Feature Story

Examining the Complexity of Nursing Practice

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Think about it. Multiple patients, each with varying levels of anxiety. Patients needing discharge instructions. Others requiring assistance with the simplest tasks. New patients are admitted. Physicians direct changes to previous care instructions. Family members ask for updates and reassurance. In addition to managing multiple patients, their families and physicians, there’s the challenge to integrate evidence-based practices into daily clinical care. No two days are alike.

Welcome to the “complexity of patient care,” a concept that encompasses everything from integrating research into clinical care to how we adapt and manage the constant changes and patient variables that occur during a “typical” shift.

In this issue of Notable Nursing, we examine how complexity of patient care impacts our daily duties as nurses – and how Cleveland Clinic staff is developing innovative ways to cope with its demands and challenges.

In the cover story, Christina Shane, MSN, RN, AOCNS, a Clinical Nurse Specialist at Cleveland Clinic, refers to nursing as a dynamic process requiring communication and adaptation to strengthen healthcare delivery and to improve patient outcomes – in short, to bring order to complexity.

I’m proud of how our nursing staff responds to this dynamic process and the positive ways they approach the complexity of patient care. By doing so, they continually improve the quality of care provided at Cleveland Clinic.

I hope you enjoy reading about our plans and efforts.

SARAH SINCLAIR, RN, BSN, MBA, FACHE
Executive Chief Nursing Officer
Chair, The Stanley Shalom Zielony Institute for Nursing Excellence

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Examining the Complexity of Nursing Practice

Today’s healthcare environment requires nurses to manage multiple demands with effective strategies.

As a nurse scholar, Patricia Ebright, DNS, RN, is a recognized expert in the emerging field of complexity science. She has studied how nurses prioritize care and factors that determine decision-making. This is important because nurses are the only healthcare professionals who provide care to several patients simultaneously. Ebright’s seminal research was the first of its kind to examine the relationship of work complexity to performance behaviors of registered nurses during actual work situations.
The renowned Ebright, an Associate Professor in the Department of Adult Health at the Indiana University School of Nursing, visited Cleveland Clinic in October to deliver her presentation “Understanding What We Do: The Complexity of Nursing Practice and Incorporating Evidence-Based Practice into Nursing Care.” Her remarks resonated with the nurses in the audience including Christina Shane, MSN, RN, AOCNS. Shane is a Clinical Nurse Specialist (CNS) and was one of the people responsible for facilitating Ebright’s presentation to nurses in Northeast Ohio.

Shane’s role as a CNS at Cleveland Clinic reinforces the intricacies of decision-making that Ebright’s work has revealed. “One of the things CNSs do is identify potential problems and help nurses work through those issues,” Shane says. She is one of about 30 Clinical Nurse Specialists on Cleveland Clinic’s main campus. Each CNS is responsible for one or more units and is actively engaged in assisting nurses with prioritizing care, deciphering the significance of subtle patient cues, and resolving system issues that may impede the delivery of safe patient care. “We help identify and bridge the gaps between current research findings and upgrading clinical practice in order to improve patient outcomes,” she says.

Managing Complex Patient Variables in Daily Nursing Practice

One of the major areas of Ebright’s research focuses on the expanding realm of patient complexity. It has been suggested that clinicians now have a large armamentarium of treatments to manage the more than 13,000 diseases, syndromes and types of injury identified by the World Health Organization international classification of diseases. Nurses are responsible for implementing the medical plan of care as well as managing crises, preventing hazards in a technological environment, evaluating patient response to therapeutic interventions, educating patients and their families about the medical regimen and ushering patients into death. In order to address these competing time demands, Ebright identified six care management strategies that nurses use successfully in their daily practice: stacking, anticipatory thinking, proactive monitoring of patient status, delegating and handing off care strategically, stabilizing and moving on, and using memory aids.

Shane gives an example of managing the demands of multiple patients on her oncology unit. A nurse may be addressing the anxiety of a newly diagnosed patient who is worried about...
Patricia Ebright’s seminal research was the first of its kind to examine the relationship of work complexity to performance behaviors of registered nurses during actual work situations.

the potential side effects of chemotherapy, a patient who is experiencing unrelenting pain, a patient who is immunosuppressed and febrile and a patient whose blood pressure is dropping.

“Lots of what nurses do in providing care for patients is invisible; you can’t put it on a to-do list and check it off.” Shane says. Shane quotes Marjorie Wiggins’ writing from On the Edge; Nursing in the Age of Complexity: “Nursing can never be isolated from the complexities and weaknesses of the healthcare environment as the ‘nurse lives where the patient lives’ and is the link between all healthcare providers and systems that support the patient.”

Shane notes that nurses with different skill levels will respond differently to each situation and the mentoring and coaching of other nurses is another key aspect of the CNS role. Managers ensure the safe provision of care by paying attention to the “expert ratio” on the floor, otherwise known as “thoughtful staffing.” Their planning helps to ensure that the right skill mix is present for every patient. Ebright also spoke about the importance of the “right staff at the right time,” and in her presentation addressed the need for both nursing faculty and nursing administrators to examine effective strategies that support the clinical decision-making of nurses.

Shane is an admirer of Ebright’s work and feels it is important in today’s fast-paced challenging world of healthcare. “All of the things we’ve known or suspected about the competing demands upon the nurse have been validated by Dr. Ebright’s research,” she says.

