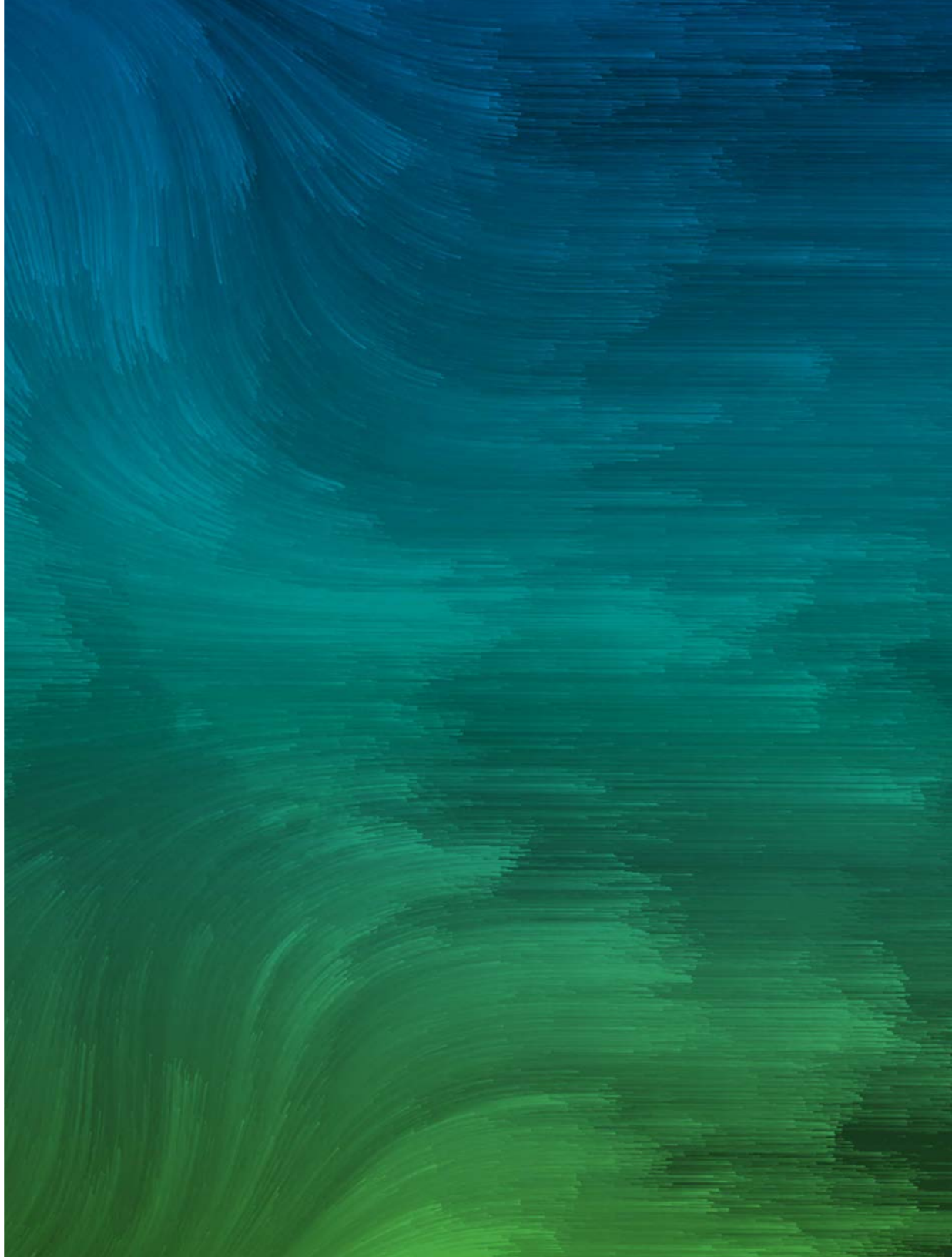
SHAPING THE CARE OF OUR PATIENTS

2016 NURSING ANNUAL REPORT

Salinas Valley Memorial Healthcare System

A Public Healthcare District



Agnes Lalata (left), Director of MedSurg, and ***Carla Spencer*** (right), Director of Emergency Services, collaborating with ***Christie Gonder*** (center) on patient throughput.

"Communication between nurses and patients is essential to achieving outstanding patient care."

MESSAGE FROM THE CNO

Since our doors opened and every year that followed, the nurses at Salinas Valley Memorial Hospital (SVMH) have been providing quality care with compassion. It is simply what we do. This year is no different, but we delivered our brand of care with a transformational twist.

As healthcare reform launched a new era, our nursing team followed suit. We introduced new technologies to improve efficiency, developed new processes to improve the patient experience, grew our service lines, directed our care to drive quality outcomes, modified our organizational structure to improve consistency of that care and collaborated with new partners to advance our nurses' professional development — all to provide the best patient care possible.

Without nursing education and knowledge, new hospital technology cannot be utilized to its full potential. So, with time and much registered nurse (RN) engagement, Salinas Valley Memorial implemented a hospital-wide state-of-the-art replacement of its cardiac monitoring equipment. Another advanced technology — a network visibility system — optimizes patient flow by sharing information that improves communication to achieve timely patient placement. An opportunity arose to install a patient and asset tracking system to provide families and those charged with their care something both parties greatly value during their hospital experience: time and information. Our system improves wait times for patients and provides their families with valuable knowledge during their loved one's surgery. It can reduce time wasted searching for equipment and increases time spent with our patients. Other equipment and software has been added to manage IV insulin and prevent oversedation, both ways we increase safety and improve patient outcomes.

Our nurses identified new ways to improve interdepartmental efficiency, which improved operating room start times, room turnover times and timely handover reports. Through shared governance, our nurses participated in unit-based councils and developed a video to educate coworkers on this patient-centric process to involve patients in their care.

Through a multidisciplinary collaboration of nursing and medical staff leaders, our staff contributed its high standards and the result was another accreditation for The Comprehensive Community Cancer Program from the Commission on Cancer and a new certification from the Joint Commission for Chest Pain Certification.

New avenues of communication began with a monthly Chief Nursing Officer (CNO) Town Hall meeting, a blog and Clinical Newsletters. There is also a new follow-up communication called Stoplight Report which serves as an outlet for process, equipment, patient safety and flow recommendations.

Nursing leaders and staff members helped facilitate new growth programs with OB hospitalists and an Infusion Center, both of which will provide focused and specialized care.

Many in the nursing department embarked on new personal journeys with a higher percentage managing full-time schedules, becoming consistent charge nurses and working 12-hour shifts. Local colleges and hospitals collaborated to provide a bachelor of nursing program that SVMH will make more available and manageable for its nurses through tuition reimbursement. The LEAD Academy will provide charge nurses education to implement initiatives and expand RN accountability.

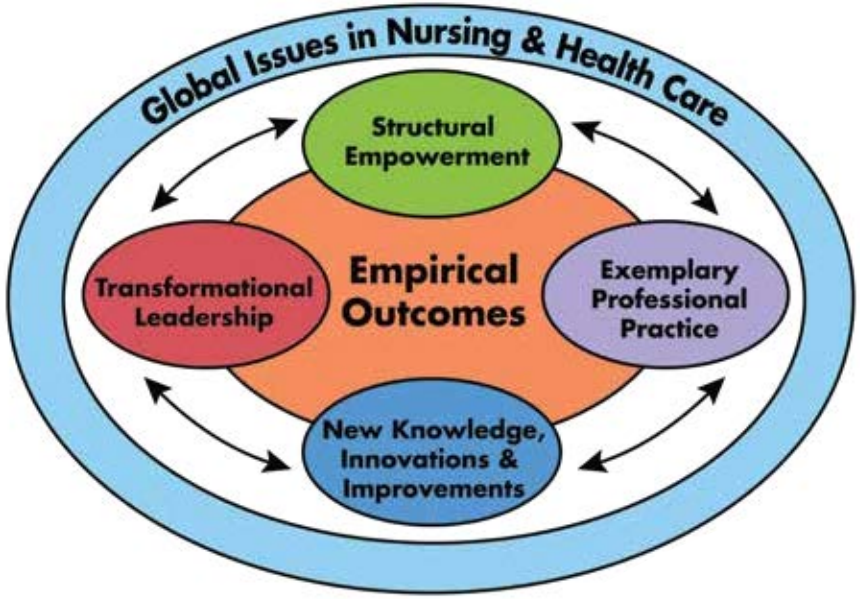
And all of it has been done to provide the best patient care possible.

Christie Gonder, MBA, BSN, RN
Chief Nursing Officer (CNO)

MAGNET® MESSAGE

This year, the nursing division engaged a small team of nurses to begin laying the foundation to align with Magnet® principles by using knowledge and expertise to improve the discipline of nursing and ultimately improve care for patients, families and the community. Magnet is the highest level of recognition a hospital can receive for quality nursing care. Approximately 7 percent of all registered hospitals in the United States have achieved ANCC Magnet Recognition® status (AHA, Fast Facts on US Hospitals, 2015). Magnet hospitals must demonstrate exemplary patient experience, staff engagement and sustained quality outcomes in more than 35 measurable areas. Attaining this goal takes several years of preparation and commitment from every staff member to transform hospital culture and sustain improvements.

MAGNET RECOGNITION PROGRAM® MAGNET® MODEL



THE MAGNET® MODEL CONTAINS 5 COMPONENTS

1. Transformational Leadership
2. Structural Empowerment
3. New Knowledge, Innovations & Improvements
4. Exemplary Professional Practice
5. Empirical Outcomes

