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Notable Nursing

Spring 2018 | A Publication for Nurses by Nurses

The Stanley Shalom Zielony Institute for Nursing Excellence

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Dear Colleagues and Friends,

In my 25 years as a nurse, the conversation about how to manage the stress of our jobs has been a constant. What's new in recent years is that nursing wellness has become an organizational priority.

At Cleveland Clinic, wellness is part of our culture through the support of our Wellness Institute. We have a dedicated Nursing Wellness Director who is focused on developing programs and providing ongoing wellness communication to our nursing team. And the Wellness Institute, in conjunction with nursing leadership and nursing human resources, has developed a variety of fitness programs, stress management tools and career development resources for us to rely on. (I invite you to learn more about these offerings in our wellness feature on p. 16 of this issue.)

Having access to wellness and stress management resources is truly a gift, and the nurse leadership team and I often talk about how we need to practice what we preach. We are doing our best to model healthy behaviors for our nursing staff. In addition to healthy diet, exercise and stress management, modeling healthy behaviors means taking time to listen, providing educational opportunities for career advancement, and embracing and validating the contributions of all of our nurses.

Some examples of how we provide support to our nurses in their roles are highlighted in this issue. First is our new Transition to Practice Training program to better onboard newly graduated advanced practice nurses (see p. 14). And second is a feature story on what we are doing to support our nurses who find a passion and choose to research and publish their findings to advance evidence-based nursing practice (p. 10).

So, in the midst of a fast-paced work environment where demands are great and there never seems to be enough time, we are doing our best to make our nurses' well-being an integral part of our nursing strategy. Because healthier nurses who feel supported are much happier. This leads to healthier patient care interactions and better outcomes for all.

I hope you find this issue informative. Please contact us anytime to share your thoughts and ideas with us. You can reach us at notablenursing@ccf.org.



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On the cover: Nurse manager Katherine Galvan, BSN, RN, leads a team huddle at Cleveland Clinic Fairview Hospital.



How Cleveland Clinic Nurses Are Using

Telehealth Technology in Novel Ways

Lessons learned from telehealth pilots, with new programs on tap for 2018

Using telehealth to provide care is No. 5 on Cleveland Clinic's list of the top 10 medical innovations for 2018, and with good reason: The service is booming, with 7 million patients nationwide expected to use telemedicine in 2018.

Cleveland Clinic has long been expanding beyond brick-and-mortar healthcare, says Jeffrey Arnovitz, MSN, CNP, with Digital Health, a division within Cleveland Clinic's Office of Clinical Transformation. "Distance Health is part of an initiative to transform Cleveland Clinic for the future," he says.

In many ways, nursing is leading the way, both for out-patient visits and inpatient care.

LOG ON, GET CARE

Cleveland Clinic launched Express Care® Online in 2015. This service allows patients to schedule appointments and see providers remotely using their smartphone, tablet or computer. The service includes on-demand visits (for immediate health needs) as well as scheduled follow-up visits.

Arnovitz was one of the first advanced practice nurses to see Express Care Online patients, and he's now the coordinator. "When we're online with patients, our goal is to deliver the same level of care we would deliver if they were in traditional in-office care," he says.

However, caring for patients remotely requires nurses to modify their skills. For example, with traditional care delivery in an office setting, you obtain a history, perform a physical exam, make an assessment and prescribe a plan of care.

"With telemedicine, you have to modify the approach to the patient. You obtain a history and the exam is completed virtually, so this requires creative techniques," Arnovitz says. That may mean guiding the patient to palpate their own lymph nodes or sinuses or leading the patient through their own range-of-motion exam.

At first this can be challenging for nurses, but Arnovitz notes that his colleagues have become skilled at delivering digital healthcare.

On the regulation side, state laws have been a barrier for telemedicine and remote prescribing, but things are changing. "The laws are catching up to this new level of practice," Arnovitz says, noting licensure can still be an issue. (He is currently licensed in 13 states.)

Pictured above: Seeing a patient via Express Care Online, Jeffrey Arnovitz, MSN, CNP, is the APRN/PA Coordinator for Digital Health/ITD.

continued on page 4

Patient satisfaction with using Express Care Online is very high, according to a survey Arnovitz and his colleagues conducted. They measured key metrics such as ease of access, ease of use, time savings and overall satisfaction with the service.

Nearly 80 percent of patients who used the service and participated in the survey said they would use it again, and on a scale of 1 to 10 (10 being very likely) for recommending Express Care Online, 62 percent gave it a 10.

“Care is delivered when and where patients want it, without leaving home. They don’t have to sit in a waiting room, or deal with the other ‘soft costs,’ like parking, childcare or missing work,” Arnovitz says.

TELEHEALTH FOR PAIN MANAGEMENT

“Last year, the nursing institute started to dip its toe in the telehealth waters for our inpatients,” says Nelita Iuppa, DNP, MS, NEA-BC, ACNO for Cleveland Clinic’s Office of Nursing Informatics.

In 2017, her department completed two pilot programs, one with the acute pain management service (APMS) and one with wound care.

“We partnered with APMS to shorten turn-around time for seeing patients,” says Marlene Oblak, RN, nurse specialist for Nursing Informatics. The time between when an on-call doctor was paged and when he or she arrived at a patient’s bedside averaged 32 minutes.

The APMS pilot aimed to reduce response time and facilitate communication by using remote technology to let doctors and patients connect. Nurses rolled a cart outfitted with a computer monitor to the patient’s bedside, and then initiated the connection with the doctor. On the other end, the doctor could talk to the nurse and the patient via computer, smartphone or tablet.

“It reduced the amount of time patients had to wait for a new pain intervention by 25 minutes,” Oblak says. She notes that it was also a great collaboration between nurses and physicians as they worked together on treatment plans for complex epidurals and patient care assessments.



