

nurses leading

STANFORD HOSPITAL & CLINICS NURSING ANNUAL REPORT

2011



STANFORD
HOSPITAL & CLINICS

Stanford University Medical Center

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**NURSES ARE THE HEART OF
HEALTHCARE.**

-DONNA WILK CARDILLO

welcome

FROM THE PRESIDENT & CEO

At Stanford Hospital & Clinics I've been so moved to see how our nurses heal through science and compassion, one patient at a time.

Stanford nurses indeed believe that the next patient who walks through our doors—whether a friend, neighbor, family member, or new acquaintance—deserves the absolute best in patient care. Our nurses share with me that this not only involves incorporating the best in science into our care, but also sharing what's best in humanity—personal concern, consideration, and compassion.

Whether our care involves emergency care, surgery, intensive care, medical and surgical recovery, care coordination, cancer treatment, or outpatient services, I see this broader commitment to humanity every day in our nursing team. Moreover, I see our Stanford nursing team continuously strive for greater heights by discovering new clinical approaches, pursuing quality improvements, and establishing C-I-CARE relationships (Connect, Introduce, Communicate, Ask, Respond, and Exit).

Each and every member of our nursing team makes *the* difference to someone every day. On behalf of our patients, Stanford, and society, thank you for your incredible commitment to care!

Amir Dan Rubin
President and Chief Executive Officer
Stanford Hospital & Clinics

FROM THE CHIEF OF STAFF

In the 12 years I have been at Stanford, I have never ceased to be impressed with the quality of the nursing care here.

Our nurses are truly the best on the planet. The achievement of Magnet™ status is additional validation that nursing care at Stanford is outstanding day after day, year after year. Nursing is hard work, both physically and emotionally, and your amazing compassion and dedication are second to none. I am proud to say that I started my career as a nurse, and that taught me more than a lot of physicians will ever know about the importance of the work you do. On behalf of all physicians at Stanford, thank you for taking such good care of our patients, and thank you for taking such good care of all of us. Together we are a great and unbeatable team.

Ann Weinacker, MD
Associate Professor of Medicine
Pulmonary and Critical Care
Chief of Staff
Stanford Hospital & Clinics

When one of our nurses realized that the residents did not know what she and her coworkers did in her unit, she decided to take action.

She checked the literature, found a mentor, and developed the tools to demonstrate just how nurses contribute to the efficiency and success of the hospital. Residents were matched with nurses to follow their daily routines, and her efforts have been incorporated into the Stanford medical school curriculum to teach students about the role of nurses in patient care. (You can read more about this project on page 9.)

This is a stunning example of how nurses can—and do—make an impact. Nurses here are beyond compare, with a readiness to learn and to implement change. When I walk through the clinics or stop by different units during my regular rounds, it is easy to find nurses demonstrating exceptional dedication and service. Providing the highest level of care is the norm at Stanford Hospital & Clinics (SHC), and our nurses demonstrate the ability, expertise, insight, and skill to exceed these standards. In terms of patient outcomes, the power of nurse involvement cannot be overstated.

Roles are changing. Today's nurses act in partnership with physicians and are taking on more responsibility for protocols and standardized procedures. Nurses serve on medical staff committees and are fully involved in hospital-wide reviews of practices and policies. It is an evolution that makes perfect sense: They are proven experts in clinical care, medical science, facilitation, education, and advocacy.

I am proud of the incredible way Stanford nurses consistently meet the challenges of such a demanding yet rewarding profession. Our goal at SHC is to empower nurses to meet the highest standards of compassion and professionalism.

An environment of accountability is possible only if there are the tools to prepare for change. We are revitalizing our professional development resources to provide more opportunities in training, improving skill sets, and personal growth. We are cultivating a culture that fosters innovation and promotes a deep sense of responsibility and ownership.

Our Magnet designation is clear recognition of who we are and what we are doing right. Thank you to all the nurses who understand the art and science of caring and who make Stanford Hospital & Clinics such an exceptional place to work, learn, and make a difference.

Nancy J. Lee, MSN, RN, NEA-BC
Chief Nursing Officer
Vice President of Patient Care Services



Nancy J. Lee, MSN, RN,
NEA-BC



Amir Dan Rubin



Ann Weinacker, MD



inspire

Connecting the Dots

Nowhere are nurses required to maintain as many competencies each year as in the intensive care unit setting.

On E2, the medical/surgical ICU, there are over 180 nurses with 17 annual and biannual mandatory competencies. To track this complex array of requirements, a three-person team was created to devise a solution. The team included Agnes Monteclaro, BSN, RN, CCRN, staff nurse on E2; JoAnn Schumaker-Watt, BSN, RN, CCRN, unit educator of E2; and Teri Vidal, BSN, RN, CCRN, unit educator of E2. Together they conceived and created the “Dot Board: An Accountability Chart for Mandatory Competencies and Requirements.”

A 3 feet by 5½ feet laminated board, the dot board is displayed in the corridor where it is visible to staff but not to visitors and functions as an annual report card. Staff names are listed vertically while competencies/requirements are listed horizontally across the top of the poster. Each competency is a different color. When a nurse completes a competency, a color-coded sticky dot is placed in the appropriate column corresponding to his or her name. A colored star indicates when a nurse has completed all 17 competencies/requirements.

Under the previous system, it was difficult for nurses to track their progress since the information was filed in multiple binders in the manager’s office, placing the primary documentation responsibility with the unit managers and educators. The dot board increases staff participation and accountability in completing competencies and clinical requirements, allowing nurses to readily identify their individual progress.

Since initiation in January 2008, nurses are in healthy competition to earn dots to fill in the “report card.” The poster has also generated questions about available classes and/or conferences to earn mandatory stroke and trauma hours. There has been continued improvement in completed competencies.

One nurse commented, “I look at the dot board frequently to make sure I’m up to date on all my competencies. It is a great tool to communicate when competencies are due, and it also holds staff accountable for their own unit competencies. I love the star when I get all my dots.”

The dot board has proven to be such a success that the project was accepted as a poster session for the American Association of Critical Care Nurses Conference in Washington, DC in May 2010.

98%
of the 90 E2/ICU nurses surveyed responded positively to the dot board

DOT BOARD COMPETENCIES:

- Trauma Hours
- Stroke Hours
- CRRT Recertification
- I-Stat Recertification
- ACLS/BLS Recertification
- Epidural Recertification
- Ng5 Fit Test Mask
- Restraint Competency
- Medication Administration Competency
- HealthStream Completion
- CCO/SvO2
- Train of Four
- Medtronic Pacer Box
- Zoll Defibrillator/ External Pacer
- Level One Rapid Infuser
- Camino ICP Monitor
- External Ventricular Drain

Magnet Journey

Every four years a Magnet organization must reapply for Magnet status and host a site visit with Magnet appraisers to maintain the prestigious Magnet designation. From June 20 to 23, Stanford had its first redesignation site visit with four Magnet appraisers. The site visit was rigorous and involved visits to almost 50 units and departments where nurses work, interacting with hundreds of staff.

Additionally, the appraisers conducted 15 sessions attended by over 270 staff, physicians, hospital and nursing leaders, various committees, non-clinical services departments, and members of our community including patients, families, and nursing school deans. There were multiple breakfast and lunch meetings with over 130 staff nurses, as well as numerous formal presentations given by staff nurses on topics such as shared governance, the Professional Practice Model, nursing research, quality and patient safety, nursing innovations, and patient and staff satisfaction.