AWARDS

Introduction to Critical Care Nursing, 5th edition, received the Book of the Year Award by the American Journal of Nursing in the category of Critical Care-Emergency Nursing. The book was edited by DEBORAH KLEIN, MSN, RN, CCRN, CS, of Cleveland Clinic, along with Mary Lou Sole, PhD, RN, CCNS, CNL, FAAN, and Marthe Moseley, PhD, RN, CCRN, CCNS.

KATHY HILL, MSN, CCNS, CSC, a Cleveland Clinic Clinical Nurse Specialist in the surgical ICU, has been awarded the 2010 American Association of Critical Care Nurses (AACN) Circle of Excellence Award. This award recognizes and showcases the excellent outcomes of individuals in the care of acutely and critically ill patients and their families. Kathy will be honored at the 2010 AACN National Teaching Institute and Critical Care Exposition in Washington, D.C., May 15-20.

CHRISTINA SHANE, MSN, RN, AOCNS, has worked at Cleveland Clinic for 10 years. She started as a staff nurse in the outpatient leukemia unit and has been in her current role as a Clinical Nurse Specialist in the Nursing Education and Professional Practice Development department for two years. Shane received her undergraduate degree at Ursuline College and her master’s degree at Kent State University.

MARY BETH MODIC, MSN, RN, CNS, CDE, contributed to this story.

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The intensive care unit nursing staff spearheaded an effort to implement daily rounds based on compelling changes in collaborative multidisciplinary team communication and patient outcomes at two hospital intensive care units.* In the research and quality improvement reports, after implementing multidisciplinary rounds and a rounds checklist, the care team’s understanding of goals for each patient was improved and post-implementation, intensive care unit length of stay was reduced.

Since implementing daily multidisciplinary rounds in Fairview’s 22-bed combined med-surg intensive care unit in June 2009, results have been these and more, Dudas says.

“Having the entire team together to review each patient, every day leads to faster problem resolution, higher satisfaction among patients and nurses, and better compliance with quality standards,” she reports.

“By bringing attention to a specific goal during daily rounds, we find that we can achieve a specific quality outcome and then move on to a new goal. In this way, we have improved our compliance with evidence-based practice guidelines, such as practices to reduce ventilator-associated pneumonia.”

Rounds include the charge and bedside nurses, one of the unit’s three intensivists, residents, a dietitian, a case manager, a pharmacist, the trauma coordinator, a pastoral care representative and any attending physicians who are on the unit and available. When appropriate, patients and families also are included.

“The goal is to communicate among the team about the care plan for each patient,” Dudas explains. To do this, the team uses a standardized checklist based on evidence-based best practices. During rounds, the team reviews each patient’s diagnosis, the primary issue keeping the patient on the unit, appropriateness of that placement, life support orders, respiratory risk, the nursing care plan and any issues or problems relative to the goals outlined by the checklist.

Daily rounds are the ideal time for nurses to address unresolved issues and get an immediate answer from another member of the team, Dudas says. “Rounds have turned out to be a time-saver for nurses because they can have all of their concerns addressed at a specific time,” she notes.

Night shift nurses participate in daily rounds by making notes on the rounds sheets about their concerns overnight. “This has proven to be a simple way to make sure the night staff’s needs are being taken care of,” Dudas says. “It keeps them in the communication loop and feeling part of the team.”

With 22 complex patients to cover every day, Dudas says that the biggest challenge has been to keep rounds to under an hour. Adhering to this time limit is important for keeping the physicians involved, she adds, and their support has been key to the success of daily rounds.

“The physicians see it as an opportunity to keep all members of the care team involved,” she says. “Rounds keeps us focused on delivering the best care for each patient.”

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**MICHELLE DUDAS**, RN, BSN, is Nurse Manager of the Scott Intensive Care Unit at Fairview Hospital. She earned her BSN from Regis University in Denver, Colo., and has been with Fairview Hospital since 1997. She was named to her current position in 2005.

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ER Protocol Puts Chemo Patients on Fast Track to Treatment for Neutropenic Fever

Oncology patients at Hillcrest Hospital (a Cleveland Clinic hospital in Mayfield Heights, Ohio) are benefiting from a new approach to managing chemotherapy-induced febrile neutropenia.

Febrile neutropenia is defined as body temperature > 100.4° F in the presence of an absolute neutrophil count <500–1,000 cells/ml.

“Neutropenic fever is a potential complication of myelosuppressive chemotherapy that typically presents in seven to 10 days after treatment,” explains Erika Hawley, RN, BSN, MBA, OCN, Nurse Manager for Outpatient Gynecology and Medical Oncology. “These patients are highly susceptible to infection and need a timely antibiotic onboard to avoid sepsis, septic shock and death.”

With the goal of improving door-to-antibiotic times for patients who come in through the emergency room (ER) or the cancer center with symptoms of neutropenic fever, cancer center nurses led the effort to establish a standardized care pathway for managing this complication. The pathway streamlines triage and quickly gets patients started on an antibiotic.

The care pathway allows a standard order set to be carried out as soon as the patient’s condition is confirmed. The patient’s status is evaluated according to a standard index for risk stratification in febrile neutropenia. This formula considers the patient’s absolute neutrophil count, age, co-morbidities, blood pressure, renal and liver function and oxygen status.

If the patient presents in the ER when the cancer center is open, the cancer center secretary is called and arrangements are made for immediate transport to the center’s neutropenic bay. On the patient’s arrival, nursing notifies pharmacy, draws blood and establishes access for IV antibiotics. Test results are returned in 10 minutes, and antibiotic infusion is started immediately if febrile neutropenia is confirmed.