The telehealth monitor in a patient's room; below: Gladys Harris of Nursing Informatics tests the technology using her cellphone to communicate with the bedside nurse and patient.

TELEHEALTH FOR WOUND CARE

The second pilot was a partnership between the main campus wound care consult team and the nursing staff in Fairview Hospital's medical and surgical intensive care units.

"The Fairview Hospital team wanted to be able to evaluate patients more quickly, to be able to have someone look at the wound and start initial treatment until the patient could be seen in person by a wound care nurse on-site at Fairview," Oblak explains. During communication, main campus wound care nurses were equipped with an iPhone®, and the Fairview nurses used the rolling telehealth cart at the patient's bedside. Initially, they struggled to maneuver the monitor and get it close enough for the main campus nurse on the other end to clearly see the wound. Nursing Informatics staff eventually added an adjustable arm to the telehealth carts, which improved the process.

"We were able to shorten the amount of time for patients to be seen," Oblak says. Also, skin assessment and staging of wounds by the wound care nurse at main campus [that was completed via telehealth] consistently matched the assessment of the in-person Fairview wound care nurse. Thus, the methodology was accurate and trustworthy.

However, there were some drawbacks to the program, Oblak says. "Our nurses loved the concept and could see the benefit, but found the process challenging." Fitting the telehealth equipment into their workflow was tricky, and often required greater numbers of nurses to make the equipment function properly and be helpful (such as having one nurse to maneuver the monitor, another to hold the patient and one to complete the patient assessment).

Because of high patient acuity, the ICU patient population may not have been the ideal setting. "It's a great technology, but we're still trying to find the right fit to enhance care for inpatients," Oblak says.

WHAT'S AHEAD FOR NURSING AND TELEHEALTH?

Iuppa is very optimistic about the future of telehealth, noting that the pilots play an important role because these evaluations help everyone learn, and also help make the case for building out the infrastructure for telehealth on inpatient units.

"Currently, the infrastructure isn't there to integrate telehealth capabilities into a patient's room. But nurses like the efficiency of the process, and we can already see that telehealth is a great tool for facilitating quick-answer types of scenarios," Dr. Iuppa says.

There are two nursing telehealth initiatives Dr. Iuppa hopes to put into place this year.

The first is to use telehealth technology to enable more seamless handoff between nurses and to better engage patients. "If we think about patients who need to be admitted from the ER into the hospital, for example — telehealth could help them connect with their upcoming nurse and better understand why they are being admitted, making a smoother transition," Dr. Iuppa says. Nurses can use the technology to connect with one another as well, which can enhance direct communication and improve interdepartmental dialogue.

The second program is a dial-an-expert-nurse initiative for nurses who need a mentor in any given situation. "Newer nurses could use this to ask more experienced nurses questions, or it can be used when nurses need help with patients or procedures. The expert nurse could be a support person who guides them through processes and provides tips. Ultimately, both nurses and patients benefit," she says.

Although hands-on care is often irreplaceable, virtual care creates value by saving time, creating efficiencies, enhancing clinical care and facilitating long-distance connections. "We're laying the groundwork for the future of virtual healthcare," Dr. Iuppa says. "Our resources are mobile, our patients are mobile, and we need to be flexible and creative in managing healthcare."

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Continuous Improvement

NURSE-LED CI PROJECT EXAMINES BARRIERS TO PURPOSEFUL HOURLY ROUNDING AND CREATES SOLUTIONS TO IMPROVE THE PROCESS.



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The daily huddle for nurses on a med-surg unit at Fairview Hospital gets them ready for a busy day that includes purposeful hourly rounding.

When Kelly Hancock, DNP, RN, NE-BC, Executive Chief Nursing Officer of Cleveland Clinic, and her nursing leadership team select continuous improvement projects for the Zielony Nursing Institute, they consider one key question: What matters most? That core question, at the heart of Cleveland Clinic's culture of improvement, encourages everyone — from management to caregivers — to align around, clarify and standardize practices that matter most.

In the spring of 2016, nursing leadership chose purposeful hourly rounding as a top priority.

“Researchers found that purposeful hourly rounding keeps patients safe and improves outcomes, quality and the patient experience,” says Susan Coyne, BSN, RN, Senior Continuous Improvement Specialist for the Zielony Institute. “We have always believed in purposeful hourly rounding and had standard operating procedures in place for it. But we were inconsistent in our application and needed to understand why.”

Deborah C. Small, DNP, RN, NE-BC, then CNO of Cleveland Clinic Fairview Hospital (now CNO of Cleveland Clinic London), volunteered her hospital to spearhead the continuous

improvement project on purposeful hourly rounding. (Dr. Small has recently been named CNO of Cleveland Clinic London.) In May 2016, a 25-bed medical-surgical and telemetry unit (5 Pavilion) and a 12-bed medical-surgical and telemetry unit (5 West) initiated the purposeful hourly rounding pilot. Soon after, a 36-bed medical-surgical unit specializing in oncology and women's health (Parkview 1) joined the pilot.

The units held multiple meetings with leadership, continuous improvement staff, clinical nurses and patient care nursing assistants (PCNAs) to consider four main questions:

- What does purposeful hourly rounding look like?
- What should it look like?
- What are the barriers to rounding?
- How do we remove those barriers?

AUDITING HOURLY ROUNDING PRACTICES

“The original policy for purposeful hourly rounding states that nurses should round on every patient, every hour and ask them about the four Ps,” says Katie Galvan, BSN, RN, CMSRN, Nurse Manager of 5 Pavilion and 5 West. The four Ps are:

- Position — Are you comfortable?
- Possessions — Do you have everything you need?
- Personal Needs — Do you have to use the bathroom?
- Pain — Are you uncomfortable or having any pain?