The visit was extensive and comprehensive in depth and breadth, involving every department. The efforts were overseen by the Magnet Redesignation Team, which included nurse leaders from all over the organization. Members of this team were responsible for compiling the 750 pages of narrative and gathering the 600+ exhibits that were submitted in February 2011. The documents were scored by the four Magnet appraisers as “excellent,” which was the impetus for the site visit. The purpose of the visit was to clarify, amplify, and verify the information in the documents.

At the heart of the Magnet journey are the direct care nurses who passionately and expertly care for patients and families every single day. These nurses ensure the best possible outcomes are achieved, using an amazing mix of knowledge, expertise, experience, and compassion. A select group of 40 staff nurses, Magnet Champions, were instrumental in preparing their colleagues for the site visit. From this group of Champions, ten staff nurses stepped forward to escort the Magnet appraisers for the four-day visit. Elvie Wohlers, RN, North ICU, commented, “It was an honor to be a Magnet Escort during the site visit. I saw the passion that Stanford nurses have everywhere I went in the hospital. It made me proud to be a nurse and it ‘defined’ why I still enjoy nursing after 35 years.”

The Magnet appraisers said the site visit logistics were “flawless,” which is a tribute to the coordination and cooperation of all departments, at all levels. Above all, Stanford nurses truly shined during the visit. The appraisers commented on the apparent level of compassion and commitment witnessed when interacting with direct care nurses everywhere. Stanford nurses are on a continuous journey to improve care and service for patients as well as improve the Stanford work environment for nurses and all employees. It demonstrates that Stanford nurses continue to be in the forefront, leading the nursing profession and improving health care delivery. They exhibit an incredible ability, power, and wisdom that helps them explore, always looking for greater challenges and new innovations that will continue to improve the patient experience. Stanford nurses overcome obstacles to give the right care, every single day, one patient at a time.



Magnet Escorts (and others) from left to right: Tia Kadiu, C2; Salem Paschal, G2/D2; Marieke Trevor, E2; Dawn Hasegawa, ED; Nancy Lee, CNO; Stephanie David, E3; Kathleen Hickman, Magnet Program Director; Christina Wing, D3; Leitha Sangermano, Practice Coordinator; Katie Stephens, B3/C3; Farrah Kashfipour, E1; Michelle Sours, OCS; Vickey Weir, Education Specialist (Elvie Wohlers, North ICU – not pictured)



empower

Cultivating Collaboration

An incident with a difficult physician, a fellow at the time, convinced Monica Cfarku, BSN, RN, that physicians might not understand the role, responsibilities, and scope of practice of the professional nurse.

When physicians had a better understanding of a nurse's role, the respect and communication greatly improved between the two disciplines.

Cfarku, a staff nurse on E1, the blood and marrow transplant unit, decided to survey 25 physicians, and what she found was that very few had a true understanding of the myriad roles nurses play. A literature review revealed similar situations in other organizations and underscored the need for interprofessional education between nurses and physicians.

Cfarku met with Clarence Braddock, PhD, MD, associate dean for medical education, who was immediately interested in implementing interprofessional education into the medical school curriculum. The outcome was the creation of an interdisciplinary performance crew consisting of seven professionals from various disciplines who would simulate a patient discharge scenario for first- and second-year medical students. After the simulation, a question and answer session assesses students' perceptions of communication and responsibilities among the professions. The overall goals of the class are to teach students there is no hierarchy during medical team communication and to demonstrate that each discipline brings a unique perspective and expertise that together provide best patient outcomes. To augment the interprofessional class, second-year medical students also have the opportunity to shadow a professional from one of the disciplines for several hours. The observation time allows for enhanced understanding of the power of collaboration between members of the multidisciplinary clinical team.

Cfarku continues to gather data on medical students' level of learning before and after nurse shadowing. She remains focused on her goal of eliminating and addressing misconceptions or biases about the nursing role before medical students become physicians so that every member of the team understands that communication, along with respect among clinical disciplines, is the key to success in improving patient outcomes.

Steps to Better Care

90.3%

said “nurses took time to listen,” a 1.9% increase

84.1%

said “nurses kept me informed regarding treatment,” a 4.4% increase

Overcrowded emergency departments are neither new nor unique to Stanford Hospital & Clinics. Yet one of the causes of overcrowding in Stanford’s Emergency Department (ED) is that it has become a holding area for patients who need to be admitted to an inpatient service.

To help alleviate overcrowding in Stanford’s ED, an interdisciplinary team was convened in 2006 to identify ways to provide safe patient care and reduce the number of observation patients admitted to inpatient beds. Standards of care and best practices were gathered from the Emergency Nurses Association (ENA) and the American College of Emergency Physicians to create the Clinical Decision Unit (CDU), which opened in April 2007. The purpose of the CDU is to continue the ED work-up, including the differentiation process to rule out or rule in disease, and to continuously evaluate whether interventions to resolve the underlying pathology are effective.

Despite this effort, patient satisfaction with communication among staff had not improved. In November 2009, a communication summit was held to improve communication in the CDU. The summit was designed to help staff understand the impact of poor communication on patients and families, to illustrate and elevate the problem of poor communication to leadership, and to create action plans for process improvement. The CDU leadership team adapted principles from ENA, the American Association of Critical Care Nurses, and the Agency for Healthcare Research and Quality program TeamSTEPPS® to foster improvements in communication and teamwork skills. TeamSTEPPS is an evidence-based system that uses three phases to advance patient safety through improved communication and teamwork. Two processes of the CDU were identified as specific areas for development: communication among interdisciplinary team members and communication of the plan of care with patients and families.

The interdisciplinary team in the CDU includes ED nurses, ED technicians, nurse practitioners/physician assistants (NP/PA), and an ED attending physician. At least three times a day, the ED nurses, ED technicians, and the NP/PA conduct “board rounds,” where staff gather around the patient tracking board, discuss each patient’s progress, and review the plan of care for each patient. The process of interdisciplinary rounds is facilitated by the physical layout of the nurses’ station where all team members sit in an open area and can easily communicate and contribute information about care issues. The plan of care is written and revised on a dry-erase patient tracking board with the names of patients hidden behind a door. Any changes are communicated to the entire team and are tracked on the dry-erase board and in the electronic medical record.

During the admission process, the interdisciplinary team members introduce themselves to the patient and family, perform their admission assessments, and discuss the initial plan of care while sitting down when possible. The patient and family are invited to ask questions and participate in the plan of care. The final plan of care is agreed upon by the care team with the patient and family. In every patient room, the names of the primary nurse, ED technician, NP/PA, and the plan of care are written on a dry-erase board.

Anecdotal reports from patients and families reveal that this form of communication has significantly improved patient satisfaction, and as the tables below indicate, the strategies implemented as a result of the communication summit have led to an overall improvement and increase in patient satisfaction scores.

