to present. The most notable decline in CLABSI rates was upon the graduation of the Clinical Nurse Leader in May 2010.

Conclusion:

The interventions over the past three years are numerous and the data shows a decline in CLABSI rates for ICCU, but the most significant decline is noted after the Clinical Nurse Leader graduation and full-time position was implemented on the unit.

Abstract title: Home Safety: Fixing Fractures Before They Fall

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Background Information: Falls are among common adverse events reported, the devastation falls have on the elderly are catastrophic. A single fall that fractures a hip can change their life forever, and even cause complete dependence or even death. More than one third of the elderly fall each year, 1.6 million are treated in emergency departments for fall related injuries, and falls are the leading cause of death from injury. Studies have shown that fourteen percent of people fall in the first month after discharge from the hospital. Falls are more frequently reported than medication errors, equipment related incidents, and documentation errors. Each year, up to 50% of hospitalized patients are at risk for falls and almost half of those who fall suffer an injury burdening the health care organization with increased cost per case, and increased length of stay; the average hospital stay for patients who fall is 12.3 days longer and injuries from falls lead to a 61% increase in patient care costs.

Aim: The Clinical Nurse Leader (CNL) of the Geriatric Evaluation and Management Clinic leads the interdisciplinary team to discuss hospital discharges. The clinic issues related to patient discharge that are discussed in the team meetings improve the clinical function to meet the needs of the patient. Prompt action to meet those needs improves safety and opens the lines of communication between the patient and the care provider. Follow up appointments are usually scheduled 7-10 days after discharge. The high risk time for falls to occur is in the 24-72 hour

window transitioning to home. By contacting the patient during the high risk window, we provide increased awareness and opportunity to prevent a fall.

Methods/Programs/Practices: Follow up calls are made 24-72 hours post hospitalization. The CNL reviewed the literature to determine what questions would be asked on the post discharge call and scripted questions so that multiple team members could make the calls and still be able to gather the same information. The questions that were scripted are as follows:

- 1) Since your discharge have you had any difficulty standing, transferring, or changing position in bed?
- 2) Since your discharge are you able to toilet and bathe yourself?
- 3) Since your discharge have you experienced any dizziness or unsteadiness?

Outcome Data The calls initiated responses from the patients that extended beyond just home safety. Discussion and implementation of simple home safety techniques resulted in a 75% reduction in falls post hospitalization. The geriatric populations who generally have low health literacy, short term memory loss, inability to hear well with background noise, and poor vision have difficulty with discharge instructions and transitioning to home. Unaddressed needs post hospital were identified through the calls. The CNL led the weekly team meetings to discuss the findings from the calls to develop plans of care.

Conclusion: The CNL identified the need for post hospitalization follow up call to improve communication with the patients to discuss home safety. It is noted that patients who had a fall in the hospital had more needs to be met to promote home safety. Falls post hospitalization are self reported and the circumstances are not well documented. Patients report increased satisfaction and reduced anxiety transitioning to home post hospitalization with follow up calls. Teach family and patient fall prevention safety at every encounter. Improved handoff from hospitalists to primary care physicians and clinics to prevent falls and fractures post hospitalization especially with patient who have new disabilities.

Abstract title: Community Based Participatory Research: An Intervention Model for Homeless Women with Children Navigating the Health Care System

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Background Information: The YWCA Transitional Housing Program of St. Paul (YWCATHP) and St. Catherine University (SCU) of St. Paul, MN began a partnership in 2006. The time frame for this project was September, 2009 until October, 2010.

Women and families who are experiencing homelessness have competing basic needs such as food, shelter, and safety which supersede health care needs, especially health prevention and promotion. With the feminization of homelessness, services must be provided in a manner that is

responsive to the complex nature of the needs of homeless women and their family. The application of basic literacy skills of reading, writing, speaking and understanding becomes a complex skill set in the health care setting. Navigating the health care system includes the gamut of activities from securing healthcare insurance and a provider, completing endless complex medical forms, finding one's way around the hospital, clinic, or government agency and making health care decisions. Health care decisions can be as simply as which day to schedule an appointment, and as challenging as providing informed consent for cancer treatment.

Aim:

The purpose of this community based participatory research study was to evaluate navigation of primary care by homeless women with children who were residents of a transitional housing program (THP) in Minnesota. Data was collected at three different points in time. An intervention program was created for this specific population which is at risk for inadequate access and navigation of the health care system. The intervention model based was designed to strengthen health-learning capacity skills which would enhance participants ability to navigate the health care system. Three navigational tasks were targeted: getting and keeping appointments (access and utilization); communicating needs to health care provider (patient-provider relationship); and advocating for self and family (self-care).

Methods/Programs/Practices:

The intervention program was a small study (n=21) conducted at a Midwest transitional housing program which serves women and their children. The pilot project utilized the community-based participatory research model. Quantitative data was collected at admission to the transitional housing program, before the three part intervention program and three months after the conclusion of the educational program. Participants' comments (qualitative data) were requested in the last three survey questions. An evidence-based intervention model was created and implemented which focused on improving outcomes not through the customary approach of providing information, but rather at a more basic stage in the process. The health-learning capacity skills model (Wolf et al., 2009) was integrated with the limited health literacy research project of Harvard University (Ruma, Soricone, Santos, Zobel, & Smith, 2005).

Evidence-Based Practice: The theoretical framework for this study emerged from three conceptual models: The Gelberg-Andersen Behavioral Model for Vulnerable Populations (Gelberg, Andersen, & Leake, 2000) which was utilized in The UCLA Homeless Women's Health Study (Arangua, Andersen, & Gelberg, 2006); Paasche-Orlow and Wolf's (2007) Causal Pathway Linking Health Literacy and Health Outcomes; and Wolf and his colleagues' (2009) Health-Learning Capacity Model. The intervention component of this project was guided by the Institutes of Medicine's (IOM) report, Health Literacy: A Prescription to End Confusion (2004) and The Health Literacy Study Circles (2005) developed at Harvard University Schools of Education and Public Health.

Outcome Data

The genesis of this research project was the agency's concern for whether their residents had established a regular source for health care needs. Descriptive data analysis comparing admission data to six months after admission revealed an increase in the residents' identification of a regular source for health care needs. The comparison of pre-intervention and post-intervention

survey results demonstrated change in the health behaviors of the residents: increase use of regular source of health care; more appropriate use of the emergency department; and decrease endorsement of survey response option “do not know” which reflects enhanced sense of empowerment. Residents also reported improved self-perception of their health after the completion of the intervention program.

Conclusion:

The intervention program was conducted at a Midwest transitional housing program which serves women and their children. The data analysis of pre- and post- intervention program survey results revealed some shifts in the participants’ response that suggests improved navigation of the health care system. These shifts included improved self-perception of personal health and increased satisfaction with health care providers. There was a downward shift in the highest frequency of emergency room usage (four or more in past three months) which is consistent with more appropriate emergency department usage. The agency would like to integrate the intervention program into the ongoing Life Skills Program. The research will continue to participate in the program.