“Nurses felt it wasn't appropriate to ask those questions of every patient in the hospital and did not follow through in a systemic way when rounding,” says Galvan. To get to the root of the issue, the three med-surg units began self-auditing their rounding practices. Nurses and PCNAs completed a simple audit log indicating whether they rounded each hour and assessed all four Ps (yes or no) and, if not, why.

Galvan and Matthew Frye, BSN, RN, CMSRN, nurse manager of Parkview 1, also had one-on-one conversations with caregivers about rounding that revealed their distress. “One nurse told me she was unable to go into each of her six patient rooms every hour,” recalls Galvan. “She felt like she was letting us down because she wasn't able to do what we asked of her.”

IDENTIFYING BARRIERS TO ROUNDING

Through the self-audits and one-on-one conversations with caregivers, Galvan and Frye discovered several reasons why purposeful hourly rounding wasn't always accomplished, including the following (see next page):

BREAKING DOWN BARRIERS

After the three medical-surgical units at Fairview Hospital identified barriers to purposeful hourly rounding, they created solutions to remove those barriers. Here are examples of three obstacles to rounding and how they were addressed:

BARRIER: UNIT EMERGENCIES

SOLUTION: Nursing staff created a unit workflow that clearly describes staff roles during times of emergency. It identifies the caregivers needed at the bedside during rapid response and code blue situations. It also details caregiver duties that can be dismissed after the emergency medical team arrives. The workflow places emphasis on rounding on other patients during emergencies.

BARRIER: FULL COMPLIANCE WITH ROUNDING DECREASES FROM 7 P.M. TO 11 P.M.

SOLUTION: The late-evening timeframe coincides with high admissions, high-volume medication administration and staffing level changes from

day to night shift. Med-surg unit nursing teams are striving to increase communication and accountability among peers during traditionally busy times. Teams have utilized role-playing and brainstorming in small groups to help staff approach sensitive conversations, such as when a PCNA needs to ask an RN for help with rounding.

BARRIER: MISSED DOCUMENTATION OF ROUNDING IN THE ELECTRONIC MEDICAL RECORD (EMR)

SOLUTION: During staff meetings, huddles and practice council meetings, med-surg unit leaders placed educational emphasis on accurate documentation. All staff received education on the rounding documentation feature within the EMR. In addition, staff performed random real-time feedback audits related to hourly rounds documentation.

- Patients were sleeping — Nurses and PCNAs didn't want to wake up sleeping patients to ask them the four Ps.
- Lack of an acuity system for nursing assignments — Patient assignments on units were made based on room rather than acuity. When nurses had higher-acuity patients in their assignment, they did not always have time to round on everyone.
- Unit emergencies — “When we asked people why they couldn't round, the first reason that came to mind was that there was an emergency or rapid code in progress,” says Frye.
- Contradictions in policies — The sleep guidelines policy conflicted with guidelines for purposeful hourly rounding. In the sleep guidelines policy, recommendations included having nurses limit interruptions between 9 p.m. and 7 a.m. Nurses were uncertain which policy to prioritize.
- Lack of communication — When nurses could not complete a round because of a lunch break, an emergency or

other competing priorities, nurses and PCNAs didn't ask for help from peers, charge nurses or nurse managers.

Using data from self-audits, Frye created an Excel spreadsheet to analyze and graph the results. The spreadsheet helped med-surg unit teams better understand rounding compliance and noncompliance trends and specific barriers. Data were also used to examine trends over time and rounding compliance improvement.

DEVELOPING PROCESSES TO PROMOTE ROUNDING

Utilizing data and anecdotal evidence from caregivers, med-surg nurses began to consider what hourly rounding should look like and how to remove barriers. “No matter what, every single hour, 24 hours a day, someone should be rounding,” says Galvan. “That doesn't mean we're going to use the same language, ask the same questions or wake people up. Nurses now are empowered to round using the ‘observe vs. ask’ guidelines.”

Instead, caregivers considered patient circumstances. “Critical thinking and a focus on patients drive what caregivers



Fairview Hospital nurse Jaclyn Michel, BSN, RN, during her hourly rounds.

do when they go into a room,” says Peg Homyak, MSN, RN, NE-BC, Director of Acute Care Services at Fairview Hospital. Sometimes nurses simply look in on the patient. Other times, they ask some or all of the four Ps. Nurses on the medical-surgical unit created a visual management tool to help caregivers identify what hourly rounding should look like based on three basic criteria: Is the patient awake and a fall risk, awake but not a fall risk, or asleep?

To promote rounding adherence, a nurse manager dashboard was created that shows real-time current and previous-hour data in the electronic medical record. Rounding documentation non-adherence to standards of practice allows nurse leaders and charge nurses to initiate conversations with caregivers on rounding barriers and potential resolution. For example, an assistant nurse manager noticed that a clinical nurse hadn't documented rounding at midnight. In conversations, she discovered the caregiver was busy with a patient who had continuous bladder irrigation (CBI). The assistant nurse manager offered to deal with the CBI so the nurse could round on other patients.

Med-surg unit nursing teams also reviewed conflicting standard operating procedures (SOPs) on pain, sleep and delirium. They aligned SOPs with the new purposeful hourly rounding policy.

IMPROVING THE ENVIRONMENT FOR PATIENTS AND NURSES

“The steps taken to improve hourly rounding consistency help the team understand the problems from a broad perspective, so that best solutions are implemented,” says Coyne. Improvements in rounding are reflected in Press Ganey survey scores for the three med-surg units. Between April and June 2016, the responsiveness score for the units was 62.7 percent. A year later the score rose to 70.7 percent. The quiet environment score for April through June 2016 was 51.6 percent. It increased to 75 percent between April and June 2017.

