Feature Stories

Ambulatory Nursing

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Where and how healthcare is delivered is changing. People are increasingly accessing care as outpatients. This is creating greater opportunities for nurses to be mid-level providers and to deliver the level of care and intervention once thought the provenance of primary care physicians.

A wonderful example of how nursing is responding to this “new normal” of care delivery is ambulatory care nursing.

Ambulatory care nursing is fast-paced and demanding. Ambulatory care nurses work in multiple environments that require focused assessments of patients’ needs and flexibility in responding to unpredictable circumstances. Their presence is felt throughout the range of care—from educating in wellness and prevention to helping patients manage chronic diseases to supporting end of life.

Cleveland Clinic serves as a prime example of the growing need for skilled ambulatory nurses. In 2010, we saw more than 4 million outpatient visits—an increase of 5 percent over the previous year. Visits to our 15 family health centers increased 4 percent, to close to 1.7 million. We performed nearly 130,000 outpatient surgeries last year.

The hallmark in the extraordinary level of activity and growth is ambulatory care nursing.

In this issue of Notable Nursing, we examine some best practices created and used by our ambulatory care nurses to provide innovative, skilled and quality care to our patients. We look at just what it means to be a Cleveland Clinic ambulatory care nurse.

The Zielony Nursing Institute is 11,000 people strong. We’re proud of our collaborative spirit and dedication to excellence. Our exceptional ambulatory care nurses are just one example 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.

Sarah Sinclair, RN, BSN, MBA, FACHE
Executive Chief Nursing Officer
Stanley Shalom Zielony Chair for Nursing Advancement
Chair, The Stanley Shalom Zielony Institute for Nursing Excellence

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Ambulatory Nursing: Nurses Leading Shared Medical Appointments

SMAs for osteoporosis patients

Rebecca Hall, MSN, works for Cleveland Clinic’s rheumatology and immunologic disease practice at the Lorain Family Health Center. She researched, planned and designed the format and structure that led to the initiation of SMAs at her facility in March 2008, modeling them after group visits being done there for diabetes patients. Today, she and Fady Al-Ashkar, MD, manage six groups of osteoporosis patients that include five to nine participants. While the groups meet every six months to a year, its members ultimately decide how often they will meet.

“For each individual patient, we check vitals, their lab work, and review all medications. Our goal is to improve patient adherence to treatment recommendations. We do this by fully understanding their disease and treatment plan and then helping patients understand what osteoporosis is and the details regarding their disease, such as what bone density measurements and Vitamin D levels mean,” Hall says. “By coming to group appointments, many patients discover treatments that others find effective, such as different medications.”

Each group session lasts 90 minutes, with Hall examining patients one-on-one while Dr. Al-Ashkar meets with the group as a whole. Groups consist of both men and women, with a wide spread in ages, ranging from the early 50s to mid-90s. Many benefits have become evident from the approach, including prompt access to appointments, a reduction in wait times and improved physician productivity, according to Hall.

“While the [physical] examination format for the initial and subsequent SMAs remains the same, the educational piece differs. We try to build upon and reinforce educational content of previous visits by encouraging family members or partners to attend for extra support,” Hall says.

SMAs for diabetes patients

Building on the role of educator, Phyllis A. Bruno, MSN, CDE, Diabetes Program Coordinator at Cleveland Clinic Florida, has been facilitating as the behaviorist during SMAs at the facility since they began more than five years ago. With an average of six to 12 patients per group visit, each session lasts between 90 minutes and two hours, and it’s during this time that education becomes a key benefit for patients, according to Bruno.

“After the medical assistant takes each patient’s vitals, and collects their signed consents and their documentation of home blood glucose readings, they are seen individually by the doctor. In the time in between the physician consulting with individual patients, I have a window of opportunity to step in as the ‘behaviorist’ and educate patients in a group on issues such as the meaning of their hemoglobin A1c levels and clarifying the doctor’s instructions,” says Bruno.

“Overall, we’ve seen a cost and time savings (from SMAs), and patients who take advantage of group visits also show maintained hemoglobin A1c levels of 6.5 or less.”

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.
Fingolimod significantly reduces multiple sclerosis attacks; however, it has potential serious side effects, especially with the first dose. While studies have shown that the drug’s benefits outweigh its risks, patients must be monitored during the first six hours after their initial dose, which created a need for the Mellen Center’s SMA, according to Claire Hara-Cleaver, APN.

“We started our group visits in December 2010 with 10 patients per session. While our SMA may be similar to others with a non-licensed independent provider (in our setting, a licensed practical nurse) taking vitals for each patient, the six-hour session following fingolimod’s dosage allows the nurse practitioner to give a 45-minute presentation on the ins and outs of the drug’s treatment and dosage allows the nurse practitioner to give a 45-minute presentation on the ins and outs of the drug’s treatment,” says Hara-Cleaver.

“Throughout the first eight sessions, we developed a checklist specific to the SMA — a standard protocol that each APN follows to ensure that all patients receive the same care and education.”

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SMAs for MS patients

Just as the SMA in Florida began in an effort to better meet patients’ needs, so did group visits at the Mellen Center for Multiple Sclerosis Treatment and Research (a part of Cleveland Clinic’s Neurological Institute) in Cleveland. Created in response to the FDA’s approval of fingolimod (Gilenya™), the first oral drug for multiple sclerosis, the Mellen Center’s SMA is a blessing for patients suffering from the relapsing form of the disease.

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SMAs for cardiology patients

Kathy Gambino, MSN, CRNP, Manager of Preventive Cardiology and Rehabilitation and the Women’s Cardiovascular Center, agrees that SMAs enhance the ability to provide education to patients. With a focus on cardiovascular risk prevention, including management of diabetes, high hypercholesterolemia, hypertension and metabolic syndrome, Gambino’s quarterly SMA is unique in that it includes counseling from a registered dietitian.

Group visits are based on managing a patient’s cardiovascular risk factors, such as hyperlipidemia, and how these factors affect their overall health. “We’ve found that an SMA supplements a patient’s regular visit by providing more thorough information regarding dietary means for reducing risk factors. For some patients, lack of insurance coverage for nutrition service interventions is overcome by an SMA. By incorporating the dietitian in the SMA, the visit can be billed under the nurse practitioner as an established visit that is typically covered by insurance,” Gambino says.

Gambino’s SMA is managed by nurse practitioner Loretta Planavsky and registered dietitian Julie Zumpano. Both Planavsky and Zumpano tag-team education initiatives for the group sessions through informative lectures that target specific needs of individual patients.

“Dietary services are aimed at improving serum laboratory values such as low HDL cholesterol, high LDL cholesterol, and high triglyceride and glucose levels, in addition to weight management. All play an enormous role in the care and prevention of heart disease. The education provided enhances patients’ knowledge of how physiologic factors affect cardiovascular risk. The SMA provides patients an opportunity to ask questions about how to make necessary changes based on their individual treatment goals,” states Zumpano.

While the SMA is still in the early phases of implementation within preventive cardiology, the goal is to make the program readily accessible and convenient for patients and their family members or partners who are encouraged to attend, according to Planavsky.

“Our physicians see the benefit of SMAs and encourage their patients to join based on the health advantages of optimal diet and other self-care strategies that our dietitian offers. SMAs are beneficial for everyone involved,” says Planavsky.

