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**Care Transitions**
**Innovations in Intervention**

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In the year following passage of the Affordable Care Act (ACA), nurses across the country are embracing the challenges and benefits presented by healthcare reform and the environment it is creating. As more people require medical care with fewer resources, the ACA speaks directly to and supports the need for recruiting new nurses into the profession, promoting career advancement and improving patient care delivery.

This advancement and growth of the nursing profession is vital within each practice area, especially as it relates to the critical period when patients transition between these settings. In a system that is becoming more complex with no clearly defined specific responsibilities for effective patient hand-offs, nurses are a fundamental link for reducing transitional problems and ensuring patient safety. Their attention to detail, from patient education to ongoing advocacy after discharge, is the driving component to overcoming transitional challenges.

Cleveland Clinic nurses are at the forefront of developing innovative transitional care programs. Over 11,000 nurses are dedicated to working together seamlessly across the Clinic’s health system to collaborate and deliver advanced care that meet each patient’s needs.

In this issue of Notable Nursing, we share some best practices in transition care created and used throughout various settings — from the pediatric intensive care unit to palliative care — by our advanced practice nurses and their teams. These unique programs speak volumes to our nurses’ commitment to creating solutions for patients and their families.

Additionally, we examine our efforts inspired by the Institute of Medicine (IOM)’s report on the Future of Nursing. The report’s four key directives and their impact on nurses’ roles, responsibilities and education were detailed this past summer at our Nursing Leadership Summit by IOM report Committee Member, Michael R. Bleich, PhD, RN, FAAN, of Oregon Health & Science University. Dr. Bleich reminded each of us that nursing is the only discipline that studies the person in the context of family and community — a trait that is the glue for patients throughout their care.

The Zielony Institute is proud of our collaborative spirit and dedication to excellence. Our exceptional transitions in care innovations and Institute of Medicine-driven programs are key examples of our commitment to deliver on the promise of world-class care.

I hope you enjoy reading about the advances we make each day in nursing.

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Cleveland Clinic is proud to support the Forest Stewardship Council® (FSC®) certification helps ensure that the world’s forests are managed in a positive manner: environmentally, socially and economically.
Healing Hearts Beyond Hospital Borders

Extending patient care beyond the hospital walls helps to bridge the gap between discharge and primary care, reducing risk of complications during a vulnerable window of time.

Hospital readmissions are under the microscope. Beginning October 2011, Medicare will begin holding healthcare providers accountable for the cost and quality of care they provide by linking payments with process-of-care measures.

As the new law will initially focus on acute myocardial infarction and heart failure, nurses at Cleveland Clinic’s Sydell and Arnold Miller Family Heart & Vascular Institute are part of teams initiating programs to improve the transition from hospital to home and reduce the number of preventable readmissions.

On the front lines, nurses are key players in preparing patients and families for a successful transition to home. Through frequent coaching and recurring follow-up initiatives, the institute is aiming to extend care beyond the hospital walls and fill the gap between the time the patient is discharged and the time they see their healthcare provider for the first follow-up.

Maureen O’Malley, MSN, RN, CNP, guides patients in her role as nurse practitioner in the Section of Heart Failure and Cardiac Transplantation.
Connecting beyond the hospital

Providing continuity of care and maintaining a connection with patients after they leave the hospital was part of the motivation behind the 48-hour and 10-day follow-up calls, which all patients in the institute began receiving in June of this year.

“All patients are getting a phone call by a nurse and they’re being asked a series of questions related to symptoms and medications and to make sure that they don’t have any questions after they’ve left the hospital,” says Betsy Stovsky, MSN, RN, Manager, Heart & Vascular Institute Website and Resource & Information Center. “All patients get a call within two days after discharge, and we are currently evaluating whether all patients require a 10-day call.”

In the series of post-discharge follow-up calls, nurses check the patients’ status, make sure they are taking their medications appropriately, determine if they have any new or increasing symptoms and address questions that they may have upon their return home. Patients also receive a magnet with a phone number they can call if they have any questions or concerns. The phone line is staffed weekdays from 7 a.m. to 7 p.m. by nurses from the Heart & Vascular Institute. After hours and on weekends, the calls roll into their call center.

“A lot of the calls are related to education issues about medications or discharge instructions,” Stovsky says. The follow-up nursing service provides another way for nurses to continue to educate and track patients. If the patient has more urgent issues, the nurse will triage the call to a nurse practitioner who will contact the patient directly to address issues. Data is being collected on patients who receive program services, and it will be reviewed monthly to determine if the program is associated with readmission rates and patient satisfaction scores.

“We also want to look at trends in issues that patients identify during phone calls to determine if opportunities exist in implementing process improvements before our patients leave the hospital,” says Stovsky. For example, noting trends in issues that arise in patients with heart failure after discharge or common questions among cardiothoracic surgery patients will help nurses provide better care while patients are in the hospital, and may minimize those same issues in the future.

“We are not sure if the phone call itself will make an impact on readmissions, or maybe it will be the issues discovered during the calls that will assist the healthcare team in helping patients plan better for when they go home. I do think it will make an impact in some way. Right now, patients seem very happy to have access to a nurse when they return home,” she says.

Following through the continuum of care

Follow-up efforts are also being made by coordinating a seven-day post discharge appointment for patients with either their primary care provider or, preferably, their cardiologist or advanced practice nurse in the heart failure clinic, says Maureen O’Malley, MSN, RN, CNP, nurse practitioner in the Section of Heart Failure and Cardiac Transplantation on the main campus.

“We make that appointment before the patient leaves the hospital so that they have it in hand at discharge and know when and where they need to go when they come back,” O’Malley explains.

Generally, appointments consist of a physical examination, review of lab work, collection of additional laboratory or other testing as necessary, and a subjective assessment of the patient’s current status. The subjective assessment includes an evaluation of patients’ adherence with diet restrictions, fluid management and activity and exercise aspects of the plan of care.

“One of the most important things we do is medication reconciliation and making sure patients are taking the right medications at home based on what was prescribed for them at discharge,” O’Malley says. “If there are differences, we look into why and we try to troubleshoot those issues.”

Improved patient health after discharge is reflected in the Heart Failure section’s readmission rates. Data collected for the first full year of the follow-up efforts program indicate a nearly five percent decrease in readmissions compared to pre-program. The team is looking forward to comparing 2011–2012 data with 2010–2011 data to see if the trend continues, O’Malley says.

Reducing post-discharge complications

Another team of professionals consisting of nurse practitioners, RNs and LPNs, as well as physical therapists, nutrition and occupational therapists make up the institute’s Heart Care at Home Transitional Care Program. The program aims to reduce avoidable readmissions within 30 days of discharge through three key initiatives: coordination of care, health coaching and home care follow-up appointments.
The effort began two years ago with a telemonitoring program in which patients are sent home with on-loan devices that record daily vital signs such as weight, blood pressure, heart rate and blood oxygen saturation. Nurses make weekly phone calls to address medication, coordination of care and diet. In June, the program expanded to include transition coaching to skilled nursing facilities, says Sandra Chlad, MSN, RN, CNP.

