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INTERPLAST
FROM STANFORD TO THE WORLD

TEAMWORK TACKLES CLINICAL PROBLEMS

SHARED DECISION MAKING

ELECTRONIC MULTIDISCIPLINARY
DOCUMENTATION COMING TO STANFORD

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From the Chief Nursing Officer

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



Here at Stanford we are committed to creating an environment that encourages and promotes shared decision making. Much of this *Stanford Nurse* issue is devoted to celebrating projects and examples of our staff participating in decision making. To create this environment requires a new way of thinking, being, and doing. Our model of “shared governance” is designed to encourage staff at all levels to emerge as leaders; it values each person for the vital contributions he or she makes in creating a positive work environment.

I am proud to say that we are well on our way to achieving interdisciplinary shared governance. The Clinical Practice, Quality, Education and Research Councils are active and are well attended by all members of our multidisciplinary team. Most of our nursing units now have at least one unit-based council. These councils are now actively making decisions that improve practices and the work environment. Our staff reports that their opinions and ideas are valued and feel that productive work is being accomplished in their councils.

We are working hard as a management team to eliminate top down decision making when appropriate and to empower staff at the unit level to make decisions. When a decision is necessary, it is our job as leaders to provide those closest to the issue enough information to make solid decisions to guide their practice. We have completed several large projects and created ongoing forums in which staff have made decisions related to these projects over the last 12 months. These projects include the Nurse Model, Resource Nurse Role Development, Electronic Documentation Development Core Team, IV Pump Selection, and Staff Advisory Board to the Center for Education and Professional Development. These initiatives have been successful because the decisions regarding these projects have been made by those closest to the work to be done. It has also created a great sense of “buy-in” and ownership. Members of these teams have felt that their contributions are valued and that they have positively influenced patient care and their work environment.

You have my commitment as your Chief Nursing Officer to continue to support this shared decision making environment and to create more opportunities in the upcoming year to gain input from our experts, as well as the staff.

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

Interplast *from Stanford to the World*

BY MARY E. LOUGH, RN, MS, CNS, CCRN

Stanford nurses volunteer their skills to bring free reconstructive surgery to children—and now adults as well—in developing countries. Interplast was founded 35 years ago by Dr. Donald Laub, former chair of Stanford's Department of Plastic and Reconstructive Surgery, to bring much-needed treatment to children with cleft lip, cleft palate, or contractures from burn scars. From a modest Bay Area project serving needy children in Central American countries, Interplast has grown into an international organization, whose medical volunteers and in-country medical partners have provided more than 54,000 life-changing surgeries for impoverished patients. In addition, Interplast offers advanced training for local medical personnel and helps them establish locally managed programs.



Betty Kolbeck, RN

Stanford doctors and nurses have been a part of Interplast from the start. Although their backgrounds and experiences are different, three Stanford nurses working with Interplast share much the same motivations and rewards.

Cynthia Myslinski, RN, has been a staff nurse in Stanford's ICU for more than 20 years, and a volunteer recovery room nurse for Interplast for almost as long. Rosemary Welde, RN, BS, MBA, is a staff nurse in Stanford's

OR and, like Cynthia, she has been an Interplast volunteer for some 20 years. Betty Kolbeck, RN, went on her first Interplast trip as a recovery room nurse in 1987. Betty and Rosemary also serve on Interplast's nursing committee, which meets quarterly to set guidelines and resolve issues related to nursing. Betty is also on the quality assurance committee, while Rosemary serves on Interplast's board of directors and a number of committees.



Cynthia Myslinski, RN, La Paz, Bolivia, 2004

medical team may handle 80 to 100 cases although, Rosemary said, “we’re concerned more about quality than the absolute number of cases.”

“but we focus on helping local staff adapt techniques and equipment to their local environment, so what they learn from us works for them.”

In the past few years, Interplast has shifted its emphasis and now focuses on teaching the local doctors and nurses who work with volunteers on

the surgical cases. “Now we nurses have a teaching role at the bedside or in formal classes,” said Betty. Betty and Cynthia work with recovery room nurses, teaching techniques such as airway management, infection control, and physical assessment. Likewise, Rosemary in the OR spends a lot of time teaching sterile technique and other procedures for scrub and circulating nurses. “In the OR we do things pretty much the same way as we do at Stanford,” said Rosemary, “because we want to serve as role models for the local people.” Interplast brings in its own equipment and supplies “but we focus on helping local staff adapt techniques and equipment

Interplast teams of medical volunteers make two-week trips to developing countries, now going to South America and Asia as well as the Central American countries where it started. On the first day, the volunteers hold a clinic for potential patients who have responded to local publicity. Then for the next four or five days, they operate from 7 am to 8 pm to correct cleft lips, contractures, and other deformities. After a day or two off to rest and see the local area, they return to work another five days. Over this time, a



Rosemary Welde, RN, My Tho, Vietnam



Cynthia Myslinski, RN, with local nurses, Bangladesh, September 2004

to their local environment, so what they learn from us works for them.” By taking on this teaching role, Interplast teams leave behind them the treated patients, but they also leave their own skills and knowledge to improve treatment for future patients.

Rewards

“There are absolutely no other resources for these children,” Rosemary said. “Their families can’t afford the surgery and the children are scorned by their community.” For all three Stanford nurses, the most immediate reward for their work is seeing the treated patients reunited with their families. “My biggest reward is when I put a baby back in its mother’s arms after recovery—and her face lights up,” Betty said. The

change in a patient’s appearance is incredible, Rosemary added, and it changes their lives forever.

“Their families can’t afford the surgery and the children are scorned by their community.”

All three nurses also mention the rewards of working with their medical teams. “I like the way that Interplast teams start as strangers and quickly develop camaraderie and lasting bonds,” Cynthia said. Interplast’s scope also gives its volunteers the opportunity to work with colleagues around the world, Rosemary added.

