CNL Summit
2014

POSTER PRESENTATIONS

January 16-18, 2014
During the reception on Thursday, January 16, posters will be presented within two different time slots, from 5:30 to 6:30 pm and 6:30 to 7:30 pm. Poster presentations will be divided alphabetically into the two time slots as listed below. Posters will also be available for viewing on Friday, January 17, until 12:45 pm. Full abstracts are listed alphabetically in the back of this document.

**Posters A-M**

**5:30 to 6:30 PM**

**Abstract title:** Safe, Effective and Well-Coordinated Patient Transition after Elective Total Joint Replacement: A "Scheduled Discharge"

**Author Name & Credentials:** Rene Ambos, MSN, RN, CRNI®

**Institution:** MidState Medical Center

**City/State:** Meriden, CT

**Primary Contact Email:** bcdrene@comcast.net

**Abstract title:** Supporting Dissemination through a National CNL Manuscript Writing Workshop Series

**Author Name & Credentials:** Alice Avolio, MS, RN, NE-BC; Ashley Jones, BA; Sharon Valente, PMHCNS-BC, ANP, PhD; Marjory Williams, PhD, RN, NEA-BC

**Institution:** VHA Office of Nursing Services

**City/State:** Portland/Oregon

**Primary Contact Email:** Alice.Avolio@va.gov

**Abstract title:** Improving HCAHPS scores through patient care technician workflow redesign

**Author Name & Credentials:** Thomas Bassett MSN, RN-BC, CNL

**Institution:** VA Pittsburgh Healthcare System

**City/State:** Pittsburgh, PA

**Primary Contact Email:** Thomas.Bassett@va.gov

**Abstract title:** IMPLEMENTATION OF RESPITE ROOM ON SURGICAL UNIT TO DECREASE MEDICATION ERRORS

**Author Name & Credentials:** Tru Byrnes BSN, RN, PCL, CMSRN,

**Institution:** Carolina Medical Center

**City/State:** Charlotte, NC

**Primary Contact Email:** Tru.Byrnes@carolinashealthcare.org

**Abstract title:** Implementing the ABCDE Bundle in a 30-Bed Mixed ICU

**Author Name & Credentials:** Cindy Cervini, BSN, RN, CCRN

**Institution:** St. Vincent's Medical Center

**City/State:** Bridgeport, CT

**Primary Contact Email:** JCCervini@aol.com
Abstract title: Delirium Screening in Geriatric Trauma Patients
Author Name & Credentials: Meridith Gombar Creeden RN, MSN, CNL
Institution: Carolinas Healthcare System
City/State: Charlotte, NC
Primary Contact Email: meridith.creeden@gmail.com

Abstract title: Implementation of a Robust Intervention to Address Central Line Associated Blood Stream Infection Rates in an Acute Oncology and Stem Cell Patient Population in an Academic Setting
Author Name & Credentials: Regina M. Degennaro, DNP, RN, AOCN, CNL
Institution: University of Virginia School of Nursing
City/State: Charlottesville, VA
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Abstract title: Sustaining a Nurse's Skill Set with a Nursing Skills Education Board (NSEB)
Author Name & Credentials: Christina DiBernardo
Institution: VA Long Beach Healthcare System
City/State: Long Beach, CA
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Abstract title: Healthcare Reform and the CNL
Author Name & Credentials: Kathy Faber, MSN, CNL
Institution: St. Joseph’s Regional Medical Center
City/State: Paterson, NJ
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Abstract title: Clinical Nurse Leader Project: Chlorhexidine Gluconate Education
Author Name & Credentials: Elizabeth Farr, RN, MSN, CNL
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Abstract title: Decreasing the Occurrence of Hospital Acquired Pressure Ulcers through the Implementation of Multidisciplinary Interventions
Author Name & Credentials: Jaquita Gardner, MSN, RN, CNL
Institution: Jack C. Montgomery VAMC
City/State: Muskogee, OK
Primary Contact Email: jaquita.gardner@va.gov

Abstract title: Setting Realistic Expectations and Increasing Hospital Patient Satisfaction Scores related to Pain Management Utilizing Evidenced Based Practice.
Author Name & Credentials: Amanda Gregory RN, MSN, CNL
Institution: Carolinas Medical Center
City/State: Charlotte, North Carolina
Primary Contact Email: amanda.gregory@carolinashealthcare.org
Abstract title: Response Time Improvement Process with Implementation of No Passing Zone
Author Name & Credentials: Kotaya Griffith RN, MSN, CMSRN, CNL
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Abstract title: No More Frequent Flyers
Author Name & Credentials: Lauren Hartwig MSN, RN, CNL & Heather Nordstrom MSN, RN-BC, CNL
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Primary Contact Email: lauren_hartwig@trihealth.com and heather_nordstrom@trihealth.com

Abstract title: Connecting Healthcare Silos: Integrating the Clinical Nurse Leader for Care Transitions
Author Name & Credentials: Jessica Hatch, RN, MS, CNL and Sarah Plante, RN, MSN, CNL
Institution: Lawrence General Hospital
City/State: Lawrence, MA
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Abstract title: Noise Reduction in the Acute Inpatient Setting
Author Name & Credentials: Heather Helton MSN, RN, CMSRN, CNL
Institution: Carolinas Medical Center
City/State: Charlotte, NC
Primary Contact Email: heather.helton@carolinashealthcare.org

Abstract title: From Clinical Outcomes Nurse (CON) to Clinical Nurse Leader (CNL): A Collaborative Strategy to Improve Outcomes Now
Author Name & Credentials: Nancy Hinzman DNP, RN
Institution: College of Mount St. Joseph
City/State: Cincinnati, Ohio 45233
Primary Contact Email: nancy_hinzman@mail.msj.edu

Abstract title: The Effects of Multidisciplinary Team Education on Total-Joint Surgery Patient Length of Stay
Author Name & Credentials: Marsha Howard, MSN, RN, CNL
Institution: Texas Health Presbyterian Denton Hospital of Denton, Texas
City/State: Denton, Texas 76249
Primary Contact Email: marsha0408@gmail.com

Author Name & Credentials: Kimberly Kirkpatrick, MS, RN, CNL; Audra Pfund MS, RN, CNL; Meredith Willett MS, RN, CNL; Michelle Rhoney MS, RN, CNL, CMSRN
Institution: Portland VA Medical Center
City/State: Portland, OR
Primary Contact Email: kimberly.kirkpatrick@va.gov
Abstract title: Using evidence based practices to reduce CAUTIs at a small, rural VA facility in Montana
Author Name & Credentials: Stephanie Larson, RN-C, MSN, PCCN-CMC
Institution: VA Montana HCS
City/State: Fort Harrison, MT 59636
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Abstract title: Emphasizing Patient Collaboration in Preventing Falls
Author Name & Credentials: Noel B. Mendez, MS, RN-BC, OCN, CNL, Myrna Martinez, MS, RN, OCN, CNL
Institution: University of Texas MD Anderson Cancer Center
City/State: Houston, TX
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Abstract title: Educate Before You Medicate
Author Name & Credentials: Shaden Mustafa, MSN, RN, CNL
Institution: Seton Hall University
City/State: South Orange, NJ
Primary Contact Email: shaden.mustafa@gmail.com

Posters N-Z
6:30 to 7:30 PM

Abstract title: Journey to Improving Core Measure Compliance: From Opposition to Ownership
Author Name & Credentials: Ashley Neal, MSN, RN, CNL
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City/State: Denton, TX 76201
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Abstract title: The VRE Compliance Improvement Project (CIP): A CNL Lead Initiative to Increase Early Identification of VRE Colonization to Reduce VRE Transmission on an Oncology/Stem Cell Transplant Unit.
Author Name & Credentials: Derietra L Neal-Ferguson, MSN, MPH, RN, CNL
Institution: VHA, Bay Pines Veterans Administration Healthcare System
City/State: Bay Pines, Florida
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Abstract title: Team Building Relationships in Recruiting
Author Name & Credentials: Brunella Neely, MSN, RN, CMSRN, CNL
Institution: Texas Health Resources
City/State: Arlington, Texas
Primary Contact Email: BrunellaNeely@TexasHealth.org

Abstract title: “Turning the Tide: A CNL-led Initiative to improve PATIENT hand hygiene to Prevent Hospital Acquired Infections”
Abstract title: Improving Medication Communication and Patient Satisfaction Using Medication Cards
Author Name & Credentials: Audra Pfund MS, RN, CNL
Institution: Portland VA Medical Center
City/State: Portland, Oregon
Primary Contact Email: audra.pfund@va.gov

Abstract title: Application of the Prody Model for Continuous Quality Improvement to Enhance Work-Life-Balance in Nurses of a Clinical Microsystem Caring for Veterans
Author Name & Credentials: Cynthia Presley, MSN, RN, CNL, PCCN
Institution: Texas Health Harris Southwest Hospital
City/State: Fort Worth, Tx.
Primary Contact Email: Cynthiapresley@texashealth.org

Abstract title: CHF education: Meeting the Measure
Author Name & Credentials: Dianne Ragno MSN, RNC, CNL
Institution: Veterans Affairs Medical Center
City/State: West Palm Beach, Florida
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Abstract title: Creating and Sustaining RN Ventilator/Tracheostomy Competency: A CNL-led Collaborative Approach
Author Name & Credentials: Michelle Rhoney MS, RN, CNL, CMSRN
Institution: Portland VA Medical Center
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Abstract title: Examination of the Practice Environment to Support Advocacy for the CNL
Author Name & Credentials: Linda Roussel, DSN, RN, NEA-BC, CNL; Angela Jukkala, PhD, RN, CNL, CNE; Lisle Hites, PhD
Institution: University of Alabama Birmingham SON
City/State: Birmingham, AL
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Abstract title: Improving Staff Satisfaction and the Culture of Teamwork by Implementing Team STEPPS® on PCU
Author Name & Credentials: Carmen Salone, MPH, MSN, RN, CNL
Institution: Texas Health Resources Southwest
City/State: Fort Worth, Tx
Primary Contact Email: CarmenSalone@texashealth.org
Abstract title: Advocacy for CNL Professional Role Identity
Author Name & Credentials: Antoinette Shedlarski, RN, MSN, CNL, Angela Jukkala, RN, PhD, CNL, Pamela Patterson, RN, MSN, Jacob Vaughn, RN, MSN, CNL, Carolyn Curry RN, MSN, CNL, Vernesa Long, RN, MSN, CNL, Kristen Noles, RN, MSN, CNL
Institution: University of Alabama at Birmingham Hospital and UAB School of Nursing
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Abstract title: THE EFFECTIVENESS OF A NURSE-DRIVEN PROGRESSIVE MOBILITY PROTOCOL ON REDUCING DVTS
Author Name & Credentials: Valerie Short, MSN, RN, CMSRN
Institution: Carolinas Healthcare System
City/State: Charlotte, NC
Primary Contact Email: Valerie Short, MSN, RN, CMSRN

Abstract title: The CNL as a catalyst for highly reliable nursing care
Author Name & Credentials: Grace Sotomayor, MBA, DNP, RN, NEA-BC, FACHE, CNL
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Abstract title: Improving Bedside Handoff
Author Name & Credentials: Jacqueline Stitt, MSN, RN, PCF
Institution: Texas Health Presbyterian Hospital Dallas
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Abstract title: Do You Hear What I Hear? - Attention to Alarm Fatigue
Author & Credentials: Pamela Abraham, MSN, RN, CNL, Catherine Edmonds, MSN, RN, CNL, Jennifer Kareivis, MSN, RN, CNL, Marianne Sweeney, MSN, RN, CNL & Virginia Clerkin, DHED, MSN, RN, CTN-A, CNL, Linda D'Antonio, MSN, RN, CCRN, CNL, Cara Abitante, MSN, CNL, Terry Mongan, MSN, CNL, Shaden Mustafa, MSN, CNL
Institution: Hunterdon Medical Center, Flemington, New Jersey & Seton Hall University
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Abstract title: Achieving Excellence: Clinical Nurse Leaders and Pathway to Excellence Nursing Designation
Author Name & Credentials: Melanie Tallakson MSN, MPH, RN CNL, Josie Villanueva, MS, RN NEC-BC and Georgina Delos Reyes, MSN RN
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Abstract title: Raise the SBAR for Patient Safety
Author Name & Credentials: Stephanie Teets, RN, MSN, CNL
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Abstract title: Triple Aim: MedsToGo
Author Name & Credentials: Elizabeth Triezenberg MSN, RN, CNL, CNRN
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Abstract title: Clinical Practicum as a Marketing Tool for the CNL Role
Author Name & Credentials: Mary E. Weyer, EdD, APN, CNS, CNL & Mary Oesterle, EdD, RN, CNL
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Author Name & Credentials: Megan Williams MSN RN CNL
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Abstract title: Current State of Health Literacy and Diabetes in the Adult Population
Author Name & Credentials: Joselyn Wright MSN, RN, CMSRN, CNL
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Poster Abstracts
(Alphabetical order by primary author’s last name)

Abstract title: Safe, Effective and Well-Coordinated Patient Transition after Elective Total Joint Replacement: A “Scheduled Discharge”
Author Name & Credentials: Rene Ambos, MSN, RN, CRNI®
Institution: MidState Medical Center
City/State: Meriden, CT
Primary Contact Email: bcdrene@comcast.net

Background Information:
The microsystem selected as a pilot for this project, a medical-surgical inpatient nursing unit, has an average daily admissions of 10 patients and between 10-12 discharges daily with the average patient acuity of 5-7 on a point scale of 1-10 where 10 represents patient requiring most nursing care hours. It has a unit based oncology social worker, a case manager, a social worker, a pharmacist, and a dietician to compliment collaboration with the nurse manager and the clinical resource leader for lateral integration of patient care.

Baseline data collection revealed the following:
• Patient and staff dissatisfaction.
• Patient flow and throughput disruptions.
• Poor transition to the rehabilitation facilities.
• Inability to admit patients to the unit.
• Lost revenue.
• Baseline average discharge time of 4:10 pm.

Aim:
• To discharge patients within 30 minutes before or after their scheduled discharge time.
• To move the average discharge time three hours earlier from its prior state (4:10 pm) by March 15, 2013.

Methods/Programs/Practices:
Utilizing Lean methodology, a new process was developed to pilot a scheduled discharge for all elective total joint replacement patients. Timeline of hospitalization was flow charted and future design for patient transition was created for improved patient flow of all elective total joint replacement patients scheduling tasks earlier than the Scheduled Discharge (SD) with time allotment for key activities. Patients were given discharge appointment at 10:00 am, 10:30 am or 11:00 am; weeks before the date of surgery. In-room display of discharge appointment was posted at the bedside upon patient's admission to the inpatient medical-surgical nursing unit to help the patient and family plan for the anticipated discharge date & time.

Outcome Data:
• Scheduling tasks earlier than the day of discharge was practicable.
• During the 6-month period, 36% were discharged by the appointed time; 67% were discharged on March 2013.
• Average discharge time moved back to 1:10 pm from 4:10 pm.
• The pilot resulted to an initial savings of $28,627.00
• Projected annual savings of $261,000.00

**Conclusion:**
Patients and their families, significant others, or caregivers sometimes desire more communication about the anticipated day and time of hospital discharge (Manning, et al, 2007). We designed a process to improve patient flow on a medical-surgical inpatient nursing unit limited to elective total joint replacement patients. A tool by which SD was displayed at the bedside and a flow chart was used as a roadmap to a patient’s transition to the next level of care. The result of this project was favorable as evidenced by moving average discharge time 3 hours earlier compared to its prior state. Moreover, this project suggests that patients, families, significant others, caregivers, and all the disciplines satisfaction (in relation to the SD) warrants further investigation.

**Abstract title:** Supporting Dissemination through a National CNL Manuscript Writing Workshop Series

**Author Name & Credentials:** Alice Avolio, MS, RN, NE-BC; Ashley Jones, BA; Sharon Valente, PMHCNS-BC, ANP, PhD; Marjory Williams, PhD, RN, NEA-BC

**Institution:** VHA Office of Nursing Services

**City/State:** Portland/Oregon

**Primary Contact Email:** Alice.Avolio@va.gov

**Background Information:**
The Clinical Nurse Leader (CNL) role was developed in 2007 and is still fairly new. There are 2,955 certified CNLs nationwide and 345 of those are employed by the U.S. Department of Veterans Affairs (VA). Despite growing numbers of CNLs in the VA system dissemination of CNL work continues to be sparse. CNLs are involved in many activities that improve patient care such as continuous quality improvement, evidence-based practice (EBP) and staff development. Sharing this information advances knowledge, informs practice, improves nursing care and promotes the CNL role. Writing with the goal of publishing is an important way to share information so that others may benefit. There are many barriers to manuscript development for the action oriented, clinically focused CNLs who may not consider that they are writers. These barriers include lack of experience and time, low confidence in writing ability and lack of a writing mentor. Writing is a skill that can be taught. Writing classes can address specific barriers and put a structured process in place where individuals can learn by doing. By helping the writer get started, working on sections and providing feedback at each step, individuals can be given the necessary support to develop their writing skills.

**Aim:**
To describe the development and implementation of a national writing workshop.

**Methods/Programs/Practices:**
In 2012 the CNL Manuscript Writing Class – “Writing for publication – from project to publication” was offered to all VA CNLs. A short self-assessment survey for participants was
administered prior to the first class. Participants used a 5-point Likert Scale to rank their agreement on 22 specific items about writing and publishing. They were also asked to identify the aspect of writing that they found the most difficult. Results were used to guide the content and discussion topics for the writing classes. Class content objectives were: 1) Describe the process of publishing a professional CNL article, 2) Identify potential journals for CNL articles, 3) Draft sections for the article, and 4) Define the principles of authorship, permissions, and article submission. The class format was virtual using web and audio conferencing systems. Nine one-hour classes were delivered over a ten month period. Evaluation of the class was solicited after the classes were completed.

**Outcome Data:**
Forty-seven CNLs indicated interest and 23 participated in the monthly class. ‘Getting started’ was identified in both the pre and post assessment as the most common writing problem. ‘Time’ was identified in the post assessment as the number one barrier to completing the writing with respondents indicating they did not have time to work on a manuscript due to competing workload demands. Specific comments included, “biggest problem is making time to spend on writing” and “finding time.” Other comments indicated that supervisory support for writing would be helpful. The majority felt that the presenter was knowledgeable, the information useful and of high quality and the class was effective in supporting manuscript development. Almost half identified they needed more individual help. Most participants felt that class frequency was appropriate but others were not able to adjust their schedule or workflow to accommodate classes. One manuscript has been accepted for publication and three manuscripts are in progress with specific journals interested in reviewing.