	Q3 2010	Q4 2010	Q1 2011	Q2 2011
Nurses took time to listen	88.4	88.1	88.0	90.3
Nurses kept you informed regarding treatment	79.7	81.0	81.9	84.1

Quenching a Thirst for Lifelong Learning

2011 HIGHLIGHTS

4,000+
nurses attended classes
at the CEPD

30%
of class attendees are
non-Stanford nurses
from the community

10
certification review
classes offered in
various specialties

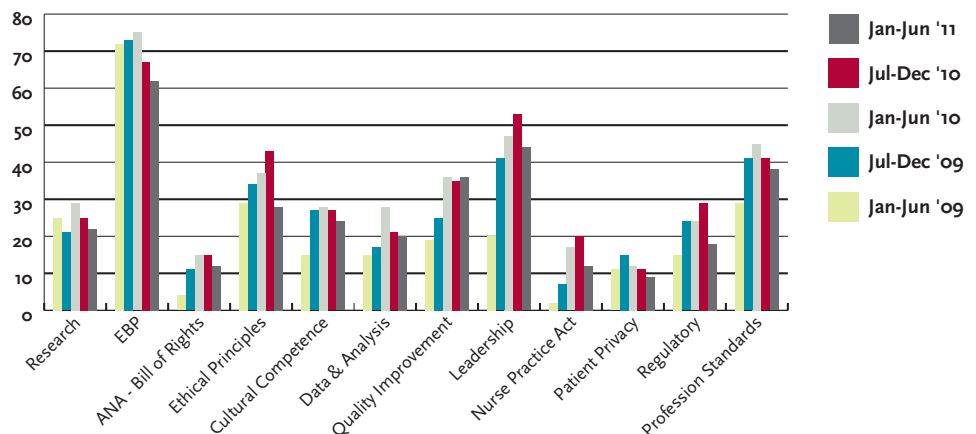
325
nurses completed CEPD
custom developed home
studies

One of the few nursing continuing education centers in the San Francisco Bay Area, Stanford Hospital & Clinics' Center for Education and Professional Development (CEPD) offers a variety of clinical specialty, leadership, and professional development classes, supporting the educational needs of nurses at Stanford and in the community.

With onsite classrooms and faculty, students have the opportunity for face-to-face communication with speakers and colleagues in formal and informal group settings.

The sharing of new knowledge and innovation is a high priority at SHC. The speakers, experts in their specialty from Stanford and throughout the country, incorporate evidence-based practices and research in their presentations. Suzanne Taylor, MSN, RN, manager of CEPD, ensures the classes are in alignment with SHC's organizational mission, values, and strategic plan. The development of the Content Tracking Forms to incorporate the Magnet recommended topics in CE classes has proved to be a best practice. Data collected and summarized each year has shown an increase in the number of Magnet topics included in class presentations. The CEPD at Stanford is unique and provides an environment in which lifelong learning is fostered and embraced.

MAGNET-RECOMMENDED TOPICS OFFERED





The Power of Peer Coaching

“We want to bring out the best we possibly can be as nurses and cultivate our culture of care by strengthening ourselves and each other, providing peace of mind, and stimulating positivity and inspiration that will be evident in the work we do on E3.”

—Jean Marie Villanueva, RN, staff lead for the E3 Care Coaches

“This work keeps us connected to why we became nurses in the first place.”

—Robin Martin, RN, one of the lead service champions for C3 unit

At the heart of nursing care is communication. To inspire a culture of world-class service, over the past two years, teams of dedicated nursing staff volunteers on 10 inpatient units have convened every month to champion best practices in interpersonal communication and service skills.

Known by a variety of names (GEMSS, Service Excellence Champions, Care Coaches, Connecting Hearts Coaches, and Service Ambassadors), the teams are mentored by nurse managers but led by staff nurse chairs and include 12 to 15 volunteer members. In addition to being committee members, each of these staff serve as peer-to-peer coaches and are networked to three other colleagues on their units. Peer coaches also include nursing assistants and unit secretaries.

In the monthly meetings and subsequent coaching interactions, there is a focus on positive reinforcement and supportive peer encouragement. This does not mean that feedback is avoided, but the coaching process incorporates a non-evaluative, reciprocal learning and development approach. Methods such as storytelling and appreciative inquiry are used to build on individual strengths and to set goals to enhance relational, communication, and service skills.

The coaching groups support each other’s individual goals through “commitment cards” and periodic check-ins. The committees also set unit goals for improvement based on Press Ganey results and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data. Each group decides on a monthly educational focus. Special projects have included implementing best practices, such as better use of the white boards, reducing call lights through hourly rounding, transferring trust through bedside reporting, improving MD/RN rounding, enhancing the admission and the discharge process, and conducting post-discharge phone calls. Many of the champions/coaches represented their units by taking part in the recent development of the C-I-CARE “words that work” and video scenarios.

Karen Jazmin, RN, staff chair for the GEMSS Committee, describes how the F3 unit implemented the service excellence peer coaching process:

The committee name, GEMSS, stands for “Going the Extra Mile for Service and Safety.” This committee was established for the purpose of promoting, energizing, and sustaining service excellence efforts with the end goal of improving patient satisfaction. Fourteen staff members lead this committee, and each member is paired with three to four peers in a mentoring-coaching group. With dedication and perseverance from everyone, it is not surprising how much positive change has come to the unit since the GEMSS inception.

The committee members underwent training with Lisa Miller, MS, RN, whose role in coaching has been invaluable. Under the guidance of the F3 management, GEMSS has met monthly. Sharing stories with each other renewed our spirit, inspired us to do better (not only as nurses, but as people) and united us as a nursing team. A creative bulletin board was set up for our “theme of the month” that focused on patient needs and concerns such as transfer of trust, hourly rounding, and noise reduction as part of healing. As part of the mentoring-coaching effort, the members invested time, focused on positivity, and followed through with their subgroups. Staff engagement was inherent and a change in unit culture was apparent. As one patient wrote in a letter to the hospital administration... “It was amazing to watch each team as the shift changed. Everyone was consistent, systematic, and thorough. The team approach in F3 was amazing to watch from a patient’s perspective and I marvel at the close feelings that everyone seem to have toward each other.”

With the groundwork paved by GEMSS, the hospital-wide introduction of C-I-CARE comes as no surprise to F3 staff. This only further strengthens the effective interaction each staff has with patients, family members, and each other. Communicating effectively by utilizing the C-I-CARE spirit continues to foster a caring and knowledgeable environment on our unit.

Some of the most inspiring stories are shared by the GEMSS members or patients:

Ms. B was a patient in F3 for more than a month. She was healing from a large gaping abdominal wound and had been bedridden for quite some time. Elvie Rambac, RN, was the nurse caring for her on the day she requested a haircut because her son from out of town was coming to visit her for the first time. Despite the multiple nursing tasks at hand (i.e. wound dressing change, replacing electrolytes, etc.) that Elvie had to do with Ms. B, Elvie made every effort to make sure Ms. B would get her much-desired haircut, knowing how important this was to her. Elvie contacted an outside hairstylist, set an appointment for her to come see the patient, and even paid for the service out of her own pocket. There are no words to describe the undeniable gratitude in the patient’s eyes.

Such a personal story has inspired us to be better caregivers, underscoring the fact that science and a caring heart must come together to improve patient experience.

**F3 QUARTERLY
HCAHPS DATA FOR
COMMUNICATION
WITH NURSES**

92nd
percentile compared to
the Press Ganey client
database

98th
percentile compared
to the Consortium of
Teaching Hospitals
database

When You Reach Out and Touch Someone

67%
of patients agreed to be
telephoned

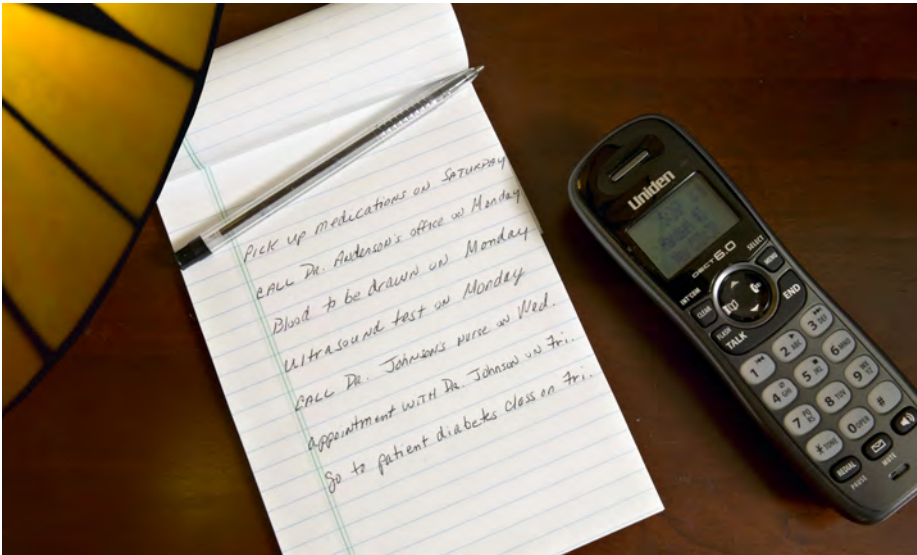
56%
of patients were reached

A pilot program launched in April 2011 on D2/G2S IICU, the Discharge Phone Call Program, was designed to understand how patients experience the discharge process at Stanford Hospital & Clinics and how the staff can work as a team to improve the experience for the patient.