The team receives a referral from the hospital of patients who are at risk of readmission or have had frequent hospitalizations, in addition to those who would benefit from the program, explains Carol Hall, MSN, RN, CNP, Program Coordinator Transitional Care portion of Heart Care at Home. Care coordinators are trained to identify red flags that are early warning signs of high risk of readmission.

“The program actually begins when somebody has been admitted to the hospital. A member of our team begins coaching, which involves helping patients recognize early signs and symptoms of worsening status,” Chlad explains. “If patients know what to look for and what to report, they call their doctor sooner and get treatment without having to be admitted to the emergency room.”

When patients go home, nurses follow up within two days to deliver and set up monitoring equipment and review the medication schedule again. Then, nurses make weekly phone calls to ensure patients have follow-up appointments as needed. They also review dietary measures.

For patients transitioning to skilled nursing facilities, Hall consults with patients while they are still hospitalized and then follows up within 24 to 72 hours of their transition to the facility. She continues weekly, and as needed, skilled nursing care site visits to educate patients and ensure heart failure protocols are being followed. Hall also facilitates follow-up appointments to a heart failure clinic and identifies potential problems that increase this patient population’s risk of readmission.

Patients typically are in the skilled nursing facility an average of 16 to 22 days, Hall says. Upon discharge, Hall continues to coordinate care among primary care providers by consulting with physicians, home care case managers and telemonitoring care coordinators. Hall or Chlad will see patients within 24 to 72 hours of transition to home to assess the home environment, confirm medications, and reinforce health coaching of early warning signs that put the patient at risk of readmission.

Whether patients transition home or to a skilled nursing facility, the team makes every effort to avoid readmissions, Hall says. For example, patients who are seen in the Clinic’s emergency department for potential complications will have a 23-hour stay in the department’s Clinical Decision (Observation) Unit. When patients arrive in the emergency department or to an office visit, it is imperative that providers know who to call and how to reach physicians caring for patients in the skilled nursing facility. Communicating the plan of care between providers establishes appropriate hand off and may be an important factor in avoiding readmission.

The Heart Care at Home staff regularly tracks and reviews readmissions in three categories — heart failure, other cardiovascular problems and other emergencies — in an effort to identify areas of the program or processes to improve. Teams are collecting data to learn the impact of the program. A recent proxy measure of Cleveland Clinic’s Home Care Agency found by Medicare’s Home Health Care Compare showed that unplanned hospital admissions for patients in general was 10 percent lower than the state average, and eight percent lower than the national average.

“The largest impact I see is that skilled nursing facilities are coming into a new culture,” Hall says. “This includes increased critical thinking skills and early identification of warning signs on the part of the staff. Reviewing patient status before discharge allows us to see if home is the best option.
Outpatient care managers bridge gaps in care

At Cleveland Clinic’s Fairview Hospital, Linda O’Donnell, BS, MSHCA, RN, CMC, Director of Care Management, is experimenting with the concept of having an outpatient care manager bridge the gap between the time patients are discharged to the time they see their physician for their first follow-up.

“I think making sure that patients have an advocate is really what’s critical,” she says. “When you have so many various people involved, there’s so much potential for elements of care to fall through the cracks.”

O’Donnell has assigned a case manager to the group of hospitalists at Fairview Hospital who see all patients, including heart failure cases. Prior to patients’ discharge, case managers will introduce themselves to both the patients and their families, make sure patients have all the paperwork needed for optimal home care and ensure that they understand the information. Then, the case manager follows up with a phone call at 24 and 48 hours, and seven, 14 and 31 days. Case managers also check to make sure patients receive the correct medications, have follow-up appointments scheduled, understand the plan of care, and take other actions to stay healthy, she says.

The outpatient case manager also works closely with a local internal medicine family practice group and communicates with them via electronic medical record message software. The case manager will note any red flags or make sure the internal medicine team is aware when patients transition to a skilled nursing facility.

Though the program has been in place for a short time and clinical outcomes are not yet available, O’Donnell says that the response from doctors and patients has been overwhelmingly positive. She’s looking forward to identifying the impact of the program on hospital readmissions and on their Healthy Communities Access Program (HCAP) scores, which address collaboration efforts in finding and solving service gaps, access to health care for uninsured people and electronic communication and coordination of care between healthcare providers.

“Patients are very grateful that there’s someone touching base with them; they like the idea of someone being able to coordinate their healthcare and making certain they are on the right path,” O’Donnell says.

References:
Communications **Enhances** Patient Care

and that we are consistent in our communication about the patient’s care.” Accurate information in the EMR also helps nurses continue effective care as patients are transitioned within the hospital for testing or procedures.

The Nursing Institute began using an SBAR format approximately three years ago. Since then, continuous improvements and modifications have been made to reports to ensure that tools meet the changing needs of patients and communication requirements.

“Most of the Clinic’s main campus and four of its eight regional hospitals have EMR technology in place,” says Zytkowski. “Only one of nine of the health system’s hospitals is missing the SBAR handoff software. Our nurses have found this tool useful, especially when sharing key information with transport staff during transport for tests and procedures.”

Cleveland Clinic has also begun rolling out IV Smart Pumps, which wirelessly capture data directly from the hospital’s pharmacy about the medication, dosages, and even interaction warnings. Pumps are currently at three of the system’s northeast Ohio hospitals, Zytkowski explains. The remaining health system hospitals are on track to begin using Smart Pumps before the end of 2011.

An additional system-wide effort that aids in communication is the integration of cardiac monitors into the EMR in the Clinic’s intensive care nursing units. “The hemodynamic devices submit vital signs and other hemodynamic data from the monitor directly into the EMR, eliminating the need to transcribe data into the electronic record resulting in data recording being more seamless, immediate and accurate,” says Zytkowski.

**Personal and interdepartmental efforts maintain care continuum**

Ongoing communication is a key to quality care while patients are hospitalized, and it also facilitates an appropriate discharge, according to Betty Napoleon, MSN, RN, CCM, a certified case manager in the Clinic’s Care Management Department. The department, created a year ago, brings together social workers and nurse case managers to coordinate care and better facilitate the discharge planning process.

“Discharge planning starts on the day of admission,” emphasizes Napoleon. “As a team, we’re working together along with physicians and other disciplines to identify needs early in the process of the hospitalization so that resources can be put into place to assist patients most effectively when they are discharged.”

Case managers are also part of multidisciplinary rounding as a way for each team member involved to stay current on all information regarding hospital patient care activities, as well as making sure that any needs in terms of discharge are addressed early.

In terms of reducing readmission rates, case managers review discharge plans to be sure they are at the appropriate level of care so that patients will transition to a safe and supportive environment and receive the support they will need.