Equally important, the new purposeful hourly rounding process empowers caregivers. “It allows nurses to use critical thinking and judgment,” concludes Homyak. “And that's exactly what we want them to do.”

Email comments to notablenursing@ccf.org

More Continuous Improvement Projects

The purposeful hourly rounding pilot is one of many continuous improvement (CI) projects undertaken by the Zielony Nursing Institute. “We have a culture of continuous improvement, where every caregiver is capable, empowered and expected to make improvements in their work every day,” says Susan Coyne, BSN, RN, Senior Continuous Improvement Specialist for the Zielony Nursing Institute. The articles on pages 18 and 19 feature CI projects that led to best practices for inpatient medical emergencies. This year, our online nursing section on ConsultQD will include several “just do it” CI projects that have led to cost savings for supplies.

The Power of Publishing

**Authoring books, chapters
and journal articles:
Why it's worth it**

Critical care nurse Nancy Albert's first experience as an author was enough to get her hooked. Writing her 1994 article on laser angioplasty and intracoronary stents was hard work, but seeing her words in print and knowing they could help educate readers gave her a personal boost.

Nearly 25 years and 280 publications later, Albert, PhD, CCNS, CHFN, NE-BC, now Cleveland Clinic's Associate Chief Nursing Officer, Research and Innovation, is helping other nurses feel that same enthusiasm. (She is also medical editor of *Notable Nursing*.) The Zielony Institute also encourages and supports writing by all its nursing staff.

"Writing for publication is very satisfying," says Dr. Albert. "First, when I write, I spend a lot of time reading other papers, so I learn a lot on the topic. Second, writing is often a team sport. I love working with others to bring a paper to life. It is fun to get others' perspectives, as input always makes a paper better. Finally, writing is a little like a jigsaw puzzle: You need to fit the right words onto the blank page. It often involves shuffling, revising and reworking to get the perfect fit. It is a challenge, and when it all works together, it is very rewarding."

WHO SHOULD PUBLISH — AND WHERE

Nurses at all levels can and should publish, Dr. Albert says. It's not just for those with advanced degrees.

As new knowledge emerges in medicine, basic science, the social sciences and other areas, nurses can help others understand how findings affect high-quality patient care, she says.

"At Cleveland Clinic, all nurses have the opportunity to be innovative, make changes in our workplace, conduct research, and implement evidence-based practices and continuous improvement projects — all of which can be published," Dr. Albert says.

PUBLISHING OPPORTUNITIES FOR NURSES INCLUDE:
Newsletter articles. Most nursing associations produce newsletters for their members. Nurses can contribute brief articles about best practices or guideline recommendations, for example.

Journal articles. Many journals publish new research study results and implications. Others publish review papers (summaries of existing research) and articles on best practices and quality initiatives. "Choose the right journal for your article," Dr. Albert advises. "Understand what the journal likes to publish, and follow its author guidelines. Do not submit a review paper to a journal that primarily publishes new research, for example."

Books or book chapters. Generally, book editors invite known experts to write about a certain topic.

HOW TO GET PUBLISHED

"The steps to publishing are simple, even though the process may be time-consuming and feel like a marathon," she says.

Once an author submits a manuscript to a journal or book publisher, an editor will assign two or more experts to review it. These reviewers are looking for novel content, accurate writing, use of primary references, flow of content, use of figures and tables, formatting — all elements that make a manuscript easy to read and understand.

The editor will review feedback and determine whether the manuscript will be accepted for publication, need revisions or be rejected.

"Only 2 percent of manuscripts are accepted upon first review," Dr. Albert notes. "Authors should expect to receive feedback, rewrite and resubmit."

If a manuscript is rejected, authors can use feedback to make revisions before submitting the manuscript to another journal.

BUILDING A CULTURE OF NURSE PUBLISHING

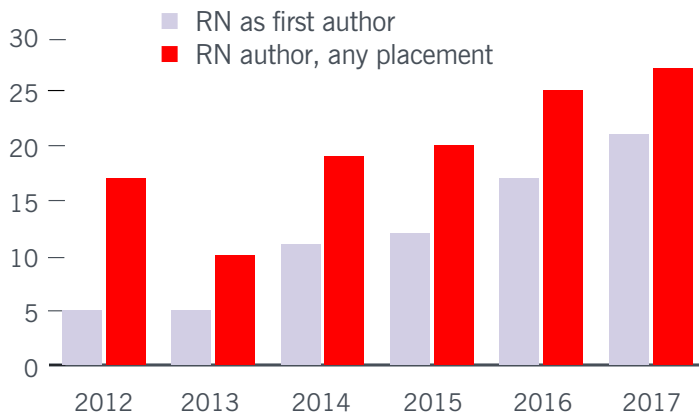
Writing articles and books takes time — lots of it. Yet Cleveland Clinic nurses authored 119 publications in 2017 alone (see table). And 27 papers (involving Cleveland Clinic nurse principal and co-authors) were original research (see graph).

Besides relying on their own drive and perseverance, these nurses have benefited from organizational support.

NUMBER OF PUBLICATIONS BY CLEVELAND CLINIC NURSES

Year	Total publications	Journal articles	Book chapters	Books
2017	119	62 - 27 research - 35 nonresearch (review)	53	4
2016	87	61 - 26 research - 35 nonresearch (review)	22	4
2015	99	85	12	2

Published Research Papers with CC Nurse Authors, By Year



HOW CLEVELAND CLINIC SUPPORTS NURSE AUTHORS

Time. “Just as for education and quality efforts, leaders make time for nurses to write up their work,” says Dr. Albert. “We have found it best to mentor nurses in writing in three- to four-hour blocks of time rather than multiple short increments of time. In many cases, nurses will come in before their shift or on their days off to keep their publishing efforts moving forward.”

