

NURSE

S T A N F O R D

VOL 26, NO. 2

STANFORD HOSPITAL AND CLINICS

FALL 2006



CARING IN A HIGH TECH WORLD
THE NURSING WORK GROUP

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Stanford Nurse is published by the Division of Patient Care Services. It is distributed to the Stanford nursing and medical communities, selected individuals, schools, organizations, and professional journals. Address correspondence to: Editor, *Stanford Nurse*, Center for Education and Professional Development, 300 Pasteur Drive, MC 5534, Stanford, CA 94305-5534. *Stanford Nurse* is indexed in the Cumulative Index to Nursing & Allied Health Literature.

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From the Chief Nursing Officer

CINDY DAY, RN, MS, CNAA, VICE PRESIDENT FOR PATIENT CARE, CHIEF NURSING OFFICER



I'm very excited about the fall edition of *Stanford Nurse*, as it highlights some of the many initiatives underway at Stanford Hospital & Clinics that are exemplary of the incredible spirit of collaboration in the institution.

Nurses are involved every day at the bedside and with projects and initiatives on their units, the institution, and the community that require collaboration with their peers and colleagues. The characteristics of collaboration have been identified as shared understanding of goals and roles, effective communication, shared decision making, and conflict management. The stories you will read about in this edition exemplify nurses and their colleagues effectively collaborating in order to improve the patient's experience, enhance patient safety, and build new programs.

Dr. Shuer's article highlights just how important our physician colleagues believe nursing is to patient care, and how valued we are as colleagues. The story about EMD expresses the key role nurses played in the success of our ambitious Electronic Multidisciplinary Documentation launch. And the article about the opening of G2S underscores what a crucial part nurses can play in identifying the needs of the hospital and creating solutions to fill them.

Collaboration is essential as we continue our efforts to enhance professional practice, patient care, and our practice environment. We have many more initiatives underway (i.e. RFID tracking for equipment, electronic bedboard, etc.) that will enhance our environment in the near future. We should all be very proud of the strong culture of collaboration at Stanford Hospital & Clinics and the very important role that nursing plays.

A handwritten signature in black ink that reads "Cindy Day". The signature is written in a cursive, flowing style.

Caring in a High Tech World

The Cath Angio Lab Takes a Team Approach

BY JACQUE KIXMILLER, RN, BSN
CLINICAL EDUCATOR, CATH ANGIO LAB

The Cath Angio Lab at Stanford Hospital & Clinics encompasses five specialty areas: interventional radiology, cardiology, neuroradiology, electrophysiology, and pediatric cardiology. Utilizing the latest digital imaging techniques, patients undergo invasive, catheter-based procedures to diagnose and treat a wide variety of disease processes.

Historically, the primary focus of the Cath Angio Lab was facilitating diagnoses. With the evolution of technology, improvements in imaging capabilities and advances in microtechnology, smaller and more maneuverable catheters have allowed physicians in the Cath Angio Lab to treat patients who, in the past, would have required more invasive or surgical procedures. This allows patients a shorter recovery time with less pain and disruption to their daily lives.

A team approach

Treating patients in the Cath Angio Lab requires a multidisciplinary team approach. Working collaboratively with the physicians and fellows, RNs and radiology technologists staff the procedure area and are supported

by a team of nurse practitioners, RN schedulers, coordinators, and physician assistants. Dr. Lawrence Hofmann, medical director

for interventional radiology, says, "It is truly a team approach."

The patient's experience

For the patient, the journey typically starts with a referral. For interventional radiology, Dr. Hofmann says, "the misconception is that IR is a turnkey service. We need a thorough history, a thorough exam, and a thorough review of the imaging to determine the appropriateness of a procedure. We utilize RNs as schedulers

because of their clinical background. NPs and PAs act as physician extenders, assisting with outpatient clinics, covering rounds on patients with indwelling tubes, and serving as outreach for our growing practice." Similarly, cardiology, electrophysiology, and neuroradiology services utilize RNs as schedulers and coordinators. The RNs' clinical expertise allows them to educate patients regarding their procedures and organize their clinical



Left to right: Claudia Harrison, RN, patient care manager; Lupe Salinas, RN, staff nurse; Darcey Shinko, office assistant.

care. “Our nurses go the extra mile to make things better for our patients,” says Dr. David Lee, medical director for interventional cardiology.

Upon arrival in the Cath Angio holding area, the RN staff reviews the patients for correct preparation, alerting physicians to abnormal lab-work, and assuring that the patients are ready for moderate sedation and that all documentation is in order. The holding room staff provide the emotional support patients need. “Even as technology advances, our job is to maintain the utmost personal attention to our patients,” says Mavis Tumaneng, RN.

In the procedure areas, the RNs and radiology technologists (RTs) work together. While the procedures and equipment are high tech, the focus of the staff is on caring for the individual patient. The RTs provide the expertise for imaging while the RNs lead the patient care. “Our physicians use information from the nurses, RTs, fellows, and residents. The staff is concerned about the individual patient’s well being and comfort throughout the process,” says Dr. Hofmann. “I enjoy helping patients,” reflects Bob Tallerico, RT Manager for Cath Angio. “The technical challenges keep it interesting.”