MAGNET® COUNCIL MEMBERS

CHRISTIE GONDER

MBA, BSN, RN, CNO

KIRSTEN WISNER

MS, RNC-OB, CNS, C-EFM, MAGNET DIRECTOR/ NURSING RESEARCH COORDINATOR

DOREEN FAIELLO

MHA, RN, ACCREDITATION/ REGULATORY SPECIALIST

LEA WOODROW

SENIOR ADMINISTRATIVE DIRECTOR QUALITY MANAGEMENT

KIMBERLY STEWART

MED SURG, SN, RN III

KYREEN CABERTO

SN, RN II

SHERRI PORTILLO

MSN, RN, CLINICAL NURSE EDUCATOR/SUPERVISOR

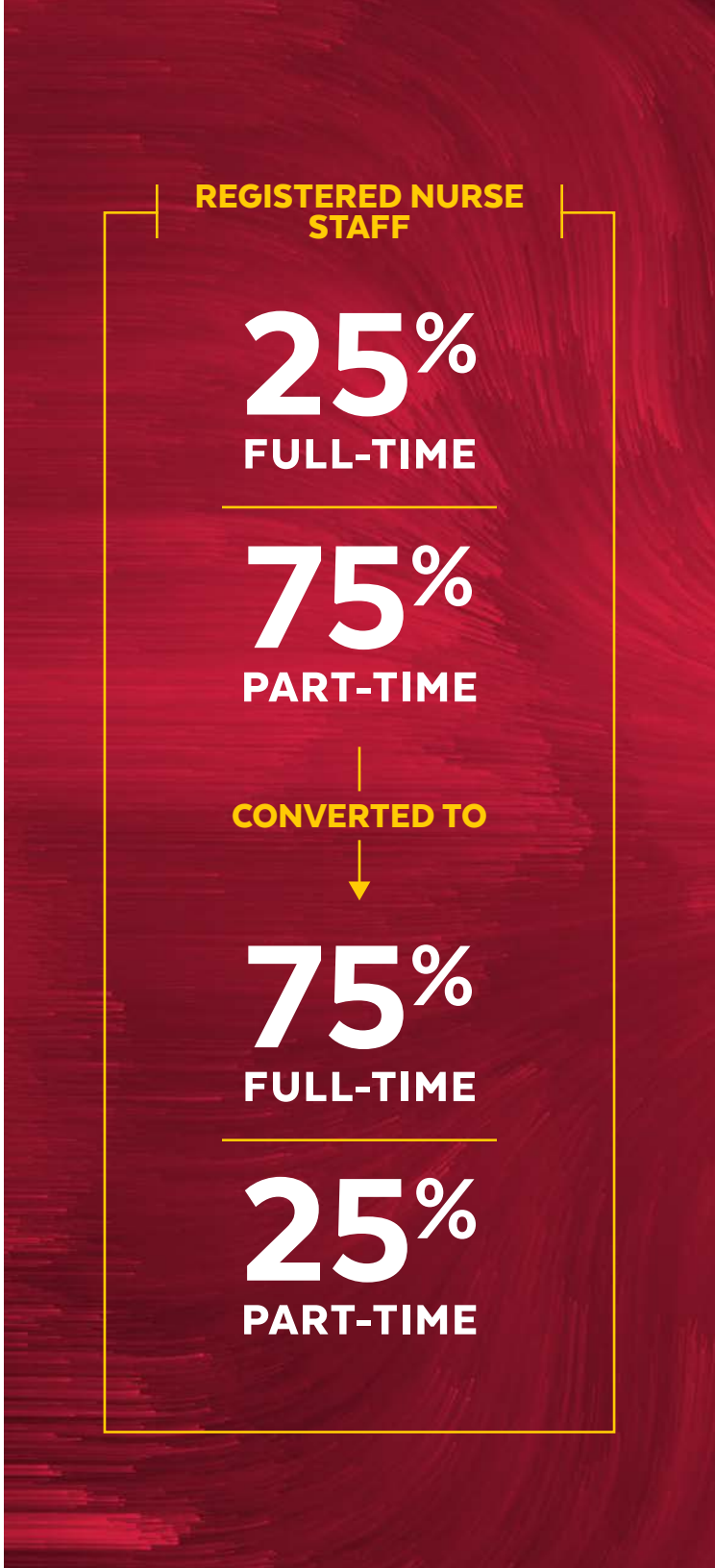
NANCY SCHOLINK

MANAGER OF HUMAN RESOURCES

TRANSFORMATIONAL LEADERSHIP

Salinas Valley Memorial Hospital (SVMH) and California Nurses Association reached an agreement during the fact-finding process following negotiations on the restructuring of nursing services. The goal of the restructuring was to improve staff consistency, create efficiency in patient flow, enhance patient experience and drive optimal quality outcomes.

- Changed from a 25 percent full-time and 75 percent part-time registered nurse (RN) staff to a 75 percent full-time and 25 percent part-time ratio to improve the continuity and consistency of care.
- Created a float pool with staff competencies in a minimum of three areas to improve the flexibility to staff in areas of need.
- Merged the Assistant Head Nurse (AHN) and charge nurse assignment and scheduled selected full-time charge nurses with the skill and competency to drive patient experience, quality initiatives, throughput, compliance and accountability.
- Provided LEAD Academy training to all nurses awarded the charge nurse assignment. This was a six-month intensive training provided by the Hospital Council of Northern & Central California. The training program is designed to empower recently hired, newly appointed or previously untrained healthcare leaders to better understand and use their strengths. It is built on the underlying principle that effective leadership requires productive relationships to support excellence in patient care, sustainable business objectives and a safe patient environment.
- Implemented 12-hour shifts in most areas of the hospital as voted by the staff RNs.
- Opened an Observation Care Unit for outpatient- and observation-level patients to improve patient flow and effectively manage the length of stay.
- Implemented Town Hall Meetings to bring nursing updates and communication directly to the nursing staff rather than the staff needing to find additional time in their busy schedules to come to Chief Nursing Officer (CNO) Forums. These brief meetings last about 30 minutes, occur monthly, and are evenly rotated between day and night shifts and give nursing staff an opportunity to share ideas to improve processes to provide optimal efficient, effective and safe patient care.



Clockwise from top left: ***Julie Vasher, DNP, RNC-OB, CNS, C-EFM,*** Clinical Nurse Specialist of Perinatal Services, ***Daniella Robison, MSN, RN,*** Manager of Labor and Delivery and ***Norma Coyazo, RN,*** L&D conferring in an OB Emergency Department room; ***Glorinda Pastorius, MSN, RN,*** Director of Critical Care and ***Debi Fullington, RN,*** Charge Nurse conferring; ***Trini Juarez, MBA-HCM, BSN, RN,*** Senior Administrative Director of Patient Care Services and ***Lilia Meraz-Gottfried, MSN, RN,*** Director of Clinical Informatics discussing the McKesson (MPV) patient tracking system.

STRUCTURAL EMPOWERMENT
SHARED GOVERNANCE

Shared Governance

- Began a shared governance committee called the Practice Council comprising members who have had extensive involvement in improving nursing practice. This new Practice Council will continue to support and lay the foundation to attain professional Magnet® standards and overall drive improvement in nursing services. The goals of this committee are to give input on the nursing strategic plan and vision, define Salinas Valley Memorial Hospital's (SVMH) professional practice model, optimize and standardize the shared governance structure and align all nursing departments throughout the hospital. The Practice Council promotes clinical nurse input and involvement throughout the organization, encourages nurses to be involved in decision-making that affects their practice and care environments and encourages a culture of safety and quality improvement by using new nursing evidence-based practices to improve patient and organizational outcomes.

- The nurses selected for this council are council chairs or serve in an advisory or mentor role. The goal is to have representation from all unit practice councils. Members are listed below:

Co-chairs
Najiba Caplan, BSN, RN/MedSurg
Dalila Ceja, BSN, RN/Telemetry

Mentor, Director of Perioperative Services and Clinical Improvement
Clement Miller, MSN, RN, NEA-BC

Critical Care Practice Council
Michael Brown, BSN, RN/HC, PCCN

Perinatal Council
Kirstin Herman, BSN, RN, RNC-OB

NICU Council
Shauna Henson, RN, RNC-NIC

Emergency Department Improvement Council
Becky Rodriguez, BSN, RN

Perioperative Clinical Practice Council
Abby Acosta, BSN, RN, CPAN, CAPA
Frances Bullman, MSN, RN

Ortho-Neuro-Spine
Olga Breboneria, BSN, RN

Patient Care Resources
Meg Brown, BSN, RN

Cardiac Catheterization Laboratory
Suzette Urquides, DNP, MSN, RN

Diagnostic Imaging
Cece Alejandre, BSN, RN

ICU
Tracy Chavez, BSN, RN

Accreditation/Regulatory Specialist
Doreen Faiello, MHA, RN

Educators
Wendy Keema, MSN, RN, CCRN-CMC, PCCY, CNRN
Dianne Soria, BSN, RN

Magnet Director/ Nursing Research Coordinator
Kirsten Wisner, MS, RNC-OB, CNS, C-EFM

Clockwise from top left: ***Linda Mase, RN***/ Telemetry and ***Brianne Silvestre, CNA***/HC at a Critical Care Practice Council discussing toileting rounds; ***Cathy Gomez, MSN, BSN, RN,*** Manager/MedSurg discussing rounding tool with ***Marie Marbach, RN, CN***/MedSurg; ***Kelly Flower, MSN/MHA, RN,*** Manager of Critical Care and ***Erika Moncayo, RN***/ Observation Care Unit at a Critical Care Practice Council discussing bedside rounding.

STRUCTURAL EMPOWERMENT
PROFESSIONAL DEVELOPMENT

Professional Development

- Joined a collaborative relationship with community hospital and academic partners of nursing programs on the community and state level to discuss ways to advance nursing education. The goal is to have 80 percent of registered nurse (RN) employees earn their bachelor of science in nursing (BSN) degree as recommended by the National Academy of Medicine. With input from all stakeholders, many curriculum changes were made in this community to support the working RN. Community hospitals also began funding and sharing resources to financially assist nurses in support of their return to school for a BSN degree. In 2016, 40 RNs were approved to receive subsidies for their BSN education.
- Entered into a contract agreement with the Western Governors University BSN program for a 5 percent reduction in rates for BSN and master of science in nursing (MSN) competency-based online programs.
- Over the past eight years, only experienced nurses at Salinas Valley Memorial Hospital (SVMH) or nurses completing a nurse residency program from the local associate degree college were hired. In 2016, the hospital began a BSN new-graduate program and hired 14 BSN graduates. In addition to the new program, the local community nurse resident program continues to be offered. The nurses who successfully complete this program, demonstrate a good fit with core competencies and are concurrently enrolled in a BSN program are offered positions at SVMH. These initiatives are encouraging future employment growth of the BSN professionally trained nurse.
- Participate with the local high schools in a program called the Summer Health Institute, which is designed to engage, develop and educate students about healthcare professions.
- Educational hours and a certification bonus are offered to encourage RNs to gain specialized career education and development in their area of practice.

Kirsten Wisner speaking on Magnet Journey and Shared Governance at the Advancing Your Nursing Career lectures and university education fair.

Clockwise from top left: ***Rose Maniwang*** with NICU twins; Perioperative Services Daily Scheduling Huddle (from left): ***Leslie Hawthorne, RN, CNOR, CN, Juan Gomez,*** CBSPD, SSPD Supervisor, ***Deb Avilez, BSN, RN, CPAN, CAPA,*** Manager/Perianesthesia, ***Debbie Ralph, BSN, RN,*** AHN/Outpatient Services, and ***Missy Erausquin, RN, CNOR,*** OR

NEW KNOWLEDGE, INNOVATIONS, AND IMPROVEMENTS

Nursing Research Council

- We had our first meeting of the Nursing Research Council on April 29, 2016. The council is in its early stages of development and will be under the umbrella of the hospital-wide Hospital Research Committee, the entity that oversees all clinical research at Salinas Valley Memorial Hospital (SVMH). Our goal is to promote the development of a robust program of nursing research, mentoring and evidence-based practice (EBP) and enculturate an understanding and appreciation for nursing science and its use in everyday practice. This council will assist nurses in the development of nursing research studies, quality- and performance-improvement projects and in the evaluation, dissemination and implementation of results. Situating the Nursing Research Council within the broader Hospital Research Committee enables us to benefit from the rich research experience of various physician researchers at SVMH and will have the added benefit of promoting interdisciplinary research activities and collaboration between medical and nursing staffs.
- Our efforts are currently focused on developing the Practice and Quality Councils and the work of the Implementation Team (the group that is going to advise our efforts around education and dissemination of shared governance in our organization).