When the cancer center is closed, patients remain in the ER for treatment and possible hospital admission, if necessary.

“The goal was door to antibiotic in less than one hour, from any point of entry,” Hawley says. In the first 18 months, times averaged 56 minutes in the cancer center and just over 60 minutes in the ER, she reports. Plus, “The anecdotal feedback from patients has been phenomenal,” she adds.

Hawley joined forces with Molly Loney, CNS, and oncologist Omer Koc, MD, to assemble a team that included an infectious disease specialist, oncology and infectious disease pharmacists, clinical nurse specialists from oncology and the ER and the Quality and Patient Safety Institute. The team defined the patient criteria and the desired outcome and developed the standard orders.

Right before the new protocol was implemented, Hillcrest oncologists sent a letter to all referring physicians explaining the new protocol. This was a simple, but effective way to communicate the goals and get their buy-in, Hawley notes.

Patient education also plays a significant role in making the protocol effective, she adds. All patients who have chemotherapy at Hillcrest have one-on-one, 45-minute visits with a PharmD who educates them about their individualized treatment plans, including febrile neutropenia, its symptoms and risks. Patients receive a red flag refrigerator magnet listing the symptoms and a wallet card that identifies them as at-risk for the condition. “When patients arrive in the ER, all they have to do is show their card, and we go into action,” Hawley says.

Implemented early in 2008, the febrile neutropenia protocol earned the Cleveland Clinic health system the Silver Safety Award for the year.

ERIKA HAWLEY, RN, BSN, MBA, OCN, is Nurse Manager of outpatient medical and gynecologic oncology at the Cleveland Clinic Cancer Center at Hillcrest Hospital. She received her BSN from East Tennessee State University and her MBA from the University of Phoenix. She is a Certified Oncology Nurse from the Oncology Nursing Certification Corporation and a Certified Chemotherapy Biotherapy Trainer through the Oncology Nursing Society, of which she is a member. Her special interest is in identifying and instituting processes that improve the safety, quality and efficiency of patient care while providing exceptional customer service. She has worked at Cleveland Clinic for six years.

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Nursing Care After a ‘World’s First’ Procedure
In December 2008, Cleveland Clinic surgeons performed the first near-total face transplant in the United States. The 22-hour procedure involved a team of eight surgeons who replaced 80 percent of trauma patient Connie Culp’s face — essentially transplanting the full face except her upper eyelids, forehead, lower lip and chin. This was the largest and most complex face transplant in the world to date.

Many Cleveland Clinic nurses were involved in Ms. Culp’s care — pre-op nurses, surgical nurses, surgical intensive care unit (SICU) nurses and nurses who provided round-the-clock bedside care for the months she remained in Cleveland Clinic’s care following her surgery and discharge from the acute care units. Several of them came together recently to share their experiences.
Nursing in the Surgical Intensive Care Unit

Ms. Culp was different from so many other SICU patients not only because of the groundbreaking new procedure she underwent, but because of her overall good health.

“She was never unstable (in the SICU). She was a young, viable woman who had an extensive surgery,” says Cindy Cleveland, RN, a SICU nurse who also handled the admission and prepping of Ms. Culp for surgery.

Her health, which was a necessary prerequisite for performing the transplant in the first place, along with her easygoing personality and positive attitude, actually made caring for Ms. Culp for nearly two weeks in the SICU relatively straightforward. “She went with the flow and never complained,” says Heather Palmlund, RN. In fact, the most complex facet of her care was the use of special cleaning solutions and creams for her newly transplanted face, according to Meghan Pishnery, RN, BSN, CCRN.

For any questions that arose, nurses had immediate access to consult with a physician. The nurses and physicians were constantly in touch with each other during Ms. Culp’s recovery. The constant contact added an unusual intensity to the situation, but was beneficial and supportive to all because of the newness of the procedure.

“It was an amazing, cohesive team (of physicians and nurses) who worked so well together,” says Kelly Lichman, RN. “It was very supportive.”

Complex Nursing Care During Recovery

During her recovery at a location near Cleveland Clinic, Ms. Culp received round-the-clock care from transplant nurses. While the hands-on clinical part of the care involved nasal and oral flushing, antibiotics and teaching Ms. Culp to take care of herself, the nurses found themselves providing another dimension of care — emotional support.
“With every patient you develop some sort of rapport,” says Bethany Walden, RN. “But they are usually only in the hospital for five to seven days. We were intensely involved with (Ms. Culp). We spent months with her.”

The nurses spent lots of one-on-one time with Ms. Culp during her recovery, getting to know her and vice versa. Because there was so much public attention on her case and her identity was being protected with heavy security, it was important that she developed trust with those who were taking care of her. The nurses said in a way they became like “personal assistants” even escorting her to medical appointments, for which she wore disguises.

“Because of [Ms. Culp’s] minimal contact with family or friends before the public announcement of her identity, we (nurses) became her family and main support system during her extended care,” says Pat Lock, RN, Nurse Manager on the Solid Organ Transplant Unit. As a result, each of the nurses developed a unique bond with her, which “probably helped her a lot,” she added.

While the nurses learned a lot from the experience of taking care of Ms. Culp on a clinical level, it was what they learned from her on a personal level that seems to have made the most impact on them. “She changed me as a person,” Lichman says. “Her spirit is amazing. You think you’re having a bad day and then you think of someone like her who has been through so much and still lives life so fully. She doesn’t have a bad word to say about anyone.”