Flexible Staffing

Cleveland Clinic Nurses Meet Challenges

One of the largest barriers to successfully meeting the staffing-to-demand challenge is the lack of a sufficient flexible workforce.1 Healthcare has largely focused on traditional full-time and part-time unit-based staffing, with little focus on building robust float pools. In addition, traditional staffing models have used the census to determine average daily patient demand,2 without focusing on hourly fluctuations due to discharge and admission patterns. Use of traditional staffing models has resulted in less than optimal staffing across the patient day.

Cleveland Clinic developed a solution to overcome current barriers. Cleveland Clinic Staffing Resources (CCSR). CCSR is an enterprise-wide flexible staffing pool that partners with each of the 10 Cleveland Clinic hospitals to provide highly skilled clinical staff on an as-needed basis. CCSR clinical staff currently includes RNs of various specialties, LPNs, dialysis technicians and surgical technicians. CCSR recruitment plans include health unit coordinators, medical assistants and nursing assistants.

Historically, CCSR provided resources to units when they had an unplanned increase in census or were short-staffed. The group is evolving, according to Lindsay Muns, Director of Business Development. Going forward, through the use of advanced scheduling practices and staffing tools, CCSR also will help facilities coordinate with one another to make sure that they are using all resources efficiently within and across facilities. “Our goal is to become a one-stop shop for flexible staffing needs,” says Muns.

The dynamic new direction and services being offered will increase flexibility for CCSR nurses and the quality of the staff assigned to specific work areas, which is a comfort for managers who use CCSR’s services. “You know that you are getting a Cleveland Clinic-trained nurse,” notes Muns.

“That is one of our strongest selling points and the number one satisfier for our customers [managers]. The number one satisfier for our nurses has been flexibility and the ability to plan their schedules,” says Muns.

Further, CCSR will be incorporating predictive modeling into its operations so that optimal staffing decisions can be made ahead of time, rather than at the last minute. Anticipating fluctuations in hourly, weekly and seasonal demand and adjusting the supply accordingly not only results in decreased cost for the organization, but also results in increased coverage and world class care for our patients.

References:

1. Advisory Board Company, Nursing Executive Center Interview and analysis, 2010.
Positive scores show that the rounding initiative led by Cleveland Clinic Executive Chief Nursing Officer Sarah Sinclair has made a difference. More than a year ago, Sinclair began emphasizing “rounding with purpose,” which means “proactively meeting and anticipating the needs of the patient and the family.”

“It’s not just peeking your head in,” says Lisa A. Bell, BSN, Nurse Manager, Pediatrics and Pediatric Epilepsy Monitoring. Cleveland Clinic nurses are expected to make patient rounds every hour during the day and every two hours at night.

Since implementing purposeful rounding, pediatrics has seen a dramatic decrease in the use of patient call lights. As a result, the pediatrics nursing staff can better plan their schedules and spend more time getting to know patients and their families. “In pediatrics, we take care of the whole family. Our families get admitted to the hospital over and over again and get close to nurses. They really appreciate the interest we take in them,” says Kristen Powaski, BSN, Assistant Nurse Manager, Pediatrics.

Impact of Rounding on HCAHPS

Feedback from Cleveland Clinic patients about nurse responsiveness confirmed what most nurses know — that regular rounding increases patients’ satisfaction. Of the patients who responded to the HCAHPS survey, 89 percent said that a nurse visited them at least every two hours. They rated the effectiveness of the regular visits as “very good” or “good.” Patients who were always visited at least every two hours rated their satisfaction at or above the 90th percentile in most patient satisfaction areas.

On the cardiac stepdown units, rounding is discussed at weekly and monthly meetings. During each patient visit, nurses fill out rounding checklists to confirm that they have attended to the four Ps — potty, position, pain and placement. The nurse managers model purposeful rounding and ask patients if their needs are being met.

“When we execute rounding properly, you can feel it on the floor. We have very positive, happy patients,” says Josalyn R. Meyer, BSN, Nurse Manager, Cardiac Stepdown.
Rounding helps nurses identify problems before they become serious or life-threatening. While making rounds, a pediatric nurse observed a 13-month-old brain cancer patient suddenly become irritable and feverish. She recognized that he was septic and immediately called a physician; the patient was transferred to the ICU, where he was placed on intravenous antibiotics. "She saved his life," says Bell. "The physicians here really respect the nurses because they know they will call them if something isn’t right."

Frequent visits help nurses prevent patient falls and skin breakdowns and manage pain more effectively. "We can stay on top of pain because we’re in there so often. We adjust the pain medications as soon as the patient’s pain level increases," says Bell. "The physicians here really respect the nurses because they know they will call them if something isn’t right."

"When we execute rounding properly, you can feel it on the floor. We have positive, happy patients."

~ Josalyn R. Meyers, RN, BSN, Nurse Manager, Cardiac Stepdown Units

Ambulatory Nursing: An Integral, Leading Role in Today’s Healthcare Environment

Meeting a patient’s rapidly changing needs is at the core of a nurse’s role, and today this is increasingly being emphasized as more and more patients turn to ambulatory settings for their care. As an integral part of this dramatic shift in the healthcare environment, ambulatory care nurses are complex resources within the various surroundings they serve.

Due in part to healthcare reform opening people’s eligibility for services that were once unaffordable, the swing toward gaining treatment through ambulatory care is a trend that Angela Shobey, RN, witnesses each day. Shobey is an ambulatory care nurse at Cleveland Clinic’s Twinsburg Family Health and Surgery Center whose multi-dimensional role is accessed by numerous specialties. An inpatient cardiology nurse for nine years, Shobey’s move to ambulatory care has given her insight into this opposite spectrum of nursing and the demands it entails.

"Ambulatory nursing is very different from inpatient [nursing]. It’s not simple, and teamwork is essential, with registered nurses, licensed practical nurses, medical assistants and physicians all relying on each other throughout the day. You also have to be resourceful in the outpatient setting because you are often limited to what tools you have available," says Shobey.

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An ambulatory nurse’s ‘typical’ day

As the demand from specialties such as internal medicine, orthopaedics, gastroenterology and endocrinology in ambulatory care settings continues to increase, so does the need for ambulatory nurses. While Shobey manages care for a broad spectrum of patients, including those in general cardiology and neurology, the bulk of her day is dedicated to orthopaedics. From the time the health center opens, she begins reviewing more than 40 scheduled patients and the ongoing added appointments the computer screen registers every few minutes.

“Same-day scheduling is unique and allows our patients ideal access to care that they might have had to wait days for in the past, but I constantly have to check the schedule to make certain we can meet every patient’s needs," Shobey says. Housed in a small office she shares with two physicians, an orthopaedics resident and a medical assistant, Shobey’s role is not limited to monitoring appointments. Anyone dropping in will be surrounded by the continual hum of physicians’ dictations and countless requests for her to prepare cortisone injections while she staffs a continually ringing phone line with patients’ requests. Fielding requests regarding pain management and referrals to specialists, managing insurance denials for testing, and steroid injection reimbursement are a normal part of her day.

“You can’t be in this position straight out of nursing school. This role requires experience and a breadth of knowledge as to how the pieces of a patient’s care interconnect. There..."
just two years ago now has a perioprosthetic humeral fracture, and after a quick X-ray, Shobey and the team of physicians determine that the patient needs an immediate referral to Cleveland Clinic’s main campus. Within 15 minutes, calls made by Shobey make this happen.