Being prepared for anything is also key to working in the Cath Angio environment. The patient population ranges from the relatively healthy to the critically ill patient, and includes all ages from neonate to the elderly adult. “You have to be adaptable,” confirms Dr. Lee, “because our procedures change all the time. Our nurses use their common sense. If something doesn’t sound right or look right, they give their opinions and provide input into patient care.” When treating patients with life threatening diagnoses such as acute MIs, strokes, or hemorrhages, time is of the essence and working as a team is imperative. Dr Hofmann says, “As we have evolved into a therapeutic specialty, our cases have increased in complexity, increased in risk, and increased in length.” Procedure room staff also interact with other specialties such as EEG technicians, respiratory therapists, anesthesia, and the OR staff to provide the highest level of care. “I enjoy interfacing with all the other departments and different services,” says Claudia Harrison, Patient Care Manager for Cath Angio. “It’s great to work with such talented medical teams.” While the patient care and procedures are technically challenging, the collaboration is what staff enjoy most. “I have fun



Tessie Anderson, RN, staff nurse



Theresa Mallick-Searle, NP, and Monica Gerstner, RN, nurse coordinator

here,” says Eva Mendez, RN. “We always have a good time – my patients always tell me how much fun we are!” According to Bles Tsung, RN, “I work here because of the collegial aspect of this area. We get to work with the best and the brightest.” Buddy Rosser, RT, agrees: “I like working with our doctors, the patients, and the rest of the staff.”

Looking ahead

Advancing the science has always been a priority for the Cath Angio Lab. “We have a rich tradition of innovation. IR is a central hub of medicine for translating bench-top discovery to bedside care,” says Dr. Hofmann. Image guided molecular interventions are the wave of the future. “Safely delivering drugs,

continued on page 4

continued from page 3

proteins, genes, or stem cells to the desired location will be carried out by IR,” he continues.

Cardiology has also moved beyond the traditional coronary interventions to include closure for atrial septal defects and patent foramen ovals utilizing a percutaneous approach. “We will be doing percutaneous valve replacements and repairs of left atrial appendages in the Cath Lab,” says Dr. Lee. He anticipates that gene therapy and biodegradable stents will be available in the next five years. Participation in national trials and research protocols allows Cath Angio patients access to the latest devices and procedures available. A research trial utilizing stem cell therapy for myocardial revascularization will soon be underway in Cath Angio.

Tessie Anderson, RN, says, “I’ve worked in Cath Angio for 17 years. It’s never boring! There are so many opportunities. The research, new technologies, and innovations mean things are always changing.” According to Bles Tsung, RN, “There are always learning opportunities here. It’s really up to the individual to take advantage of the opportunities.” “I love what I do. I look forward to coming to work!” agrees Kim Reed, RT. **SN**

Caring in Collaboration

Name: Mary Marcellus
Occupation: RN Coordinator for interventional neuroradiology
Years at Stanford: 25

“I have worked with the Interventional Neuroradiology team for more than 13 years. I started just before the first interventional-specific neuroradiology fellow. In the years since that time the procedures have become more refined and the volume has skyrocketed. Coming from an ICU background, the Cath Angio Lab was a very different environment for me. At first I thought I would never be able to tell one vessel from another! Claudia Harrison was the primary neuro Cath Angio Lab nurse, and she taught me a lot about what patients experienced while they were in the lab. The techs and physicians taught me about what I was looking at when I looked at an angiogram. Since I spoke with patients before they came to Stanford, and examined them in clinic before they were admitted, I could share the information I gathered with the Cath Angio Lab staff. I think we are all able to give the neuro patients the very best care because of our combined expertise.”

Name: Theresa Mallick-Searle
Occupation: Nurse Practitioner, interventional radiology
Years at Stanford: 10

“The nurse practitioner role in Interventional Radiology is new to Stanford, and quite unique in its scope. As the nurse practitioner in Interventional Radiology I work very closely with all members of my team, including IR physicians, physician assistants, nurse coordinators, and especially the radiology nurses and technologists in the Cath Angio Lab. As an advanced practice nurse, my scope of practice allows for greater participation in patient care decision-making and management. This freedom allows our physicians to spend more time in the Cath Angio Lab meeting the ever-growing demand of our service. No two days are ever quite the same in Interventional Radiology, so my role is a fluid one with some dependable constants. There are always patients that require consenting for procedures, there is always patient and staff education that needs to be done, there are always hospitalized patients to be managed, and there are always clinic patients to be seen.”

A Personal Perspective

Sunday, May 28, 2006, is forever etched in Susan McKay's mind. After dinner and a pleasant day at home, her husband Brent told her he didn't feel well, and went upstairs to rest. A moment later she heard him scream for her.



Susan McKay, RN

She found him lying down, a frightening shade of ashen gray. He described feeling numb from head to toe. As the nurse manager for Stanford's Ambulatory Treatment Unit, Susan's nursing instincts took over as she realized she couldn't risk transporting him to the hospital herself, and immediately dialed 911. The fireman who arrived quickly assessed, started lines, and placed him on a cardiac monitor. When the monitor read 60/30, I told him, "We've got to go now!"

Once they arrived at the nearest hospital – Kaiser in Redwood City – the emergency doctor put him on a monitor and confirmed that he was very likely having a heart attack. Explaining that Brent needed to get to a cath angio lab right away, he suggested either San Francisco Kaiser or Stanford. "We're going to Stanford," Susan said.

"It felt so good to come to such a familiar place," she recalls. Since the ATU handles all pre and post procedure care for Stanford's Cath Angio Lab, the lab is practically a second home for Susan, and the team members are close colleagues. In fact, as Brent was wheeled into Room 1, Susan immediately recognized the fellow, who she had known since he was an intern in medicine. "Todd, it's my husband," she remembers saying.

"It was nearly midnight by the time we arrived," Susan

reflects, "yet the on-call team was ready for us. They worked like a well-oiled machine – but still made the time to be so kind to me as they set up the sterile field and prepared for an angioplasty."

Once the procedure was over, Dr. Alan Yeung came to the waiting room to see her, actually showing her the blood clot that was the culprit and explaining that while Brent's main artery had been 80% clogged – a condition called the "widow maker" – his other vessels looked very good.