All commented on Ms. Culp’s sense of humor, intelligence and positive outlook. She was always concerned about the welfare of the nurses taking care of her — worried about whether they had eaten and asking about their families.

“All of us feel honored to have taken care of her,” Lock says. “We all were impacted by her spirit and her personality.”
Medical information and hospital procedures are moving online, changing the way nurses and other medical professionals do their jobs. When the Cleveland Clinic Department of Nursing Informatics implemented an electronic medication administration record (eMAR) system to improve efficiency and patient safety, the team wanted to know if nurses using the system were satisfied.

Nursing Informatics worked closely with nursing managers and staff nurses during the planning and implementation process, which took several years. To help nurses learn the new system, Nursing Informatics offered a day-long training class and provided on-site assistance. “There was some resistance to the new system,” says Suzanne Gallagher, RN, BSN, MPA, Clinical Systems Analyst, Department of Nursing Informatics, “but many nurses were excited about it.”

The eMAR system is currently used by all inpatient units at the Cleveland Clinic main campus and at nine of the 10 regional hospitals. The Emergency Department is moving online this year.

Before eMAR was implemented, a physician wrote the medication order, a hospital unit coordinator transcribed the order onto a medication administration record (MAR), and a nurse reviewed the order for accuracy and faxed the order to the pharmacy where it was filled and sent to the unit. Nurses then recorded the medication administration on the MAR.

Today, physicians enter medication orders directly into an order entry system that is integrated with the eMAR system. The order is automatically sent to the pharmacy. The pharmacist verifies the order and sends a notification to the nurse, who ensures the order is accurate and later documents the administration on an electronic record.

While implementing eMAR in 2007 and 2008, Gallagher conducted a research study to learn nurses’ perceptions of the system regarding satisfaction with workload, teamwork, ease of documentation, drug information accuracy, patient safety and nurse/pharmacy communication; 719 nurses participated. Anonymous surveys were completed within one month of implementation (baseline) and at three and six months following implementation. Nearly half of the nurses were not routine computer users; but many had a strong clinical background (mean of 13 years nursing experience).

“There haven’t been many studies of nurses’ perceptions about eMAR and whether perceptions change over time. We were very interested in examining nursing satisfaction with the electronic system and learning if eMAR was perceived to improve medication accuracy and safety for patients and eased workload for nurses,” says Gallagher.

In general, satisfaction with eMAR on all themes studied improved significantly over time, except that eMAR did not enhance nurse/pharmacy communication. “Lack of improvement in nurse/pharmacy communication may be a reflection of broader communication needs beyond eMAR and also, the time it takes to receive a medication once an order is placed,” says Gallagher.

In analysis, researchers learned that nurses with more experience and those who were less comfortable with computers were less satisfied with eMAR at baseline. However, nurses have come to appreciate our electronic medication administration system. “We no longer get complaints. I hear comments like ‘how did we live without this’ and ‘don’t take it away’,” says Gallagher.

Suzanne Gallagher, RN, BSN, MPA, recently retired. She was a Clinical Systems Analyst in the Nursing Informatics Division of the Nursing Institute. She worked at Cleveland Clinic for 15 years. Gallagher received her bachelor’s degree in nursing from St. Louis University in Missouri and her master’s degree in public administration from Cleveland State University.

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Some medical-surgical units were undergoing a change in skill mix (RN and LPN), causing nurse leaders to wonder about the units’ complexity of care patterns. A change in skill mix could alter workload and add to complexity of care for staff members. Thus began a study on the complexity of care delivery.

Deborah Solomon MSN, RN, Clinical Nurse Specialist for urology, gynecology and short stay units, had difficulty finding quantitative research results in the literature that discussed the level of complexity of care by RNs and LPNs. She did, however, find a qualitative research report by Ebright, et al (2003) on the complexity of RN work in acute care settings. “This study excited me since the work and cognitive patterns of Ebright, et al rang true to me and what I had felt was an accurate depiction of care complexity in my 30-year nursing career,” Solomon says. “I wanted to explore the patterns of complexity that had emerged from the work of Ebright, et al.”

Solomon’s first step was to develop a quantitative 48-item tool based on the patterns of work and cognitive complexity of care found in the Ebright, et al report. Once developed, the tool underwent content validity testing to be sure the patterns matched the qualitative research findings. Then, a study was conducted on medical-surgical units to learn what patterns of complexity were most frequent and if patterns of complexity differed by nurse characteristics, nurse role responsibilities and nurses’ perceptions of environmental stress.

The study, which began in April 2008 and was completed in December 2009, included 38 acute care RN and LPN nurse caregivers at Cleveland Clinic. Nurses were primarily female RNs. Most had more than two years of experience on the floor and 50 percent had 10 years of experience as a nurse. Seven “work complexity” patterns and three “cognitive complexity” patterns were studied. “When we looked at the occurrence of each complexity pattern, the pattern with the highest complexity score was a cognitive pattern: nurses as patient care managers. And the next highest score was a work pattern: interruptions in immediate tasks,” Solomon says. Solomon found that work complexity patterns, but not cognitive complexity patterns, differed by nurse and workplace characteristics. She also found that complexity of care was significantly higher in nurses with more role responsibilities and in nurses with more environmental stressors.

Solomon feels this research is important. “The tool needs to be studied by more nurses and in different settings to determine its full usefulness,” she says. In any hospital, patient acuity is steadily rising and nurses’ workloads may need to be reviewed. Results could raise awareness of workload issues and lead to new work processes that decrease complexity of care. Solomon hopes to replicate this study in a larger group of nurses and in multiple hospitals that vary by acuity and setting (urban vs. community based).