"Each day changes, minute by minute. Technology can both help and hinder our ability to keep our skills up-to-date for best patient care management. Also, in this environment, we are required to be skilled at assessing symptoms, understanding medication changes and, most importantly, educating patients about the plan of care," says Shobey.

Ongoing education
Teresa Rowe, RN, understands the high priority patient education plays in ambulatory care. With nine years of inpatient nursing experience, Rowe has spent the last eight years as an ambulatory nurse at Cleveland Clinic’s Wooster Family Health Center. With her primary focus on gastroenterology services, most of Rowe’s day is dedicated to delivering education that is necessary for each patient’s overall treatment.

"Although patients are usually healthy when seen [in ambulatory gastroenterology], they often don’t understand the importance that diet and preparation for endoscopy play, the significance their discharge instructions have on their care, and how crucial medications and their potential interactions with other drugs can be," explains Rowe. "In this role, your attention needs to be centered on those who need the most care — in this case, the elderly, who often don’t understand much of the information we give them. It’s my job to keep repeating the information in hopes that they’ll gain an understanding before going home."

Building on communication is key for wellness and health promotion for ambulatory patients, while also a primary piece for the professionals who deliver care. With an eye toward a more holistic approach, those who serve on an ambulatory care team rely on each other for a patient’s overall care, according to Shobey.

"In this world, we face everything from reimbursement concerns to a patient’s emotional issues due to their illness or lack of recovery from surgery to emergent care needs — all happening between each 10-minute slotted patient visit. It’s the broad scope of each day that relies on our experience and teamwork to give our patients the best care," she says.

Ambulatory care by phone
Both Rowe and Shobey acknowledge that their role as ongoing patient educators relies on repetition, and many of the calls they receive during office hours are for a patient’s reassurance. Yet, when the office closes, Cleveland Clinic’s telehealth program, Nurse On Call, is a valuable resource for their patients. A form of ambulatory care, telehealth nursing is growing to meet the needs of follow-up care as well as preventive health information due to patients being discharged earlier than in the past. It involves offering medical care or advice through electronic means, whether by telephone, online or videoconferencing. The American Academy of Ambulatory Care Nursing states that telehealth is an integral part of ambulatory care nursing, with nursing informatics — computer skills, interviewing and interpretation of information given by the patient — being required to provide safe, patient-centered care.

"We manage calls from 1,032 physicians’ patients, which includes questions on everything from the needs of infants to centenarians," says Gina Tabone, MSN, RNC, Nurse Manager, Nurse On Call.

Keeping the 45 part-time nurses who field Nurse On Call’s requests current on the latest medical information is imperative, according to Tabone, who has been with the program for more than 10 years and serves as its education and protocol specialist. To ensure the best telehealth care, each nurse on the team is required to complete annual competencies and attend monthly staff meetings that often feature experts from various Cleveland Clinic Institutes.

"Because our staff works 24 hours, seven days a week, not everyone can make every meeting. To make certain they receive the latest education information for our patients, we’ve recently begun videotaping the meetings and posting each meeting’s minutes on our Intranet to be accessed for their guidance," Tabone says.

Email comments to notablenursing@ccf.org.

"We manage calls from 1,032 physicians’ patients, which includes questions on everything from the needs of infants to centenarians," says Gina Tabone, MSN, RNC, Nurse Manager, Nurse On Call. "We are a dotted line to their next level of care, and our telephone triage relies solely on listening to the patient.”
Caring for transplant patients

Michelle Lard, MSN, CNP, a nurse practitioner in the Nephrology Department Long-Term Post-Transplant Clinic, works a few days a month at an Express Care clinic at a Cleveland Clinic family health center. Treating healthy people with acute problems like sinus infections couldn’t be more different from her day job: caring for outpatient kidney and pancreas transplant patients. “I see people for 10 minutes [in Express Care],” says Lard. “I couldn’t review my [transplant] patients’ medications in 10 minutes!”

While Lard enjoys the change of pace, her greatest satisfaction in working in the post-transplant clinic is “building long-term relationships with patients.” She begins seeing patients about three years post-transplant, when their condition is stable and they no longer have any active surgical issues. She has the expertise to understand the unique needs of transplant patients, many of whom have comorbid conditions and side effects resulting from anti-rejection medications. Lard enjoys being a specialist and having the authority to order tests and make decisions. “I have the professional satisfaction of treating a complex population effectively,” she says.

Lard met one of her most complex patients in 2000 when she worked as a transplant coordinator. That year, Sue,* a 48-year-old woman with a history of diabetes, underwent kidney and pancreas transplants. Lard has been her healthcare provider since she came to the post-transplant clinic. “With two organs to protect, adjusting her medications is a balancing act,” she says.

Advanced practice nurses often develop lasting relationships with their patients, whom they see through some of the toughest times of their lives. Here, two Cleveland Clinic nurses recount stories of patients who continue to touch their lives, even long after their treatment has ended.

The Power of Advanced Practice Nurse-Patient Relationships

“I’m involved in so many aspects of my patients’ lives. We get to know them and their families so well over the course of their treatment, working through school issues and addressing their developmental needs as well.”

~ Holly Kubaney, MSN, CNP, CPON

*Names and ages of patients have been changed.
Over the years, Sue has undergone open-heart surgery, had a hip replacement and suffered from meningitis. Lard is the person she turns to for help with all her health problems, whether they are transplant-related or not. “I feel that she trusts me implicitly. When outside physicians prescribe medications, she always tells them, ‘I need to call Michelle,’” says Lard.

Sue also calls Lard to discuss her personal life. “Her family issues affect her as much as her physical issues. Patients need someone to talk to who knows who they are,” Lard says.

Lard has a similarly close relationship with Louis, a 32-year-old patient who had a kidney transplant in 2001. When she became his nurse three years ago, “we bonded right away.” He felt comfortable with me and trusted me. No matter what is going on, he calls me.” Lard admires his spirit. “Here’s a young man who is trying hard to live his life, working, volunteering, in his community, marrying and having a child.”

Over the years, Louis’s kidney function has declined and “we are trying to prepare him for dialysis,” Lard says. In these situations, Lard has learned that “patients need us to be optimistic but honest. That helps maintain trust.”

It is never easy for Lard when her patients have setbacks: “It breaks my heart to see someone so sick at such a young age. Sometimes you feel like this person can’t catch a break.” Fortunately, she also sees patients do well.

Helping children and their families

Holly Kubaney, MSN, CPNP, CPON, an advanced practice nurse in the Department of Pediatric Hematology/Oncology, has had her share of heartbreaking days. “But those days are overshadowed by the close, lasting relationships she has had,” says Lard.

Kubaney has been proud to witness Maria’s growth. “From a scared 14-year-old to a confident, married professional woman.” When Maria’s family celebrated her good health 10 years after her diagnosis, Kubaney was there. “How could I not help them celebrate?” she says.

Kubaney always enjoys her follow-up appointments with 8-year-old Donny, who was diagnosed with a sarcoma at the bottom of his foot at 17 months. When it became clear that amputating Donny’s foot offered his best chance for long-term survival, Kubaney helped the family find peace with the decision and reassured them that they were making the best decision to ensure the best outcome for Donny.” Still, the day she accompanied Donny’s family to the OR for his surgery was one of my top five most difficult days.”

Donny adjusted well to his prosthetic foot. During his year of chemotherapy, he was a bright light in the clinic. “He loved coming to the clinic and playing with the staff. Everyone doted on him,” Kubaney says. He continues to do well. “Somehow I want to attend his high school graduation,” she says.