A few days later Brent celebrated his birthday in the cardiac surveillance unit, but, as Susan admits, they were happy to celebrate anywhere.

"I knew our Cath Lab was good," she says, "but that evening I really saw their exceptional blend of expertise and caring. I could feel that their heart was in their work."

"I can't say enough about the team: Alan, Todd, Dympna Doherty (the nurse), and Randy Dove (the technologist)," she goes on. "I want to acknowledge them for the difference they make."

It is, she says, what truly distinguishes Stanford. "You do your work with skill but also compassion. It's what I see here every day. And this experience has made it so personal for me; it's given me an even stronger passion for the work I do." **SN**

"I knew our Cath Lab was good," she says, "but that evening I really saw their exceptional blend of expertise and caring. I could feel that their heart was in their work."

The Nursing Work Group

A Key Factor in the Success of EMD

BY CONNIE TAYLOR, RN, MPA, DIRECTOR OF NURSING INFORMATICS

Electronic Multidisciplinary Documentation (EMD) is arguably the most complex project ever tackled by Stanford Nursing. In this story I will describe the project briefly, and then introduce you to the amazing Nursing Work Group (NWG): the Stanford staff nurses who played a key role in the development and successful implementation of the project.

A bold and ambitious plan

With physician order entry (POE) firmly established and electronic flowsheet charting implemented in the ICUs, nursing leadership turned its attention in November 2003 to launching electronic documentation in the rest of the patient care areas. The advantages of EMD were clear: nurse access to electronic orders placed by physicians with the ability to chart against those orders, improved patient safety as a result of electronic medication documentation and barcoded medication administration, improved access to the medical record, expedited chart audit monitoring, and potential increase in staff productivity.

In partnership with information technology (IT), nursing engaged an external consultant to provide an assessment of the environment (including suggested strategies to improve nursing workflow and patient safety through the use of electronic documentation), to identify resources needed, and to ascertain the barriers to implementation.

Creating a test case

A prototype “Solutions Room” was visited by nearly 400 direct care providers, including nurses, pharmacists, physical, occupational and speech therapists, infection control practitioners, social workers, and case managers. Here, staff viewed the prospective documentation module and technology (including computers on wheels or COWs) and were asked to complete a survey about EMD. An astonishing 98% expressed resounding support for EMD and the value it brought to patient safety and improving the documentation process.

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A budget was submitted and approved in September 2004. The plan was to design, build, and implement electronic nursing documentation in Phase I, and to bring up ancillary clinical departments in Phase II. An EMD Executive Steering Committee comprised of nursing, medical staff, pharmacy, and IT professionals was established and co-led by Vice President of Patient Care Services and Chief Nursing Officer Cindy Day and Chief Information Officer Carolyn Byerly. A physician advisory group was formed, and a Nursing Informatics Department established. The EMD project kicked off in October 2004.

Recruiting the Nursing Work Group

Staff nurses from ten different patient care areas were recruited to work with IT facilitators, comprising the Nursing Work Group (NWG). Each NWG member represented his or her own unit plus one “sister” unit, so that all units involved in Phase I of EMD had equal representation. Staff nurses applied for the positions after seeing flyers for the project and with encouragement from their managers. They were interviewed and chosen by a team consisting of Director of Practice and Education Marilyn Mahugh, Senior Nursing Informatics Specialist Sara Munk, and Margo Saum, a member of the initial consulting team who now worked



Arni Elfrink and Nancy Becker

with Stanford IT. The charge of the NWG was to determine current and future workflows, give input to screen builds, assist with integrated testing, help develop training curriculum and material, and eventually staff the team used to support “go-live” and provide field expertise.

In January 2005 the NWG started working together regularly, collaborating with Nursing Informatics, the EMD multidisciplinary workgroup, and IT to assist in every phase of the EMD project. The group researched unit needs, redesigned workflows, and developed support materials. They developed the interdisciplinary plan of care (IPOC) and mapped the details of barcode medication charting (BCMC), with the dedicated involvement of ancillary disciplines and pharmacy. As the build progressed the NWG began to assist in development of training tools. They “branded” the EMD program with the SMART (Safety, Medication barcoding, Accessible patient data, Real time, Timely updates) COW logo.

An Epic shift

A change in the scope of the project occurred in late 2005 when SHC made a strategic decision to implement another

electronic medical record system, Epic®. With Epic coming in the near future, the plan for Phase II (EMD for ancillary clinical departments) was postponed until Epic go-live. At the same time, a strategic decision was made to continue building charting for nursing documentation because of the benefits to be gained from online documentation, and the opportunity to lay the groundwork for Epic by transitioning all of the inpatient nursing staff from a paper environment to online charting.

When EMD was officially launched on May 9, 2006 in the Ambulatory Surgery Center and the Surgery Admission Unit, the NWG switched hats to become the lynchpins of the at-the-elbow EMD Support Team, affectionately dubbed the “Red Rovers.” As EMD has rolled out, each new go-live uncovered different issues across the nursing units, some unique to the practice flow of the units, some universal to the system as a whole. The NWG weighs in on potential solutions to each issue. With the progression of the rollout, barcode medication charting (BCMC) encountered unanticipated issues that had not shown up in the extensive integration testing before go-live. The NWG worked intensively with the unit staff to determine if the primary issues were hardware, software, or training so that the EMD Executive Steering Committee could base decisions about BCMC on actual data.

On October 11, 2006, EMD went live on the final unit. As the project ended, several NWG members stayed on the transition support team. The rest returned to their home units and will still be involved with EMD as Super Users.