The program's primary intent is to improve communication between patients and staff concerning discharge instructions and follow-up care. The program also benefits nurses by providing a better understanding of the patient experience and allowing them to engage in service recovery, if needed. Lastly, the program provides opportunities for both employee recognition and process improvement.

Through the Discharge Phone Call Program, patients are called within 72 hours of discharge from the hospital. A designated float nurse makes these calls during allotted time periods throughout the day using a script. The script was developed after consultation with Wyoming Medical Center, an early adopter of discharge phone calls, and after interviewing Karen Stuart, RN, assistant nurse manager of the emergency department, about internal practices regarding telephone encounters. The script has since been modified to model the C-I-CARE format: *connect with people, introduce yourself and your role, communicate what you are going to do, ask permission before undertaking an activity, respond to patient's questions, and exit courteously with an explanation of what is to come.*

During the discharge phone call, the nurse discusses discharge instructions and ensures that all patient questions are answered. Service recovery is a significant part of the discharge phone call process; patients are asked about the care they received in the hospital, and if they express dissatisfaction with any aspect of their care, the nurse promptly addresses the issues. The nurse ends the phone call by thanking the patients for allowing SHC to care for them.



71%
of patients reached were
contacted within
72 hours of
post-discharge

97%
of patients contacted
expressed positive
responses

REACHING OUR GOALS

The goals of the pilot project included implementing a standardized process of reaching out to discharged patients within 72 hours post-discharge, as well as contacting all patients who agreed to be called in that time frame. When patients were asked about their experiences of care, 97 percent expressed positive responses and the three percent who had negative responses suggested improvements around personal issues, all of which have been acted upon.

The Discharge Phone Call Program has proven to be beneficial in many ways. The program reduces the calls the unit receives from discharged patients who have questions after they arrive home and alleviates the frustration patients feel when their phone call is transferred from department to department or nurse to nurse. Nurses also find the program rewarding, as discharge calls give them the opportunity to receive direct positive feedback. Due to its success, the program is now being introduced to other departments throughout the hospital and clinic areas.

Honoring Excellence: A Snapshot of Awards from Nurse Week 2011



Daisy Award winners

DAISY AWARDS

The Daisy Award, a national award given annually, honors exceptional nurses who demonstrate a “Caring H-E-A-R-T: Honesty, Excellence in Education or Research, Advocacy, Respect, and Teamwork.” From more than 160 nominations, seven awards were given to nurses from Medical/Surgical, Critical Care, Operating Room, and the Clinics. Daisy Award recipients were Karen Jazmin, F3; Jacque Kixmiller, Cath Angio; Ashley Lauderman, E1; Beverly Salangang, E1; Donna Terry, D1; Angela Vega, ED; and Gary Yip, ED. Recipients were presented framed certificates, the Daisy Award signature lapel pin, and a hand carved stone sculpture of The Healer’s Touch.



Ling Chen, MSN, RN

FRIENDS OF NURSING BETTY CRETEKOS SCHOLARSHIPS

Nurses were also recognized through the Friends of Nursing Betty Cretekos Scholarship. This scholarship encourages nurses to participate in their professional organizations by supporting their ability to attend national meetings. The winners of the Friends of Nursing Betty Cretekos Scholarship were Ling Chen, MSN, RN, Ambulatory Surgery Center, to attend the National Nursing Staff Development Organization’s Meeting, and Helen Alford, RN, G2P/H2, to attend the National Psychiatric Nursing Symposium.

NEW BSN GRADUATES

The first graduating class of nurses receiving their BSN degrees from Holy Names University in Oakland was recognized at the Award Ceremony. The graduates included: (pictured left to right) Nancy Becker, D1, Martha Berrier, Pain Clinic, Michael Bautista, E3, Yanli Jiang, B1, and Lucindia Oswald, D Ground (not pictured).



BSN Graduates

MEDICAL STAFF EDUCATION AWARDS

Ann Weinacker, MD, Chief of Staff, picked the winning ballots to receive the Medical Staff Educational Awards this year. The medical staff honors SHC nurses by providing two education awards of \$500 to support tuition related to a degree program or attendance at a professional conference. The winners were Chen Ting Kuo, G1, for Clinical Leadership and Management at George Washington University School of Medicine and Health Sciences, and Courtney R. Davis, G2/H2, for her MSN, Adult NP, Psychiatric NP, at the University of California, San Francisco.

**ONCOLOGY NURSING CERTIFICATION CORPORATION
NURSE OF THE YEAR AWARD**

Maureen O'Hara, RN, OCN, has been OCN® certified since 1989 and was one of the first nurses at Stanford to become oncology certified. She has spent more than 20 years mentoring other nurses at SHC and in her community to become certified. O'Hara spends extensive time volunteering for the American Cancer Society and the Leukemia and Lymphoma Society. Her strength lies in educating patients and families about their disease, treatment, side effects, and symptom management. She was given this award for her significant contributions to oncology nursing and service. She was presented with the crystal award at the ONS Annual Congress in May 2011.



**Maureen O'Hara, RN,
OCN**

ASSOCIATION FOR VASCULAR ACCESS (AVA) –

SUZANNE LAVERE HERBST AWARD FOR EXCELLENCE IN VASCULAR ACCESS

Nadine Nakazawa, BS, RN, OCN, CRNI, is presently the Presidential Advisor for AVA. Nakazawa has been involved in the vascular access arena for most of her nursing career. She started the Peripherally Inserted Central Catheter (PICC) program at Stanford in 1990. She has participated in the Vascular Access Device Committee since 1983 and chaired that committee for 14 years until 2007. She teaches maintenance care and complication management of central vascular access device courses locally, regionally, nationally, and internationally. Nakazawa also teaches courses on PICC insertion using ultrasound. The focus of this award is on interventions that promote optimal outcomes for individuals requiring vascular access. The award publicly recognizes individuals who have made a substantial contribution to vascular access practice by improving patient outcomes and contributing to the science of vascular access. She was presented this award at the Association for Vascular Access' Annual Scientific Meeting in Maryland in September 2010.



**Nadine Nakazawa, BS,
RN, OCN, CRNI**

**INDUCTION INTO THE AMERICAN CARDIOLOGY COLLEGE (ACC) AS AN
ASSOCIATE OF THE AMERICAN CARDIOLOGY COLLEGE (AACC)**

Eileen P. Pummer, MSN, RN, CCRN, CPHQ, AACC, was inducted as an Associate of the American Cardiology College during their annual convocation ceremony held in New Orleans in April 2011. The ACC's Board of Trustees approved the AACC designation to recognize Cardiac Care Associates who, through advanced education, training, and professional development, have dedicated themselves to providing the highest level of cardiovascular care for their patients. The focus of this award is on recognizing national board certifications and member interest in advanced learning, skill building, and professional recognition.