On a typical day, Kubaney talks with one of the many family members who stay in touch with her. “We see families at the worst time of their lives. We support them during the difficult trauma of diagnosis through the entire treatment process. We help them live as normal a life as possible through treatment and then adjust to being off therapy and living as cancer survivors. The bonds we develop are pretty amazing.”

Forming these close relationships is easier when you have something that’s increasingly scarce in healthcare: time. For Kubaney and Lard, longer appointments are the norm. “We want to spend time with our patients,” says Lard.

In two recent studies, the Department of Nursing Research and Innovation looked at aspects of workplace relationships that can affect nurses’ job satisfaction and performance: nurse-physician communication and workplace bullying.

In the nurse-physician relationship study, 1,400 participants (800 nurses and 600 physicians from inpatient and ambulatory units representing every specialty) completed a survey covering respect, communication, collaboration and values. “We wanted to find out how nurses and physicians feel about their practice environment and how well they understand each other,” says Sandra L. Siedlecki, PhD, RN, Senior Nurse Researcher in the Department of Nursing Research and Innovation, and principal investigator for the study.

Physicians reported being treated with respect more often than nurses did, but the two groups defined respect differently. “To physicians, respect was the absence of negative behavior, while nurses felt respected when colleagues listened to what they had to say. Both groups agreed that respect and understanding each other’s roles are most important in a professional environment and reported more positive communication than negative.”

Most significant was the finding that 53 percent of nurses reported that a physician’s behavior affected their decision to contact the physician about a patient. “This has major implications for patient outcomes,” says Dr. Siedlecki. “If a nurse and physician don’t get together and share information, it can hurt the patient.”

Dr. Siedlecki is following up on this study by interviewing nurses and physicians who work well together to identify best practices that can be shared with the medical and nursing staffs.

Physicians and nurses aren’t the only healthcare colleagues who can have interpersonal issues. In a workplace bullying in healthcare study conducted by the Department of Nursing Research and Innovation in collaboration with The Ohio State University Medical Center, researchers found that any member of a healthcare team can mistreat coworkers.

The study was the first to look at bullying across a variety of hospital environments — inpatient medical-surgical, the operating room and ambulatory care — and to include nurse educators who serve in multiple hospital environments. The 223 Cleveland Clinic participants, who included nurses and other non-physician healthcare providers, completed surveys that addressed perceptions of bullying, negative acts in the workplace, emotional exhaustion and job satisfaction.

“We thought that the OR might have the most bullying, but we found that the frequency and intensity of bullying was similar across different environments,” says Nancy M. Albert, PhD, CCNS, CCRN, Director of the Department of Nursing Research and Innovation, and principal investigator for the study.

Participants reported being bullied by administrative clerical staff, technicians, physicians, nurses and nurse managers/directors. Not surprisingly, for most participants bullying was associated with emotional exhaustion and job dissatisfaction.

While only a small percentage of participants reported that they had experienced frequent bullying, a higher percentage reported mistreatment that fit the criteria for bullying. “We need to do a better job of helping people recognize bullying and understand that it isn’t acceptable.”

Bullying undermines trust among colleagues, which can have a negative effect on decisions, productivity, nurse job satisfaction, retention and patient care,” says Dr. Albert.

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Express Care

Ambulatory Nursing: Express Care

Delivering Quality, Convenient Care Through Nurse-Run Clinics

Increasing patient access to convenient, quality primary care can become a reality through the guidance of nurse practitioner-run express clinics, according to Jennifer Andrey, MSN, CNP, Director of Cleveland Clinic’s Cardiac Program Development.

A team of experienced nurse practitioners helped prompt the creation of Cleveland Clinic’s Express Care in 2009 to meet the increasing requests for walk-in medical care. Located within four of Cleveland Clinic’s family health centers throughout Northeast Ohio, the clinics provide medical attention for urgent, non-emergent health problems in patients 18 and older through evening and weekend clinical services. Nurse practitioners and their support staff provide care for patients with minor issues and symptoms, ranging from cold and flu symptoms to common rashes and sinus and urinary tract infections.
As the number of retail walk-in medical clinics continues to grow nationally (the current number is projected to double across the country by 2015), nurse practitioners are becoming a driving force for walk-in care services. The trend is evident at Cleveland Clinic’s Express Care clinics, which have treated more than 23,000 patients as of December 2010. “The primary benefits for patients are avoiding the emergency department and having the convenience of clinics within the community family health centers. Our volume has increased tremendously due to the popularity of services we provide,” says Andrea. “The benefit to me professionally is the ability to maintain my clinical skills while meeting the needs of our patients.”

Success based on demand
Express Care’s concept is based not only on a walk-in clinic’s premise but also on the detailed requests of its patients. Prior to its creation, patients throughout Northeast Ohio were surveyed on key points regarding retail health clinics. Questions included their familiarity with the care delivered by a nurse practitioner or physician assistant, the hours that one would suit them best, and their willingness to be seen at a walk-in clinic.

“We found that the more serious their condition, the more [the patient] wanted to be seen at a Cleveland Clinic facility over a retail clinic,” says Cathy Lutz, MSN, Director of Cleveland Clinic’s Nursing Regional Operations, who was instrumental in the conception of Express Care clinics. “We defined who we are and where we provide care based on demand but also on the detailed requests of its patients. Questions included their familiarity with the care delivered by a nurse practitioner or physician assistant, the hours that one would suit them best, and their willingness to be seen at a walk-in clinic.”

Express Care’s days and hours of operation vary by location, but the long-term goal is to offer care seven days a week at each family health center. In addition to nurse practitioners, the clinics consist of a team of licensed professional nurses and front-desk secretaries to aid with the triaging of patients whose families often work non-traditional hours and rely on the expanded evening and weekend clinical services. By looking at the whole picture of care from the moment the patient arrives, and by designating individuals to provide distinct services based on their training, the overall patient experience is quick, according to Lutz. “I’ve trained to do everything from the log-in of patients and vitals to point-of-care testing,” says Brian Paladino, LPN, who assists the Express Care team on a part-time basis. “It’s my role to conduct a quick triage of the patient and explain what we can and can’t provide for them, and to facilitate the next step of care if needed. This is a great experience for me due to our team — we’re successful because we can anticipate each other’s needs and the needs of the patient.”

During a recent four-hour period we saw 22 patients,” says Jeffrey Arnosti, MSN, CPNP, ACP, CCCC, who offers care at one of the clinics part-time in addition to his full-time position on Cleveland Clinic’s Kidney Transplant Team. “Patients come to us in three ways: through our Nurse On Call service, through calls to our front desk or by simply walking in. [Patient] volume is a challenge, but we are helping fill a void of care that is resulting in high patient satisfaction.”

While walk-in access to care is a primary reason for Express Care’s success, another benefit for existing Cleveland Clinic patients is the ability to have their medical history readily accessible. “We can easily and quickly review [an established Cleveland Clinic] patient’s medical history — information that a retail clinic doesn’t have,” says Rebecca Pillar, LPN, a part-time provider at another Express Care location. “Having quick access to their information aids us and the patient with timely care in an environment that has fluctuating volumes of patients.”

To continue its reach and increase patient access for Cleveland Clinic’s primary care services, an additional express clinic is slated to open within the next year. “It’s our ongoing goal to address each patient’s demand for convenience and increase patient bonds to our system, while creating another channel for Cleveland Clinic’s wellness mission,” says Lutz. “The diverse groups of nurse practitioners and their colleagues at the clinics have a lot of pride in the care they provide. By supporting each other, Express Care will continue to be a success.”

