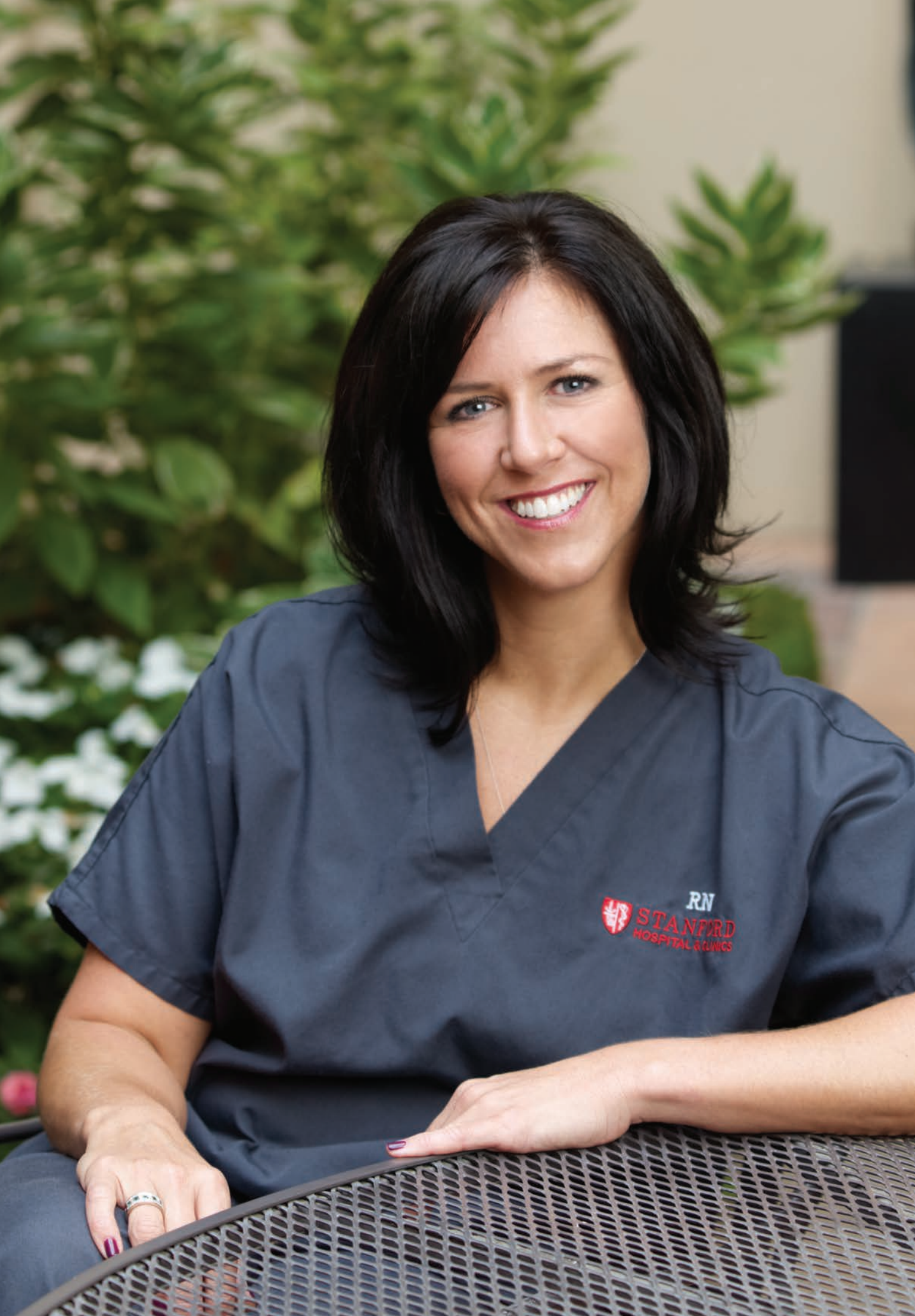
STANFORD NURSES: *committed to care*

STANFORD HOSPITAL & CLINICS NURSING ANNUAL REPORT 2012


RN
STANFORD
HOSPITAL & CLINICS

welcome

FROM THE CHIEF NURSING OFFICER

The idea behind nurse professionalism is really quite fundamental: It's all about the patients.

The patients who come to Stanford Hospital & Clinics benefit from access to clinical expertise, caring and compassionate nurses, and a powerful infrastructure that most other hospitals cannot offer. Patient needs drive our institutional goals and objectives, but it is our nurses who enable us to excel.

To meet the demands of a dramatically changing health care system, nurses must change and grow. As we enter a new era of professional practice standards, nurses need to think critically and be creative in implementing new strategies—and be empowered to act on their expertise. Nurse professionalism is about taking a leadership role in caring for our patients; it's about active participation in solving problems, addressing challenges, and sharing perspectives.

Nurses at Stanford make a tremendous contribution to the patient experience as advocates, decision-makers, educators, and collaborators. Our nurses are effective members of the health-care team, and advocate for the patient through intervention and support, which requires high levels of expertise in communication, analysis, and interpreting data. These are the skills that raise the standard of health care. This is what nurse professionalism is all about.

It takes a special person to embody the qualities of a professional nurse, and it is our institutional responsibility to provide the resources to support nurses to develop these skills and talents. We have implemented a number of new programs including the Professional Nurse Development Program, Role Based Practice and team•care so nurses can continue to build their repertoire of professional skills and knowledge.

As a personal endeavor to enhance the professional practice environment, I truly value the ongoing open conversations I have with nurses. As we dialogue and problem solve together, I know we are building a lasting culture of nursing excellence and professionalism.

Our redesignation as a Magnet hospital reflects the highest level of nursing professionalism in shaping health care, improving patient outcomes, and empowering leaders. As you read some of the activities and accomplishments of the past year, I hope the message of nurse professionalism makes you proud and inspired to do even more.

Thank you for what you do for every patient, every family, every day… because it is ALL about the patient.

Nancy J. Lee, MSN, RN
Chief Nursing Officer
Vice President, Patient Care Services

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

Amir Dan Rubin

Wendy Foad, MS, RN

FROM THE PRESIDENT & CEO

As I visit with patients and families across our hospital and clinics, I'm deeply moved by how often I hear heartfelt appreciation and praise for our outstanding nurses.

Moreover, I also see that patients are noticing improvements in our care delivery systems. Indeed, as we strive to deliver outstanding care to every patient during every encounter, we recognize this takes fantastic people who embrace best practices, work as a team, and focus on continuous improvement. This past year our nursing team has advanced our efforts on all of these fronts.

Our nurses have found new ways to learn and to advance patient safety through our TRANSFORM team-based simulation efforts, with these approaches being disseminated even further in 2013. Our efforts not only improved team camaraderie but resulted in earlier recognition of sepsis risks and helped improve patient outcomes.

On behalf of all of our patients, let me again share my congratulations, recognition, and accolades to each and every one of our nursing team members for showing an incredible commitment to care for each and every patient on every encounter, every time!

Amir Dan Rubin
President and Chief Executive Officer

FROM THE ASSOCIATE CHIEF NURSING OFFICER

It has been a wonderful year for nurses at Stanford Hospital & Clinics.

One notable accomplishment was achieving Magnet redesignation for another four years. We demonstrated the highest standards of excellence in nursing as we continue to excel, remaining highly focused on our nurse-sensitive patient outcomes and on staff and patient satisfaction. We continue to expand our evidence-based practice and our knowledge of nursing as a science and as a caring and healing profession.

Nursing has focused on patient satisfaction this year and implemented C-I-Care (connect, introduce, communicate, ask, respond, exit) on every unit and department in the hospital. We developed huddles and learning opportunities to enhance listening skills and other important topics. The comments we have received from patients reflect the positive changes in our approach to them, especially when they are at their most vulnerable. Using the right words and gestures, taking time to listen during our purposeful rounds has touched their hearts and soothed their spirits. This special nursing connection and contact gives patients the ability to heal physically so they can go home sooner to continue their recovery.

Thank you for your commitment to outstanding nursing care. I look forward to another successful year together.

Wendy Foad, MS, RN
Associate Chief Nursing Officer

Magnet Redesignation

6.7%
of American hospitals are Magnet designated

On April 18, 2012, a conference room filled to standing room only waited anxiously for the phone call from the American Nurses Credentialing Center (ANCC). The phone rang. The room went silent. And then, a great eruption of cheers.

Stanford Hospital & Clinics was redesignated as a Magnet facility for another four years (2012-16). This distinguished recognition—held by only 6.7 percent of hospitals nationwide—was a monumental achievement in Stanford's Magnet journey.

The process took longer than expected. Documents were submitted in February 2011 and accepted without further requests. The ANCC Magnet site visit in June 2011 went well, but more work was required to achieve redesignation status.

A large contingent of nurses—most of them Magnet Champions—attended the October 2011 Magnet Annual Conference in Baltimore and absorbed new knowledge. They returned invigorated and developed the foundation for the corrective action plan that led Stanford to a successful site re-visit in March 2012.

The Magnet Recognition Program® Model focuses on five components based on outcome measurements and documentation:

- Transformational Leadership
- Structural Empowerment
- Exemplary Professional Practice
- New Knowledge, Innovation, and Improvements
- Empirical Outcomes

The final report from the Magnet Program Office highlighted three standards that were noted as exemplary at Stanford Hospital & Clinics. The first, under Structural Empowerment, highlighted Stanford's work in addressing the health-care needs of the community, and recognized the establishment of community partnerships and financial support for community-based services, activities, and health education.