Mentors. Cleveland Clinic offers mentoring by experienced authors from its Office of Nursing Research and Innovation. Anyone can make a request for support.

Funding. Cleveland Clinic recently introduced a publishing grant to help nurses fund writing time that replaces or supplements their regular work hours.

Publishing benefits more than the nurse authors and their readers, contends Dr. Albert. Disseminating high-quality knowledge advances the science of nursing practice and strengthens an entire nursing organization.

“Sharing knowledge through publishing helps nurses better understand the importance of constantly learning and growing in our profession,” Dr. Albert says.

Email comments to notablenursing@ccf.org



Meet Our Nurse Authors

These Cleveland Clinic nurses are recent authors. Here are their insights on writing.

Journal article

Patricia A. Marin, DNP, NP-C, of Cleveland Clinic Richard E. Jacobs Health Center

Marin PA, Bena JF, Albert NM. Real-world comparison of HbA1c reduction at 6-, 12- and 24-months by primary care provider type. Prim Care Diabetes 2018 Feb 21. [Epub ahead of print]

Why she did it: When I started at Cleveland Clinic 30 years ago, I worked in the cardiovascular area. Later, when I moved into primary care, I still had an interest in preventive cardiac nursing and helping patients manage cardiovascular risk factors, like diabetes and high cholesterol. I proposed establishing a chronic care clinic and administrators challenged me to validate the concept. That's what I tried to do with my research article: show the value of nurse practitioners in improving the outcomes of patients with diabetes.

The process: I came up with the idea and drafted a research proposal. I needed help collecting and managing data. I found a mentor to help me identify the best research methodology and to support analysis of data, which came from patients I had seen over a three-year period. It was a labor-intensive project that I did after work and on my days off for several years. The manuscript was a process of reporting results.

The reward: Publishing this article is a professional milestone. The topic was based on my own passions as a nurse practitioner in cardiovascular and primary care. Now I'm able to promote the value of nurse practitioners internally and externally, including internationally.


Book chapter

Antoinette Neal, BSN, CRNI, VA-BC, of Cleveland Clinic's Home Care Pharmacy

Neal A, Drogan K. Parenteral access devices. In: Mueller CM, ed. The ASPEN Adult Nutrition Support Core Curriculum. 3rd ed. Silver Spring, MD: American Society for Parenteral Enteral Nutrition; 2017.

Why she did it: Someone from my industry association, the American Society for Parenteral and Enteral Nutrition, recommended me for the project. I jumped at the chance. I have a passion for working with the parenteral population and am involved in many complex cases that most nurses do not routinely manage. I wanted to help teach the most



Pictured (left to right): Patricia A. Marin, DNP, NP-C (Dr. Marin's journal article can be found at ScienceDirect.com). 

Antoinette Neal, BSN, CRNI, VA-BC

Linda Stricker, MSN, RN, CWOCN, and Barbara Hocevar, MSN, RN, CWOCN

current, evidence-based practice so others know what to do when lines are compromised and other types of vascular access are needed.

The process: It took a year of working on the chapter during off-hours as I didn't have time during my workday. Most time was spent researching current practices. I'd go on PubMed.gov and to Cleveland Clinic's research libraries to read articles in recent issues of medical journals. Once I had literature evidence, I put my knowledge into words. Four editors reviewed my writing and sent edits, questions and comments. Discussion and revisions strengthened the final content.

The reward: Publishing was worth the effort. I learned so much about my topic. It's an honor to be among other thought leaders, helping advance my nursing specialty.

Book

Linda Stricker, MSN, RN, CWOCN, Program Director and Barbara Hocevar, MSN, RN, CWOCN, Assistant Director, both of Cleveland Clinic's R.B. Turnbull Jr., MD, School of Wound, Ostomy and Continence Nursing

Stricker L, Hocevar B. Wound Management: A Comprehensive Guide for Nurses. Brockton, MA: Western Schools; 2017.

Why Linda and Barbara did it: The publisher contacted us because they were looking for nurses who had extensive knowledge of wound management. We had both written journal articles and book chapters before, and thought working on an entire book would be a good stretch for us and good publicity for Cleveland Clinic's wound, ostomy and continence school.

The process: It took us 14 months to write the 23 chapters, appendix, glossary and index. We focused on one section at a time and set aside writing time every day during and after work hours. As we'd submit sections to the publisher, editors and other reviewers would send us feedback and edits. We'd rewrite as needed. You can't let it bruise your ego! The teamwork was so valuable.

The reward: There's so much professional satisfaction. We created a book that will help nurses help their patients better. And through our research, we updated our knowledge too.

Email comments to notablenursing@ccf.org

Program Eases Advanced Practice Nurses into New Roles

Advanced practice registered nurses (APRNs) are at the forefront of preventive and primary care. At Cleveland Clinic and medical centers across the nation, there is a surge in positions available and in new graduate APRNs ready for new work. Today, more than 1,700 APRNs care for patients across the Cleveland Clinic health system.

As the need for APRN providers explodes, so too does the need for quality onboarding, says Anne Vanderbilt, MSN, APRN, Director of Advanced Practice Nursing at Cleveland Clinic.

“New-hire APRNs are already certified and credentialed to practice fully,” says Vanderbilt. “But a large majority of them — 65 percent of those at Cleveland Clinic — are new graduates. We want to support their transition from academia into practice and prepare them to thrive here long term.”

To ensure the highest quality of care and maximize productivity sooner, Vanderbilt and a team have started a systematized onboarding training program called Transition to Practice (TTP) for new-grad APRNs. The program also includes physician assistants (PAs) who fill similar roles throughout Cleveland Clinic.