The issues with BCMC notwithstanding, EMD for nursing has been a successful endeavor. There are many factors contributing to this success, including the nursing leadership and resources allocated to assist with the build, training, and oversight of the process, the unit-based leadership in creating excitement and enthusiasm among their staff, and the willingness and openness of the staff nurses to adopt these new processes and technologies. But one of the most critical factors is the involvement from day one of the staff nurses who comprise the Nursing Work Group. Their participation has been invaluable, and all of these talented RNs are tapped to be subject matter experts (SMEs) for their units as we move forward to the design-build-validate (DBV) phase of the Epic implementation.

Meet the Nursing Work Group

Although I was not involved in the initial selection of this group, as director of nursing informatics I have been intimately involved since May 2005. They are a terrific group of people and representative of the high caliber of nurses at Stanford. I am so impressed with their individual and collective talents that I want to share their stories with you.

HELEN ALFORD ably represents the psychiatric units, G2P and H2. She has been an RN for 31 years, attaining her BSN in 1990 from Indiana University NW, and is certified through ANCC as a psychiatric nurse. Helen was originally interested in the NWG position because she is very interested in processes and wanted to not only watch but be involved in this change at Stanford. The most challenging aspect? It requires her to wear many hats: student, teacher, decision maker, group member, initiator, leader, idea generator, and effective communicator. Helen is grateful for the opportunity to learn something new each day and share those experiences with a great group of people. When she's not busy with EMD and her home unit, Helen enjoys gardening and traveling.

D1 CCU/CSU and B2 are lucky to have **NANCY BECKER** as their EMD champion. Nancy has a diploma from St. Luke's Hospital in San Francisco and joined Stanford 26 years ago. Her primary interest in joining the NWG was to make sure that the needs of the Coronary Care and Cardiac Surveillance Units were addressed. She describes EMD as "the biggest change to our practice in my career" and finds the most challenging aspect to be supporting the adaptation to computerized charting for persons who are less receptive to change. This challenge is more than balanced by the continued pleasure of collaborating with the other members of the NWG – "a great bunch of people." Nancy also enjoys all the different avenues of nursing that she has been exposed to during the rolling go-live schedule. She plans to return to D1 as a staff nurse and unit educator, and wants to help with the Epic implementation.

"I also wanted to give input from an end user perspective (from a non-computer-savvy sort of way, that is)."

TESS CANDIA is a staff nurse on B3, and also represents C1. An RN for 12 years, Tess obtained her BSN in the Philippines from Divine Word College. She is a certified neuroscience registered nurse (CNRN). Her impetus for applying to the NWG stemmed from her curiosity about the transition from paper to computerized charting. "I also wanted to give input from an end user perspective (from a non-computer-savvy sort of way, that is)." Tess found learning how to use the program properly challenging, and finds that even now she is learning new things. What makes it all worthwhile for her is when a unit successfully goes live. "When someone tells me 'I get it now' and I know that the person means it. At the end of the day, that's all that matters." When Tess isn't busy with EMD, her favorite activities are playing with her son and curling up with a good book.

ARNI ELFRINK has been in nursing for almost 26 years. She obtained her BSN from Texas Women's University after getting a BA in English from UCLA. Arni works in North ICU and is certified as a critical care registered nurse (CCRN). On the EMD project, she also represents E2ICU. In applying for the NWG, Arni felt that "the Nursing Work Group was a chance to do something totally different in nursing and at the same time have my bedside experience be relevant. It was an opportunity to represent my peers on a project that impacts us on a daily basis." Arni was challenged by having to learn a new skill set, but is satisfied by having the opportunity to work with such a diverse yet cohesive group. She describes the experience as "really fun and educational" and also enjoys the hands-on experience of supporting the nurses during the go-live period. Although Arni is returning to the bedside, she is interested in exploring new opportunities in nursing informatics.

"It was an opportunity to represent my peers on a project that impacts us on a daily basis."



Top Row: Bob Mathews, Kim Nguyen, Arnie Elfrink, Cindy Meyer, Jody Leeds. Middle Row: Helen Alford, Belle Pul-lano, Sara Munk. Front Row: Marie Perez, Nancy Becker, Tess Canda, Margo Saum

BOB MATHEWS, the lone male voice on the group, is by no means "token." Bob represents the orthopedic units, C3 and B1, as well as Dialysis. He has been interested in nursing documentation for many years, and participated in the redesign of the med-surg flowsheet in 1994-95. Bob started at Stanford 27 years ago, and obtained his ADN at De Anza College School of Nursing 23 years ago. He went on to get a BS in Health Care Administration. Bob is certified through ANCC as an orthopedic nurse, and belongs to the National Organization of Orthopedic Nursing (NAON). Bob was attracted to the NWG position by the prospect of being "part of the most important change to nursing at Stanford." The challenge for him was learning the functions, tips, tricks, and nuances of the Carecast

system, and this is balanced by the satisfaction of knowing that he has helped so many nurses learn and use the new EMD system. Bob would like to continue with the Epic project in some role. "I see myself transitioning away from patient care and more into nursing informatics." Away from work, Bob enjoys nearly all outdoor sports and loves traveling with his wife and four children.

E3 and C2 have the benefit of **CINDY MEYER**, who has been an RN for 19 years. Cindy graduated from Harbor College in Los Angeles with an associate degree. She was drawn to the NWG by the opportunity to help provide the bedside nurse perspective to the computerized system and, like other members of the NWG, has consistently been the "voice" of the staff nurse. While meshing all the

subtleties of bedside nursing with a computerized system has been challenging and sometimes frustrating, Cindy finds this frustration is offset by the opportunity to train the staff and help them to understand how the new system will benefit their patient care. Cindy plans to return to bedside nursing on E3 after the EMD implementation is complete and will be an EMD Super User on her unit. She also wants to assist with the transition of EMD to Epic and to participate in staff training when Epic goes live. Cindy is grateful that "my involvement in the EMD project has given me a broader perspective of how all disciplines of the hospital interface with each other." She leads a very balanced life outside of work, enjoying family and gardening (in that order!).