According to Helen Conroy, MSN, RN-BC, Director of Care Management for main campus, one way case managers aim to uphold communications and continuity of care during discharge is through a pilot program that began in July. The program is aimed at facilitating the transition of patients with heart failure from hospital to skilled nursing facilities that aren’t linked with Cleveland Clinic’s DrConnect, an Internet-based service specially developed to provide community physicians with real-time EMR information about the treatment their patients received at Cleveland Clinic.

To aid staff communication with shifts in sites of treatment, Care Management notifies the Clinic’s Referring Physician Center who in turn delivers discharge summary letters to skilled nursing facilities within 24 hours of patients’ transitions. Letters summarize patient care while in the hospital so that facilities can follow through with the care plan initiated during hospitalization.

Additionally, an optimal continuum of care is enhanced through effective patient education. “We do a lot of teaching onsite and support verbal education with literature that the patient takes home and can refer back to,” Napoleon says. “Patients are always given a follow-up phone number for appointments and additional contact phone numbers if they have questions, and they’re encouraged to use those.”
The team within Cleveland Clinic’s Bariatric and Metabolic Institute located on the main campus found that inconsistent patient adherence to self-care hydration behaviors that were discussed before hospital discharge was an important factor that prompted avoidable readmissions.

At the institute, several initiatives are unfolding to minimize complications and curb potentially avoidable readmissions in patients who undergo weight loss surgery. According to nurse manager Steve Booth, BSN, RN, one main initiative is the launching of a rehydration effort to address patients readmitted due to dehydration after surgery. Assuring proper hydration is a focus area that institute leaders believe can positively impact outcomes, he says.

Follow-up after bariatric surgery occurs at one week, one month, three, six, nine, 12 and 18 months at the institute’s clinic. Subsequently, annual visits are scheduled. The clinic’s efforts to prevent dehydration following surgery are reinforced through the evaluation of patients in the Clinical Decision (Observation) Unit or the ambulatory clinic.

“When patients present with dehydration — either discovered during a scheduled appointment or when they are asked to come in to the clinic for evaluation — they can be treated during office hours and rehydrated if necessary. During off hours, patients can be diagnosed and treated in the Clinical Decision (Observation) Unit,” says Booth. “In either treatment area, the care team assesses the stability of patients to determine if dehydration management was sufficient. The goal is to treat patients efficiently in an ambulatory setting and then allow them to go home.”

Currently, institute personnel are in the process of formalizing a protocol to manage the flow of bariatric surgery patients affected by dehydration and ensure that the current plan of care meets patients’ needs and is safe and effective. The team is using preliminary case results to determine the impact of their approach so that overall care is enhanced and patients are satisfied with their healthcare experience.

The rehydration effort is an important initiative that not only improves clinical status, but is also aimed at facilitating patient education. Adherence to dietary recommendations is a primary component of post-discharge recovery; thus, optimal patient choices regarding diet are crucial. Further, patients require education on caring for incisions, so that they heal at the expected rate. In addition, nursing staff are being evaluated on their efforts to regularly meet patients’ clinical and personal needs throughout the hospital stay. Re-education and validation of patient competency in self-care is a focus, as well as listening to patient concerns and meeting psychosocial needs. “We’re hoping to sustain positive patient satisfaction scores as a surrogate for providing essential skills that are important to patients,” Booth says.

References:
Coinciding with shorter post-surgical length of hospital stay, many non-Medicare patients are discharged directly home. In the Medicare population, researchers of large, multicenter studies found that patients recovering from major hip and knee surgery were more likely to be rehospitalized at 30 and 90 days\(^1\), and that after hip arthroplasty there was an increase in skilled care post discharge from 1991–2008.\(^2\) While survival improved, 30-day all-cause readmission increased.\(^2\)

Thus, there is a national need for transition care following orthopaedic surgery. Cleveland Clinic’s Orthopaedic and Rheumatologic Institute, in collaboration with Cleveland Clinic Care at Home, has invested in quality improvement strategies aimed at improving effective and appropriate discharge planning, providing closer outpatient follow-up care, and optimizing patient education to reduce hospital readmissions.

**Proactive Planning, Ongoing Education Reduce Orthopaedic Readmissions**

Changes in the Centers for Medicare & Medicaid Services (CMS) healthcare reimbursement guidelines have narrowed the scope of patients who qualify for acute rehabilitation following joint replacement surgery.

Capitalize on internal resources

Cleveland Clinic’s Euclid Hospital, with its large population of orthopaedic patients, reformatted its post-surgical rehabilitative therapy programs for patients having single joint replacements by creating transition linkages to either a skilled nursing unit or an acute rehabilitation unit within the hospital.

After surgery, the decision to transition to acute rehabilitation or skilled nursing is based upon a patient’s skills needs, insurance coverage and how much physical therapy they can tolerate. Alternately, patients can be discharged with home care. Rehabilitation nurse liaisons help to facilitate transitions to post acute care or home care services. Assessment is completed prior to hospital discharge to determine the best post-discharge rehabilitation venue, says Pat Kirchner, RN, Prospective Payment System manager.

Euclid hospital programs appear to be effective. Of 191 patients discharged from January 1, 2011, only two (one percent) were readmitted to the hospital during their post-acute stay.

Strong, fundamental nursing is what Susan Stroski-Duhigg, RN, Director of Post Acute Services, Sue Faint, RN, Clinical Nurse Manager of Euclid’s 46-bed rehabilitation unit, and Kristi Gogala, MSN, RN, Clinical Nurse Manager of its 40-bed skilled nursing unit, attribute a large portion of their success to.

Jennifer Lipps, RN, Cleveland Clinic’s Euclid Hospital
Successful outcomes require coordination by many caregivers. “One of the nice things about the post-acute setting is the strong interdisciplinary model,” Stroski-Duhigg says. In both the skilled nursing and the acute rehabilitation settings, the multidisciplinary team works with each patient to develop an intensive individualized therapy program aimed at helping the patient restore optimal function.

“Accurate and timely nursing assessment, infection control, patient and caregiver education, deep vein thrombophlebitis prophylaxis, and effective pain management to facilitate full participation in therapies are what make a patient’s stay successful. In addition, patient education continues to serve patients once they return home,” Stroski-Duhigg says.

Proactive steps

Education begins before patients are admitted for orthopaedic surgery. The Total Joint class at Euclid Hospital provides patients with information on the benefits of surgery, how to prepare for surgery, what to expect during and after surgery, potential risks and complications, how to ensure an easier recovery, and how to manage rehabilitation and recovery.

Through collaborative care after surgery, any red flags that develop are addressed immediately, minimizing complications and reasons for readmission. Nurses go to great lengths to assist the therapy goals by getting patients up and moving around. They also proactively educate patients on caring for their surgical incision, including training them on what the incision site should look like and what to note as potential signs of infection.