EASING INTO AUTONOMY

No matter the Cleveland Clinic institute or department, all APRNs/PAs will eventually participate in a one-year TTP program. Today, caregivers in primary care departments spend four days a week alongside another provider during the first three months after hire. The provider dyad may start off by seeing patients together and gradually transitions to seeing patients independently and verifying findings with each other. On the fifth day of each week, participants attend lectures, discuss case studies and have extra time to learn billing and documentation practices in a nonclinical setting.

“Our new-hire APRNs are not autonomous right away,” says Vanderbilt. “That’s a big change for some institutes. We expect everyone to front-load APRN training.”

Transition to Practice is modeled after other accreditation programming from the Accreditation Council for Graduate Medical Education and the American Nurses Credentialing Center. New hires gradually increase autonomous practice

after the first three months, but continue four to eight hours of nonclinical training per week.

Throughout the program, new APRNs receive frequent and detailed evaluations so they can continue to advance their skills and knowledge. During their second six months, non-clinical training is reduced to eight hours or less per month, and participants are asked to explore a subject of interest for a professional development project, to be submitted at the end of the yearlong program.

ENSURING A CONSISTENT ONBOARDING EXPERIENCE

In July 2017, Cleveland Clinic Wooster Family Health and Surgery Center was the first to launch the TTP program. The first cohort included three APRNs in a primary care clinic. They’re using a customized McGraw-Hill SmartBook® interactive learning platform to master Cleveland Clinic care paths for 47 clinical conditions in nine specialty areas.

New APRN Julie Podlogar says the TTP program is one of the main reasons she came to work at Cleveland Clinic Wooster. After 25 years as an inpatient nurse at a smaller hospital, she went back to school at Kent State University in 2014 to get her APN degree. “I learned so much in school, but when you’re clinically practicing as an APRN, it’s so different. I’m also new to outpatient nursing, and the stressors are different than when you are practicing as part of a team on a hospital unit, where other providers make decisions. This program gives us good support. I really like the pace of it and getting to see different specialties.”

Additional cohorts throughout the health system began in fall 2017, including specialty tracks in general surgery and acute care. Task forces, predominantly composed of experienced advanced practice providers, are designing curriculum and guiding implementation of the program. An oncology track launched in spring 2018.

“At Cleveland Clinic, education is part of our mission,” says Vanderbilt. “This curriculum is designed to help transition new APRNs into highly functional practitioners and ultimately ensure high reliability in our patient care. We believe this will also lead to more-satisfied long-term employees.”

Email comments to notablenursing@ccf.org



At Cleveland Clinic's main campus, Anne Vanderbilt, MSN, APRN, leads a discussion in the Transition to Practice program for advanced practice nurses. At right, program participant Christina Muha, MSN, CNP, listens to the discussion.

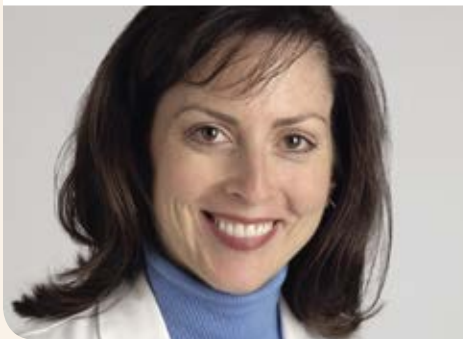
Currently, per the National Council of State Boards of Nursing, there are more than **267,000 APRNs** in the United States.

APRNs include:

- Nurse practitioners
- Clinical nurse specialists
- Nurse anesthetists
- Nurse midwives

Measuring Care

In many research studies, patients experienced equivalent outcomes when they received primary care from APRNs, compared with physicians. And patient satisfaction scores tended to be equal or higher with APRNs. The cost of APRN care is often lower than the cost of physician care.



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Holli Blazey, CNP (bottom left), is Nursing Wellness Coordinator. At right, Judi Bar leads nurses in a yoga session. Above are wellness activities at the annual nursing wellness retreat, including meditation and aromatherapy.

Caring for the Caregiver

Focusing on the Well-Being of Nurses

In recent years, Cleveland Clinic has turned increasing attention to helping its nurses deal with job stress and work-life balance issues. Cleveland Clinic's high-acuity environment, like so many others, can present nurses and other caregivers with ongoing physical and emotional challenges that can lead to burnout and poor health.

In a May 2017 study led by Kronos Inc., 63 percent of the 257 U.S. nurses studied had suffered burnout. And almost all of them described their work as mentally and physically demanding. Numerous prior studies have supported the long-standing belief that nursing is one of the most stressful occupations and that nurses' physical health and emotional well-being often are adversely affected by their jobs.

If the issue of burnout is not addressed, hospitals stand to lose as well, as nurses can become disengaged and eventually opt to leave the profession. And severe levels of stress are not only unhealthy, but they can negatively affect patient care.

"With 23,000+ nurses, our institute makes up the largest number of caregivers in the health system. It's so important that we have programs that can accommodate the diverse needs and schedules of our nurses," says K. Kelly Hancock, DNP, RN, NE-BC, Executive Chief Nursing Officer for Cleveland Clinic. "When nurses' personal wellness suffers, they cannot be at their best — for themselves, their patients or their families. Our nurse leaders encourage involvement in activities to help reduce stress, increase job satisfaction and support work-life balance."

PROGRAMS THAT PUT NURSING WELLNESS INTO ACTION

"We want to make a positive impact on the stress levels of our caregivers," says Holli Blazey, CNP, Nursing Wellness Coordinator. In 2017, Blazey organized a nursing wellness retreat that included guest speakers Michael Roizen, MD, former chairman of Cleveland Clinic's Wellness Institute, and Dr. Hancock. Free massages, yoga, Zumba® and stress

resiliency classes were offered and chefs demonstrated the preparation of healthy recipes. The event was very well-received by the nurses who attended, Blazey says, and she is currently working on hosting a similar event later this year.