Cynthia finds her reward in the change of pace from Stanford’s ICU. “It’s an opportunity to work in a more relaxed atmosphere where I can be sure my patients will recover quickly, get well, and go home to a more normal life than they would otherwise have. I know that we have made a difference, and I feel fulfilled.” Other nurses also welcome the change of pace. “With Interplast, you’re practicing medicine the way you learned it,” Betty said. “You can concentrate on taking care of the kids without so much paperwork and other distractions.”

What do Interplast nurses bring home with them? “Gratitude,” Betty said. “I feel grateful for what I have here, and grateful that I can help give patients care they

wouldn’t otherwise receive.” Interplast nurses agree that there is a lot of psychic income, Rosemary added; “We get so much in return for our time.”

“My biggest reward is when I put a baby back in its mother’s arms after recovery—and her face lights up.”

For nurses as well as their patients, Interplast can be a life-changing experience. “When I left for my first Interplast trip,” Cynthia said, “I was in my 20s and already beginning to feel burned out. When I returned after two strenuous weeks in Honduras, I knew that I really enjoyed what I did and didn’t want to leave the profession. Now, Cynthia added, she returns from each trip with a new perspective on her work in Stanford’s ICU, “and I know I’m doing what I should be doing.”

Mary E. Lough, RN, MS, CNS, CCRN, is a Clinical Nurse Specialist in Stanford’s adult ICU. Cynthia Myslinski, RN, is a Staff Nurse IV on the same unit. Rosemary Welde, RN, BS, MBA is a Staff Nurse IV in Stanford’s operating room, and Betty Kolbeck, RN, is a Recovery Room Nurse. For more information about Interplast, visit their web site: www.interplast.org.

A Balance of Work and Play

Stanford's nurses balance their busy work lives with many other activities...



IRENE UNGSON, RN
Staff Nurse, C3

I started scrapbooking 20 years ago to preserve our family memories in a beautiful way. Now I teach origami gift album classes. It's a great creative outlet for me.



JOHN SMITH, RN
Staff Nurse, ED

I started bull riding on a dare and got hooked on the sport. I've had 18 broken bones, 8 concussions... and a million memories I wouldn't trade for anything! When you get that perfect ride and hear the crowd cheer, it makes all the injuries and hard work worth it.



FROM LEFT TO RIGHT: MARIAN DOLAN, ALLEN CORTEZ, LAURIE BACASTOW, RHEENA TENORIO, AND SHELLY YOUNG.

The B3 Spa Girls, who get together every few months for a day of stress reduction and teambuilding at the Ritz.



KIM BONNETT, RN
Staff Nurse, NICU

I've played the violin for 21 years. Now I play in the Peninsula Symphony and the Fremont Symphony. I spend at least a night or two a week in rehearsals or concerts—a great way to relax and spend time with friends I've met through my music.

CAROLE NAKAMURA, RN
Unit Educator, D/E Ground

I inherited my love of music from my dad, who was a jazz musician. I've been playing the violin for 32 years. Classical music is the perfect stress reliever after a hard day's work.



LAURA COLE, RN
Staff Nurse, NICU

I ride Sebastian, my Arabian gelding, both for pleasure and competition. Here, we just won first place in an English Hunter Pleasure Competition.



MARCIA WALSH, RN
Staff Nurse, OR

I breed and show Jack Russell terriers and train them for agility competitions. In this picture, my dog Xena beat out the border collies to win first place!

Teamwork Tackles Clinical Problems

To improve something you first need to understand how it works. It follows, therefore, that to find solutions to problems that involve clinical care, you have to involve the staff at the bedside.

Pressure Ulcers

BY: PAM SIMMONS, RN, MS, AND
SUSAN M. HAMMERSTAD, RN, MS, CMSRN

Recently Patient Care Services (PCS) undertook the challenge of improving the way we prevent and treat pressure ulcers. We created an interdisciplinary team to review our processes of care and to suggest effective changes. It included staff nurses, clinical dietitians, a physical therapist, a pharmacist, intensive care unit and medical-surgical nurse educators, an operating room nurse educator, and a Quality and Patient Safety Department representative. Critical expertise was provided by the Wound and Ostomy Clinical Nurse Specialist, and the group was facilitated by the PCS Quality Management Coordinator.

This emphasis on the overall system encouraged a feeling of teamwork and spurred group members to want to improve the processes within their areas of expertise.

Our team began its work by asking each team member, “The patient is admitted to your unit. What is the first thing you do related to pressure ulcers, then what do you do next, and then what?” This approach illustrated that final patient

outcomes were more a function of current processes than the result of individual actions. This emphasis on the overall system encouraged a feeling of teamwork and spurred group members to want to improve the processes within their areas of expertise. It also helped us identify issues that were more appropriately handled at an organizational level.

When the detailed care process description was finished, we were able to identify opportunities to update and strengthen our staff training, training tools, policies and protocols. Subgroups, in collaboration with others in their specialty areas, worked on these and brought their work back to the larger team for review and approval. Monthly pressure ulcer prevalence surveys using a detailed data collection tool then helped validate our action plans and provided direction for additional strategies.

Assembling Expertise

The team worked well because each person shared his or her special expertise. For example, the Wound and Ostomy Clinical Nurse Specialist drew from her experience in our hospital to focus our work on issues that truly needed improvement. The medical-surgical nurse educator’s expertise in developing succinct, user-friendly teaching materials helped us to create teaching tools, which, from the start, were clear and useful. The physical therapy specialists on the team contributed their knowledge of positioning devices, support surfaces and rehabilitation activities.

The clinical dietitians helped us understand the key role a patient’s nutritional status plays in the risk for skin breakdown and healing. As a result, for example, we initiated nutrition guidelines that should make a critical difference in dealing with the diarrhea that can accompany tube feedings and erode a patient’s already fragile skin. Finally, the staff nurses on the team always kept us focused on the real world where care is delivered 24/7.

The strength of the group lay in its diversity and in the hands-on clinical skills of each of its members. Our success can provide a model for shared decision making on clinical improvements throughout the institution.