**Eileen P. Pummer MSN,
RN, CCRN, CPHQ, AACC**

**AMERICAN ASSOCIATION OF CRITICAL CARE NURSES (AACN)
CIRCLE OF EXCELLENCE**

Mary E. Lough, PhD, RN, CNS, CCRN, CNRN, CCNS, was inducted as a member of the AACN "Circle of Excellence" before an assembly of over 7,000 nurses attending the National Teaching Institute in Chicago in May 2011. The Circle of Excellence award recognizes and showcases excellent outcomes by individuals in the care of acutely and critically ill patients.



**Mary E. Lough, PhD,
RN, CNS, CCRN, CNRN,
CCNS**

Certifications and Academic Advances

Acute Care Nurse Practitioner – Board Certified (ACNP-BC)

Susan Cassidy – October 2010, Clinical Neuroscience Center

Lisa Guertin – October 2010, Heart Transplant

Christine Hartley – December 2010, Heart Transplant

Laura Starr – October 2010, Lung Transplant

Advanced Nursing Executive-Board Certified (NEA-BC)

Nancy Lee – February 2011, Administration

Cardiac Surgery Certified (CSC)

Joy Panlilio – June 2011, North Intensive Care Unit

Certified Dialysis Nurse (CDN)

Maria Meimban – May 2011, Dialysis

Certified Nurse Manager and Leader (CNML)

Myra Lang – April 2011, B2

Critical Care Registered Nurse (CCRN)

David Caballero – June 2011, E2

Robin Cleary – June 2011, North Intensive Care Unit

Joy Furuya – November 2010, Heart Transplant

Aysheh Ibrahim – June 2011, North Intensive Care Unit

Bree Jensen – May 2011, E2

Katherine La – October 2010, North Intensive Care

Jacqueline Major – April 2011, E2

Carina Manchester – February 2011, E2

Marcy McCracken – September 2010, E2

Maria Natividad – April 2011, E2

Carlos Ocampo – October 2010, North Intensive Care

Denise Paulo-Colaci – February 2011, E2

Shannon Phleger – May 2011, E2

P Primrose Picardal – May 2011, D1

Taylor Santo – April 2011, E2

Eric Soriano – April 2011, North Intensive Care Unit

Sarah Tyndall – October 2010, E2

Leticia Mendoza – November 2010, Medical Specialties

Certified Emergency Nurse (CEN)

Simon Atkinson – September 2010, Emergency Services

Rosario Ebuena – July 2011, Emergency Services

Jamie Stone – January 2011, Emergency Services

Li Anne Tseu – September 2010, Emergency Services

Certified Flight Registered Nurse (CFRN)

Dan Freeman – October 2010, Emergency Services

Certified Gastroenterology Registered Nurse (CGRN)

Karen Golding – October 2010, Endoscopy

Nilar Khaing – October 2010, Endoscopy

Certified Medical Surgical Registered Nurse (CMSRN)

May Africa – October 2010, C2

Irene Cruey – October 2010, F3

Stephanie David – January 2011, E3

Robin Garrison – July 2011, E3

Teuta Kadiu – October 2010, C2

Diane King – February 2011, C2

Monika Kurzyski – November 2010, C2

Alexandria Luc – December 2010, F3

Nancy Ma – October 2010, C2

Kay Nguy – April 2011, F3

Kristi Norris – August 2011, C2

Joselyn Peralta – October 2010, C2

Jo Anne Rones – November 2010, B3

Sara Silberschatz – April 2011, B3

Hazel Joy Uy – October 2010, C2

Clinical Nurse Leader (CNL)

Hanna Chadwick – August 2011, Operating Rooms

Certified Nurse Manager and Leader (CNML)

Myra Lang – April 2011, B2

Certified Nephrology Nurse (CNN)

Jung Park – October 2010, Dialysis

Certified Nurse Operating Room (CNOR)

Tina Billingsley – August 2011, Operating Rooms
Nha Thai – December 2010, Ambulatory Surgery Center
Jewell Van Treese – March 2011, Outpatient Surgery Center – SMOC
Earl Yoshihara – June 2011, Ambulatory Surgery Center

Certified Neuroscience Registered Nurse (CNRN)

Majel Cantoria – March 2011, EGR
Amy Cheung-Taylor – November 2010, E2

Certified Perianesthesia Nurse (CPAN)

Catherine Barnes – October 2010, Post Anesthesia Care Unit
Raymond Pickett – April 2011, Surgery Admission Unit

Certified Pediatric Emergency Nurse (CPEN)

Luis Morales-Villon – July 2011, Emergency Services

Certified Registered Nurse Infusion (CRNI)

Catherine Masik – September 2010, Nursing Float

Certification in Travel Health™ (CTH®)

Nancy Masunaga – May 2011, Vaden Health Center

Certified Wound and Ostomy Care Nurse (CWOCN)

Stacy Cox – August 2011, C2

Nurse Executive – Board Certified (NE-BC)

Cynthia Deporte – February 2011, E3

Nurse Practitioner – Certified (NP-C Adult)

Salena Quan – October 2010, Occupational Health Services
Elika Rad – July 2011, Chest Clinic

Nurse Practitioner – Certified (NP-C Family)

Leslie Clark – October 2010, Patient Transfer Center

Oncology Certified Nurse (OCN)

Colleen Hobson – November 2010, E1
Vanessa Malbog – May 2011, E1
Mary Salom – November 2010, Infusion Treatment Area
Gina Igel – March 2011, Operating Rooms

Orthopedic Nursing Certification (ONC)

Marilou Donina Cerbo – July 2011, DGR

Progressive Care Certified Nurse (PCCN)

Donna Dahlke – January 2011, D3
Trinie Lynn Harris – November 2010, B2
Ratna (Anna) Livson – December 2010, D3
Betsy Newby – February 2011, B2

Registered Nurse – Board Certified (RN-BC)

Blesila Jocson-Tsung – October 2010, Cath Angio Labs
Jacqueline Kixmiller – December 2010, Cath Angio Labs
Evangeline Mendez – January 2011, Cath Angio Labs

Vascular Access – Board Certified (VA-BC)

Yvonne Trevino – January 2011, PICC Program

Doctorate/University Degree

Mary Lough, PhD, RN, CNS, CCRN, CNRN, CCNS,
Doctor of Philosophy in Nursing, University of California, San Francisco, July 2011, E2

Master/Graduate Degree

Chadwick Hannah, MSN, RN, CNOR, Master of Science in Nursing, Clinical Nurse Leader, Springhill College, May 2011, Operating Rooms
Teresa Donohoe, MS, RN, NP, Master of Science, Acute Care Nurse Practitioner, University of California, San Francisco, June 2011, North Intensive Care Unit
James Manibusan, MSN, RN, Master of Science in Nursing, San Jose State University, May 2011, DGR
Jennifer Pancoe, MSN, RN, CNS, Master of Science in Nursing, Adult Acute Care Clinical Nurse Specialist, San Francisco State University, August 2011, North Intensive Care Unit
Chito Pascual, MSN, RN, Master of Science in Nursing, University of Phoenix, March 2011, B2
Anthony Siniscal, MBA, BSN, RN, CEN, Master of Business Administration, Florida Institute of Technology, August 2011, Emergency Services

Bachelor/University Degree

Michael Bautista, BSN, RN, Bachelor of Science in Nursing, Holy Names University, June 2011, E3
Nancy Becker, BSN, RN, Bachelor of Science in Nursing, Holy Names University, June 2011, D1
Martha Berrier, BSN, RN, Bachelor of Science in Nursing, Holy Names University, June 2011, Pain Clinic
YanLi Jiang, BSN, RN, Bachelor of Science in Nursing, Holy Names University, June 2011, B1
Lucindia Oswald, BSN, RN, Bachelor of Science in Nursing, Holy Names University, June 2011, D Ground
Kristen Rhinehart, BSN, RN, CNOR, Bachelor Science in Nursing, Jacksonville University, December 2010, Operating Rooms
Karen Winford, BSN, RN, Bachelor of Science in Nursing, Chamberlain College of Nursing, February 2011, B2



engage

Comforting Care

In recent years a proliferation of palliative care programs has developed throughout the United States in order to meet the needs of our sickest and most vulnerable patients.