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DEBORAH SOLOMON, ACNS, BC, RN, earned her associate degree in nursing from Lakeland Community College and her bachelor’s degree in nursing from Ursuline College. She received her master’s degree as a Clinical Nurse Specialist from Kent State University. She has worked at Cleveland Clinic for 10 years.

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Euclid Hospital’s Emergency Department **Redesigned** for Improved Patient Satisfaction
“In terms of patient satisfaction, one of the most common emergency department complaints is definitely waiting time,” says Richard Lowery, RN, MBA, Director of Emergency Services at Euclid Hospital. Holding time before a patient is transferred to a room, referred to as “throughput,” is a key concern.

The ED is a unique place, Lowery explains. “We initiate work for the rest of the hospital. For us to work efficiently, however, we need to communicate and collaborate well with other areas of the organization.”

The ED staff formed a team in early 2007 to examine the problem. The team developed a comprehensive list of reasons the ED couldn’t get patients admitted more quickly and also identified which areas had the worst delays. This information was shared with all hospital departments. The departments analyzed their internal processes to see what could be done to eliminate unnecessary delays. A good example of how this worked effectively, according to Lowery, was in Environmental Services. “Environmental Services uses a computer program to know which beds are dirty and which beds are clean. This information wasn’t accessible to individuals doing patient access and bed registering so they would know what beds are available,” he says. Once that changed, things moved more smoothly.
“Our biggest win for getting patients to their rooms quickly, however, was a fax report sheet,” Lowery explains. “We got input from each department on what information would be helpful for them to receive from the ED.” An ED nurse now inputs all the requested information on the fax report sheet and faxes it to the floor where the patient is going so the nurses have all of the information they need. “A small but very important thing we did on the fax report sheet was having a space at the bottom where the ED nurse puts his or her name and phone number, so the nursing unit can contact him or her directly,” he notes. “This saves a huge amount of time and frustration.”

The team also created a physician transfer order sheet that goes with the patient to the floor, so the nurses can begin care as soon as the patient arrives. The new initiative was piloted on the 40-bed medical/surgery unit the last quarter of 2007, with good results. It was then rolled out to other units throughout the hospital.

RICHARD LOWERY, RN, MBA, graduated from St. Alexis Hospital in Cleveland and has an undergraduate degree in health management from Ursuline College and an MBA from Lake Erie College. He has worked in emergency medicine for Cleveland Clinic for 25 years.

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In early 2008, the outpatient surgical nursing staff at Euclid Hospital (a Cleveland Clinic hospital in Euclid, Ohio) estimated that 10 to 15 percent of patients scheduled to have surgery didn’t come through the pre-admission testing department. The reason was that these individuals were already patients in the hospital. Unfortunately, these patients missed the opportunity to learn important information about their upcoming surgery. The surgical nursing staff felt that to optimally prepare all patients for surgery it was important to reach out to this population and educate them. So, in June 2008, they launched a new program called SPIRIT, which stands for Surgical Preparation Information Review and Instruction Team.

“We developed a packet of information for these patients that included information on cough and deep breathing, deep vein thrombosis, pain assessment, PCAs and blood transfusion,” explains Barb Lavalley, RN, Assistant Nurse Manager in the Surgery Center. “We also created a surgery instruction guide to help the patient and his or her family understand the surgical process. The guide includes basics such as not eating prior to surgery and includes information about what to expect in the OR suite.” Depending on schedules and workloads, the surgical nurses try to distribute the information packets the day before the patient’s surgery.

RESULTS from the SPIRIT program have been positive, according to Jill Sharwar, RN, Surgery Center staff nurse. “We’re now able to touch base with the majority of these patients, and they’re better prepared than they would have been. Also, the patients’ pre-op nurse was often the one who visited them with our packet. Seeing a familiar face helps alleviate some of the patients’ anxiety.” Sharwar estimates that SPIRIT has distributed about 250 pre-op information packets since the program began.

LOOKING TO IMPROVE the surgery patient experience further, however, SPIRIT expanded in August 2008 to include postoperative visits to all surgery patients. “We talk to patients in their room, asking about their surgical experience and if there was something we can do better,” Lavalley explains. “The feedback has been helpful overall. Specifically from our target population we learned that, while our information packets were helpful, these patients still had some concerns that couldn’t be adequately addressed in that half-hour visit by our surgical nurse prior to surgery.” In response to that need, the SPIRIT team developed a booklet and contacted physician offices asking them to provide the information to their patients during a pre-surgery office visit. The booklet will also be available in Preadmission Testing.

According to Sharwar, a core group of six surgical nurses conduct the post-operative interviews. More than 400 post-surgery interviews were completed between August 2008 and November 2009.
Mirroring Cleveland Clinic’s systemwide principle of “patients first,” South Pointe Hospital (a Cleveland Clinic hospital in Warrensville Heights, Ohio) introduced a host of initiatives in September 2007 to support it. “We have fully committed ourselves to a culture that promotes healing of the mind, body and spirit,” explains Laura Valco, South Pointe’s Director of Patients First. “We’ve created a soothing environment for patients.”

Ideas to create that new culture came from day-long employee retreats held off-site. Every employee attended a retreat. “We took 24 employees at a time from all different departments and levels to mix it up. During the idea generation period we asked everyone to forget about costs and other barriers and come up with ways to create the ideal hospital,” she says.