Abstract title: The Influence of Patient Care Integrator’s on the Reduction of Never Events: Hospital Acquired Pressure Ulcers (HAPU)

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Background: There is a public mandate for the US healthcare system to become more efficient while remaining patient-centered. Recognizing the need for this role, nursing leaders at Sinai Hospital of Baltimore created the CNL-inspired Patient Care Integrator (PCI) position as part of the Sinai Hospital Integrated Care Model for a high-volume, 36-bed high acuity Intermediate Care Unit (IMC). The PCI role is one mechanism by which that mandate is being addressed. The PCI’s created a performance improvement initiative in the IMC to increase the quality of patient care and decrease never events. Never events are recognized as undesirable events resulting from admission to a hospital. Hospital acquired pressure ulcers (HAPU), one of the never events, produce an unsafe and adverse situation for patients; leaving them with negative lifelong physical and emotional effects resulting in poor patient outcomes. Furthermore, HAPU create a significant financial burden for hospitals increasing the necessity for an innovative quality process focusing on preventative measures, patient safety and nurse education. Conduction of chart audits as well as interpretation of unit specific data revealed gaps in patient care, documentation and staff education ultimately leading to the development of a pressure ulcer prevention program. **Outcome Data:** Implementation of the pressure ulcer prevention program has been successful in the IMC. With continued collaboration among the PCI’s, Wound Ostomy and Continence (WOC) RNs and the unit specific Champions of Skin Integrity (CSI) representatives, the unit has been able to achieve a 0% rate for the past 3 quarters; below the

National Database of Nursing Quality Indicator's benchmark of 2.90%. There has been continued improvement in RN documentation of pressure ulcers along with prevention and management of pressure ulcers. The pressure ulcer prevention protocol has facilitated RN and Patient Care Associate (PCA) camaraderie and teamwork because there is an understanding that pressure ulcers are preventable. **Description of Program:** Implementation of the program included daily chart audits, real time clinical Integumentary assessments on patients with Braden scores less than or equal to 16, patients with a LOS greater than 3 days and patients transferred from ICU to IMC. A 'Lunch and Learn' educational session for unit staff members was provided which included an explanation of dressing products from the unit's formulary supply, a hands on mannequin with multiple pressure ulcers of various stages and posters addressing how-to stage, measure and manage pressure ulcers. Chart documentation was audited daily in 4 categories: the Braden score, completion of the Integumentary assessment, Q2 hourly turns and whether the nurse driven orderset: "Prevention-patient's on bedrest" was in place. If the documentation was lacking in any of the 4 categories, the PCI's would follow-up with the RNs and PCAs to ensure that the proper skin preventative measures were in place. The PCI's, RNs and PCAs rounded daily on at-risk patients conducting a thorough Integumentary assessment to monitor the progress of existing wounds and to prevent wounds from occurring by performing turns and applying barrier cream, waffle boots and ear pads for patients wearing oxygen. The PCI's and RNs would consult with WOC RNs on a daily bases to provide quality care to population of at-risk patients. Additionally, the CSI representatives conduct monthly skin prevalence on all patients in the unit. **Summary:** The pressure ulcer prevention program was successful in decreasing the prevalence of HAPU among critically ill patients in the IMC utilizing existing resources. The PCI role at SHOB helped to bridge the gap and increase quality patient care through this quality improvement initiative which was highly effective in improving patient outcomes and drastically reducing HAPU. The PCI served as the lateral integrator across disciplines and assumed accountability for achieving this targeted outcome through demonstrating safe, effective and quality patient care in this complex healthcare system.

Abstract title: Examining Rural Point of Care Nurse Leadership

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Background Information: High quality, safe care that is free from preventable error and harm is an expectation in all healthcare settings. Limited resources, lower volumes, small staffs, and inadequate technology often present significant challenges for rural hospitals developing and implementing quality and safety improvement programs. However, quality and safety are dependent not only on the structure in which care is provided but also upon the process of care delivery. While practice guidelines, computer-aided decision support, standardized performance measures, and data feedback capabilities are all requisite components of a rigorous quality and

safety improvement program, little is known about capacity of rural nursing leadership to effectively implement these programs at the point of care.

Aim: The purpose of this project is to describe rural Chief Nursing Officer (CNO) perceptions of the strengths and weaknesses of rural nursing leadership at the point of care.

Methods/Programs/Practices: Rural hospital CNOs will be emailed a letter of invitation to participate in a study to examine nursing leadership at the point of care (microsystem). CNO's agreeing to participate will follow a link to an online survey. At this website, they will be asked to respond to a demographic questionnaire providing information about the hospital, nursing and nursing leadership within the organization. Additionally, they will be asked to provide information describing how well they believe nurse leaders at the point of care are prepared to improve quality and safety. Follow-up emails will be sent at 2 and 4 weeks.

Outcome Data: In progress.

Conclusion: Findings from this study will provide information about rural nursing workforce needs related to quality and safety improvement and provide empiric data to inform development of a program to bring the Clinical Nurse Leader role into the rural health system.

Abstract title: An Innovative CNL Endeavor: Promoting Evidenced-Based Practice through Nursing Grand Rounds

Authors/credentials: Debbie Newman RN, MSN, CNL and Joanna Olson RN, MSN, CNL

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Background Information:

Clinical Nurse Leaders (CNL) partnered with Advance Practice Nurses (APN) at the Central Texas Veterans Health Care System to implement nursing grand rounds as part of the evidence-based nursing practice program infrastructure. Evidence-based care defines care that integrates best scientific evidence with clinical expertise, knowledge of pathophysiology, knowledge of psychosocial issues, and decision making preferences of the patient. The evidence supports the use of nursing grand rounds for the dissemination of recent clinical and research based information as a universal practice. A forum that focuses on staff nurses' presentations provides an opportunity for bedside clinicians to grow and develop professionally with guidance and mentorship provided by CNLs and APNs.

Aim:

To encourage a culture of evidence-based practice and continuing professional development while providing support so learning can be unencumbered without distractions of heavy workloads.

Methods/Programs/Practices:

Nursing Grand Rounds recurs the third Tuesday of each month with videoconference to off campus sites. Interested presenters are invited to submit their topics at the beginning of each year. Potential presenters are provided with guidelines to include objectives that insure the evidence based intent of grand rounds. The focus of grand rounds includes the use of case studies, best practices, and presentation of research studies, practice problems, barriers, issues, and/or methodologies. After a screening process, presenters are selected and assigned a month to present. To generate awareness of scheduled presentation, posters are displayed throughout the facility and broadcast messages are disseminated via e-mail to include community based outpatient clinics.

