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Cleveland Clinic
Notable Nursing
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Ready, Willing and Able:
Preparing for a Range of Emergencies — p. 10

The Stanley Shalom Zielony Institute for Nursing Excellence
Dear Colleagues and Friends,

Across the country last year, hospitals were on high alert as Ebola reached our shores when a handful of healthcare workers fell ill. Thankfully, this infectious disease did not become a national epidemic. It did, however, serve as a sober reminder to all in healthcare of our need to stay one step ahead of potential widespread emergencies.

In our feature story this issue (page 10), nurse leaders from different patient care areas at Cleveland Clinic provide insight into how we are preparing for a range of emergency situations. From containing infectious diseases to responding to stroke patients and managing care at large citywide events, our hospitals and nurses are proactively working and preparing to save lives and improve wellness.

On a larger scale, The Stanley Shalom Zielony Institute for Nursing Excellence created a new council to ensure that Cleveland Clinic nurses have a voice at the table in matters of national healthcare and health policy. The new Nursing Institute Legislative and Health Policy Council convened late last year to engage in and influence health policy from an expert vantage point in a nonpartisan way. For details, see the article on page 8.

On the technology front, Cleveland Clinic nurses are focused on using the electronic medical record (EMR) to its fullest potential (see article on page 6). Over the past year and more, new EMR modules were implemented to improve the documentation of patient health information and to reduce redundancies. Although we have all experienced a learning curve with the EMR, today the robust system is saving nurses time and satisfying patients.

In other features in this issue, we explore how ethics rounding on a multispecialty unit (page 14) is helping nurses better address the complexities of healthcare, and we highlight some noteworthy nurse partnerships that are advancing career plans and care practices (page 3). And as we do in each issue, we take a closer look at some innovative research projects and best practices that are having a significant impact on patient care at Cleveland Clinic.

We have a great issue of Notable Nursing for you. I hope it gives you ideas for creativity and innovation in your own setting. Please contact us to share your thoughts on our activities or to explore how we can work together to advance our vital profession. You can reach us at notablenursing@ccf.org. I look forward to hearing from you.

K. KELLY HANCOCK, MSN, RN, NE-BC
Executive Chief Nursing Officer
Cleveland Clinic health system
Chief Nursing Officer, main campus
Mentor David Holloway  |  Nicolas Houghton

Getting Accepted to Present Nationally

With a topic in mind for a presentation for the Air Medical Transport Conference, Nicolas Houghton, MSN, ACNP-BC, CFRN, reached out to his manager, David Holloway, MSN, ACNP, CCRN, CFRN, for help. He knew it would be a challenge to have his paper accepted. This national conference is the only one of its kind for the field of medical transport. Holloway, the APN manager for Critical Care Transport, had presented at this conference in the past. “It was an online submission process, and I needed help in framing the topic and wordsmithing it so it would be a relatable subject for people who attend this conference,” says Houghton. “Dave helped me bridge the gap.”

His topic idea came from a transport experience he had with a patient who presented with an airway stent, specifically, the Montgomery T-tube stent. His eventual title for the talk was “Interventional Airway Stents: Not Your Average Cup of ‘T.’” Since there has been an increase in placement of stents in the airway (although still fairly uncommon), Houghton wanted to share the positive outcome he had with others in the field.

“It was a great topic — it just needed a little finessing,” says Holloway, who met with Houghton a few times to work through the details. Conference attendees included paramedics, nurses, physicians and a myriad of people in the critical care transport industry. Presenting to this audience, Holloway says, is not easy. “You have to walk the line between providing enough technical information and making the presentation appealing to a broad audience. Nico did a great job getting the audience to interact.”

Houghton used live text messaging during his talk to invite audience participation, and in the end, he received highly positive survey feedback from attendees at the October 2014 conference in Nashville.

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“He was able to take an esoteric topic and make it relevant and interesting to the wide audience,” says Holloway. Concurrent with the conference planning, Houghton has been busy pursuing his doctoral degree and plans to graduate in 2015. Soon after the fall 2014 conference where he spoke, Houghton again asked Holloway for professional guidance on his final written project for school. “Dave has really been there for me through my conference presentation and through school,” says Houghton.

Professional conferences provide invaluable learning and exposure for nurses. This is why Cleveland Clinic’s Zielony Institute encourages nurses at all levels to find national events that offer growth opportunities. Each year, nurse leaders from throughout the institute present at hundreds of these conferences, and many pair up with newer nurses to serve as a guide.

Here we take a closer look at three groups of nurse mentors and their mentees and how these partnerships open up communication, lead to professional development and advance innovations.

Above (left to right): David Holloway, MSN, ACNP, CCRN, CFRN, and Nicolas Houghton, MSN, ACNP-BC, CFRN
Teamwork Leads to Innovation

For Katie Frate, BSN, RN, improving vascular access for pediatric patients has become a mission. Together with longtime pediatric nurse Jane Hartman, MSN, CPNP, Frate ignited an effort that helped lead to a new nurse-led Pediatric Vascular Access Team (PVAT) in Cleveland Clinic Children’s.

The pair joined efforts two years ago when they attended the scientific meeting of the Association for Vascular Access (AVA) in Tennessee. “I was in awe at the first conference I went to,” says Frate. “I got to meet people and see what was going on out there in other children’s hospitals.” Says Hartman: “It’s so important for nurses to explore and be part of an organization that is ‘bigger than them.’”