"...my involvement in the EMD project has given me a broader perspective of how all disciplines of the hospital interface with each other."

KIM NGUYEN was another staff nurse on D3/D2, but for the Nursing Work Group she represented D/EGR (aka D/E Garden). Kim came to Stanford in 2003 from Barnes-Jewish Hospital in St. Louis, and was shocked that Stanford was not documenting electronically. "I could definitely attest to the many benefits of computerized charting, from nurse satisfaction and efficiency to patient safety." Kim was one of the original group of "Superknowers" who assisted with the Solutions Room in August of 2004. When the opportunity to be a part of the EMD project opened up, she jumped at the chance. "I felt strongly that Stanford has to modernize its patient care and health practice standards to truly be called a 'world class' hospital, and to have any chance of achieving Magnet status." Kim feels that being part of the NWG has allowed her to contribute both her nursing and electronic documentation background experiences to the project, and feels privileged to be a voice for nursing, the end users. After her home unit and sister unit went live, Kim moved on to the Epic project as a Patient Care Analyst.

"I felt strongly that Stanford has to modernize its patient care and health practice standards to truly be called a 'world class' hospital..."

MARIE PEREZ represented her home unit, F3, and also SAU and ASC. She has been an RN for six and a half years, with a BSN from St. Mary's College – Samuel Merritt College. Marie is a member of the Academy of Medical-Surgical Nurses (AMSN). She first became interested in the concept of the NWG because she was part of the original group in July 2004 that worked with staff in the Solutions Room. She was also here when physician order entry (POE) was launched in June 2001 and felt that information was very poorly relayed to the nurses and physicians. "I wanted the rollout of EMD to be different, and I wanted to have a say in helping to get the word across to the nurses." She is gratified by seeing and hearing how the staff really like the EMD program and comment on the benefits of having it. Eventually, Marie would like to be part of the Epic implementation, working with the system as a nurse instead of an IT analyst. Her immediate plan, however, is to expand her family. Her second child arrived on October 29.

Belle says her personal challenge was overcoming what her son Mike calls "a complete lack of the geek gene."

BELLE PULLANO just celebrated her 38th anniversary as an RN. She obtained her diploma at St. Francis Hospital in Trenton, New Jersey. Belle represents D3/D2, the intermediate ICU. Belle also worked with FGR, the oncology unit. Her reasons for applying for the NWG were clear: "I felt we did not receive enough training when we went to POE, and consequently my ability to advocate for my patients was adversely affected by my lack of computer skills. I could no longer show a new intern how to write the orders I needed to provide the care that my patients needed. Although I was not computer-savvy, I came away from the original Solutions Room with an excitement for the possibilities of a happy marriage between bedside nursing and the computer. Becoming a member of the NWG was my way of getting engaged and understanding what I was getting into. It was important to me that experienced bedside nurses have input from the

beginning." Belle says her personal challenge was overcoming what her son Mike calls "a complete lack of the geek gene." (Mike also did the graphic work on the SMART COW logo.) Belle loves seeing staff nurses overcome their fear and have success with EMD. She is looking forward to returning to bedside nursing. She would like to have some involvement with the Epic implementation because she feels that her EMD experience has been very valuable, but will never give up bedside nursing. Outside of work, Belle and her husband Gregg enjoy going to plays and concerts, traveling, and doing things with their three adult children. "I'm an avid reader and an unavid exerciser, but I'm working on that!" **SN**



Creating a Unit from the Ground up

BY TERRIE GORDON-GAMBLE, RN, MSN

As any administrative nursing supervisor will tell you, an ongoing challenge is matching beds at the appropriate level of care with patients. ICU beds, monitored beds, Intermediate Intensive Care beds, even medical/surgical beds can all be in short supply at Stanford Hospital. As a result, patients needing ICU beds sometimes endure long waits in the Emergency Department or Post Anesthesia Care Unit, or in medical/surgical units when they have orders to transfer to a higher level of care.

A puzzling paradox

Eight beds on G2 were typically under-utilized. Sometimes detox or pain service patients were roomed in these beds, but for some reason – perhaps the proximity to the psychiatric unit – there was ongoing confusion about which patients were appropriate for this unit and who would provide the nursing care once they were roomed there.

So we asked: How could we make better use of this space – particularly given the ongoing space crunch we face? Along with Debra Grant, ADN, I began to research whether there was a patient population in the ICU or IIC that could be roomed on another unit if the nurse-to-patient ratio was higher than the state-mandated ratio of 1:5 on the medical surgical unit. We found that many patients stayed in the ICU when they no longer needed invasive monitoring, mechanical ventilation, or other critical care provisions, simply because they need hourly monitoring, which they couldn't get on a general care unit. All of these patients were being roomed in the ICU, yet none of them required critical care.

Physicians lend their support

Once we had identified an appropriate patient population for this potential new unit, the next step was to secure the support of the involved physicians. Dr. James Chang was eager to have his plastics patients monitored closely, but outside the ICU. Dr. Stephan Busque was enthusiastic about the potential for having all of his renal transplant patients together on a unit that could provide hourly monitoring, again outside the ICU. And the endocrinology service was more than happy to have a place for diabetic patients who required hourly interventions but not critical care.

From humble beginnings...