Outcome Data:

Nursing Grand Rounds at CTVHCS will begin its third year of existence in February 2012. Interdisciplinary effort, Leadership support, and staff interest have contributed to the sustainability of the program. Nursing Grand Rounds has expanded to include Darnall Army Medical Center at nearby Ft. Hood, as well as the VA North Texas Health Care System in Dallas via videoconference. Since its inception, multiple disciplines have presented to include staff nurses, clinical nurse leaders, physicians, advanced practice nurses, clinical nurse specialists, and nursing leadership. A recent request to change from the third Tuesday to the second Tuesday of the month to avoid a current conflict preventing physicians from regularly attending Nursing Grand Rounds reflects the level of organizational interest in this evidence based nursing venue.

Conclusion:

Nursing Grand Rounds provides a forum for members of the healthcare team to share their expertise, experiences, and foster the advancement of nursing practice by addressing the learning needs of nurses in clinical practice to promote excellence in evidence-based practice. The success of this initiative is one indicator of the organizational impact of leadership by CNLs and their partnership with APNs and other members of the health care delivery team.

Abstract title: Improving Oncology Patient Outcomes through Expansion of the CNL Role

Authors/credentials: Joletta Phillips RN, MSN, CNL

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Background Information: The CNL role was implemented on the inpatient Oncology/Acute Medicine unit approximately a year after the initial CNL roles were implemented in other acute care units in our organization. The oncology/acute medicine unit was, therefore, anticipating the role and expecting rapid return impact upon implementation. Issues related to pain management were already identified as a concern for the Nurse Manager of this microsystem. Opportunities for improvement had been identified in pain assessment, pain control, and the documentation of PRN effectiveness. Additionally, patient flow through the inpatient acute care units was not consistent for patients on oral chemotherapy, as all inpatient units were not equally comfortable with providing care for these patients and were quick to transfer patients requiring oral

chemotherapy to the Oncology unit thus disrupting the patient's continuity of care. Delays in discharge to home had also been identified and seemed to be related to communication breakdown in the interdisciplinary care team.

Aim: As a new CNL to a micro-system with preset expectations, it was evident that leadership for the unit saw and embraced the opportunity for a CNL to perform an assessment and provide an action plan to improve current processes. The goal was to improve patient care outcomes, ensure best practices were being implemented that was evidence-based, decrease costs, and decrease length of stay. A process improvement approach was employed as a demonstrated method to introduce process changes that are directed at improving quality, reducing costs, and accelerating throughput.

Methods/Programs/Practices:

- Roll out of a large education endeavor on pain management with in-service and poster presentations to the staff. Medications and side effects as well as pain assessment were addressed. Data was presented to show comparison on documenting PRN effectiveness with our unit in comparison to other inpatient units. Reminders were implemented as a team approach.
- Collaboration with Chief of Oncology on oral chemotherapy and the need for patients to be transferred to the oncology unit. A small list of oral medications was devised for inpatient units to refer to in making decisions regarding the need for patient transfer. This list was placed into the Nursing Policy and Procedure on Administration of Antineoplastic Medications. A power-point presentation was prepared with collaboration with chemotherapy certified nurses and was presented to all inpatient unit Nurse Managers and nursing staff.
- Development of a discharge checklist to ensure the patient is discharged in a timely manner with all necessary equipment, medications, and instructions. The checklist outlines who is responsible for each aspect of the patient's discharge.

Outcome Data

- PRN effectiveness documentation improved from the 60-70% to 80-95% within one month after the Pain Management process improvement project. There was a significant improvement in staff understanding of pain assessment and different strategies to manage pain other than using medication.
- Interward transfers of patients on oral chemotherapeutic agents has decreased drastically since change of policy and educational in-service. Nursing staff on other units feel comfortable with providing care for these patients in a safe and effective manner.
- Patients are discharged in a timely manner with all aspects of their discharge addressed in an organized and professional manner. Now staff can take ownership and know their responsibilities towards discharge goals for the patient.

Conclusion:

The process improvement projects are continuously being implemented to ensure sustainability. Data is collected on a monthly basis to assess PRN documentation and effectiveness. Pain assessments are monitored periodically in chart reviews. The Oncology unit continues to be referenced by other units in regards to safe handling of patients on oral chemotherapeutic agents

but transfers are no longer an ongoing problem. The discharge checklist has been implemented well on the unit and staff state that it helps with prioritizing their patient care assignments to ensure patient have everything they need upon discharge.

Abstract title: Initiation and Development of a Fall Prevention Pilot Program: A Collaborative Effort

Authors: Dianne Ragno MSN, RNC, CNL; Jean Barry, MS, MSN, RN, CNL

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Background:

Falls are one of the most common adverse patient events with in the VAMC and are the leading cause of injury-related death among individuals 65 years and older. Falls result in 90,000 serious injuries and approximately 11,000 deaths each year. The most serious fall related injuries are hip fractures and intracranial hemorrhages. One in five patients who suffer a hip fractures from a fall has a life expectancy rate of less than one year post injury. In the year 2000, the cost of falls was over 19 billion dollars. This number is projected to spiral to over 32 billion dollars by the year 2020.

Healthcare facilities across the country share a common goal in their attempt to reduce falls and injuries from falls. Reducing the risk of patient harm from falls has been identified as a national patient safety goal by the Joint Commission. In an effort to reduce falls within our facility, supported by the Associate Chief Nurse; Clinical Nurse Leaders approached the nurse manager of 6A, a 33 bed medical unit with an innovative idea to develop and implement an evidence based fall prevention pilot program.

Goal:

To develop and implement a comprehensive pilot program to reduce falls and injuries from falls in the medical center.

Method:

Literature review: Research concludes no single intervention has been successful in the reduction of falls. The research endorses multi-interventional and multidisciplinary engagement for the most successful fall reduction programs.

Plan: Develop and implement an evidence based multidisciplinary and multi-interventional fall reduction program as part of a collaborative effort with the fall prevention coordinator and the nurse manager of 6A.

Implementation: Initially staff knowledge and understanding of the WPBVA fall policy was reinforced. A standard operating procedure was written specific for the fall pilot program. Staff was educated on the program, interventions and goals. All patients would be assessed for fall risk upon admission, transfer and change in mental status. Specific criteria were developed for physical therapy assessment and evaluation.