Cleveland Clinic's Wellness Department offers a full menu of programs geared toward improving the health and well-being of caregivers. "Our biggest obstacle is nurse awareness of all of our offerings," Blazey says. She regularly gives presentations at different locations throughout the health system to spread the word on what is available (see box below).

Plans for the future include helping busy nurses eat healthy meals at work by offering "dietitian approved" grab-and-go-meals in the main cafeteria. Blazey also hopes to implement a wellness e-coaching program.

SCHEDULING SUPPORT FOSTERS NURSE JOB SATISFACTION

Since 2010, Cleveland Clinic has been utilizing the Kronos® workforce management system. The Kronos mobile app allows nurses to see their schedules, pick up open shifts and request time off.

"A manager truly works to accommodate nurses' scheduling needs and wishes, which helps support work-life balance," says Meg Duffy, MS, BSN, RN, Senior Director of Staffing and University Outreach. Once a schedule is posted, adjustments may be needed in response to census fluctuations and last-minute staffing changes. To manage these challenges, Zielony Institute Project Manager Anna Gesing, MBA, is leading the implementation of a newly instituted module through the Kronos system. This module allows Centralized Staffing Operations' caregivers to send text messages that alert nurses to work shifts that suddenly become available.

"A top priority for the staffing office is to ensure safe staffing levels with the correct skill mix. When this is achieved, nurses feel more supported and ultimately more engaged and satisfied," says Stephanie Gargiulo, BSN, RN, Nurse Manager, Centralized Staffing Operations for the Zielony Institute. "It makes a difference to nurses when they know we care," she says.

AT YOUR FINGERTIPS: ONLINE ACCESS TO WELL-BEING

On the Cleveland Clinic human resources portal that is available to all Cleveland Clinic employees, a "My Well-Being" tab is dedicated to "one-stop shopping for wellness activities and resources," says Jill Prendergast, Senior Human Resources Director for Nursing.

The portal houses links to a full menu of support services, including the Healthy Choice program for employees to

earn significant discounts off their health insurance premiums by meeting personalized medical, fitness and nutrition goals. Of the more than 36,000 health plan members who participate in Cleveland Clinic's Healthy Choice program, half of them are in coordinated care programs to manage chronic diseases.

Nurses can also access the HR portal to view their individualized career development plans and their total compensation and benefits package, as well as information on the many wellness activities available to them.

PROVIDING REAL-TIME CARE AND SUPPORT

Nurse Manager Donielle Finding, MSN, MBA, RN, at Cleveland Clinic Medina Hospital, takes full advantage of Cleveland Clinic's wellness offerings to provide support for caregivers on her unit who deal with daily end-of-life care and emergent situations. When there has been consistent unit stress over a period of a few weeks, she has brought in a massage therapist, reiki practitioner and pet therapist/dog dyad. She has also held nutrition classes on the unit and organized her staff to take part in Cleveland Clinic's Annual 5K nursing run.

"Just showing employees that you care goes a long way," she says. "That little thing you can do that shows 'I realize this isn't easy' provides so much support. Diversion activities don't always make the stress go away, but I've seen a rise in employee energy level."

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Some Wellness Offerings

Currently Available to Cleveland Clinic Caregivers

- Access to several community and on-site fitness centers
- Smoking cessation program
- Annual Nursing Run (5k), as well as an employee run
- On-site yoga classes at several locations and online 10- or 20-minute "yoga on demand" demos
- Annual Nursing Wellness Retreat
- Wellness Grand Rounds (livestreamed or watched via video on demand)
- A robust Wellness website and an Employee Wellness Facebook Group (closed)

Best PRACTICES

No. 1

In Cleveland Clinic's culture of continuous improvement (CI), nurses are empowered and expected to make improvements in their workplace. Some CI projects require time, planning and resources, and others are quick fixes. "Just do it" — or JDI projects — are simple solutions that can be put into place quickly to make immediate improvements.

Last year, nurses throughout the Cleveland Clinic health system implemented many JDIs. Two of them led to new best practices when medical emergency response teams are called to nursing units for cardiac arrhythmias, acute respiratory changes and other emergencies.

EMERGENCY PACER BUNDLE KIT

Cleveland Clinic's main campus has three 24-bed medical/cardiovascular stepdown units. Following a code blue last spring on one of the units, the caregiver team participated in a routine post-code review and analysis that led to creation of an emergency pacer bundle kit.

"The Adult Medical Emergency Team (AMET) did great, and the patient was fine," says Mia DiChiro, BSN, RN, PCCN, interim nurse manager of the units. "But the nurses thought, why not take the extra step in preparing for and having all the equipment right where you need it during an emergency?"

Previously, external pacers, wires and 9-volt batteries were stored in the medication room. Nurses would grab the pacer from a drawer, then enter a code to retrieve the wires and battery from a supply cart and place the batteries in the pacer. The staff believed they could streamline this process. "Time is critical, especially in a code situation," says DiChiro. "Two minutes can feel like two hours."

Now, thanks to the JDI suggested by Assistant Nurse Manager Michelle Chaffin, BSN, RN, PCCN, all external pacemaker

components are hanging in one area in the medication room, ready to use. Implementing the emergency pacer bundle kit has resulted in an average 2.5-minute time savings during codes.

TRANSPLANT-SPECIALTY CARE UNIT EMERGENCY CARE

Another JDI improved care when AMETs were called to the transplant-specialty care unit on Cleveland Clinic's main campus. "Nurses were concerned about delays in care during medical emergencies when they had to run from the patient's room to the supply cart or medication room to get equipment and supplies," says Peter Rozman, BSN, RN, CMSRN, nurse manager of the unit. "Nurses also saw opening the full crash cart as a waste of time, steps and resources if the emergency wasn't a code blue," adds Rozman.