By Pam Simmons, RN, MS, Quality Manager Coordinator for Patient Care Services and Susan Hammerstad, RN, MS, CMSRN, Nurse Educator, Stanford Hospital and Clinics.

Choosing an IV Medication Safety System

BY JULIE RACIOPPI, RN, MSN

When a decision affects nearly every RN in an institution the size of Stanford, how do you reach consensus, for example, on the selection of a key piece of equipment? Our steering committee for the selection of an IV Medication Safety System discovered just what it takes when we set out to select a new technologically advanced system.

Advances in infusion pump technology now provide increased protection against medication errors through higher accuracy, greater precision, improved reliability, and human factor protection. The time was right – these newer technologically advanced infusion devices had much to offer in improved patient safety.

Starting the Selection Process

Selecting a new medication safety system began with the involvement of two key hospital administrators. Cindy Day, RN, MS, CNAA (Vice President, Patient Care Services, Chief Nursing Officer) and Nick Gaich (Vice President, Materials Management and Customer Service) were aware of the recent improvements in infusion pump technology. To oversee the selection process, they strongly supported the formation (in May 2004) of a ten-member steering committee representing key areas and departments of patient care and clinical technology: Nursing, QI, Biomedical Engineering, Anesthesiology, Pharmacy and Materials Management.

The first order of business for the steering committee was to develop a request for information (RFI) and send it out to all manufacturers of infusion devices. The RFI we sent out to the vendor community included more than 200 questions asking for specific details of each of their medication safety

systems. Then, the steering committee met to thoroughly review the vendor responses and decide on the critical design features. Through this process we were able to narrow the field of qualified vendors to be invited for hands-on evaluation to only two IV medication safety systems. We asked each nursing unit/area to select a representative to attend a full-day evaluation of the two systems and many members of the biomedical engineering department to do the same, thus gaining crucial input from the end users.

Nursing and biomedical engineering evaluations took place on November 15, 2004. The nursing evaluation began with a brief overview of the technology advances in question and reviewed the tool the RNs would use to rate each infusion system.

The completed evaluations from each of the nursing representatives were sent to the Quality Department for collation and



Front: Debra Bell, Laura Morris; Chairs: Glenn Jones, Su Tsao, Purna Prasad, Kathi Lucas; Couch: Gisso Oreo, Julie Racioppi, Pam Schrieber, Vickey Weir, Irene Chang

statistical analysis. The nursing staff overwhelmingly agreed on a preferred medication safety system, which was also the top choice of the biomedical engineering group. The key element for the success of this entire process was the involvement of representatives of each of the end-user groups in the actual hands-on evaluation of these systems. Yes, it was more than a year in the making, but the process for selecting a medication safety system at Stanford was a successful one!

Julie Racioppi, RN, MSN, is Patient Care Manager at Stanford. She co-chaired the steering committee with Rex Fieck, Director of Materials Management.

Electronic Multi-Disciplinary Documentation Coming to Stanford!

BY MARGO SAUM, RN, MSN, MBA

You're a staff nurse on a busy medical floor. It is 6:30 a.m. and time to prepare for change of shift report. You came in a few minutes early to have time to collect your thoughts and have one more cup of coffee. Instead, you find yourself scrambling for all the papers for your four assigned patients. That's four MAR's (Medication Administration Records), four shift assessment forms, four worklists, numerous order session reports, plus all the other miscellaneous information and papers. The residents are looking for all the same papers – and who has the last set of vitals on the patient in 202 anyway? You are about to get organized and try to take a sip of coffee when – wait – your assignment has changed. You need to start a new paperwork search. And you have only been here 15 minutes!

Shift report is about to change. Imagine, if you will, a nursing area bubbling with activity, but *quiet* – no residents competing for the same pieces of paper or interrupting your thoughts with more questions about things that are already documented – somewhere! This will be the Stanford Hospital nursing station in the not-too-distant future. When the Electronic Multi-Disciplinary Documentation (EMD) Phase I project is completed, all inpatient nursing documentation (the MAR, the assessments, the worklists, the labs) will reside on the computer – accessible from any terminal and only a click away. Stanford Hospital

embarked on an exciting new age of computerized documentation when the EMD Documentation project kicked off in January 2005.

The goal of EMD is to chart or document patient care across all disciplines, using IDX Carecast instead of pen and paper or preprinted forms.

EMD: The Goal

The goal of EMD is to chart or document patient care across all disciplines, using IDX Carecast instead of pen and paper or preprinted

forms. Charting usually takes place in “real time” at the point of care. A patient's charting can then be viewed on-line by any clinician with appropriate security. This multi-phased project will begin with in-patient nursing documentation on 20 nursing units (Phase 1), followed by documentation in the remaining hospital-based services, including physician documentation (Phase 2).

Planning for Change

In preparation for this change, planning for the project went on throughout 2004 and into January 2005. Multidisciplinary work teams participated in numerous planning workshops to define the scope of the EMD Phase I project:

what will be done, what resources will be required, and the schedule on which it will be done. Among their critical tasks, these multidisciplinary work teams validated requirements for the project. These included bar-coded medication charting and changing; mobile computer-based charting devices for nurses and nursing assistants; and vital signs automatically recorded to the vital sign flow sheets.

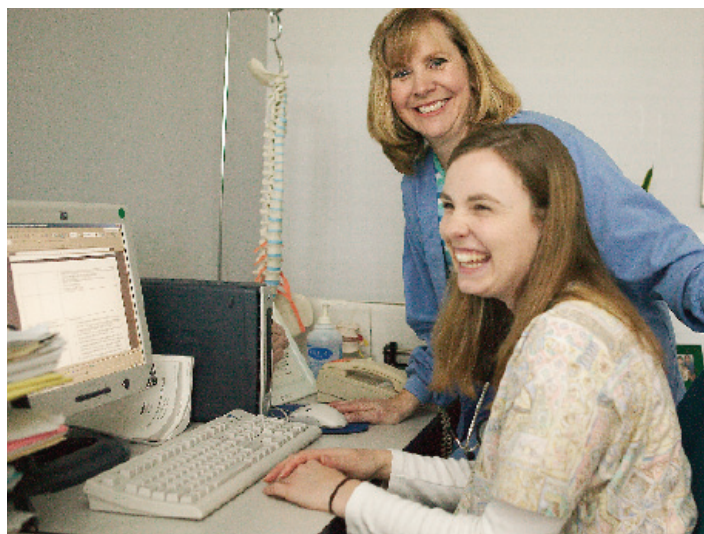
Getting Ready for EMD

As part of the planning phase in the summer of 2004, a Solutions Room with live demonstrations of the charting system was set up to introduce the hospital nursing and ancillary staff to the project. Staff members watched

a short demonstration of how on-line documentation would work. They were able to see, push and maneuver prototype carts with laptops/PCs mounted on them, test out bar coding of medications, and try a new vital signs device that transfers the vital signs electronically to the on-line vital signs flowsheet when completed and validated.