Along with functional therapy, patients are educated on adaptive equipment they might use at home to function safely and independently as they continue to develop strength. Further, upon acute rehabilitation unit discharge, patients are educated on home-going medications and follow-up physician visits. Transitioning to either outpatient care or home therapy is completed by electronic documentation transmission of current status to patients’ orthopaedic healthcare providers and home care programs involved.

Recently, the team has added a mid-level provider to continue to provide support to patients, their families and the frontline nursing staff. Laura Bobrowski, BSN, RN, CNS, works to strengthen and enhance the teams’ education, as well as be an additional support to both nursing and medicine.

“We continue to follow patients once they leave the rehabilitation program, so if a problem is identified, the therapist can communicate with the patient’s physician,” says Ruth Yodice, MHA, PT, Rehabilitation Program Administrator. Inpatient social work staff coordinates follow-up therapy based on the recommendations of the rehabilitation team. Euclid Hospital also has a comprehensive outpatient rehabilitation facility that provides the same model of care delivery, providing patients with options for continuity in ambulatory care.

Collaborative care: It works

Systemwide, transitions between acute and post acute care settings are handled with a patient-centered approach and collaboration in mind. “Interdisciplinary collaboration with the patient’s surgeon is crucial to seamless care,” says Renee Coughlin, PT, DPT, MHS, Director of Rehabilitation for Care at Home. “Patient hand-off communication between levels of care is facilitated when clinicians in each setting initiate communication with clinicians who assume responsibility for patient care at the next level. Medication reconciliation at each level, precautions and follow-up appointment arrangements are important factors to successful recovery and fewer hospital readmissions.

Discharge directly to home from acute care is quite common following uncomplicated single joint replacement surgery. In 2008, using best evidence and collaboration between Cleveland Clinic’s Home Care and the Orthopaedic Surgery Department, a process for a collaborative intervention was initiated in which the physical therapist
serves as case manager. The therapist fulfills activities that are normally carried out independently by nurses and therapists in facility-based care settings.

Outcomes data from the CMS-mandated comprehensive patient assessment form (OASIS) compares patient status at the start of home care services with patient status at discharge from home care in a number of quality domains. Data was extracted from 431 patient records related to home care services provided following a joint replacement procedure at Cleveland Clinic and discharge directly to home from acute care in 2009. When comparing data regarding home care services from start to finish, patients’ functional outcomes improved and all-cause rehospitalization was low, at 1.9 percent. The 2009 results support the ongoing process that includes continued cross-disciplinary collaboration beginning at the time of the preoperative appointment to post-discharge initiation of physical therapy services within 24 to 48 hours. Integrated care resulted in a decrease in length of stay for both total hip and total knee replacement patients, and patient experience was enhanced because patients preferred home as their recovery location.

“I believe the primary factor in helping decrease readmission rates is educating patients and ensuring their understanding of care expectations,” Stroski-Duhigg says. “If patients are well educated in the hospital, they take that knowledge and care expectations home with them and know what actions to take, what to look for and when to call the doctor.”

References:
When a patient faces a chronic disease or a finite time frame, there are often mixed emotions on the part of the patient and their family, as well as the nurses and physicians providing care. At the same time, the patient may require treatments that are unfamiliar to nurses in specialties outside of palliative medicine or hospice settings. By using palliative and hospice care services, the patient and family can work through changes in hopes and needs to ensure optimal and efficient care delivery.

Enhancing nurses’ support of patients

Educating nurses on better approaches to end-of-life care results in more options that can be used to improve the quality of patient care during stressful and upsetting periods, says Diana Karius, MS, RN, AOCN, Clinical Nurse Specialist, Hematology, Oncology and Palliative Medicine.

Karius is part of a palliative medicine team at Cleveland Clinic that is working toward educating physicians and nurses on the definition of palliative medicine and how it can complement primary and specialty care for the benefit of the patients, their families and healthcare staff. To do this, the palliative medicine team created a tool kit aimed at improving nurses’ confidence in managing patients at end of life. The kit was developed by a multi-specialty group of nurses from the Taussig Cancer Center, intensive care unit and hospice, spearheaded by Chris Shane, MSN, RN, CNS, and a graduate student.

Utilized since February 2011, the tool kit was conceived after reviewing results from a questionnaire on nurse comfort in caring for patients at end stages of life. The survey showed nurses had a desire for resources that could enhance their knowledge about skills that are important at end of life, which corroborated with the initial 2009 palliative medicine Comfort and Capability survey completed by nurses working on hospital units that had the highest death rates (cancer floors and the medical and surgical intensive care units). Not surprisingly, nurses who were more experienced in caring for dying patients and those with some training in palliative care had higher comfort levels and assessed themselves as being more capable of taking care of patients at the end of life.

The primary goal of the tool kit is to boost nurses’ confidence in caring for patients in their original environment. “Patients and families have relationships with caregivers on units where they receive their primary treatment — whatever that specialty may be,” Karius explains. “It is unfortunate that when a patient’s medical condition deteriorates and both the patient and family look to trusted caregivers for support, the patient may be transferred away from familiar environments of care. Patients, families and caregivers must develop new trusting relationships at the worst possible time of their lives.”

The tool kit binder provides information specific to nurses’ growth and includes informational sheets on resources for counseling and bereavement services nurses can share with dying patients and families. For nurses, content includes an explanation of the dying process — signs and symptoms and tips on how to interact with families and patients in situations that are beyond routine care. Nursing processes after a patient’s death are included. Additionally, the kit offers advice on medications for pain control and other symptoms, based on a palliative medicine medication formulary that nurses who do not routinely work in palliative or hospice care may not be familiar with, Karius explains.

Because response has been so positive and interest continues to grow, the next phase of the tool kit will be to complete a coaching element. Karius believes that mentoring nurses in developing a strong comfort level in patient and family engagement is important at this stage of patient and family care. Thus, using demonstration education methods, nurses will be able to visualize how experienced nurses interact with dying patients’ and family members.

Ultimately, Karius would like to see earlier collaboration between the palliative medicine and the primary service team, before reaching end of life. “Patients may live many years...
with incurable diseases. We wish to keep them as healthy and happy as possible for as long as possible,” she says. “The end-of-life tool kit is just one piece of the education process aimed at familiarizing specialty caregivers with the benefits of palliative medicine for themselves and patients.”

From approaching loss to supporting grief:
Maintaining continuity of care

Guided by a holistic approach of emotional, social and spiritual support, the Clinic’s team of hospice professionals help facilitate a plan of care discussion with the family. Further, hospice caregivers assist with making arrangements that result from care planning discussion and are a link to hospital personnel when patients go home. Moreover, hospice care members will follow up with the family after a patient’s death and provide meaningful support and resources.

The neonatal team within the Newborn Intensive Care Unit (NICU) at Fairview Hospital recognizes the value of hospice specialists in end-of-life care when the situation is appropriate. “We found that early hospice consultation provides continuity of care throughout the grieving process,” says Denise Speer, BSN, RN, Clinical Manager of the NICU.