**Conclusion:**
Course evaluation data indicated that ‘time to write’ and ‘getting started’ were the number one barriers identified by participants. A number of steps were taken to strengthen this process with the second cohort. Interested parties were asked to submit an application and obtain supervisory support. The application and supervisory letter of support specified expectations regarding writing time. The lack of specific and formal mentoring outside of the virtual monthly class structure was reflected in the writers who indicated they needed more help and may also have contributed to incomplete manuscripts. In our second cohort writers will be assigned mentors and the mentor expectations have been defined. The class schedule for cohort 1 was kept flexible in order to accommodate time for writing. However, this lack of a set schedule may have contributed to the attrition that occurred over the ten months. A regularly scheduled monthly class was established for the second cohort. Other barriers were projects that lacked baseline data and difficulties with methodology and analysis of projects. The VA Office of Nursing Services (ONS) Evidence-based Practice goal group was asked to participate in cohort 2 to help improve this content area. This class was successful in helping to develop manuscripts demonstrating CNL effectiveness and provided information to improve future manuscript development classes.
Abstract title: Improving HCAHPS scores through patient care technician workflow redesign
Author Name & Credentials: Thomas Bassett MSN, RN-BC, CNL
Institution: VA Pittsburgh Healthcare System
City/State: Pittsburgh, PA
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Background Information:
As of October 2012, the Centers for Medicare and Medicaid Services (CMS) began linking a portion of hospital reimbursement funds to patient satisfaction, or “the patient experience.” Patient satisfaction currently accounts for 30% of a hospital’s overall score under CMS’s Value Based Purchasing Program, mandated by the Affordable Care Act. For a large healthcare facility, millions of reimbursement dollars could be at stake. The patient experience is measured using a standardized survey form called the Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS). HCAHPS asks recently discharged patients to score their inpatient stay on a wide variety of measures including physician and nurse communication, medication and discharge teaching, hospital room and unit cleanliness, noise around their room (especially at night), and responsiveness of the nursing staff to their needs. Comparisons can then be made by CMS and healthcare consumers from hospital to hospital and unit to unit. Hospitals showing improvement in these areas will receive a greater reimbursement than facilities that do not.

Aim:
Nursing assistants (NAs), also known as Patient Care Technicians (PCTs) can have a significant impact on patients’ perceptions of unit cleanliness, noise levels and staff responsiveness to their needs. Enabling the NA/PCT staff to work more efficiently should allow greater responsiveness to the patient’s needs. This microsystem project attempted to demonstrate that a redesigned workflow model for NA/PCT staff would result in improved HCAHPS scores for that particular unit in the areas of unit noise, cleanliness, and patients receiving prompt assistance. The CNL would implement change primarily via the role functions of clinician, educator, systems analyst/risk anticipator, and team manager.

Methods/Programs/Practices:
The project evaluated the effectiveness of the Reliable and Variable Rounder Nursing Care Redesign model currently implemented on some inpatient units at UPMC Presbyterian Hospital in Pittsburgh, Pennsylvania. The model divides the NA/PCT workload into “predictable” and “unpredictable” tasks. The “predictable” work (daily, routine patient care such as baths and vital signs) is completed by the “reliable rounder”. The “variable rounder” responds to the “unpredictable” needs (call lights, patients going to and returning from tests, patient discharges and new admissions) allowing the reliable rounder to avoid interruptions. The project also addressed noise reduction and alarm desensitisation among staff on a cardiac telemetry unit.

Outcome Data:
Comparison of HCAHPS scores of the microsystem unit before and after project implementation reflected improvements in all of the nursing sensitive focus areas: staff responsiveness, perceived unit noise, and unit cleanliness.
**Conclusion:**
Enhancing the patient experience of care is now a greater priority that ever for healthcare providers. Improved HCAHPS scores and the positive effect they have on reimbursement under the Affordable Care Act is an outcome the Clinical Nurse Leader is uniquely prepared to deliver.

**Abstract title:** IMPLEMENTATION OF RESPITE ROOM ON SURGICAL UNIT TO DECREASE MEDICATION ERRORS

**Author Name & Credentials:** Tru Byrnes BSN, RN, PCL, CMSRN,

**Institution:** Carolina Medical Center

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**Background Information:**
Work-related fatigue has a negative impact on nurse’s performance and patient safety due to medical errors (Barker & Naussbaum, 2010; Jha, Duncan, & Bates, n.d.; Fallis, McMillian, & Edward, 2012; Scott, Hofmeister, Rogness, & Roger, 2010). Nurses need to stay vigilant during medication administration; however long shifts, beyond eight hours, were associated with a decrease in mental alertness and concentration (Scott, Roger, Hwang, & Zhang, 2006). As a result, the likelihood for nurses making medical errors nearly doubled when they worked 12.5 or more consecutive hours. Scott and Roger et al. (2006) research study found 224 errors and 350 near errors due to long hour shift duration and fatigue. Out of these 28.2% involved administration of medications. Research studies have recommended strategies to reduce nursing fatigue and decrease medication errors by altering work environments (Barker, & Nussbaum, 2011) and allowing nurses who work 8 to 12 hour shifts to take a short nap during their break time.

**Aim:**
The main purpose of this clinical innovation project was to help reduce nurse's fatigue and improve patient safety by decreasing medication errors. The goal of this initiative was to decrease medication error by 10% in 60 days and 20% at the end of the year. Our top priority is patient safety.

**Methods/Programs/Practices:**
Descriptive method using data collection tool documenting nurses utilization of the respite room. The medication incidence reports data was collected by risk management before and after implementation of the respite room. The total number of medication errors was recorded two months before and after the implementation of staff respite room. The staff was surveyed concerning the respite room amenities and guidelines. The waiting room near nursing station was converted into a respite room for staff easy access.

**Outcome Data:**
The findings showed over 40% reduction in medication errors in 2 months post implementation of the respite room. This is a significant reduction in medications errors, which exceeded our
goal of 10% by 30%. The reduction in medication errors directly impact patient safety and prevention of other adverse outcomes.

**Conclusion:**
The main purpose of this project was to improve patients’ safety. The results showed the benefits of having a respite room will improve workflow, staff satisfaction, and patient safety. The recommendation would be to continue to encourage nurses’ utilization of the respite room and provide ongoing communication of factors contributing to fatigue and the risks it poses to patient safety.

**Abstract title:** Implementing the ABCDE Bundle in a 30-Bed Mixed ICU
**Author Name & Credentials:** Cindy Cervini, BSN, RN, CCRN
**Institution:** St. Vincent's Medical Center
**City/State:** Bridgeport, CT
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**Background Information:**
Based on the January, 2013 SCCM Delirium Guidelines, we realized that we were treating ICU delirium in ways that were not only not recommended, but may have been contributing to, delirium. Further analysis showed that this was a culture that was present throughout the institution. As a result, we looked at what was then our current practice, and how it needed to be modified to best model the SCCM guidelines. A unit specific ABCDE bundle grew out of this initiative, and now includes a daily ventilator wean screening, a pain, agitation, delirium (PAD) bundle and early mobility initiatives, all of which are presented in a patient-centered manner.

**Aim:**
The aim is three-fold: To decrease ventilator days, increase mobility (and thus decrease hazards of immobility) and decrease delirium rates. Decrease of ventilator days and increased mobility of critical care patients will be achieved by increasing mobility earlier in the hospital course, as well as by proper management of pain, agitation and delirium (PAD).

**Methods/Programs/Practices:**
A unit-specific bundle was created with multi-disciplinary input, including: Intensivists, Clinical Leader, Critical Care Educator, bedside nurses, Clinical Pharmacist, Respiratory Therapy, and Physical Therapy. One-on-one education was provided to each staff member about the reasons for each section of the bundle as well as how to implement the bundle. How to perform the CAM/CAM-ICU scale was taught, and with permission from the author, Rick Bassett, the Progressive Mobility Continuum was modified to the specifics of our unit in order to be implemented as well. Laminated pocket cards with the CAM-ICU on one side and the SCCM THINK pneumonic were created and distributed to each staff nurse once they completed their ABCDE education. Laminated, reusable Progressive Mobility Continuum Charts have been made and hung in each patient room in order to communicate which level of activity the patient
has completed to staff nurses, physical therapists and families. Education was also provided to the physicians. Although the effort was started in June, 2013, October 1, 2013, was our official "ABCDE Bundle Roll-Out Day".

**Outcome Data:**
Because this initiative was rolled out on October 1, the current plan for outcome data is to track ventilator days monthly, expecting a decrease, as well as to simply audit whether or not the ABCDE bundle is being implemented correctly by the staff nurses. We will also track barriers to implementing the bundle, using this as part of the PDSA cycle to reevaluate and modify our bundle for increased compliance and effectiveness. Once using the bundle becomes a more distinct part of the ICU culture, we will audit rates of delirium as well, comparing them to rates at like hospitals nationwide. Anecdotal data about specific patients, their treatment, and methods implemented to decrease delirium has been positive thus far.

**Conclusion:**
The SCCM guidelines on pain, agitation and delirium, as well as the EBR on hazards of immobility showed that our 30-bed mixed ICU needed culture change re. the practices of care including medication, delirium management, and mobility. As a result, a unit-specific ABCDE bundle was created, with these goals: to decrease ventilator time; improve management of pain, agitation and delirium as based on pain scores, SAS scores and delirium rates; and increase the rates of early mobility to minimize EBR proven hazards of immobility. This bundle was created by a multidisciplinary team, and each staff nurse was educated individually. The official roll-out was October 1, 2013, and formal results of the implementation are pending.

**Abstract title:** Delirium Screening in Geriatric Trauma Patients  
**Author Name & Credentials:** Meridith Gombar Creeden RN, MSN, CNL  
**Institution:** Carolinas Healthcare System  
**City/State:** Charlotte, NC  
**Primary Contact Email:** meridith.creeden@gmail.com

**Background Information:**
Geriatric patients are at a high risk of developing delirium during their hospital stay. Geriatric trauma patients are at an even higher risk of developing delirium due to severity of injury and the unplanned nature of their hospitalization. Currently the institution where this CNL works does not have a delirium screening process for floor (non-ICU) patients.

**Aim:**  
Implement a screening process to identify delirium in geriatric trauma floor patients. The CNL met with a multidisciplinary team to help develop a new admission order set for geriatric trauma patients that includes a delirium screen performed by the bedside nurse. The delirium screening process needed to be cost and time effective while still producing sound results. Further, nurses needed to be educated on the diagnosis of delirium.
Methods/Programs/Practices:
The CNL performed a literature review to identify the best delirium screening tool for floor patients. Once the tool was identified, input from staff Psychiatry physicians was obtained to verify that the best tool was being used. Cost and time effectiveness is achieved by the primary care nurse performing the screen, which takes less than 5 minutes and is done each shift. Pre data was collected by the CNL on the target population for 40 days. The staff on the units housing the floor trauma patients were inserviced on the diagnosis of delirium and how to perform the delirium screens. The trauma service developed a new admission order set for the geriatric trauma patient that includes the delirium screen on all geriatric trauma patients. This order set has recently been launched and now all geriatric trauma patients are receiving a delirium screen each shift by the primary care nurse.

Outcome Data:
Implementation of the geriatric trauma admission order sets has just occurred. The CNL is tracking compliance with ordering the correct order set for the geriatric trauma patient, nursing completing the delirium screens, and number of patients that are identified as screening positive for a suggested diagnosis of delirium. Currently, nursing is identifying patients that have delirium that might otherwise not have been identified. Currently collecting post-implementation data.

Conclusion:
Delirium is a serious medical condition and geriatric trauma patients are at a high risk for developing delirium during their hospital stay. At this institution, there was no process to screen for delirium. This CNL picked a validated delirium screening tool founded in evidence based practice to screen the identified high risk population. Nurses were educated on delirium and the use of the screening tool. The trauma service has launched a new geriatric admission order set that includes the delirium screening tool to be done by the primary care nurse. This order set has recently been implemented and the primary care nurses are identifying patients with a suggested diagnosis of delirium. Identifying delirium will improve patient outcomes, decrease length of stay, and decrease cost of hospitalization.
Aim:
The aim was to assess the microsystem, analyze the gap, standardize process and implement the evidence in the acute hematology/oncology patient care setting and to reduce CLABSI's as infection rates rose to reduce morbidity and mortality in this patient population.

Methods/Programs/Practices:
A systems gap assessment was recommended, performed and analyzed. A knowledge deficit regarding existing policy was identified. Educational sessions addressed this gap. An educational intervention was proposed, implemented and evaluated. Nurses in the Adult Hematology/Oncology (AHO), a 29 bed unit, and Adult Stem Cell Transplantation (ASCT), an eight bed unit, implemented an intervention to reduce CLABSI rates. Four steps included: 1) education; 2) standardized approach to central venous catheter (CVC) maintenance; 3) practice audits three times per week on all patients and 4) immediate peer feedback. Nurses completed CVC education and collaborated with the medical team to address appropriateness of CVCs. CLABSI nursing champions were identified to support education and interdisciplinary collaboration.

Outcome Data:
Reduction in CLABSI rates was demonstrated by implementing CL insertion and maintenance "bundle" approach (Centers for Disease Control and Prevention, 2011). Prior to implementation, CLABSI rates were 4.85 (AHO) and 3.21 (ASCT) times the National Healthcare Safety Network (NHSN) Mean. Post intervention, rates decreased to 1.15 times NHSN Mean within one quarter. Both units reached over 185 preventable CLABSI free days. The CLABSI rate for AHO in October-December 2012 measured 6.79 (NHSN Mean 1.40) and measured 7.71 for ASCT (NHSN Mean 2.40). In April – June the AHO rate measured 1.62 and measured 0 for ASCT. Findings post-intervention included: 1) reduced practice confusion; 2) increased compliance of 98% with best practices; 3) no breaks in sterility; and 4) increased policy knowledge.

Conclusion:
Findings are consistent with recommendations for reducing CLABSI in non-ICU setting. Pre and post data indicate education and process standardization reduced CLABSI incidence and addressed a quality and safety gap for health systems.

Abstract title: Sustaining a Nurse's Skill Set with a Nursing Skills Education Board (NSEB)
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**Background Information:**
Although nurses become licensed and obtain competencies on various skills, it is not uncommon for nurses to forget certain skills that are not used daily. As a result, best practice guidelines and proper technique can often be forgotten. Not only does this compromise the quality and safety of care being delivered, but it can undermine a nurse’s confidence and add to the stress incurred by the demands of everyday nursing.

In an effort to sustain a skill set and high level of confidence with a nurse’s extensive scope of practice a “Nursing Skills Education Board” (NSEB) was introduced to a medical-surgical inpatient care unit, and was designed to complement a given topic presented during unit in-servicing. The NSEB is located at or near the nurses’ station showcases a nursing skill and/or competency every other month with the main purposes of providing valuable information to staff, increasing the awareness and implementation of proper skill techniques, increasing the confidence of nursing staff, and improving the quality and safety of patient care.

The NSEB displays key points, visual aids, and associated policies, procedures, and competencies. In order for the NSEB to be effective it needs to engage the staff who pass by it. This is done by using catchy titles and headings, a simple layout highlighting most pertinent information, and engaging pictures/graphics.

**Aim:**
For nurses to sustain a skill set and high level of confidence within their extensive scope of practice using a NSEB to compliment unit in-services. A NSEB was implemented on a medical-surgical telemetry unit in an effort to sustain a nurse’s skill set and high level of confidence, provide valuable information to staff, increase awareness and implementation of evidence based practice, promote proper skill techniques, and improve the quality and safety of patient care.

**Methods/Programs/Practices:**
Plan-Do-Study-Act Methodology was followed to implement this project. Plan: According to Willis, 2006, involving more senses during learning creates more memory pathways, increasing the likelihood of later recalling information. Learning methods were in the form of in-services and NSEBs. Do: Surveys were created to assess the nurses’ level of confidence in their own skills and thoughts about in-services/NSEBs. In-servicing and posting of the NSEBs were carried out. Posttests to evaluate the effectiveness of information presented were passed out and collected. Study: Information and data obtained from surveys were analyzed to evaluate effectiveness of NSEBs. See outcome data below. Act: Biggest barrier is the sustainability of the board. To get frontline nurses involved in future board topics and NSEB initiation, maintenance, and sustainability, it is ideal to incorporate the NSEB into the unit’s shared governance model. It is also recommended that units partner with nursing education to sustain efforts and provide additional modes of learning (i.e. incorporating a skills lab, etc.).

**Outcome Data:**
Confidence in Nursing Skills Pre-Survey showed only 6% of RNs were very confident in their ability to perform skills within the scope of practice (63% were confident, 28% somewhat confident, 3% not confident). Pre-NSEB implementation assessment of in-services indicated 19% of RNs thought in-services were very helpful, 62% helpful, and 19% somewhat helpful.
Pre-NSEB implementation assessment of display boards indicated 3% of RNs thought they were very helpful, 47% helpful, 44% somewhat helpful, 6% not helpful. Post NSEB and in-service quiz demonstrated that 94% of staff were able to correctly answer >7/8 free response (not multiple choice) questions demonstrating information retention. 100% of nursing staff surveyed agreed that combination of in-service and NSEB increased their confidence with regards to topic/information presented. NSEB and in-service topic included prevention of lower extremity pressure ulcers and the use of the Heelift boot. Although the use of the Heelift boot is not a new product at our facility, usage on the pilot unit increased by approximately 166% (6/month to 16/month). Anticipated outcomes would be a decrease in lower extremity pressure ulcers (more time is needed to evaluate this).

Conclusion:
NSEBs contain information pertaining to the dissemination of new knowledge or the reinforcement of correct procedure and skills. They are a wonderful compliment to unit in-services. Often times information given at an in-service is quickly forgotten, and valuable information is not retained. NSEBs not only promote and reinforce learning, but they can help promote the use of a new product that enhances patient care. NSEBs highlight best practice by featuring methods or approaches by which best practice is promoted and maintained. As a compliment to in-services, NSEBs help improve care given to patients by enhancing RN confidence, accuracy, and effectiveness of how patient care is performed.