Implementation Team

Kirsten Wisner, MS, RNC-OB, CNS, C-EFM,
Magnet Director/Nursing Research Coordinator
Sherri Portillo, MSN, RN, Clinical Nurse Educator/Supervisor
Michael Brown, BSN, RN/HC, PCCN, Critical Care Practice Council Co-Chair
Kelly Flower, MSN/MHA, RN, Manager of Critical Care
Pat Valenzano, BSN, RN, Director of Women's and Children's Services
Shauna Henson, RN, RNC-NIC, NICU Council
Kristin Herman, BSN, RN, RNC-OB, Perinatal Council
Julie Vasher, DNP, RNC-OB, CNS, C-EFM,
Clinical Nurse Specialist of Perinatal Services
Diana Bokemeier, BSN, RN, Procedural Nurse Manager
Deb Avilez, BSN, RN, CPAN, CAPA, Manager/Perianesthesia
Abby Acosta, BSN, RN, CPAN, CAPA, Perioperative Clinical Practice Council
Carla Spencer, Director of Emergency Services
Becky Rodriguez, BSN, RN, Emergency Department Improvement Council
Marian Fox, BSN, RN, Clinical Manager/MedSurg
Najiba Caplan, BSN, RN/MedSurg
Charvelle Noble, RN, CN/MedSurg

Quality Council Members

Sherri Portillo, Co-chair, MSN, RN, Clinical Nurse Educator/Supervisor
Aizel Castaneda, Co-chair
Agnes Lalata, Director/MedSurg
Linda Roquemore, Director of Rehab Services & Wound Care
Patricia Johnson, BSN, RN, Nursing Excellence Council
Charvelle Noble, RN, CN/MedSurg
Lea Woodrow, Senior Administrative Director Quality Management
Kirsten Wisner, MS, RNC-OB, CNS, C-EFM, Magnet Director/
Nursing Research Coordinator

NURSING RESEARCH COUNCIL LEADERSHIP

LISA GARCIA

MSN, RN, CNS, SN III/ PEDIATRICS AND NURSING RESEARCH COUNCIL CO-CHAIR WITH KIRSTEN WISNER

KIRSTEN WISNER

MS, RNC-OB, CNS, C-EFM, MAGNET DIRECTOR/ NURSING RESEARCH COORDINATOR

Interdisciplinary Patient Huddle on 3rd Tower. From left: ***Irma Rubio, RN; Matt Countryman, DPT***/Physical Therapy; ***Cathy Gomez, MSN, BSN, RN,*** Manager/MedSurg; ***Cara Couture,*** Patient Experience Ambassador; ***Marie Marbach, RN, CN***/MedSurg; and ***Michelle Orta, RN,*** Case Manager.

FALL PREVENTION PROGRAM

Improving Outcomes Through a New Fall Prevention Strategy

Fall prevention is a major patient safety initiative in healthcare. Particularly in acute care settings, preventing falls can enhance outcomes, decrease morbidity and mortality rates and reduce care costs.

Challenge

An operating fall risk program at Salinas Valley Memorial Healthcare System lacked risk stratification and featured only general interventions, resulting in patient and staff dissatisfaction.

When a fall risk prevention program audit showed areas in need of improvement,
a multidisciplinary fall team at Salinas Valley Memorial Healthcare System worked to implement a new program designed to promote better outcomes. ***Linda Roquemore,*** Director of Rehab Services & Wound Care, and ***Mike Le,***

Solution

Investigate various fall risk assessment programs and implement a new assessment program that includes risk stratification, customized interventions to match specific fall categories and the ability to prioritize care for patients with the highest risk of falling.

New Protocols

- Rollout of the Johns Hopkins Fall Risk Assessment Tool.
- Updated fall risk assessment documentation screen, including definition of high-risk-to-fall factors.
- Revised policy and procedures in management and prevention of falls.
- Customized interventions designed to match each fall risk category.
- Requested physical therapy consult for any patient categorized as high-risk-to-fall.
- Data gathering and analysis after rollout to further improve the fall risk program.

Implementation

- Pilot program to compare the operating fall risk program with the Johns Hopkins Fall Risk Assessment Tool prior to rollout.
- Fall Prevention Awareness Day, including a Wheel of Fortune® – type game, to educate staff about the new fall risk assessment tool and protocol.
- Online e-learning module.
- Education during staff rounds for all nursing units with one-on-one follow-up.
- Presentations at unit staff meetings.
- Compliance audits.

Salinas Valley Memorial Healthcare System

Fall Prevention Innovation Program:
Our Journey Toward Best Outcomes

Doreen Faiello, MHA, RN; Lourdes Escolta, MSN, RN, CNS, CMSRN, CNN, ONC; Agnes Lalata, MSN, RN, CMSRN

PURPOSE AND/OR OBJECTIVES:

The purpose of this project is to identify current innovations and best practices related to fall prevention in the acute care setting.

BACKGROUND AND SIGNIFICANCE:

Fall prevention is one of the major hospital initiatives for patient safety. Our 2014 CalNOC data indicates variation in fall incidences, where 50% of the data points scored above the mean. The fall team completed chart audits, staff interviews and patient rounding. The outcome identified that the majority of our patients were being categorized as high risk to fall (HRTF) using the current Morse Fall Risk Scale (MFRS) causing patient and staff dissatisfaction. Our current fall risk program lacks risk stratification and interventions were generalized. Implementation of an effective acute care fall prevention program brings utmost clinical value from an outcomes measurement and patient safety perspective. Furthermore, Costello and Edelstein (2008) explain that fall-prevention costs continue to increase significantly. A single incident of fall can impact morbidity and mortality rates as well as increase utilization of a variety of health care services and resources.

DESCRIPTION OF PRACTICE CHANGES:

Careful fall risk-assessment and stratification is one of the key elements for fall prevention. The team reviewed a variety of fall risk assessment tools, and found the Johns Hopkins Fall Risk Assessment Tool (JHFRAT) as the most appropriate based on our patient demographics. The JHFRAT was implemented as a pilot program to ensure reliability and validity. During the pilot program staff rated the patient's fall risk using both the MFRS and the JHFRAT. The tool was evaluated for ease-of-use, risk stratification, and practical application. Following successful evaluation of the pilot program, the hospital's electronic fall risk assessment documentation screen was revised to formally adapt the JHFRAT model. Related policy and procedure in management and prevention of falls was updated accordingly. Risk stratification also involved the development of customized interventions to match each fall risk category, namely: low, moderate, and high. The interventions are interdisciplinary. The team revised the fall definitions to match CalNOC. A hospital-wide Fall Prevention Awareness Day was held including a Wheel of Fortune game. All these action plans led to improved patient outcomes.

EDUCATION AND IMPLEMENTATION:

Staff education was accomplished in two phases. The first phase was using an online e-learning module. Following the completion of the e-learning module the changes and modifications of the new Fall Risk Scale went live in the computer system. Education staff started rounding on all the nursing units to provide follow up one on one education and answer any questions. Additionally the new Fall Risk Scale was discussed at unit staff meetings. In conjunction with the additional education, audits on compliance were being performed with feedback going to the nursing units Directors.

RESULTS/OUTCOMES:

Results validated that majority of patients were now classified as moderate risk under the JHFRAT tool that was previously identified as HRTF under the MFRS. Preliminary results indicate that the risk stratification improved outcomes and patient satisfaction by accurately identifying patients at risk. Staff indicates JHFRAT is easy to use and has the ability to prioritize care for patients at highest risk to fall. After incorporating CalNOC fall definitions the team was able to gather meaningful data analysis for further program improvement.

CONCLUSION:

The team concluded that the JHFRAT is a more effective risk assessment for our patient demographics. Although early in our data collection and analysis, the new tool in combination with the stratification of fall interventions for low, medium and high risk are making a difference in patient care and safety. The raw data shows a steady decrease in falls each month.

CHALLENGES AND LESSONS LEARNED:

The implementation of the JFHRAT Fall program brought about some challenges and ultimately lessons learned.

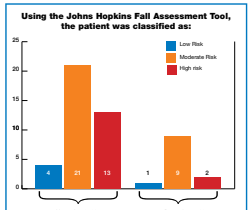
- Starting from the trial to evaluate the effectiveness and ease of use of the tool. The tool was a paper form. Reflecting back had we been able to develop the clinical screens to trial the tool in MedItech may have identified issues and provided the opportunity to resolve them prior to the housewide implementation.
- Adding the intervention where Physical Therapy consult is added if the patient is HRTF was not highlighted in the staff education. This was a new intervention for both the nursing and Physical Therapy staff. This has resulted in a steep learning curve for both departments.
- Staff education took on many forms. One of them was the e-learning module. The most successful mode of teaching was the rounding by the educators. They provided one on- one learning. In addition unit champions were enlisted to assist with additional education.
- One of the criteria for meeting a HRTF is High Risk Factors. Staff was very creative at how they defined High Risk Factors. The Team in collaboration with Clinical IT redesigned the screen to define the High Risk Factors.

REFERENCES:

Costello, E. & Edelstein, J. E. (2008). Update on falls prevention for community-dwelling older adults: Review of single and multifactorial intervention programs. Journal of Rehabilitation Research Development, 45(8), 1135-1152.

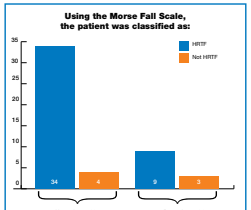
Poe, S. S., Cvach, M. M., Gartrell, D. G., Radzik, B. R., & Joy, T. L. (2005). An evidence-based approach to fall risk assessment, prevention, and management: Lessons learned. Journal of Nursing Care Quarterly, 20(2), 107-106.

Using the Johns Hopkins Fall Assessment Tool, the patient was classified as:



	Low Risk	Moderate Risk	High risk	TOTALS
November 2014	4	21	13	38
December 2014	1	9	2	12
TOTALS	5	30	15	50

Using the Morse Fall Scale, the patient was classified as:



JHFRAT Post Implementation Audit

	June 2015	July 2015	August 2015	September
Patient's Fall Risk was assessed as:				
Low Risk	21	9	15	29
Moderate Risk	38	47	36	18
High Risk	30	42	48	41
Noted fluctuation between Moderate & Low Risk	11	9	6	24
For patient's assessed as HRTF was:				
Chair/Bed Alarm documented	18	28	19	29
No documentation found for Chair/Bed Alarm	35	6	0	0
No documentation found for Physical Therapy Consult	41	11	44	29
Chair /Bed Alarm inconsistently documented	47	39	13	71
Physical Therapy ordered by physician	59	72	31	57
Bed check alarm documented as "no"	0	33	69	43
When "High Risk Factors" are chosen, identify the risk factors				
Active Seizures	0	13	0	0
Acute ETOH on CIWA	17	13	0	0
New Onset CVA with Residual Weakness &/or Cognitive Impairment	17	25	80	75
Post Op Joint Replacement	0	13	0	25
Unable to Identify Based on Documentation	67	38	20	0

Fall Prevention Awareness Day, including a Wheel of Fortune® - type game, to educate staff about the new fall risk assessment tool and protocol.

RESULTS

- Risk stratification improved outcomes and patient satisfaction.
- Staff finds the new fall risk assessment tool easy to use and effective in helping them prioritize care for patients with the highest risk to fall.
- Steady decrease in patient falls has been noted each month since the program was launched.

Salinas Valley Memorial Healthcare System

Fall Prevention Awareness Day: GAME ON!

Doreen Faiello, MHA, RN; Lourdes Escolta, MSN, RN, CNS, CMSRN, CNN, ONC; Agnes Lalata, MSN, RN, CMSRN

Make SVMHS A
FALL FREE ZONE

BACKGROUND/SIGNIFICANCE:

Fall prevention awareness is a top patient safety priority for high performing healthcare organizations. Hence, when a member of the Fall Team brought back information from a conference about celebrating the first day of Fall with a fun event on Fall Prevention Awareness, the Fall Team immediately started to plan the event utilizing an interactive teaching methodology that is far different from the usual Informational Fairs. The Team wanted to attract staff from every department to participate in SVMHS' First Annual Fall Awareness Day. The Team enlisted the help of the Marketing Department who came up with the Wheel of Fortune Game. The next challenge was to find a location visible to all departments and staff. The cafeteria was chosen as the perfect location. The next challenge was to structure the times the game was available or staff to play. The Team chose times that would enable staff from all three shifts to participate.

Since its introduction, The Wheel of Fortune is now being used for Orientation; Safety Fairs and even this year's NICU reunion. The Wheel of Fortune game can be used as a teaching strategy that can enhance learner's participation and knowledge retention in a fun and interactive manner.