The second, under Exemplary Professional Practice, showcased Stanford nurses assuming collaborative leadership in three interdisciplinary projects, which demonstrated to the Magnet appraisers how Stanford's nursing is focused on patient outcomes and quality care. The projects included:

- A simulated education program (TRANSFORM—designed to reduce hospital complications, particularly septic shock and acute respiratory failure, and unplanned transfers to critical care and to reduce the observed to expected mortality ratio).
- A standardized neurological assessment for post-stroke patients in the intensive care unit
- The Team Sepsis Project, which demonstrated novel approaches in predicting mortality

The third exemplar was in New Knowledge, Innovations, and Improvements. A number of innovations were described by nurses at all levels during the site visit, and four were commended:

- The drive-through triage project developed by the emergency department as an alternative model to reduce the transmission of disease during the flu season
- *A Bath a Day: Keeping MRSA at Bay* project that reduced the methicillin-resistant staphylococcus aureus (MRSA) nosocomial infection rate with no evidence of cross-contamination
- Safe Connections project to prevent misconnection of intravenous, epidural, and enteral feeding tubes
- An evidence-based algorithm for peripheral intravenous catheter insertions by a direct care nurse who has received international recognition

These noted exemplars illustrate the exceptional work done by Stanford nurses every day. To be granted redesignation as Magnet is a tremendous accomplishment and all nurses should feel great pride in this achievement for Stanford and for the professional practice of nursing.

Magnet redesignation celebration

Partnership Adds to Quality of Patient, Staff Experience

"I volunteer my time as a patient advisor because I believe in Stanford and its ability to provide excellent care. Together staff and patients are building an innovative new partnership here ... one that transforms the experience for both"
– Patient Advisory Council Member

"I know that what I am experiencing doesn't happen by accident. There is a plan, and people are trained to the plan. Clinical expertise and safety processes are evident, and the staff is in lockstep to provide me the very best care and healing."
– B2 patient, on the new practice of Bedside Nursing Report

There is indeed a plan to improve the patient experience and to embrace the patient and family as partners in care. The Stanford mission, "healing humanity, one patient at a time, through science and compassion," supports this strategy. From C-I-CARE (connect, introduce, communicate, ask, respond, and exit) to patients as quality team members to opening visiting hours in the intensive care units, Stanford is changing the way it engages with patients.

Stanford's program is based on the key principles of Patient- and Family-Centered Care (PFCC):

- People are treated with respect and dignity.
- Providers communicate complete, unbiased information in ways that are affirming and useful.
- Individuals build their strengths through health-care experiences that enhance control and independence.
- Collaboration among patients, families, and providers occurs in policy and program development, professional education, as well as in the delivery of care.

The Patient- and Family-Centered Care Program works with departments throughout the organization to place patients in a position of real influence, where their wisdom and experience can be used to redesign and transform care systems.

Program components are anchored in the core Patient Advisory Council (PAC), a team comprising 12 patient and family members and five health-care professionals. The council formed three years ago and advises on programs and initiatives such as the new hospital design, At Your Request, Team Care, My Health, and the Quality Summit. The council's goals are to ensure that Stanford policies and practices reflect PFCC, advocate for PFCC through staff education, and develop trained patient advisors who represent diversity.

The Stanford PFCC program currently has three components and continues to evolve. The first component consists of four specialty Patient Advisory Councils which are linked with the core PAC with the goal of improving care for specific diagnoses. The Cystic Fibrosis Patient Advisory Council formed alongside the development of services for cystic fibrosis patients entering adulthood. The Heart Transplant, Cancer Center, and Orthopedics Councils followed shortly thereafter, and four more specialty PACs are being formed. Each specialty council brings together patients and families experiencing specific health challenges and the health-care team that provides services. The PACs were integrated into the Shared Governance structure this year. More than 50 patients and family members volunteer their time.

The second component, the Patient Speakers Bureau was formed this year to provide staff education. Patients received training to prepare them to tell their stories, and more than 100 staff have attended presentations. Feedback has been overwhelmingly positive: "Very applicable stories that will improve the way I practice ... bring them to my floor so all the nurses can hear!"

The third component is the Peer 2 Peer program, designed to foster happier, healthier lives and reduce isolation. A peer mentor is matched to an individual with a similar disease or condition and provides one-to-one support, sharing personal knowledge, experience, and compassion. The mentor receives extensive training and works closely with professional staff to uphold safety standards and to maintain mutually satisfying relationships.

Patient Advisors also participate in councils and task forces throughout the hospital. PAC members participated in School of Medicine admission interviews, the Magnet Redesignation site visit, and the Augmentative Pain Therapy Team/Comfort Cart development, and they starred in C-I-CARE training videos. New projects include participating in medical staff simulation training regarding difficult conversations with patients, as well as the Wayfinding project for the new hospital.

Fueled by the principles of the Patient- and Family-Centered Care program, unique practice changes have also occurred in individual units. Led by staff RNs, six inpatient units have implemented bedside nursing report, and all units will follow by the end of the year. In a survey of staff on the implemented units, more than 90 percent believed it added to the quality of care, with feedback such as:
"I feel more connected and have closure at the end of my shift."
"It is good to have a quick visual assessment at the beginning of my shift"
"It adds trust to patient care."

As the PFCC program at Stanford expands, both nurses and patients continue their commitment to improving the patient care experience.

STRUCTURAL EMPOWERMENT

PNDP Showcases Nursing Achievements

49
clinical nurses

40
PNDP classes offered

17
drop-in lounges held

The Professional Nurse Development Program (PNDP) is a sweeping innovation at Stanford Hospital & Clinics, transforming the original nursing ladder program that was implemented in the early 1970s.

Career ladders incorporate a number of existing systems to invest and reward the nursing professional at the bedside. The overarching purpose for the PNDP is to educate, retain, and recruit the best in the profession.

Stanford's nursing strategic plan (2010-2015) focuses on excellence in the professional practice environment and is supported by its goal to create a healthy work environment that strategically enhances the recruitment and retention of health care professionals based on professional role expectations, models of care, staff engagement in the work environment, governance structures, and interdisciplinary relationships. As part of this vision, the PNDP provides guidance and support so that nurses can successfully work at the bedside and provide evidence-based best practice at all times.

In today's climate of health care reform, nurses need to showcase their skills, talents, and professionalism. The PNDP empowers nurses to align the national nursing agenda with Stanford's vision, goals, and strategies and to compare the relevance of the national nursing agenda to their practice. Three national reports provide a foundation for the future of nursing practice: the Institute of Medicine's *Future of Nursing: Campaign for Action*, the Carnegie National Nursing Education Study, and Magnet® Sources of Evidence.

For Stanford Hospital's PNDP the nurse is required to put together a professional nursing portfolio, which is a collection of materials that document the nurse's expertise, competencies, professional leadership, and career path. It is a requisite to write and present exemplars from clinical practice. The PNDP is based on Patricia Benner's theory *From Novice to Expert*, which identifies seven domains of nursing practice. Her theory is drawn from the Dreyfus model of skill acquisition, which proposed that nurses pass through five levels of proficiency as they develop: novice, advanced beginner, competent, proficient, and expert.

In 1984, Benner published a study which identified that what nurses do in clinical practice translates to how they develop. She asked practicing nurses to describe specific cases or situations they had encountered that stood out in their memories. These experiences are called exemplars or paradigm cases because they changed the perceptions of the nurse and developed skills and critical thinking. Clinical exemplars are an important tool for making the work of nursing visible to nursing colleagues, other health care professionals, and the health care consumer.

To date, 49 staff nurses have been promoted to clinical nurses. Each nurse who has taken part in the PNDP has indicated that the process allowed them to heighten their attention to the fact that they always keep their patients' needs at the forefront of their nursing practice. Many of the nurses are seeing firsthand how integrating theory and evidence enhances the transfer of knowledge and facilitates the delivery of quality services and effective care.

In addition to self-growth and professional development, the portfolio can be a valuable tool for the annual performance appraisal. The portfolio details a nurse's progress in developing competencies for practice and demonstrates how the nurse has achieved the performance standards.

Stanford has developed seminars, workshops, and classes to support nurses through the PNDP process, such as:

- Basics of Benner and Reviewing Exemplars
- Writing Skills workshops
- Power of Presentation Coaching drop-in sessions
- Exemplar Writing drop-in sessions
- Writing Peer Evaluations

"Finally, Stanford nursing is being recognized for our first-rate care. Now we can come out of the shadows and when people think of Stanford they will not just think of world-class physicians but world-class nurses as well!"
– Monica Cfarku, RN, CN IV