Abstract title: Healthcare Reform and the CNL
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Objectives: St. Joseph’s Regional Medical Center’s (SJRMC) Maternal Child’s Goal for 2013 is to become a more Breastfeeding Friendly Hospital by using the “Ten Steps to Successful Breastfeeding” in particular number three: “Inform all pregnant women about the benefits and management of breastfeeding” and number ten: “Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.” This goal strives to be compliant with the American Academy of Pediatrics recommendations, “to exclusively breastfeed an infant until six months of age,” Healthy People 2020 proposal of 85% combination breastfeeding rate at discharge, and the Affordable Care Act’s guidelines to demonstrate resources, training and research of health professionals needs for the promotion of breastfeeding, while providing prevention and public health proficiency in reducing health disparities (U.S. Department of Health and Human Services, 2012).

Methods: Part I: Staff (medical, nursing, and ancillary) was surveyed from five units within the Maternal Child Division and one affiliated women’s maternal health community clinic on their knowledge of breastfeeding benefits to both mother and infant. Part II: Staff as above was surveyed on current practices on breastfeeding and any obstacles, concerns, observations or
processes standing in the way of increasing their breastfeeding rates. A total of 62 nurses and 16 physicians were surveyed. Pre and posttests were given to ensure staff was gaining sufficient knowledge from the educational session.

**Results:** Part I: It was identified that educational in-services would be beneficial in achieving the goal surrounding understanding and knowledge of the benefits of breastfeeding and that there was a need for improved communication between Newborn Nursery’s and the Mother-Baby nurse’s station to improve nurse/patient work flow. Part II: It revealed that time constraints was the biggest obstacle when considering breastfeeding for mothers. They also believed that the easy accessibility of formula within the hospital impedes the promotion of breastfeeding. Pre and posttest results revealed that the majority of attendees improved their scores by more than 20% after receiving the educational information on breastfeeding, benefits to both mother and infant, and the benefit of immunity, decreased incidence in asthma, diabetes, and childhood obesity. Interestingly, our breastfeeding rates continuously fluctuate between 76% and 80%, however we recognized the need to be more culturally competent for our Spanish population as a result of these surveys and perused resources for our clients which is currently being piloted.

**Conclusion:** A Gap Analysis by the Clinical Nurse Leader Laura Niewiadomski demonstrated the need for improved communication between the staff of existing policy surrounding distribution of formula in cribs, rooming in practices when breastfeeding, and the referral for lactation consultants as a resource for breastfeeding mothers on the weekends. The CNL’s proposal to make changes in practice and have more accessible resources available in order to improve breastfeeding rates was accepted. The development and implementation of a visual daily roster and distribution of formula list for both nursing stations by the staff assisted them in appropriately distributing formula to only formula fed infants.

**Abstract title:** Clinical Nurse Leader Project: Chlorhexidine Gluconate Education  
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**Background Information:**  
This Clinical Nurse Leader (CNL) project was completed during the immersion experience between March 2013 and June 2013 on 7 East/5 East medical-surgical floors at Ronald Reagan UCLA Medical Center. The methodology used to design the project was Plan, Do, Study Act (PDSA). According to the National Health Institute (NHA), PDSA provides a framework for improvement by trialing an intervention and then assessing its impact. The CNL project is part of the curriculum of the Masters Entry Clinical Nurse Program (MECN) at the UCLA School of Nursing.

**Aim:**
The overall purpose of the project was to decrease the incidence of CLABSI events on 7E/5E. Data from the units showed that from November 2012 to January 2013, the rate of CLABSI events increased 7.0%. In fact, in January 2013 the rate was the highest it has been in the past 12 months.

Measurable objectives of the project were determined to be the following: (1) Hold at least three in-services, (2) Two-thirds of the total care partners of 5E/7E will attend, and (3) Observe a two-point increase in scores between the pre-test and post-test among those in attendance.

**Methods/Programs/Practices:**
Studies show that Chlorhexidine Gluconate (CHG) bathing is an effective way to decrease the risk of central-line infections. Teaching the staff how to properly administer a CHG bath could achieve the overall goal of decreasing the incidence of CLABSI events on 7E/5E.

A step-by-step demonstration of a CHG bath was delivered during the in-service using a Barbie doll to represent a patient. A pre-test and post-test were given to the participants to complete in order to determine the effectiveness of the in-service. The implementation of this educational intervention exercised the CNL roles of educator and outcomes manager. The CNL role of educator was observed during the in-service as the CNL taught staff the importance of CHG bathing, the current hospital policy, and provided a demonstration. The role of outcomes manager was demonstrated by synthesizing the data from the pre- and post-tests to evaluate the increase in knowledge among staff.

**Outcome Data:**
Objective 1: Hold at least three in-services. Outcome: Six in-services were held between May 16 and May 27 for the staff.

Objective 2: Two-thirds of the total care partners (CPs) of 5E/7E will attend the in-services. Outcome: There were 36 care partners and 83 registered nurses on the unit. A total of 32 staff members attended the in-services: 17 were care partners and 15 were registered nurses. The attendance rate of care partners was 53% and the attendance rate of nurses was 20%.

Objective 3: Observe a two-point increase in scores between the pre-test and post-test among those in attendance. Outcome: There were a total of 30 pre-tests with an average score of 3.77 out of 6 points. A total of 28 post-tests were taken with an average score of 5.68 out of 6 points. This makes a point difference of 1.91 between the pre-test and the post-test scores.

**Conclusion:**
The increase in scores between the pre-test and post-test shows that the teaching was effective. Teaching staff how to effectively give a CHG bath can perhaps decrease the incidence of CLABSI events. This project was planned and implemented in a limited time frame and the overall purpose of reducing CLABSI events is a long-term goal that is not evaluable without additional data.
Abstract title: Decreasing the Occurrence of Hospital Acquired Pressure Ulcers through the Implementation of Multidisciplinary Interventions

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**Background Information:**
Hospital Acquired Pressure Ulcers (HAPUs) are pressure ulcers that occur during hospitalization and pose a significant problem for patients, nurses and hospitals. However, previously existing pressure ulcers not discovered on the initial assessment are included in the HAPU tally. Veterans Affairs developed VANOD (VA Nursing Outcomes Database) to track HAPU within the VA. According to VANOD, the benchmark for pressure ulcers is 2.11% of patients admitted to the hospital. HAPU rates for our local site in March 2013 exceeded the National Benchmark. The cost to treat a pressure ulcer can range from $5,000 to $50,000 depending upon the severity of the wound. Currently, Veterans admitted to our Medical/Surgical Units are to have a complete skin assessment on admission and every twelve hours by the Registered Nurse (RN). However, the nursing staff was not meeting this goal. The problem was addressed by encouraging adherence to the standards of care in a systematic manner to properly assess skin integrity, identify risk factors, prevent and properly stage and manage pressure ulcers. A focus of this initiative was accurate identification of pressure ulcers on admission to avoid inaccurate identification of an extant ulcer as a HAPU.

**Aim:**
The aim of this project was to implement skin champions as second nurse verifiers to help increase compliance with current policy and to decrease the incidence of HAPU’s. The IHI created standards for patients being admitted to the hospital which includes regular assessment of skin, valid risk factor tools, and daily skin inspection. Having a system in place to monitor quality indicators help standardize and improve the process.

**Methods/Programs/Practices:**
A literature review was conducted and twenty-eight articles were reviewed, the majority of which were non-experimental research, organizational (quality improvement) non-research, and case studies. Seventeen of the articles indicated that a multidisciplinary team approach to include skin champions improves patient care, decreases bed days of care, decreases cost, and decreases risk for infection related to HAPUs. The implementation of the “Muskogee VAMC Process” enlisted a multi-professional/multidisciplinary team approach to skin assessments and HAPU prevention monitoring. This included the implementation of Skin Champions (as 2nd nurse verifiers), turn clocks and timers, a centralized wound care cart with wound care protocols and visual/educational references provided by the wound-ostomy care nurse (WOCN). The goals are to identify pressure ulcers and risk factors on admission in order to prevent HAPUs, and appropriately manage the patients for optimal outcomes. This nurse assumed the role of process monitor to educate and encourage staff to comply with current standard of care to improve wound assessment.
**Outcome Data:**
HAPU’s rates have decreased 54%, from 4.95% in March 2013 to 2.68% in September 2013. This process has increased awareness of skin assessments and improved compliance with identification and prevention of HAPUs. This also has saved the hospital thousands of dollars by decreasing number of pressure ulcers to treat, length of stay due to pressure ulcers, and nursing time spent having to care for pressure ulcers.

**Conclusion:**
Using a team approach to identify and solve patient care problems results in better outcomes for not only the patient but also the facility, associates, and care providers. This process alone saved the hospital anywhere from a minimum of $270,000 to a maximum of $2.7 million.

**Abstract title:** Setting Realistic Expectations and Increasing Hospital Patient Satisfaction Scores related to Pain Management Utilizing Evidenced Based Practice.

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**Background Information:**
It is reported that 80 percent of patients experience pain postoperatively with between 11 and 20 percent experiencing severe pain (Wells, Pasero, McCaffery, 2008). Post surgical pain has been linked as having one of the highest dissatisfaction rates within the acute care setting (Martin, Kelly, Poosa, 2012). Pain is important in healthcare since it is a question asked after patients discharge and tracked for reimbursement purposes. Patient satisfaction is dependent upon meeting or exceeding expectations (Bozimowski, 2012). Many patients have unrealistic expectations and goals related to pain management while in the acute care setting. Some patients feel their pain rating should be at a zero due to the vast amounts of pain control options while in the hospital. Patient perception has become so important that government and reimbursement agencies have required hospitals to make satisfaction scores transparent to the public (Bozimowski, 2012). Pain has now been labeled as the” fifth vital sign” (Aston, 2012, p. 1), is subjective, and can have harmful effects on patients healing and coping.

**Aim:**
Demonstrate the importance of the CNL role in increasing pain scores in HCAHPS through process improvement and innovation of the pain boards. Historically, pain scores at Carolinas Healthcare System, based on Hospital Consumer Assessment of HealthCare Providers and Systems (HCAHPS), are low in relation to patients’ levels of satisfaction with pain control. On 11A, a 24 bed step down trauma unit, the Clinical Nurse Leader (CNL) created and implemented a laminated pain board (see Figure A) that is placed on the wall of each room at the foot of the patient’s bed. It was created to be easily erasable and has large font for those who are visually impaired. The pain board contains 3 components that include 1) an area to write an agreed upon pain goal; 2)any scheduled pain medications; and 3) any as needed (PRN) pain medications.
along with next dose available time. The average realistic pain rating on a scale of 1-10 for an acute care setting is from a 3-4. Nurses should utilize education for patients and families to help establish a mutual pain goal that is realistic and while promoting patient centered care. The pain board was implemented to 1) set the expectation early through education that a pain score of zero is unrealistic and 2) decrease anxiety and stress by having next available time of medications present and visible to the patient at all times.

Methods/Programs/Practices:
Data was collected for 2 years prior to the implementation of the pain boards through quarterly satisfaction scores in Professional Research Consultants (PRC) which is a Carolinas HealthCare System purchased database to collect patient satisfaction scores. The staff were then educated on usage of the pain boards. After a month of education, audits were performed by either the charge nurse or nurse manager to ensure the boards were being filled out correctly and in entirety. The CNL’s on this unit attended a pain class held by a colleague who is pain certified in order to expand our knowledge base of pain management. The CNL’s also attended a pain seminar presented by the Institute for Natural Resources (INR). Audits continued over the following 3 months until the unit was at 100% compliance for pain board utilization. Data was then collected over the next four months from HCAHPs to determine if pain satisfaction scores did in fact increase.

Outcome Data:
Early results were positive. The first four months after implementation of the pain boards the HCAHPs scores increased significantly. See Figure B. However starting month five, HCAHPs scores had decreased. This in part is due to the metric not being audited or sustained. Overall usage in the pain boards have decreased.

Conclusion:
The goal of pain management in the acute care setting is to ensure our patients feel as though we are controlling their pain adequately in order to increase our pain satisfaction scores within HCAHPs. The nurse must first set the expectation that a pain score of zero is an unrealistic goal through the use of effective communication, education, and a trusting relationship while setting their numeric pain goal. The patient having their pain management regimen written and visible should help to decrease anxiety and help to alleviate any fears related to next pain medication dosage availability (Martin, Kelly, Roosa, 2012). Patients who set and attain their goals and are well informed are more likely to report higher satisfaction in regards to pain management (Bozimoski, 2012). Patients are also more likely to report higher satisfaction with pain management if they feel the providers did everything they could to control their pain, not necessarily if their pain was actually being well controlled (Aston, 2012). It is critical that nurses utilize these pain boards that have proven to have positive outcomes. Leadership presence is a major key in utilization and sustainability.
Abstract title: Response Time Improvement Process with Implementation of No Passing Zone  
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**Background Information:**
As a surgical unit we were consistently below the goal with our Professional Research Consultants (PRC) & Hospital Consumer Assessment Healthcare Providers and Systems (HCAHPS) responsiveness of staff score. A literature review was conducted looking to improve patient call light response time. Evidence showed implementation of "No passing Zone" will improve staff response time to call lights (Tonges & Ray, 2011).

**Aim:**
The aim of the No Passing Zone was created to remind all staff that we are to answer patient's call lights and not to pass by any patient's room with a blinking call light. The main purpose of this safety initiative was to improve patient's quality of care by improving staff response time. The goal of this initiative was to improve PRC/ HCAHPS responsiveness of staff scores by 10%.

**Methods/Programs/Practices:**
A No Passing Zone process map was created with key stakeholders input. The staff was given an in-service along with the process map and roll out date. The "No passing Zone" signs were posted on the unit as a reminder for staff. Patients and their families were provided education about the initiatives to improve staff response time. The call light reports were pulled monthly to review call lights response time and PRC/ HCAHPS scores were reviewed daily.

**Outcome Data:**
PRC HCAHPS shows a positive trend in the upward direction in responsiveness of staff since implementation of No Passing Zone. The 2nd and 3rd quarter data results show a significant increase over 1st quarter data. The 1st quarter was 53.52% pre-intervention, 2nd quarter was 77.72% and 3rd quarter was 68.08% post-intervention. So we exceeded our goal of 10%.

**Conclusion:**
After the implementation of the No Passing Zone there was an improvement in responsiveness of staff score. The main purpose of this safety initiative was to improve patients’ quality of care. The recommendation would be to continue to have ongoing communication and encourage staff utilization of the No Passing Zone to maintain positive outcomes.

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Abstract title: Implementing Patient Care Follow-Up: Inpatient to Outpatient  
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Background Information:
Care managers utilized a readmission risk tool and noted that there was indeed an increased readmission rate for patients deemed high risk. The Clinical Nurse Leader role was established in collaboration with an existing nurse navigator program to help guide high risk patients to a safe discharge and decrease the incidence of hospital readmissions within 30 days.

Aim:
All patients are evaluated on admission and every three days by the care managers using the readmission risk tool. All patients identified as high risk are followed by the CNL and referred to the navigator nurse program for follow up. This allows a personalized care plan in the acute care setting to be continued through the navigator program in the outpatient setting. The CNL’s goal is to maintain a less than twenty percent readmission rate for these patients who are deemed high risk.

Methods/Programs/Practices:
- Readmission Risk Tool utilized by care coordinators
- CNLs follow all high risk patients during admission- paying special attention to their length of stay compared to GMLOS, focus on new medications (pharmacist intervenes with polypharmacy), chart reviews to make sure all interventions are being completed during inpatient stay, PT/OT consults, utilizing both the Get Well Network interactive patient program and Mosby's patient education at bedside to prepare for expectations at discharge
- Warm handoff given to navigator liaison at discharge if needed
- At discharge, whether sent to ECF or home, high risk patient is followed by a navigator nurse or social worker, who troubleshoot outpatient issues in an attempt to prevent readmissions

Outcome Data:
In the first year of the CNL role at our organization, the goal for readmission of high risk patients was at twenty percent or less. Two nursing units at different hospitals utilized the CNL role with the following results:

1. In October 2012, the vascular/telemetry unit had a 60% readmission rate for high risk patients and this rate decreased to 20% by June of 2013.
2. In October 2012, the medical and intermediate care unit had an 18.2 % readmission rate for high risk patients and this decreased to 15.1% by June of 2013.

Conclusion:
In the first year of the Clinical Nurse Leader role there were five CNL’s at two hospitals. The role will greatly expand over the next three years with the implementation of a CNL cohort program where the organization will send fifteen selected staff to complete their MSN, CNL certification. This expansion of the role throughout the organization will provide a CNL for every nursing unit in the hospital system to impact all high risk patients.
Abstract title: Connecting Healthcare Silos: Integrating the Clinical Nurse Leader for Care Transitions
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Background Information:
Insufficient care coordination during patient transitions has been attributed to a significantly increased likelihood of poor self-management and an increased risk of hospital readmissions. Investigation into avoidable re-hospitalizations, the costs associated, and the risk of patient harm have been driving much reform in healthcare, including the foundations of Accountable Care Organizations.

Through compiling research and case study evaluation, the Institute for Healthcare Improvement (IHI) found that a focus on health literacy and self-management coaching, enhanced discharge planning and transition to home, and restructuring of handoff process to primary care to be the major components in innovative readmission reduction efforts (Schall, et al., 2011). Furthermore, proper medication reconciliation is expressed throughout the literature as most instrumental to the success of care transitions.

The setting for this quality improvement project is a disproportionate community-based hospital and a non-profit patient centered medical home (PCMH) located in an elevated-need and medically underserved area of Massachusetts. The PCMH comprises 6 sites throughout the community with a total panel size of 47,000 patients. Among these patients, over 10% have a diagnosis of diabetes mellitus (DM), congestive heart failure (CHF), and/or chronic obstructive pulmonary disease (COPD). Approximately 80% of patients at the PCMH also utilize services of this community hospital for inpatient care.

Aim:
The global aim of this quality improvement project is to develop an integrated system of bi-directional care management and coordination between a community hospital and NCQA-recognized PCMH to improve the quality of care for shared patients with DM, CHF, and COPD.