The following interventions were then implemented:

- Evidence based research provided to staff and patients on the subject of falls

- created and updated monthly to display current unit fall statistics, evidence information and educational material related to fall and injury prevention "Fall Wall" based
- green non-skid socks to visual cues (i.e. green armbands and signage) for those patients identified as being a high fall risk Addition of
- "NO PASSING ZONES" Created
- hourly rounding Initiated
- "huddles" instituted Post fall
- therapy referral for patients. meeting specific criteria Physical
- use of bed alarms Reinforced

Outcomes:

A comparison of FY 2010 and FY 2011 indicated a 16% decrease in falls. The pilot program was initiated in the middle of February 2011 and has been in place for 6 months at the time the statistics were obtained. We anticipate that when data is compared for one year post implementation, the percentage in the reduction in falls will be greater. Several interventions such as the use of green socks for patients identified as a high risk of falls, and the "No Passing Zones" were adopted by other acute care services throughout the hospital. Utilization of bed alarm system was improved. We are also projecting an increase in patient satisfaction scores. The project is ongoing, 6A plans to continue this program on the unit, the staff supports this decision.

Serendipitous outcomes:

The "No Passing Zone" was considered as a best practice by the SOARS surveyors. SOARS surveyors acknowledged low noise levels during their survey of the unit. 6A staff noted an overall decrease in the use of call bells on the unit.

Findings:

Incremental introduction of interventions appeared to improve staff buy in. Although huddles were completed, at times, clinical issues interfered with attendance by all of the team members. Compliance rounds improved the use of bed alarms. Findings also identified area for improvement in the documentation and use of the MORSE fall assessment tool. The support of the nurse manager and falls coordinator as well as buy-in from the staff continues to be crucial to the success of this program.

Vision for the future:

Adoption of the fall pilot program hospital wide. Engagement of fall champions to develop an in-service for nursing staff on the MORSE fall scale. Improve attendance at fall huddles to optimize information gathering useful in prevention of future falls. Expand the roles of pharmacy, nutrition, housekeeping as well as physicians and residents.

Abstract title: A Clinical Nurse Leader's Effort to Improve the Perception of Patient Privacy on an Acute Inpatient Medical-Surgical Unit.

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Background Information:

Privacy is a fundamental rule in the Nursing Code of Ethics, yet studies show many patients experience lack of privacy in hospital settings. Based on the Portland VA Medical Center's performance measures, patient perception of privacy is lacking, with satisfaction 10% lower than national results. Unit-specific data demonstrated patients and staff believed patients' privacy to be an issue. As a result, the Clinical Nurse Leader (CNL) on one unit decided to focus on this measure.

Aim:

The aim of this quality improvement project was to improve processes related to patient privacy. The purpose of this project was to determine if a CNL-led informational session regarding patient privacy, along with staff utilization of "Patient Care, Please Knock" signs and plastic clothespins to keep curtains closed, improved patient and staff member perception of privacy at the Portland VA Medical Center (PVAMC).

Methods/Programs/Practices:

The quality improvement project included all staff on the medical-surgical unit, as well as patients during specific time periods on the unit. The CNL developed and presented staff informational sessions regarding patient privacy, highlighting the three main privacy concepts determined by an extensive literature review: Noise, dignity, and staff behaviors. During these informational sessions, the CNL introduced two environmental interventions for staff to utilize. First, nurses were informed to use laminated "Patient Care, Please Knock" signs, which were safety pinned to patient curtains in every two- and four-person patient rooms. The purpose of the signs was to limit interruptions. Second, the bed curtains on the unit were short and lacked overlap, thereby creating opportunities for patients' bodies to be exposed during private moments, such as bathing or going to the bathroom, so plastic clothespins were purchased to aid in keeping curtains closed. Pre-intervention data were collected from patients and staff prior to intervention implementation, and post-intervention data were collected three months after. Independent t-tests were used to compare pre- versus post-intervention surveys and the chi-squared was used to compare post-discharge surveys.

Outcome Data

There were no statistically significant differences in satisfaction with privacy when comparing patients who completed surveys pre-intervention (N = 38) versus those who completed surveys after the privacy project was implemented (N = 29). Staff members scored all privacy survey questions higher post intervention compared to pre-intervention. Five questions were rated significantly higher ($p < .05$) post-intervention, including staff discussing only pertinent topics,

lowering their voices during privacy conversation, and overall unit effort in maintaining patient privacy. Although not statistically significant, hospital-wide privacy performance measure data post-intervention improved from 81.9% to 83.7% patient satisfaction. There was lack of conclusive evidence regarding post-discharge surveys.

Conclusion:

The CNL-led quality improvement project demonstrates that implementing staff informational sessions and environmental interventions (signage and clothespins) increases staff member perception of patient privacy and may increase patient perception. The project included numerous outcomes measured using quantitative methods, making the outcomes more reliable and valid. The environmental layout should be considered when developing new hospital units to account for maintaining patient privacy, such as creating more 1-person rooms or purchasing large enough curtains to close around patient beds. However, even with environmental constraints (like four-person patient rooms) within healthcare facilities, simple staff-led interventions, such as speaking one's intentions and adding onto existing features, like utilizing curtain clothespins and signs, can improve perception of privacy on units.

Abstract title: Improving Outcomes Through Staff Development

Authors/credentials: Glenda Riggs RN, VHA-CM

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Background Information:

Prior to 2008 the SAVAHCS ICU unit did not have a Clinical Nurse Leader (CNL). New staff nurses were given a new employee orientation and then began work on the unit. The standard work (standard practices) of ICU nurses was not clearly defined. Nursing staff were not directly involved with monitoring patient outcomes such as infection rates. The introduction of the CNL role provided the opportunity and resources to formalize the orientation and training of ICU nurses and to involve staff in performance improvement at the bedside, unit, and organization levels.

Aims:

1. Improve staff performance by identifying standard work
2. Improve monitoring of staff practice by CNL rounds on all ICU patients and provision of support to staff.
3. Improve patient outcomes and satisfaction
4. Empower the nurses to participate in interdisciplinary patient/family meetings and Systems Redesign teams for quality improvement.

Methods/Programs/Practices:

The CNL reviewed the needs of the unit and found several issues that could be changed to improve standard work. She identified the need for education, orientation, competencies, support and accountability in order to establish standard work. An evidence based critical care program

was designed and implemented to meet the needs of new graduates as well as seasoned nurses. A staged orientation program was also designed and implemented based on a successful model in the literature that customized the learning process in order to meet nurse's individual needs and reinforce standard work (Chestnut & Everhart, 2007). Once education and orientation programs were in place the need for competencies was addressed to standardize and maintain nurse's skills while reinforcing standard work. The Mosby's competency program was initiated to track the competencies and help standardize the work of nurses for the veterans. Support and accountability for nurses was initiated with CNL rounds on all patients in ICU to monitor performance measures and evaluate patient needs. The CNL worked with staff nurses to create multidisciplinary Systems Redesign teams for evidence- based protocol changes such as for hyperglycemia, hypoglycemia and sepsis.

Outcomes

As a result of introducing the CNL role to ICU several changes are evident:

- VAP and central line infection rates have dropped dramatically.
- Staff turnover has significantly improved
- Staff participation in systems redesign teams resulting in improved sepsis mortality and hypoglycemic events.
- Staff completion rates of 100% for second orientation, and competencies

The VA has a new policy that requires IRB approval before any specific data can be shared in a conference. I am in the process of getting their approval. I have left my data vague until I have their approval.