Ten nurses were hired – six from Stanford units and four from other hospitals – and all came with ICU, IIC, or transplant experience. They were excited about being part of a new unit. In August 2005, supplies were purchased, including a Doppler monitor with a state-of-the-art pencil probe and an MP 30 monitor for measuring central venous pressures. Staff received 24 hours of education in the care of patients with renal transplants, flaps, and digit re-implantations. A temporary nurses' station was set up in a corner of the Psychiatry dining room and four beds were opened for any patient needing hourly interventions. The first two patients were admitted in September 2005, and the unit was formally named G2S (for surgical) to differentiate it from G2P (for psychiatry).

...to a successful and stable unit

Since these humble beginnings just a year ago, the staff has grown to 15 nurses and the unit to 8 beds. Sixteen hours of education in the care of trauma patients and insulin drips has been added. A slightly larger nurses' station has been created and an even larger one is due to open next month. The unit is living up to its promise as a highly effective “in-between” unit with an average census of 6 patients per day and over 1,500 patients days in the first 10 months.

Barb Odin, Nurse Manager of the E2 ICU, appreciates the impact of G2S on the ICU.

“It gives us a place to send patients who still need hourly care where we know that they will be well cared for. G2S has greatly impacted the positive flow of patients in and out of the ICU. One patient's mother, who was a nurse, told me G2S was a warm, supportive, and clinically good place for her son, and she was grateful that such a unit existed at Stanford.”

Best of all, patient reviews have been positive, too: “As one patient recently said: ‘I've never had better care...’” 

Inside the Ambulatory Surgery Center

BY WENDY CHUA, RN

The world of surgical nursing is secluded and tucked away from the public. Even non-surgical nurses don't typically know what goes on behind the closed doors of the operating room suite. Yet it's a fascinating and constantly challenging specialty. We hope this story will reveal the variety of roles we play as peri-operative and peri-anesthesia nurses.

Preparing the patient

The Ambulatory Surgery Center has three major settings: pre-op, surgery, and PACU (Post Anesthesia Care Unit or Recovery Room). We begin by interviewing each patient in pre-op prior to surgery, collecting as much data as we can for hospital records. This is a very important part of the process, and assures patients that we will care for them in accordance with their specific needs. The pre-op nurses place armbands on patients for identification and to signify any allergy alerts. Another critical part of the process is surgical marking: the patient actively participates to identify the surgery site and signs the "consent for surgery" document, adhering to JCAHO's safe practices. The patient's passport with a green "GO" sticker at the front

of the chart assures that the checklist is complete and the patient is ready for surgery. The surgical nurse who meets the patient in pre-op prior to proceeding into the operating room re-checks the consent for surgery to make sure that we have the right patient, procedure, and surgical site.

Preparing the surgical suite

The surgical nurse is also responsible for assuring that the room is ready for surgery. Is the equipment in place and in good condition? Are the surgical instruments sterile? Are the dressings and medication requested by the surgeon at hand? If there are implants to be used, are these available and/or is the sales rep present?

During surgery

During surgery, the critical role of a nurse as patient advocate comes into play, especially while the patient is sedated. Assisting the anesthesiologist during induction of anesthesia, surgical positioning, and preps are just a few of the surgical nurse's responsibilities. A "time out" is called to make sure everyone is in agreement as to the procedure planned. The consent is read, including the name of the patient, the position, and any allergy alerts. Nurses perform a surgical count before and after surgery to make sure that everything is accounted for and nothing is left inside the wound, and maintain steril-

ity throughout the procedure. During long cases, the nurse either calls or goes to the waiting area to update the family and answer any questions.

In PACU/Recovery

After surgery, patients are admitted to the PACU, where specially trained nurses monitor them continually until the effects of anesthesia have resolved and the patient is comfortable. Inpatients are then transferred to a nursing unit, while patients who are to be discharged are transferred to Phase II recovery. The Phase II nurses assess each patient's readiness for discharge, making certain



Wendy Chua, RN, and Joan Carlson, RN

All in a day's work

The patient was scheduled for a laparoscopic ovarian cystectomy, biopsy, and possibly an open surgical procedure – all fairly routine procedures. Yet the fact that she was four months pregnant and facing surgery for a potential malignancy made it anything but routine for the young woman and her husband. They were understandably anxious in pre-op, but I was able to alleviate their concerns a bit by fielding questions about the extent of the procedure, the effects of anesthesia on the fetus, recovery time, and how quickly they would receive results from the biopsy.

We received the results of the biopsy during the procedure, and I was able to share the happy news that the biopsy was negative with the patient's husband, who was anxiously waiting to learn the results. I still recall his tears of joy as he hugged me, and his wish that I extend his thanks to everyone for their hard work.

that the patient and his or her caregiver understand post-op care requirements, including diet, wound care, and how to contact the doctor for follow-up care.

Working in the Surgical Services department is both challenging and rewarding. When we make follow-up calls to patients a few days after surgery, it is gratifying to hear how much better they feel or how fast they are recovering. Satisfaction

surveys sent by patients after they have been discharged include quotes like “knowledgeable and ready to listen and explain questions” and “warm and caring – helped to make me relaxed and less anxious.” This tells us that we're making a difference every day. **SN**



Advance for Nurses magazine has named Stanford nurse Susan Nekimken, RN, MPA, CMSRN, Patient Care Manager, winner of the Best Nurse Leader 2006 award. Following

are excerpts from the nominating letter submitted by the unit management team for D/E GR. Congratulations, Susan!

Challenges: What challenges has your nurse leader faced and how did he/she overcome them?

Susan has faced many challenges within her still relatively short tenure on D/E GR at SHC. She had to contend with the low morale of the unit when she started as our patient care manager and she did a wonderful job of boosting the morale of the staff by proving herself to be a fair and honest leader...celebrating every little victory the unit receives...and recognizing the staff who went above and beyond the call of their duties by creating the “ABCD” award. She also had to get our unit ready for JCAHO within three months of her hire and she did a fabulous job of getting our unit prepared without stressing all our staff...we passed with flying colors.