The specific aims of the project over a 3 year period are: develop a care management process map for hospital/PCMH patients with DM, CHF, COPD; develop risk stratification tools for DM, CHF, and COPD; implement a process to refer greater than 50% of all shared hospitalized diabetic patients to a certified diabetes educator (CDE); increase completed diabetes self-management education (DSME) visits at the PCMH by 50% above baseline; increase documented care coordination within the electronic medical record (EMR) between the hospital and PCMH by 50% (above baseline); track a 6-month baseline of near miss medication events prevented by clinical pharmacist interventions.
**Methods/Programs/Practices:**
The IHI’s Improvement Map served as the backbone guiding the project, specifically employing Plan, Do, Study, Act (PDSA) cycles to test changes. The theoretical framework the project is built upon is Everett Roger’s Diffusion of Innovations; introduction of the Clinical Nurse Leader (CNL) as the portfolio manager is the innovative approach to bridging the hospital and primary care practice.

An interdisciplinary team across the organizations was assembled with a CNL as project lead ensuring lateral integration, outcomes management, evidence-based practice, and patient/family-centered care. The team includes: 2 CNLs, 6 Clinical Care Nurse Coordinators (CCNC), a Care Coordinator Nurse Manager (CCNM), 2 Clinical Pharmacists, a Transition of Care Hospitalist, and a PCMH Site Director/Resident Coordinator. Imperative to success of the project was early adoption and sustained involvement from point-of-care staff, as well as continual executive leadership support.

Detailed care management mapping was created and implemented for each of the chronic conditions, which include interventions from hospital admission, through hospitalization, and conclude at the completed primary care follow-up visit. Stratification tools were developed in an effort to predict and manage risk for each of the chronic conditions. All shared patients hospitalized with DM, CHF, or COPD are identified on a daily basis by the CNL at the hospital, who then initiates care coordination between the interdisciplinary team, linking back to the CCNCs at the PCMH via the EMR. Additionally, a pilot study on a Medical Surgical floor includes a Clinical Pharmacist from the PCMH who sees patients throughout their stay, performs medication reconciliation alongside the attending provider, and provides patient and family education on medication management. The CNL oversees the Clinical Pharmacist to assure the medications are appropriate and accessible (i.e. insurance coverage and prior authorizations); that psychosocial factors are addressed; and that receiving CCNCs are aware of follow-up needs.

**Outcome Data:**
In the first year of measurement for DSME referrals to a CDE at the PCMH, the hospital far surpassed the goal of 50% and actually referred 95.7% of patients to a CDE (7/1/12 - 6/30/13). Currently the hospital is at a rate of 96.6% for DSME referrals (7/1/13 - 9/30/13). The baseline measure for completed DSME office visits at the PCMH was 13.4% prior to the implementation of this project and after one year of the project commencing, the rate increased to 19% (7/1/12 - 6/30/13), indicating a 42% improvement. Now in the second year of data collection, the current rate is 22.2% (7/1/13 - 9/30/13) and shows continual expansion every month. The increase in meaningful care coordination documented in the electronic medical record from a baseline of 6.6% (July 1, 2012 to June 30, 2013) to 14.1% (July 1, 2013 to September 30, 2013) reveals a 113% improvement that continues to trend upward as the project commences. Moreover, readmission rates have decreased by 24% for diabetes and 21% for heart failure since the implementation of the project (baseline period: 6/2011-5/2012; re-analysis: 6/2012-5/2013).

**Conclusion:**
Key to the success of this project was: granting inter-organizational access to our respective electronic medical records; frequent reevaluation of process, goals, and meaningful outcomes; and implementing the CNL as the bridge between hospital and primary care. The Transitions of Care Note in the PCMH EMR and the Hospital medical chart, allows us to work towards
standard and consistent documentation of care management along with addressing specific agreed upon data elements: care coordination, medication reconciliation, and patient activation.

Limitations of the project include inability to isolate specific interventions directly contributing to reduction in readmission rates. The hospital and PCMH are both undergoing an array of evidence-based practice improvements for an overall bundled approach to improving care coordination and transitions of care.

A wealth of quantitative data, use case scenarios, and lessons learned have emerged from this project that are driving our future operations and care delivery vision.

Abstract title: Noise Reduction in the Acute Inpatient Setting
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Background Information:
Noise levels are elevated in the healthcare setting, causing dissatisfaction and harmful effects. Numerous studies have shown that hospital noise has a variety of negative effects on patients, which can delay the healing process and lead to longer hospitalization. Even though standards for noise levels in healthcare have been established, the current practice for noise level reduction is nonexistent.

Aim:
The purpose of this evidence-based project was to measure and reduce the peak levels of noise on an adult medical telemetry unit at Carolinas Medical Center; aiming to improve patient satisfaction with the level of noise at night.

Methods/Programs/Practices:
An evidence-based practice change project was conducted on a medical telemetry unit. Education on the harmful effects of noise was provided to staff. A quiet time during the day and environmental changes at night were implemented. Noise levels were measured pre- and post-implementation using a decibel meter in two patient rooms. Patient satisfaction with noise at night was measured pre- and post-implementation by Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores.

Outcome Data:
A strong positive correlation was found between the intervention and the reduction of peak noise levels (r = 0.01). The reduction of peak and average noise levels between 1900 and 0659 were found to be statistically significant (p < 0.02). The percentage of patients surveyed stating
it was always quiet at night increased from 66.7% to 72.5% after the interventions were implemented (p < 0.07).

**Conclusion:**
Peak noise levels can be reduced and patient satisfaction about noise at night can be increased. A standard for noise within the acute inpatient setting has been identified; however, no setting has been shown to meet the standard despite the implementation of noise-reducing interventions. Further studies must be conducted on noise within the healthcare setting in order to implement appropriate interventions.

**Abstract title:** From Clinical Outcomes Nurse (CON) to Clinical Nurse Leader (CNL): A Collaborative Strategy to Improve Outcomes Now

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**Background Information:**
The impact of the clinical nurse leader (CNL) on patient outcomes has been greater than expected. TriHealth, like other health care organizations, has identified the need to employ more CNLs. There are 103 clinical nurse leaders (CNLs) licensed in Ohio (2,524 in the US). Despite aggressive recruitment, there has been little success in recruiting qualified external candidates for CNL positions within the TriHealth organization. TriHealth proposed a collaboration with the College of Mount St. Joseph to pay to educate a cohort of high performing, experienced TriHealth nurses over a period of three years.

**Aim:**
During the three years of part time course work combined with full time employment on select units throughout the TriHealth organization, the nurses chosen for the cohort will serve as clinical outcomes nurses (CONs) on designated units within the organization, and after graduation and certification, serve as CNLs on the same units. TriHealth is hopeful that the impact of this cohort of CONs on patient outcomes on selected units will be felt immediately as these select, highly motivated nurses move through a rigorous, three year CNL track curriculum, while working full time on their units.

**Methods/Programs/Practices:**
Shortly after the chosen CNL track students complete the first course in the curriculum, The CNL Role and Ethical Considerations, they will each assume the role of clinical outcomes nurse (CON) on select units. The sixteen nurses selected for the cohort have a combined 325 years of experience as RNs, and were chosen from a competitive, highly qualified pool of applicants.
Outcome Data:  
The result of this unique collaboration is hoped to be measurable, improved outcomes over the three years that the CONs are working and taking CNL courses, and beyond.

Conclusion:  
The CNL plays a critical role in influencing critical metrics for health systems including safety, employee engagement, and finance. Health care organizations must strategize and collaborate with institutions of higher learning to meet the need for improved patient outcomes now.

Abstract title: The Effects of Multidisciplinary Team Education on Total-Joint Surgery Patient Length of Stay  
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Background Information:  
• The Diagnosis-related group (DRG) 470 is major joint replacement of hips and knees. Total joint replacement is the top third diagnosis of the microsystem studied at THDN.  
• Most hospitals receive payment of a fixed amount for the operating cost of each case according to the DRG.  
• The national average length of stay for total knee replacement is 3.9 days and the national average length of stay for total hip replacement is 5.0 days (DiGioia, A. & Embree, P. 2011). The average length of stay at Texas Health Presbyterian Denton Hospital is 3.8 days for DRG 470 total joint replacement.  
• The Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) is the first national, standardized, publicly reported survey of patients' perspectives of hospital care.  
• Low scores prompted the surgical microsystem to focus on improving nurse communication to enhance patient satisfaction

Aim:  
The aim of this project was to involve a CNL student led multidisciplinary team for total joint patients in an effort to decrease length of stay and improve Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) patient satisfaction scores on a fifty-five bed acute surgical microsystem at Texas Health Presbyterian Hospital of Denton, Texas (THDN).

Methods/Programs/Practices:  
• The CNL student assembled a multidisciplinary team, consisting of the orthopedic surgeon, microsystem staff, physical therapist, and case manager. The team also included the patient and family.
• The CNL student coordinated the education of the staff nurses on clinical guidelines and safe transfer through scheduled classes, email, and individual coaching.
• RNs indicated goals for the day on the communication board in patient rooms.
• The registered nurse and patient care technician delivered coordinated care and encourage patient independence and mobility.
• The physical therapist initiated early and aggressive post-operative rehabilitation and informed the patient of the goals to be achieved before discharge. Daily progress was reported on the communication board.
• The case manager coordinated details required to complete the discharge of each patient.
• Focused clinical leader rounding utilized Studer principles, 4 P’s (pain, positioning, personal needs, placement) and AIDET (acknowledge, introduce, duration, explanation, thank) to develop relationships with patients.

**Outcome Data:**
Historical length of stay data was collected prior to implementation of this study. Patient satisfaction scores were examined with focus on communication with nurses. Six weeks after project implementation, length of stay and HCAHPS scores were compared to the three months pre-project to assess the effectiveness of the program on LOS. Length of stay decreased from 3.8 days to 3.1 days. HCAHPS scores increased from 71.3% to 88.9% for the overall score “communication with your nurse“.

**Conclusion:**
• CNL student contacted each patient by phone pre-operatively, to review anticipated hospital course and to answer questions.
• Although pre-operative education classes were offered during the study, all patients chose not to participate.
• Upon arrival to the surgical floor, post-operative patients were evaluated by the physical therapist on the day of surgery. Standing at the bedside was the goal of early intervention.
• The case manager visited with patient and started discharge planning on the first post-operative day.
• Length of stay decreased as the result coordinated care from a multidisciplinary team, early and aggressive ambulation, and discharge planning
• Length of stay for patients receiving total joint replacement was reduced from 3.8 to 3.1 days.
• HCAHPS scores results increased from 71.3% to 88.9% for the overall score “communication with your nurse”.
• HCAHPS scores increased from 58.3% (n=15) to 75% (n=8) for the question “Nurses kept you informed” “Nurses explain in way you understand” 70.2 % to 71.1% and 76% to 88.9% for overall score “communication with your nurse”.
The study, revealed significant results over a short time period.

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Background Information:
A Clinical Nurse Leader (CNL) in an urban tertiary-care teaching facility performed an initial assessment of her medical-surgical (med-surg) microsystem and observed that there were 5 different types of beds. The beds had either air (for patients at risk for skin breakdown) or non-air mattresses. The CNL noticed RNs were unable to identify air versus non-air beds, and therefore, were renting specialty air beds for at-risk patients. The rental air mattresses could only go on a bed frame that had a non-air mattress on it. At times the nurses would take their patient off of an air mattress bed and look for a bed with a non-air mattress in order to install the rental air mattress. Despite the availability of air beds comparable to the rental air mattresses, rental mattress usage remained high. The facility had 5 inpatient med-surg units, 3 with a CNL and 2 without.

Aim:
Properly utilize beds owned by the facility in order to decrease the number of specialty mattresses rented, and achieve a decrease in hospital-acquired pressure ulcers (HAPU).

Methods/Programs/Practices:
As part of the daily identification of patients at high risk for skin breakdown, the CNL reviewed the care of those patients with a Braden score less than 17. The CNL evaluated the patients’ need for air beds and ensured patient were on the correct mattress surface. The CNL created an informational bed chart with pictures of the various beds available to help RNs select the appropriate support surface. As a result, use of specialty rental mattresses decreased on her unit. The CNL then collaborated with three CNLs on two other med-surg units and the Wound Care Specialist to develop a bed algorithm for nurses to identify the appropriate bed for their patients. Despite the algorithm, nurses still had difficulty identifying air and non-air beds. Therefore, laminated labels were placed on each patient bed. All inpatient units were educated about this algorithm and the bed labels.

The other CNLs began monitoring patients’ bed needs and provided education to nurses on their respective med-surg units. The CNLs and Wound Care Specialist collaborated with Information Technology to receive an electronic alert when a rental specialty support surface was ordered, which allowed the CNLs to provide in-time education and prevent unnecessary rentals.

Outcome Data:
Pre-implementation, bed rental costs totaled $20,242 (April-December, 2012). Post-implementation total rental bed costs decreased 40% to $12,186 (January-September, 2013). The costs of rental beds on units with CNLs decreased significantly post-implementation. Pre-implementation, bed rental costs on units with CNLs totaled $10,054 (April-December, 2012).
Post-implementation rental bed costs on units with CNLs decreased 73% to $2,754 (January-September, 2013). CNL Unit 1 decreased bed rental cost by 75% (pre-implementation cost $4,410 and post-implementation cost $1,098). CNL Unit 2 decreased bed rental cost by 83% (pre-implementation cost $5,644 and post-implementation cost $954). CNL Unit 3 opened in January, 2013, and bed rental costs post-implementation were $702.

Bed rental costs on units without a CNL decreased 7% post-implementation. Non-CNL Unit 4 decreased bed rental cost by 35% (pre-implementation cost $8,046 to post-implementation $5,256). Non-CNL Unit 5 increased bed rental cost by 195% (pre-implementation cost $2,142 to post-implementation $4,176).

Across all units, HAPU prevalence decreased or remained at zero post-implementation.

**Conclusion:**
CNLs were effective in decreasing bed rental costs, while decreasing the number of HAPUs. The electronic notification that a rental bed had been ordered was useful for CNLs to follow-up and educate nurses one-on-one in real-time. They worked with staff to reinforce appropriate utilization of available facility-owned beds and determine when to rent, if needed.

Over time, the labels on all facility-owned beds helped increase RN competence in placing patients on the appropriate bed.

The CNLs played an integral role in decreasing bed rental costs in comparison to units without CNLs. These results support the impact and value of the CNL role. Hospitals should strongly consider employing CNLs as an effective strategy to decrease costs and improve patient outcomes.

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**Abstract title:** Using evidence based practices to reduce CAUTIs at a small, rural VA facility in Montana

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**Background Information:**
Urinary tract infections account for more than 40% of all healthcare associated infections (HAIs), making them the most common type of HAI in the U.S. During 2011, catheter associated urinary tract infections (CAUTIs) represented the major burden of HAIs in VA Montana Healthcare System (VAMTHCS), consistent with national data.

**Aim:**
A multidisciplinary and innovative program was devised and implemented using evidence-based best practices for insertion and maintenance of indwelling urinary catheters (UCs) in order to reduce the incidence of CAUTIs at our facility.
Methods/Programs/Practices:
In June of 2011, UC insertion and maintenance bundles were implemented as part of VHA’s Inpatient Evaluation Center (IPEC) initiative to standardize and utilize best practices for preventing CAUTIs. The project was designed and coordinated through a unique partnership between the Infection Prevention Program and a Clinical Nurse Leader program graduate student. The first step was to seek buy-in from a multidisciplinary group of stakeholders including physicians, the Infection Prevention and Control Committee, Purchasing and Nursing to determine what supports would enable staff to readily comply with UC insertion and maintenance bundles. The intervention strategy was focused on the purchase and use of an all-in-one indwelling UC kit that acted as the driver of change and made implementing the bundles easy for staff.

Outcome Data:
The pre-intervention period incidence rate (12/1/10-6/30/11) was 4.2 CAUTIs per 1,000 catheter days. In contrast, the post intervention period rate (7/1/11 through 8/31/13) was 1.5 CAUTIS per 1,000 catheter days. This change represents a 64% reduction in the rate of inpatient CAUTIs after implementing the interventions in June 2011. This reduction in inpatient CAUTIs has resulted in a significant cost savings to the facility as well as decreased morbidity. National Health and Safety Network (NHSN) surveillance definitions were used to identify and report CAUTIs to IPEC. Sample size was too small to calculate statistical significance.

Conclusion:
We experienced a dramatic impact on the incidence of CAUTIs at VAMTHCS through the use of a standardized UC kit that contained all the elements needed for insertion. The next activities for CAUTI reduction will be focused on decreasing UC utilization, increasing the use of alternatives, and initiating prompt removal to decrease duration.

Abstract title: Emphasizing Patient Collaboration in Preventing Falls
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Background Information:
Falls are the leading cause of hospital acquired injury. In oncology patients, falls may lead to a very serious disruption in care that may delay the patient’s treatment. In acute care hospitals fall rates range from 1.3 to 8.9 per 1000 days despite the utilization of evidence-based risk assessment tools and fall prevention programs. As a Clinical Nurse Leader (CNL), this quality care threat provides a platform to explore, collaborate, and implement a change to the existing fall prevention program to improve patient care outcomes.
**Aim:**
The aim of this quality improvement initiative was to explore the use of revised written and in person patient education materials on the occurrence of falls in a 32-bed medical oncology unit. A further aim was to reduce the occurrence of falls and increase the days without falls occurring in this patient population.

**Methods/Programs/Practices:**
The CNL focused on collaborating with patients and caregivers to raise the awareness of the patient’s fall risk and give patients more control over their care and prevention of falls. Printed patient education with detailed information on fall prevention measures was placed in a sign posted in all rooms of a 32-bed medical oncology unit. The sign was discussed with patients and family members on a daily basis by the nurses and CNLs during their patient rounds. This complemented the fall prevention program already in place and highlights the CNL role as an effective collaborator within the microsystem. Nurses also continued to use other fall prevention methods, such as focused hourly rounding, use of nonskid socks, and consistent use of bed alarms. A post fall debriefing was held after every fall. Nurses on the unit as well as the patient were involved in the debriefing to raise awareness and discuss what could have been done differently to prevent the fall. A subset of the population was identified as higher risk and more focused measures were implemented to prevent falls. Fall events were discussed monthly during Safety Committee meetings co-led by the CNL and clinical nurse and as part of the unit team meetings to increase awareness of the importance of this safety initiative.