Hartman’s current peripheral vascular research project to develop vascular access initiation guidelines for pediatric patients (approved by Cleveland Clinic’s Institutional Review Board) has also been a great lesson for Frate. This work contributed to the development of the new PVAT, which got underway in early 2015.

In September 2014, Hartman presented “Two-Plus-Two-Plus-Two Is Too Many; Using Benner’s Theory to Initiate Pediatric Vascular Access Guidelines” at the AVA conference in Washington, D.C., with Frate by her side. With Hartman’s encouragement, Frate applied for a national scholarship and was one of only three nurses across the country to receive funds that allowed her to attend the event.

This fall, Frate will take the lead in presenting her own topic, “The David and Goliath of Vascular Access, How One Staff Nurse Slayed the Giant,” at the 2015 AVA conference in Dallas. “I was fortunate that Jane took me under her wing,” says Frate. “I would not be where I am today without her help and resources. Being on the floor is stressful, and she encourages me to make the right choice every time.”

Both Hartman and Frate say their professional relationship will continue to improve vascular access for the most vulnerable population — our children. “The vascular access project unfolded beautifully with support from leadership and Katie’s dedicated effort,” says Hartman, who has been in the field for years advocating for a nurse-led PVAT team. “This just shows how one person’s passion can ignite a movement.”

Encouraging Career Development at One Hospital

Perhaps nowhere in the Cleveland Clinic health system has career development been so pronounced in the past two years as at Medina Hospital. At this rural regional
hospital, the number of participants in the Career Ladder program jumped from 16 nurses in 2011 to 65 in 2013, and it continues to increase.

You might trace this back to 2012, when 20-year Medina nurse veteran Kathy Burns, MSN, RN, ACNS-BC, ACCNS-A/G, CEN, became the facilitator for the hospital’s Education and Professional Development Committee. In this role, she invited more staff nurses to be involved and empowered them to take on new projects.

Three staff nurses, in particular, took on leadership roles on the committee — Andrea Allen, BSN, RN, CMSRN; Anna Maria Damm, BSN, RN; and Jennifer Fuller, BA, RN, CMSRN. With Burns’ guidance on writing an abstract, the foursome put together the “Charting a Path for Professional Development” project, which they presented at the American Nurses Credentialing Center’s Pathway to Excellence© Conference in Texas in May 2014. Soon after, Allen, Damm and Fuller updated the project and presented the poster at Cleveland Clinic’s own Shared Governance Day, where it won “fan favorite” from among 200+ posters.

The objective of the project was threefold: increase participation in the Career Ladder program, promote continuous learning through education and recognize nurse accomplishments via the health system awards program.

In addition, Damm took the lead on coordinating a career fair at the hospital that now brings dozens of college representatives from nursing schools to the hospital campus each fall. She also serves as a one-on-one mentor for nurses who are looking to advance their careers.

Says Damm: “After obtaining my BSN, I was motivated to encourage others. Hopefully, I’m helping nurses realize that it’s not as overwhelming and impossible as they might think to get their degree. We can help shape the future of nursing.”

Together, Allen and Fuller worked on a poster that promoted the Career Ladder program. The poster has been displayed prominently throughout the hospital. Today, they also offer one-on-one career mentoring to other nurses.

Says Fuller, “This project is important for the nursing profession as a whole because it brings awareness of higher education, certification and our career ladder.” Says Allen: “This doesn’t just benefit us — it benefits our patients and the hospital.”

All three nurses agree that they could not have had such an impact on career advancement at Medina Hospital without Burns’ leadership. “Kathy was instrumental in encouraging us and supporting us. It was great to know she believed in our abilities,” says Damm.

“As nurses it is so important that we pass on what we know,” Burns says. Or “pass the torch,” as they say.

Email comments to notablenursing@ccf.org.
After months of work, staff from the Office of Nursing Informatics unveiled a revised admission assessment document in Cleveland Clinic’s electronic medical record (EMR) system in April 2014. The simplified document, which is used for all inpatient admissions from medical-surgical units to ICUs, was a hit with nurses: It decreased required data entry elements by nearly 75 percent and reduced the average time spent completing the assessment from 49 minutes to 18 minutes.

The Zielony Institute strives for EMR documentation optimization. That’s a dense phrase for a simple concept: “It’s all about leveraging technology to give time back to nurses for patient care,” says Marianela Zytkowski, DNP, MS, NEA-BC, RN-BC, FHIMSS, Associate Chief Nursing Officer of Nursing Informatics at Cleveland Clinic. Staff in her office worked to standardize and streamline documentation.

Council leads the charge

When Cleveland Clinic adopted Epic, its EMR system, the healthcare system transitioned many of its paper documents to electronic ones. But nurses soon realized that documents could be enhanced. “People constantly try to create electronic documents that replicate paper documents, and it’s just not going to work,” says Steve Mailer, BSN, RN, a manager in the Office of Nursing Informatics. “We need to let go of what we used to do on paper and capitalize on the strength of electronic medical records — for example, clinical decision support that is embedded in the EMR.”

Cleveland Clinic began the documentation optimization process in earnest a couple of years ago. “We look to decrease documentation when we can, although that’s not
always possible," says Marlene Oblak, RN, a manager in the Office of Nursing Informatics. "If we can’t decrease it, we strive to at least streamline it to make it a little easier."