Email comments to webbaking@ct.org.

References:

This concern has gained the attention of hospitals nationwide. Cleveland Clinic began utilizing ambulatory care settings for the management of chronic conditions more than a decade ago. Today, this approach has grown into a facility managed by advanced practice nurses for the ongoing chronic care needs of patients in the four Cleveland Clinic health system hospitals on the east side of Cleveland.

“Chronic care services are the bridge between the hospital, doctor and patient,” says Karen Fagnilli, Regional Director, Vascular and Chronic Care Services for Cleveland Clinic’s eastern community hospitals. “We are very unique in our approach in that many centers offer only one component of care, such as an infusion center or a heart failure clinic. We offer comprehensive care that ranges from heart failure and wound care to pain management needs.”

Located adjacent to one of Cleveland Clinic’s community hospitals, Chronic Care Services prides itself on being a one-stop shop for its patients. For the cardiovascular patient and those suffering from heart failure, care includes monitoring labs for iron levels, treatment for chronic kidney disease, maintaining proper serum glucose levels and overall management of blood pressure, in addition to traditional medication and lifestyle management associated with a heart failure diagnosis, according to Fagnilli.

“Our nurse-run Chronic Care Services clinic works closely with physicians in order to aggressively follow each patient’s medical history. Our care is a godsend for the physician – for instance, the interventional cardiologist who may be performing a procedure and cannot break away from the case to manage patients’ ongoing needs. We’re here to fill that gap,” says Fagnilli.

Chronic Care Services’ typical patient is seen monthly to manage his or her care, and this approach is particularly beneficial for patients with chronic pain. Offering comprehensive, specialized care for conditions such as chronic abdominal, muscle and joint pain, ulcers and cancer pain, the Pain Management Center is a first line of defense for patients who are trying to avoid more invasive forms of treatment, according to Debbie Bijak, MSN, CPNP, Nurse Practitioner, Center for Neurological Restoration (a division of Cleveland Clinic’s Neurological Institute). “I see 50 to 75 patients each month, on average. [In Chronic Care Services]. My role ranges from physical exams to administering nerve block injections,” says Bijak, who also provides care for inpatient services. “But about 50 percent of my job is based on communication with patients.”

As in other ambulatory care settings, Chronic Care Services’ success is steeped with educational opportunities for its patients. A case in point is Bijak’s dedication to providing the latest information to her patients for managing their pain. Through demonstrating proper exercises, administering print resources, or education on diet modification, each patient’s condition is thoroughly reviewed and followed. After each patient visit, the advanced practice nurse discusses care needs and services provided with the patient’s doctor. “I’ve developed such close relationships with patients due to the frequency of their visits that I have their medical charts memorized. Access to services such as same-day scheduling and preoperative consultations makes the care we offer amazing,” says Bijak.

Ambulatory Nursing:
Chronic Care Services
Regional Approach Delivers Innovative Care

The statistics are telling: In 2009, 145 million people — almost half of all Americans — lived with a chronic condition. And by 2020, about 157 million Americans will be afflicted by chronic illnesses, according to the U.S. Department of Health and Human Services.
Nurse Communication and Legal Risk: Upholding Ethical and Legal Responsibility with Proper Protocol

By understanding the scope of nursing practice, nurses can avoid legal risks surrounding the issue of communicating information to their patients, according to Rosemarie Pierson, RN, BA, member of the Cleveland Clinic Ethics Committee.

One of the major principles of healthcare ethics that nurses must uphold in all patient-related situations is beneficence, or promoting the doing of good to benefit the welfare of others. Beneficence can be challenging when there is a need to talk with patients about sensitive topics. While nurses have an obligation to have crucial conversations with patients and family members to keep them informed of the patient’s health status, they may need to be mindful of patient’s rights and the breadth and depth of information they can legally offer.

“We are not there to diagnose a patient — it’s important to think about how to answer questions honestly when the response the patient is looking for is outside of a nurse’s scope of practice,” says Pierson, who is the first staff nurse to serve on Cleveland Clinic’s Ethics Committee. “While nurses may choose to divert responses to questions they are unsure about in order to avoid legal risk, avoidance is not the answer. Instead, nurses should review the question and determine what they can answer. They should begin the conversation and refer parts that are beyond their scope to the right person who can provide the patient and family with the answers they seek.”

Even as legal risks surrounding acceptable communication change frequently, nurses often can find solutions by biasing their care on respect and dignity. Cleveland Clinic’s code of conduct is based on this philosophy and encompasses honesty; being assertive but not aggressive; offering sincere apologies; delivering what is promised; avoiding excuses; giving and asking for help; giving and accepting praise along with constructive feedback, paying attention to body language; and respecting other people’s time, space and silence, according to Pierson.

To additionally aid a nurse’s communication concerns, Cleveland Clinic’s Office of Patient Experience offers H.E.A.R.T., an innovative program that teaches a consistent, empathetic approach to handling patients’ concerns and questions from the moment they arise. By Hearing the patient’s story, Empathizing with concerns, Apologizing for any disappointment, Responding to the patient, nurses help ensure that they are meeting the patient’s needs and communicating in a way that satisfies physical and emotional care needs.

Two of the biggest legal concerns related to nurses’ communication with patients involve privacy and end-of-life issues. According to HIPAA, nurses are responsible for keeping all patient records and personal information private and accessible only to the immediate care providers. If a patient’s records are exposed or privacy is breached, the liability may fall on any healthcare provider involved, but since nurses have greater access to patient charts, they may be more at risk.

Nursing by phone

Cleveland Clinic’s Nurse On Call telehealth practice adheres to stringent guidelines that ensure compliance with HIPAA regulations, according to Gina Tabone, MSN, RN, Nurse Manager, Nurse On Call.

“We require the caller to provide patient identifiers before beginning any call, which includes verifying each patient’s Cleveland Clinic identification number or Social Security number. An issue that can cause a challenge for staff is when parents request the health information of their young adult child who is 18 or older,” says Tabone. “They often don’t understand that we cannot routinely release the child’s medical information to them because they’re adults. Nurse On Call staff will facilitate the request by initiating a three-way call to include the child in the conversation and accommodate a parent’s request.”

Bimonthly staff meetings and frequent in-services keep Nurse On Call’s team up-to-date on the latest practice and privacy issues that address the best way to avoid legal risks during an encounter with a caller. It is vital that the triage nurse follow the established Nurse On Call process during each conversation.

“We always begin with an opening statement that informs the patient that he or she is speaking to a Cleveland Clinic registered nurse and that the call is being recorded. Our nurses then ask the caller, ‘How can I help you?’ The call is then classified as being either a symptom-based call, or a request for health information or guidance in selecting a Cleveland Clinic physician,” says Tabone. Any recommendation for care is always followed with the question, “Do you understand the recommendation that I provided you?” Tabone says they find that the patient may not always agree with what the nurse has advised (call 911, schedule an appointment, avoid spicy foods, etc.) — but the nurse must verify that he or she has effectively communicated the intervention to the caller. Clearly spoken statements are a way to protect both the patient and each nurse. A closing statement is used at the completion of all symptom-based calls. “If anything new develops, if anything gets worse or if you are concerned for any reason, either call us right back, or proceed immediately to the nearest emergency department.” All telephone encounters are recorded. It is essential that what is heard on the audio version of the call match the written documentation. Ensuring that audio and written reports match is a component of quality monitoring.