In addition to discussing the plan of care with family members and making arrangements that facilitate the plan of care, integration of hospice services early assists with unexpected loss during the during the birth process, including pastoral care, counselor and social worker services.

“The death of a baby is never routine,” Speer says. “Nurses approach each situation individually, including the unique circumstances. Relationships between caregiver specialties are key to delivering optimal support and empathy to families.”

References:
IOM Report Inspires Efforts

Responding to the need to assess and transform the nursing profession due to demand for care and the 2010 Affordable Care Act, the Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) launched a two-year initiative in 2008 to produce a report that would ultimately make recommendations for the future of nursing. Its report, *The Future of Nursing: Leading Change, Advancing Health*, is based on recommendations from the Committee on the RWJF Initiative on the Future of Nursing, at the IOM.

Released in October 2010, the report’s four key directives explore how nurses’ roles, responsibilities and education should change significantly to meet the broadest healthcare overhaul since the 1965 creation of the Medicare and Medicaid programs.

Since its release, Cleveland Clinic nurses have used the IOM report as a launching pad for the creation and implementation of enterprise-wide initiatives.
Historically, daily interdisciplinary rounds on a nursing unit have been led by the medical team.

In January 2011, nurses in the pediatric bone marrow transplant unit at Cleveland Clinic Children’s Hospital began leading morning rounds.

Nurses provide the care team with an overview of patients’ conditions based on their previous night’s status, the most recent vital sign and fluid intake and output levels, and then cover patient-specific information requested by a physician, such as patient events and characteristics.

“The nurses, who are closest to patients, have an hour-by-hour understanding of what’s happening at the bedside. So for the nurse to lead rounds makes sense,” says Janie Burke, MBA, BSN, RN, CPN, Clinical Nursing Director, Children’s Hospital.

Other areas within Cleveland Clinic that rely on nurse-led rounds include the adult bone marrow transplant unit, palliative medicine and the cardiovascular ICU. This type of rounding helps ensure that the nurse, who implements the medical plan of care, is in agreement with the physician, patient and family on the course of patient recovery, says Burke.

Another way nurses are using their education to enhance patient care is through the teach-back method. When nurses share medical information with patients, ranging from instructions regarding medicine and diet to post-discharge care, they ask patients to repeat the information. For instance, a nurse might say, “Just so I’m sure I said it correctly, can you tell me what I said about this medication?” For teach-back to work optimally, nurses using it must be very knowledgeable about patients’ self care plans for general information and diagnosis-specific content. In addition, nurses need to be able to read patients’ cues, since it may not be obvious if a patient has health literacy or other issues that impede their ability to learn or retain healthcare information. Thus, it is up to nurse educators to use all their senses when assessing patients’ understanding of education information, so that they can respond optimally after using the teach-back method.

“When you use the teach-back method, nurses put the onus on themselves to make sure they are clear,” says Cindy Willis, MSN, MBA, RN, CMRSN, who serves as Senior Director of Nursing Education at Cleveland Clinic’s Fairview, Lakewood, Lutheran and Medina Hospitals.

Cleveland Clinic rolled out the teach-back method in November 2010 at one floor on its main campus and one at Fairview Hospital. Since then, more than 1,400 nurses at five hospitals have been trained through presentations, a video and role-playing. “Some patient satisfaction scores are increasing on discharge teaching as a result of our teach-back method,” says Willis.
Hundreds of Cleveland Clinic nurses are engaged in achieving higher levels of nursing education, says Joan Kavanagh, MSN, RN, Associate Chief Nursing Officer for Clinical Education and Professional Development.

“Our chief nursing officers’ philosophy on nursing education is in agreement with the Institute of Medicine report,” she says, adding that Cleveland Clinic encourages any nurses with an associate degree to achieve a baccalaureate within five years of being hired. Through the provision of generous tuition support, nurses are able to attain their degrees in a cost-effective manner. An online learning option is an efficient way for nurses to maintain their work schedules while taking classes.

Cleveland Clinic supports local nursing schools through the Deans’ Roundtable, a partnership that began in 2005 between Cleveland Clinic and Northeast Ohio nursing schools. Its purpose initially was to create a regional strategy to aggressively address the nursing shortage in Northeast Ohio. It has since expanded its focus to include the exploration of ongoing opportunities for collaboration and partnership between practice and academia.

Cleveland Clinic is also taking an active role in the development of advanced practice nurses through collaboration with local colleges and universities. Cleveland Clinic regularly collaborates with multiple schools to provide nurse practitioner and clinical nurse specialist preceptor hours to allow nurses to get the clinical experiences they need to complete their education. In May 2010, the first students graduated from an on-site nurse practitioner program created in collaboration with Kent State University.

Other educational programs include:

Training nurses to care for critically ill patients.
About eight years ago, Case Western Reserve University (CWRU) identified a need in its nursing program curriculum for training cardiac acute care nurse practitioners. The school approached Cleveland Clinic for help, says Janet Fuchs, MSN, MBA, NEA-BC, Senior Director, Ambulatory Nursing, because of Cleveland Clinic’s outstanding reputation for heart care. Fuchs served as the coordinator and helped develop the program, which gives students the opportunity to learn about diagnostic procedures and spend clinical time with experts at Cleveland Clinic.

Training certified registered nurse anesthetists (CRNAs).
In the 1980s, the accrediting agency for nurse anesthesia educational programs required that a master’s degree be awarded to all graduates, says Angela Milosh, MSN, RN, CRNA, Assistant Director, School of Nurse Anesthesia. So in 1989, Cleveland Clinic’s School of Nurse Anesthesia affiliated with the Frances Payne Bolton School of Nursing at CWRU and became a graduate program.

Cleveland Clinic CRNA faculty provides 50 percent of the didactics for the 28-month program, in collaboration with CRNA faculty from CWRU. Student registered nurse anesthetists (SRNAs) complete clinical work at Cleveland Clinic in specialty rotations such as cardiothoracic surgery, neurosurgery, obstetrics, pediatrics and outpatient surgery. The SRNAs average about 750 clinical cases, which is higher than the required minimum of 550 cases, Milosh says. Their clinical hours total an average of 1,700 to 1,800. “We believe that’s what they need to have to be safe, competent providers,” she says.

Pursuing a doctorate in nursing practice (DNP) degree.
In 2010, Cleveland Clinic partnered with CWRU to enhance nurses’ ability to pursue a DNP. The CWRU Frances Payne Bolton School of Nursing is noted for its legacy of excellence and tradition in nursing education. Cleveland Clinic is working on a second cohort for the on-site post-master’s DNP program to start in January 2012.
Collaboration among nurses and physicians is not optional; it’s essential.