Last year, the Nursing Institute formed the Nursing Informatics Technology Council (NITC). One of the council’s responsibilities was to promote nursing satisfaction through standardization of documentation and optimization of the EMR. The NITC has approximately 50 members, including staff from Nursing Informatics, the Office of Quality and Practice, the Office of Nursing Education and Professional Development, and bedside nurses. This last group is vital to the council, as bedside nurses help determine what the ideal EMR should look like and validate changes or design drafts.

**Bedside nurses benefit**

Mailer calls the revised admission assessment document “one of our biggest wins” because it affected caregivers enterprise-wide. “We zeroed in on pieces of documentation that were unique to the admission process and removed extraneous data,” he says. In determining what data to weed out, the Nursing Informatics team considered the importance of data, based on regulatory agency requirements and hospital policies and procedures.

One section that was improved was documentation of medical history. Rather than including an extensive medical history list, documentation was pared down to a core list of pre-existing medical conditions that are important patient care factors. “Medical history was already being documented by other providers,” says Mailer. “Eliminating redundancies had an added benefit of improving the patient experience, as we decreased the number of repetitive questions patients were asked.”

**Addressing confused patients**

Adding in clinical decision support is key to many changes. Decision support tools include computerized alerts and reminders, condition-specific order sets, focused patient reports, and more. Last year, Cleveland Clinic began using a new delirium screening tool — a modified Brief Confusion Assessment Method (bCAM) — to better identify patients with delirium symptoms. In September, the healthcare system went live with a page in its nursing progress record that leads caregivers through the delirium screen.

The page begins with basic questions to determine whether patients’ status is at their pre-hospital baseline. Depending on patient responses, other follow-up questions appear. When patients test positive, nurses can click on a delirium intervention bundle, which is composed of a list of a dozen possible interventions to help patients. Interventions include minimizing unnecessary noise, frequently reorienting the patient, encouraging family member presence at the bedside, consulting with pharmacy on medications that may cause or alleviate delirium, and others. Finally, there is a link to a nursing protocol for care of patients with delirium.

“Dealing with delirium is a delicate balancing act from one patient to the next,” says clinical nurse specialist Catherine Skowronsky, MSN, RN, ACNS-BC, CMSRN. “To have everything right there at your fingertips at the bedside is so helpful." Ultimately, that’s what all EMR documentation optimization is about: helping nurses and improving patient safety and care.
A Voice for NURSING

Institute creates a new council to educate nurses on public policy and encourage involvement.

Nurses influence patient outcomes at the bedside, and they can play an equally important role in shaping policy in the political arena. “With changes going on in healthcare and health policy, nurses are well-poised to affect the outcomes and help craft practice decisions, not only for patients, but for the profession as well,” says Nancy Kaser, MSN, BS, RN, ACNS-BC, NEA-BC, a clinical nurse specialist at Cleveland Clinic. “For that to happen, nursing needs to have a voice.”

The Zielony Institute announced its new Legislative and Health Policy Council at the 2014 Nursing Leadership Summit, where approximately 450 nursing leaders throughout the health system gathered in an interactive, educational forum. The summit’s theme was the voice of the nurse in the transformation of healthcare.

The keynote speaker was Rebecca M. Patton, MSN, RN, CNOR, FAAN, the past two-term president of the American Nurses Association. As ANA president, Patton met frequently with key policy leaders, including President Barack Obama and his staff as the healthcare reform bill was developed, debated and passed. During her Nursing Leadership Summit presentation, Patton urged attendees to get involved in health policy: “We can’t step back from any more pieces of legislation and the opportunities to craft them.” (To listen to Patton’s keynote address, go to clevelandclinic.org/voiceofRN.)

Kaser was one of many nurses inspired by Patton’s message, just as she had been motivated by a professor at the Frances Payne Bolton School of Nursing at Case Western Reserve University in Cleveland. “I was very lucky to have a dynamic professor on health policy,” says Kaser. “Dr. Faye Gary, EdD, RN, FAAN, sparked my interest. When the opportunity came up to join the council, I said, ‘Yes!’” She also agreed to co-chair the council alongside Meredith Lahl, MSN, PCNS-BC, PPCNP-BC, CPON, Senior Director of Advanced Practice Nursing at Cleveland Clinic.

“Rebecca Patton’s keynote address got everyone energized around what policy is,” says Lahl. “She helped nurses in the room understand it is not only our right, but our obligation as citizens to advocate for our patients and our profession.”
Lahl knows firsthand the importance of getting involved. In 2013, she worked with colleagues to help pass Ohio House Bill 139, allowing clinical nurse specialists, certified nurse-midwives, certified nurse practitioners and physician assistants to admit patients to hospitals under certain conditions.

“This was my first introduction to health policy,” recalls Lahl. “It was an interesting experience, identifying stakeholders and understanding their perspectives. It was great to see everyone from different roles come to the table and agree on a position to move practice forward.” Lahl traveled to the state capitol on Feb. 18, 2014, to watch Ohio Gov. John R. Kasich sign the bill into law.

Strengthened by this experience, Lahl hopes to encourage other nurses to become advocates. She and Kaser led the first meeting of the Legislative and Health Policy Council last September. “One of our first goals is educating council members so they know how and where to get involved,” says Lahl. Attendees at the kickoff meeting were given a simple homework assignment: Find out who your legislators are at the state and national level.