Conclusion:

The CNL has been established as the outcomes manager in ICU. Initiating standard work through education, orientation and competencies is crucial to improving patient outcomes. The CNL can be the key to developing a culture of evidence based health care at the bedside. CNLs are leaders that have a responsibility to empower the nurses to achieve excellence.

Chestnut, B., & Everhart, B. (2007). Meeting the Needs of Graduate Nurses in Critical Care Orientation Staged Orientation Program in Surgical Intensive Care from the Critical Care Nurses.

Abstract title: A CNL in a non-CNL Role: Implementing a Palliative Care Bundle in an ICU to Reduce Moral Distress

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Background Information:

Integrating a new-to-practice CNL operating in a non-CNL role offers opportunities for creativity and utilization of existing roles in new ways. Using a unit-based research project as a vehicle for role integration, the presentation offers an example of a solution in a tertiary hospital MICU setting.

The research project itself uses a palliative care bundle as an intervention for decreasing moral distress. Building on the work of Andrew Jameton and others in the area of moral distress, and Katherine Kolcaba's Comfort Theory as a palliative care approach, the strategy uses measurable outcomes to track the impact of an intentional palliative care focus as a method of decreasing moral distress.

Aim:

Integrating a new CNL into a non-CNL role, through participation in hospital-wide initiatives and a unit-based research project. The substance of this work addresses a prominent issue – that providing appropriate end-of-life care has become a primary concern of nurses and the public, but that the highly technological critical care environment may not facilitate such care. In an extensive literature review, several studies revealed a high prevalence of moral distress among intensive care nurses. Since this phenomenon has been attributed in part to the emotional stress of caring for the dying patients, providing therapies for which burdens may at times outweigh the benefits, conflicting communication, and lack of pain and symptom management; it is reasonable to hypothesize that an ICU palliative care improvement effort might measurably affect moral distress. Using a CNL to help implement this strategy provides opportunities for leadership development and draws on the training and expertise of the CNL in the execution of the project.

Methods/Programs/Practices:

1. VHA "Care and Communication Bundle" of ICU Palliative Care Quality Measures
2. Daily rounds
3. Moral Distress Scale-Revised. (2007). Permission to use this study was obtained from Ann Hamric, PhD, RN, FAAN

Outcome Data

An initial, retrospective chart review was performed to measure if any of the palliative care quality measures were being done. It is hypothesized the moral distress among the nurses in this particular MICU will be high.

An exploratory, non-experimental, descriptive study design was selected. Before the start of the study, the primary investigator will present this study to the University of Pennsylvania internal review board for approval. This study is voluntary and is to represent the population of MICU nurses through a convenience sample of all available staff nurses who fit the criteria of having worked full time and have a minimum of one year nursing experience. Completing the on-line survey will imply consent by the participants.

Data collection is ongoing at the time of this abstract submission.

Conclusion:

The new-to-practice CNL can quickly contribute from his education and specialized training through creative use of opportunities to take on leadership roles with hospital-wide and unit-based initiatives. In this instance, by combining Kolcaba's theory of comfort and the ICU, not only will moral distress be decreased for nurses, but a new, more positive environment will be created for patients, families and nurses. The CNL, the practice unit, and the hospital all benefit from the arrangement.

Abstract title: CNL Lead Interdisciplinary Pharmacy rounds at an acute care hospital enhance HCAHPS scores for the domains pain management and communication about medication.

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Background Information:

Today's healthcare providers are being asked to provide "Transparency" with the care they provide. This driving force created a desire to improve reported data collected. St. Lucie Medical Center implemented improvement strategies intended to increase HCAHPS (Hospital Consumer Assessment of Healthcare providers and Systems) scores.

The focus areas were pain management and communication of medication. In 2008, SLMC quickly began preparations which included the creation of HCAHPS team leader meetings, strategic plans/requirements, review of HCAHPS questions regarding medication education, and the establishment of unit daily pharmacy rounds. Immediately it was identified that we had to review current processes in place and evaluate their effectiveness.

The presentation will portray a hospital wide project, step by step. There will be commentaries from all interdisciplinary team members.

Aim:

Our goal is to increase HCAHPS scores, reach and maintain scores above CMS average. An additional purpose is to obtain consistent scores. We also wanted decrease the patient's pain and improve their understanding of the medication regime.

Methods/Programs/Practices:

We wanted to establish ongoing communication with our patients and the families. There needed to be follow through among all team members.

The team had to meet resource needs and add value to the rounding process. It was decided to Identify key personnel for rounding (Unit Managers, Pharmacists, and CNLs). Each person's role description was outlined. We developed scripts for communication and designed patient information handouts.

Outcome Data

There was a significant trend formed with improved HCAHPS scores for the following domains: pain management controlled, pain management help, communication about new medicine, and communication about medication side effects. These results will be displayed over a 12 month period.

Conclusion:

Today's current practice is well established. The CNL and Pharmacist both round with patients and their families daily. We discuss topics ranging from admitting diagnosis, plan of care, & medication regime.

Abstract title: Restraint Free: A Quality Improvement Project

Authors/credentials: Joanne Rushing, MS, RN, CNL

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Background Information:

Research shows a lack of evidence to support restraint use for injury prevention and reduction of falls. Restraints are also demeaning for the patient and families. In 2009 Restraint data for the telemetry/stroke floor was 134 Patients Restrained for a total of 388 days. During this same data period there were 57 Falls. Staff's limited knowledge regarding alternatives to restraints as well as a culture in which restraints were the standard contributed to the high rate of use.

Hospital policy states that all patients are provided with an environment which minimizes circumstances that give rise to restraint use and maximizes a safe environment without restraints. JCAHO's patient Safety Standards focus on reducing need for restraints led to this quality improvement project.

Aim:

To decrease the number of restrained patient's through cultural change.

Methods/Programs/Practices:

Utilizing the Unit Based council: brainstorm alternatives to restraint use, education of nurses, restraint decision tree, distraction basket, trend data shared with nurses weekly and sitter check list.

Outcome Data

As of September 2011, zero patients restrained with no increase in fall rates.

Conclusion:

Nurses were empowered to use evidence based practice to create cultural change. House wide implementation of restraint free patient care, sitter checklist and decision tree.

Abstract title: Refining the Restraint Process in the PICU through Implementation of CNL Led Restraint Rounds

Authors/credentials: Mary-Jo Smith, MSN, RN, CNL

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Background Information: Despite the good intent of preventing treatment interference, restraint use can come at a cost to patients, families, and health care organizations. Regulatory agencies require that a patient be restrained in the least restrictive restraint for the shortest amount of time possible. Restraint use poses particular ethical, policy and equipment challenges

for the pediatric population as there are no national pediatric benchmarks and few studies specific to pediatric restraint use to guide best practice. Because of the large volume of high risk therapies requiring tubes and devices, the Pediatric Intensive Care Unit (PICU) consistently uses the greatest number of restraints with the longest average restraint episode duration in the Children's Hospital. Additionally, nursing documentation of the time of restraint removal was inconsistent, putting the unit at risk for regulatory incompliance.