“In an organization like Cleveland Clinic, where healthcare reform is driving change, the focus on outcomes and patient satisfaction is so important. Physicians can’t do it alone,” says James Young, MD, Professor of Medicine and Executive Dean, Cleveland Clinic Lerner College of Medicine of Case Western Reserve University and Chairman of the Cleveland Clinic Endocrinology & Metabolism Institute. “We must figure out creative ways to get physicians and nurses to work more collaboratively.”

That’s the goal of the physician/nurse collaboration committee, formed approximately 18 months ago and co-chaired by Dr. Young and Sarah Sinclair, MBA, BSN, RN, FACHE, Executive Chief Nursing Officer. Composed of nurse and physician leaders, the committee is collecting data and creating strategies to improve collaboration. “The root of the issue is professionalism, respect and communication,” says Dr. Young.

After surveying bedside nurses and interviewing physicians, the committee developed three task forces aligned around specific strategies: defining physician and nurse professionalism, creating care teams, and designing better methods for physician/nurse/patient communications centered on rounding.

Models for effective rounding already exist throughout Cleveland Clinic. “Healthcare providers that manage chronic illness know that it’s a team effort,” says Mary Beth Modic, MSN, RN, CNS, CDE, a clinical nurse specialist in diabetes. “I truly believe my opinions are solicited and utilized by physicians in providing patient care.”

The committee hopes to identify best practices within the Clinic and conduct demonstration projects on a variety of units. Collaboration is challenging in units with a broad spectrum of patients being treated by a variety of medical teams, says Dr. Young.

“We know that collaboration based on respect and positive regard is integral to transforming healthcare in this country,” says Modic. “When we work together synergistically, patients as well as society benefit.”

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Cleveland Clinic’s Nursing Informatics Department integrates countless technologies across the health system with one primary goal: “We want nurses to spend less time entering data and more time using that data for clinical care,” says Marianela Zytkowski, DNP, MS, RN, Director of Nursing Informatics.

Tools that nurses rely upon include wireless glucometers that electronically transmit lab results; communication devices that allow for texting, paging and real-time communication between nurses, patients and clinicians; and tracking boards so nurses know exactly what’s happening to patients, whether they are receiving treatments, undergoing tests or in their rooms.

At the center of the information infrastructure is Cleveland Clinic’s electronic medical records system. “The Nursing Institute was the forerunner in standardizing documentation across the health system within our electronic medical records,” says Zytkowski. “With the electronic medical records system, we are building similar documentation infrastructures across the continuum of care, so all nurses use the same format and vocabulary. We are trying to get a unified voice.”

“Nursing truly has a clinical practice model that is driven enterprise-wide,” says C. Martin Harris, MD, MBA, Chief Information Officer and Chairman of Cleveland Clinic’s Information Technology Division. That model is being integrated into other areas such as the ICU, where physicians, nurses and other allied health professionals across the system have begun to standardize data collection and increase interdisciplinary collaboration.

Better data collection ultimately leads to improved staffing. Cleveland Clinic’s new Human Resources Information System can store the qualifications, certifications and practice capabilities of all medical practitioners. When managers match that information with clinical care data, they can optimize staffing. “Our goal is to deliver the best care to patients,” says Dr. Harris. “One component of that goal is matching the right clinicians with the proper skill sets to patients with those needs.”

Finally, effective workplace planning may involve getting answers to questions through nursing research. Having an information infrastructure that allows for easy retrieval of patient data can enhance the research process. Projects that would be non-feasible with paper medical record review simply due to the time it would take to collect data may not only be feasible with electronic medical records retrieval, but may also decrease data variability and minimize missing data. The standardization processes associated with the electronic medical records system will advance research capabilities and make it easier to obtain data necessary for new knowledge.

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Nursing Research Collaborations Grow Nursing Science

Nurse researchers today play an essential role in building and analyzing the scientific foundations of nursing clinical practice. In an era when new technologies and methods are introduced at a breakneck pace, nurse researchers at Cleveland Clinic and across the country stand at the front lines, monitoring the ways those technologies and methods can be used most effectively to promote the best possible patient outcomes.

In recent years nurse researchers have increased the utilization of collaborative relationships within their own hospitals and with other institutions. Research collaborations can increase the significance of specific nursing studies, facilitate the research process and may spark new understandings in unexpected ways.

One obvious benefit of collaboration among nurse researchers at various hospitals is their ability to access a larger, more varied patient population. “This is a 335-bed hospital serving rural south Georgia,” says Bonni Cohen, MSN, RN, ANP-C, FNP-C, an instructor in the graduate school at Valdosta State University and coordinator of the Nurse Practitioner Program there. “We serve a population with high rates of heart failure and diabetes, and a large population of low-income families.”

Recently Cohen collaborated with Cleveland Clinic, which serves a more urban population, to study ways in which nurses deliver education about heart failure. “The hospitals also differ in staff training and expertise. “The majority of nurses at the two hospitals in rural south Georgia have an associate nursing degree, while at the larger urban hospital there may be a greater percentage of bachelor’s or graduate-level nurses,” Cohen says. “This mix of training adds to the diversity of the nursing sample. Comparing healthcare institutions, nursing staffs and resources additionally adds to the depth of data.” Having two different centers participate in a study improves sample size and increases the generalizability of the results.

Similarly, Karen S. Yehle, PhD, MS, RN, an Assistant Professor at the Purdue University School of Nursing, feels her research has benefitted from partnerships with more urban hospitals, including her work with Cleveland Clinic. “We are in rural Indiana, and we’re not part of a large academic health center. Partnerships enrich our data,” she says. Just as much, collaborations bring in fresh ideas. “When you collaborate with other people you bring together differing points of view, which can be very stimulating, very synergistic.”

Urban research centers likewise experience the invigorating stimulation of collaborative research. “When we step outside our own group or institution and engage with other thought leaders or clinical experts, you learn their perspectives and the new insights often bring a new richness to the project,” says Nancy Albert, PhD, CCNS, CHFN, CCRN, NE-BC, Director of Nursing Research & Innovation at Cleveland Clinic.

Albert is currently involved in a research project on heart failure, collaborating with five other research sites, one of them in Sweden. “The researcher there collected data on 100 patients, obviously a large number of subjects,” Albert says. “Our Swedish colleague helped energize the entire research team. When some research collaborators are able to meet or exceed single-center data collection goals, other collaborators may think, ‘If she can do it, I can do it too.’ The positive thoughts can help move the entire project forward.”
Collaboration uncovers practice variations

Collaborations among various hospitals also uncover practice variations that require further study to determine which clinical practices are the most effective. This year Esther Chipps, PhD, RN, Clinical Nurse Scientist at Ohio State University Medical Center, conducted a study that included over 400 neonatal nurses from seven different hospitals. The survey asked about clinical practices related to continuous positive airway pressure (CPAP), a relatively new technology recently adopted for low-weight premature infants. “We found that practices across the seven sites were highly variable, with little standardization,” Chipps says. “Because we collaborated, we were able to recognize that this is a clinical problem that should be addressed nationally.”