During the first several meetings, the council developed a charter, established a meeting schedule and identified the need for involvement from key stakeholders, such as Cleveland Clinic’s Government Relations team and local legislators.

**Council members share their experiences**

The Legislative and Health Policy Council began educating its members by turning to internal experts. “We have a wealth of knowledge at our very own doorstep,” says Kaser. Representatives from Cleveland Clinic’s Government and Community Relations team discussed what they do and how nurses can partner with them. Additionally, council members will share how they’ve become involved in public policy.

One of those members is Gina Gavlak, BSN, RN, Diabetes Program Development Coordinator at Cleveland Clinic’s Lakewood Hospital. As chair of the American Diabetes Association’s National Advocacy Committee, she works closely with ADA staff and volunteers on multiple state and federal issues. She also leads the ADA’s Capitol Hill lobby days and advocacy days. “I hope to share what I’ve learned with members of our council, to learn from others and work together to get more nurses involved,” says Gavlak. In March of this year, she led the ADA’s Call to Congress event and spoke with legislators about the diabetes epidemic and the need for better medication, technologies and prevention strategies and a cure.

Council member Mary Kennedy, MBA, BSN, RN, Chief Nursing Officer of Cleveland Clinic’s Medina Hospital, also has some policy experience. She previously attended legislative committee meetings and forums hosted by the Cleveland-based Center for Health Affairs, covering such topics as the medical home model and insurance exchanges. In 2013, Kennedy completed a nine-month civic education program hosted by Leadership Medina County that’s designed to help participants better understand
The highlight was a two-day trip to the state capitol, where the group met with legislators and attended a General Session of the senate.

Lahl and Kaser hope that nurses such as Gavlak and Kennedy will encourage others to get involved. “It’s imperative to have an engaged workforce that is aware of what’s going on outside our four walls that affects patient care and our profession,” says Lahl. “It’s the crux of leadership.”

Email comments to notablenursing@ccf.org.

**Why Should Nurses Be Engaged in Policy?**

This is a question that Rebecca M. Patton, MSN, RN, CNOR, FAAN, asked and answered during a keynote address at the Zielony Institute’s 2014 Nursing Leadership Summit. “We are the largest group of healthcare providers, and, more importantly, we have a front-row seat every day when we take care of our patients,” said Patton, past two-term president of the American Nurses Association.

“Nurses can explain things in a manner that individuals outside of healthcare can understand.”

Mary Kennedy, MBA, BSN, RN, Chief Nursing Officer, Cleveland Clinic Medina Hospital

“Nurses know healthcare. Legislators know about policymaking. We need to help each other.”

Nancy Kaser, MSN, BS, RN, ACNS-BC, NEA-BC, Clinical Nurse Specialist, Cleveland Clinic

“In Gallup polls nursing is rated as the most trusted profession. We are not thought of as being influential and instrumental in making decisions, but we really should be! We are at the front line of patient care.”

Meredith Lahl, MSN, PCNS-BC, PPCNP-BC, CPON, Senior Director of Advanced Practice Nursing, Cleveland Clinic

“Nurses have unique insight regarding patient care. Sharing our stories is one of the most effective ways to advocate.”

Gina Gavlak, BSN, RN, Diabetes Program Development Coordinator, Cleveland Clinic Lakewood Hospital
Quick response to stroke patients

In July 2014, Cleveland Clinic’s Cerebrovascular Center launched one of the country’s first mobile stroke treatment units (MSTU). The MSTU resembles an ambulance on the outside, but is equipped and staffed inside like a virtual emergency room dedicated to stroke diagnosis and management. The MSTU brings potentially lifesaving tissue plasminogen activator (tPA) to ischemic stroke patients, rather than waiting for them to enter the emergency department (ED).

“The benefits are extraordinary,” says Scott Swickard, MSN, ACNP, Clinical Operations Manager for Critical Care Transport at Cleveland Clinic. “By bringing this unit to patients at the time they are having the stroke, we take an emergency department directly to their driveway. We are able to provide treatment so much faster than I ever thought possible.” Stroke centers strive to deliver tPA in the ED within an optimal 4.5-hour window after symptom onset. The average time from patient entry into the MSTU to tPA administration is just 19 minutes.

“The difference the MSTU makes is related to outcomes,” says Swickard. “Quicker treatment may equal fewer disabilities and a greater chance of going home after a stroke event, rather than requiring rehabilitation care for neurological deficits. Our goal is to achieve best outcomes that lead to high quality of life after discharge.”

The MSTU is based at Cleveland Clinic’s main campus and dispatched (along with a standard ambulance) via the city of Cleveland’s 911 system for suspected stroke. When strokes are diagnosed in the unit, the MSTU transports patients to a stroke center with appropriate resources to care for the severity of stroke symptoms. Every effort is made to keep patients within their normal care networks and close to home. Between July and November 2014, the MSTU was dispatched 421 times and transported 125 patients.

Preparing for a disease outbreak

In 2013, Cleveland Clinic debuted a state-of-the-art unit capable of handling patients with chemical contamination or environmental viral infections, such as Ebola. “Like any emergency situation, you have to be prepared for disease outbreaks,” says Shannon Pengel, MSN, RN, NE-BC, Clinical Nursing Director of Cleveland Clinic’s Sydell and Arnold

continued
Pediatric Readiness

More often than expected, the primary care pediatric office serves as the entry point for an ill child into the emergency care system. In 2013, EMS was activated 29 times for pediatric patients across Cleveland Clinic’s 18 ambulatory sites, with the majority of emergencies for patients under age 5 who were in respiratory distress.