Ninety-eight percent of the nearly 400 staff members who completed the survey indicated their support for the project.

Staff members completed a short survey at the end of their visit to the Solutions Room. The survey indicated overwhelming staff acceptance of the idea of electronic documentation! Ninety-eight percent of the nearly 400 staff members who completed the survey indicated their support for the project, many commenting that electronic documentation was overdue at Stanford. Concerns were mentioned as well, and documented to resolve as part of the project process.



Joy Ryan (standing) and Faith Vanderlinden

Stanford Hospital staff embraced the many reasons to move forward with electronic documentation. They agreed that the EMD Phase I project will improve patient safety, always a major emphasis at Stanford Hospital. Safety improvements resulting from on-line documentation include:

- bar coding of medication, which re-checks the “5 rights” of medication administration
- automatic totaling of intake and output, Braden Score, Falls Risk Score
- built-in alerts and reminders

In addition, faster, centralized access to more accurate and readable patient documentation will support rapid, accurate decision-making, and thus improve patient care. Because the

documentation is kept on-line long term, patients who return to Stanford Hospital (or the Emergency Room) will have their previous documentation readily available for review.

Phase I project will improve patient safety, always a major emphasis at Stanford Hospital.

The Nursing Workgroup Tackles EMD

An EMD nursing workgroup was convened to lead the nursing documentation analysis and build. Interested nurses were interviewed for 10 nursing workgroup positions; they were chosen based on their enthusiasm, nursing experience, and the recommendation of their peers and manager. Throughout 2005,

these nurses will work 2 to 4 days a month on the project, and then full time to assist with testing, training, and go-live support.

Moving Forward

The nursing workgroup members are your representatives! In collaboration with the Nursing Informatics department, the nursing workgroup members will each be responsible for 1 or 2 nursing units and communicate the needs of the staff and patients on those units to the IT analysts who will build and tailor your documentation screens. You will communicate the needs of your unit to your workgroup representative, who will keep you informed of decisions and the reasons behind them.

The success of this project is directly related to everyone’s willingness to work together. With multidisciplinary input, we can meet the goal of enhancing patient care through the best electronic documentation system.

Margo Saum, RN, MSN, MBA, is Senior Healthcare Consultant for HIA/Information Technology.

Patient Care Services Councils... Staff Nurses Take the Lead

BY CAROLE NAKAMURA, RN, BSN AND KELLY JOHNSON, RN, BSN, CEN

As Stanford moves toward achieving Magnet status, staff nurses and other front line caregivers are taking on a greater share in the decisions that affect them. In 2003, Patient Care Services introduced four PCS Councils—Practice, Education, Quality, and Research—to provide central forums for discussion and shared decision making. At the start, managers and educators were appointed as co-chairs to guide development of each council and its leadership.

In late 2004, as planned, staff nurses began to replace the managers as Council co-chairs, starting with the Practice Council and the Education Council. Drawing on their early experience as Council leaders, two staff nurses discuss their experiences.

Carole Nakamura, RN, BSN

Carole started her nursing career at Queen's Medical Center in her native Hawaii in 1984. When she planned her move to the Bay Area, she had her heart set on Stanford because of its impressive reputation, especially in nursing. Encouraged by Duane Walker, VP of Patient Care Services (and formerly Stanford's Director of Nursing), Carole came to Stanford in 1987 as a staff nurse on the medical units D and E Ground and later became the unit educator as well. When the two units merged in 1993, Carole served as co-chair, with the unit manager, on the unit practice council established to guide the move. "We had active and passionate involvement from the staff," Carole said, "since we were making our own decisions on how best to run the merged unit." Always eager to contribute to hospital committees and groups, Carole has helped to develop procedures and standardized care plans that directly involve nursing practice. Discussions in these multidisciplinary

committees lead naturally to shared decision making. "Over the years," Carole said, "we have tried out many new systems, processes, care delivery modes, and cross-trained roles." Many of these changes, she added, were the result of a collaborative approach or shared decision making.

Carole sees the Education Council as an important body of resources to affect educational and training decisions for all staff. She welcomes her appointment as co-chair as an opportunity to represent the staff nurse's perspective. "The Council has opened up a new perspective for me," she said. "I can meet Stanford's administrators and witness how much effort goes into keeping everyone informed. I have a much better view of the 'big picture'—of what goes into the planning and decision making related to achieving the hospital's goals."



(L) Carole Nakamura (R) Kelly Johnson

Beyond helping the Council meet the hospital's goals, Carole has her own goals for the Education Council. "I would like to see staff nurses not only aware of the hospital Councils and their own unit councils," she said, "but eager to participate in them." In addition, Carole said, "I would like the Education Council to have a role in letting all hospital staff know what the Councils are accomplishing and how we are shifting toward true 'shared governance' at Stanford."

Kelly Johnson, RN, BSN, CEN

Kelly first came to Stanford's Emergency Department as a traveling nurse in 2000, and she stayed. "I like practicing nursing in a place with cutting edge medicine," she said, "and in both teaching and learning there is a great collaboration here that I have not found elsewhere, even in other teaching institutions around the country."