Practice measures in place are those that are safe and do not increase risk to remote nurses (and patients using the telehealth system). They are based on the American Academy of Ambulatory Care Nursing’s Telehealth Nursing Practice Administration and Practice Standards (2007). This helps define clear responsibilities and accountabilities for both the telehealth nurse and telehealth provider. It’s a nurse’s responsibility to make certain that everything is done and said in regard to a patient’s care is documented. If it is not recorded with the proper time and proper message, the nurse can be held liable. By maintaining up-to-date, detailed patient medical records, negative outcomes can be avoided — especially related to end-of-life issues, according to Pierson.

End-of-life care

“There are often legal risks related to [end-of-life situations],” she says. “For instance, when patients are admitted with a durable power of attorney for healthcare and/or living will, caregivers need to be sure not to misunderstand the intent as a do-not-resuscitate (DNR) order. Prior to hospital admission, a signed DNR order by the physician is not enough to constitute a legal hospital order; it must be written by a healthcare provider and signed off after admission to be considered legal.”

“Nurses need to also be sensitive to cultural differences that may impact attitudes and end-of-life issues. Further, they need to know they are not alone when faced with the often difficult task of communicating with patients. There are numerous resources to ease nurses’ communication burdens, including nurse coordinators, nurse managers, chaplains and social workers — they are there to make nurses’ jobs easier, especially when dealing with sensitive issues,” Pierson says.

Email comments to notablenursing@ccf.org.
In recent years, the notion of evidence-based design has become increasingly prominent in healthcare facilities in an effort to:

• improve patient safety
• improve overall healthcare quality
• reduce staff stress and fatigue levels
• increase effectiveness in delivering care
• reduce patient/client stress and improve outcomes

To support its efforts to provide outstanding patient experiences, superior clinical outcomes and improved quality of life for the people it serves when its ambulatory clinic opens in 2012, Cleveland Clinic Abu Dhabi (CCAD) utilized a team of experts to design a facility that incorporates the 12 fundamental factors that researchers demonstrated to be essential in creating a healing environment:

• clear way-finding
• attractive building layout
• single-patient rooms
• noise control
• large windows
• access to nature
• variable light intensity
• air quality
• positive distractions
• furniture arrangement
• finish materials
• ergonomics

Entering CCAD’s Ambulatory Clinic
Patients, family and visitors will be welcomed by a “greeter desk” when they enter, and CCAD’s way-finding system consists of a signage system throughout the hospital that is consistent in design. In the CCAD lobby, nature extends indoors, and the reception desks will draw people to them with warm wood tones and illuminated counters.

The Family and Visitor Waiting Area
CCAD will be an entirely transparent building, allowing optimum light throughout the facility, including in patient rooms. Bright light, whether natural or artificial, has been shown to improve patients’ health and reduce depression (1-3). Exposure to morning light is believed to improve outcomes in depressed patients (1-3). At CCAD, indirect cove lights, downlights and exam lights have been designed to provide varied illumination for patient comfort and clinical light levels, and allow for exposure to intense bright light that has been associated with decreased stress level and less pain (4).

Researchers also found positive distractions to have an encouraging effect during visits (5); thus, the design of CCAD was created to allow patients, visitors and staff to enjoy the surrounding natural environment. The stone and wood palette introduces the warm tones of the desert into the waiting rooms.

Organization of the facility is concentrated in a “bull’s-eye.” Gathered in each bull’s-eye are the clinical staff work areas, providing convenient travel distances and a visual center. Two separate spines provide efficient and distinct access for patients and staff. The east-west spine provides access for patients as they move through the waiting area to the exam rooms. The north-south spine enables connectivity between departments and the ability to cover other areas safely and efficiently.

Special attention was given to furniture arrangement and finishing materials. Patients are often very anxious and stressed when entering exam rooms. So, to relieve stress, clinic exam rooms have been designed to convey a spa-like atmosphere by incorporating peaceful and soothing colors and textures. Head wall panels slide to reveal medical gas connections, scopes and other clinical instruments hidden within. To relieve the horizontal surfaces of clutter, the material carts, paper towels and cleaning supplies are housed within the cabinet casework.

References:
The two-day program is led by Cleveland Clinic’s top executives, including Executive Chief Nursing Officer Sarah Sinclair, RN, BSN, MBA, FACHE; Chief of Staff Joseph Hahn, MD; Chief Financial Officer Steven Glass; Chief Information Officer Martin Harris, MD; Chief Administrative Officer for Clinical Services Cindy Hundorff; and many others. In addition to learning directly from Cleveland Clinic leaders, attendees have the opportunity to engage in one-on-one conversations with them.

Called the Executive Visitors’ Program, it is one of two healthcare executive education programs Cleveland Clinic recently launched for outside leaders. The other, the Samson Global Leadership Academy, offers attendees a full two-weeks of leadership and management training. Cleveland Clinic is one of the few organizations that offer executive education specifically for healthcare executives including nurses.

“The rationale to create these programs was twofold,” says James K. Stoller, MD, MS, Chair of the Cleveland Clinic Educational Institute. “First, Cleveland Clinic has a long and successful track record of training executive leaders. We recognized early that leadership development was lagging in the healthcare sector, yet strong leadership of healthcare organizations is urgently needed, particularly in today’s complex healthcare environment. Second, we wanted to accommodate, in a structured and consistent fashion, all the requests we receive from outside executives to visit and learn from Cleveland Clinic.”

Dr. Stoller explains that the competencies to lead and manage differ from those needed to be an effective clinician or researcher, and that traditional nursing programs may under-prepare nurse leaders who suddenly are entrusted with responsibility for budgets, strategic planning, employee engagement and conflict resolution.

Sinclair agrees. “Opportunities like these are crucial for nurse leaders and nurses everywhere looking to advance into leadership positions. Not only can this type of training help enhance careers, but it also can have a cascading effect, which ultimately promotes better patient outcomes,” she says.

Caryl Hess, PhD, MBA, is overseeing Cleveland Clinic’s healthcare executive education programs. To learn more, please visit clevelandclinic.org/ExecutiveEducation or contact Dr. Hess at 216.445.8898 or at hessc@ccf.org.

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Robbi Cwynar, MSN, and colleagues examined sleep disturbances during early convalescence in patients who underwent coronary artery bypass graft (CABG) surgery.

Research purposes included learning:

• incidence of sleep disturbance and association of patient characteristics and sleep disturbance
• prevalence of use of patient-initiated interventions to reduce sleep disturbance
• usefulness of sleep disturbance interventions
• likelihood that sleep disturbance level was decreased in patients who had an advanced practice nurse (APN) appointment early after discharge
• likelihood that sleep disturbance was associated with cardiac and other medication use

Seventy patients who had undergone CABG surgery were called by an APN, who asked questions using a modified General Sleep Disturbance Scale (GSDS).

Cwynar explained, “The GSDS measures three dimensions of sleep disturbance — sleep quality, daytime functioning and medication for sleep — during the previous week. Each item is rated on a scale of 0 (no days) to 7 (every day). Sleep disturbance was measured using the overall sleep disturbance score and sleep pattern subscale scores. Sleep disturbance interventions were measured using GSDS medication for sleep subscale. Site-specific supplemental items allowed us to determine if home-going instructions benefited patients’ sleep.”