With the volume of pediatric emergencies doubling in 2014, Community Pediatrics began taking a proactive approach, says certified pediatric nurse practitioner Cheryl Cairns, MSN, RN, CPNP, who worked closely with Community Pediatrics Vice Chairs Ruth Imrie, MD, and Michelle Medina, MD, to address emergency readiness. The team developed a comprehensive Mock Code Tool Kit for emergencies in outpatient pediatrics along with an essential list of pediatric emergency equipment needed for most resuscitation situations.

“We piloted the tool kit in three of our locations, and mock exercises are now being done quarterly at all our ambulatory pediatric sites,” says Cairns. “Our goal is to continue to refresh pediatric resuscitation skills among office staff.”

The mock training is helping improve the knowledge of each member of the Community Pediatrics team by increasing exposure to pediatric resuscitation scenarios, equipment and documentation standards in a controlled, nonthreatening environment. In addition, each outpatient office is being fitted with the necessary emergency equipment, including oxygen, suction apparatus and automated external defibrillators.

“It has been a big undertaking to do the mock exercises and outfit offices. Our goal is to be ready and to ensure optimal pediatric survival,” says Cairns.

Email comments to notablenursing@ccf.org.

Ready, Willing and Able continued

Miller Family Heart & Vascular Institute and Critical Care. “It’s critically important to understand how to care for these patients as well as keep our caregivers safe.”

The contained unit features everything healthcare providers need to manage patients, including a built-in lab so blood samples do not have to leave the area for testing and three beds, two of which are ready for intensive care-level care. Each patient care room has two adjoining rooms — one where caregivers put on personal protective equipment and another where they take it off. To minimize the risk of spreading infection, the unit has a separate, secured entrance and adjoins the hospital’s intake area and emergency department. “As patients are triaged, they can literally walk right into the unit,” says Pengel.

A multidisciplinary team helped design the unit. “It was an amazing effort by countless caregivers throughout the organization, from Infectious Disease to Facilities, Environmental Services and Employee Health and Safety,” says Pengel.

Six care teams of 15 healthcare practitioners are trained to work on the unit. Teams include nurses, respiratory therapists, critical care physicians, internal medicine physicians and pediatric providers. Each team has six nurses — two each from medical-surgical units, the intensive care unit and the emergency department. In addition, other caregivers are available to respond if necessary, including a surgical team, nephrologists and dialysis nurses. When a patient arrives on the unit, teams are activated and rotate care, three days on and three days off.

Care teams received hands-on and simulation training. A large part of the hands-on training was devoted to getting personal protective equipment on and off properly. “As nurses, we use protective equipment all the time for isolation precautions, such as C. diff,” says Pengel. “But Ebola is very different.” One of the training techniques involved putting chocolate syrup on care team members’ gloves and gowns, then time was spent taking off the equipment without allowing syrup to touch skin. Early on, nearly everyone “contaminated” themselves. The chocolate syrup exercise “helped us change our processes,” says Pengel. “Now, instead of having employees take off their own equipment, someone else does it for them.”

After hands-on training on the unit, teams participated in 16 hours of simulation training. It began with instruction on Ebola — what it is and how it spreads. Then teams put on protective equipment and went through various scenarios. For instance, they practiced cleaning up vomit and drawing blood. Today, caregivers take part in ongoing simulation training twice a year.

Treating people at major events

Cleveland Clinic’s Emergency Preparedness Team works hand in hand with the Center for Health Affairs and local and state departments of health to help ensure the safety and health of participants and spectators at large community events. For both the 2013 National Senior Games and the 2014 Gay Games that were held in Cleveland, Cleveland Clinic had medical teams on-site at major venues to provide first aid and run triage.
“You have to be proactive at these events,” says James Bryant, MSN, RN, CEN, Associate Chief Nursing Officer for Emergency Services at Cleveland Clinic. “It’s not as simple as taking care of patients. These are high-profile media events, so we have to be prepared for anything.” Most people treated at the Senior Games had “bumps and bruises” associated with sporting events, says Bryant.

Nearly 11,000 senior athletes competed in 19 sports at the Senior Games. Caregiver teams of nurses, paramedics and physicians set up tents outside the primary stadiums. They treated athletes’ ailments such as twisted ankles and dehydration. Only 16 people were sent to the hospital.

Cleveland Clinic is also vigilant about recognizing illnesses that could occur en masse at large events, such as food poisoning. When the Senior Games were in progress, the healthcare system placed a plaque in each emergency department asking visitors to let them know if they were a spectator or athlete at the Senior Games. If so, nurses and physicians placed a note in electronic medical records and in a database managed by the Ohio Department of Health. The database flags common words, such as fever, headache and vomiting, and sends hospitals a daily report. “In the course of a day, two people with those symptoms won’t raise your suspicion,” says Bryant. “But in aggregate, if several patients have a similar condition and also a commonality such as attending the Senior Games, it spikes your interest.”

Cleveland Clinic has already begun emergency readiness planning for the 2016 Republican National Convention, which will be held in Cleveland. “When high-level leaders are involved, another dimension of planning takes place,” says Bryant. The hospital will team with the Secret Service and others to ensure the safety and health of all attendees.