As co-chair of the Practice Council, she shares responsibility for setting the agenda and for keeping the meetings moving smoothly so that each agenda topic is covered. She may also help set up sub-groups to work on issues that need more information or input from others before they come before the Council for approval. "I've found that very few topics affect just one unit or discipline," Kelly said. "Our different opinions and ways of doing things make for lively discussions in the Council meetings, but we all truly have one goal: taking care of our patients well." Council leadership is broadening Kelly's own perspective on her practice: she is learning how to use current research, for example, "and I can see how evidence-based practice fits in with my love of knowing why."

Kelly, like Carole, hopes to move the interdisciplinary Practice Council toward more staff nurse involvement. In the Emergency Department, she finds that problems and differences in practice occur because of faulty communication. "The Council's open discussion with all the units and practices helps us 'walk in each other's shoes' and come up with solutions that work for all of us," she said. "By bringing in evidence-based practice," Kelly adds, "we can make sure that we are practicing at our best throughout the institution."

In contrast to Carole, Kelly is taking her experience with the hospital-wide council back to her unit. "In the Emergency Department," she said, "we are just setting up unit-based councils, starting with the Education Council." When the unit Practice Council is formed, she and the unit's Assistant Nurse Manager will serve as chairs. Their first task, Kelly said, is to bring the concept of shared governance to her peers. Kelly feels empowered in these meetings, and she hopes her coworkers will share her enthusiasm. "I love being an active participant in how I practice," she said. "I can take an active role in maintaining the high standards I believe in."

Carole Nakamura, RN, BSN, is Staff Nurse IV/Unit Educator on medicine unit D/E Ground. Kelly Johnson, RN, BSN, CEN, is Staff Nurse IV in the Emergency Department.

Unit Council Shares Decision Making

Councils at Stanford Hospital and Clinics have been in place for a number of years. The E1 council is distinguished by being truly staff nurse led. Theresa Tayco, RN, Unit Council co-chair, describes their council structure and accomplishments.

I came to Stanford as a staff nurse eight years ago, and I have been a member of the E1 Unit Council since it was formed in March, 2002. I am completing my second term as the council's chair. Our primary goal, from the start, has been to address problems, concerns, and issues relating to the nursing practice on the unit. Council membership is open to any nurse on the unit. We currently have about 7 members, most of them staff nurses, but our manager and CNS also attend meetings.

One issue, we found, was the need for a medication room. A task force of nurses (Council members and others) worked diligently on the project, which is nearing completion. Its centralized work area helps efficiency throughout the unit.

One of the Unit Council's primary functions is to improve communication on the unit and with management, a need identified in a staff survey last year. In response, we now have staff meetings, with posted agendas, prescheduled throughout the year. These staff meetings include time for round-table discussions on issues and concerns. Each Unit Council meeting includes a review of what the other unit-based committees are doing, so we can function as a central body for all activities on the unit. In addition, we have developed a quarterly newsletter to inform our staff of the ongoing activities of these committees: the Quality Improvement Council, Education Committee, Social Committee, and Management Team.

Theresa Tayco, RN, is a Staff Nurse on E1 (Bone Marrow Transplant).



Meet Cindy Day, Chief Nursing Officer

BY MARILYN MAHUGH, RN, MSN, CNA, BC

To be the Chief Nursing Officer (CNO) is a very demanding role. This person must have a strong vision for the best quality patient care, articulate the vision, and define the required resources to make the vision a reality. As a member of the Senior Executive team, the CNO leads the nursing excellence efforts in the organization.

She must be able to juggle multiple priorities and demands for competing programs. She represents Stanford Medical Center in many local, regional and national forums. At the end of the day she must be satisfied that the varied teams that she is responsible for are creating a safe work environment in which to deliver the highest quality patient care... in short, she walks on water, while at all times looking and acting in a dignified and professional manner with a smile on her face.

Here at Stanford, our CNO is Cindy Day. What prepared Cindy Day to take on this role and what drives her to continue to strive for patient care excellence in this complex environment?

Cindy grew up in sunny San Diego and watched her sister become a nurse. She started college at the University of California, San Diego but transferred to Point Loma College, because of the reputation of the nursing program. "I wanted to find a career that would make a meaningful contribution and switched from philosophy to Nursing." Cindy is used to challenges. Soon after graduation, she was a new mom of a baby girl and a new grad at UC-San Diego. She was learning two new roles and within a year, her husband's job took them to Ohio. She became a pediatric staff nurse and nurse educator at Mercy Medical Center, started graduate school at Ohio State University, and had a second daughter during her first quarter of graduate school. She received her MS in Nursing and then started a nursing quality assurance program after graduating.

Cindy has a strong commitment to higher education and has been instrumental in bringing Stanford the Transformational Scholarship program and a new onsite SFSU masters program scheduled for the fall of 2005. Cindy says that "going to graduate school was the most empowering experience in my career." The program focused on skills that prepared her to take on new roles in the future. It is Cindy's goal to share this sense of empowerment by creating convenient opportunities for our staff to continue their formal education.



Cindy Day receives her nursing pin.

In 1984, Cindy and her husband and daughters returned to California and she started her nursing career at Stanford. She began as Assistant Nurse Manager and later became a nurse manager for a surgical unit. In 1990, Cindy started what later became a national model for nurse case management. As the Director, she created an interdisciplinary team of Nurse Case Managers and Social Workers. Cindy's vision and passion for interdisciplinary collaboration was a key factor in the success of this program and continues today to be instrumental in her work. In 1997, when Stanford merged

with UCSF, Cindy was appointed corporate Vice President for Coordination at all four hospitals: Stanford, UCSF, Packard, and Mount Zion Hospital.

Shortly before the merger ended in 2000, Cindy returned to her position as Vice President for Quality and Medical Staff Services. This role provided the opportunity to learn more about departments outside of nursing, including admitting and medical staff. The combination of all these positions prepared Cindy well for her next role. She was appointed Vice President for Patient Care Services and Chief Nursing Officer in 2001.