**Outcome Data:**
Six months after the implementation of this collaborative approach in fall prevention, there was 40% reduction in the fall rate. Falls that occurred were mainly assisted falls without injury. The number of days between falls was also affected, with a maximum of 50 days between falls. Patients and families were more compliant with calling for assistance at all times and the nursing team more vigilant to implement measures.

**Conclusion:**
The nursing team, along with the CNLs will continue to educate patients and caregivers on fall prevention using this approach. Although there is increased collaboration between caregivers and patients, and the number of falls has significantly decreased, we must continue to focus our efforts in maintaining and improving patient outcomes.

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**Abstract title:** Educate Before You Medicate  
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**Background Information:**
Lack of patient medication education was identified on the surgical suite (178-bed) of a teaching community hospital. This problem was identified through informally observing Registered Nurses as they administered medications and through the consistently low scores on questions 16 and 17 of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. These two questions on the survey are concerned with the patient’s satisfaction in receiving medication education. Improving patient education is essential to improving quality outcomes (patient medication adherence) and risk reduction (readmission to the hospital) as the New England Healthcare Institute (2012) found that “One-third of [all] adverse drug events resulting in a hospital admission were related to non-adherence.” Also, improving patient satisfaction and HCAHPS scores are critical to improving the cost-effectiveness of the organization as reimbursement from the Centers of Medicare and Medicaid Services (CMS) is contingent upon these scores. CMS withholds 1% (starting fiscal year 2013) of hospitals' annual reimbursements. Hospitals have to then earn the money back by gaining a high score on both the HCAHPS survey and Core Measures. Therefore, improving patient medication education is essential in improving quality outcomes (patient medication adherence), risk reduction (readmission to the hospital), HCAHPS scores, patient satisfaction and ultimately cost-effectiveness for the organization (reimbursement from CMS).

**Aim:**
“Educate Before You Medicate” was a project focused on improving patient medication education at the surgical suite of a community hospital. The aim of this project was to improve patient medication education, patient care outcomes (medication adherence), risk reduction (readmission to hospital), HCAHPS scores, and cost-effectiveness (reimbursement from CMS) of the organization. An innovative medication "cheat-sheet" was created to help fulfill these aims.

**Methods/Programs/Practices:**
This project consisted of informal observations done at both pre and post-intervention. After pre-intervention observations were completed, Registered Nurses were surveyed concerning any barriers they felt that hindered patient medication education. After collecting initial data, it was determined that the intervention to best improve patient medication education would consist of both educational sessions with the nurses and the implementation of a medication "cheat-sheet." Educational sessions were conducted in small groups with a maximum of five nurses at a time. These sessions included a poster, handouts and discussion with the nurses. The educational content consisted of the importance for patient medication education, how to best provide such information, where to find this information and the introduction of the medication "cheat-sheet." These sheets were attached to every bedside computer and included a list of the most used medications on the unit with indications and side-effects (briefly stated). They served as a quick reference to aid nurses in patient medication education. Post-intervention observations were conducted to determine whether the nurses were applying the new information and whether they were using the "cheat-sheets" when teaching their patients.

**Outcome Data:**
Post-intervention observations showed an 11% improvement in nurses providing medication names to their patients, a 34% improvement in nurses providing the indications and an 11% improvement in nurses providing the side-effects to their patients. The medication "cheat-sheet"
was an effective quick reference for the nurses to use throughout their hectic shift which they preferred to the much more time-consuming process of searching for medications using the computer system.

**Conclusion:**
As the above mentioned trends continue, improvements in quality outcomes (patient medication adherence), risk reduction (readmission to the hospital), HCAHPS scores and cost-effectiveness (reimbursement from CMS) are expected. Future recommendations include, expanding the medication "cheat-sheet" by utilizing pharmacy and creating tailor-made sheets for each unit house-wide.

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**Abstract title:** Journey to Improving Core Measure Compliance: From Opposition to Ownership

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**Background Information:**
Core measures are nationally approved, evidence based, quality guidelines for patient care. National experts in healthcare identified criteria in key areas that determine if the care given in hospitals is appropriate, timely, and preventive. By meeting specific guidelines for certain disease processes, the patient's outcomes improves. Core measures are the basic, minimum care needs for patient care and contribute to reducing morbidity, mortality, complications, and readmissions. These quality measures are the basis of Federal Value Based Purchasing (VBP) program.

In 2010 as a part of the Patient Protection and Affordable Care Act, core measures became one of the measures to calculate incentive payment from the VBP program. The Centers for Medicare and Medicaid Services (CMS) is now more selective about the spending of healthcare dollars. In 2013, CMS finalized VBP measures in two patient care domains for Federal Fiscal Year 2013. The clinical process of care (core measures) domain has twelve measures, weighted 70%, and the patient experience of care domain has eight Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) dimensions, weighted 30%. Repayment will now be based on quality of care rather than volume. Core measures is an indicator of a hospital and a medical staff’s ability to work together to develop reliable processes of care that deliver basic good medical care that is likely to produce better outcomes.

**Aim:**
The aim of this project was to develop a process to foster reliability, accountability, and ownership of the core measures with nurses. The Quality department had established a process to identify core measures for patients who met criteria, and rounding on the units had started and dissolved. Nurses were aware of core measures, but unsure of all the elements and what the
meaning behind why the core measures were being done. The goal of this project is to improve core measures scores to maintain an Appropriate Care Score of > 95% and compliance rate at 100% with no fallouts beginning in the 2nd quarter of 2012 thru the 4th quarter of 2012.

**Methods/Programs/Practices:**
In 2009, a core measure multidisciplinary workgroup led by the Quality Department began to meet about the new quality measures and how the various departments will be responsible for ensuring the quality measures are done. In the fall of 2010, a daily surveillance program was developed by Quality to monitor each patient who met criteria for any of the core measures. Soon after, core measure rounding was implemented on the nursing units to increase awareness and compliance of the quality measures. Core measures rounding included a member from Quality, Social Worker and/or Case Manager, a Patient Care Facilitator (now Clinical Nurse Leader), Charge Nurse and a Primary Care Nurse. The Quality Department began educating all hospital staff on core measures in hospital orientation in 2011. By the end of 2011, the workgroups ceased functioning, and at the beginning of 2012, the rounds had dissolved.

A new Clinical Nurse Leader was hired in the 2nd quarter of 2012 and assumed the role of being accountable for ensuring the core measures were completed on the 55-bed Medical Unit. The Clinical Nurse Leader and Nurse Manager teamed together using the PDSA cycle to work on processes that would empower the nurses to be more knowledgeable of core measures and to eventually completely own the process. With the assistance of Quality, the core measure badge buddy was created by the Clinical Nurse Leader and Nurse Manager to give the hospital staff a quick reference for all elements that should be completed on those patients. In addition to the badge buddy, reference tip sheets and flyers were posted around the unit. Also, communications via email, huddles, staff meetings, etc. were sent to reinforce the importance of core measures and what they meant to the patients and hospital. Daily, the Clinical Nurse Leader would review the core measures for the unit with the charge nurse and develop a plan on completing the core measures. The Clinical Nurse Leader would follow up with various nurses to communicate core measures and validate completion. When needed, the Clinical Nurse Leader performed the required tasks to meet the measures' criteria. In the 3rd quarter of 2012, care sessions were implemented by Quality. If a fallout or miss on a specific measure occurred, the nurse who discharged the patient would meet with Quality to get re-educated and discuss the missed opportunity. Currently, that process has changed to any nurse who touched the patient during their hospital stay would have to meet with Quality for a care session after a fallout. Weekly multidisciplinary core measure workgroup meetings restarted in the 3rd quarter of 2012 to discuss challenges, process, and successes with the hospital's core measure process.

By the 4th quarter of 2012, staff became more confident with core measures and expressed more engagement in the process. The Clinical Nurse Leader, Nurse Manager, and Nursing Supervisors began educating on the new VTE prophylaxis core measures and continued to reinforce current quality measures. This new measure had also been included on the badge buddy previously. The Clinical Nurse Leader transitioned from being the sole owner of core measures to the charge nurses and staff nurses taking complete ownership for the core measure process on the medical unit. The unit leadership follow up with the core measures on issues that may occur, but the daily process is managed by the charge nurses. Challenges still arise as requirements for reporting are ever changing, but we are satisfied with being on the journey from opposition to ownership.
**Outcome Data:**
The outcome data for the medical unit is as follows:

*Improved ACS score of at least 95% and 100% on all performance indicators by the end of 2012*
*Complete ownership of core measure process by charge and staff nurses.*
*Badge buddy and various forms of communications and education contributed to staff’s knowledge and awareness of core measures.*
*Multidisciplinary core measure workgroup meetings decreased from weekly to biweekly*
*Multidisciplinary rounding to restart for all patients*

**Conclusion:**
Lateral integration of disciplines of the Quality department, medical staff, physical therapy, respiratory therapy, and medical unit's leadership and nurses allowed for successful outcomes of the quality measures. The Clinical Nurse Leader used the microsystem assessment to assess the state of the medical floor's core measures status and communicated with the Nurse Manager and Quality Department to develop a plan for education and compliance. The implementation of the badge buddy abled staff to have a quick, personal reference for items needing to be accomplished on certain patients. Continued follow up, education, and evaluation of current processes allowed for real time identification of process barriers, failures, and successes. Nurses gave feedback of what worked well, what were challenges, and suggestions, and the medical unit's nursing leadership worked the multidisciplinary team to work on better strategies for hospital implementation. As a result of support, education, and repetition, the nurses are now owners of core measures and attribute to improving the outcomes of patients.

**Abstract title:** The VRE Compliance Improvement Project (CIP): A CNL Lead Initiative to Increase Early Identification of VRE Colonization to Reduce VRE Transmission on an Oncology/Stem Cell Transplant Unit.

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**Background Information:**
Vancomycin Resistant Enterococci (VRE) is a multi-drug resistant organism (MDRO) associated with increased morbidity and mortality, especially among patients experiencing immune-compromising illnesses. VRE is responsible for 12% of all hospital acquired infections and is associated with increased admission to critical care units and lengthy and costly hospital stays.

On the inpatient unit of interest, baseline data showed actual admission and weekly VRE ASC compliance was below expected rates of 95-100%. For FY 2011, admission compliance rates
averaged 80.4% (range 55-93%), and for weekly cultures, averaged 91.5% (range 72-97%). A moderate negative correlation was seen for both weekly VRE swab compliance and VRE infection rates for Stem Cell Transplant (SCT) patients (r = -0.34); and admission swab compliance and colonization rates for non-SCT patients (r = -0.41). During this same time period, VRE colonization and infection rates per 1000 patient days were 4.2 and 1.9 for non-SCT patients and 6.7 and 1.3 for SCT patients. A moderate positive correlation was seen between admission swab compliance and VRE colonization (r = 0.3). Together, these data suggest that poor VRE swab compliance is associated with increased VRE colonization and infection, and late identification of VRE colonization.

To reduce VRE transmission, the Centers for Disease Control and Prevention (CDC) recommends performing VRE active surveillance cultures (ASC) as a "best practice". The VRE ASC Compliance Improvement Project (CIP) focused on improving VRE ASC compliance to interrupt VRE transmission and reduce healthcare acquired infections.

**Aim:**
The primary aim of the VRE Compliance Improvement Project (CIP) was to increase and maintain VRE culture compliance rates at 95-100%. The goal was to achieve a 10% increase per month over a 6-month time period, and thereafter to maintain compliance at 95-100%. While it was recognized that factors other than improving VRE swab compliance rates influence success at reducing VRE colonization and infection, interrupting transmission was identified as an effective and necessary first step. Moreover, an effective ASC program was deemed necessary to accurately monitor trends, and identify areas where improvements were needed.

**Methods/Programs/Practices:**
An assessment of the microsystem VRE ASC processes was conducted to identify project barriers and facilitators. A multidisciplinary team of healthcare providers, lead by the CNL and unit project champion, guided project development, implementation and evaluation. The project was implemented on a 28-bed Hematology/Oncology unit caring for patients with malignancies of the blood and those undergoing stem cell transplants. The project incorporated: cause and effect analysis, staff and patient education, the use of the process maps to clarify staff roles and responsibilities, and a 30-day trial of the proposed unit workflow modification. An iterative process incorporating staff interviews, multidisciplinary team meetings and a 30-day trial interim report provided opportunity for staff involvement, feedback and ownership of the project. Changes in workflow, as a result of the project, was directed and approved by staff impacting direct care and support staff.

**Outcome Data:**
Outcome Evaluation: At day 7 of the 30-day trial, VRE admission swab compliance reached 93%. However, by day 14, compliance rates fell to 77.7%. This drop was later attributed to the actions of 2 nurses who failed to collect 5 admission swabs. VRE ASC compliance rates and infection rates per 1000 patient days of care have been requested and are pending for January 2013 through December 2013. E-mail communications, from the Infection Control Coordinator, reports that the intervention was largely successful, but have had lapses as a result of staff-turnover and patient census.
Process Evaluation: The staff provided positive feedback about changes to the unit workflow. Specifically, they reported that having a pre-packaged VRE kit in the room set-up facilitated obtaining the VRE ASC. Patient education material was reviewed positively by staff and patients, and they agreed that the process map clearly explained who did what, when, and how. Verbal commitment supporting the project was 100% and there was general agreement that the process reflected and respected the opinions of staff at the bedside. Of the 15 staff members who participated in the mini VRE in-service, 100% met learning expectations. Project components that did not work well were removed. For example, placing patients in contact precaution until a VRE status was obtained was rejected by the staff and removed from the protocol.

**Conclusion:**
While it is recognized that improving VRE swab compliance rates alone will not immediately reduce VRE colonization and infection rates, interrupting transmission is a necessary step in this process. The VRE CIP illustrates how the CNL can lead the multidisciplinary team effort to improve performance and positively impact patient outcomes by conducting an assessment of the microsystem and implementing the CNL role of clinician, outcomes manager, educator, information manager, systems analyst/risk anticipator and team manager.

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**Abstract title:** Team Building Relationships in Recruiting  
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**Background Information:**
Texas Health Resources partnered with Texas Christian University in 2008 to establish a Clinical Nurse Leader program, and implement the role throughout the system. The application of team building theory became essential in the recruitment of successful candidates for the program. Without a focus on relationships, aimed at improving both academia and the practicing CNL student, the relationship would not be effective and would fail.

**Aim:**
The aim of team building through partnership was to improve the entire CNL program and practice of the student following graduation. The entire spectrum from recruitment to practice must be considered by all members of the team when evaluating a program. Effective communication through team building is essential. By belonging to a team one has a feeling of something larger; a commitment to the mission and goals of an organization with a vision of success. Important to the practicing partner is the success of the academia program and vice versa when the two work in a team environment.

**Methods/Programs/Practices:**
Texas Health Resources and Texas Christian University personnel have established a team working relationship for the benefit of the CNL partnership. Employees of both organizations
(while separated) value one another and have a true sense of teamwork. Through clear expectations and communication team members understand the commitment and ownership needed to accomplish the defined goals and objectives. The reporting relationship and accountability is clear for appropriate and effective collaboration. This has not been accomplished easily and has required open communication and commitment between both partners to establish.

**Outcome Data:**
Since the inception of the team approach to relationship building was introduced in 2010, there has been no student attrition, Students report feeling supported by the relationship evident between the university and the healthcare system. Since 2010 Texas Health Resources (THR) has had a total of 24 CNL program graduates from Texas Christian University (TCU). In 2014 the program at TCU will be expanded to a twice a year entry with expectations to double enrollment, as THR expands the CNL role throughout the 14 hospital system.

**Conclusion:**
Through the use of team building principles, Texas Health Resources has improved recruitment efforts, on-boarding, and the ultimately the education of their staff for the implementation of the CNL role throughout the system. Prior to the establishment of the team building principles, the two partners (THR and TCU) had difficulty with establishing effective collaboration and student attrition was a problem. Now the two are effectively working together and have improved and expanded the program with excellent outcomes.

**Abstract title:** “Turning the Tide: A CNL-led Initiative to improve PATIENT hand hygiene to Prevent Hospital Acquired Infections”

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**Background Information:**
Traditionally, infection prevention in hospitals focuses on staff hygiene practices with little focus on the role that patient hand hygiene has on transmission of bacteria. There is research that infers that self-infection occurs most frequently from hand-to-mouth, hand-to-nose, and hand-to-eye contact. Other research found a higher rate of patient-indexed outbreaks of norovirus than of staff-indexed outbreaks. This latter finding suggests that patient hand hygiene may have a role in infection transmission.

A Clinical Nurse Leader (CNL) in an urban tertiary-care teaching facility completed an initial assessment of her microsystem and found current protocols for staff hand washing. However, there was no protocol for promoting hand hygiene for patients to reduce the risk of self-infection and environmental contamination.
**Aim:**
1) To assist in reducing infection rates to 0% or maintain a 0% infection rate for central line associated blood stream infections (CLABSIs), catheter associated urinary tract infections (CAUTIs), and Methicillin-resistant Staphylococcus aureus (MRSA) transmission rates for fiscal year 2014.
2) At least 75% of patients will agree or strongly agree that education by staff has improved their hand hygiene habits.

**Methods/Programs/Practices:**
The CNL collaborated with her unit manager and an ICU RN to initiate a patient hand hygiene protocol on a medical-surgical unit. Staff was in-serviced on the protocol and used this information to educate patients to improve their hand hygiene habits leading to a reduction in the risk of self-transmitted infection. On admission, patients were educated on the importance of hand hygiene and were given personal hand sanitizing gel to keep at their bedside. Patients were informed to use the gel or soap and water after toileting, before eating, or before touching their wounds, lines, or drains. In addition, reinforcement of education occurred every shift, before meals, and after toileting.

To determine the effectiveness of nurse education on patient hand hygiene habits, a questionnaire was provided to all patients on day of discharge. Data collection began one month prior to implementation of protocol.

Two months post-implementation, nurses’ perception on the effectiveness of patient education on hand hygiene habits were assessed by a questionnaire.

**Outcome Data:**
100% of nurses and nursing assistants were educated on the protocol.

The initial goal of reducing infection rates to 0% or maintaining a 0% infection rate for CLABSIs, CAUTIs, and MRSA was met.