PURPOSE:

The purpose of the game is to make learning fun and even win some prizes in order to reinforce fall prevention strategies among all hospital departments.

DESCRIPTION OF EVENT:

The first Fall Awareness Day was in September 2014. The first year, the Team provided candy and hand sanitizers as prizes. Everyone who participated stated had a good time.

SVMHS just completed the 2nd Annual Fall Awareness Day. Participation doubled the second year. The Team enlisted more staff nurses to host the game which was still held in the cafeteria. Also the 2nd year, Employee Health joined our Awareness Day to demonstrate Safe Patient Handling and Mobility Aides. The Team donated two gift cards as the "Grand Prizes". The Team also enlisted support from Environmental Services who donated 10 free cafeteria meal vouchers; 10 Starbucks gift cards for $5 each; three miscellaneous gift bags from the Foundation and a Department Director. Attendance this year included the CMO, Sr. Administrative Director Risk Management; Sr. Administrative Director Regulatory Compliance/Organizational Improvement and Sr. Administrative Director Nursing Operations.

LESSONS LEARNED FROM THE FIRST YEAR:

- Advertise earlier
- Include more non-clinical questions regarding Fall Prevention

PLAYING THE GAME:

Much like the popular game show, the participant spins the wheel but instead of shouting out a letter when the wheel stops, a category is revealed. The team chose the following categories:

- Documentation
- Assessment
- Pictures
- Environment
- After the Fall
- Rounding
- Signage
- Fall Education
- Why Do Patients Fall
- Handoff
- Free Space (Players Choice)
- Miscellaneous (Host Choice)

OUTCOMES & STAFF FEEDBACK:

"Very interactive and engaging."

"I did not think being from a non-clinical area that I could play—I learned something today."

"Good information and very short so it did not take time away from my lunch break."

Salinas Valley Memorial Healthcare System

UCSF School of Nursing

Parents' Perspectives On Navigating the Work of Speaking Up in the NICU

Audrey Lyndon, PhD, RNC[1]; Kirsten Wisner, MS, RNC, CNS[1,2]; Carrie Jacobson, PhD, CNM[3]; Kelly M. Fagan, BSN, RN[4]; Linda S. Franck, PhD, RN[1]

[1]University of California, San Francisco; [2]Salinas Valley Memorial Healthcare System; [3]San Francisco State University; [4]Lucille Packard Children's Hospital

BACKGROUND AND SIGNIFICANCE

Effective communication among team members and with patients is a hallmark of safe and highly reliable patient care.

Efforts to engage patients and families in helping to maintain safety have included encouraging patients and families to speak up about their concerns, and for example, to ask clinicians to wash their hands. However, patients and family members may experience substantial barriers to speaking up, their concerns may be different from clinicians' concerns, and they sometimes fear that speaking up could impact care of their loved one.

Despite calls to partner with patient and families in safety and campaigns underway to encourage them to speak up, parents' views on communication about safety in the NICU are poorly understood.

Parents' have a sophisticated understanding of safety that includes physical, emotional and developmental dimensions.

The interplay of physical, developmental and emotional safety from the parents' perspective.

Lyndon A et al. BMJ Qual Saf 2014;23:902-909

BMJ Quality & Safety

PURPOSE

To describe neonatal intensive care unit (NICU) parents' perspectives on factors influencing communication in the NICU, in order to identify barriers and facilitators of parents' ability to speak up about safety concerns.

METHODS

Study Design and Data Collection

Parallel mixed methods convergent design

- Qualitative strand used constructivist grounded theory. Data included in-depth interviews and observations.
- Quantitative strand included an 84-item questionnaire with Likert-type, multiple choice and open ended questions.
- Measures: parent stress, parent assessment of family-centered-ness, degree of concerns, and likelihood of speaking up in response to lack of hand hygiene.

Setting and Sample

- 50-bed, regional tertiary academic NICU
- Participants were parents of infants ≥72h old with a range of diagnoses
- 55 parents enrolled
- 46 completed questionnaires
- 14 parents participated in interviews
- 6 hours of observation

DATA ANALYSIS

Data from the two study strands, questionnaires and interview/observation text were analysed separately and then compared. We used descriptive statistics and correlation analysis to evaluate responses to demographic and rating-scale questions and thematic analysis to evaluate free-text on questionnaires. Constructivist grounded theory and dimensional analysis were used to develop a theoretical explanation for parents' perspectives on communicating safety concerns.

FINDINGS

Forty-six parents returned questionnaires, fourteen of whom were also interviewed. Most parents (75%) rated themselves likely or very likely to speak up in response to lack of hand hygiene; however 25% of parents rated themselves unlikely to speak up in the same situation. Parents engaged in a complex process of ***navigating the work of speaking up*** in the NICU that entailed ***learning the NICU, being deliberate about decisions to speak up***, and at times ***choosing silence*** as a safety strategy.

Decisions about how and when to speak up were influenced by multiple factors including their understanding of threats and of internal and external resources available to respond, personal challenges regarding speaking up, having a defined pathway for voicing concerns, clinician approachability, clinician availability and friendliness, and clinician responsiveness.

CENTRAL PERSPECTIVE: NAVIGATING THE WORK OF SPEAKING UP IN THE NICU

Speaking up is characterized as work and as a process of navigating because parents were deliberate in their decision to voice concerns, and in general, perceived speaking up as risky.

Speaking up is also conceptualized as socially and personally complex as parents were very aware of and concerned with how speaking up may affect their relationships with clinicians and their standing on the team, how speaking up may affect their baby's care, and because some parents described their personal struggles with speaking up.

The choice to take the risk to speak up was partially influenced by parents' knowledge of the situation and their threat assessment.

Parents' knowledge was situated in a process of learning the NICU, that included learning what things meant, such as alarms and clinical signs, knowing their baby, and figuring out whom to approach with their concerns.

CONCLUSIONS

Findings from this study align with other studies about patients and families in other clinical areas and with studies of clinicians. Speaking up about safety concerns is often a challenge and is personally and socially complex.

Partnering with parents to speak up about safety will likely take more than simply telling them or inviting them to do so.

To engage parents as true partners in safety, clinicians need to recognize the complex social and personal dimensions of the NICU experience that influence parents' willingness to speak up about their concerns.

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RECOMMENDATIONS

- **Partnering with parents to speak up about safety will likely take more than simply telling them or inviting them to do so.**
- **To engage parents as true partners in safety, clinicians need to recognize the complex social and personal dimensions of the NICU experience that influence parents' willingness to speak up about their concerns.**

PARENTS' PERSPECTIVE ON NAVIGATING THE WORK OF SPEAKING UP IN THE NICU

Studying Barriers to Parent Communication in the NICU

The neonatal intensive care unit (NICU) is a complex environment that often includes barriers to parent-caregiver communication. Parents may feel their concerns are different from those of the NICU team and speaking up – even about a safety issue – could impact the care of their child. These barriers stand in the way of effective outcomes.

Challenge

NICU parents' perspectives that influence their comfort and ability to communicate effectively with NICU staff are not well understood.

Nurse researchers collaborated to study barriers to parent communication with NICU staff. Researchers included: ***Audrey Lyndon, PhD, RNC; Kirsten Wisner, MS, RNC-OB, CNS, C-EFM,*** of Salinas Valley Memorial Healthcare System; ***Carrie Jacobson, PhD, CNM,*** of San Francisco State University; ***Kelly M. Fagan, BSN, RN,*** of Lucille Packard Children's Hospital; and ***Linda S. Franck, PhD, RN,*** of the University of California, San Francisco.

Solution

Researchers at San Francisco State University, Salinas Valley Memorial Healthcare System, the University of California, San Francisco, and the Lucile Packard Children's Hospital Stanford conducted this study to better understand factors in influencing parent-clinician communication in the NICU.

Study Components

- 46 parents of infants ≥72 hours old with a range of diagnoses
- 46 completed questionnaires
- 14 participated in interviews
- Six hours of observation
- Questionnaire and interviews were designed using constructivist grounded theory/parallel mixed methods convergence.

Findings

Parents engage in a socially and personally complex process of navigating the work of speaking up while their child is in the NICU. Decisions about how and when to speak up are influenced by multiple factors including:

- Their understanding of threats and internal and external resources available to respond.
- Personal challenges regarding speaking up.
- Having a defined pathway for voicing concerns.
- Clinician approachability, availability and friendliness, and responsiveness.

PRESSURE INJURY AWARENESS CAMPAIGN

Taking Responsibility to Thoroughly Identify Pressure Injury Risk at Admission

Pressure injuries are not only painful, they put a patient at high risk for infection and can significantly increase hospital stays – and healthcare costs. Development of a stage III or IV pressure injury during hospitalization is considered a provider-preventable condition (PPC) and, as such, care related to these conditions is not reimbursed. Therefore, timely and accurate assessment of preexisting pressure injuries upon hospital admission has financial as well as public health benefits.

Nurses of Salinas Valley Memorial Healthcare System are dedicated to efficaciously preventing and treating pressure injuries. The following nurses initiated the It Starts With Me program to improve safety outcomes: ***Heather Barigian, BSN, RN; Silvia Fierro, BSN, RN, PHN; Carl Going, RN; Irma Magdaleno, RN; Jennifer Nicholson, BSN, RN; Linda Sarratt, RN, AHN; Maria Torculas, RN; and Sandra Zamora, BSN, RN, PCCN.***

Challenge

When a patient refuses to be touched and/or have clothing removed for a skin inspection, a thorough examination can be difficult. These barriers could lead to delayed identification of a preexisting pressure injury, failure to detect and treat a worsening pressure injury and the inability to detect signs of a newly developing skin lesion.

Solution

Implementation of It Starts With Me, a system-wide program to ensure accurate identification, prevention and documentation of pressure injuries.

New Protocols

- New admission skin assessment signed off by two nurses.
- Thorough documentation if patient refuses assessment.
- Green arm bracelet put on each admitted patient recommended for wound consult.

Implementation

- Printed educational material.
- Presentations to the wound care committee and quality control.
- In-service education.
- Electronic messaging.
- Intrahospital messaging.

Salinas Valley Memorial Healthcare System

It Starts with Me!
A Pressure Ulcer Awareness Campaign

Heather Barigian, RN, BSN; Silvia Fierro, RN, BSN, PHN; Carl Going, RN; Irma Magdaleno, RN; Jennifer Nicholson, RN, BSN; Linda Saratt, RN, AHN; Maria Torculas, RN; Sandra Zamora, RN, PCCN

BACKGROUND & SIGNIFICANCE

Development of a stage III or IV pressure ulcer during hospitalization is considered a provider preventable condition (PPC) and as such, care related to these conditions is not reimbursed. Hence, timely and accurate assessment of preexisting pressure ulcers on admission to the hospital have financial as well as public health implications.

CASE STUDY

Patient was admitted to unit with multiple barriers for nurses to complete a thorough skin assessment due to the following reasons: 1) patient refused to be touched, and 2) patient refused to have clothing removed for skin inspection. Four days following transfer to another floor, his primary nurse removed a Mepilex dressing on his coccyx, which revealed a stage III pressure ulcer.

PROBLEM STATEMENT

Lack of thorough skin assessment in the presence of multiple barriers to care could lead to delayed identification of a preexisting pressure ulcer, failure to detect and treat a worsening pressure ulcer, and to detect signs of a newly developing skin lesion.

THE PROJECT

The group of nurses involved in this patient's care proposed a solution to prevent such a scenario from happening again. This resulted in the initiative titled, ***"It Starts with Me."***

The purpose of the project is to improve patient safety by ensuring accurate identification, prevention, and documentation of pressure ulcers.