At Stanford Hospital & Clinics, the Palliative Care Service is an internal consultative model. Patients are referred to the service when the primary teams need assistance or support with patients who have a life-limiting or progressive illness, or when they have refractory symptoms such as pain, nausea, and dyspnea.

Before meeting the patient, it is imperative that the palliative care team understands the reason for the consult, the disease process, treatment plans, and the goals of the primary team. The palliative care team then assists with clarification of goals of care, advance care planning, pain or symptom management, transition to comfort care or hospice care, and/or psychosocial support. Because the Palliative Care Consult Service is under the Department of Medicine, the consult must be placed by a physician. However, nursing staff, social workers, chaplains, dieticians, or speech pathologists frequently prompt the primary care team to make a palliative care referral. Occasionally, the consult is at the request of the family.

The palliative care assessment focuses on the “four quadrants” of holistic care: 1) physical, 2) psychological, 3) social, and 4) spiritual issues. The team provides ongoing support, education, and information sharing, and communicates the outcome of all discussions to the primary team and documents details of the dialogue in the medical record, which provides critical information for discharge planning. The palliative care social worker can help with both practical and psychosocial needs, including financial issues, bereavement issues, end-of-life preparation for children, caregiver support, and closure with family members. Materials designed especially for children, such as coloring books, can help them cope with loss and grief.

When a consult involves recommendations for pain or symptom management, there is scrupulous follow up every day regarding the status of symptom relief. A primary goal of the palliative care team is to enhance communication with patients and/or family members. The philosophy is that the patient and the family comprise the unit of care, so the team strives to meet or talk with a family member of every patient seen by the consult

65-70
new consults per month

“The Palliative Care program is an incredible program that continues to grow and thrive every day! We are expanding our coverage to the outpatient clinics and to the Cancer Center. The program is truly appreciated by the patients and families that we serve and has been embraced by the professional staff at Stanford Hospital & Clinics.”

– Judy Passaglia, MSN, RN, Palliative Care Program Manager

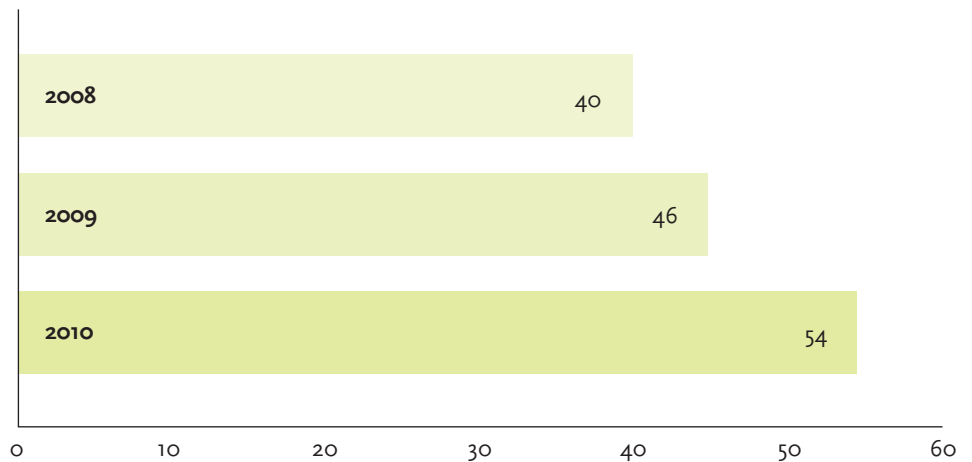
service. The palliative care team thus often attends family meetings with the primary team and might coordinate a family meeting when there is a need for clarification regarding the plan of care and potential next steps. The content of the meeting (patient/family perception of the disease process, medical team perspective, goals of care, options, next steps) is documented in the medical record by the contributing palliative care team member.

Patients who are terminal are referred for comfort care measures, symptom management, and family support. Family tensions are eased when family members understand the physical changes that are natural in the dying process, and the palliative care social worker plays a key role in assessing the bereavement support needs of the survivors.

The service has expanded since its inception four years ago. There are currently more consults in critical care, the Emergency Department, and the Clinical Decision Unit. The Palliative Care Service is in the process of developing a “supportive care model” for the Stanford Comprehensive Cancer Center. In collaboration with the Cardiovascular Surgery Program, patients to receive a left ventricular assist device will have a palliative care consult for advance care planning before the device is placed.

The Palliative Care Service invites collaboration with nursing and all professional staff. As the team and the program grow at SHC, it is the ultimate goal to weave this service into the fabric of quality patient care.

AVERAGE PALLIATIVE CARE CONSULTS PER MONTH



A Transformational Experience

A nurse enters a hospital room and finds a patient experiencing anxiety, shortness of breath, and new onset lung rales coupled with a drop in arterial oxygen saturation (90%).



The unit's clinical nurse specialist (CNS) is also in the room passively observing whether the nurse will raise the head of the bed, call the resource nurse, and communicate using the SBAR (Situation-Background-Assessment-Recommendation) method to the resident. After approximately 15 minutes, the CNS announces, "That's a wrap," and leads the nurses to reflect and debrief on the exhibited team behaviors and to discuss opportunities to improve. The patient isn't human, but rather is made of plastic and electronics... SimMan 3G, to be accurate.

This scenario is typical of what transpires during a bedside (in situ) simulation training exercise as part of a research study called TRANSFORM, funded by a grant from the Gordon and Betty Moore Foundation and matching funds from Stanford Hospital & Clinics. TRANSFORM's aim is to improve early detection and treatment of hospital-acquired complications through in situ simulation training to enhance clinical outcomes. The medical-surgical units selected to participate in the study include B2, B3, D1/CSU, and E3.

"When we developed the simulation training for TRANSFORM, we conjectured that the frequency of simulation training might seriously modulate our ability to produce outcome changes," said Nancy Szaflarski, PhD, RN, program director of Clinical Effectiveness Innovation. That's why the TRANSFORM researchers decided to conduct four simulation exercises on each study unit per month. From an operations viewpoint, this was a very challenging feat. "Our decision is paying off. In the first six months of intervention, we are appreciating significant decreases in the rates of severe sepsis and acute respiratory failure, as well as risk-adjusted mortality, on our study units," Szaflarski said. The CNSs and the unit-based medical directors of the units had undergone simulation training and provided the manpower for the staff simulation training. "The kudos really go to them since they were strongly committed to conducting this training with both nurses and residents on both day and night shifts on their respective units," said Szaflarski.