STEP BY STEP THOUGH THE PNDP PROCESS

By Monica Cfarku, RN, Clinical Nurse IV

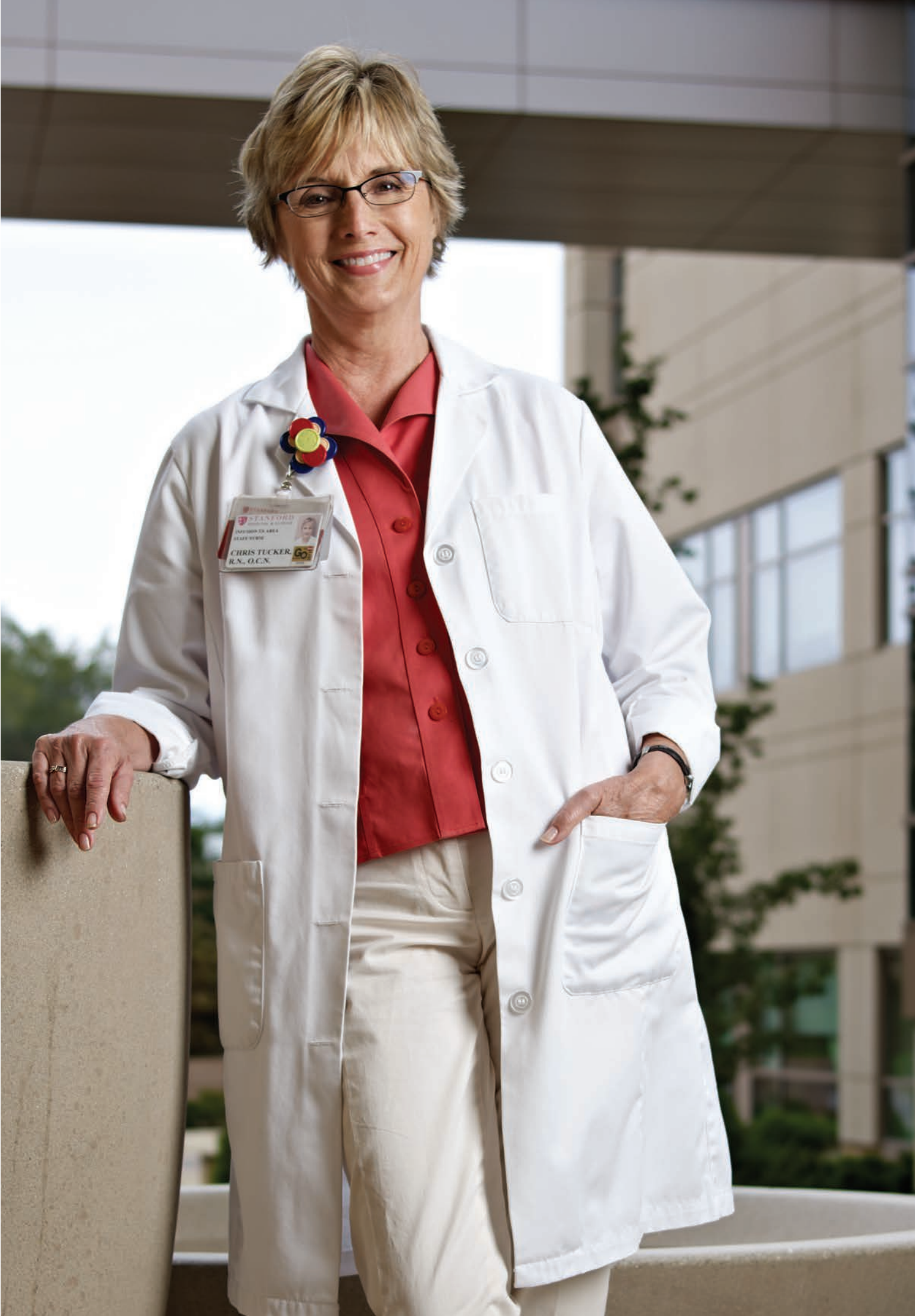
My PNDP journey began with the calculation of achieved points. At the time, I was in school and cut back on some of my hospital-wide and unit-based activities. Despite this change in participation, I was very pleased to see that I had acquired the points needed to achieve a Clinical Nurse IV by helping out where and when I could.

The next phase was the Assessment of Clinical Expertise or, as I like to call it, the "Bennerization" of my nursing capabilities. This was an enlightening process, as I was confident that I would meet all seven domains as an expert, yet I didn't. I was somewhat disheartened but determined, so I spent the next several months working on the remaining domains. By the time the next PNDP application process came around, I had achieved the ranking of expert in almost all of the domains.

With that hurdle behind me I began the last stage of the process, which was writing the exemplars. I described my actions but left out the critical thinking behind those actions, which I assumed was obvious. To document my cultural thinking process was challenging, as critical thinking had become ingrained in my daily practice and was now second nature. Additionally, the culture of nursing is one of modesty. Most nurses do not like to herald successes because we believe that providing expert care should not be considered an accomplishment but simply the daily standard of practice. I began to talk out my exemplars with managers, clinical nurses, members of administration, and peers and began to understand why my exemplars were lacking. I then revised my exemplars in a way that clearly demonstrated examples of my expert skills.

With my portfolio completed, the last hurdle was to present before the PNDP panel of nurses. As I waited, I did some deep breathing to calm my nerves; then the door opened, and it was time. Walking into the room I was struck by the welcoming atmosphere—every person in that room smiled and greeted me, which immediately put me at ease.

Once I was seated I was asked to talk about my work experience and to "tell my story." I was thinking, "Is this it? There was nothing to be nervous about!" Every person paid attention as I spoke, which I felt demonstrated true respect and professionalism. At the end, the panel thanked me for coming and said that it was a privilege "to hear about all of the wonderful things" that I was doing. I was informed that I would find out the results in a few days but was happy to find an e-mail the next morning informing me that I had achieved a CN-IV.


STANFORD
CHRIS TUCKER, R.N., O.C.N.

Addressing the Challenges of Open Visiting Hours

On September 6, 2011, a significant cultural change took place on E2/Intensive Care Unit (ICU): The unit implemented its new policy of Patient- and Family-Centered Care and open visitation. The era of formal and restrictive ICU visiting hours had ended.

Prior to this change, family visitation was limited to 30 minutes on the even hour beginning at 10 a.m. and ending at 10 p.m. Exceptions to the policy were made for special circumstances such as end-of-life and comfort care. Conformity with the visitation policy was inconsistent among the nurses. Compliance also varied among patient families. Families considered the visitation policy to be inconvenient, restrictive, and unwelcoming, which led to feelings of anxiety, distrust, and dissatisfaction.

The transition to an open visitation was in response to the needs of families. ICU family visits were no longer restricted; instead, visitors were offered nearly unlimited time to be with their family member.

CHALLENGES

Anticipating challenges with open visitation created stress, anxiety, and dissatisfaction among the E2 nursing staff, who were concerned that the continued presence of visitors would interrupt their concentration, impede workflow, create distraction, and increase workload.

- Nurses felt limiting visitation allowed them to focus on caring for patients without interruption and intrusion. Unlimited visitation would take away their full concentration on caring for the patient.

- Nurses already struggled with the large and increasing volume of documentation, forms, and paperwork. The prospect of being under constant observation, scrutiny, and inquiry by visitors was also stressful.

- Nurses were concerned about the amount of time that would be refocused from the patient to the family, the ability to maintain patient privacy, and the ability to complete work in a timely manner.

Sue Nekimken, MPA, RN, CMSRN, patient care manager of E2/ICU, acknowledged these concerns. She and the E2 assistant patient care managers set out to learn what they could do to help the nursing staff of approximately 180 put this change into practice. Teri Vidal, BSN, RN, one of the unit educators, joined a group of Stanford representatives at a four-day Patient- and Family-Centered Care Conference in North Carolina in November 2010. At the conclusion of the conference, Vidal formed a goal for E2/ICU—to bridge open visitation to the bedside nurse's ability to take care of the patient. The premise established the role of the Family Coordinator.

ROLES AND RESPONSIBILITIES

Patient-Family Coordinators (FCs) are a group of 20 E2/ICU nurses with exceptional communication skills. They are assigned on both day and night shifts. With the guidance of assistant patient care managers Cindy Parke, MS, RN, and Anita Girard, RN, the FCs coordinate patient/family workflow on the unit. Their responsibilities include:

Welcome and Orient Families

The FC greets and welcomes families to the ICU. The orientation begins with a walking tour of the unit. At the main nursing station families are introduced to the resource nurse and unit secretary, and are asked to provide contact information and create a password. The FC explains the purpose of a password and discusses patient privacy.

The walking tour provides an opportunity to discuss unit policies, such as limited cell phone use and restricted food and drink. The FC calls attention to the location of hand sanitizers outside every patient room and explains infection control practices and the purpose of the yellow isolation carts. If an expected admission has an assigned bed, the family is shown the room and introduced to the nurse who will be taking care of their loved one.

Establish and Bridge Communication

For both privacy and safety reasons, families are informed that there are times when they will need to step away from the bedside and be in the waiting area and that compliance is expected. These times include when sensitive medical information is discussed, focus on medication administration is needed, and baseline physical assessment is done.

Families may also be asked to step out during procedures, tests, or scans. The FC explains that family members are expected to extend the same courtesy and respect for other patients that they want their loved ones to receive.

The FC role is especially beneficial during unexpected admissions from a Code Blue or Rapid Response Team emergency when physicians and nurses need to be especially focused. During such crucial times, the FC can provide current information on the patient's condition until the family is allowed to be at the bedside, answering questions about a variety of issues, such as what the family member will look like and the purpose of all the different tubes, drains, and lines. The FC also identifies and contacts support services, including the social worker and chaplain.

At the end of each shift the FCs report to one another. The report includes follow-up items such as expected admissions, transfers and discharges, anticipated family arrivals, incomplete documentation, sensitive family dynamics, and patients transitioned to comfort care.

VISITOR COMMENTS

"She was wonderful. The nurse came out of the unit and took the anxiety down a whole notch."

"It was obvious our friend was in capable hands. By the time we got to the room our anxiety was eased and we could focus on our friend."