Patient Outcomes: How has your nurse leader made a difference in patient outcomes?

Susan has been involved with hospital-wide development plans such as the “Early Discharge” project and our unit has received recognition and prizes because of the changes she implemented and the positive results they produced. She is always available to see patients and family members who have complaints.

Overall Impact: How does your nurse leader contribute to how well the unit works?

She remains positive amidst all the chaos and challenges she faces every day and she inspires the people who work with her.

2006 NURSE WEEK



A Balance of Work and Play



In this picture, **STAFF TEAM-MATES FROM F3** show us what it is like to navigate on the Middle Fork of the American River. Charissa "Cha Cha" Santos, RN, organized this trip as well as many other unit outings and celebrations.



VALERIE MARRONE, an assistant nurse manager from NICU, has made over 40 quilts since she began the hobby six years ago. She loves quilting because it involves design, color, and sewing. Valerie has taught children's art classes in color and design and has helped them design quilts that she assembles as gifts for their teachers. Valerie often donates her quilts for fundraising events.



EVA MENDEZ, a staff nurse from the Cardiac Cath Laboratory, took up hula dancing several years ago. She has been a member of Te Mau Tamari'I A Tiarel Nu Kainali'I A Kiele for the past three years. Eva performs both modern and ancient hula. She is shown here in blue performing an ancient Hawaiian Hala Kahiko.

From the Chief of Staff

LAWRENCE M. SHUER, CHIEF OF STAFF

A Magnet for Nurses

I have been consistently impressed with the professionalism of my nursing colleagues throughout the 28 years that I have been associated with SHC, particularly as the definitions of that professionalism have evolved.

Years ago nursing “professionalism” was too often seen as a “trickle down” effect of medical professionalism. Nursing professionalism was too often defined by each nurse’s willingness to empathize with patients and to strictly follow “doctor’s orders.” While carrying out medical orders responsibly and compassionately is certainly important for everyone, what we are seeing now is a recognition that nurses have a defined leadership role in both bedside care and institutional management that didn’t exist even a few years ago.

This focus on nursing professionalism is part of a broader trend toward defining all healthcare professionalism in measurable and rigorously disciplined ways. Hence, we are not only hearing but also living and breathing such concepts as evidence-based medicine, clinical analytics, and quality improvement tools. Many of these tools or enhancements are products of incorporating evolving scientific progress into practice. The improvements are also a result of better information technologies, such as electronic medical records, which permit physicians, nurses, administrators and other hospital professionals to work more precisely and efficiently. Other enhancements are based on an increasingly sophisticated and educated workforce that is ready to meet multidisciplinary leadership challenges.

For example, on the unit where I do most of my work, 15 registered nurses and two nurse practitioners took the initiative recently to become board certified in neurosciences. Since a year or two ago only 34 nurses throughout the state had achieved this status, the accomplishment is obviously a feather in the cap of our institution. The board certification success is testament to the long hours of study, hard work, skill development, caring, and leadership initiative shown by

my 17 colleagues.

Throughout the hospital we are launching a new professionalism program heavily involving nursing and the cooperation of our medical staff. Cindy Day, vice president for patient care services, and her staff are applying for Magnet Status for SHC from the American Nurses Credentialing Center’s (ANCC) Magnet Recognition Program. This is the highest level of national recognition offered by the ANCC. The program’s goals are to identify excellence in the delivery of nursing care to patients, promote an environment that supports professional nursing practice, and to provide a mechanism for nursing services to disseminate their best practices among institutions.

To achieve the Magnet award a facility must demonstrate measurable quality standards in patient care and professional practice. This is documented through a rigorous application process, including a site visit. Nursing involvement in hospital leadership and governance is pivotal – nurses must enjoy strong and effective representation on the institution’s planning and policy-making bodies. Avenues for professional development for nurses must also be documented. To facilitate the application process, outstanding nurses are recruited on units throughout the hospital to serve as Magnet Champions. Recruitment of these nursing leaders is under way now.

Put simply, Magnet Status reinforces a culture of excellence that I believe will enhance our nursing staff’s sense of pride and professionalism. ANCC surveys have shown that Magnet Status improves nursing retention and we are, after all, facing a statewide nursing shortage.

Let’s make clear that we already have great nurses whose morale we can observe every day from the inspiring stories they share with us in many formats. With the enthusiasm, leadership, and skill of our nurses and their physician colleagues, I’m confident that we will become a Magnet institution.

In Recognition of...

CONFERENCE PRESENTATIONS

Debbie Bone, RN: "Disaster Preparedness – Hurricane Katrina/Nurses in the Field," Occupational Health Nurses Association of Santa Clara Valley, February 14, 2006, San Jose, CA.

Patricia Jenkins, RN, MPA: "Making the Case for Palliative Care" and "Communicating with Patients and Families Approaching End of Life," Stanford University School of Medicine Pain and Palliative Care Symposium, Hawaii, October 2006.

Nadine Nakazawa, RN, BS, OCN: "PICCs: Clinical Efficacy in Challenging Healthcare Environment" Japanese Society of Environmental Infections Annual Conference, February 25, 2006, Tokyo, Japan.

Nadine Nakazawa, RN, BS, OCN: "Pathogenesis and Prevention of CRBSIs," Orange County APIC Chapter Conference, August 8, 2006, Long Beach, CA.

Debra Thaler-DeMers, RN, OCN, PRN-C: "Intimacy and Sexuality" Oncology Nursing Society, Santa Clara Valley Chapter, Cancer Hot Topics Day, September 30, 2006, Saratoga, CA.