All of the ideas have been catalogued and a steering committee reviews them and decides which can be implemented immediately and those that may require more planning and additional funding. Frontline staff are always asked for their input before an idea is implemented.

Valco references a number of the ideas. “We established comfort volunteers to have more people in touch with patients,” Valco explains. “The volunteers can bring patients things like a blanket, a glass of water or the book cart.” Pet therapy also has been instituted, as has the practice of giving each surgery patient a flower after a procedure. Patients also can take advantage of bedside hand massages.

Noise has been reduced. “Eliminating overhead paging and going to direct individual paging was a very important change that everyone appreciates,” Valco says.

Three days a week volunteers bake cookies in portable ovens on carts in the corridor of each floor. The aroma draws patients and families, who help themselves to the cookies.

Customized room service is another popular idea. “Our menu is designed similar to a restaurant menu,” Valco says. “Patients can not only choose what they want to eat, but when. That’s part of our ‘Platinum Rule’ of asking the patient what he or she wants and offering choices.”

Caregivers also receive special attention. Fresh baked waffles are shared on staff appreciation days and twice a week they can take advantage of an on-site massage partially funded by the hospital. There are also designated relaxation rooms for staff where they can “take five” for a needed break.

The hospital based its program on the Planetree model. Planetree is a nonprofit organization founded in 1978 that provides education and information to healthcare organizations to encourage efforts to create patient-centered care in healing environments. The name Planetree was taken from the roots of modern Western medicine — the tree Hippocrates sat under as he taught some of the earliest medical students in Ancient Greece.

“To make this work, our staff underwent a cultural shift in the way they see their jobs,” says Valco. “We work every day to personalize, humanize and demystify the healthcare experience for our patients and their families.”

Laura Valco graduated from Cleveland State University with a master’s degree in education, focusing on adult learning and development. She has been with Cleveland Clinic for 10 years. Prior to her current position at South Pointe Hospital, she was program manager in the Community Relations Department.

Email comments to valcol@cchseast.org

Left to right: Tish Glover, RN; Kathy Doytek, RN, Amy L. Johnson, BSN, RN
Megan Nelson, RN, is co-chair of the program and was named the first “wellness champion” on her hematology/oncology unit. Wellness champions represent their units and provide information to their co-workers to encourage them to make healthy life choices. It’s Nelson’s responsibility to mentor wellness champions from as many as 40 units.

Nelson meets regularly with the wellness champions and solicits their ideas to develop best practices for the wellness program. The ideas become monthly themes, which she promotes via a specially designated wellness bulletin board located on her unit. The wellness champions then implement the themes on their own units. Several units now have their own wellness bulletin boards, Nelson says.

“The stairs challenge is the best thing we’ve done three years in a row,” she says. “The challenge for the first and second years was to simply take the stairs 12 times a month. In summer 2009, however, we ramped things up by having participants count every stair step they took and try to beat my total. That was a real challenge because I take the stairs all the time,” she says. Winners received protein bars as prizes.

There’s a significant emphasis throughout the wellness program to encourage nurses to drink enough water to stay hydrated. One of the ideas the units came up with was a competition based on the popular Food Network Iron Chef program, but without the stress of a time limit. To focus on healthy recipes, the rule was that all dishes must include vegetables or fruit. “Employees bring in salads or dishes they keep warm in crock pots,” Nelson explains. Patients, families and staff buy sample tastings for $1 each and vote for the best dish. The winner gets the money that was collected.

Other monthly themes include eating healthy snacks and going vegetarian for a month. Encouraging smoking cessation and healthy weight management are two important elements of the wellness program as well.

To encourage nurses to exercise, Nelson posted on the wellness bulletin board photos of herself performing various exercises. She is proud to have lost 40 pounds since the program began.

“I believe in the wellness program, and I know it’s greatly appreciated by our nurses,” Nelson says. “We’ve had several people lose weight, quit smoking and adopt a healthier lifestyle, which is terrific.”
MEGAN NELSON, RN, OCN, received her nursing degree from Kent State University. Nelson came to Cleveland Clinic in 2000 as an oncology nurse. She is now Assistant Nurse Manager on weekends on both the Solid Tumor and Palliative Medicine units.

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Challenges in Delivering Healthcare Education to Patients

NURSES MANAGE THE SOMETIMES DIFFICULT PROCESS

When delivering patient education information verbally, keep the instructions simple. Instructions containing medical jargon may confuse and overwhelm patients, causing them to stop listening to the information, says Mollie Secor, RN, MEd, Manager of the Cleveland Clinic Center for Consumer Health Information (CCHI).

CCHI produces education materials for every department in the hospital. While most of CCHI’s output is new, occasionally its writers and editors revise materials that have been generated elsewhere, such as information about new protocols issued for particular procedures. The challenge, then, is to translate that updated information, which usually contains complex ideas written in formal language and professional healthcare terminology, into simpler language. This must be done because eventually information in those materials will be disseminated to patients in person or on departmental websites that patients access.

Printed patient education materials should be written at an eighth-grade level or lower, and nurses should aim to use language suited for that level, Secor says. “In fact, in certain areas, it’s better to provide instructions at the fourth- to sixth-grade level. And give patients plenty of opportunities to ask questions.”

Make sure patients understand any educational materials given to them by “testing” patients with simple questions after they have read the materials, says Roberta Sas, RN, MEd, Assistant Director of the CCHI.

“I once had a patient who was too embarrassed to say he couldn’t read,” Sas remembers. “I found that out by asking him to read some instructions to me.”