MANAGEMENT COMMENTS

"Prior to implementing the FC role, the management team routinely had to meet with family members who were unhappy for various reasons on average of one to two times per week. Since initiating the FC role, our team has met with only one unhappy family member. "

Complete the Nursing Admission Documentation

After the unit orientation, the FC finds a private location to give the family a folder that contains information to guide and assist them during their loved one's ICU admission. This includes a brochure detailing the hospital's C-I-CARE framework for patient care, describes the members and roles of the ICU team, explains infection control practices, patient privacy, and unit policies and guidelines, and provides list of hospital phone numbers and local lodging. If the patient admitted is a stroke patient, the family is also given the educational stroke brochure.

The FC completes the nursing admission documentation with information provided by the family about advance directives, medications, vaccinations, smoking, and significant medical history. The FC ensures that consents and appropriate documentation are completed.

Bedside Nurse Assistance

In addition to documentation, teaching, and supporting families, the FC assists bedside nurses on E2/ICU with breaks, admissions, discharges, and post-operative patients while waiting to speak with families.

CONCLUSION

While the transition to open visitation was challenging, the FC has clearly been beneficial in reducing anxiety and increasing satisfaction for both nurses and patient families. The FC continues to play an important role in establishing trust with families and recognizing and including families as part of the team. Nurses appreciate the consistency of information the FC provides and the FC's ability to establish expectations and guidelines with families.

STAFF COMMENTS

"Families have been noticeably less anxious since they are informed of the unit policies that provide a more consistent message to our families."

"The initial contact with the FC sets the expectations that our hospital is dedicated to caring for both patients and families."

"The FC role is essential if we want to transition to family-centered care and prevent burnout in our nurses."

Evidence-Based Fellowship and Research

Creating and strengthening practice knowledge advances precision in nursing care.

Research studies focus on generating new knowledge in nursing practice. Stanford nurses are involved in the production and continual improvement of ideas that are of value to the profession, and to advancing the frontiers of core content in theory and practice.

FY2012 NURSING RESEARCH STUDIES

PI-PRIMARY INVESTIGATOR CO-PIS	ADDITIONAL STUDY TEAM NURSES	UNIT	STUDY TITLE
Sharon Butler, MSN, RN	Sue Gates, Candy Zeitman, Jenny Thai, Ling Chen, Mary Lou Jackson, Sheryl Michelson, Thomas Amba, Joanne Olsen (Mentor)	PeriOp–Main OR	Hand Hygiene Products Used by Operating Staff in the Performance of Surgical Scrub
Juan Carlos C. Montoy and S.V. Mahadevan Garrett Chan, PhD, APRN, FAEN, FPCN, FAAN (Co-PI)	NA	ED	Opt-in vs. Opt-out HIV Screening in Emergency Departments: A Randomized Trial
Gayle Ma, MSN, RN	Annette Haynes (Mentor)	D1	A Knowledge Assessment of the Evidence-Based Practice Guidelines for Central Line Bundles
Divina Masaquel-Santiago, MSN, RN	Lynn Forsey (Mentor)	F Ground	Nurse Practitioner Perceived Level of Autonomy in a University Hospital
Sandi Nishimura, MSN, RN	Joanne Olsen (Mentor)	Nursing Quality	Effectiveness of an Algorithm: Skin Protective Products Used in an ICU Pilot
Betina Pellisic, MSN, RN	Lynn Forsey (Mentor)	F Ground	Are Nurses Motivated to Exercise?
Diana Striffler, MSN, RN	Mary Spangler(Mentor), Joanne Olsen (Mentor)	G1	Serum Cholesterol Differences Between Day and Night Shift Nurses
Catherine Sullivan MSN, RN	Lynn Forsey (Mentor)	Main OR	Nurse Attitudes Toward Death and Dying

New to the report this year are nursing case studies, a clinical practice research methodology. Case studies are used to examine specific phenomena to gain insights in forming useful explanations and knowledge of the differences in the characteristics of care that contribute to outcome. These case studies focus on observable facts or events reflective of the scope of practice of a registered nurse or advanced nurse practitioner. Comparison methodology contributes to the discovery of patterns across the cases for the development or confirmation of theory.

FY2012 NURSING CASE STUDIES

INVESTIGATORS	UNIT	CASE COMPARISON TITLE
Denise Greci-Robinson, MS, RN,CNS Carole Kulik, MSN, RN, ACNP Joanne Olsen, PhD, RN, CPHQ, CPSO Pamela Pilotin, MSN, RN, CPHQ	Research, Practice and Education	What are the voiding patterns characteristic of patients that fall during hospitalization?
Colleen Hobson, BSN, RN Theresa Latchford, MS, RN, CNS	BMT	When comparing two blood and marrow transplant recipients with the same preparative regimen, what factors are identified in the event of a patient fall?

Improving patient outcomes through the integration of new research knowledge into clinical practice is the focus of the Evidence-Based Practice (EBP) Fellowships. Eight new fellows and four new coaches are the most recent alumni of the EBP fellowship program this year. The EBP fellowship provides clinicians with structured education, coaching, and release time to improve patient care by seeking out best practices in the research literature and then implementing new practice tailored to their unit cultures.

Coaches are an integral part of the program, providing mentorship, clinical expertise, and guidance for the fellows. This year, in addition to their coaches, the group had the benefit of additional guidance from Joanne Olsen, PhD, RN, CPHQ, CPSO, the new director of transdisciplinary research.

The program is offered annually to Stanford Hospital & Clinics Patient Care Services staff under the leadership of Lynn Forsey, PhD, RN, program director-nurse scientist, and the UCSF Center for Nursing Research & Innovations.

2012 SHC EVIDENCE-BASED PRACTICE FELLOWS

EBP FELLOW	COACH	UNIT	PROJECT TITLE
Anna Michaela Black, BSN, RN	Ed Shradar	ED	Decreasing 72-hour Return Visits in a Pediatric Emergency Department through a Standardized Approach to Discharge
Laura Cole, BSN, RN, OCN	Sara Carney	E1-BMT	Early Implementation and Documentation of BMT Patient and Caregiver Discharge Education
Nancy Hsieh, MPH, RD, CNSC	Lorraine Chatterjee	Clinical Nutrition	A Dietician-Initiated Enteral Nutrition Algorithm in Critical Care
Chris Lewis, RN-BC	Brenda Hann	Cath Angio	Does Offering Patients a Choice Regarding Mobility Improve Patient Satisfaction and Decrease Pain?
Jean McCormack, BS, RN, CWOCN, CFCN	Anne Klevay	Wound Ostomy	Feeding Without Harm: Preventing Gastrostomy Tube related Hospital-Acquired Pressure Ulcers
Katherine McMahon, RN	Judy Passaglia	G1-Neurosurgery	Optimizing End-of-Life Care by Increasing Nurse Self-Efficacy
Elizabeth Stark, MA, PT	Julie Nevitt	Rehab Therapy	Implementing an Evidence-based Mobility Algorithm for the Intermediate Cardiac Care Unit
Jenny Thai, BSN, RN, CNOR	Ling Chen	Ambulatory Surgery	Contact Precautions Best Practice for Ambulatory Surgery Center: Using a New Guideline for Intra-Op Staff

Stanford nurses who are pursuing advanced degrees can also take advantage of the resources available in the Patient Care Services research department to complete their studies. Gayle Ma, MSN, RN, Master of Science Nursing, Education Specialty, used the opportunity provided by her master's degree capstone project to improve nursing care.

Central line-associated bloodstream infection (CLABSI) is a hospital-acquired infection and linked with increased length of stay, morbidity, and mortality. Eradicating CLABSI was the impetus for Ma's master's capstone project, a quantitative study to determine gaps in knowledge and lapses in practice that may contribute to an occurrence of CLABSI. The study assessed the knowledge level of ICU nurses and central line champions on the guidelines for CLABSI prevention to determine the effectiveness of Stanford's central line champion committee, called the Vascular Access Device committee. Results are being used to develop the next stage of education needed to attain and sustain zero CLABSI rates.

Resources Focused on the Advanced Practice Provider Role

THE CENTER FOR ADVANCED PRACTICE INCLUDES:

- Director of Advanced Practice
- Lead Advanced Practice Providers
- Onboarding and General Orientation
- General Council and Leadership Council
- Advanced Practice Provider Newsletter
- Executive (APPex) Forums
- Clinical Preceptors
- Social Media

In March 2012, Stanford Hospital & Clinics formally launched the Center for Advanced Practice, which provides administrative infrastructure and a central organization of processes and resources for Advanced Practice Provider (APP) roles: physician assistants (PAs), nurse practitioners (NPs), nurse anesthetists (CRNAs), and clinical nurse specialists (CNSs).

Stanford has approximately 250 credentialed and privileged APPs practicing in more than 40 specialties in both inpatient and outpatient settings. While the vast majority of these privileged APPs (approximately 75 percent) are employed by Stanford Hospital & Clinics, many others are employed by Lucile Packard Children's Hospital, Stanford University, Palo Alto Medical Foundation, and Menlo Medical Clinic, and have a clinical relationship at SHC.

APPs are considered medical providers who treat, diagnose, prescribe, and perform or assist in surgical procedures in collaboration with physicians. NPs represent roughly 65 percent of all privileged APPs, followed by PAs (28 percent), CNSs (5 percent) and CRNAs (2 percent).

A tremendous amount of progress has been made over the course of the past year:

- Membership in the Interdisciplinary Practice Committee (IDPC) has expanded to include more PAs and NPs, along with more physicians to improve representation among different specialties where APPs practice.
- A 10-point recruitment plan was constructed to address hiring needs of APPs across the organization.
- Marketing materials were developed to showcase the Center for Advanced Practice and the roles it represents.
- APP job descriptions were improved, detailing a clearer scope of practice and responsibility, and privilege forms were developed in partnership with the Medical Staff Office to better align with physician structures and processes.