Aim

Global Aim: To increase awareness of the restraint process in the PICU.

Specific Aim: To reduce the average restraint episode duration and improve restraint documentation through implementation of Restraint Reduction Rounds (RRR).

Methods/Programs/Practices: A multidisciplinary team was formed with a CNL student as team leader. PICU staff members completed a restraint focused survey to gain insight to areas in need of improvement. Frontline staff created process maps and flowcharts of the restraint process and completed a fishbone diagram to identify causes and effects of the restraint process breakdown. This group met frequently during the project to monitor successes and barriers to implementations and identify opportunities for continuous improvement. A Restraint Resource Nurse (RRN) implemented Restraint Resource Rounds (RRR) prior to daily multidisciplinary patient goal rounds during the time period of February-April 2011. The CNL student assumed the role of RRN. During rounds, the RRN posed restraint focused questions aimed at reducing restraint episode duration and provided real time staff education and coaching. The restraint order process was standardized through the addition of a restraint checkbox to the daily patient goal rounding sheet and a pop-up reminder box was added to the electronic extubation order set as a visual cue to providers to discontinue restraints and corresponding order if applicable. Education included posting restraint process and order reminder cards on all computers, distribution of a restraint education resource sheet and weekly "Restraint Tip and FAQ" emails. A new pediatric sized restraint alternative skin sleeve was also introduced. An important adjunct to the project was the RRN's communication with other Children's Hospitals to share best practices.

Outcome Data: The RRN observed prospective and retrospective weekly and monthly restraint data and compared to February-April 2010 metrics. During the project, all data was transparent and monthly metrics were posted in the staff lounge with identification of trends, successes and opportunities for improvement. After implementation of Restraint Reduction Rounds, the 3 month average restraint episode duration decreased from 28.3 hours to 23.6 hours, representing an overall reduction of 4.7 hours (16.6%). Weekly documentation audits of restraint removal time showed marked improvement, increasing from 74% to 100% and the unit is now in full regulatory compliance. The interventions used are easily transferrable to other patient care units, both adult and pediatric.

Conclusion: Restraint Reduction Rounds in the PICU proved to be an effective way to raise awareness and improve the restraint process. The presence of the CNL student in the role of Restraint Resource Nurse kept restraint practice at the forefront of unit practice. Initiation of a multidisciplinary team at the microsystem level promoted shared vision, problem solving and solutions by process end-users. While assuring regulatory compliance, restraint focused rounding

can lead to a shared restraint reduction culture and improved outcomes for all restrained patients, even the littlest ones.

Abstract title: Increasing Access to Medical Care through Case Assessment and Continuity

Authors/credentials: Mary Joy Spears, RN, BSN, CMSRN & Paula Sinde, RN, BSN

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City/State: Cleburne, TX

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Background Information:

The Affordable Care Act has motivated health care to stretch their resources and broaden their horizons to ensure quality care with continuity to prevent costly readmissions. The role of the Clinical Nurse Leader compliments both quality care and continuity in the hospital and through transitions to home or other health care facilities. Texas Nurse Association encourages organizations to find ways to increase access to medical care outside of the hospital.

Aim:

The purpose of this project is to decrease readmission rates of congestive heart failure and pneumonia by an additional 5% over the next quarter by collaboration, case assessment, education, and preventative care in the hospital and after discharge. Increasing a patient's access to medical care and close follow up after discharge will prevent unnecessary readmissions and improve quality of care.

Methods/Programs/Practices:

The CNL participates in briefings with the health care team of social services, case management and charge nurses to communicate patient needs and obtain appropriate consults. Providing patient centered care that includes the patient in the plan of care is promoted through bedside report at shift change. The CNL is proactive in communication with patients and families to anticipate discharge needs through lateral integration. Communication to the next level of care is encouraged at discharge to transition smoothly without rebound. Phone calls are made to home health nurses to report history, concerns, and follow up care needed. Transition House Calls are ordered on qualified high risk patients, providing the patient with a phone call and visit from a Nurse Practitioner in the home within 48 hours of discharge. Home health companies and long term care facilities are partnering with the hospital to address high risk patient's special needs. The Clinical Nurse Leader performs follow up phone calls on all patients she/he follows to ensure questions are answered and needs were met.

Outcome Data

Premier Healthcare Alliance formed by over 200 hospitals nationally are working to improve the health care of individuals by evaluation and reporting statistics. Premier data reports show a 5% quarterly decrease in readmission rate of heart failure at Texas Health Cleburne by implementation of the methods described. The CNL role began at Texas Health Cleburne in January 2011. The heart failure readmission rate at Texas Health Cleburne decreased from 18%

in the first quarter of 2010 to 8% in first quarter of 2011 by our collaborative efforts. This statistic brought our hospital within the top performer target. ARHQ reports Texas Health Cleburne does not exceed the national average for readmission for heart failure and pneumonia.

Conclusion:

The current quarterly status of readmission rates are 10.5%, an exemplary performance in comparison of the national average of 24%, but constant efforts and process evaluation is needed to maintain high quality care. National competition will increase as other facilities modify their care to meet the standards of health care reform and Medicare mandates. The goals of Texas Health Cleburne by implementation of the Clinical Nurse Leader are not only to increase the awareness of the need for change but to provide a microsystem approach to implementing practices at the bedside that will make a difference in patient outcomes. We hope to continue to decrease the readmission rate for congestive heart failure and pneumonia by 1-5% each quarter and maintain an annual readmission rate of below 10%.

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Premier Inc. (2011) *Clinical Performance Report*, Texas Health Cleburne, Premier Inc. 13034 Ballantyne Corporate Place, Charlotte, NC 28277

Abstract title: Setting the Course: Intentionalizing a Clinical Nurse Leader Hiring and Retention Strategy that impacts Quality Outcomes

Authors: Rachel Start, RN MSN; Karen Mayer, RN MSN; Susan Carroll, RN MSN

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Objectives:

1. Describe an ongoing initiative that focuses on hiring and retention of Masters Prepared New Graduate Nurses that are AACN Clinical Nurse Leader Certificate Candidates.
2. Describe the initiative's impact on an institutions Quality measures, nurse retention and patient satisfaction scores.
3. Describe ongoing initiatives being spearheaded by the Clinical Nurse Leaders and future work planned for and by this group.