Emergencies take on many forms, from acute events to disease outbreaks to food poisoning at convention centers to mass casualties in an accident. Being prepared requires foresight and planning. “We really hope nothing happens at these large events and that we never see an Ebola outbreak,” says Bryant. “But we’ve come together as a team to be prepared just in case.”
Managing ETHICAL ISSUES

Nurses Learn to Manage Ethical Issues Through Ethics Rounds

An elderly man is admitted to the hospital with a fungal infection. Infectious disease specialists prescribe a powerful medication that causes severe side effects. The patient’s family voices concerns and asks to stop the medication. The Infectious Disease team advises otherwise. The patient cannot speak for himself.

What’s a nurse to do?
Ethical issues like this often leave nurses in the middle, says clinical nurse specialist Kelly Haight, MSN, APRN.

“Nurses want to advocate for patients and families, but it’s hard to know what to do when a team of doctors wants to take things another way,” she says. “Moral distress has a huge impact on nurses. When you think you know what's right for a patient but don’t see it carried out, it affects your ability to do your job. And it can lead to burnout.”

Discussing real-life controversies
A staff nurse on one of Haight’s floors, Brandee Reese, BSN, RN, has a passion for nursing ethics. Reese minored in philosophy while earning her BSN and later took an ethical nursing class upon joining Cleveland Clinic. Soon after, she suggested that ethics rounds could benefit nurses on her multispecialty step-down unit.

Reese’s supervisor loved the idea and urged her to pursue it. Cleveland Clinic’s Director of Clinical Ethics, Martin L. Smith, STD, offered his support as well. Dr. Smith had helped lead ethics rounds before, for nurses working on intensive care units. Ethics rounds on intermediate care units would be a first for nurses.

To help champion the cause, Reese recruited other nurses from her unit, including Zoe Zelazny, BSN, RN, who has a master's degree in ethics and policy studies.

“Dr. Smith helped us get things started,” says Reese. “Initially we invited nurses from our floor and the nearby heart and lung transplant floor and met every two weeks. In advance, we’d send an email or talk to nurses about cases they’d like to discuss — often situations currently happening on the floor.”

Reese and her team would type up a case study and send it to Dr. Smith, who would enlist bioethicists from Cleveland Clinic’s Department of Bioethics and other experts to share experiences and insights at the nurses’ next meeting.

“The forums allowed nurses to share their concerns about patient care in a safe environment,” says Dr. Smith. “They also pushed them to think creatively, from an ethics perspective, about appropriate steps to help the patient and future patients in similar situations.”

Out of these “ethical reflections,” according to Dr. Smith, comes “collective wisdom” and empowerment for nurses. “Often, someone would say, ‘Oh, I didn’t think of it that way before, but I will next time,’” says Reese.

‘If Bioethics were involved, how would they handle this?’
The rounds also made nurses more aware of Cleveland Clinic’s Ethics Consultation Service, which they can access as needed. Before ethics rounds, it was typically nurse managers who would request the Ethics Consultation Service — and usually only when situations would escalate and tensions would rise.

“Ethics rounds have shown our nurses how to align situations with an available resource, rather than feeling helpless or that they’re not advocating adequately for their patients,” says Haight. “There is help.”
But discussions have been just as valuable, adds Zelazny. “Even when we don’t call on the Department of Bioethics for help, we have become more able to think about how Bioethics would handle a situation,” she says.

The difference: one year later

It has been more than a year since these ethics rounds began. Haight is leading a research study, “The Effects of Nursing Rounds on Nurse Perceptions.” Data are being collected through nurse instruments. Data analysis is the next step.

“Regardless of the study results, we’ve already noticed a difference in our staff nurses,” says Haight.

“We can be more comfortable in situations, knowing we don’t have to manage alone,” says Reese. “We are better prepared to discuss morally distressing situations with families and are better able to advocate for our patients.”

The Department of Bioethics team is now more involved in patient cases than it used to be, she adds.

“Nurses now know they can do something more than just empathize with patients,” says Zelazny.

Spreading the word

Today, the intermediate care units have ethics rounds once a month at 8 a.m., so both day- and night-shift nurses can attend. Up to 20 attend each half-hour meeting.

“Time is a nurse’s most valuable treasure,” says Haight. “The fact that our nurses are taking time to attend these meetings is proof they value them.”

Will ethics rounds spread to other units? “I recommend ethics rounds for nurses on any unit where risk of moral distress and burnout is highest,” Dr. Smith advises nursing leaders nationwide. “ICUs and intermediate care units, which often have more complex patient cases, may be the first places to consider.”

It doesn’t need to be a huge program, says Zelazny, noting that a good start might be having someone from a hospital’s ethics consultation service or committee come and talk to a handful of nurses.

Better for everyone

As for the elderly patient in the scenario above, he ended up transferring to an intensive care unit, where he passed away, despite having the controversial medication removed.

Nurses studying this case learned to be more proactive in generating discussions among patient families, medical services and Cleveland Clinic’s Ethics Consultation Service — including involving the consultation service early in a conflict.

“When patients and families know they’re being heard, and nurses take actions on their behalf, they may be more likely to choose us again for their medical care,” says Zelazny.

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Cleveland Clinic’s Marymount Hospital recently implemented a program to reduce interruptions during two crucial times each day when routine medications are being administered — at 9 a.m. and again at 9 p.m.