- Regulatory oversight, data acquisition, tracking, and evaluation have also improved, thanks to coordination and alignment with Human Resources and the Medical Staff Office.
- The first two CRNAs were incorporated into the Center for Advanced Practice in September 2011.

White lab coats are the uniform among all APPs. The coats are personalized with the APP's name, credential, specialty, and hospital logo, and complement professional attire or blue scrubs. A colorful "extender" attaches below the hospital identification badge to display and clarify their role. Team Cards, which include the APP's photo, title, and specialty, are also supplied to patients.

Criteria for employment were elevated to beyond what the State of California requires for licensure and certification. Stanford NPs, CRNAs, and CNSs are required to have a master's or doctoral degree in nursing and be nationally board certified; PAs must have a minimum of a bachelor's degree.

"The Center for Advanced Practice really represents a targeted investment, engineered specifically around APPs, to promote an optimal environment and culture that not only improves physician and APP practice and satisfaction, but improves the entire patient experience," says Nicholas M. Perrino, NP, director of advanced practice.

Perrino oversees the vision and operations of the Center for Advanced Practice with support from the Director of Patient Care Services Practice & Education Carole Kulik, NP; Vice President of Patient Care Services and Chief Nursing Officer Nancy J. Lee, MSN, RN; and Chief Medical Officer Norman Rizk, MD.

"Only a small handful of academic medical centers have this kind of centralization around APPs in place, so many hospitals across the country are looking to Stanford for what this roadmap will ultimately look like."
– Nicholas M. Perrino, NP, Director of Advanced Practice

PROCESS IMPROVEMENT IN THE SAU

Team Assessment Makes a Positive Change

On-time pre-op completion rose from 86% to
93%

On-time first case in room rose from 31% to
71%

Operating Room turnover improved from 43 minutes to
39 minutes

The Main Operating Room Surgical Admissions Unit (SAU) was struggling with issues such as crowding, long patient wait times, physician delays, and unavailable equipment. In response, a pre-op Management Action Team (MAT) was formed.

The purpose of the MAT is to focus on critical issues and implement rapid improvements, which entails assembling key stakeholders, decision makers, and staff. The pre-op MAT included anesthesiologists, surgeons, nurses, and managers. Their objective was to analyze the practices in the SAU that centered on the processing of patients for admission to the operating room (OR). Baseline measurements were taken on two key performance indicators: pre-op completion on-time (86 percent) and first case in room on-time (31 percent).

The team immediately went to work to improve these baseline measurements. MAT members began by defining and studying the patient workflow of the surgical admissions process. They identified several issues that impeded the process: poor workflow organization, unclear targets for staff, and ineffective communication. The MAT assigned specific sub-teams made up of subject matter experts, MAT members, and staff to analyze root causes and suggest improvements. The MAT meets weekly to review data, implement improvements, and assess the effectiveness of changes.

To establish clear and concise goals and communication, the MAT developed a scorecard system that contained area-specific metrics. Data for the scorecards are derived from multiple sources, including the hospital electronic medical record database, area audits, and staff reports. The scorecards gave management and staff a common platform for communication which led to multiple staff-driven improvement initiatives.

A daily huddle was established to focus on the most influential events affecting surgical delays and patient throughput. The huddle is an important format for identifying and sustaining improvements. Pre-op nurses, OR nurses, and management use checklists and data collection tools during rounds to gather information for huddle discussion geared toward improving patient throughput for the SAU and OR.

The huddle takes place after all first cases are in the OR. The information is summarized and posted on a 3'-by-5' whiteboard that displays metrics, issues, trends, staff suggestions, and actions. Issues are discussed and resolved, and actions are reviewed. Refined actions are implemented immediately.

Other major initiatives that have been implemented to improve on-time surgical case starts include:

- Modifying the Pre-Anesthesia Evaluation Checklist and ensuring that it is filled out before the morning of surgery to identify patients with complex needs
- Utilizing the Post-Anesthesia Care Unit (PACU) area for first case pre-op admissions to minimize overcrowding in SAU
- Refining the Pre-Op Boarding Checklist to develop better communication and accountability among all team members
- Revising the policy around issuing and applying the green "go" sticker. This allows all team members—not just nurses—to communicate that all boarding pass elements are met and the patient is ready to safely proceed to the OR by placing a green go sticker on the front of the patient chart.
- Developing a "stop sign" process to provide OR nurses with a tool to indicate room-ready issues

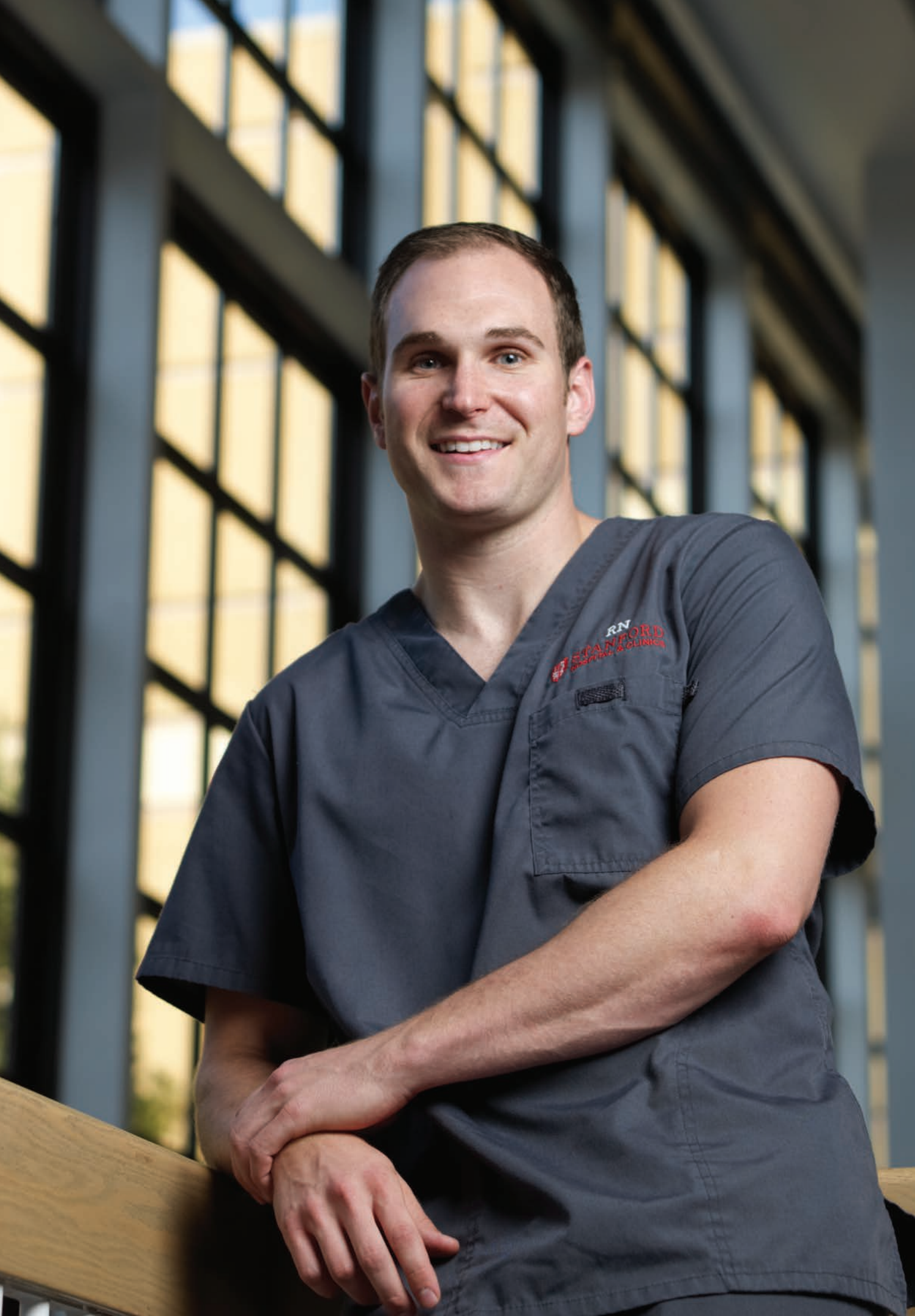
Over the course of six to eight months, the pre-op MAT improved the key performance indicators. Pre-op completion on-time is consistently above 90 percent, and first case in room on-time is above 80 percent. These improvements have led to a significant impact not only on key performance but also on patient satisfaction, staff satisfaction, and overall communication.

EMPOWERING THE OR STAFF

The OR staff has a vested interest in the time it takes to turn over a room from a finished case to a beginning case. The OR had turnover times that lasted more than one hour, with an average of 43 minutes. To improve the turnover time, the neurosurgery department organized a team to examine their process and came up with a template of what needed to be done in a turnover, by whom, and when.

They examined a spine surgery case that took 59 minutes to turn over. The team identified what actions were necessary, not necessary, and changeable, and after making modifications the team was able to cut down the turnover time for a similar spine surgery case to 29 minutes.

The OR staff is very pleased they contributed to this study and made the changes to their practice. The OR's turnover time now averages 39 minutes. The team will be disseminating the room turnover information to all services with the hope of cutting down turnover times and making the main operating room (MOR) available for more cases. With more available time on the schedule, the MOR can be more efficient with less downtime. Empowering the staff to make positive change has been an enormous success.