In the sample, the mean patient age was 68 years (± 10 years) and 20 percent had post-discharge sleep disturbances. Many variables were assessed, such as medical history, type of procedure, obesity, serum laboratory values at baseline, hospital complications and medication use. It was surprising that so few variables were associated with sleep disturbance after discharge. “Of the few risk factors we found for sleep disturbance, many were non-modifiable. For example, some sleep disturbance subscales were associated with age, history of myocardial infarction, diabetes, stroke and heart failure, postoperative atrial fibrillation, longer ventilator hours, longer length of stay (hospital and intensive care), and some surgical complications,” noted Cwynar. Obesity was one modifiable factor that could be targeted, and pain medicines decreased the likelihood of sleep quality disturbance.

Cwynar says that the lack of problems with nighttime sleep was somewhat unexpected. “Our hypothesis was that patients would have trouble sleeping postoperatively,” she says. “What we found was that not many patients experienced this problem. Also, an APN outpatient visit did not have any effect on sleep disturbance level. The information gained from this study could impact what we teach patients preoperatively. We also found that there were a few things that patients did (patient-initiated interventions) that helped them to sleep. “These patient-initiated interventions included: no naps during the day, pain medication use approximately one hour before bed, and taking a walk before going to bed. Sleep disturbances during early convalescence were a prominent issue after CABG surgery and that simple remedies may be effective.”

The program was popular from its inception in 2008. At that time, 172 nurses applied for upward clinical ladder status; 107 were accepted at a level 3 status.

Nonetheless, Robin Irons, MSN, wanted to know whether a nurse’s clinical ladder level was a good indicator of his or her clinical expertise. This was an important question, as the ladder program’s levels imply climbing clinical expertise, yet the application process requires evidence of personal work and accomplishments reflecting advanced nurse professionalism but not clinical competency. Irons wished to learn if advanced professionalism was associated with increased clinical expertise and competency.

According to Irons, this study was designed to answer two questions:

1. Do nurses beyond step 2 of the clinical ladder perceive themselves to have more advanced clinical competence compared to RNs at clinical ladder level 2?
2. Do nurse demographics moderate relationships between clinical ladder level and clinical competency?

The research team concluded that in the early postoperative period (the first week) after CABG, sleep disturbances were not frequent. Most were due to non-modifiable factors; however, reducing weight and using pain medications can improve sleep, says Cwynar.

Cwynar says that this study will not necessarily change our nursing approach to patient education. Nevertheless, the information gained is of value. According to Cwynar, “Our results can reassure patients that sleep disturbance may not be a prominent issue after CABG surgery and that simple remedies may be effective.”

Email comments to notablenursing@ccf.org.

Cleveland Clinic’s nursing clinical ladder program allows clinical RNs at the staff nurse level to receive titles acknowledging their experience and skills as clinicians, leaders, mentors and educators, along with a financial reward.

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Establishing Medication Zones

Establishing a boundary of no interruptions for the preparation and administration of medications can help decrease distractions and ensure optimal patient care. It also empowers nurses to be proactive in ensuring safe practice, according to Carolyn Carter, RN, BS, CCRN, Director of Critical Care Services at Cleveland Clinic Florida.

In an effort to address the national issue of medication errors — a concern that remains the fourth leading cause of sentinel events in hospitalized adults, according to The Joint Commission’s 2009 Sentinel Event Statistics — several nursing units throughout Cleveland Clinic’s health system have designated a “No Interruption Zone” to strengthen each nurse’s role in the safe administration of medications. In Florida, a medication distraction intervention was instigated in part by a research report in Critical Care Nurse by Kyle et al. (2010;30:21-29), who assessed the literature for causes of and strategies to reduce medication errors, and then carried out a pilot study to assess the number of interruptions that occurred when a No Interruption Zone was created during medication preparation.

“We looked at how long it took to administer medications, the location of the medication storage machine and, most importantly, how many interruptions typically occurred during the medication preparation time. To help improve the overall delivery of medications, we created a No Interruption Zone in August of 2010 to enforce compliance with best practices for the delivery of care,” Carter says. “By using red tape to ‘block off’ an area on the floor in the intensive care unit, we are promoting limited interruptions during medication preparation.”

Since implementing the No Interruption Zone program, Carter and her ICU colleagues have seen improvements in overall medication preparation and administration. Additionally, improvements were realized by addressing the department’s physical conditions when developing the No Interruption Zone, such as placement of the medication storage machine and identification of an area of solitude for medication preparation. Nurses appreciate having authority over establishing and maintaining boundaries during the medication preparation and delivery process.

In an informal audit completed by the department, nurses found that prior to the No Interruption Zone program, medication time from order to administration took anywhere from two to 31 minutes for various reasons, including distractions. Since making changes in the medication preparation and administration processes, the time is now an average of six minutes.

Similarly, nurses on Cleveland Clinic’s main campus addressed medication errors in April 2010. Dan Hanaian, RN, MBA, Nursing Director, Orthopaedic & Rheumatologic Institute, noted that for each medication pass, nurses had, on average, five distraction interruptions, an alarming rate that led to a medication zone program to decrease interruptions.

“In areas where there are rooms designated for medications, signs were placed on the doors stating that distractions are prohibited. In areas where the medication machines are in an open area, we’ve formed a boundary with red tape,” says Hanaian. “Additionally, we are assessing the use of wearing a red lanyard that holds a laminated card stating ‘medication passing’ during each medication’s preparation and delivery.”

Cleveland Clinic Children’s Hospital emulated Orthopaedic & Rheumatologic’s efforts through use of the same visual identifiers during a three-month pilot. In addition to wearing red lanyards during medication preparation and distribution, nurses are required to report each medication administration on a checkout sheet.

“We’re still in the process of determining if this process is of value,” says Jane Burke, BSN, MBA, CIPS, Clinical Nurse Director of Cleveland Clinic’s Children’s Hospital. “While visual cues such as red tape around the medication station may be beneficial to a point, there are many variables that lead to distractions. Medication errors are an everyday concern for us, and we are empowering our staff to say they can’t be interrupted during this role and that others should be respectful of their needs, but distraction is only one variable contributing to medication errors. We need to look at all of the steps that lead to proper medication distribution, including paying attention to details such as right dosage, right drug and the physical layout the drug is being prepared in. Creating medication No Interruption Zones is one step among many that we will continue to consider to avoid errors.”

Email comments to notablenursing@ccf.org.

Establishing a boundary of no interruptions for the preparation and administration of medications can help decrease distractions and ensure optimal patient care. It also empowers nurses to be proactive in ensuring safe practice, according to Carolyn Carter, RN, BS, CCRN, Director of Critical Care Services at Cleveland Clinic Florida.

In an effort to address the national issue of medication errors — a concern that remains the fourth leading cause of sentinel events in hospitalized adults, according to The Joint Commission’s 2009 Sentinel Event Statistics — several nursing units throughout Cleveland Clinic’s health system have designated a “No Interruption Zone” to strengthen each nurse’s role in the safe administration of medications. In Florida, a medication distraction intervention was instigated in part by a research report in Critical Care Nurse by Kyle et al. (2010;30:21-29), who assessed the literature for causes of and strategies to reduce medication errors, and then carried out a pilot study to assess the number of interruptions that occurred when a No Interruption Zone was created during medication preparation.