DESCRIPTION

Our goal is to **ASSESS** by implementing the following steps:

- **A** ASSESS THE PATIENT FROM HEAD TO TOE
- **S** SCREEN THE BODY FOR
- **S** SKIN ABNORMALITIES
- **E** EVALUATE WITHIN 24 HOURS OF ADMISSION. If a patient has or does not have a pressure ulcer, a
- **S** SECOND RN WILL BE REQUIRED TO VERIFY HER OR HIS FINDINGS AND A
- **S** SIGNATURE WILL BE REQUIRED

If a patient has a pressure ulcer:

- Place a green armband on the patient.
- Order a wound consult
- If the patient refuses to be assessed, document the reason and include it in handoff and nurse's notes
- It is 100% the primary nurse's responsibility to ensure the body image documentation is completed.

EDUCATION

In order to communicate and spread the word about the initiative, we:

- Developed a poster board and win tip sheet handout
- Developed a power point and screensaver
- Presented to wound care committee, and quality control
- Presented to the Critical Care nursing cluster at Competency Camp
- Provided one on one in-service to the med-surg nursing staff cluster
- Plan to present at the charge nurse meetings as well as follow up for re-education
- Encouraged all nursing staff to help spread the word
- E-Blast to all computers
- In cafeteria on STARComm message
- Policy faire for the future

IMPLEMENTATION

There are two main changes that are being highlighted with the ***"It Starts with Me"*** campaign.

1. The requirement of a second RN's signature on the initial Skin Assessment in the worklist on Meditech. The primary nurse and a second nurse must sign the skin assessment whether the skin is

Green arm bracelet put on each admitted patient recommended for wound consult.

RESULTS

- Nurses report enhanced confidence in assessing and prioritizing pressure injury care and prevention.
- Team commitment to improving patient care observed.

Salinas Valley Memorial Healthcare System

PRESSURE ULCERS

Identification, Treatment & Prevention

I. Photograph: Upon discovery and with changes; document every Sunday

II. Braden Scale

Braden 18 or less = AT RISK
➡ **RN to order Skin Care Complex**

Braden 19 or greater = NO RISK
➡ **RN to order Skin Care Simple**

➡ **RN to implement intervention in order sets**
Skin Care Complex: includes Bariatric Skin Care
Skin Care Simple: basic skin care for ALL patients

III. Skin Care Simple /Skin Care Complex

Skin Care Simple
Braden Score greater or = 19

- Keep skin clean and dry
- Assess skin every shift
- Minimize pressure
- Encourage adequate nutritional and fluid intake and document
- Apply Sween-24 lotion to skin daily, not in between toes

Skin Care Bariatric
for BMI 50 or greater

Additional interventions

- Lift on unit
- Repositioning Sling [SSP]—use with lift
- SCD Device — bariatric size
- Ultra Dry Underpads [SSP]
- Implement order for skin care: **complex**
- Special attention: MASD in skin folds

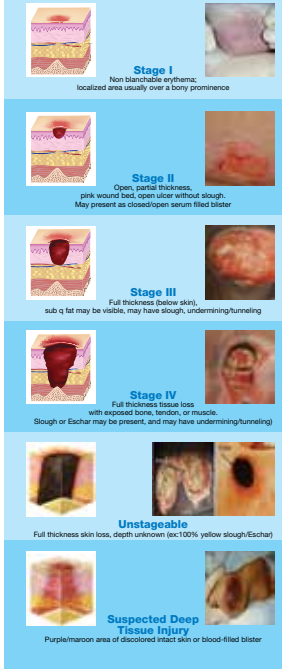
Skin Care Complex
Braden 18 or less = at risk

- Turn Q 2 Hours
- Apply Sween-24 Lotion to skin daily, not in between toes
- Keep HOB below 30 degrees if tolerated
- No massage over bony prominences
- Minimal use of under-pads/linen
- No use of diapers unless diarrhea present
- Comfort bath cloths/bedside care spray for skin care daily and prn
- Barrier cloths and/or clear barrier cream to buttocks/perineum bid and prn after each episode of incontinence
- Pannus inspection/care q shift with comfort bath or bedside care spray
- Use no-sting barrier spray to intertriginous skin daily prn
- InterDry to skin folds after cleansing q5d and prn if soiled
- Offload heels at all times
- Upgrade sleep surface if needed

IV. Dressing: RN may apply foam dressing q3d & prn

V. Place Order: Wound consultation for any Pressure Ulcer greater than Stage II

Stages



Stage I
Non blanchable erythema;
localized area usually over a bony prominence

Stage II
Open, partial thickness,
pink wound bed, open ulcer without slough.
May present as closed/open serum filled blister

Stage III
Full thickness (below skin),
sub q fat may be visible, may have slough, undermining/tunneling

Stage IV
Full thickness tissue loss
with exposed bone, tendon, or muscle.
Slough or Eschar may be present, and may have undermining/tunneling)

Unstageable
Full thickness skin loss, depth unknown (ex:100% yellow slough/Eschar)

Suspected Deep Tissue Injury
Purple/maroon area of discolored intact skin or blood-filled blister

If you are unsure of stage:
DOCUMENT ➡ Unable to determine stage
ORDER ➡ Wound Care Consultation

Moisture Associated Skin Damage

IAD—Incontinence Associated Dermatitis
From chronic exposure to urine or liquid stool
(Use: history to determine causative factors of skin disorder)
TREATMENT
- **Cleanse:** Comfort bath cloths/bedside care spray
- **Protect:** Shield barrier cloth and/or barrier cream bid & prn

ITD—Intertriginous Dermatitis
Damage caused by skin on skin friction and moisture (Pannus, buttocks/breasts or any skin fold)
TREATMENT
- **Cleanse:** Comfort bath cloths/bedside care spray
- **Protect:** Comfort shield barrier cloth and/or barrier cream bid & prn
- **Wick moisture** with InterDry; change q5d & prn if soiled
- **Additionally:** May use no-sting barrier spray in skin folds daily after am bathing, and use InterDry as above)

Peristomal Moisture Associated Dermatitis
Inflammation and erosion of skin related to output from the stoma
TREATMENT
- Change wafer/pouch q3d & immediately prn leakage
- Use stoma-adhesive powder/barrier spray to crust peristomal skin/to protect and heal skin

Periwound Moisture Associated Dermatitis
Over-hydration of skin surrounding wound causing maceration, skin breakdown, may delay healing of wound
TREATMENT
- **Protect:** Peri-wound with no-sting barrier
- Change dressing more frequently to manage exudate
- Wound consult for assessment of wound/determine need for new dressing

Dry Stable Black Heel Eschar
- Do NOT debride dry stable black heel eschar
- Cleanse with N/S and pat dry
- Apply no-sting barrier film or betadine swab to affected area daily
- May apply loose GAUZE dry dressing only, **NO FOAM**
- Offload heels at all times

Skin Tears
- Cleanse with N/S, pat dry
- Apply no-sting barrier film to peri-wound skin
- May use steri-strips to approximate skin edges prior to foam application**
- Apply foam dressing (Use stockinet/kerlix if needed with white foam)
- Change weekly or if strike through drainage





On Nurses' Day, every nurse working received a daisy as recognition of their hard work with a note that said:

Happy Nurses Day!

Each time we care for a patient, hold their hand, smile and share kind words, we are helping to heal their body, heart, mind and spirit. Thank you for the compassionate care you provide.

-Christine Gonder





EXEMPLARY PROFESSIONAL PRACTICE

Engaging the Patient/Family and Staff

The DAISY Award®

- Partnered with other healthcare organizations to honor and recognize nurses who have demonstrated compassionate care. Ongoing recognition of high-performing staff results in job satisfaction, retention, teamwork, pride and a healthy work environment.

Instituted Patient/Family-Centered Care Forums

- Scheduled monthly.
- Invited interdisciplinary groups of staff members to listen to patient and family stories to learn more about patient experience. These patient and family perceptions acknowledge the great work staff members already do and encourage them to learn ways they can improve their delivery of patient care.

Bedside Report

- Staff developed training materials, simulation examples and a video of a bedside report to engage the patient at the center of the care.

The national DAISY Award was developed by the family of J. Patrick Barnes to celebrate extraordinary nurses who demonstrate skill and compassion. These nurses are deserving of our respect and recognition. Salinas Valley Memorial awards DAISY to one nurse every other month.

NURSE BEDSIDE SHIFT REPORT

Changing Handoff Protocol to the Bedside

Effective handoffs at nurse shift changes are the foundation for patient care continuity and appropriate treatment. Yet, communication breakdowns are consistently ranked among the top three contributors to adverse events in healthcare. The dynamic hospital setting makes a handoff complex, particularly when it is not done at the bedside.

Challenge

Nurse shift changes require effective and efficient communication of patient information to prevent adverse events and medical errors. When handoffs happen outside the patient's room, care quality and patient safety can be at risk and an opportunity to enhance patient-caregiver engagement can be lost.

Solution

Engage patients and their families in their care and allow them to communicate important clinical information to healthcare providers through a bedside reporting process during nurse shift changes.

New Protocols

- Bedside nurse reviews the "Bedside Shift Report" brochure with the patient the day of admission and invites the family to participate in the process.
- Bedside handoff process happens twice daily from 07:00 to 07:30 and 19:00 to 19:30.
- Charge nurses ensure the process is being practiced.
- Ambassadors or nurse champions from the Critical Care Practice Council encourage adherence to the new process by actively discussing the benefits of bedside reporting and monitoring the project's successes and challenges.

Implementation

- Educational video for staff.
- Online e-learning module.
- Patient brochure in English and Spanish that explains the bedside shift report.
- Posters and flyers for staff reminders.
- Presentations at Nursing Competency Camps.
- Staff survey for feedback.

To increase care quality and patient safety, a team of nurse researchers at Salinas Valley Memorial Healthcare System initiated a change in handoff protocol to incorporate patient involvement. Nurses involved in the project included: ***Michael Brown, BSN, RN***/HC, ***PCCN***/Critical Care Practice Council Co-Chair; ***Raymundo Moralez, BSN, RN, PCCN***/Heart Center/Critical Care Practice Council Co-Chair; ***Laura Brem, BSN, RN; Erika Moncayo, RN***/Observation Care Unit; ***Linda Mase, RN***/Telemetry; ***Carol Fuller, RN; Stephanie Fierro, CNA; Patty Borna, UA.***

Salinas Valley Memorial Healthcare System

Nurse Bedside Shift Report

Michael L. Brown, RN, BA, BSN; Raymundo Morales, RN, BSN, PCCN; Laura Brem, RN, BSN; Erika Moncayo, RN; Linda Mase, RN; Carol Fuller, RN; Stephanie Fierro, CN

BACKGROUND & SIGNIFICANCE

Communication breakdowns have consistently ranked among the top 3 leading contributors to adverse events in healthcare settings since 2004. Patient and family involvement in care can improve communication and safety outcomes by engaging patients in their care and allowing them to contribute important clinical information to healthcare providers. The use of bedside report has been shown to reduce the incidence of falls, aid in the detection of blood product incompatibility increase patient and nurse satisfaction, and improve communication between clinicians and between clinicians and patients.

THE PROBLEM – A CASE STUDY

A patient was transferred to our unit from the emergency department and the off-going nurse provided report at the nursing station. After report, the oncoming nurse assessed the patient and found him obtunded, as well as identifying numerous other assessments that did not align with what was reported during handoff. Since the off-going nurse was gone, details regarding the patient's baseline status could not be verified. Hence, multiple tests and studies were ordered to further investigate the patient's condition. This case illustrates a situation where conducting report outside of the patient's room resulted in a missed opportunity for important sharing and verification of information during handoff. If both nurses had witnessed the patient's current state, the off-going nurse could have contributed his/her evaluation of the patient's status in light of prior assessments, which may have resulted in fewer treatment delays and unnecessary interventions and tests.