RN
STANFORD
HOSPITAL & CLINICS

RECOGNITION FOR PATIENTS AND EMPLOYEES WITH U.S. MILITARY SERVICE

In Honor of Veterans

On Memorial Day 2012, Stanford Hospital & Clinics launched its Honoring U.S. Military Veterans Program to recognize patients and employees who have a United States military affiliation.

This hospital-wide program offers all military veteran patients and employees the option of receiving a red, white, and blue keepsake wristband to identify those who have served.

The vision for the program stemmed from both a loss and a need for Greg Hoovler, RN. In 2011, the year he lost his stepfather, a decorated Korean War veteran, Hoovler felt that there was an unmet need to honor patient veterans who were hospitalized—not just on Veterans Day but year-round.

"I thought a lot about my stepfather on Veterans Day last year, remembering the beautiful ceremony culminating in the American flag being presented to my mother by the Navy Honor Guard as they played 'Taps'. I think he would be very proud of this program. The Navy was such a source of pride for him," says Hoovler.

In other hospitals where he has worked, small flags or placards were placed on bedside tables for inpatients who were hospitalized on Veterans Day. He thought, "Something more needs to be done to honor the sacrifice this special group made in service to our country."

After passing the veteran recognition concept by management, the vision for a program took off like wildfire. "Everyone I spoke with became excited and supportive and embraced the concept with enthusiasm," he recalls. "Many shed a tear." In the following weeks, a team was assembled to put the vision into action. The team had all of the elements in place and was able to launch the program, fittingly, on Memorial Day.

"I believe that this very simple yet powerful display will accomplish several objectives," says Hoovler. "Patients will see Stanford Hospital & Clinics as even more unique in catering to the individual, and patients and employees will feel pride in wearing the wristband. Caregivers will be given the opportunity to open dialogue about an important and personal aspect of an individual's life, and thank them for their service."

Hoovler hopes that perhaps the power of this simple gesture of offering a Veteran wristband will be adopted by other health-care facilities across the country.

"I believe that deeper relationships can be built among caregivers, patients, families, and employees throughout all levels of care. In many cases this avenue of communication will be therapeutic to many patients."
– Greg Hoovler, RN

TEAM•ROUNDS

Improving the Patient Experience

PRESS GANEY SATISFACTION SCORES AFTER IMPLEMENTING TEAM•ROUNDS

93%
said staff worked together

88%
felt ready for discharge

83%
satisfaction with discharge speed

94%
were likely to recommend

A priority at Stanford Hospital & Clinics is to provide the best care for our patients, and our patients expect nothing less.

To live up to our mission and to meet our patients' expectations, Nancy Lee, MSN, RN, chief nursing officer and vice-president of Patient Care Servies, Wendy Foad, MSN, RN, associate chief nursing officer, and Kim Pardini-Kiely, MS, RN, vice president of quality and effectiveness, launched team•care, a new program that critically examines and improves the patient experience from admission through discharge.

Team•rounds, a key component of team•care, are daily interdisciplinary meetings at which representatives of the care team gather to discuss the treatment plans for their patients. The primary objectives are to ensure that the entire team is working toward a common care plan and to identify and address potential barriers to transfers and discharges. Effective team•rounds improve coordination and collaboration, thereby improving our patients' experiences.

Discussions are focused on the goals for the day and the admission. The team identifies and addresses any potential barriers that might delay treatment or discharge, and ensures that the patient and/or the patient's family is aware of and involved in the development of the treatment plan. Before team•rounds, communication consisted of numerous conversations among the various disciplines throughout the day; team•rounds meetings streamline these conversations, providing a venue for the entire team to meet and discuss the plan at the same time.

To supplement the dialogue during team•rounds, one member of the team documents a summary of the discussion in the patient's electronic medical record note section. Every member of the team can easily review the patient's progress and discharge plans in one central location.

Increased interdisciplinary collaboration has created a more cohesive work environment for all members of the care team. Martha Berrier, BSN, RN, patient care manager for D1/coronary care and cardiac surveillance units, reports that "It's great having all the disciplines in the room at the same time. We know the plan of care first-hand and deliver a consistent message to the patients. We can focus on barriers to discharge days before the

patient is actually discharged, and there seem to be fewer 'last minute' surprises and delays. It's really been very exciting to be able to sustain this high level of communication."

The improved collaboration of team•rounds has resulted in fewer delays and a smoother hospital course from admission through discharge. For example, when a physician indicates that a patient will be discharged with intravenous (IV) antibiotics, the nurses and case manager begin the involved process of coordinating the peripherally inserted central catheter placement and home IV antibiotics, including necessary nursing care and family education, well in advance of the discharge.

The positive effects of improved care coordination are demonstrated by the increase in Press Ganey patient satisfaction scores. The four Press Ganey questions associated with team•rounds have all shown housewide increases when comparing the pre-implementation period to discharges after implementation of team•rounds.

With a strong infrastructure in place, team•rounds is now in a phase of continuous process improvement. Program managers have partnered with representatives from each discipline to assess and enhance participation, ensuring that discussions are both efficient and productive for all members of the team. As team•rounds continues to evolve and becomes ingrained in the daily hospital routine, both patients and staff benefit from improved interdisciplinary communication and coordination.

Pilot Program for Head and Neck Oncology Patients

PRESS GANEY SATISFACTION SCORES DURING THE PILOT PROGRAM

100%
said staff were courteous (8% increase)

92%
satisfaction with wait time (18% increase)

90%
said they knew what to expect (6% increase)

More than 70 oncology nurses provide care for approximately 36,000 cancer patient visits each year at the Stanford Cancer Center Infusion Treatment Area (ITA).

Nurses administer treatments for many different types of cancers and have a broad knowledge base of diseases and therapies. Developing a professional relationship with patients and physicians in a fast-paced environment with such diverse patient assignments can be a challenge.

Alexander Colevas, MD, associate professor of medical oncology at Stanford Hospital & Clinics, was interested in exploring the concept of primary care nursing. The model is patient centered, with a specific nurse or two assigned to provide care for a patient. The model allows the nurse to learn specifics about a complex patient's needs and builds trust, thereby decreasing the patient's anxiety. It also improves nurse/patient and nurse/physician communication and gives the nurse the opportunity to notice subtle patient changes. Improved communication with the patient and the care team enhances patient safety and may decrease treatment time. However multiple shifts, nurses working fewer days a week, and ongoing changes to patient treatment schedules make implementation of primary nurse alignment difficult.

Dr. Colevas, the physician champion, and his clinic team, Richard Luciano, NP, and Jamie Laskowski, BSN, RN, nurse coordinator, were invested in implementing a primary care team for head and neck cancer patients. The ITA leadership and a small group of ITA nurses, also known as the "Gang of Five," worked with Dr. Colevas and his team to implement a primary care pilot.[1]

The Gang of Five received additional education to support the extremely complex head and neck patients who experience severe side effects during treatment. These five nurses completed the Oncology Nursing Society Head and Neck online module, attended tumor boards, and were encouraged to see the patients during their physician visit.

1 The ITA Leadership: Torey Benoit and Donna Healey. The "Gang of Five" ITA nurses: Carol Bell, MSN, RN, OCN, Christine Tucker, BSN, OCN, Gail Moore, RN, OCN, Margaret Caley BSN, RN and Beverly Wheat, BSN, OCN.

The goal of the pilot was to ensure that 50 percent of patient visits were with the same oncology nurse. The secondary goal was to see an increase in Press Ganey scores related to patient satisfaction.

Pre-pilot data showed that 10 patients over the course of 50 treatment visits were cared for by the same nurse more than once only 10 percent of the time. During the primary care pilot 37 percent of patients received care from the same nurse more than once. Press Ganey scores increased slightly in areas related to patient satisfaction.

Communication between the head and neck oncology clinic and the ITA was streamlined, resulting in improved nurse satisfaction as a greater sense of teamwork and the ability to provide more efficient and timely care was achieved. "We saw a closer ongoing connection with patients and a greater trust from the provider," says Chris Tucker, BSN, OCN. "Pages get answered faster, which allows us to work more efficiently."

"I am more cognitive of my responses when I am talking to a nurse I know and work with regularly," states Dr. Colevas. "Nurses who may have been a bit more timid about patient issues are now very comfortable with challenging me." The nurses' commitment to professional development was demonstrated by their participation in educational opportunities, ONS training, and tumor board participation. Dr. Colevas' ongoing visibility and connection with the ITA nursing staff has been critical in the pilot program's success.

A patient letter received by Dr. Colevas exemplifies the benefits the head and neck oncology patients have seen: "When my treatments began, I was assigned to Chris as my regular nurse in the ITA. I had never heard of the primary nurse program until I asked Chris how I got so lucky to have her as my regular nurse. She explained that this program was created to ensure that one nurse was assigned to one patient for the duration of his/her treatment. As a beneficiary of this program, my experience has been consistently pleasant and positive. The primary nurse program ensures that the patient can discuss progress, ask questions, and express concern. I found my experience in the ITA, with Chris as my regular nurse, to be an integral part of my path to better health. I wish you continued success with the primary nurse program, and I hope it can be expanded in the future. You have my gratitude."

Nurses Key in Helping Improve Patient Pain Scores

Pain is very challenging to treat and often difficult to assess. Nurses have incorporated many processes into their workflow to improve pain management for the patient.

Hourly rounding is used as an opportunity to check the "4 Ps," (pain, personal needs, positioning of patients and items, prevention of falls). Each hour nurses assess the patient's pain level and offer appropriate interventions. Pain management is discussed during staff huddles at the beginning of the shift and during nurse-to-nurse shift reports.