Illiteracy is just one challenge nurses face when delivering patient education materials. Sas suggests that follow-up phone calls will help ensure that patients have understood any directions that had been given to them.
NURSES CREATE CANCER EDUCATION LIBRARY FROM GRANT

The Cleveland Clinic Cancer Center at Hillcrest Hospital (a Cleveland Clinic hospital in Mayfield Heights, Ohio) was awarded a $3,000 grant from the American Cancer Society to create a cancer education resource library so patients, their families and physicians can access the latest cancer information.

What was once an unused alcove off the main hallway is now a cancer resource library. Pamphlet holders and bookcases that house more than 500 books, magazines, DVDs, pamphlets and brochures line the walls. A color printer hooked into a computer enables people to read and reproduce articles from safe, established Internet sites.

Materials for cancer patients and their families address common physical and psychological questions and concerns, in addition to general information promoting healthy lifestyle choices and emotional well-being.

The resource tools were supplied by sources including the National Institutes of Health, the American Cancer Society, the Leukemia Lymphoma Society, Cancer Care Connect, the Oncology Nursing Society and the National Ovarian Cancer Coalition and The Gathering Place, a cancer support center.

“The people who benefit the most from this are patients,” says Erika Hawley, BSN, MBA, OCN, Manager of Outpatient Medical and Gynecologic Oncology at Hillcrest Hospital. “We also have information about support services and survivorship. Our latest acquisition is a book about children with cancer, to help people talk with their children about what they’re going through.”

Jill Polk, MS, CGC, Hillcrest Hospital Cancer Center, wrote the proposal that enabled the facility to build the resource center, Hawley says.

MOLLIE SECOR, RN, MEd, is the Manager of the Cleveland Clinic Center for Consumer Health Information. She received her BSN from Columbia University, BS in Elementary Education from Kent State University and MEd from Cleveland State University. She is a Certified Diabetes Educator from the American Association of Diabetes Educators, and is a member of the Northeastern Ohio chapter of the American Association of Diabetes Educators. She has worked at Cleveland Clinic for 18 years.

ROBERTA E. SAS, RN, MEd, CDE, is the Assistant Director of the Center for Consumer Health Information. She received her RN from Cuyahoga Community College, BSN from Ursuline College and MEd from Cleveland State University. Sas is a Certified Diabetes Educator and is a member of the Northeastern Ohio chapter of the American Association of Diabetes Educators. She has worked at Cleveland Clinic for 34 years.

ERIKA HAWLEY, BSN, MBA, OCN, is the Manager of Outpatient Medical and Gynecologic Oncology at the Cleveland Clinic Cancer Center at Hillcrest Hospital. She received her BSN from East Tennessee State University and her MBA from the University of Phoenix. She is a Certified Oncology Nurse from the Oncology Nursing Certification Corporation and a Certified Chemotherapy Biotherapy Trainer through the Oncology Nursing Society, of which she is a member. She has worked at Cleveland Clinic for six years.

Email comments to secorm@ccf.org, sasr@ccf.org, and ehawley@cccheast.org.
Nursing Annual SHARED GOVERNANCE Fair

More than 250 Cleveland Clinic nurses participated in the 3rd annual Shared Governance Nursing Fall Fair in November on Cleveland Clinic’s main campus. Twenty-five posters highlighting best practices were displayed and judged and nurses received continuing education credits for evaluating them.

The poster winners were:

1st PLACE
The Use of an H1N1 Manual to Improve Efficiency of Calls
(Nurse on Call)

2nd PLACE
Promoting a Healthy Work Environment
(Cardiovascular Intensive Care Unit)

3rd PLACE
Nursing Documentation: Just Do it!
(Cardiac Short Stay/PACU)

FAVORITE
Closed Staffing — Staff Satisfaction
(Surgical Acute Care Unit)

Deborah Small, RN, BSN, MSN, NE-BC (CNA), Associate Chief Nursing Officer, Clinical Practice and Research, delivered a keynote address on how nursing care drives quality. Meredith Lahl, RN, MSN, CNS, Chair of the Shared Governance Coordinating Council, delivered a presentation titled: “The Nuts & Bolts of a Shared Governance Council Chair.”
Nursing Portal Prepares Nursing Students to Work with the Electronic Medical Record

New government policies will offer incentives to hospitals using electronic medical records (EMRs); therefore, hospitals making the conversion to EMRs will expect their new nursing hires to be able to utilize this technology.

To facilitate this new skill development for nursing students in Northeast Ohio, Cleveland Clinic has launched an Internet portal access site designed to help nurses learn not only EMR skills but to understand how EMRs can actually improve patient safety. “Knowledge of how to use EMRs will be required if a student nurse wants to do a rotation at Cleveland Clinic, but a familiarity with EMRs will benefit any nurse at any institution,” says Tom Gregorich, MBA, CPHIMS, Assistant Director of eClevelandClinic.

The portal supports nursing programs at colleges and universities that are members of the Deans’ Roundtable.* The portal’s courses, which nursing students can access from any computer with Internet capability, each take about two to three hours to complete. A seminar for student nurses that covers the same topics lasts about six hours.

The nursing portal will include four courses:
- **Introduction to the EMR**: EMR components; legal and ethical issues; and benefits and challenges of the EMR.
- **Applications of the EMR for Use in Healthcare**: using EMRs as communication and educational tools for the healthcare team, patients and their families.
- **EMR Screens for Nursing Practice**: navigation of documents through the system (soon to be available).
- **Epic Screen Flow/Scenario**: a practicum (soon to be available).