Pre-implementation, 41 patients completed the questionnaires, whereas 21 patients completed the questionnaire post. Pre-implementation, 66% of patients agreed/strongly agreed that education by staff had improved their hand hygiene habits, whereas 96% of agreed/strongly agreed post. Pre-implementation, 69% of patients agreed/strongly that staff assisted them with their hand hygiene, whereas 96% of patients agreed/strongly agreed post. Pre-implementation, 61% of patients agreed/strongly agreed that staff discussed hand hygiene on a regular basis, whereas 91% of patients agreed/strongly agreed post.

Two months post-implementation, 25 nurses participated in a questionnaire. 72% of nurses agreed/strongly agreed that the education they provided improved patients’ hand hygiene habits, whereas 28% of nurses were neutral. 92% of nurses agreed/strongly agreed that the patient hand hygiene project had increased their awareness of the importance of patient hand hygiene, whereas 4% were neutral, and 4% disagreed. 88% of nurses agreed/strongly agreed that the patient hand hygiene project will help reduce the spread of hospital-acquired infections, whereas 4% were neutral, and 8% disagreed. 92% of nurses agreed/strongly agreed that after the patient...
hand hygiene project is completed, they will continue to educate patients on their hand hygiene as part of their nursing practice, whereas 4% were neutral, and 4% disagreed.

**Conclusion:**
Considering the many variables and possible modes of transmission of infection, it was difficult to link a patient hand hygiene protocol with infection rates. However, nosocomial infections rates remain at zero, demonstrating positive patient outcomes and quality of care. The majority of nurses agreed/strongly agreed (88%; N = 25) that the patient hand hygiene project will help reduce the spread of hospital-acquired infections. In addition, 92% of nurses agreed/strongly agreed their awareness of patient hand hygiene on prevention of infections increased.

The aim of improving patient hand hygiene was met. However, nurses may underestimate the impact their education has on changing patient behaviors. Approximately 1/3 of nurses (28%; N = 25) thought their education didn’t improve patient hand hygiene habits. However, patient questionnaires revealed that their habits were improved by the education (96% agreed/strongly agreed; N=21). Other positive outcomes of the protocol were that 96% of patients agreed/strongly agreed that staff assisted them with their hand hygiene and 91% agreed/strongly agreed that staff discussed hand hygiene on a regular basis (N = 21).

The patient hand hygiene protocol was adopted by 100% of nursing staff during implementation. The majority of nurses agreed they incorporate patient education of hand hygiene into their nursing practice, which helps sustainability. Due to the success of the patient hand hygiene protocol and positive response by nurses, the protocol was incorporated into the routine admission assessment.

The success of the patient hand hygiene initiative has led to the adoption of this protocol on other medical-surgical units.

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**Abstract title:** Improving Medication Communication and Patient Satisfaction Using Medication Cards

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**Background Information:**
Over 1.5 million Americans are injured by medication errors annually, resulting in extra medical costs of $3.5 billion. Medication education can help prevent adverse events, however studies show that many hospitals fail to provide adequate instructions to patients and families and that patients perceive receiving less education about medications than caregivers believed had been given. Improving our ability to communicate the necessary details about medications and their side effects to our patients is one way to ensure our patients safety, both during their stay and
after discharge. Within our 36 bed Medical-Surgical unit, there was no consistent process in place regarding medication education yet three HCAHPS questions specifically address medication teaching and communication. Average percentile rankings on Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) questions regarding medication communication ranked below the 75th percentile. Over 63% of survey respondents stated that they had received medications that they had not taken before. The HCAHPS score for the question “Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?” was at the 74.8% percentile. Additionally, in regards to survey responses for the question “Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?” only 44% of respondents perceived that they had received adequate education regarding possible side effects. A microsystem assessment conducted by the Clinical Nurse Leader identified this as an opportunity to improve patient knowledge and increase satisfaction scores.

**Aim:**
The aim of this project was to develop an evidence-based education tool that addressed inconsistent medication education in an effort to improve patient knowledge and increase HCAHPS patient satisfaction scores regarding medication communication. The intervention proposed in this project will provide nurses with a tool to improve medication communication regarding new medications and their side effects.

**Methods/Programs/Practices:**
A lead team was formed to develop and manage the project. This team included the Clinical Nurse Leader, nurse manager, nurse director, clinical pharmacist, and staff nurses. The CNL conducted an extensive literature review, and using evidence-based research, developed an education tool that included: 1) Patient medication cards for medicines most commonly prescribed during a hospital stay on the MS/Tele unit. Cards contain trade name, date prescribed, explanation of drug purpose, and corresponding side effects. Cards were written at the 6th grade level, using common words and short sentences in large easy-to-read type. 2) A laminated master medication list scripted to complement the medication cards in order to provide consistent education. The list hangs in each room near the computer and Whiteboard for easy access. 3) Zippered clear plastic bags to store medication cards at the bedside, labeled with patients name and date. Nurse interventions included identifying new medications and providing cards and education to the patient.

The CNL provided in-services to nurses on implementation of and rationale for methods to improve medication communication, effective teach-back methods and use of scripting when engaging patients in a discussion around new medications in order to provide consistent nurse-to-nurse teaching. Additionally, nurses were educated on the HCAHPS questions related to medication communication. Education was provided during staff meetings, Unit Based Council meetings, bulletin board postings, and individual coaching. Nurses were updated monthly on HCAHPS medication communication scores at staff meetings and Unit Based Council meetings.

**Outcome Data:**
The purpose of this project was to increase patient knowledge and to improve patient satisfaction scores related to medication communication on MS1. Prior to project implementation percentile rank scores for the question “Before giving you any new medicine, how often did the staff tell you what the medicine was” were at the 74.8 percentile. After implementation the score
improved to the 86.2 percentile, an increase of 11%. The score for the question “Did the staff explain possible side effects in a way that you could understand” increased from the 44.0 percentile to 51.9 percentile, a modest increase of 8%. Although the results indicate that providing an evidence-based intervention has improved patients perception of medication communication and increased satisfactions scores, further coaching is necessary to hardwire the process as evidenced by continued low scores regarding explanation of side effects.

**Conclusion:**

Evidence has shown that when patients are involved in and understand their treatment plans, they are more likely to comply, heal faster, and have better outcomes. Medication education encourages patients and families to become actively engaged in their care, reinforces the importance of some medications as a health strategy, and decreases medication errors. Presenting information in a legible easy to read format that makes sense to patients and families better addresses the needs of the elderly and increases health literacy. Nurses felt that this tool provided a user friendly approach for discussing medications with patients and their families, provided opportunities for teach-back. Improved HCAHPS survey scores regarding the medication communication questions support the implementation of these nursing strategies to improve medication communication. As HCAHPS scores continue to level the playing field by provide a transparency in reporting, we must make the quality of care that we provide the very best that it can be. Using an evidence-based teaching tool provides an opportunity to hardwire a consistent and patient friendly method of educating our patients about their medications and their side effects. This project shows that using evidence-based practices to increase patient knowledge regarding medications can also increase patient satisfaction scores related to medication communication.

**Abstract title:** Application of the Prody Model for Continuous Quality Improvement to Enhance Work-Life-Balance in Nurses of a Clinical Microsystem Caring for Veterans

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**Background Information:**

The IOM (2005) stated that research involving the reduction of error prevention and patient safety is a legitimate academic pursuit. The federal government allocated $50 million annually for patient safety research. Funding was almost entirely spent on information technology, leaving many variables of patient care unaddressed. This study has contributed to the body of knowledge discussing the effectiveness of a theoretical and evidence-based system for implementation of programs that foster a healthy work environment while providing a tool for organizations to incorporate frontline core staff into policy decisions to aid in the reduction of performance gaps through improvements of the organizational infrastructure. The study has also advocated for nurses and their unique body of knowledge as an imperative source for appropriate
and safe policy development.

**Aim:**
The primary purpose of this mixed method, qualitative and quantitative, study was to demonstrate improvements in nurse workplace satisfaction through the implementation of the Compressed Work Schedule (CWS) program on the Medical Surgical Telemetry (MST) unit clinical microsystem at the VASNHCS.

**Methods/Programs/Practices:**
This study utilized a descriptive design using mixed methods of qualitative inquiry and quantitative data analysis. The qualitative section of the study utilized focus groups from a cohort of nurses working in the MST unit clinical microsystem to address questions pertaining to nurses’ perceptions of work-life-balance, quality of nursing care, and job satisfaction. The quantitative section of the study utilized a comparative retrospective research design of data from the same clinical microsystem. The dependent variables or effect are nurses’ work satisfaction scores, working conditions, job satisfaction, hours-per-patient day, and incidence of patient falls. The independent variable or cause, is the compressed work schedule (CWS) program which was implemented in 2011. The study design is appropriate as the goal of the research attempted to address associations with the phenomenon that has already occurred. The study was approved by the Institutional Review Board of the VASNHC and the University of Nevada-Reno prior to data collection (protocol # 2013S094).

**Outcome Data:**
Information obtained from this study evaluated potential improvements in nurse workplace satisfaction through application of the Prody Model for Continuous Quality Improvement (PMCQI) by improving work-life-balance for the nurses of the MST Unit clinical microsystem of the VASNHCS. The study also assessed the effectiveness of incorporating front line staff in the development of evidenced-based policy as a key element for improved patient outcomes and an improved work environment work environment. The study contributes to the body of knowledge for nursing care as indicators of patient outcomes through the assessment of improved work environment and its effects on the prevalence of patient falls. The implementation of the CWS using the PMCQI model improved work life balance of the nurses. The change to the CWS was a protective factor (p = 0.007) against patient falls in the MST unit clinical microsystem. Since the implementation of the CWS patients have a 39% lower odds of experiencing a fall (OR = 0.61, 95% CI = [0.46 – 0.82]).

**Conclusion:**
Quality of care delivered provides job satisfaction to the nursing staff of the MST unit clinical microsystem. Nurses were delivering quality care with fewer nursing hours delivered to the patients. Organizations must efficiently use nursing staff and incorporate the human element into their staffing plans to provide effective and safe care to the Veterans served. Given the complexities of the hospital system, the need for high reliability within organizations is necessary for improved patient outcomes. Nurses at the bedside have the most knowledge of the clinical microsystem. Identifying nurses and their input into policy is imperative to tailor supporting interventions to meet the needs of the microsystem. Incorporating front line staff into
policy and decision making can help organization achieved strategic planning goals and improve patient outcomes.

**Abstract title:** CHF education: Meeting the Measure  
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**Background Information:**  
Heart failure occurs when the heart cannot pump blood effectively enough to meet the body's metabolic needs. It is one of the most common causes of hospitalization and rehospitalization in the United States. The CDC reports that approximately 5.7 million people in the United States have heart failure, which is the primary cause of more than 55,000 deaths each year. The associated cost is $34.4 billion each year in health care services, medications, and lost productivity.  
Nurses play an important role in patient education which is critical for patients diagnosed with heart failure to manage symptoms thereby reducing readmission rates and maintaining quality of life. Specific criteria identified by the Joint Commission (JC) guides facilities on education that is required to help patients recognize and manage symptoms of heart failure. These written discharge instructions or educational materials must be provided to the patient in written form to meet the core measure HF-1. Each of the following topics must be addressed to meet the measure: Diet, activity level, discharge medications, follow up appointments, weight monitoring, and what to do if symptoms worsen.

**Aim:**  
The aim of this project was to review the current practice of discharge education for patients with CHF; and to implement interventions that could help improve compliance with the JC core measure HF-1 by improving the consistency and documentation of education for patients with heart failure upon discharge from the hospital.

**Methods/Programs/Practices:**  
> Reviewed current practices and documentation of heart failure education as well as previous facility scores related to the HF-1 measure.  
> Collaborated with quality management to review and identify specifics of the measure.  
> Quality Management researched the HF-1 measure and developed a standardized discharge education note containing all the components required to meet the core measure.

In conjunction with quality management, the following was also completed:

> Standardized the process for identification of patients requiring CHF education upon discharge.
> Collaborated with informatics to modify the nursing discharge template by autopopulating a note with the required education for patients with a diagnosis of heart failure. The note is printed, reviewed with, and provided to the patient prior to leaving.

> Educated staff on required education and documentation to meet the measure, changes associated with identification of patients with heart failure, and changes to the discharge template.

**Outcome Data:**
Standardization of the CHF discharge note ensures the education provided on discharge contains each of the 6 components required to meets the HF 1 measure. This allows the patients to be better equipped to control and manage symptoms which improves their quality of life and can help reduce readmissions.
Prior to implementation we were unable to consistently meet the measure, the target score being 95% or more.

Post implementation scores as indicated below

<table>
<thead>
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<th>Quarter</th>
<th>Score</th>
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<tbody>
<tr>
<td>2</td>
<td>100%</td>
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<tr>
<td>3</td>
<td>95%</td>
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<tr>
<td>4</td>
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**Conclusion:**
Core measures reflect care provided by facilities nationwide. The provision of care that meets the core measures reduces morbidity, mortality, reduces complications and readmissions. A collaborative effort between the Clinical Nurse Leader, Quality Management, Informatics and the nursing staff proved successful in meeting the performance measure HF-1 on the provision of education and written discharge instructions for patients with heart failure. Since the implementation of changes to the process of providing discharge instructions, the facility has met or exceeded the JC core measure for each Quarter.

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**Abstract title:** Creating and Sustaining RN Ventilator/Tracheostomy Competency: A CNL-led Collaborative Approach

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**Background Information:**
Clinical Nurse Leaders (CNLs) on a complex medical-surgical unit specializing in ventilator/tracheostomy (vent/trach) patients were concerned that nursing care for this patient population did not follow current evidence-based literature, standardized procedures were focused on ICU care, and there was a lack of formal education and orientation for new staff.
leading to a decreased confidence in the nurses' ability to care for these patients. Also, nursing staff reported lack of collaborative, coordinated care for these patients.

**Aim:**
1) To develop an evidence-based, hands-on competency in-service to ensure best practice of vent/trach patients, 2) To work collaboratively with experts to promote communication and coordination of care, and 3) To increase staff nurse confidence in their care of the vent/trach patient.

**Methods/Programs/Practices:**
After an extensive literature review of current practice, collaborating with experts, and benchmarking in the community, CNLs found practice changes were needed in the current care of vent/trach patients. An interdisciplinary workgroup, including Respiratory Therapy (RT), Critical Care Clinical Nurse Specialist (CNS), and staff nurses was formed to gather evidence, update protocols, and create a hands-on, interactive, evidence-based educational in-service for nurses. Management approved the use of over time and compensatory time to cover the unit so working staff could attend and participate. Nurses were required to attend the competency in-service prior to caring for vent/trach patients. Specific changes in care of this population included: suctioning both orally and in-line before/after turns, monitoring cuff pressures, and Ventilator Associated Pneumonia (VAP) prevention.

**Outcome Data:**
All eligible nurses (working on the unit longer than 6 months) completed the 2-hour competency in-service (N = 31). Test scores assessing staff knowledge averaged 37% correct pre-implementation and 97% correct post-implementation (N = 28). Three-month post-implementation, test scores averaged 75% correct. Staff level of confidence increased immediately post-implementation from an average of 6.2 to 8.2 on a 10-point Likert scale, with zero being totally unconfident and 10 being completely confident. Three-month post, nursing confidence levels remained high at an average of 8.

**Conclusion:**
To maintain unit-specific competencies, an educational plan should be developed and yearly refreshers provided. Involving unit staff in the development of evidence-based education led to an increase in staff buy-in, resulting in positive nursing practice changes. Involving RT and a CNS in the planning and education strengthened collaboration between these disciplines and nursing. Nurses appreciated having a hands-on, interactive in-service with uninterrupted time to cover the topic, allowing them to focus on learning, knowing their patients were being taken care of. Due to the success of the vent/trach competency in-service, the CNL and nursing staff have started developing other specialized nursing competencies utilizing this collaborative approach to education, which includes involvement of unit staff, soliciting feedback, and collaborating with experts.
Abstract title: Examination of the Practice Environment to Support Advocacy for the CNL
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Background Information:
Despite the vision of the CNL being developed nearly a decade ago, implementation of the CNL role and utilization of these graduate prepared nurses in other practice roles remains limited. Examining the current practice environment and identifying barriers and facilitators to CNL practice are essential to inform advocacy efforts.

Aim:
Examine the current CNL practice environment and identify barriers and facilitators to practice and to identify specific actions to guide advocacy efforts.

Methods/Programs/Practices:
Seventeen structured telephone interviews were conducted with CNLs and non-CNLs practicing in urban healthcare settings within Central Alabama between July 15 and August 30, 2013. CNL-educated nurses represented the majority of interviewees (N=10). Separate interview protocols were developed each group of interviewees. On average, interviews lasted between 15 – 25 minutes.

Questions for CNL participants included: Describe the experience of being a CNL in your employment setting; Describe how your actual practice role reflects use of the CNL practice roles developed during your CNL educational program (ex. leadership, outcomes manager); and Describe familiarity with the CNL role and skill set within your practice setting. Questions for non-CNL participants included: Describe your organization's willingness and capacity to create CNL positions; Describe your personal understanding of the CNL skill set; and Describe other organizational practice roles that you think a CNL is educationally prepared to fill.

Outcome Data:
CNL evaluations varied across institutions and positions held by a CNL (i.e., a specific CNL position versus a non-CNL position held by a CNL-trained nurse). Several hospitals had multiple levels of evaluation from peer to CNO. Employee evaluations did not always reflect the CNL skillset, especially if a CNL was employed in a non-CNL position. For CNLs specifically employed in a CNL position, interviewees suggested that the evaluation process in many cases was still under development.

Conclusion:
Despite local, regional and national efforts, the CNL role and skillset are still not fully understood, formally recognized, or utilized. It is probable that these gaps are attributable to relatively recent introduction of CNL certified individuals in the region's healthsystems. However, it is also likely that limited empiric evidence supporting the added value of the CNL combined with significant changes in health care reimbursement have also contributed to this problem. Both CNL and non-CNL interviewees advocated for increased efforts to promote the
benefit of the CNL in quality and safety improvement and the utilization of the CNL knowledge and skill in existing advanced nursing roles such as nurse educators and case managers.