Studies have demonstrated that health care institutions with greater numbers of nurses educated at BSN or higher levels report higher quality and safer patient care. Furthermore, with the advent of the Institute of Medicine's Future of Nursing Report, the mandate for leadership from nursing to enhance the efficiency and quality of the health care environment has been made imperative. This presentation will describe an ongoing initiative at a community hospital in the

Chicago land area that is aimed at hiring and retaining Masters prepared new graduate nurses that are able to sit for the AACN Clinical Nurse Leader Certification. Various components of this initiative will be described and are: Development of collaborative relationships with 3 regional MSN College of Nursing programs, development of a hiring strategy that sets a transformational leadership charge during interview, development of a clinical practice ladder and development of a think- tank type task force utilizing the clinical nurse leaders to drive change in the institution. Additionally, quality outcomes, patient satisfaction and nurse retention measures before and after will be compared.

Abstract title: Somewhere Over the Rainbow – Integrating Novice Nurses into the CNL Role

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Background Information:

The American Association of College of Nursing and Institute of Medicine have identified the leadership and quality care gaps and called for improvements in nursing care, leadership, and quality management. The AACN delineated the Clinical Nurse Leader role focusing on the expert nurse CNL who improves patient and unit outcomes (2). Novice nurse CNL graduates face unique challenges without previous socialization into professional nursing. No literature highlights the needs or productivity of the entry-level CNL. Novice CNL grads need to learn socialization in role, teamwork, credibility, and collaboration. In surveys, GLA nurse managers and leaders rate the novice CNL grads lower in some areas compared with traditional graduates. CNLs can demonstrate their contributions and benefits of masters education in 2-3 years. Without evidence about the novice CNL, VAGLA is implementing this innovative internship and mentorship. The task is to move new RN/CNLs from novice to leader while simultaneously creating a supportive environment, educating staff and nurse managers about the role. Creative solutions are required.

CNL Career Development and Integration: Initially CNLs focus on bedside practice. to develop their clinical role and a doctorally prepared mentor in Nursing Education coached them in integration, leadership, change agent, data collection, and performance improvement. Mentors emphasized socialization, professional attitude, system understanding, teamwork and collaboration. Doctorally prepared mentors assist the CNL grads to complete their development plan, attend courses (e.g., Coaching/Mentoring, systems redesign, CNL conferences, and research), complete certification, and design and conduct performance improvement projects.

Aim:

1. Facilitate competence of novice CNL as bedside clinician
2. Mentor CNL to develop performance improvement projects and demonstrate outcomes that improved patient care
3. Conduct a barrier analysis and educate managers and staff on role of CNL
4. Facilitate movement of the novice CNL from new grad into CNL role
5. Demonstrate outcomes of their projects

Methods/Programs/Practices:

We conducted a barrier analysis, compared novice CNL new grads after 2.5 years with traditional graduates. We evaluated the impact of their practice by comparing units with a CNL to comparable units without a CNL in performance measures. We encouraged CNL to participate in our EBP mentorship program and work closely with their mentor. The novice CNL grads in emergency, pre/post operative, PCU, and critical care units participate in the dynamic change orientation on their unit. They educated staff about the CNL role, assisted with system design, and evidence based projects on several units. They are in a perfect position to champion our evidence based projects on their unit and build on our successful EBP program and enhance our Magnet journey. They attended an evidence based mentorship class and their projects included an educational intervention for wound care documentation in PCU, patient education, and documentation in the emergency room, educational projects to improve the LVN's skills and practice, and flu campaign outcomes. Impact shows effects of the novice CNL grad projects to improve care on their own unit and on care line and system data. We have completed our first manuscript and submitted it for publication in a peer review journal. The first manuscript on this program is under review.

Outcome Data

GLA has 8 Novice CNL grads in critical, emergency, and acute care. Since these novices started in summer 2008, correlational data indicate the following practice changes. Measures of quarterly falls data in acute care during a 2 year period show a decrease from 4.86 to 3.31 and this is below the GLA and the VISN benchmark for falls. Hence we have reduced 1.5 falls consistently. We have reduced the BCMA workarounds when nurses fail to scan patient wristbands. From May 09 to Mar 10, the BCMA wristband scans have increased from 61.96% to 96.78%. BCMA errors and workarounds have decreased significantly. In a one year period, Critical Care restraints have decreased 21%. Restraint use spiked in November due to a decrease in sitters/safety attendants who had previously lowered the restraint use. PCU/HICU restraints have remained low from 0-3%. Other projects include increasing documentation of PRN effectiveness, and examining the benefits of the charge nurse role in ED. Novice CNL grads have improved staff knowledge and competence in wound care assessment and evaluation in PCU. A Novice CNL increased handwashing 10-15% in critical care. CNL grads have improved direct and value added care on their units. The number of certified nurses in their areas has increased. Quality of care reported in GLA system data increased from 77 – 81.8%. Patient satisfaction for the units with CNLs ranged from 91-100% (5W); 93-98% (5S); 82-98% (4E) and these scores are higher on average than most of the units without CNLs. As statisticians know, one must view correlations cautiously as they are often multidetermined, so the next we will improve measurement accuracy and strategies. Patient satisfaction has also increased in the areas with CNLs.

Conclusion:

Initially novice nurse CNL have a different level of competencies than new graduate RNs and may need socialization and coaching. With coaching/mentoring these novice RN/CNL s can be leaders at the center of the microsystem to promote quality outcomes. More education is needed to clarify the CNL role so that staff understand it. CNLs also need mentoring to master the IRB process and data analysis of large data sets unique to specific hospital settings. Ongoing education is needed in data analysis of large data sets and lean approaches to change and system redesign. The CNLs need supportive managers and leaders to help them navigate the large hospital system and negotiate the supplies, resources, and networking needed to make change. CNLs can facilitate impressive improvements in system redesign and in performance indicators.

Abstract Title: Controlling Condom Catheter-Associated Infections (CCAI) while preventing indwelling urinary Catheter Associated Urinary Tract Infections (CAUTIs)

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Background Information:

In the quest to prevent urinary catheter associated infections, health care facilities have ignored the fact that the alternate method can also be a culprit for UTIs. For years condom catheters have been used to manage incontinence as well as to lower the risk of infections. During the months of August through September of 2010, 6 out of 7 of the total UTIs on NU 1D, occurred in condom catheter patients. This is equivalent to 86% of the total UTIs. These results prompted the need to intervene on UTIs in condom catheter residents.

Aim:

The purpose of this project was to reduce the incidence of urinary tract infections in patients with condom catheters, while preventing urinary catheter associated infections. Thus the prevention of urinary tract infections in condom catheter patients will reduce the overall incidence rate of hospital acquired urinary tract infections.

Methods/Programs/Practices:

We selected one nursing unit and implemented several measures to achieve this objective. This consisted of a condom catheter protocol requiring daily catheter changes and perineal care with documentation, improved hand hygiene, improved personal hygiene, staff education and hydration. This study compares dates in a 3 month interval. The dates September- November 2010 were compared to dates December- February 2011. A literature review was performed to determine evidence- based protocol interventions.