Each course also contains a quiz, and the results of the quizzes can be accessed by school administrators who follow students’ progress.

"Most of today’s nursing students are already computer-savvy and have a good grasp of point-and-click.

*The Deans’ Roundtable is a consortium of deans and directors from Northeast Ohio schools of nursing and nurse leaders of the Cleveland Clinic health system. This group was formed in 2006 to address the nursing shortage needs in Northeast Ohio, especially the faculty shortage.

Continued on next page
methodology, but the portal will teach them that EMRs are a different type of document,” says Diane Jedlicka, PhD, RN, CNS, Chair of the Division of Nursing at Notre Dame College, and a member of the Deans’ Roundtable. “There are confidentiality issues involved. For example, you can’t put patient data on Facebook.”

Other aims are to get students to realize that EMRs help streamline patient management. “It’s easier for students to enter their patient information directly into a document rather than leave little scraps of paper hanging everywhere,” Jedlicka says. “The message is clear to all nursing staff — this will help you coordinate and document your patient care in a timely and efficient manner.”

Cleveland Clinic, in collaboration with the Dean’s Roundtable and University Hospitals (a Cleveland area hospital system), developed the portal. EMRs not only help improve nurses’ efficiency, but hospital efficiency as well, says Gregorich. In referring to the 2009 American Reinvestment and Recovery Act, Gregorich comments, “Any healthcare organization that can demonstrate to the Department of Health and Human Services that EMRs result in more efficient and safer care to patients will achieve a financial incentive.”

Use of the EMR is essential for the promotion of patient safety, says Anna Mary Bowers, MSN, RN, Director, Nursing Education Technology and Simulation at Cleveland Clinic.

She adds that as a powerful communication tool, patient data entered into the system is instantly available to all healthcare professionals involved in a patient’s care. Constant awareness of a patient’s status and needs is essential to the delivery of world-class care and the assurance of patient safety. Timely, prompt communication of patient data provides a means of immediate decision support to all healthcare team members who are planning and delivering patient care. Both students and experienced nurses who use the portal develop an understanding of how data entered into the EMR is shared between disciplines, moving it from simple data entry to information and knowledge that enhances patient care and safety.

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ANNA MARY BOWERS, MSN, RN, became Director of Nursing Education Technology and Simulation in 2009. She began her career at Cleveland Clinic in 1999 as a clinical instructor for Nursing Informatics. In 2004 she joined Nursing Education on Cleveland Clinic’s main campus as a clinical instructor. She became an Education Nurse Specialist overseeing the daily operations of Cleveland Clinic’s onsite school of nursing.

Bowers is adjunct online faculty for St. Joseph’s College of Maine. She is a 1976 diploma graduate of St. Vincent Charity Hospital School of Nursing. She received her BSN from Graceland University in 2001. She received her MSN from St. Joseph’s College of Maine in 2006. She is currently completing the final course in her post master’s certificate in nursing informatics at Walden University. With the exception of St. Vincent Charity Hospital School of Nursing, all of Bowers’ education has been achieved through distance education.
As Director of Healing Solutions in the Office of Patient Experience, Michelle Cameron, RN, BSN, HN-BC, is passionate about the health and wellness of Cleveland Clinic’s nurses, patients and employees.

Becoming a nurse never crossed her mind early on, she recalls. “The concept of health and wellness gradually entered my life in unexpected ways,” she explains. “My grandfather had emphysema, and as a child, I was curious about his medical equipment and trips to the hospital. My grandparents emigrated from Slovenia, and my grandmother used herbs, vitamins and exercises for her own care, along with Western physicians. She gave me her Prevention magazines. I devoured them and became curious about health and wellness.”

Cameron also helped care for the mother of her family’s pastor and found that experience interesting and rewarding. It was something that happened while she was working in a nursing home studying to be a teacher that inspired her to become a nurse. “One of the patients wanted a shower to help her with her breathing,” she recalls. “Even though the nurse on duty said it wasn’t the patient’s bath night, I stayed later and bathed her after my shift was over.” Cameron remembers standing in the hall thinking, ‘We need to treat people better. They know what they need, and we need to listen to them.’ With that, she was on her way to becoming a nurse.

According to Cameron, who was adopted, no one in her adopted family tree is in the health profession. “When I located my birth family, however, I found a tree full of nurses and medical professionals. So maybe becoming a nurse was in my genes!”

A graduate of Kent State University School of Nursing, Michelle is also board certified in holistic nursing by the American Holistic Nursing Association. She worked at Mt. Sinai Medical Center and was with the Lake County General Health District as Director of Around the Clock Home Care and Health District Home Care before becoming a Cleveland Clinic employee six years ago. Immediately prior to her current position, she was Program Manager in Nursing World Class Service, where she developed and managed the Nursing Wellness Program.

Cameron is proud of “Code Lavender,” a program she created two years ago on main campus. “It’s like ‘Code Blue’ except it’s for the human spirit,” she explains. A team of transdisciplinary healing services practitioners responds within 30 minutes to a Code Lavender that is requested for an employee, patient or families experiencing stressful demands that exceed their current capacity.

“The team members provide relationship-centered care,” Cameron says. “The focus is on offering support through a number of approaches, including touch therapies, such as Reiki, Healing Touch and massage; spiritual assistance; counseling; and therapeutic presence, among other techniques.” The healing service practitioners reached more than 6,000 employees and more than 6,000 patients and family members through Code Lavender in 2009.
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