Abstract title: Improving Staff Satisfaction and the Culture of Teamwork by Implementing Team STEPPS® on PCU

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Background Information: The CNL used the Dartmouth microsystem assessment tool where staff expressed concerns regarding teamwork on the unit (The Dartmouth, 2011). For hospitals and other healthcare organizations, emphasizing and striving for a teamwork culture could have important implications for increasing patient satisfaction and other patient-oriented performance measures. The TeamStepps initiative was developed by the Department of Defense Patient Safety Program and is an Evidence based comprehensive teamwork training system designed to improve quality and safety in healthcare. Job dissatisfaction has been strongly associated with nurse turnover and intent to leave highlighting the importance of understanding what promotes nursing job satisfaction. Teamwork has been associated with a higher level of job satisfaction.

Aim: The purpose of this project is to improve the culture of teamwork, through the Implementation of Team STEPPS. Team STEPPS are Strategies & Tools to Enhance Performance and Patient Safety thus improving staff satisfaction scores and percentile scores for Press Ganey employee satisfaction survey (Press Ganey, 2011).

Methods/Programs/Practices: Members of the CNL's healthcare team, registered nurses, patient care technicians, unit secretaries, and monitor technicians will be involved in voluntary team building exercises. The CNL incorporated team building exercises, trust building activities, refocus on the mission of Texas Health Resources, goals of Team Stepps, and the importance of communication into the Unit Based Council retreat and subsequent staff meetings. Weekly Team STEPPS definitions were presented to staff via email and handouts placed on the unit to familiarize staff with Team STEPPS definitions and terms. During the Unit Based Council (UBC) retreat, the CNL presented information regarding the project, benefits of project, and outcomes of the project were discussed. THR’s Mission statement, Promise Statement, and Values were also presented. The CNL developed a communication tree so that the leaders of the smaller teams can disseminate information to keep the lines of communication open to all team members.
Outcome Data:
Press Ganey Employee Partnership Survey Report was used to analyze whether the team building exercises have worked or not. The surveyors calculate percentage and percentile scores from the Press Ganey survey. Three questions will be analyzed and data will be compared pre and post project implementation.

1) There is good coordination of effort in my work group.
2) Members of my work group treat one another with dignity and respect.
3) Employees in my work group are fully attentive to the needs of others.

Staff retention and retention of top performers will also be used to determine the success of the project.

After three months of project implementation the staff was surveyed, using three questions extracted from the Press Ganey Employee satisfaction survey (Press Ganey, 2011). The answers were tabulated and a percentage of the responses showed an improvement in staff perception of teamwork on the unit. The percentages of increase ranged from 3.6-10.5

Conclusion:
The improvement noted by staff suggests that staff were receptive to the CNL’s project, even though the project was limited to only a three month time frame. The CNL received a limited number of follow up surveys from staff. Only Team STEPPS in-services and definition game used. The CNL approach to improving teamwork and team participation on the unit will continue by adding more team building exercises.

Abstract title: Advocacy for CNL Professional Role Identity
Author Name & Credentials: Antoinette Shedlarski, RN, MSN, CNL, Angela Jukkala, RN, PhD, CNL, Pamela Patterson, RN, MSN, Jacob Vaughn, RN, MSN, CNL, Carolyn Curry RN, MSN, CNL, Vernesa Long, RN, MSN, CNL, Kristen Noles, RN, MSN, CNL
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Background Information:
The Affordable Care Act has redefined healthcare reimbursement and re-energized the focus on quality and patient satisfaction. Healthcare systems care delivery models must be revised to maximize reimbursements and meet new demands. The clinical nurse leader is the only graduate prepared nurse educated with the advanced knowledge and skill required to lead teams in the improvement of care coordination, health system outcomes and patient health services outcomes (value). Although the Clinical Nurse Leader role was created nearly a decade ago, successful implementation within many healthcare organizations has been challenging. Identified barriers to successful implementation of the role include confusion about the CNL role, perceived conflict
with other practice roles, limited health system resources, and limited empiric evidence supporting the added value of the CNL.

One of the basic roles of the CNL is advocacy for the profession. Through academic preparation to support success in this role, CNL leaders within a large academic health center initiated the development of a CNL council to demonstrate the impact of the CNL on patient and organizational outcomes within the microsystem. While changes in healthcare reimbursement have created multiple challenges within healthcare, they also provide a unique opportunity for the CNL to highlight their unique knowledge and skill set. Health system administrative leaders need clinical leaders with the capacity to lead interprofessional teams, facilitate effective communication, understand complex health systems, and create innovative care delivery models. CNLs are well prepared to meet this need.

Aim:
The aim of this project was to demonstrate the capacity of the CNL to lead quality improvement initiatives across diverse microsystems within an AHC.

Methods/Programs/Practices:
Two CNL leaders recognized the lead to advocate for the CNL within the AHC. The initial step of this project entailed obtaining administrative support to form a CNL council and provide needed financial support for a pilot project. The second step as to take advantage of the strong relationship existing between CNL leaders within the AHC and the School of Nursing. The CNL Council was formed from CNL leaders with the AHC, CNL Leaders within the School of Nursing, and a nursing administration leader from within the AHC. Additional council members were sought based on role function and capacity to make a significant contribution to the initial pilot project. Two CNLs in advanced nursing roles and 2 CNL students were invited to join the council.

As the Council was charged with demonstration of the value of the CNL, project selection was a critical task. Through an assessment of organizational quality and safety needs, the first improvement project the council undertook was to facilitate implementation of point of care (POC) nursing documentation utilizing workstations on wheels (WOWs). Currently, most nursing units in the facility perform shift report and charting away from the patient's bedside. Mobile workstations have been purchased and are being distributed. This project offers a unique opportunity to highlight the CNL skill set as prior attempts to implement POC documentation on pilot units had been met with resistance and experienced very limited success.

Through utilization of the microsystem assessment process on care units, CNLs are well prepared to identify microsystem level barriers and facilitators to POC documentation and utilization of the WOWs. CNL led unit based teams are critical to the development of relevant evidence based plans to conduct small tests of change using plan-do-study-act cycles. The impact of POC documentation on both long and short term healthcare outcomes will be assessed through examination of staff satisfaction, patient satisfaction and documentation compliance.

Outcome Data:
Outcomes data reflecting patient satisfaction, staff satisfaction, and care quality/safety will be collected and examined. Anticipated metrics include: patient satisfaction surveys (PressGaney
reports); staff exertion levels (captured through pedometers); staff satisfaction with documentation; and an evaluation of documentation accuracy and adequacy (quality) through chart audits.

**Conclusion:**
In process, pilot unit data will be available in December.

**Abstract title:** THE EFFECTIVENESS OF A NURSE-DRIVEN PROGRESSIVE MOBILITY PROTOCOL ON REDUCING DVTS

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**Background Information:**
Patients become deconditioned easily during hospitalization. Bedrest can cause physical, psychological, and physiological complications. Bedrest can result in muscle wasting, weakness, deep vein thrombosis, pressure ulcers, accelerated bone loss, and increased risk for delirium (Kortebein, Ferrando, Lombeida, Wolfe, & Evans, 2007). These complications can also lead to a prolonged length of stay. It is often challenging for nurses to mobilize patients due to multiple tasks and limited resources. The lack of mobility protocols has also contributed to this problem. A standard approach must be utilized to mobilize patients to reduce deep vein thrombosis (DVTs) and improve patient outcomes. On 10A, an adult medical telemetry unit, 39% of patients were out of bed at least once daily. There were two hospital-acquired DVTs on the unit in March 2012.

**Aim:**
The unit implemented a nurse-driven progressive mobility protocol to increase mobility and decrease hospital-acquired DVTs. The percentage of patients out of bed at least once daily was measured for one month pre-implementation and six months post-implementation. Hospital-acquired DVTs were measured monthly throughout the year. Education was provided to all staff through in-services. The protocol was used with all patients admitted to the unit. Patients who were actively dying were excluded.

**Methods/Programs/Practices:**
Formed an interdisciplinary team of nurses, physical therapists, occupational therapists, a clinical nurse specialist, and assistant vice president of the medical division. Developed a nurse-driven progressive mobility protocol. Educated staff on the effects of immobility, the mobility protocol, equipment, and setting appropriate mobility goals. Daily huddle reminders. Mobility goals written on patients' white boards. Patient and family education.
**Outcome Data:**
- Patients out of bed at least once daily improved from 39% pre-implementation to 94% post-implementation
- Two DVTs were recorded in March 2012; however, no DVTs were acquired post-implementation
- Patients out of bed at least once daily improved from 39% pre-implementation to 94% post-implementation
- Two DVTs were recorded in March 2012; however, no DVTs were acquired post-implementation

**Conclusion:**
Nurses are able to make changes in practice to improve patient outcomes. Nurses can reduce hospital-acquired DVTs by utilizing an interdisciplinary approach, developing a nurse-driven progressive mobility protocol, and encouraging patients to get out of bed.

**Abstract title:** The CNL as a catalyst for highly reliable nursing care
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**Background Information:**
The role of the Clinical Nurse Leader (CNL) is to ensure that evidence based practices (EBP) are followed in nursing care delivery. Hourly rounding and bedside report are two such practices associated with high patient satisfaction and quality of nursing care. Compliance with them on the study unit in an academic medical center was unreliable.

**Aim:**
The aim of this study was to evaluate whether a CNL led EBP improvement strategy would have an impact on nursing staff compliance.

**Methods/Programs/Practices:**
The study was conducted on a 36 bed medical oncology unit in an 893 bed academic medical center. 3 CNLs used Rosswurm and Larrabee’s EBP model supplemented by Cullen and Adams’ implementation guide to coach nursing staff. Direct observations of bedside report and hourly rounding on 12 randomly selected patients were done for a 24 hour period before and after CNL intervention.

**Outcome Data:**
The primary outcome was increased nursing staff compliance with all required elements of rounding and bedside report. The average number of required rounding elements completed after CNL intervention increased by 32.1% and the average number of required bedside report elements completed after intervention increased by 32.9%.

**Conclusion:**
CNL interventions can improve nursing staff compliance with rounding and bedside report.

**Abstract title:** Improving Bedside Handoff

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**Background Information:**
One of Join Commission’s 2007 National Patient Safety Goals is to implement a standardized approach to bedside handoff communication. Failure in communication between shift reports are a leading cause of sentinel events in the United States. Patient Satisfaction is receiving greater attention as a result of pay for performance, a strategy to improve health care delivery offering financial incentives to providers meeting defined quality targets and the public release of the Hospital Consumer Assessment of Healthcare Providers systems (HCAHPS) survey.

**Aim:**
The purpose of this research project was to affirm that improving bedside handoff would increase patient satisfaction scores and potentially decrease nurse overtime by developing a standardized report sheet. Using Rogers Diffusion of Innovation theoretical framework for change, the project was conducted on 24 bed medical-surgical unit at Texas Health Dallas (THD).

**Methods/Programs/Practices:**
Based on the medical-surgical unit input lead by the Clinical Nurse Leader (CNL) student with collaboration of the lead team the project was deemed necessary to improve communication between nurses and patients. The project consists of collecting and disseminating data from the Dartmouth microsystem assessment tool, organized training through in-services and poster presentation. Staff was surveyed about concerns and perceived barriers to change were addressed. Ninety percent of the staff felt the project would be beneficial.

**Outcome Data:**
Comparisons between baseline an post implementation data with the HCAHPS survey questions indicated an increase in "how often nurses explained things in a way you could understand" from 78.3% to 100% and increase of 21.7% but reduced in the response to how often did nurses treat you with courtsey and respect from 79.2% to 75% a decrease of 4.2%. Through observation and
The data provoked questions regarding the importance of such factors as readiness, timeliness, duration and appropriateness of bedside handoff.

**Conclusion:**
The large body of relevant literature review shows that improving bedside handoff contributed to patient satisfaction; however, more data is needed to determine the effects of specific aspects of nursing handoff communication. Preliminary findings revealed that, in general, nurses were satisfied with the project and have incorporated the report sheet into the unit culture, although ongoing revisions are made on the standardized report sheet. Bedside handoff continues to evolve and now is a stable part of the unit culture. All nurses did not fully comprehend that involving patients in their care is a key quality measure that contributes to the performance of nursing rather than hindering it.

**Abstract Title:** Do You Hear What I Hear? - Attention to Alarm Fatigue

**Author & Credentials:** Pamela Abraham, MSN, RN, CNL, Catherine Edmonds, MSN, RN, CNL, Jennifer Kareivis, MSN, RN, CNL, Marianne Sweeney, MSN, RN, CNL & Virginia Clerkin, DHED, MSN, RN, CTN-A, CNL, Linda D'Antonio, MSN, RN, CCRN, CNL, Cara Abitante, MSN, CNL, Terry Mongan, MSN, CNL, Shaden Mustafa, MSN, CNL

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**Background:**
The Joint Commission and the Economic Cycle Research Institute (ECRI) have reported that alarm fatigue (AF) is a potentially deadly event (The Joint Commission [JC], 2013, para. 2; "Technology Hazards," 2012, p. 4). “Alarm fatigue” is defined as the desensitization of healthcare workers to the environmental noises surrounding them, research indicates that in acute care settings 350 alarms per patient daily can result in habituation (Pishori, 2012; The Association for the Advancement of Medical Instrumentation [AAMI], 2011: Welch, 2012). “Nurses become desensitized to the audible alarm systems; there are so many that go off during shifts” (D’Antonio, 2012). Currently, all nursing units at Hunterdon Medical Center have clinical alarms. The nursing staff is trained to listen for these alarms and respond appropriately, but over time the tones can blend into the background.

The Patient Safety Group at Hunterdon Medical Center (HMC) is also focusing on the topic of Clinical Alarms. The group is identifying and calculating risks of all alarms present in the institution utilizing the questions: How well are we doing at HMC? Does our maintenance of alarms, alarm parameters, staff competency and policies reflect a robust alarm safety program? How can we improve? The Clinical Nurse Leaders are working in conjunction with the group to provide feedback regarding the alarms, facilitate data collection and education to the staff, and ultimately, modification of nuisance alarms to decrease alarm fatigue.
Aim:

The purpose of the study is to identify the most prevalent audible alarms in the clinical setting. An educational program will be presented to the healthcare workers to disseminate the results and increase staff awareness of alarm fatigue.

Methods/Programs/Practices:

Focusing our initial efforts on Hunterdon Medical Center’s three medical-surgical units, the Clinical Nurse Leader (CNL) students, instructors and CNL mentors have formed a multidisciplinary team. Upon review of the organization’s policy regarding clinical alarms, the group identified alarms heard on the units. One hundred hours of observation were performed, documenting types of alarms and frequency of occurrence on a data collection tool. Pre-intervention observation of types of clinical alarms and percent of occurrences was compiled to determine the highest frequencies and stratified for clinical impact on patient safety.

As the complexity of medical technology increases, education becomes paramount to both novice and experienced nurses. Education plans include an in-service to staff in November 2013. A multi-sensory program will be developed to facilitate various types of learning styles including an audio component and slide presentation. Topics such as the definition of alarm fatigue and examples of sentinel events related to the desensitization of healthcare workers to clinical alarms will also be provided. A multidisciplinary team effort will result in positive patient outcomes in a safer care environment. Post intervention data collection will be obtained using the same methods as pre-intervention data collection with results being disseminated to administration and staff.

Outcome Data:

Pre-intervention data collected from August 1, 2013 through August 18, 2013 demonstrated that the top three clinical alarms noted on the units included call bell, Intravenous (IV) pumps, and moderate priority telemetry alarms. Pre-data from the three units revealed 43% of the total observations were regarding the moderate telemetry alarms. Patient call bells were the second most observed alarms at 18%. In addition, IV pumps were the third most observed alarm at 10%. After staff education is completed, post intervention data will be collected and analyzed. We predict increased awareness of alarm fatigue will correlate with a decrease in frequency of audible clinical alarms.

Conclusion:

Increased awareness and attention to audible clinical alarms by healthcare workers will result in greater patient satisfaction, reduction in environmental noise, and therefore, promoting positive patient outcomes.
Abstract title: Achieving Excellence: Clinical Nurse Leaders and Pathway to Excellence Nursing Designation

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Background Information:
Clinical nurse leaders (CNLs) are instrumental microsystem change agents in improving the quality of care provided to Veterans and their families. The impact of CNLs on improving quality of care for Veterans at the microsystem level in patient satisfaction, innovation, financial and internal processes has been documented in the literature. The outcomes focused processes developed and implemented by CNLs at the microsystem level can transcend and improve the care provided at the mesosystem and macrosystem of a healthcare organization. Healthcare organizations seeking to attain national nursing designations such as the American Nurses Credentialing Center's Magnet and Pathway to Excellence designations can benefit from strategically utilizing CNLs throughout their organization.

Aim:
The goal of this poster presentation is to examine how the clinical nurse leader role can contribute to a healthcare organization seeking to achieve a national nursing designation such as the Pathway to Excellence.

Methods/Programs/Practices:
1) Analysis of the CNL role and how it promotes the 12 Standards of the Pathway to Excellence designation.
2) Interviews with VA Long Beach nursing leadership and staff regarding the CNL role in achieving the Pathway to Excellence designation.

Outcome Data:
1) 100% (3/3) CNLs actively involved in the Pathway to Excellence designation activities.
2) The majority (2/3) of the CNLs contributed written evidence-based examples of achieving one of the 12 Standards of Pathway to Excellence to the application document.
3) VA Long Beach staff and leadership self report of CNL role in achieving the Pathway to Excellence designation:
   Concepts & themes identified from interviews:
   a) increased visibility of CNL role throughout the organization
   b) increased collaboration among CNLs, nurse managers, nursing leadership and other hospital departments
   c) increased knowledge of CNL led evidence-based practices

Conclusion:
Clinical Nurse Leaders (CNLs) are influential change agents in promoting evidence-based, collaborative, and unit based leadership needed to achieve organizational excellence. The CNLs impact on microsystem patient outcomes can improve the care provided at the mesosystem and macrosystem levels of an organization. This analysis revealed that the CNL role can effectively
contribute to an organization's goal of achieving excellent patient care and outcomes. CNLs active involvement achieving organizational nursing designations can also increase the staff awareness of the CNL role and promote the spread of evidence-based practice throughout the organization. Healthcare organizations seeking to attain national nursing designations such as the Pathway to Excellence designation can benefit from strategically utilizing CNLs throughout their organization.