In this role, Cindy said, she provides leadership for clinical decisions, working with managers, directors and staff to develop a shared vision in line with our over-all organizational goals. Besides Nursing, she is responsible for Pharmacy, Social Work, Clinical Nutrition, Case Management, Rehabilitation, Respiratory Care, and Infection Control. “I try to get all these areas aligned on patient care priorities,” she explained. “Interdisciplinary collaboration and coordination at the department level is as important as that same collaboration at the bedside – helping facilitate this is one of the most rewarding parts of my job.”

As she sees it, her role is to lead and drive change by finding the right people and the resources to implement an idea. “I provide vision and direction,” Cindy said; “I advocate for patient care and advanced nursing practice.” A key factor in her plans and goals is her passion for the nursing profession, and a key goal is to do everything possible to position nurses at the bedside to lead. One way she is working to accomplish this goal is by the implementation of Shared Governance.

How does Cindy create the personal energy and renewal to lead and contribute each day? Cindy makes a point of balancing her responsibilities at Stanford and in the community with other aspects of her life. Now married for 30 years, she is starting yet another new role as grandmother for her two young grandchildren. She is an avid reader, plays golf and enjoys quilting, knitting and frequent trips to her family home in Hawaii. She attributes much of her professional success to her husband, Pat, who has supported her throughout her educational and career opportunities. Cindy has great vision and passion for the work she does everyday.

Marilyn Mahugh, RN, MSN, CNA, BC, is Director of Education and Practice at Stanford Hospital.

One on One with Cindy Day

Nursing practice at Stanford is moving toward a new shared governance model, where staff at all levels get together to solve problems and improve patient care. As a way to create mutual awareness, Cindy will spend an occasional day with a staff nurse. The experience will expose staff nurses to the breadth of administrative work at the hospital. Likewise, Cindy will learn the perspective of the nurse at the bedside. Joy Ryan, RN, BSN, unit educator and staff nurse on B3, neurosurgery, was the first nurse to participate. Cindy started her day at 7am with Joy joining her at 9am. “We hit the ground running,” Joy said. First came a half-hour meeting with the Manager of Infection Control, followed by another with the Director of Respiratory Care.

“I expected Cindy to focus on global issues, far away from day-to-day activities,” Joy said. However, she was amazed at Cindy’s level of involvement with patient care issues. Joy quickly learned that Cindy had a hands-on knowledge of details involving patient care. “Throughout the day,” she said, “I saw her involved in the dynamics of specific patients and their families.”

By 10 a.m., Cindy and Joy were on their way to a capital budget meeting with members of the executive team followed by a meeting with the clinical nurse specialists and educators. Cindy and Joy left the hospital for the monthly Rotary Club meeting in Los Altos. Cindy’s attendance at these meetings is one of the numerous ways she represents the hospital in the community at large. “It was impressive to have Stanford represented in this group,” Joy said, especially since many of its members are influential community leaders. After lunch, Cindy and Joy returned to the hospital for yet another meeting, this one with the Director of Pharmacy

By the end of the day Joy was struck by the amount of detail Cindy could process, asking questions and noting action items along the way. Cindy makes time for interactions at a personal level as well, Joy found. “I was surprised at how many people she knows and relates to in a personal way—she knows and asks about their families.”

The day was a rich exchange of information, Joy and Cindy agreed. They talked, for example, about Cindy’s concern about safety issues. One of her key goals is to create a culture where staff members feel free to come forward and identify ways to make patients safer. “I was glad to have the chance to discuss patient care safety with Joy,” Cindy said. “She was able to give me her perspective, as a staff nurse, on the barriers to reporting errors and other problems involving nursing.” Joy and Cindy also talked about ways Cindy could interact more with nursing—how she could improve visibility and communication. Cindy looks forward to sharing her daily experiences with other staff nurses in the future.

Marilyn Mahugh, RN, MSN, CNA, BC, is Director of Education and Practice at Stanford Hospital.

Mentorship Program Guides New Hires

BY JOAN MERSCH, RN, MS, AND SUSAN NEKIMKEN, RN, MPA

The turmoil that a new graduate nurse faces in moving from student into nursing practice has long been recognized. Some of the feelings that new graduates share include helplessness, powerlessness, frustration and dissatisfaction. The transition from student nurse to practitioner has been tagged “reality shock” and the two-year turnover rate for new graduates runs between 35% and 60%.

Promoting a Culture of Mentorship

To ease this transition, in October 2004 Stanford introduced a pilot program designed to promote and reward mentorship on our nursing units. To create a nurturing environment for Stanford’s many new graduate nurses, we envisioned a culture where the new graduate would develop not only clinical competence but the self-confidence in the professional role that comes with having strong role models and excellent coaching along the way. With support and growth opportunities, we believed that new graduates would stay at Stanford for at least three years.

In order to develop the vision that would create the culture, a task force of managers, staff nurses, a clinical nurse specialist and an Associate Director of Nursing was assembled (see list at right). Rather than prescribe details of what is a very personal relationship between the mentor and mentoree, the group sought only to create only basic standards for all of these alliances.

First, the task force defined the basic expectation of any mentor: to provide support and guidance to help new graduates develop their skills and continue their employment at Stanford Hospital and Clinics. We saw mentors as experienced professionals who could act as a resource, drawing on their own clinical competencies to provide constructive



(L) Hallie Dresnick (R) Isobel Fox, Unit NICU

feedback that would foster the desire to grow and improve in the professional nursing role. Mentors, in brief, would serve as role models for professional nursing practice.

Unit managers were asked to identify potentially suitable mentors for the new graduate. However, the new graduates in the pilot program ultimately decided who they could best work with and relate to during these early years of their careers. Mentors formally meet to counsel the new graduates monthly during in the first year of the relationship. In these meetings, mentors are expected to document their mentoree’s accomplishments and review progress toward established goals. To insure the progress of the new graduate, mentor and mentoree are encouraged to continually reassess their strategies for meeting professional goals. As the graduate progresses, the frequency of formal counseling sessions will gradually decline to every six months during the last year of the program. Informally, the mentor would be alert for learning opportunities for the new graduate, in order to facilitate progress up the clinical ladder to a higher staff nurse level. All of this progress is monitored by the new graduate’s nurse manager.