In addition to formal research collaborations, nursing practice benefits from close informal relationships among a variety of institutions. “Nurses need to recognize that when there is so much variability, the way their hospital is doing something may not necessarily be the best way,” Chipps adds. “We want staff to recognize the importance of picking up the phone and asking their peers at other respected hospitals, ‘Do it this way, how do you do it?’ That process should go on all the time, and at all levels.”

Academic/clinical collaborations benefit all parties

Clinical nurse researchers benefit from the advanced expertise of academics who specialize in various forms of research. “In a research-intensive university it is very common to find that 30 to 50 percent of your work time is devoted to research,” says Chris Winkelman, PhD, RN, an Associate Professor at the Frances Payne Bolton School of Nursing, Case Western Reserve University. “I am surrounded by research, it’s considered part of my job, not an add-on.”

That means Winkelman often shares her expertise with colleagues who may not be as familiar with starting or implementing a research project. “I can offer insight into Institutional Review Board processes, or constructing data collection tools, or publications and poster development,” she says.

At the same time, Winkelman values information from nurses in clinical settings about which bedside problems generate the greatest interest and deserve additional research. “Partnerships between clinical and academic settings fine-tune our research strategies,” she says. For example, in one recent research project, the clinical nurse researcher instantly knew the correct DRG codes that could be used to identify appropriate patients for the study. “In this case, my student was working on a doctoral nursing degree, and it saved her hours of time. In addition, it gave me a strategy to use in my own future research when I need to pull the correct charts for a project.”

Collaboration across disciplines

A substantial number of nurse researchers report that collaboration across disciplines brings increased depth and detail to many studies. Sandra L. Siedlecki, PhD, RN, Senior Nurse Researcher at Cleveland Clinic and an Assistant Professor at the Breen School of Nursing, Ursuline College, recently participated in a study of nutrition for hospitalized diabetic patients with two principal investigators, one a nurse and one a licensed nutritionist.

“They made a wonderful team,” she says. “Nurses are with the patients all the time, so they’re aware of the reasons people eat or don’t eat. Each nutritionist is responsible for a large number of patients, so they don’t have the same knowledge of individual patient reactions, but they do bring detailed information about what people should be getting, and the nutritional values of the trays as they are delivered.”
Yehle reports that collaboration with a pharmacist benefits nursing research significantly. "A community pharmacist looks at the issues patients face in a different way from a nurse, such as considering issues with transportation or finances that could prevent patients from taking medications," she says. "In addition, pharmacists do a great deal of patient counseling, so when we work together on research we can help patients have better outcomes."

**Research builds upon itself**

Siedlecki is particularly interested in ways of helping patients cope with pain, and one of her recent studies looked at the effects of music therapy on chronic pain. After the study was published, she got a call from a group in Canada that is putting together a larger, multidisciplinary study on chronic pain. "They invited me to work with them," she says. "This new collaborative opportunity arose naturally from the fact that when you publish and disseminate your work, people recognize your research interests and reach out to you for future projects."

Winkelman has had similar experiences after ten years of research on positioning in traumatically brain injured patients and progressive mobility ambulating mechanically ventilated patients. "My own work incorporates information from studies at University of Chicago, looking at the effects of sedation, activity and positioning in the ICU, as well as colleagues at Hopkins who are looking at team approaches to patient activities," she says. This is collaboration in the broadest sense: several teams of researchers working on related subjects to build nursing science over time.

Albert recalls one project that looked at the frequency with which nurses delivered patient education before hospital discharge. Data collection included variables such as nurse education level and their perceived comfort level related to teaching. When reviewing study results via teleconference with the multisite investigators, nurses from two hospitals began a discussion about various ways to interpret study findings.

"We started talking about the influence of nursing administration on education delivery by nurses, and the value given to patient education," Albert says. "We diverged from the initial view of study results into a new direction. We realized we needed to broaden our scope and think about the ways administrators could be an asset in fixing the problem." In this case, varied data from two different institutions, as well as cross-fertilization among researchers, led the research in a new, valuable direction.

"Nursing is a relational activity," Winkelman says. "Researchers often communicate through email, asking each other, ‘What are you working on next?’ Everyone wants to be on the cutting edge. Building relationships between nurse researchers and clinicians allows us to deliver optimal care and consistently build the evidence base for best nursing practice."

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Tracking Hand Hygiene

Phase 3 of a study that assesses healthcare workers compliance with hand hygiene policies is set to begin in early 2012.

Literature suggests that in spite of high levels of knowledge, compliance remains less than optimal.

The study, to be carried out on the dialysis unit within the Glickman Urological & Kidney Institute, will test the feasibility of using an electronic sensor system to monitor hand hygiene in the dialysis unit. The sensor system is a product of Versus Technology, Inc. Essentially, the system tracks movement of personnel, patients and equipment, but has been modified to track the use of soap and foam dispensers outside each of the bed spaces in the dialysis unit.

Michael Andersen, BS, RN, led the initial phases of the study along with Sandra L. Siedlecki, PhD, RN, CNS. They found that the sensors were not a feasible alternative to observation for the purpose of monitoring hand hygiene. During the initial study in 2010, placement of the sensors and the sensitivity of the sensors resulted in inaccurate information. Because of issues with the technology during the summer of 2010, Andersen and Siedlecki shifted the focus from sensor-generated data to observational data collection techniques. Summer interns and graduate nurses from two local universities were used as unbiased data collectors. After the 2010 study, Andersen shared results with staff and informed them of the 2011 study. A comparison of results from the observational data collection periods should be complete in September. According to Andersen, one criticism of observational methods of monitoring hand hygiene is the Hawthorne effect. However, results from phase 1 that were below expected compliance benchmarks suggest that staff awareness of being observed did not seem to artificially inflate the data.

Between the 2010 study and this upcoming 2012 study, the sensors and their placement were modified. Thus, in Phase 3, researchers will determine if the sensor modification results in more accurate hand hygiene data. Data obtained from the sensors will be compared statistically to the observational data obtained during the same time frame. In addition, all staff will be surveyed regarding knowledge of hand hygiene. This longitudinal research demonstrates the continued need to address hand hygiene issues, and to identify monitoring tools and compliance interventions that will improve this important healthcare behavior.

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Similar to standard IVs, PICCs are inserted into the arms. They also have similarities to central lines in that PICC tips terminate in the central circulation, allowing administration of all infusates and easing the process of blood sampling.

“I’ve been on the PICC team for nine years and we get a lot of questions from nursing floors about PICC management. We decided that it was important to get a valid baseline of our RNs knowledge of and comfort with line management,” says study leader Helen Paolucci, BSN, RN and member of the PICC team at Cleveland Clinic’s main campus.

**10-item questionnaire**

To assess the staff’s level of PICC-line understanding, a 10-item questionnaire was administered to RNs on two colorectal surgery floors. Units were selected because they had a high number of PICCs among their patients. The questionnaire was assessed for content validity prior to initiating the research. It included multiple themes associated with PICC management.