Outcome Data

Prior to the implementation of these measures the occurrence of infections in patients with condoms had peaked to 4 per month. We were able to drop that number to zero within four months. The total number of UTIs from September- November 2010 compared to December 2010- February 2011 decreased from 10 to 4, which is a 60% decrease in UTI occurrences. The total number of positive urine cultures for condom catheter patients decreased from 8 to 5 which is a 38% decrease from September- November 2010 to December 2010- February 2011.

Conclusion:

We have concluded that the implementation of a condom catheter care protocol among community living center residents does in fact have a positive effect on urinary tract infections and positive urine cultures prevalence in condom catheter residents. Condom catheters can be a risk factor for urinary tract infections if careful attention is not paid to care while in place.

Abstract title: Reaching Critical Mass: CNLs transforming Health Care in a Georgia Healthcare System

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Background Information:

In 2007, the School of Nursing at the University of West Georgia (UWG) responded to a call from the American Association of Colleges of Nursing (AACN) for cooperative agreements among colleges/universities and clinical agencies to prepare CNLs. Since that time, the SON has graduated a total of 7 CNLs who have taken and passed the certification exam. In 2011, the SON entered into a formal partnership with the WellStar Health System consisting of five not-for-profit, community based hospitals in Georgia. The system is committed to supporting advanced education for their nurses and has agreed to sponsor 3 cohorts of nurses over the next 3 years. The first cohort consisting of 18 nurses entered the UWG program Fall of 2011 with additional cohorts of a similar size to matriculate Fall 2012 and Fall 2013. Students are receiving financial support from the health system in exchange for a work commitment following graduation. The ultimate outcome of this partnership is a critical mass of CNLs integrated throughout the 5 hospital system who are expected to make a major impact on healthcare outcomes. A SON faculty member and a member of WellStar's clinical learning team, who is a certified CNL, have been designated to oversee the partnership. Multiple meetings have taken place over the last year in preparation for the first cohort.

Aim:

The purpose of this presentation is to share the development, implementation and plans for evaluation of the partnership.

Methods/Programs/Practices:

The steps for the development of the partnership will be discussed as well as the plan for program evaluation as follows:

1. Visioning
2. Meeting with interested nurses to discuss the CNL online curriculum (36 credit hours with 450 clinical hours) offered at UWG SON
3. Determining the application and screening process of applicants by the clinical and academic partners
4. Planning and scheduling orientation for the cohort with participation by clinical and academic partners
5. Planning for organizational and management/administrative support
6. Discussing the model for transforming practice and achieving sustainable changes
7. Assignment of dedicated persons to oversee the partnership/program with delineation of their roles.
8. Evaluating CNL competencies including reflective journaling, dashboard score board for tracking metrics, and other outcome measures.
9. Piloting implementation of 3-5 CNLS at one hospital to begin this year.
10. Sharing lessons learned and recommendations.

Outcome Data

Plans for strategically placing the CNLs for immersion experience and after graduation will be discussed along with the plan for collecting selected outcome data on selected units. Initial/preliminary informal findings will be discussed based on outcomes data collected on pilot units at the one hospital

Conclusion:

Challenges for both academia and practice have occurred. The implications, ongoing modifications and lessons learned will be shared. The presenters will provide a balanced perspective on this endeavor.

Abstract title: A Voice with Courage is Measurable

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Background Information: The Centers for Medicare and Medicaid Services (CMS) report 50,000 adults die each year from vaccine-preventable diseases in the U.S. Pneumonia and influenza are the fifth leading cause of death in older adults in the U.S.

According to the Centers for Disease Control (CDC), there are over 200,000 hospitalizations from influenza on average every year. An average of 36,000 Americans die annually due to influenza and its complications. Pneumococcal pneumonia is the most common type of bacterial pneumonia the CDC reported over 5,000 annual deaths from invasive pneumococcal disease.

Aim: Hospitalization is an excellent opportunity to provide education about vaccinations in addition to administration. Trinity Health has identified quality metrics that will be addressed to align with new best practices and reimbursement. Our mission is to decrease vaccine related health disparities across all ministry organizations. The (CDC, 2006) reported only 46% of non-Hispanic blacks and 45% of Hispanics reported receiving vaccines in comparison to 62% of non-Hispanic whites.

Methods/Programs/Practices: Trinity Health has adopted standing physician orders that allow for ordering and administration of vaccines. When the role of the CNL began in October 2010 our first project was to increase vaccination education and administration. Assessment of the current state of the vaccination program revealed that physicians, nurses and all interdisciplinary departments needed education regarding the clinical benefits of vaccines. In addition Trinity Health new work requirement requires employees to receive the Influenza vaccine.

Abstract title: Using Evidence Based Practice at the Bedside to Improve Pain Management for Veterans with Cancer

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Background Information:

Pain is one of the most feared concerns of cancer patients; pain has negative effects on their daily functioning and quality of life. Effective pain management for cancer patients was identified as an issue through patient report, MD complaints of poor pain control and RN report of patients' lack of knowledge regarding scheduled and PRN pain medications. Studies have shown that 50% of all cancer patients, and up to 75% of advanced stage cancer patients experience pain. Although 95% of these patients could be free of significant pain, 42% report that they do not receive adequate relief. Several barriers to adequate pain control have been identified through research. Studies have shown that by adequately addressing these barriers, patients can learn to control their pain more effectively. The Veteran patient population is no different than non-veterans in respect to the amount of pain experienced and the barriers they are challenged with for adequate pain relief; however the stoic nature of the Veteran becomes an additional barrier.

Aim/ Methods/Programs/Practices:

Through researching the most effective methods for educating cancer patients about pain management a pain education tool was developed. This tool can be used at the bedside during the patient's hospital stay in order to communicate the pain medication regime to the patient, as well as send it home with patients to assist them and their families with managing their pain. This tool addresses many of the barriers to effective pain management and offers patients additional pain control methods. Through use of this tool during the hospital stay, patients learn to control their pain more effectively through proper use of scheduled and PRN medications.

Outcome Data/ Conclusion:

As a result, it is expected that the average pain score for cancer patients admitted to the hospital will decrease, and the amount of PRN medications administered during the stay will increase. If a statistically significant decrease in the average pain score for cancer patients on the unit is observed, this educational tool could be implemented for use with all patients experiencing pain.

The pain education tool was implemented on the inpatient med/surg and hem/onc unit on August 15, 2011. In order to receive a statistically significant decrease in average pain scores a total of 30 charts need to be reviewed prior to and after implementation. Based on the amount of time required to achieve 30 patients prior to implementation, it is anticipated that enough charts will be reviewed by December 2011 and data will be available for presentation.