THE PROJECT

We sought to implement a change in practice around our handoff process to include bedside reporting based on our understanding of its well-established benefits. We anticipated challenges related to this change in practice which included:

- Fearing change and reluctance to "let go" of current processes
- Anticipating shift report taking longer to complete
- Dealing with sensitive information and concern about violating patient confidentiality
- Not wanting to disturb the patient

The Critical Care Practice Council was asked to lead this process change by creating structured education and teaching tools for staff and patients. We employed the following modalities:

- Produced an educational video for staff
- Developed an e-learning module within HealthStream
- Created a patient brochure explaining bedside shift report
- Constructed one-page flyers for staff
- Developed posters for the documentation computer stations
- Presented at Nursing Competency Camps
- Surveyed staff several months after implementation for feedback

IMPLEMENTATION

Bedside shift reporting was rolled out in the critical care cluster on July 1st, 2015. The bedside nurse reviews the "Bedside Shift Report" brochure with the patient on the day of admission, inviting the family to participate in the process. The handoff process typically takes 5 minutes per patient and occurs twice daily between 07:00 – 07:30 and 19:00 – 19:30. Charge Nurses ensure that the process is being practiced. Ambassadors or nurse champions from our Critical Care Practice Council encourage adherence to the new process by actively discussing the benefits of bedside reporting and monitoring the project's successes and challenges.

ONGOING EDUCATION

Upon hire, Registered Nurses and Certified Nursing Assistants are provided the educational DVD that we developed on bedside reporting as a reference for their unit orientation. Each WOW computer has a laminated "Bedside Hand-off Communication Guideline" staff reminder affixed to it. The components of bedside reporting have been simplified to the acronym *"BHOCS"* which stands for:

B – BRIEF DESCRIPTION
H – HISTORY
O – OCCURRENCES
C – CARE PLAN
S – SAFETY

LESSONS LEARNED

Feedback has been largely positive:

"When taking report at the bedside, I feel that I have a better understanding of my patient's condition and am less likely to have any unanticipated adverse events."

"This type of reporting (as a patient) makes me feel that the nurses know what's going on with me."

"At first, the process caused incidental overtime, but now I have been able to reduce the time on my reports by seeing what formerly was given to me in narrative."

"During bedside repot, a family member corrected the dosage of a medication. Had this not been caught, it could have caused the patient harm."

PRINTED MATERIALS:

Nurse Bedside Shift Report admission brochure (above) produced in English and Spanish

Bedside Hand-off Communication Guideline flyer (right)

REFERENCES:

Agency for Healthcare Research and Quality (2013). Strategy 3: Nurse bedside shift report. AHRQ: Rockville, MD.

Rutherford, P, Lee B, Greiner, A. (2004). Transforming Care at the Bedside: IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement.

The Joint Commission. (2016). Sentinel event data: Root causes by event type, 2004-2015.

RESULTS

- **Increased engagement of patients noted.**
- **Nurses report enhanced confidence in understanding patients' conditions.**

NURSING STRATEGIC VISION

PEOPLE

To foster an environment of collaboration and respect

To ensure all staff members are held accountable to their roles and responsibilities

To improve employee engagement by recognizing high performers in order to retain top talent

To keep open, honest and transparent communication

SERVICE

To provide an excellent patient experience

To keep all patients informed and provide smooth patient throughput

To work collaboratively with physicians to ensure a smooth workflow

To cultivate relationships with all our partners and customers

QUALITY

To provide high-quality evidenced-based patient care

To ensure nursing standards and regulatory compliance standards are consistently met

To drive process improvement and through initiatives, education, staff engagement and policy

FINANCE

To ensure thorough and timely care to manage length of stay and prevent readmissions

To manage labor and supplies to maximize operational efficiency in order to sustain a fiscally responsible organization

COMMUNITY

To demonstrate pride and participation in hospital and community events in order to partner with our community members

GROWTH

To support and align goals with senior management's strategic plan initiatives

The Critical Care Practice Council August 2016 meeting. From left: ***Jaron Ramirez, RN***/HC; ***Linda Mase, RN***/Telemetry; ***Dalila Ceja, BSN, RN***/Telemetry; ***Francie Espino, RN***/ICU; ***Brianne Silvestre, CNA***/HC; ***Elisabeth Sy, RN***/ICU; ***Michael Brown, BSN, RN***/HC, ***PCCN***/Critical Care Practice Council Co-Chair; ***Jennifer Jean-Pierre, RN,*** Unit Shift Supervisor/Progressive Care; ***Raymundo Moralez, BSN, RN, PCCN***/Heart Center/Critical Care Practice Council Co-Chair; ***Megan Fulton, RN***/ICU; ***Wendy Keema, MSN, RN, CCRN-CMC, PCCY, CNRN,*** Educator; ***Erika Moncayo, RN***/Observation Care Unit; and ***Kelly Flower, MSN/MHA, RN,*** Manager of Critical Care.

NURSING ACCOMPLISHMENTS: EMERGENCY DEPARTMENT

Vanessa Lockard, RN, SN III, CN, and ***Jeremy Hadland,*** Manager, discussing patient throughput to prevent expedite high acuity and high-risk patients.

In order to address the increased Emergency Department (ED) volume as well as provide exceptional care and service to ED patients, 2015 ED performance improvement initiatives included the following:

The BETA Healthcare Group's Quest for Zero: Tier 2 recognition was achieved for nursing triage risk assessment to identify gaps in the triage process followed by a comprehensive audit to develop an education plan for ED nurses. Excellence in ED – The Emergency Department achieved Tier 1 recognition for 100 percent of ED physicians, physician assistant (PA) and registered nurse (RN) staff completing specific education. This has reduced risk for the high-risk ED population.

Patient Flow/Construction – Provider staffing has been increased to accommodate the increased volume. New PAs and nurse practitioners have been added. Nurse staffing has also been increased and hours revised to better accommodate the volume. The surgery waiting overflow area is now utilized with midlevel providers, and low acuity patients during high-volume times are being seen in that setting. Construction in the ED has begun this year in order to revise and improve the patient-flow process, implement a provider in the triage area, develop the role of a pivot RN, and improve and expand the results waiting area with private consultation rooms for physician conferences and nurse discharge instructions.

EPIC (Emergency Performance Improvement Council) – The committee began in January 2015 and is a unit-based practice committee. Membership includes four RNs and two Clinical Assistants. Council initiatives include:

- **Physician Care Cards** – These are cards the treating ED physician gives to a patient, explaining what tests will be done and what to expect during his or her ED visit.
- **"Journey Through the ED"** – This further describes how the ED "works," e.g., the triage procedure may result in "sicker" patients being seen before other patients that arrived earlier to the ED.
- **Patient Callbacks** – The ED staff performs next-day callbacks for patients that present with abdominal pain to ensure the patient is improving.
- **Data Transparency** – A newsletter is developed every other month that contains relevant information, including patient experience scores.
- **Leader Rounding** – Director and clinical manager are rounding.

- **Volunteer Initiatives** – Volunteers have been retrained and priorities set, such as rounding in the waiting room during high volume times.
- **RN Rounding Cards** – These cards inform a patient of their projected wait time, ask if the patient is experiencing pain and inform the patient about delays.

InQuicker – InQuicker went live in March 2015. The system allows the patient to make a projected treatment time appointment. Registration has increased since implementation and has resulted in a 13.5 percent increase in patients using the system that have never accessed the hospital or ED, resulting in growth for the ED.

Emergency Department BETA Healthcare Quest for Zero Awards

STROKE PROGRAM

2015 VOLUME FOR THIS PATIENT POPULATION HAS INCREASED 26.6 PERCENT ACCORDING TO 2014 STATISTICS. THE MOST FREQUENTLY OCCURRING TYPE OF STROKE REMAINS ISCHEMIC. ED STROKE METRICS AND PERFORMANCE INCLUDE:

2015 STROKE METRICS	TARGET	PERFORMANCE
Door to MD exam (NIHSS)	Less than 15 minutes	90%
Door to CT complete	Less than 25 minutes	89% Average = 14 minutes
Door to CT results	Less than 45 minutes	90% Average = 31 minutes
Door to tPA	Less than 60 minutes	69% (Reportable cases only) TJC Requirement = 50%

CHEST PAIN CP/STEMI PROGRAM

ED STEMI METRICS AND PERFORMANCE INCLUDE:

2015 STEMI STATISTICS	TARGET (IN MINUTES)	AVERAGE (IN MINUTES)
Door to ECG	10	5
Door to Code STEMI call	15	3
Door to Cath Lab	50	27
Cath Lab to PCI	40	31
Door to PCI	90	58

NURSING ACCOMPLISHMENTS: CRITICAL CARE SERVICES

Critical Care Services includes the following departments:

Intensive/Coronary Care Units (ICU/CCU): 13 beds
One Main: 15 beds
Heart Center: 15 beds
Outpatient Care Unit (OCU): Capability of 12 monitored beds with a total census of 19
Fifth-Floor Tower: 14 beds
Diagnostic Imaging (DI) Registered Nurse (RN) Staff
Cardiac Catheterization Lab RN Staff
Cardiology RN Staff
Out Patient (OP) Infusion
OP Cardiac Cath Holding Area: 8 beds

Laura Ruff, RN, Diagnostic Imaging, and ***Diana Bokemeier, BSN, RN,*** Procedural Nurse Manager.

Outpatient services include outpatient infusion within three infusion rooms, cardiac diagnostic outpatient services (CDOC) and several catheterization lab outpatient rooms.

The method and rationale for maintaining or improving performance includes:

- Daily record reviews in order to provide real-time feedback to staff.
- Coaching in order to provide "just-in-time" written feedback to staff, emphasizing the importance of quality care to staff members.
- Identifying process issues in order to ensure performance variances are not related to processes.
- Reporting to Care Accountability Team/Friends of Radner during a weekly meeting in order to ensure leadership accountability for performance.

The following performance improvement initiatives have been maintained at 100 percent:

- Congestive heart failure patient education
- Pneumonia screening/vaccination
- Surgical site infection patient education
- Methicillin-resistant Staphylococcus aureus (MRSA) screening
- Ventilator-associated events process measures
- Anticoagulation (Heparin/Coumadin) patient education
- Scanning of patient armband
- Influenza screening/vaccination

Critical Care Services initiatives in which performance improvement strategies are ongoing include the following:

- MRSA swab at discharge (98 percent).
- Scanning of medications (96 percent) in the ICU. A drilldown of the process discovered the staff was scanning one medication multiple times, when the same medication required more than one single packet of the same medication. This led to a decrease in the medication scanning rates. Staff has been re-educated with the expectation that each medication must be scanned.
- Patient Flow: Emergency Department admissions to Critical/Progressive Care units.

A Critical Care Practice Council (CCPC) has been implemented with the following objectives: improve patient care; engage staff in improving patient care and experience; effectively collaborate with other unit staff; and identify practice issues with development, implementation and evaluation of timely resolutions to identified issues.

One important CCPC initiative is bedside shift report patient education. An educational brochure was developed to inform the patient and his or her family of the importance of this process that keeps the patient and family up to date on the patient's condition and plan of care.

Another important CCPC initiative is shift huddles at 07:00 (7 a.m.) and 19:00 (7 p.m.). All staff members are required to be present. The huddles are led by the charge nurse and suggested key points include presence of combative patients, patients who have experienced a fall, restraint use, unstable patients, scheduled surgical or other procedures, census and admit capacity, equipment issues and notification/discussion of any upcoming changes.