Debra Thaler-DeMers, RN, OCN, PRN-C: "State of the Science on Nursing Approaches to Managing Late and Long-Term Sequelae of Cancer and Cancer Treatment," American Journal of Nursing & University of Pennsylvania School of Nursing, March 2006, Philadelphia, PA.

APPOINTMENTS

Nancy Brook, MSN, RN, NP: American Nurses Credentialing Center's Content Expert Panel, April 2006.

Nancy Brook, MSN, RN, NP: State Representative for California to the American Academy of Nurse Practitioners, May 2006.

Mary Lucitt, RN: Court Appointed

Special Advocate of Santa Clara County, July, 2006.

Debra Thaler-DeMers, RN, OCN, PRN-C: Recognition Subcommittee, Oncology Nursing Certification Corporation, August 2006 – August 2007.

Debra Thaler-DeMers, RN, OCN, PRN-C: Secretary, Oncology Nursing Society, Santa Clara Valley Chapter, January 2006 – December 2006.

CERTIFICATES

Sheryl Blankers, RN, BSN, CCRN, CEN, CFRN: Passed the Certified Medical Transport Executive Exam, May 6, 2006.

Irene Ip, RN, MBA, CMSRN: Passed the Nursing Certification Exam, Academy of Medical-Surgical Nurses, October 2005.

Stephanie Iseri, RN, BSN, CMSRN: Passed the Nursing Certification Exam, Academy of Medical-Surgical Nurses, October 2005.

Robin Martin, RN, ADN, CMSRN: Passed the Nursing Certification Exam, Academy of Medical-Surgical Nurses, October 2005.

Carole Nakamura, RN, BSN, CMSRN: Passed the Nursing Certification Exam, Academy of Medical-Surgical Nurses, October 2005.

Elisa Nguyen, RN, BSN, CMSRN: Passed the Nursing Certification Exam, Academy of Medical-Surgical Nurses, May 2006.

Molly O'Sullivan, RN, CNRN: Passed the Certification Exam for Neuroscience Nursing, April 2006.

Pamela Schreiber, RN, MSN, CNS, CMSRN: Passed the Nursing Certification Exam, Academy of Medical-Surgical Nurses, October 2005.

Allen Sia, RN, CNRN: Passed the Certification Exam for Neuroscience Nursing, April 2006.

Aileen Simon, RN, BSN: Passed the Oncology Nursing Certification Exam, July 2006.

Nancy J. Sowers, RN, MBA, CMTE: Passed the Certified Medical Transport Executive Exam, May 6, 2006.

Victor Tamayo, RN, CNRN: Passed the Certification Exam for Neuroscience Nursing, April 2006.

ARTICLES AND PUBLICATIONS

Mary Lough, RN, MS, CNS, CCRN, CNRN: "Cardiovascular Assessment" and "SvO₂, ScvO₂, and AvDO₂ Monitoring" chapters in the *Second Edition of Critical Care Nursing Secrets*, Mosby/Elsevier: 2006.

Leanne Perez, RN, MSN: "Unusual Placement of an Endotracheal Tube in a Patient with Blunt Traumatic Airway Injuries," *Air Medical Journal*, Mosby, January/February 2006, pp 40-42.

Nadine Nakazawa, RN, BS, OCN: "Difficult PICC Insertions Column," *Journal of the Association of Vascular Access*, published quarterly, 2006.

Jim Stotts, RN, MS: "Hemodynamic Monitoring" and "Cardiac Output Monitoring," chapters in the *Second Edition of Critical Care Nursing Secrets*, Mosby/Elsevier: 2006.

DEGREES

Leanne Perez, RN, MSN: Completed the Post Masters' Certification in the Acute Care Nurse Practitioner Program, University of California at San Francisco, August 2006.

Karen Stuart, RN, BSN: Graduated with a Bachelor of Science Degree in Nursing, San Jose State University, June 2006.

AWARDS

Julia Kersey, RN: International Award for Outstanding New Practitioner, Sigma Theta Tau, April 22, 2006.

Sheryl Michelson, RN, MS, BC: Second Annual Volunteer Service Award, Stanford Medical Youth Science Program, July 27, 2006.

Laura Tracy, RN, SANE-A: Unsung Hero Award, County of Santa Clara, April 2006.

FELLOWSHIP PROGRAM

Erma Becker, RN: Evidence-based Practice Fellow completed the program offered through the Stanford-LPCH-UCSF Center for Research and Innovation in Patient Care. Project: "Concordance Approach to Improving Medication Adherence in Schizophrenic Patients," Fall 2006.

Lisa Chalfin, RN, MSN: Evidence-based Practice Fellow completed the program offered through the Stanford-LPCH-UCSF Center for Research and Innovation in Patient Care. Project: "Evaluation of Nursing Sedation Practice in the ICU," Fall 2006.

Tracy Kendall, RN: Evidence-based Practice Fellow completed the program offered through the Stanford-LPCH-UCSF Center for Research and Innovation in Patient Care. Project: "Evaluation of Pain Management in Pediatric Patients Admitted to the ED," Fall 2006.

Mario F. Pepe, RN: Evidence-based Practice Fellow completed the program offered through the Stanford-LPCH-UCSF Center for Research and Innovation in Patient Care. Project: "Implementing a Change in Orthopaedic Preps in the Operating Room," Fall 2006.

Joy Ryan, RN, BSN, CNRN: Evidence-based Practice Fellow completed the program offered through the Stanford-LPCH-UCSF Center for Research and Innovation in Patient Care. Project: "Standardization of Incisional Care for Craniotomy Patients," Fall 2006.



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Sr. Nurse Recruiter

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