“We looked at how long it took to administer medications, the location of the medication storage machine and, most importantly, how many interruptions typically occurred during the medication preparation time. To help improve the overall delivery of medications, we created a No Interruption Zone in August of 2010 to enforce compliance with best practices for the delivery of care,” Carter says. “By using red tape to ‘block off’ an area on the floor in the intensive care unit, we are promoting limited interruptions during medication preparation.”

Since implementing the No Interruption Zone program, Carter and her ICU colleagues have seen improvements in overall medication preparation and administration. Additionally, improvements were realized by addressing the department’s physical conditions when developing the No Interruption Zone, such as placement of the medication storage machine and identification of an area of solitude for medication preparation. Nurses appreciate having authority over establishing and maintaining boundaries during the medication preparation and delivery process.

In an informal audit completed by the department, nurses found that prior to the No Interruption Zone program, medication time from order to administration took anywhere from two to 31 minutes for various reasons, including distractions. Since making changes in the medication preparation and administration processes, the time is now an average of six minutes.

Similarly, nurses on Cleveland Clinic’s main campus addressed medication errors in April 2010. Dan Hanaian, RN, MBA, Nursing Director, Orthopaedic & Rheumatologic Institute, noted that for each medication pass, nurses had, on average, five distraction interruptions, an alarming rate that led to a medication zone program to decrease interruptions.

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A lifelong interest in educating patients with diabetes has earned Susan Cotey, RN, CDE, the respect of her patients and her peers.

Susan Cotey created a diabetes self-management program that helps patients — and their families — learn a whole new lifestyle. For this work, and for her lifelong dedication to empowering patients with diabetes, Cotey will receive the 2011 Circle of Hospitals Award. The award, given by the American Diabetes Association, honors an individual or group from each hospital system in Northeast Ohio who has made an impact in diabetes treatment and education.

“I was overwhelmed by the award because it felt so wonderful to be recognized by my peers,” says Cotey, 52, Program Coordinator at the Lennon Diabetes Center at Huron Hospital of Cleveland Clinic, a position she has held for the past 20 years. She has been caring for persons with diabetes since 1984, when she began nursing at the Sparks Family Hospital (Sparks, Nevada).

The Lennon Diabetes Center has a six-person staff that, with patient input, created the Huron Diabetes Self-Management Program and the book Managing Your Diabetes: You Can Do It!, a supportive guide for patients and their families.

“Patients may not realize how diabetes changes their family dynamics,” says Cotey, who graduated from the University of Wisconsin Nursing School. “This is especially true of adolescents with diabetes — family counseling becomes a huge component of diabetes management.”

Cotey’s outpatient program stresses compassionate understanding and features other patients with diabetes acting as mentors for those who are newly diagnosed. The program has been so successful, it was presented at healthcare conferences in Scotland, London and Berlin.

In addition, Cotey developed a hospital-based Diabetes Nurse Champion Program to educate nurses in all departments about how to better care for patients with diabetes. The hard work of Cotey and her team resulted in Huron Hospital receiving Diabetes Certification from The Joint Commission, a recognition shared by only 18 other U.S. hospitals.

“We’re taking diabetes treatment to a new level and helping people in new ways,” Cotey says. “That’s why I decided to become a nurse. Helping people and teaching them are the favorite parts of my job.”

Making patient safety her No. 1 goal has endeared Kathleen Singleton, MSN, CNS, CMSRN, to her patients.

Kathleen Singleton is touched whenever former patients return to thank her for her care during their hospital stay. Her desire to create better response times for med/surg patients led her to work with the Rapid Response Team at Fairview Hospital of Cleveland Clinic. And to further ensure patient safety, she brought the VOCAL program to the hospital.

VOCAL stands for Verify the physician order, Obtain the label, Check the armband for patient name and date of birth, Acquire the specimen, and Label the specimen in the presence of the patient. VOCAL aims to reduce mislabeling of specimens, says Singleton, 57, Clinical Nurse Specialist for Medical-Surgical Nursing at Fairview Hospital. “So to the Rapid Response Team, I worked with our staff in refining processes and policies, and educating patients to create better response times.”

Here’s how the Rapid Response Team works: If a nurse making rounds sees that a med/surg patient’s condition appears to be deteriorating, the nurse calls the operator to alert the Rapid Response Team to the patient’s side. “The goal is to identify a change in a patient before a full cardiovascular arrest,” Singleton says. “The intervention might lead to a chest X-ray or moving the patient to ICU. Sometimes the patient initiates the Rapid Response Team. Flyers in each patient’s room explain the procedure, plus we explain the system to each patient. Educating patients is important.”

Patient education and mentoring new nurses are important to Singleton, who graduated from the University of Akron and earned her MSN from the Frances Payne Bolton School of Nursing at Case Western Reserve University in Cleveland. She is the Immediate Past President of the Academy of Medical-Surgical Nurses, was named the 2001 STERIS Nurse of the Year and is most proud of the patient nomination for The Plain Dealer Best of the Best Award.

“Without Whose Aid, a history of nursing at Cleveland Clinic, With Madeline Soupios, RN, C, Professional Nurse III, served her country with the same dedication that she serves her patients and fellow nurses.

2011 marks a special anniversary for Madeline Soupios, an Embryology Clinic float nurse at Cleveland Clinic’s main campus. This year, Soupios celebrates 40 years of caring for patients at Cleveland Clinic, and the former Navy nurse’s celebration plans include continuing to care for patients and staff with knowledge, compassion and humor.

“I prefer to work behind the scenes and to do my job consistently well,” says Soupios. “I prefer to be remembered as a nurse who guided my staff, helped generate new ideas and mentored new staff.”

After graduating from the Helene Full School of Nursing in Trenton, New Jersey, in 1967, Soupios joined the U.S. Navy Nurse Corps, working in critical care nursing. Stationed at Camp Lejeune, North Carolina, from 1968-71, her patients included Vietnam War casualties, many with horrific injuries.

“I saw lots of soldiers come back wounded,” she says quietly. “Seeing the effects of war — well, it really made me appreciate life. And I met some wonderful people I’ll never forget.”

In 1971, Soupios joined Cleveland Clinic’s Surgical Intensive Care Unit and later served as Nurse Manager in that unit for 20 years. Today, in the Ambulatory Clinic float pool, she can float to about 25 outpatient departments and procedure areas. She also teaches skills labs and mock codes, and is a back- staffing coordinator. Additionally she is a member of the Ambulatory Clinics Continuing Education Planning Committee (on which she served as chairman for 12 years) and is also a member of the Nursing Hall of Fame Selection Committee.

She recently helped edit the second edition of the book Without Whose Aid, a history of nursing at Cleveland Clinic, which was released in December 2010. She also volunteers at events such as the Cleveland Clinic Minority Men’s Health Fair, and for organizations including the Cleveland Food Bank.

“I like to help where I can, because there are a lot of people who are less fortunate than I am,” she says. “I’ve also been a blood donor ever since my Navy days, and I encourage donors! And, lastly, my sincere thanks to all my mentors and staff I’ve met along the way in my career.”
This unique summit will provide insights and solutions to transform the patient experience. A special nursing track, “Complexities and Connections of Caregivers,” will be offered on May 22 that focuses on the unique relationship of caregiver and patient. Techniques to enhance listening skills, foster meaningful relationships and cope with moral distress will be presented. The complexities of end-of-life decisions will be examined. In addition, this track offers a novel session on the role of executive leadership in nurturing talent and contributions from all caregivers. For more information and to register online, visit empathyandinnovation.com.

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