Huddles provide a format for the pain champion to share new knowledge with the staff or to highlight challenging pain management situations on the unit. Nurses also are including the pain assessment, interventions, and level of response in the sign-out notes of the hospital's electronic medical record. This dynamic exchange in real time facilitates greater knowledge retention.

Many of the hospital units have identified nurses who are trained or will be trained to be experts in pain management. These experts, known as pain champions, complete a series of pain management classes to develop their expertise.

There are many different analgesics with unique properties and delivery methods that require an incredible amount of critical thinking and a broad knowledge base to identify which medication or combination of medications would be most effective in a given situation. If the appropriate analgesic is not ordered, the nurse must be able to discuss these issues with the primary team and be an advocate for the patient.

ON THE FRONT LINE

The bedside nurse is recognized as the front-line health-care team member. For this reason, nurse educators are working with every staff nurse to review the Pain Management Protocol and the Patient Controlled Analgesia policy, providing an opportunity to review evidence-based best practice for pain management. Increased knowledge empowers the nurse to intervene on behalf of the patient and his or her family.

As part of Stanford Hospital's goal for patient centered care in the context of pain management, the hospital is in the process of placing white erasable boards in each patient

room where staff can write the patient's personal pain goal for the day and times at which pain medications can be delivered. The patient's pain level goal may be a number (0-10) or an ability to perform an activity with controlled pain.

Patients are encouraged to watch a pain management video, which can be accessed through the in-room Skylight video system. The Comfort Cart offers written material on pain management as well as eye masks, ear plugs, and aromatherapy. The cart, which is well used and appreciated by patients, help them realize that pain control is a holistic experience and can be approached from alternative perspectives.

IMPROVING PAIN MANAGEMENT

Inna Kaplan, RN, pain champion on E1/Blood and Marrow Transplant Unit, provides ongoing e-mail communication to the nurses on her unit regarding pain initiatives, including reminders to offer patients the Comfort Cart options. Kaplan plans to create a binder with pain management reference materials for the staff.

Cheryl Passanisi, RN, nurse educator for B2/Immediate Cardiac Care Unit, reviews the electronic medical record's pain documentation with nurses on her unit to identify patients who have uncontrolled pain that should be addressed immediately. Passanisi encourages the nurses to show the pain accordion to the physician, as a powerful visual that displays actual pain experienced in real time. She believes this is an area where nurses can "make a significant difference."

Homan Chan, RN, Dialysis Unit, reports that the team of dialysis nurses assesses pain hourly and has incorporated specific strategies to decrease discomfort during hemodialysis treatment, such as increasing fluid replacement or decreasing the ultra-filtration rate.

Other projects in pain management include the creation of a unit-based "pain task force" with the unit medical director; a pain lecture incorporated into an upcoming journal club; and a colorful poster that diagrams an action plan to facilitate better pain management.

A number of nurse sensitive indicators are being tracked and displayed in all areas of the hospital. Throughout the inpatient and outpatient areas, nurses proudly share the improvement of pain scores. One indicator queries whether the pain was well managed during the patient's stay at Stanford, and the trend is moving in the right direction.

However, there is still room for much improvement. Tess Lazzareschi, RN, noted that "Pain is not the preconceived idea of the professional staff, but the patient's perception of their pain." Lazzareschi notes that it is the entire team working together—including the medical and nursing assistants—who collaborate to make the difference in pain management.

Many Faces

43%
of California residents speak language other than English

CALIFORNIA POPULATION BY ETHNICITY

40%
Non-Hispanic Caucasian

37.6%
Hispanic

13%
Asian

6.2%
Black

1%
American Indian

0.4%
Pacific Islander

Changing demographics, a more multicultural world, and culturally diverse backgrounds present a unique challenge to health-care providers.

Stanford Hospital & Clinics is located in a multicultural community where it is common to encounter people with different backgrounds, languages, healthcare beliefs and practices. Some patients prefer not to drink cold water because they believe it can impede their recovery. Another group may refuse blood transfusions because their religion prohibits infusion of whole blood into the body. Many women of Arab descent keep their bodies covered and may not seek regular physical checkups because they do not want their bodies exposed for an extended period of time. This is especially true when the woman is in the presence of non-related males, which may include male physicians or nurses. To provide the highest quality of care, it is of paramount importance to be sensitive and responsive to each cultural encounter.

WHAT IS CULTURAL COMPETENCE?

Cultural competence is defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" (*Cross et al 1989*). Diversity has many faces and includes gender, religious affiliation, language, sexual orientation, age, disability, socio-economic status, occupation, and geographic location.

Providing care for a multicultural patient populations can be complex. There is not one recipe that can be applied to an individual from a specific culture—everyone is unique and different. Expanding cultural awareness and knowledge and building upon cultural skills along with experiencing multicultural encounters allows health-care providers to develop a better understanding, appreciate differences, and accommodate patients' beliefs and values.

CULTURAL DIVERSITY COUNCIL

The Cultural Diversity Council functions under the structure of shared governance. A specialty council under the Nursing Leadership Council, the Cultural Diversity Council is comprised of multidisciplinary members representing various departments and units. These representatives and resource personnel, commonly referred to as Diversity Champions, presently include nurses, language interpreters, chaplains, social workers, and

respiratory therapists. The council collaborates with the Stanford School of Medicine and the Stanford Geriatric Education Center.

Diversity Champions bring forth issues and concerns in practice and education related to caring for diverse patient populations.

During the last year, the Cultural Diversity Council:

- Increased awareness on diversity resources such as cultural diversity website, interpreter services, and language-line phones
- Provided in-services by interpreters/champions highlighting the importance and consequences of language barriers on health-care outcomes
- Collaborated with the Stanford Center for Education and Professional Development (CEPD) to conduct diversity workshops
- Facilitated interactive learning and reflection at Nurse Week by encouraging staff to play a "Diversity Dive-In" dart game and locate origins on a global map, The World We Share
- Empowered Diversity Champions to write columns in unit newsletters
- Promoted dialogue through potlucks and sharing cross-cultural health practices
- Initiated a repository for culturally diverse vignettes that will be used to enhance learning and reflection. These vignettes describe "culture bumps" or encounters/scenarios between staff, patients, and providers that resulted in a conflict or communication gap, and provide strategy for win-win situations

FUTURE COUNCIL INITIATIVES

- Increase membership to have varied perspectives on diversity
- Assess nurses' cultural competence and align with organization's vision towards diversity
- Collaborate with different disciplines to strengthen workforce diversity as well as patient care diversity
- Participate in Nursing Grand Rounds for dialogue on diversity matters
- Celebrate National Diversity Days – with resources and information about diversity
- Develop the role and scope of a Diversity Officer

At Stanford there is a culturally diverse workforce, as well as patient population. It is essential to be culturally competent to be able to work together to provide optimal care to patients. The Cultural Diversity Council continues to identify and create educational programs to assist nurses and other members of the health-care team in becoming culturally competent. The council has been indispensable in developing key elements for Stanford Hospital & Clinics to pursue its mission: Healing humanity through science and compassion, one patient at a time.

Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards A Culturally Competent System of Care, Volume I.* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Campinha-Bacote, J. (2002b). Cultural competence in psychiatric nursing: Have you "ASKED" the right questions? Journal of the American Psychiatric Association, 8(16), 183-187.

When caring for a patient, ask the following questions to assess cultural competence *(Campinha-Bacote, 2002b):*

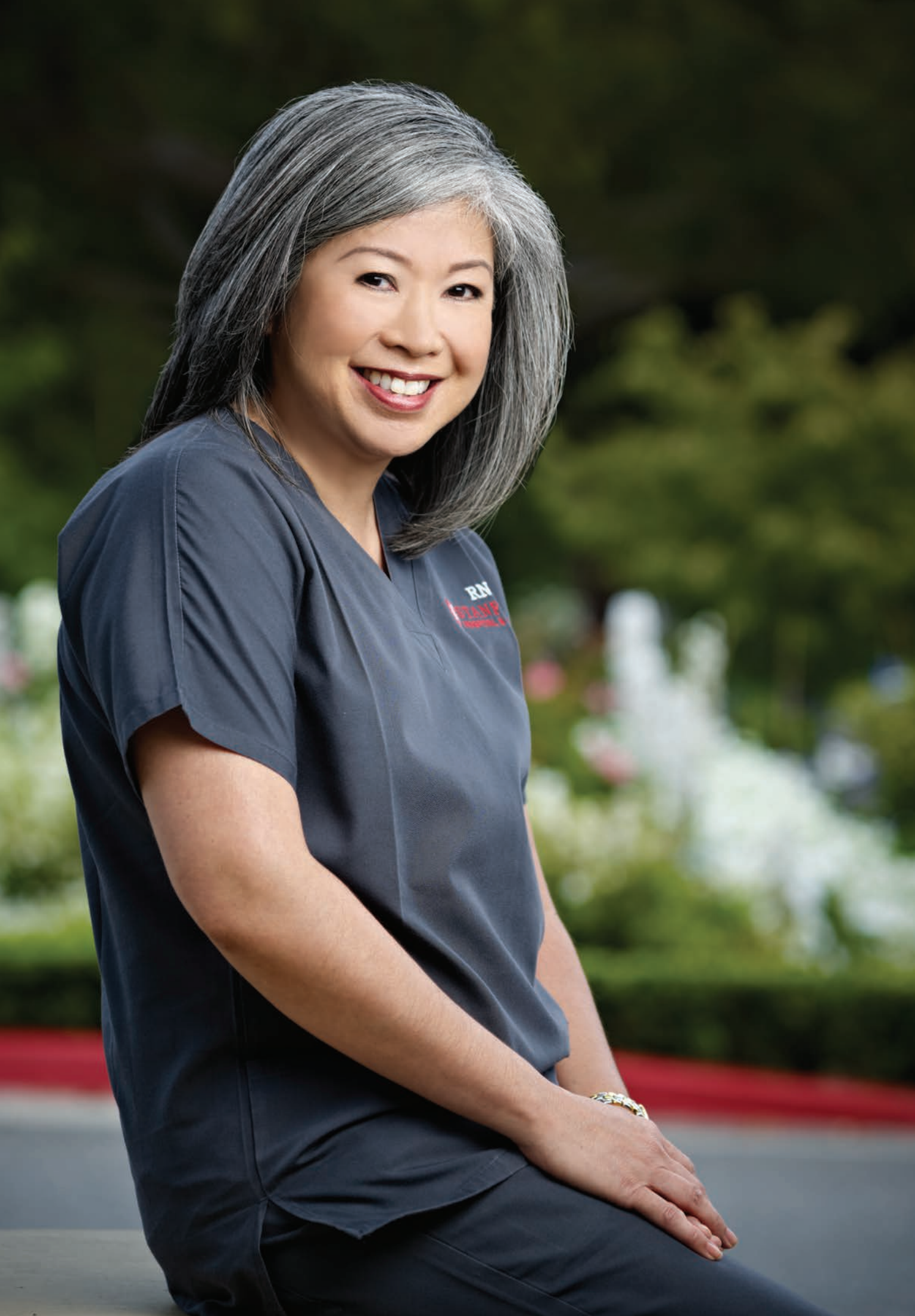
Awareness
Am I aware of any personal biases and prejudices toward different cultural groups?