During these times, a light on the unit clerk’s desk is turned on to alert the entire staff that it is “med-pass” time. The unit clerks take messages for all but the most urgent phone calls, and the staff is asked to hold all questions for nurses until they are done with medication administration. Nurses place a sign on their workstations and hang tags on patient doors to alert others that it is med-pass time. Signs are also posted in the medication storage/dispensary areas, labeling them as “no talking” zones.

Results have been impressive — a 72 percent reduction in interruptions. Before, nurses were interrupted an average of 4.28 times during medication administration; that went down to 1.19 interruptions per nurse per medication administration period. The biggest reduction was in the number of nonphysician phone calls. The nursing team hopes to see even further reductions as the program continues.

“This is not just about a light on a desk,” stresses Marymount’s Chief Nursing Officer Barbara Zinner, MSN, RN, NE-BC, who spearheaded the project. “It’s about how we do our work and making med-pass a truly sacred time.”

In an effort to help the nurses on her oncology unit, Marymount nurse manager Stephanie Conard-Scott, BSN, RN, was instrumental in the initiative. “The greatest benefit we’ve seen of this program is that it heightens awareness and empowers the nurse to safely administer medications without unnecessary interruptions from other departments.”

Zinner noted that Marymount did not have significant medication errors prior to the program; actions taken were meant to be proactive, to keep patients safe. It has had an added benefit of increasing nurse satisfaction.

“Many nurses feel that this project was liberating and allows them to do their jobs better,” Zinner says.

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PCNAs Instrumental in Success of Intermittent Pressure Compression Compliance

With the mechanical prevention of postsurgical venous thromboembolism (VTE) squarely in the hands of nursing teams, the consistent use of intermittent pressure compression (IPC) is a major issue for nurse leaders across the country.

“Since VTE prevention guidelines call for IPC stocking use 20 out of 24 hours, adherence to the quality measure requires extensive documentation,” says Deborah Solomon, MSN, RN, ACNS-BC, clinical nurse specialist on a postsurgical urology unit on Cleveland Clinic’s main campus.

The unit’s nursing team conducted data analysis in late 2012 and found that IPC documentation and wear compliance were below benchmark. The unit initiated a pilot program in 2013 aimed at improving compliance, with bedside nurses responsible for documenting every hour whether patients were wearing the mechanical stockings. However, that level of documentation for already busy nurses proved more challenging than anticipated.

Finding a better way

For the next year, the nursing team struggled in the effort and recognized that there had to be a better way. “Then we found it,” Solomon says. “We realized that this was a delegable task and devised a plan through our shared governance unit to give PCNAs ownership of IPC documentation.”

It worked. In early 2014, nurse leaders met with the unit’s bedside nurses and PCNAs to emphasize their critical role in the effort. In the following months, audits found a sharp increase in achieving IPC goals, with documentation reaching 75 percent and wear compliance at 55 percent.

PCNAs were instrumental in documenting stocking compliance every hour, Solomon says. Initially, nurses were to document even hours and PCNAs odd hours, but this system was rife with communication issues, so the PCNAs soon took over all documentation.

“The PCNAs have been fantastic — they have risen to the occasion and taken ownership of this initiative, allowing the RNs to focus on other critical tasks,” Solomon says. “With a team effort and shared governance involvement, our IPC compliance rates met benchmark, which was set at 75 percent after the stronger role of the PCNA was initiated.”

Buy-in from RNs and PCNAs

Nurses and PCNAs in the unit say the approach is a win for them and for patients.

“It makes sense for PCNAs to document wear compliance, since that goes hand in hand with their responsibilities of helping patients to and from the restroom or to be bathed — situations in which the stockings need to be removed and put back on,” says Tajana Glover, BSN, RN. “It’s a big help, because it’s one less minute I need to spend documenting, so I can focus on other work.”

Jennifer Dasko, PCNA, says she welcomed the opportunity to take this responsibility. “It makes you feel like you’re making a difference, and that’s why PCNAs do what we do,” she says. “When we do our hourly rounding, we explain to patients how important it is to wear the stockings to help with blood flow after surgery.”

Systemwide implementation

The shared governance model was so successful that all medical and surgical nursing units across Cleveland Clinic now place the primary responsibility for IPC documentation in the hands of PCNAs. And most recently on the urology unit, the observed compliance rate was about 80 percent, with documentation at 72 percent, and wear compliance is remaining steady at 55 percent.

“Giving the PCNAs ownership of this initiative was a creative solution that has been key to our continued success,” Solomon says.

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About seven years ago, the Robert Wood Johnson Foundation and the Institute of Medicine (IOM) began a two-year initiative to evaluate the nursing profession. The goal was to learn best practices to help nurses overcome barriers to leadership and realize their full potential, so they can make positive changes that advance healthcare. The more than 3 million nurses in the U.S. make up the largest segment of the healthcare workforce and, therefore, have the ability to make far-reaching changes in the healthcare system.

From the initiative came the 2010 report “The Future of Nursing: Leading Change, Advancing Health,” which provided eight recommendations and, thus, a blueprint for transforming the nursing profession.

The intent of this landmark document was to investigate change, but advanced practice nurses (APNs) at Cleveland Clinic wondered how aware their colleagues were of the report and how much they valued its recommendations.