Nursing faculty of TRANSFORM's simulation training program: (from left, front) Lynn Abel, MSN, RN (Project Manager, TRANSFORM); Christine Thompson, MS, RN (CNS, B3/C3); Annette Haynes, MS, RN (CNS, B2/D1); Molly Kuzman, MSN, RN (CNS, D2/G2S/E3); Kathy Dyble, MSN, RN (Nursing Professional Development Specialist); and Lynn Forsey, PhD, RN (Program Director, Nurse Scientist)



Half of the simulation exercises involve the interdisciplinary team and half involve nurses. “We knew we needed to build teamwork and communication skills among residents and nurses, but we also knew that newer nurses needed assistance in discerning early signs of complications and may not have the confidence to call for help early. “Experienced nurses, on the other hand, have developed good clinical skills but needed more practice with effective communication and teamwork skills,” said Lynn Forsey, PhD, RN, program director-nurse scientist. “What we’re seeing is that new and experienced nurses are reluctant to formulate the “A” and “R” for SBAR communication. Part of the reluctance stems from nurses not knowing they can make a diagnosis and share it with the resident. We’ve learned from our training that interns appreciate hearing the nurses’ assessments since they are often correct. Interns have told us they have limited clinical experience and greatly value the nurses’ thinking since it helps them narrow the differential diagnosis,” said Forsey.

While nurses and residents were initially anxious when participating in simulation exercises, the anxiety appeared to melt away during the debriefing session. “Our experience, so far, has taught us that clinicians truly enjoy this form of training and are learning practical skills to assist them in their daily practice,” said Lynn Abel, MSN, RN, project manager of TRANSFORM. “The debriefing provides a unique opportunity to reinforce aspects of evidence-based clinical care as well as to introduce and reinforce teamwork and communication principles that apply to daily practice. It also helps to build relationships between nurses and residents since they openly critique their efforts as a team and how they can improve going forward.”

While the TRANSFORM study officially ended in June 2011, a sustainability plan is being implemented to ensure that the gains in outcomes are maintained. “We worked with our microsystem leaders to develop a plan based on their requests and the feedback we received from nurses and residents,” said Forsey. The intention is to spread the knowledge gleaned from this study so that others can improve their outcomes through enhanced clinical performance and teamwork.

Caring for the Caregivers

“To care for our patients, we must care for ourselves.” The teaching of nurse theorist Jean Watson is a guiding factor in Stanford Hospital & Clinics’ professional practice model.

Based on the premise that two major factors that contribute to caregiver stress are the exacting nature of patient care and the constantly changing needs of patients and families, SHC has developed a Caregiver Stress Program. The program is grounded in nursing theory and research, and provides a comprehensive approach to managing stress.

GET HEALTHY!

The “Get Healthy!” initiative of the Caregiver Stress Program utilizes staff nurse health champions to engage their peers in activities to mitigate the long-term physical effects of stress. Many health champions have developed innovative unit programs designed to engage their peers in healthy behaviors. Two G2P unit Health Champion staff nurses organized a 10-week yoga class for their colleagues on Friday afternoons. A nurse on the E3 unit organized daily walks during lunchtime and monthly hikes to local areas. At the organizational level, two staff nurses from the D1 unit spearheaded involvement of all SHC departments in National Bike to Work Day for the last two years.

CULTIVATING A CLIMATE OF SUPPORT

In striving to establish a culture of support for nurses and other caregivers, SHC has initiated debriefing meetings for staff after trauma cases, cardiopulmonary arrests, and other stressful cases such as failure to rescue, rapid response calls, abuse and neglect situations, and breakdowns of interpersonal communication. Debriefing discussions, which typically include the situation, diagnosis, aspects of care, outcome, and emotional impact, support the psychological health of the involved staff.

CLASSES DESIGNED TO DECREASE STRESS

Guided by hospital-wide annual learning needs assessment, the SHC Center for Education and Professional Development (CEPD) offers stress management classes that help staff gain new perspectives, tools, and strategies to reduce stress in the workplace and at home.

18
Nurse Health Champions

25%
increase in staff
confidence in ability to
raise concerns regarding a
colleague’s performance

31%
increase in staff
confidence in ability
to speak up in difficult
situations without
defensiveness

HARNESSING TECHNOLOGY TO DECREASE STRESS

The CEPD also offers HeartMath classes, which use emWave technology to transform stress, regulate emotional responses, and harness the power of the heart/brain communication. Through training, coaching, and innovative technology, HeartMath provides practical methods for decreasing stress. HeartMath research postulates that a loving heart (coherent rhythm) facilitates the release of the anti-stress hormone DHEA. E3 unit nurses have pioneered the use of this technique. Since incorporating the HeartMath method, the E3 unit has shown to have lower turnover and sick time rates than the SHC nursing average.

CRUCIAL CONVERSATIONS

As part of an organization-wide effort focused on providing the knowledge and skills to help staff effectively communicate in situations that can cause stress and misunderstandings, SHC started offering Crucial Conversation courses. The Human Resource Department has hosted several courses that focus on deciphering conversations. Additionally, the CEPD offers numerous courses on communication, how to communicate more effectively and how to deal with challenging people and interactions.

MEASURABLE OUTCOMES

Surveys on the impact of Caregiver Stress Program initiatives have measured behavioral change, improved satisfaction and retention, productivity, and empowerment.

Recognizing that stress is a component of the work environment for healthcare professionals is part of the internal SHC framework for stress reduction. Through the numerous programs and venues SHC offers, there is support to mitigate caregiver stress.

Tai chi classes are offered weekly.





innovate

Helping Patients Connect

500
inpatient locations

2X
Since the beginning of
the year, usage has more
than doubled.

As recently as 2005, standard technology in patients' rooms included a tube television with poor image quality.

A Skylight Steering Committee, which included representatives from nursing, nutrition services, marketing, information technology, engineering, infection control, patient education, and guest services, began working on the issue. The result was "Stanford At Your Service" (SAYS), powered by Skylight Access, a two-way digital communications platform that turns a regular hospital television set into an interactive information, communication, and entertainment network.

The committee updated the system by purchasing new videos and adding patient information amenities to the program. Content experts selected from specialties such as cardiovascular, neurology/stroke, diabetes, respiratory, food and nutrition, patient safety, cancer, and wound and skin, assisted with the selection of patient information. Educational materials about the hospital, patient services, clinical services, and departmental services were also created and added to the system selections.

On-demand accessibility of educational videos enables patients to review information at their convenience, and the ability to view videos from the bedside has substantially improved patient access to critical healthcare information. Since the beginning of the year, usage has more than doubled due to nursing staff becoming more familiar with the system and as a result of the addition of new topics.

As the Skylight Steering Committee continued to refine the system to provide patients with more opportunities to learn about their illness and provide feedback about their care, the Process Excellence Department was asked to assist in the development and ongoing evaluation of tools to track patient feedback and provide service recovery. A tool was created to ask patients "yes" and "no" questions regarding the quality of their healthcare. If a patient answers "no" to any of the questions, the system automatically pages the resource nurse on that unit. The nurse is then expected to follow up with the patient within one hour of the page. This real-time response provides an excellent opportunity to resolve problems, provide information, and address concerns while the patient is still hospitalized. For example, when a patient answered "no" to the question, "Do you know who your doctor is?" the resource nurse spoke to the patient and informed him of his attending physician and explained the purpose of the many visits from different physicians.

When the patient gained a better understanding of the medical staff taking care of him, he was more amenable to the multiple visits he received from the physicians.

SAYS has given staff an effective way to converse with patients about issues that influence how they feel about their hospital stay. The program has also proven to be a powerful tool in helping staff cross language barriers and communicate with the hospital's multicultural patient population. Access to local and world television programs is available in a variety of languages including Spanish, Russian, Mandarin, Korean, Hindi, and Tagalog. The entire menu is also available in Spanish, the most frequent language next to English, spoken by SHC patients and families.