Comments from our Participants

Even in its early months, the new graduate mentorship pro-

gram here at Stanford has drawn positive comments. Hallie Dresnick, a new graduate from North Intensive Care Unit, told us, “Straight out of nursing school, I would not have considered a hospital that did not have a mentor program. My mentor, Isobel Fox, was the perfect match for me. She made a comfortable learning environment which enabled me to learn so much from her.” Other mentorees, Anabel Mixco-Aguilar on D/E Ground and Breana Bartels on D1, both commented on the value of consistent support from a mentor who knows how the new graduate is coming along.

Mentors likewise are enthusiastic about the program. Nerissa Del Rosario, Anabel Mixco-Aguilar’s mentor on D/E ground, observed that she had gotten to know a friend and she had had the opportunity to see a new graduate nurse grow to a full-fledged, experienced nurse. Tess Magat, also from D/E Ground, had very positive comments about her experience as a mentor for Antonette Navarro. Tess said, “It is very rewarding to see a novice nurse grow and to know that you may have a little something to do with it. You can learn from each other and both nurses will surely gain something from this program.” Rhonda Hart, a nurse mentor on D1, said that she gained new enthusiasm and a fresh outlook from the program. “The insight and compassion the mentor helps to bring,” she observed, “will help the new graduate to integrate as part of our team.”

Program Future

The mentor program is designed to promote professional growth of mentors and mentorees alike. In order to do that, the task force and mentors must continue to acquire new



(L) Antonette Navarro (R) Tess Magat, Unit DGR

knowledge and refine our skills by assessing, for example, our performance as mentors and collecting data on our successes and failures. We must look for new knowledge and new insight into the recruitment and retention of nurses. For the pilot program, we are collecting data on attrition and on mentor and mentee satisfaction, to determine the effect the program has on recruitment, retention and satisfaction. The program will then be modified to make improvements. The mentorship program is a work in progress — one way that Stanford Hospital is looking to ease the transition from student nurse to nurse clinician and thereby increase retention and satisfaction of new graduate nurses.

Joan Mersch, RN, MS, and Susan Nekimken, RN, MPA, are Patient Care Managers at Stanford Hospital.



(L) Rhonda Hart, (R) Breanna Bartles, Unit D1

MENTORSHIP TASK FORCE MEMBERSHIP

Cristina Ignacio, RN, Staff Nurse
 Stephanie Iseri, RN, Staff Nurse
 Debra Grant, RN, Assoc. Dir. Patient Care Services
 Joan Mersch, RN, Patient Care Manager
 Susan Nekimken, RN, Patient Care Manager
 Julie Shinn, RN, Clinical Nurse Specialist
 Julie Tisnado, RN, Patient Care Manger

Ten Ways to Get Involved!

BY LINDA BRACKEN, RN, EdM, MPA, AND JEANNE MCGRANE, RN, MSN, MBA

Come to work...work all day at an intense, demanding job...go home tired. Why should I look for anything else to do at Stanford University Medical Center?

The answer is simple...getting involved beyond your own unit or department broadens your horizons, and helps you influence patient care practice throughout the medical center. Your involvement also gives you a wider perspective on what goes on in the Hospital and Clinics, and increases your education about Stanford's world of nursing. You will meet people from other units, at all levels, and strengthen your resume or college application.

Opportunities to get involved are all around you, every day. To give you a start, the ten suggestions below come from your colleagues in the Emergency Department, Ambulatory Care Unit, and Ambulatory Treatment Unit.

1 Join a Practice Council and participate in decision making in the organization. "I enjoy being on the council because I can hear what other departments are doing, and I feel more of a sense of continuity with the entire hospital. I'm involved from the ground up in our project for magnet status." Kelly Johnson, RN, Emergency Department, Chair Elect of the Practice Council.

2 Join a Hospital-Wide Quality Council. "I have learned all kinds of things about other departments like Pharmacy, Lab, and Dietary. I am able to see the larger picture, not just my own unit.

What has impressed me is that every discipline is trying to improve patient care." Han Ying Fu, RN, Ambulatory Treatment Unit.

3 Join a unit-based committee to influence decisions that affect you and your coworkers on a daily basis. "I like to be a part of this committee because I can have a part in decisions about the education needs of our unit. Our goal for Emergency Department nursing is to provide safe professional care, and the education committee helps ensure this." Mike Weiland, RN, Chair, Emergency Department Education Council.

4 Join a 90-day turn-around team to make improvements at Stanford University Medical Center. "The work on the Transport team made me aware of the problems transporters face in getting their job done. Very often, the delays you see on the nursing units happen for reasons beyond the transporter's control, and our team addressed these issues. Linda Bracken, RN, EdM, MPA, Patient Care Manager, Emergency Department.

5 Apply for a Friends of Nursing scholarship and use it to fund development of new teaching tools to use with patients. "As nurses, it's a great fit with our mandate to teach." Alison Kerr, RN, CVN, Vascular Clinic Manager.



Kathy Dyble, LSTC Coordinator teaching an ACLS course

6 Identify a learning need on your unit and present an in-service on that topic. "Once you have identified a learning need, it feels good to be part of the solution." Sandy Rozmarin, RN, Clinic Quality Manager.

7 Give Blood. "Not only is donating blood a humanitarian effort, but it's fun to meet the Blood Center staff and other donors. You can even sign up for specialty times like Singles Night!" Blood donors include Emergency Department staff members Barbara Hart, MBA, Business Manager, and Patrice Callagy, MPA, CEN, APCM.

8 Train to be an ACLS/BLS instructor. "As an ACLS instructor, I work with new medical students, residents, attendings, nurses and pharmacists who all come to the Center for Education and Professional Development for the class. Working with all the disciplines makes the job interesting and helps me feel a part of the medical education for the institution." Mary Durando, RN, BS, Emergency Department.