Skill
Do I have the ability to conduct a cultural assessment and perform a culturally based physical assessment in a sensitive manner?

Knowledge
Do I have awareness of the patient's worldview?

Encounters
How many face-to-face encounters have I had with patients from diverse cultural backgrounds?

Desire
What is my genuine desire to "want to be" culturally competent? Do I have the motivation to engage in the process of becoming culturally aware, knowledgeable, skillful and to seek cultural encounters?


RN

IN RECOGNITION OF EXCELLENCE

DAISY Award Honors Exceptional Nursing Care

The DAISY Foundation was formed in November 1999 by the family of J. Patrick Barnes, who died at age 33 of complications of idiopathic thrombocytopenic purpura. In the words of the foundation, "the one really positive thing that the family could hold onto from the experience of his illness was the skillful and amazingly compassionate care he received from his nurses—even when he was totally sedated."

Touched by the remarkable care, clinical skills, and compassion demonstrated by nurses during their son's illness, the Barnes family made it their mission to recognize exceptional nurses around the country. The DAISY award—DAISY is an acronym for Diseases Attacking the Immune System—is one of the foundation's programs to express thanks to the nursing profession, for the family believes that the nurses are truly "unsung heroes." More than 1,000 hospitals across the globe participate in the award programs.

Since 2006, Stanford Hospital & Clinics has awarded an average of eight nurses every year. Winners are nominated by patients, visitors, employees, or physicians for extraordinary work with patients and are recognized at a public ceremony during Nurse Week. Each recipient receives a framed certificate, a DAISY award signature lapel pin, a copy of their nomination letter, and a hand-carved stone sculpture from Zimbabwe entitled "A Healer's Touch." The awardee's unit also receives Cinnabon's cinnamon rolls—Barnes' favorite during his illness.

Nurses who receive a DAISY award demonstrate H-E-A-R-T:

- Honesty—truthfulness and sincerity in all aspects of patient care
- Excellence in education—commitment to doing the best at all times
- Advocacy—speaking for or defending the patient's right to make choices about care
- Respect—consideration and appreciation of others and sensitivity for individual differences, needs, and concern
- Teamwork—collaboration with team members to ensure excellence in patient care

December 2011
DAISY Recipients

Nancy Lee, MSN, RN, Nursing Administration

Peter Sayon, RN, NICU

May 2012
DAISY Recipients
Beth Wu, E1
Debra Bone, C1
Heidi Salisbury,
Cardiovascular Clinic
Jean McCormack,
Wound and Ostomy
Rhonda Hart, D1
Robin Garrison, E3
Robinetta Wheeler,
Wound and Ostomy
Veronica Sherwood,
Critical Care Crisis

This past year the DAISY award was not only presented to 12 deserving nurses during Nurse Week, but a special ceremony in December 2011 acknowledged our CNO and a unit nurse. In the nomination form for Nancy Lee, MSN, RN, it was noted that as CNO and vice president for patient care services, she serves as an advocate for nurses and patients. "She is an integral part of our daily work as nurses. She takes her time to talk to patients and really connect with them. She also enjoys rounding with the nurses and sitting down with them, conversing and listening to what they have to say. During one of her visits, one of the nurses commented, "Her visit was awesome! She made time to talk to us, and the whole conversation with her was very sincere. We felt like she cares about the nurses and the patients. These nurses cannot wait for her to come back to the unit." Peter Sayon, RN, NICU, was nominated the same month by the spouse of a surgery patient who didn't speak English who wrote, "Peter took great care of her. He understands the individual needs of the patient, and he helps to accommodate everything he can. I would like to have nurses like him everywhere."

"The DAISY award is especially poignant as this is the award that is given by nurses to nurses. Both Peter and I were humbled and honored to receive the DAISY award and will continue to work to remain deserving of such recognition," said Lee.

In May 2012, Robin Garrison was nominated by one of her peers from E3, who wrote, "Robin always gives 100 percent every time she comes to work and never hesitates to offer help." One day, an admission came into the unit; Robin noticed the nurse was very busy so "she ended up going into the room and getting to know the patient. She found out that he used the last of his money to get to Stanford. She decided that doing the admission assessment and inserting the IV could wait and made sure the patient had a hot shower. She then contacted a social worker to help him with his other psychosocial issues. She also got the surgeons and psych team involved to make them aware of the patient's situation. I would be honored if Robin was my nurse if I was hospitalized."

Rhonda Hart, another recipient in May 2012, was also nominated by a peer. "Rhonda is calm and focused during emergencies. While she was assisting a physician on a procedure, they experienced a crisis. Rhonda knew exactly what to do. She remained calm, explained to the patient what had happened, and reassured the patient that the problem was being addressed. That's the kind of nurse Rhonda is … skillful, knowledgeable, compassionate, caring—simply excellent."

Stanford Hospital & Clinics is proud to have this partnership with the DAISY foundation to honor and recognize extraordinary nursing care.

Certifications and Academic Advances

CERTIFICATIONS

Accredited Case Manager (ACM)
Judith Wilson – October 2011, Case Management

Acute Care Nurse Practioner (ACNP-BC)
Teresa Donohoe – December 2011, Nursing Practice & Education

Acute Care Nurse Specialist (ACNS-BC)
Denise Giarraffa – May 2012, Infusion Treatment Area

Critical Care Registered Nurse (CCRN)
Alily Aglibot – September 2011, North Intensive Care Unit
George Neil Ciudadano, Jr. – September 2011, E2
Maria Bella Dionisio – March 2012, North Intensive Care Unit
Sara Ferraro – September 2011, North Intensive Care Unit
Celso Huiso – December 2011, North Intensive Care Unit
Michael Tonelli – April 2012, Cath Angio Labs
Eva Tran – April 2012, North Intensive Care Unit

Critical Care Registered Nurse with Cardiac Medicine Subspecialty (CCRN-CMC)
Ruby Ann Cuison – September 2011, B2
Brian Schenone – November 2011, B2

Critical Care Registered Nurse with Cardiac Surgery Subspecialty (CCRN-CSC)
Kiana Bayani – October 2011, North Intensive Care Unit
Carlos Ocampo – June 2012, D3
Eric Soriano – September 2011, North Intensive Care Unit
Elvira Wohlers – May 2012, North Intensive Care Unit

Certified Emergency Nurse (CEN)
Kay Lee – July 2012, Emergency Services

Certified Gastroenterology Registered Nurse (CGRN)
Catherine Bertrand – October 2011, Endoscopy
Patty Conway – October 2011, Endoscopy

Certified Heart Failure Nurse (CHFN)
Darlene Frie – July 2012, D1

Certified Medical Surgical Registered Nurse (CMSRN)
Sandra Boyd – November 2011, B3
Marjorie Madlangbayan – April 2012, E3
Antoinette Navarro – January 2012, C3

Certified Nephrology Nurse (CNN)
Chunhui Gan – February 2012, Dialysis

Certified Neuroscience Registered Nurse (CNRN)
Agnes Monteclaro – July 2012, E2
Jocelyn Vadil – March 2012, E2

Certified Nurse Operating Room (CNOR)
Visitation Verbo – December 2011, Operating Rooms
Lidi Wong – June 2012, Operating Rooms

Certified Post Anesthesia Nurse (CPAN)
Laurie Jackson – May 2012, Post Anesthesia Care Unit
Elizabeth Roney – May 2012, Post Anesthesia Care Unit
Betty Verhovany – April 2012, Outpatient Surgery Center

Certified Pediatric Emergency Nurse (CPEN)
Judelyn Halol – August 2012, Body Scanner

Clinical Nurse Leader (CNL)
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Orthopedic Nurse Certified (ONC)
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Post-Master's Nurse Practitioner Certificate
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Progressive Care Certified Nurse (PCCN)
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Registered Nurse-Board Certified (RN-BC)
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Steven Wilson – September 2011, Cath Angio Labs

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