With the Skylight Access televisions, patients have a gateway to the internet. Patients receive free internet connection and can read email using a remote control handset and hospital-provided keyboard.

The Patient Care Managers (PCM) receive monthly reports for their individual units as well as the data for all units combined. These results are discussed in PCM regional meetings and in the Patient Satisfaction Steering Committee meetings and provide valuable information about trends, problem areas, and action plan development.

SAYS will continue to evolve. Room service has just been added and online shopping is in development. The committee's new mission is to resolve any system issues, revise content on an ongoing basis, review requests for new content, and make recommendations for new features.

In a very short time, SAYS has created a more home-like environment for patients. With on-demand access, patients experience much less anxiety and uncertainty during their hospital stay.

“Patients usually react in a positive way when we come in for the follow-up,” said Betsy Newby, MSN, RN, Assistant Patient Care Manager, B2. “They are happy that we acknowledge their comments and reduce or change the environment in any way possible.”



A patient uses the Skylight Access system, Stanford at Your Service.

Creating Meaningful Patient Outcomes

The Evidence-Based Practice (EBP) Fellowship program at SHC is a means of improving care at the bedside and fostering professional development of the direct-care provider through education and mentorship.

The program employs continuous quality improvement processes which are the foundation for implementation of clinical practice change. The Center for Nursing Research and Innovation established the EBP Fellowship program in 2006 and SHC's program director has played an integral role in the program's success.

SHC nurses have continued to advance nursing practice and improve patient outcomes during the past year by transferring new research knowledge to clinical practice and creating new knowledge to fill existing practice gaps.

The EBP Fellowship program concluded its seventh year in June with the completion of six additional fellowship projects. Each of the fellows was able to create meaningful patient outcomes for his or her particular populations, as listed in Table 1. The fellowship is a structured program of classroom and seminar sessions that guide fellows from start to finish as they seek out and appraise best practice literature, complete a microsystem assessment, and then design a practice improvement to fit their patient populations. The coaches are an integral part of the program, providing mentorship, clinical expertise, and guidance for the fellows. The program is offered to SHC Patient Care Services staff under the leadership of Dr. Lynn Forsey, RN, program director-nurse scientist, and the UCSF Center for Nursing Research and Innovation.

When the practice literature proved insufficient to guide new practice improvements, nurse primary investigators (PIs) designed and conducted the studies listed in Table 2 to respond to clinical practice problems or new medical technologies. SHC nurses strive for clinical excellence daily. They also seek to develop new knowledge to inform and enhance our ability to create excellent patient outcomes.

TABLE 1: SHC NURSING EBP FELLOWS

EBP FELLOW	COACH	UNIT	PROJECT TITLE
Eric Cooper	Brenda Hann	Cath Lab	Decreasing Back Pain in the Post-Catheterization Patient: Using a Rotational Bed Rest Protocol
Darlene Frie	Annette Haynes	D1	Preventing CHF Patient Readmissions with Cardiac Rehabilitation Phone Calls- Answer the Phone, You're Not Alone
Brian Lee	Ann Mitchell Ellsworth	C2	Returning Bowel Motility-Gum Chewing Trial for Post-op Complex Urology Patients
Belinda Lovo	Theresa Latchford	E1	Evidence-Based Guidelines for Standardized Care for Central Venous Catheter (CVC) Skin Issues of BMT Patients
Julie Pham	Pamela Schreiber	DGr	Improving Hyperglycemia Management in the Inpatient Orthopaedic Population with a Special Focus on Mealtime Insulin Administration
Kristina Zekos-Ortiz	Deborah Bolding Milissa Knott	Resp Care	Improving Respiratory Treatment Quality and Adherence to Therapy with Cystic Fibrosis Patients

TABLE 2: COMPLETED NURSING RESEARCH STUDIES

PI CO-PIS	NURSE STUDY TEAM	UNIT	STUDY TITLE
JJ Baumann Christine Wijman, MD Michael Mlynash, MD	Garrett Chan	ED	A Comparison of Serum Potassium Levels and Potassium Replacement Requirements in Cardiac Arrest Patients with and without Therapeutic Hypothermia
James Manibusan Mark Crider (SJSU) Lynn Forsey		DGr	Relationship between Registered Nurse (RN) Safety Rounds and Patient Fall Prevention Intervention Appropriateness and Number of Patient Falls
Linda Norton Linda Ottoboni Paul Wang, MD	Nancy Becker Theresa Cotter Char Yang-Lu Eileen Pummer Annette Haynes Lynn Forsey	D1 Cardiology Clinics	Phlebitis in Amiodarone™ Administration: Incidence and Contributing Factors
David Pickham (UCSF) Julie Shinn Marjorie Funk (Yale) Barbara J Drew (UCSF)		NICU	High Prevalence of QT Interval Prolongation in Hospitalized Patients is Linked to Mortality: Results of the QT in Practice (QTIP) Study
Nancy Szaflarski Lynn Forsey Clarence Braddock, MD	Lynn Abel Annette Haynes Christine Thompson Molly Kuzman Mari Campbell	B2, B3, D1, E3	TRANSFORM: An In-Situ Simulation Driven Patient Safety Program Aimed at Early Detection and Treatment of Hospital-Acquired Complications

Research Reveals a Better Tool

The most basic question in medicine is also the key to a successful outcome: Is a treatment working? Accurate neurological assessments play a vital role in telling us whether a patient is improving or deteriorating, and nursing plays an essential role in monitoring a patient's neurological status.

Bree Jensen, BSN, RN, of E2, medical/surgical ICU, cares for acute stroke patients and patients who have undergone complex neurosurgical and neurovascular procedures and are at a heightened risk for stroke. As a participant in the 2010 Evidence-Based Practice (EBP) Fellowship, Jensen chose to evaluate neurological assessment practices in the ICU at SHC to determine if a standardized assessment tool was needed. Motivation to investigate this topic stemmed from her desire to improve assessment practices and the curiosity surrounding the neurocritical patient population.

During Jensen's literature search, she found several best-practice guidelines that identified the National Institutes of Health Stroke Scale (NIHSS) and abbreviated NIHSS (aNIHSS) as the gold standard for neurological assessment. The NIHSS is a valid and reliable eleven-item stroke assessment tool. The aNIHSS is a five-item valid and reliable tool used for more frequent neurological assessments.

Thirteen ICU nurses volunteered to take the online NIHSS certification. Jensen compared the number of neurological deficits identified when using the NIHSS/aNIHSS versus the current neurological assessment practice at SHC. Almost twice as many deficits were identified using the NIHSS/aNIHSS compared to current practice. When the results were shared with project stakeholders, it was determined that the NIHSS would be implemented in the ICU.

In February 2011, Jensen presented her findings in a poster presentation at the International Stroke Conference in Los Angeles, California. At the conference she received valuable feedback on her project. She also had the opportunity to learn about frequently used neurological assessment practices at other hospitals worldwide. Jensen felt that her experience at the conference helped to validate her project findings and was a wonderful professional growth opportunity.

Although the formal EBP Fellowship concluded in June 2010, like many other prior EBP fellows, Jensen continues to work on implementing and sustaining the recommended changes from her project. Currently, all 180 E2 nurses are completing NIHSS certification courses either online or in the classroom. Also, NIHSS and aNIHSS are being implemented into the electronic medical record ICU Assessment Flowsheet. Full implementation of the NIHSS/aNIHSS is expected in 2012.

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