**Results show high level of comprehension**

“Our nurses did very well,” says Paolucci. “Overall the total knowledge score was 81 percent correct. When we looked at individual questions, scores were perfect on 40 percent of the items.”

PICC management themes with 100 percent scores included knowledge about the steps needed to draw blood from the line, care of loose or soiled dressings and movement limitations. Scores were lower (78 percent correct) for nurses’ knowledge of steps needed when admitting a patient with a line that had migrated out.

The questionnaire also identified some areas for improvement in nurses’ knowledge of PICC management. Half of the respondents knew the first steps to take when admitting a patient with a newly placed line. Fifty-five percent were familiar with actions needed when a line could not draw blood after being flushed.

“The goal was to make RNs more aware of knowledge gaps that could be improved on through inservice education or practice. Ultimately, the goal is to better understand patients’ needs regarding PICC management,” says Paolucci. “Overall, the comfort level of study participants was high and was positively associated with the total PICC management knowledge score.”

The questionnaire included an assessment of teaching resources nurses can use regarding PICC management; thus, nurses who participated in the research were reminded of the various teaching resources available to them to help answer their questions. Resources include computer programs and Cleveland Clinic’s Intranet. Paolucci and the rest of the PICC team complete training of their colleagues following catheter placement and are available as needed for consultation.

“Our workload has increased dramatically from 483 PICCs inserted when I first started in 1993 to more than 4000 PICCs and midline catheter insertions last year,” she says. “This means constant teaching and follow-up to make sure our infection and deep vein thrombosis rates remain as low as possible. The more our RNs know, the better the quality of care becomes.”

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“We currently use a five-item scoring tool to assess a patient’s readiness for discharge,” says Lori DeWitt, MSN, RN, CAPA, CPAN, who is Cleveland Clinic’s main campus PACU and Same Day Surgery Assistant Director. “There was a concern that the scoring tool did not capture all of the things a nurse had to assess before deciding if the patient was ready to take the next step in their recovery.”

Since patient readiness for discharge involves more than the currently used tool covers, a new nine-variable tool was designed. It was then reviewed by Cleveland Clinic’s staff anesthesiologists and, after two rounds of changes and feedback, the medical director signed off on the final version prior to initiating the research study.

Four assessment items added

Four new items were added to the five already used in the assessment tool. They include pain, nausea and vomiting, temperature and heart rate. For each, scoring was created that mimicked the format used in the other items; scoring ranged from 0 to 2. In addition, two new tools were developed, one for patients undergoing spinal anesthesia and another for those given general anesthesia. “The main difference between the two new tools was in the physical activity item,” says DeWitt. “In the general anesthesia version, there were three assessment options; in the spinal anesthesia version, only two assessment options were available.”

“Putting more items into the assessment tool helps guide the transfer of a patient out of the PACU by enhancing nurses’ subjective assessment of patient status and then quantifying perceptions by objective criteria,” says DeWitt. “With the old tool, a patient may have a score acceptable for discharge, but still be experiencing symptoms, such as nausea and vomiting, that would preclude transfer. Nursing judgment was still needed to determine a patient’s readiness for discharge.”

After completing tool revisions, the next step was to validate that the new assessment tools (based on anesthesia type) made a difference. The research design involved having nurses score a patient’s readiness for discharge using both the current and new tools. Nurses continued to deliver standard care during the study, inputting the discharge score of the original tool into the computer and discharging patients as indicated. Simultaneously, nurses completed the new assessment tool on paper. They also recorded the actual time that patients met discharge criteria using both the current and the new tools to determine if having extra criteria for discharge shortened discharge readiness time.

Out of PACU 23 minutes sooner

When assessing actual time of readiness for discharge in patients given general anesthesia, the difference in readiness was 23 minutes less when using the new assessment tool compared to the current, usual care tool. There was no significant difference in time to discharge readiness in patients given spinal anesthesia.

“We found benefit using the newer assessment tool,” says DeWitt. “Patient safety is the ultimate goal when discharging a patient from PACU. The new discharge readiness tools can assist nurses in providing safe care by decreasing the subjectivity of discharge readiness. Nurses may have greater comfort in trusting that patients are actually ready for discharge based on the tool’s score.”

Safety and efficiency

DeWitt thinks that when the new assessment method is fully implemented it will meet the twin objectives of getting patients safely through the surgical recovery process and meeting Cleveland Clinic’s goal of being the most efficient hospital in the community.

“The new assessment process will increase both patient safety and efficiency,” she says. “This is a very nice combination when you can get it.”
Since 2002, Cleveland Clinic health system has honored deserving nurses with the Hall of Fame Award. Nurses are nominated by hospital employees, physicians, patients and volunteers. Then nurses are chosen from each hospital, and all winners and their guests attend an award dinner and ceremony.

This year’s winners:
Awards

Cleveland Clinic Receives National Award for Sustained Improvement in Eliminating Central Line Associated Bloodstream Infections (CLABSI)

At the recent 2011 National Teaching & Critical Care Exposition in May, the American Association of Critical-Care Nurses recognized two Cardiovascular Intensive Care Units on main campus and Cleveland Clinic’s Medina Hospital Intensive Care Unit with the Sustained Improvement Award for Achievements in Eliminating Central Line Associated Bloodstream Infections (CLABSI) by the U.S. Department of Health and Human Services, Office of the Assistant Secretary of Health, Office of Healthcare Quality and the Critical Care Societies Collaborative.

Myra Cook, MSN, RN and Laura Schenck, BSN, RN of main campus and Kathleen Burns, MSN, RN, of Medina Hospital represented the units.

Esther Bernhofer, MSN, RN-BC, received the Research Grant Award from the American Society of Pain Management Nursing (ASPMN) in July 2011.

Betty Crighton, BSN, RN, recently received the Clinical Excellence Award from the Academy of Medical Surgical Nurses (AMSN).

Diane Daiber, RN, SANE-A, was awarded the Patron Award from the International Association of Forensic Nurses in October 2011.

Lori DeWitt, MSN, RN, CAPA, CPAN, received the Mary Hanna Memorial Journalism Award from the American Society of Post Anesthesia Nurses (ASPAN).

Colleen Forster, BSN, RN, CPN, was awarded an Excellence in Clinical Practice Award from the Society of Pediatric Nurses (SPN) in April 2011.

Debbie Klein, MSN, RN, APRN-BC, CCRN, received a Circle of Excellence Award from the American Association of Critical Care Nurses (AACN) in May 2011.

Tara Malbasa, MSN, RN, CPNP, CPON, was awarded the Jean Fergusson Excellence in Pediatric Hematology/Oncology Nursing Practice Award by the Association of Pediatric Hematology/Oncology Nurses (APON).

Kitty Ribar, BSN, RN, received the Administrative Excellence Award from the American Academy of Ambulatory Care Nursing (AAACN) in April 2011.