Abstract title: Raise the SBAR for Patient Safety
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Background Information:
As part of a 360 hour residency, a capstone project on safety and quality was completed in a 271-bed suburban hospital. Opportunity for organization and standardization of shift handoff was identified in a Progressive Care Unit (PCU). In addition, opportunities for improvement were identified in nurse-physician communication, as the two provider teams expressed difficulty communicating with one another due to gaps in communication styles. According to the Joint Commission, seamless transition during handoff implementing SBAR (Situation, Background, Assessment, Recommendation), an evidence based framework for organization of information into daily communication amongst all disciplines has never been more important in institutions. Breakdown in communication is the leading cause of sentinel events in hospitals. Patients in acute care settings are especially vulnerable to adverse events such as medication errors, falls, and late recognition of patient deterioration from miscommunication. Audits were performed during shift handoff, and shift report was found to be unorganized and lacking critical patient information. A survey was completed to assess what the staff determined to be unsafe during shift handoff. Pascal's metrics for a culture of safety survey were assessed and revealed only 48% of RN's felt that the quality of information and workload transfers during shift change was positive. Results of NDNQI (falls), HCAPHS (patient satisfaction scores), and hospital medication events reports revealed higher fall rates (between 1-4/monthly) and lower patient satisfaction scores for "nurse communication" (40th percentile), as well as monthly medication events.

On an additional note, this capstone project led to the author getting recruited and hired as the first CNL in the Adventist Hinsdale Hospital System.

Aim:
The nurse will demonstrate improved knowledge and skills related to handoff communication using standardized SBAR (Situation, Background, Assessment, Recommendation) communication in a PCU. SBAR practices were aimed at closing the gap on nurse-physician communication, increasing morale, teamwork, and communication.
Methods/Programs/Practices:
A multidisciplinary SBAR team was organized and consisted of informatics nurse liaison, nursing champions, two unit clinical coordinators, hospitalist, and unit manager. SBAR education was implemented in a "bundle" to support the hospital's mission and dedication to a culture of patient safety. A cause and effect diagram was built from results of the staff surveys. An SBAR powerpoint presentation including statistics and unit data was shared. SBAR was made more visible with fliers, signage, and posters on the unit. A "PCU SBAR handoff form" was created as a working document with the nursing team inclusive of patient safety factors (fall scores, medication education, and more) and was implemented during shift change. Laminated pocket cards were distributed to the staff as a guide for the technological component of handoff. A patient case scenario exercise to organize components of SBAR, write key pieces of data in "SBAR order" on a blank worksheet, and follow up with low fidelity simulation of a "critical call to a physician" for a patient escalation was completed. In several cases, nurses needed to be redirected during review of SBAR. TeamStepps (Team Strategies & Tools to Enhance Performance & Patient Safety) training by the Agency for Healthcare and Research Quality was utilized in quick talks and huddles highlighting effective SBAR examples. An interactive tutorial with informatics nurse liaison and RN staff was initiated to standardize an SBAR computerized process. QSEN (Quality, Safety, and Education for Nursing) methods were used to assess nurses knowledge, skills, and attitudes (KSA's). Phone calls during shift report were limited to physicians and critical calls to allow nurses to focus on handoff.

Outcome Data:
The PCU did not have a fall for approximately 10 weeks. This was the longest period without a fall for more than a year. Medication events had decreased to an average of 1 event/month from an average of 4 events/month. From Press Ganey samples collected pre and mid implementation, the two questions "Communication with the nurse" and "Nurses treat you with courtesy and respect" revealed increases from patients (from 50th to 81st percentile). Data is forthcoming including Pascal's metrics annual survey. Percent of positive RN's who felt that the quality of information and workload transfers during shift change will be measured. (only 48% positive last year). This data should be available by year end. Unit post surveys were completed and there was an increase with staff satisfaction of handoff, citing it "more organized and consistent".

Conclusion:
Decreasing patient risk including SBAR into handoff was an overall success. Encouraging staff nurses to develop improved communication strategies was empowering and of optimal benefit to the patient. Staff have expressed increased collaboration with physicians, improvements in teamwork, and "positive air". Staff are holding each other accountable to provide an SBAR report at shift change to provide the safest communication for their patients. We celebrated success with SBAR kudos certificates, food chats, and motivating reminders. An SBAR resource binder was created along with a video and placed on the unit for new hires. SBAR continues to be on agendas for unit meetings and huddles.
Abstract title: Triple Aim: MedsToGo
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Background Information:
For years the Wege Family Pharmacy at Mercy Health Saint Mary's has been available to patients to fill prescriptions as they leave the hospital. By filling prescriptions hospital patients are able to utilize the 340B federal program which discounts the cost of the medication. Patients without insurance are given a discounted price while insured patients' prescriptions are filled with a competitive copay and the organization captures the gross profit of the medication. However, many patients did not use the hospital pharmacy to fill their prescriptions. Reasons stated include: inconvenience of walking across the street to fill the medication, waiting time at the pharmacy, and being uncomfortable with not using their own neighborhood pharmacy. The hospital senior leadership team supported implementation of a program to improve patient access to our pharmacy with the potential for increased revenue as long as the program was sustainable. Evidence suggests many patients do not fill their prescriptions and this has an impact on readmission and outcomes of care related to ease of obtaining them, costs, as well as payer impact on generic or formulary issues.

Aim:
Develop a sustainable program to deliver prescribed home medications from the outpatient hospital pharmacy to patients prior to discharge from the hospital. Patients would be introduced to the program and given a choice whether or not to utilize the service. Keeping in line with the Triple Aim focus, the team anticipated that prescribed medications would be delivered to the patient at no additional cost than filled at other locations; patients would desire to use the program as a convenience to them and better compliance with medication regimens.

Methods/Programs/Practices:
Partnering with the outpatient pharmacy manager and two pharmacy technician's LEAN methodology was used to create a process for a program titled MedsToGo. The process developed was piloted on the orthopedic inpatient unit. The orthopedic unit has a stable anticipatory population with discharge medications which can utilize the 340B pricing. The pilot allowed the team to make several small changes while building a gross profit to support the program as it was replicated on other units. Two months into the pilot it was determined the program should be replicated on an adjacent unit. The process was reviewed and implemented keeping close watch on the financial data to assure sustainability of the additional technician time needed. At this time hospital wide providers were educated on the program and the benefit it could provide for their patients. Successful implementation of the second unit led to hospital wide replication over the following several months. Inpatient units were added when the additional technician hours were financially supported by the program.

Outcome Data:
The program has been a large success to patients, providers and organization. A sample population of heart failure patients shows a monthly increase in patients utilizing the program

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while monthly readmission rates have decreased. Each nursing unit demonstrates a steady increase in the percentage of patients utilizing the program with overall discharge to home patients averaging approximately 50% on active units. The pilot unit has ranged from 43% utilization to as high as 93% in any given week. Hospital gross profit has been positive on a weekly basis since the initiation of the program. Providers, patients and staff verbalize satisfaction with the process and feel it is ‘something more’ we offer for our patients.

**Conclusion:**
The MedsToGo program has been a success to our organization. Not only does it provide revenue for the hospital, but it has created an unanticipated collaboration around outpatient prescriptions. Pharmacy technicians are working with the care team informing them about medication authorization, copay amount and last fill date. Medications have been switch by providers when they are told the copay amount and that the patient has no intention of filling the medication. Prescribers, patients, nurses and the technicians work together with patients who choose to use the program to find the right medication, with the right insurance coverage at the right price and have it in the hands of the patient prior to their discharge from the hospital. The systematic method used in the roll-out of the program allowed for financial stability to ensure sustainability.

**Abstract title:** Clinical Practicum as a Marketing Tool for the CNL Role  
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**Background Information:**  
Elmhurst College, a small liberal arts institution, has earned the distinction that 33 of the 35 Clinical Nurse Leader (CNL) graduates are certified by the Commission on Nurse Certification (CNC). While many of our graduates report employment in positions that support the CNL skill set (i.e., clinical coordinator, advanced practice partner, quality analyst), acceptance of the formal CNL role in our local partner hospitals continues to be a challenge. In our geographical area, the primary health system where the CNL role has been established is the Veterans Administration (VA), of which two hospitals are our clinical partners.

**Aim:**  
The primary aim of this presentation is to demonstrate how the CNL role was advanced in two clinical partner hospitals, neither of which are VAs or major medical centers. The challenge was to promote the role of the CNL in systems where it was not integrated into the nursing care delivery model. Graduate student clinical practicum outcomes became a marketing tool to foster
collaboration and to achieve role adoption. A secondary aim of the presentation is to identify the benefit of the resulting enhanced enrollment from these partner institutions.

**Methods/Programs/Practices:**
The partnership between the Department of Nursing and two local hospitals systems was long-standing for both baccalaureate and graduate nursing students. In Spring 2012, as placements for graduate nursing student clinical placement for Fall were being explored, key informant interviews with the two clinical partner hospitals, both of whom were in the early stages of the Magnet journey, identified the value of the CNL skill set. However there were barriers to CNL role implementation at both. Following these interviews, faculty reviewed data regarding employment of our CNL graduates and their job descriptions. Analysis of the findings led to development of an action plan for graduate nursing faculty to take a more active role in "making the business case" for the CNL role in nursing practice delivery models (Harris, Roussel & Thomas 2014). There was a decision the further use of the clinical microsystem approach, as a key component in clinical practicum, as a tool for communication and change. Additional elements for the practicum include Quality and Safety Education for Nurses (QSEN), Institute of Medicine's Safe, Timely, Effective, Efficient, Equitable, and Patient-Centered Care (STEEEP), as well as the American Association of Colleges of Nurses (AACN) Essentials of Master's Education in Nursing and Clinical Nurse Leader Competencies. Finally, by "telling stories" and using real time clinical outcomes from CNL students' capstone projects in these systems, a more personal and tailored relationship occurred. Input from each partner led to individualized modifications and applications in early courses and in the clinical practicum. In addition, consistent with a business model, financial incentives were offered to favorably impact decision making on our program's competitiveness as a choice for an academic-practice partnership.

**Outcome Data:**
In Summer, 2013, each of the partner hospitals created a CNL position. Two of our 2013 graduates who had completed their residency and capstone experiences at these hospitals were recruited for the inaugural CNL positions in these hospitals. They currently occupy these new positions.

In Fall 2012, both partner institutions developed scholarship programs for their employees to enter our graduate nursing program. For both hospitals, over half of the scholarship recipients identified a focus on the CNL role. In Fall 2013, these students started clinical practicum and will enter residency in January 2014. Based on leadership and employee/student feedback, one of the two hospitals sent an additional eleven students to the graduate program with the majority being CNL students in Fall, 2013.

**Conclusion:**
Experiential learning of CNL students has supported the journey of our hospital partners toward quality, safety, and peak performance. Outcomes of student work have been used for improvement in curriculum and quality and safety in practice. There is evidence that marketing of CNL student practicum outcomes is also an important factor for role adoption and there is a continued need for faculty participation in creating avenues for incorporating and sustaining the CNL role in practice.

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Background Information:
Mercy Health Saint Mary's is a primary Stroke Center by The Joint Commission and in January 2012, Mercy Health Saint Mary's successfully recruited a neurointerventionalist to perform both diagnostic and emergency procedures in the Heart & Vascular Center. It was expected that our department would meet with the neurointerventionalist and accommodate his requirements for a smooth integration. My role as CNL was to focus on each role in multiple departments and see how we could work together cohesively to create the best outcomes for our patients. Prior to the implementation of the neurointerventional program, we utilized an interdisciplinary approach to treating neurological diseases, bringing together all neurological services and team members under one roof. The one-stop approach is more convenient for patients who need to see multiple specialists. They no longer have to wait long periods or travel to see different medical providers. A centralized location also promotes easy interaction among physicians and other staff members, so they can quickly share information and consult with one another in real-time. Team members include nurses, therapists, social workers, nurse practitioners, case managers, pharmacists, physician assistants, administrators, support staff and physicians.

For the basis of this project, coordination between our own staff occurred with pre hospital EMS, staff from Emergency Department, Anesthesia, Surgical Prep & Recovery, Neuro Surgery, Inpatient Neuroscience Unit, Neuro Nurse Navigator, Billing & Coding, Centralized Scheduling and senior leadership. Each department had specific processes that needed to be analyzed and fine-tuned to allow care to happen in a fluid and efficient manner.

Aim:
Patients that arrive at Mercy Health Saint Mary's for either emergency neurointerventional or stroke intervention or scheduled diagnostic imaging have standard processes from the moment they arrive in our hospital to the moment they are discharged. There are clearly defined roles for each member of the interdisciplinary team, each member is confident in their education, and all members participate in the Just Culture and Culture of Safety philosophy of the hospital, knowing that advocating for the best practice is the right thing to do in every situation. Key members of the Neuro Intervention Team meet at appropriate intervals to discuss processes, improve outcomes and debrief among the disciplines.

Methods/Programs/Practices:
A Neuro Intervention Team was established, comprised of the CNL from Interventional Radiology, the Neuro Nurse Navigator, an Anesthesia/Surgical representative, the Manager of Heart and Vascular, IR staff RN, and IR Radiological Technologist, and a member of the hospital LEAN management team. The team and met biweekly for several months, then monthly and now quarterly as our processes continue to evolve. Three major work streams were identified initially using LEAN Principles: Procedure Process Map, Standard Process Roles, and Continuous Improvement Action List.
The Procedure Process Map is the layout of our intervention as it relates to each area the patients are guided through and each discipline that is involved in their care. At each meeting areas of concern were identified and addressed, and the Map was brought up to the current ideal. Changes are made based on feedback from all disciplines given in debriefings after each case. An example of this is initially, patients were receiving their foley and arterial line in the prep recovery area, per physician request. Staff was empowered to question the wisdom of this, and a change was made based on streamlining this to be included in the procedure room, accommodating the comfort and privacy needs of our patients and setting up a standard for anesthesia and RNs. As this workstream was developed, it became clear that Standard Process Roles would need to be clarified for each department, and further down into each role. Standards provided by NIHSS and Joint Commission set the basic framework to build up each role, and helped identify areas for greater education and teamwork. Focus groups were created with key members from each role in the process. The focus group lead by the CNL was in the Interventional radiology area. It included radiological technologists and RNs. Different individuals were consulted to the team based on their knowledge and how they were affected by the process. The team established a standard for anatomy & physiology knowledge, pharmacological interventions and equipment requirements. This created an expert within each role that could continue to educate and train new members of the team, based on the specific process identified for them. The Continuous Improvement Action List was designed to streamline all concerns and areas for improvement and partner them to the people responsible for addressing them. This is a constantly evolving list as we continue to adapt to staffing issues, new hospital policies, equipment challenges and breakdowns in communication.

**Outcome Data:**
In an ideal world, more initial data measuring staff confidence, flow of process and interdisciplinary communication would have been gathered so an accurate comparison could be made. As it stands, the improvements are verified by staff narrative, a decrease in prep and procedural delays, and a palpable increase in camaraderie between departments. Since the inception of the program, there have been 6 emergent cerebral coilings and 17 planned neuro coilings and embolizations. The CNL role is critical to project implementation, education, and the ability to continually improve the process. The team coordination has created staff that are better educated as to what they are doing and why, they have clearly defined roles, and a safe venue for voicing their concerns and suggestions.

**Conclusion:**
In January 2012 our department was presented with an opportunity for immense growth, lateral integration and an avenue to better service our patients. Through precise mapping of procedures, processes, role definition and service flow the CNL was able to create an easily identifiable, visible framework to build our team and best outcomes. By analyzing both the overall continuous improvement committee as well as the intradepartmental group the CNL was able to spot potentials for communication breakdown, process gaps and failure to meet expectations within this framework. Coordinating between departments and roles within Just Culture enabled the CNL to creatively address each of these issues in a timely manner, and receive feedback both in real time and with the debriefings. In the nearly two years since we have made the addition to our team, we have seen 23 patients with great outcomes, clearly demonstrating the need for my skills in creating a dynamic approach to care.
Abstract title: Current State of Health Literacy and Diabetes in the Adult Population

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Background Information:
Individuals with poor health literacy have deficient disease knowledge, limited blood glucose control, problems understanding diabetes, and lack confidence in managing their disease process. Approximately 40% of American adults are below functional health literacy skills. Moreover, it is estimated that 90 million adults reading level is below the fifth grade level. Low health literacy contributes to unnecessary costs in the healthcare system with frequent readmission due to lack of understanding and inability to follow discharge instructions.

Aim:
The purpose of this evidence based change project was to identify, assess, and educate patients with diabetes on a medical-telemetry unit at a southern healthcare facility with limited health literacy. Additionally, the utilization and effectiveness of the Literacy Assessment for Diabetes (LAD) health literacy screening tool and educational intervention were assessed on patients with diabetes. Lastly, improve patients’ knowledge in diabetic management.

Methods/Programs/Practices:
Patients with a history of diabetes, age 18 and older admitted or transferred to a medical-telemetry unit was asked to participate in this study. The design was quasi-experimental; an educational intervention was performed to evaluate improvement of health literacy with diabetes patients. Health literacy in diabetes was measured utilizing the Literacy Assessment for Diabetes (LAD) tool. The principle investigator also measured participants understanding of diabetes management knowledge through the use of a pre-, post, and one-week follow-up phone call test based on the survival skills. Education was provided immediately after the pretest that included signs and symptoms of hypo- and hyperglycemia, blood glucose monitoring, dietary adjustments, and medication administration.

Outcome Data:
The paired t-test for the pre-LAD and post-LAD showed that (p = 0.00005), with 94% of the participants performing at a ninth grade and above level. The pre- and posttest based on the diabetes survival skills results were statistically significant, (p = 0.00006), with the pre-test mean score of 67.5 and post-test of 87.5. The pre- and one-week follow-up phone call test proved to be statistically significant, (p = 0.003); while the post and the one-week follow phone call tests, revealed no significance, (p = 0.5).

Conclusion:
The study discovered that assessing an individuals’ health literacy level can assist healthcare providers in ensuring patients’ adherence to diabetes management. Healthcare providers should assess patients’ readiness to learn and ability to comprehend the health materials provided for diabetes management. Demographics also revealed that socioeconomics are a factor in diabetes management, with approximately 50% of the participants either retired or disabled.