A final important improvement project on the Fifth-Tower/OCU is the "It Starts with Me" campaign. The RN staff members developed the acronym ASSESS to ensure accurate skin assessment for all patients:

Assess the patient
Screen the body for
Skin abnormalities
Evaluate within 24 hours
Second RN
Signature required

The process requires a double RN signature verifying the accurate skin assessment for all newly admitted patients as well as a special armband noting a skin integrity issue.

Performance improvement initiatives for 2016 include:

- Complete restraint documentation per policy and requirements
- Improvement in the patient experience/HCAHPS scores including "quiet at night, responsiveness of staff and pain management"
- Stroke initiative for the Fifth-Floor Tower
- Licensing for Outpatient Infusion/CDOC

Future plans for the Critical Care Services include a remodeling of the Heart Center that began in May 2016 followed by the ICU/CCU remodeling that is now underway.

The RN staff members developed the acronym **ASSESS** to ensure accurate skin assessment for all patients:

Assess The Patient

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Skin Abnormalities

Evaluate Within 24 Hours

Second RN

Signature Required

NURSING ACCOMPLISHMENTS: WOMEN'S AND CHILDREN'S SERVICES

Pat Valenzano, BSN, RN, Director of Women's and Children's Services with ***Pete Delgado,*** President/CEO, presenting the 2016 BETA Award to the Board of Directors. Under Pat's leadership, SVMHS has earned seven BETA awards.

Perinatal Services

2015 Perinatal Services performance improvement initiatives included:

BETA Healthcare Group's Quest for Zero-GNOSIS™ Online Assessment

These are personal performance modules on fetal monitoring completed by obstetrician (OB) providers and registered nurses (RNs) working in Labor and Delivery. The purpose is to maintain the use of standardized fetal monitoring terminology in documentation.

BETA Healthcare Group's Quest for Zero - Culture of Safety Assessment

To enhance teamwork and communication, RNs and OB providers took the Safety Attitudes Questionnaire, which resulted in the following scores:

- Teamwork climate (Score < 25th percentile)
- Safety climate (Score < 25th percentile)
- Job satisfaction (Score < 25th percentile)
- Stress recognition (Score 50th–75th percentile)
- Working conditions (Score 25th–50th percentile)
- Perceptions of Leadership (Score < 25th percentile)

Debriefings were held with all labor and delivery staff to review scores and brainstorm ways to improve perceptions and attitudes.

Staff Simulation Drills

Staff simulation drills included ruptured uterus/ emergency C-sections, fire in the operating room and malignant hyperthermia. We had 100% participation in these drills by obstetrician (OB) providers, registered nurses (RNs), OB techs and OB anesthesiologists working in labor and delivery. Quarterly fire drills in the OR were led by senior nurse III from the Labor and Delivery unit.

Opening of the OB Emergency Department

The OB Emergency Department went live on Dec. 8, 2015. Since then, there was an average of 250 visits per month with an average length of stay less than 2.3 hours and an average admission rate of 30%. Prior to the OB Emergency Department coming online, we averaged five RN deliveries a month. With the opening of the OB Emergency Department, that amount has decreased to two a month and our goal is zero.

In 2015 we had three “life altering” events positively managed by the OB hospitalist:

- Abruption who presented to OB ED
- Shoulder dystocia – assisted a community OB provider
- Category III fetal heart rate – started the emergent C/S

Perinatal Core Measures

We undertook two key core measures that are also California Maternal Quality Care Collaborative (CMQCC) Initiatives.

- **Reduce early elective deliveries**: We incorporated ACOG-recommended guidelines for elective deliveries greater than 39 weeks gestational age, making Estimated Date of Confinement and Gestational Age required fields in the community-wide scheduling screens. Medical indicators were available to select if gestational age was less than 39 weeks. If these indicators were not documented for schedulers, the director or clinical manager had to review and approve. Our target was 3% or less for early elective deliveries.
- **Decrease C-sections**: We targeted to deliver fewer than 23.9% by C-section for nulliparous, vertex presentation.

Beta Healthcare Awards from 2010 to 2016 earned by Perinatal Services.

(Continued from page 30)

Antenatal Steroid Core Measure

As recommendations for administration of antenatal steroids changed, the perinatology committee worked to communicate those changes to our OB providers. Previous protocol was to administer two doses of antenatal steroids 24 hours apart to patients less than 34 weeks gestational age expected to deliver within a few weeks. New recommendation was announced to include patients between 34 and 36.6 weeks gestational age when labor is confirmed.

Prevention of Surgical Site Infection

We undertook two specific initiatives to prevent surgical site infections:

- **CHG prep cloths:** All C-section pre-op patients received CHG prep cloths and instruction for use. CHG prep cloths were used on the day of C-section as well. We placed a timer in the labor and delivery OR to ensure proper dry time for surgical prep.
- **Surgical dressings assessment:** The infection control manager made an assessment of surgical dressings, which included feedback from OB providers, and products that had caused skin irritations or blisters were eliminated.

Neonatal Intensive Care Unit (NICU)

To optimize care for neonates, NICU performance improvement initiatives in 2015 included:

24/7 Coverage for Intubation

Our goal was to have qualified staff able to intubate 24/7 and to use our simulation lab to train NICU RNs and RCPs in this skill. We repeat simulation lab every 12 months for staff who have not performed an intubation. Staff qualified to intubate has risen:

RN/RCP Intubators

2010	2011	2012	2013	2014	2015
13	15	17	17	17	18

Pre-medication for Intubation

Endotracheal intubation is a common procedure in newborn care. Premedication for intubation of the newborn improves intubating conditions, decreases the time and number of attempts needed to complete intubation and minimizes the potential for intubation-related airway trauma. We had 100% pre-medication of non-emergent endotracheal intubation in 2015.

NICU Central Line-Associated Bloodstream Infection (CLABSI) Collaborative

Our ongoing partnership with the CA CLABSI Collaborative aimed specifically at NICU patients was undertaken to eliminate occurrence of CLABSI events through education of NICU RNs and neonatologists. We also reviewed the process for dressing changes and revised our protocol to use a sterile technique when changing dressings and only changing dressings when necessary.

Critical Congenital Heart Disease Screens

In compliance with CA State Law (AB 1731) to provide critical congenital heart disease (CCHD) screening to all newborns, we began those screenings in May 2013. Comparative data includes:

	2014	2015
Live births	1,825	1,820
Newborns screened	1,810 / 99.2%	1,797 / 98.7%
Of those not screened	15 infants did not meet criteria for screening	23 infants were not screened – parents wishes/echo/ transferred/expired
Number of positive screenings	2	3
Outcomes from positive screenings	1 referred and no abnormal findings 1 transferred to LPCH on day 2 of life and underwent cardiac surgery with good outcome	3 referred and no abnormal findings

Healing Environment – Developmental Care

Improved neurodevelopment outcomes and minimized skin problems resulted from applying developmental care principles in our management and care of the NICU patient population. Those principles included the use of positioning devices and minimization of light and noise.

Julie Johnson, BSN, RN, Manager/Mother Baby and ***Ann Briley, RN,*** reviewing critical congenital heart disease testing equipment

(Continued from page 32)

NICU Transport Services

In 2015, our mobile intensive care ground transport service included 15 RCPs/ RNs and three neonatologists. When we initiated this service in 2012, we had a target of eight transports a year.

	2012	2013	2014	2015
# acute transports	4	5	3	1
# non-acute transports	9	9	13	6
# of transports declined	1	1	2	1
Total transports	**13**	**14**	**16**	**7**

Newborn Naming Practice Revision

The Joint Commission alerted hospitals that the practice of naming newborns by sex and with the last name of the mother (i.e., Baby Boy Lopez) is not distinct enough and might result in multiple newborns with similar identifiers. We made two changes to the naming procedure:

- **Upon admission:** At admission, we use "TBB" (to-be-born) with last name of mother and last four numbers of the mother's account.
- **At delivery:** At delivery, we use "Baby Boy" or "Baby Girl" with the first four letters of the birth mother's first name and full last name (i.e., Baby Boy Mari Lopez).

Pediatrics Department

In 2015 we initiated the following quality improvement actions in the Pediatrics Department:

Pediatrics Medication Safety

In collaboration with the Pharmacy and Pediatrics departments, we continued to use the pediatric emergency medication calculator. This allows the admitting RN to enter a pediatric patient's weight in Kg and print out a list of all emergency medications with the patient's dose already calculated based on the patient's weight. We also continued to perform "double checks" with two RNs prior to administration of any medication for all pediatric age patients. With this protocol in place, we experienced only one error in 2015 related to weight-based medication. In this case, two doses were given and then the double check caught the error and pharmacy corrected the medication dose. No harm occurred.

Pediatrics Bed Flow

We targeted improving timeliness of Emergency Department admissions and Pediatric Department discharges. In 2015 we accepted pediatric patients from the Emergency Department within 75 minutes of the bed being assigned. We discharged pediatric patients in less than 2.5 hours from the time of the physician's discharge order.

Lindsey Macbeth-Hymes with Pediatric patient.

NURSING ACCOMPLISHMENTS: MEDICAL SURGICAL DEPARTMENT

Several important performance improvement initiatives were undertaken.

Fall Management

In Fall of 2015, the Fall Risk Program transitioned to include three levels of Fall Risk: Low, Moderate and High Risk to Fall. Each fall risk includes interventions that when implemented reduce the potential for patients to fall. Based on Fall data showing that the majority of patients were falling due to toileting-related activities, the Fall team recommended implementing every two hour toileting rounds. After successful trial on the Ortho Neuro Spine Unit, toileting rounds were implemented house-wide.

The Joint Commission Certified Hip and Knee Programs

Performance measures for the hip and knee replacement patient population include:

Preoperative class attendance rate

Out-of-bed activity on the day of surgery

Patient satisfaction with pain management

Surgical site infection rate

The following is data related to the above measures:

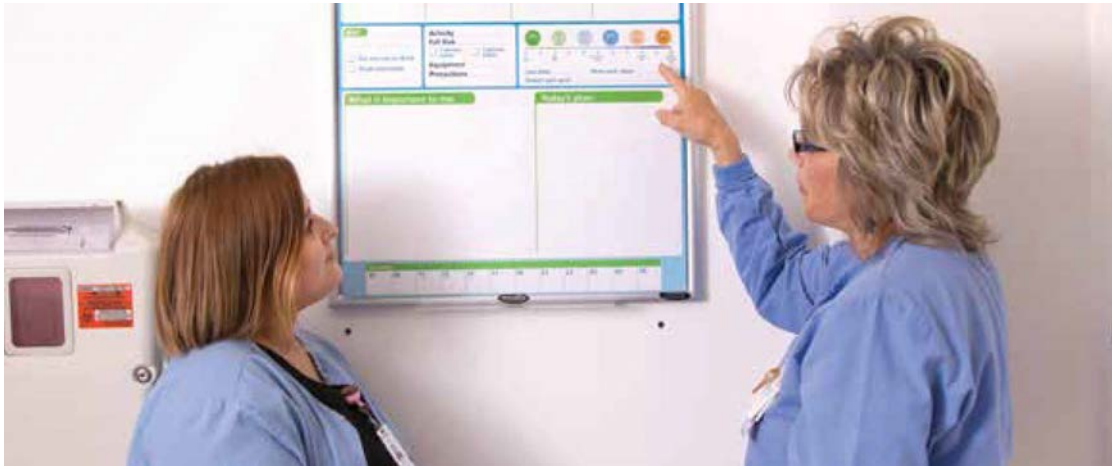
- **Preoperative Class Attendance**
  2015 performance for the hip and knee replacement population was 95 percent. Although the target of 90 percent was met, it is in the best interest of each patient to attend, and the orthopedic nurse navigator makes every attempt to have all patients attend.
- **Out-of-Bed Activity on the Day of Surgery**
  2015 performance for the hip replacement population was 100 percent and 97 percent for the knee replacement population. Since some of the patients require cardiac monitoring postoperatively, the evening charge nurse from ONS will contact the charge nurse in the monitored areas regarding the mobility protocol of the patient out of bed on the day of surgery unless there are contraindications. Staff members have been trained regarding the mobility protocol.
- **Pain Management ONS**
  Patients are asked, "How well was your pain controlled while you were in the hospital?" Possible responses are "never," "sometimes," "usually" and "always." Performance for 2015 indicated 97 percent performance ("always") for the hip replacement population and 88 percent performance ("always") for the knee population. To provide pain management that consistently meets patient expectations, the Joint Replacement Center Team, in collaboration with the surgeons, is standardizing pain management to a multimodal approach to include: scheduled pain medications; nerve blocks; non-steroidal anti-inflammatory drugs; narcotics for breakthrough pain; and patient education related to pain expectations following major surgery. Case studies were utilized to educate staff on pain management. Additionally, an orthopedic surgeon on the Joint Replacement Center Team provided staff education regarding pain management for the opiate-naïve and opiate-tolerant patient.
- **Surgical Site Infection Rate**
  There were five joint surgical site infections during 2015. To prevent infections, patients are instructed to use freshly laundered linens and clean pajamas prior to surgery; shower preoperatively with a Hibiclens® soap/scrub three times; not shave the surgical site; not have pets sleep in their bed until the incision has healed for two to four weeks; take three doses of intraoperative antibiotic therapy within a 24-hour period; protect the incision

postoperatively with a sterile dressing for 24 to 48 hours; and have themselves and their family note signs and symptoms of infection.

Improving the Patient Experience

The Medical Surgical Department is focused on improving patient experience related to the hospital environment, pain management and communication about medications. Actions taken are as follows:

- Development and implementation of a Charge Nurse Rounding Tool. The tool assesses the patient's satisfaction with his or her pain management by asking, "Have we done everything to help manage your pain? Do you need pain medication at this time?" The tool also assesses the effectiveness of patient education by asking, "Do you have any questions about your plan of care? Have you started any new medications? Do you have any questions about the side effects of the medications?" Also, quietness of the environment is assessed to determine if the patient would like a "quiet at night" kit and/or have his or her door closed at night.



Charvelle Noble, RN, Unit Shift Supervisor/MedSurg and ***Diane Mesiroff, BSN, RN, OCN, AHN***/Oncology reviewing the new whiteboard design. The design team also included ***Shena Rivera, RN***/Telemetry, ***Anna Linn, BSN, RN***/OCU, ***Agnes Lalata***, Director/MedSurg, ***Glaiza Farnal, BSN, RN, PHN***/Ortho-Neuro-Spine and ***Janet Marcroft***/Marketing & Public Relations.

Whiteboard Redesign

A taskforce was developed and patients and staff were surveyed regarding important information to be included on the board. A new design was trialed and finalized. The new redesigned whiteboards will be implemented in our inpatient care areas.

MedSurg Practice Council

The MedSurg Practice Council has worked on the following improvement initiatives and all projects in process:

- Standardizing Par Excellence (Supplies)
- Vital Signs (Post-op and Routine)
- Operating Room Handover (Creating)
- Relaunch of Bedside Shift Report

MedSurg 2016-17 Performance Improvement Initiatives include:

- Ongoing work to improve the Fall Program
- Continuing efforts to improve patient experience
- Ensuring appropriate patient activity to prevent problems related to mobility impairment
- Improving patient flow between the Emergency Department and inpatient unit, and the time from an inpatient discharge order to the actual discharge from the hospital (target is 2.5 hours and actual is 3.29 hours)
- Post-DC calls to oncology patients

NURSING ACCOMPLISHMENTS: SURGICAL SERVICES

Surgical Services initiatives for 2015 included:

Immediate-Use Steam Sterilization (IUSS)

IUSS is used for items that move directly from the sterilizer to the sterile field and are not intended for storage. Use of this process is reviewed to identify items for which IUSS criteria were not met, items for which inventory should be expanded and items that should be sterilized by other means. As of October 2015, the occurrences of IUSS ranged from zero to five monthly, and the criteria for IUSS were met each time. Sterilization of the external fixator was closely reviewed. The device is sterilized after removal from the patient to eliminate it as a means of conveying pathogens in case it must be reapplied for fracture stabilization.

Universal Protocol

Performance related to universal protocol is measured through time out, side marking and patient identification. Performance related to universal protocol is tracked demonstrating a concurrent/real-time survey of team participation at 100 percent performance.

Medication Safety

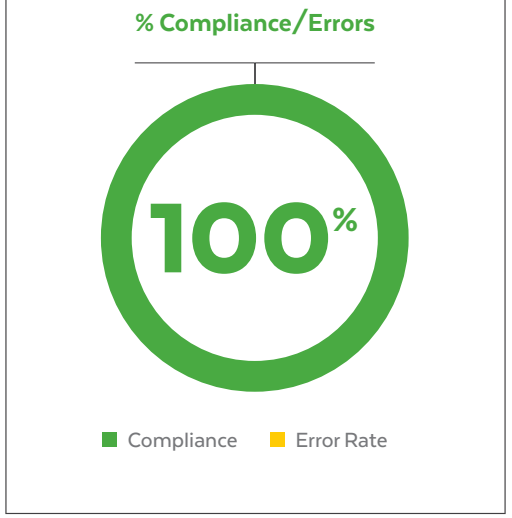
Performance for the calendar year to date has been 100 percent based on the following criteria:

- Timing of labeling
- Quality/completion of labeling
- Observation of the circulator's role as medications, agents and solutions are delivered to the sterile field
- Re-identification of medications at the time of staff relief
- Retention of original containers
- Use in PACU of the evidence-based Pasero Opioid Sedation Scale to more effectively guide pain management in post-op patients

Pediatric Patients

- Use of iPads obtained through the Children's Miracle Network began in OPS and PACU to provide distraction for pediatric patients.

CONCURRENT/REAL TIME SURVEY OF TEAM PARTICIPATION



Frances Bullman (left), ***MSN, RN,*** and ***Abby Acosta*** (center), ***BSN, RN, CPAN, CAPA,*** leaders of the Perioperative Clinical Practice Council, collaborating with ***Clement Miller*** (right), ***MSN, RN, NEA-BC,*** Director of Perioperative Services and Clinical Improvement.

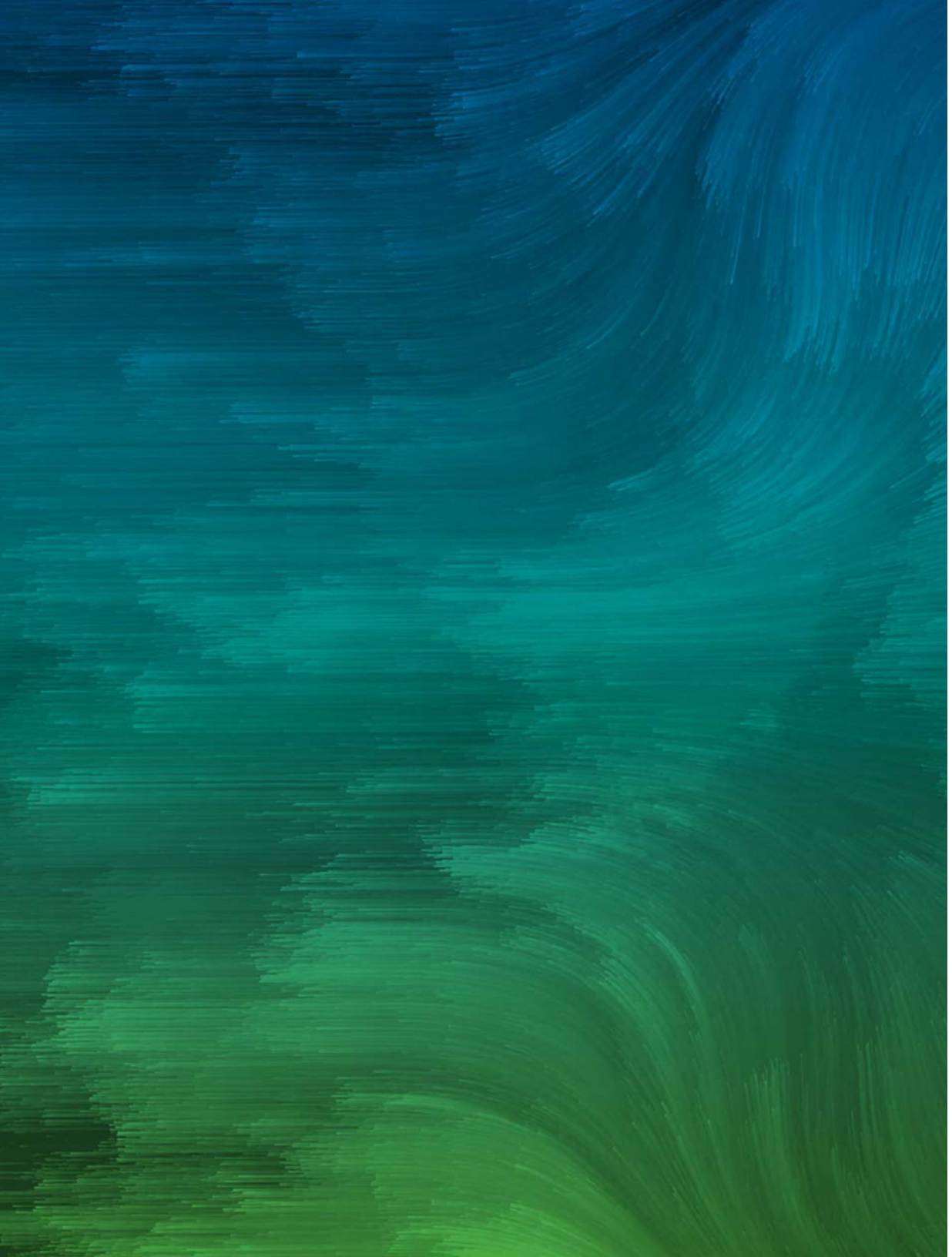
LOOKING FORWARD

Christie Gonder

Shared governance is a leadership model that aims to shift decision-making authority over professional nursing practice to clinical nurses accountable for outcomes at the point-of-care. It centers on the autonomy of nursing practice and the accountability of the nurse in his or her professional role.

Looking forward to next year, the nursing division will be developing a nursing strategic plan to align with corporate goals while promoting Magnet® standards. The focus will be on the development of a Professional Practice Model, building and strengthening our shared governance structure and continued work on building infrastructure to make nurse-sensitive quality outcomes and patient satisfaction data available to nursing and other staff in clinically meaningful ways.

We began our new year with a two-day shared governance design and planning process in which a group of 45-50 clinical nurses, nurse leaders, quality initiative leaders, educators and stakeholders from our quality, safety and human resources departments convened to learn about shared governance and begin developing the council structure. This group has worked to define and delineate accountabilities and responsibilities of the unit-based, central and coordinating councils; define decision-making and communication processes; and to define how the nursing shared governance structure should align with other organizational councils, committees and initiatives. Once the work of this group has been finalized, house-wide education about the shared governance structure will be planned as will continued work to align the organizational and nursing services strategic plans with shared governance principles and practice.



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