So, in late 2013, they conducted a survey. Of 600 Cleveland Clinic APNs who received the APN’s Awareness & Value of IOM Future of Nursing Report Survey by email, 111 responded. The results were “eye-opening,” says Principal Investigator Meredith Lahl, MSN, PCNS-BC, PPCNP-BC, CPON, Senior Director of Advanced Practice Nursing.

Overall, APN awareness scores were lower than value scores for all recommendations, meaning that even if they were not familiar with specific recommendations, after reading them on the survey, APNs considered them valuable. Overall, the recommendation to remove scope-of-practice barriers (No. 1) was rated as most valuable. Many APNs are not currently able to practice to the full extent of their education and training due to scope-of-practice limitations that vary from state to state.

The recommendation to double the number of RNs with a doctorate by 2020 (No. 5) was ranked lowest in value by APNs, reflecting their general satisfaction in their clinical roles, rather than focusing on faculty or research roles.

The takeaways from the survey, Lahl says, are the need to find better ways to educate APNs about this report, and the need for nurses to advance science. APNs may also need to receive other important large-scale documents on nursing opportunities and practicing to the full extent of their education and training.

“We have a large group of APNs at Cleveland Clinic,” she says. “We need to bring this collective group together to get involved with policy and help advance our profession.”

Nicolas Houghton, MSN, ACNP-BC, CFRN, Critical Care Transport, agrees. Houghton joined this project because it embodies research, policy and practice. Although he says he was surprised more APNs weren’t aware of components of the report, he is excited about the possibilities that acting on the recommendations could bring.

“If we can advocate at policy level to allow APNs to practice at their full scope, we can expand access to care,” he says. “We have the opportunity to take this to the next level.”

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Research

A Closer Look at Medication Adherence for Patients with Chronic Cardiac Illness

About half of all patients diagnosed with chronic illnesses do not adhere to their prescribed medication regimen (Brown & Buffell 2011; US stat.). This can be due, in part, to the complexity of needing to take several medications at varying times. Unfortunately, serious health complications can ensue if medication regimens are not followed.

So when Jayne Rosenberger, BSN, RN, a critical care and emergency department nurse at Cleveland Clinic’s Hillcrest Hospital, noticed many of the cardiology patients she saw weren’t taking their prescribed medications, she decided something needed to be done.

Initially, Rosenberger thought color-coding the prescription bottles would make a difference. By creating differences in the way prescription pill bottles looked, she thought it might be easier for patients to recognize different medications and take them as directed. When she brought the issue to a nursing research workshop, however, she realized that before coming up with a solution, she needed to know more about the problem and its scope.

So Rosenberger decided, along with her mentor Esther Bernhofer, PhD, RN-BC, Senior Nurse Researcher, Office of Nursing Research and Innovation, to investigate.

Upon securing the necessary approvals to conduct research on medication adherence, Rosenberger used a valid, reliable, simple questionnaire to answer research questions. Patients were enrolled from November 2013 to March 2014 from the busy outpatient cardiology department at Hillcrest Hospital. She and two other co-investigators approached patients who met inclusion criteria (patients had to be on at least four different medications) after they completed their appointment with a healthcare provider, to request participation.

Of 634 patients approached, 304 agreed to be interviewed — 208 men and 96 women. Mean age was 72 years. Participants provided demographic and current medication information and completed a medication adherence scale and a tool on the complexity of the medication regimen.

Bernhofer analyzed the data and was surprised at the findings: Younger adults were less adherent than older adults in taking their medications. Also, patients with higher education levels were less adherent in taking their medications than the patients with fewer years of education.

“Our expectation was turned on its head,” says Rosenberger. She and her colleagues had anticipated the findings would be the opposite.

“This proves it’s good to know what the problem is before you decide on an intervention,” she adds. “And sometimes the research findings create more questions.”

Rosenberger’s original proposed intervention of color-coding the prescription bottles was geared toward helping older patients. Now, she says, the intervention may need to be something more high-tech to appeal to younger, busy patients who may not be adhering to medication regimens for a variety of reasons.

She and her colleagues are working on the submission of a manuscript that summarizes their findings in a peer-reviewed nursing journal.

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Awards

Cleveland Clinic’s Hillcrest Hospital has joined the short list of healthcare organizations to be honored as part of the American Nurses Credentialing Center’s (ANCC) Magnet Recognition Program®, which celebrates superior quality in nursing care and innovations in professional nursing practice. According to the ANCC, Magnet is the leading source of successful nursing practices and strategies worldwide. Hillcrest is the third hospital in the Cleveland Clinic health system to earn Magnet designation, which includes its main campus (in 2003) and Fairview Hospital (in 2009).

Cleveland Clinic’s Lutheran Hospital fared well on a survey of 2,591 U.S. hospitals for safety and respect in the February issue of Consumer Reports. Much of this can be attributed to care provided by nurses. The safety scores are based on factors such as mortality rates, infection rates and hospital readmissions.

In January, Nancy Albert, PhD, CCNS, CHFN, CCRN, NE-BC, FAHA, FCCM, received the Society of Critical Care Medicine’s (SCCM) Presidential Citation at the organization’s Critical Care Congress in Phoenix, Arizona. Albert is the Associate Chief Nursing Officer in Cleveland Clinic’s Office of Nursing Research and Innovation. The Presidential Citation honors SCCM members who have made outstanding contributions to SCCM.

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The Cleveland Clinic Way

By Toby Cosgrove, MD, CEO and President of Cleveland Clinic

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