9 Take courses at the Center for Education and Professional Development or on the Stanford campus. "We have a wonderful diversity of courses and excellent speakers. It helps me keep abreast of important clinical, social, and economic aspects of health care." Maureen Burke, RN, MS, Director of Ambulatory Care.

10 Join the Stanford Employee Baseball Leagues. "Baseball team members come from all areas of the hospital. It helps me to know fellow team members when I bring a patient to their unit from the Emergency Department. They know me and welcome me. One of the ED doctors is on the team and I found that we get along well at work due to our mutual interest." Dawn Hasegawa, RN, Emergency Department.

Linda Bracken, RN, EdM, MPA, is Patient Care Manager, Emergency Department; and Jeanne McGrane, RN, BSN, MBA, is Director, Ambulatory Care.

In Recognition of...

CONFERENCE PRESENTATIONS

Sandra Correia, RN, BSN, Instructor at "Transport Nurse Advanced Trauma Course", Lubbock TX, ASTNA-Air & Surface Transport Nurses Association, November 19-21, 2004.

Mary Lough, RN, MS, CCRN (Presenter) and Barbara Odin, RN; Sasha Madison, MPH, CIC; Debra Johnson, RN, BSN, CIC; Patricia Rutherford, RN, BSN, CIC (Contributors): "Clinical Practice Changes and Education Decrease Ventilator Associated Pneumonia Rate in ICU", 2nd International British Association of Critical Care Nurses (BACCN) Conference and the First Congress of the World Federation of Critical Care Nurses, Cambridge, England, September 13-15, 2004.

Joan Mersch, RN, MS, "Acute Coronary Syndrome Guidelines", Nursing Symposium for the Sutter Heart Institute, Sacramento, CA, October 25, 2004.

Julie Racioppi, RN, MSN, "Use of Computerized Educational Program for Employee Annual Review", UHC Supply Chain Optimization Forum 2005, Phoenix, AZ, February 22, 2005.

APPOINTMENTS

Katherine Dyble, RN, MA: Appointed Division Chair of the American Heart Association Regional Faculty of Santa Clara and San Mateo County, 2005.

Debbi Johnson, BSN, RN, CIC: Elected Chairperson, City of Pacifica Emergency Preparedness and Safety Commission, 2005.

Janet Neff, RN, MN, CEN: Appointed to the Editorial Board of "Trauma Reports", December 2004.

Laura Tracy, RN: Elected President, Northern California Chapter, International Association of Forensic Nurses, January 2005.

CERTIFICATES

Joan Caldwell, RN, MSN, CNA, BC: Passed the ANCC Nursing Administration Certification Exam, October, 2004.

Sandra Correia RN, BSN: Passed TNATC Instructor Course, November 2004.

Cindy Day, RN, MS, CNA: Passed the ANCC Advanced Nursing Administration Certification Exam in Nursing Administration, October, 2004.

Joan Forte, BSN, MBA, CNA, BC: Passed the ANCC Nursing Administration Certification Exam, October, 2004.

Sandra Hammond, RN, BSN: Passed American Association of Tissue Banks Examination, September, 2004.

Debra Johnson, RN, BSN, CIC: Passed the recertification examination for Infection Control (CIC), August, 2004.

Sandra Langeman, BSN: Passed the OCN Certification, November 2004.

Sasha Madison, MPH, CIC: Passed the recertification examination for Infection Control (CIC), August, 2004

Marilyn Mahugh, RN, MSN, CNA, BC: Passed the Nursing Administration ANCC Certification Exam, October, 2004.

Nancy Masunaga, RN, MS: Passed the National Exam for College Health Nursing, October, 2004.

Laura Tracy, RN: Passed the National Certification SANE-A, International Association of Forensic Nurses, April, 2004.

JOURNAL ARTICLES

Maria Luci Andres, RN, BSN: "Motor Vehicle Crashes and the Elderly: Advocates cite the need for mandatory retesting of elderly drivers", *Journal of Emergency Nursing*, 30 (5), 509-511.

Janet A. Neff, RN, MN, CEN: "Predictors of emotional adjustment following traumatic injury: Personal, social, and material resources", Cordova, MJ, Walser, R, Neff, J, & Ruzek, J.I. (2005). *Prehospital and Disaster Medicine*, 20 (1), 7-13.

PUBLICATIONS

Faith Vander Linden, RN, BSN: "Surviving JCAHO", *American Journal of Nursing*, Accepted for publication November 2004

Faith Vander Linden, RN, BSN: "The Student Nurse's Resource List", *American Journal of Nursing*, Accepted for publication November 2004

DEGREES

Amina Huda, RN, MS: Post Master's degree in Gerontological Nurse Practitioner, University of San Francisco, December, 2004.

AWARDS

Lynn Adler, RN, BS: Special Award, Stanford Hospital and Clinics Award Program, October 2004.

Peg Albrets, RN, BSN, OCN: Special Award, Stanford Hospital and Clinics Award Program, October 2004.

Mary Ann Champagne, MS, RN: Fellowship in the American Heart Association Council on Cardiovascular Nursing, December, 2004.

Susanne Cox, RN, BSN, OCN: Excellence in Caring Award, Stanford Nurse Week, 2004.

FGround Unit, Stanford Hospital and Clinics: "Best Nursing Team 2005" awarded by *Advance for Nurses*, March, 2005.

Terrie Gordon Gamble, RN, MSN: Hero of the Year Award, Santa Clara County, April, 2004.

Amina Huda, RN, MS: Hartford Scholarship from UCSF for doctoral program, January, 2005.


Nancy Masunaga, RN, MS: Affiliates "New Professional" Award, Pacific Coast College Health Association American College Health Association Annual Meeting, New Orleans, LA, June 2004.

Debra Thaler-DeMers, RN, OCN, PRN-C: "2005 Oncology Nurse of the Year", Oncology Nursing Certification Corporation.

D. Kathryn Tierney, RN, PhD(c): Special Award, Stanford Hospital and Clinics Award Program, October 2004.



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