Jamie Stellmar, BSN, RN, a clinical nurse on the transplant-specialty care unit, spearheaded creation of an AMET supply cart. The three-drawer cart includes com-

monly used supplies, including a bag of saline, test tubes, IV start kits, flushes and suction tubing. Each of the drawers is labeled so nurses can easily access items. In addition, a defibrillator sits on top of the cart. "We can use the resources we have on the unit without having to access other equipment and supplies related to cardiac or respiratory arrests," says Rozman. "It's a win for us to have what we need at the bedside during emergencies."

Both of these medical emergency JDIs improved response times. "Bringing simple ideas forward has a big impact on patient care, improving nursing practice and our patient outcomes," says DiChiro.

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No. 2

At Cleveland Clinic's 165-acre main campus near downtown Cleveland, an average of 1,500 on-site medical emergencies are called in to the main call center each month. Two direct telephone lines are available to activate medical emergency teams (METs). The lines are for patients who are unresponsive, not breathing or pulseless and for all other medical emergencies that require rapid response.

"We have learned that our operators need very specific information to make sure that the right team responds to the right location as quickly as possible," says Karen Graves, BSN, RN. "They do not, for example, need the 'chief complaint' or other details since the operators do not have a medical background. The wrong information can delay activation of the emergency team."

To help ensure that caregivers remember exactly what they need to report to operators, Graves came up with the "LEAN" acronym in 2016:

L=Location

E=Event (code or rapid response)

A=Adult or Child

N=Number to call back if more information is needed

"The four LEAN points facilitate the most expeditious medical emergency team activation," explains Graves, who serves as the Clinical Program Manager for the Critical Response and Resuscitation Committee in the Anesthesia Institute. LEAN is now part of call center protocol.

THE CALL CENTER

In 2017, 1.6 million calls came in to 23 operators at the main campus call center. Although medical emergency calls made up a small percentage of all calls, their importance in saving lives is critical.

"With so many types of calls coming in both externally and internally, we try to standardize processes as much as we can for our operators," says Call Center Support Services Director Geraldine Brinn. "The LEAN protocol has improved

our ability to expedite the activation of emergency response teams."

Today, when a call comes in to a MET line, operators use the following script:

"Medical Emergency Line, [Operator Name], is this for a Code or Rapid Response?"

"Is this for an Adult or Child?"

"What is your location?" (building, unit/floor and bed)

"What is your callback number?"

From there, automatic programming allows the operator to dispatch the emergency.

"It can be very stressful when caregivers need to activate

an emergency response," says Shannon Pengel, MSN, RN, Associate Chief Nursing Officer in Cardiac Nursing at main campus. "The LEAN acronym prepares

nurses ahead of time for these events."

IMPLEMENTATION

Since implementing LEAN in December 2016, average work time has gone down substantially as has the average call time. "This process has reduced the anxiety experienced by both our caregivers and the operators receiving our calls," says Pengel. "In an emergency situation, our caregivers are the lifeline between the patient in need and our emergency responders."

Graves emphasizes that this initiative was a team effort by nurse and physician leaders on the Critical Response and Resuscitation Committee. "Keeping the call simple has made a difference," she says.

The LEAN protocol was submitted as part of the "2017 Innovation Inventory program." This program encourages nursing institute caregivers to share patient care innovations implemented in the previous year. The program is managed by Cleveland Clinic's Office of Research and Innovation.

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Research Projects

Separate Studies Find Delirium Is Not Being Identified in Postsurgical Cardiac Patients



Jennifer Colwill
DNP, APRN, MSN, CCNS,
PCCN



Myra Cook
DNP, APRN, ACNS-BC,
CCRN-CSC, APRN/PA

Two clinical nurse specialists at Cleveland Clinic — Jennifer Colwill, DNP, APRN, MSN, CCNS, PCCN, of the Sydell and Arnold Miller Family Heart & Vascular Institute Stepdown Cardiothoracic Surgical Unit, and Myra Cook, DNP, APRN, ACNS-BC, CCRN-CSC, APRN/PA, coordinator in the Cardiovascular ICU, Heart and Lung Transplant Stepdown Unit — completed separate research projects on recognition of delirium. Both studies revealed that nurses often failed to recognize hypoactive delirium (characterized by lethargy and sedation) in postsurgical patients.

“It is well-documented that delirium is linked to poor outcomes in critically ill patients,” says Dr. Cook. Adds Dr. Colwill, “In older patients, it is linked to falls, infections and mortality. In postsurgical patients with cardiovascular disease, delirium is associated with a longer time to recovery and functional and cognitive impairments. The longer patients are delirious, the longer it takes them to get back to baseline, even after discharge.” For these reasons, it is important that delirium be recognized early, well-managed, and prevented if possible.

STUDY METHODS

Cook decided to perform her study after noticing that delirium rates in the 76-bed cardiothoracic ICU at Cleveland Clinic were far below those found in similar patient populations. “I was concerned that we were underrecognizing delirium, which it turns out we were,” she says. The prospective study included 210 paired APRN and nurse assessments conducted during routine care in the ICU over three months. Cook, serving as the APRN, noted 24 instances of delirium in the patient

population, particularly hypoactive delirium, compared with 13 instances recorded by nurses on the unit. Cook and the nurses used an ICU-specific version of the Confusion Assessment Method (CAM) screening tool, and the lack of inter-rater agreement was statistically significant.

Likewise, Colwill found there was poor inter-rater agreement based on individual’s Brief CAM (bCAM) components between APRN-nurse dyads in regard to observation of altered mental status, inattention, altered level of consciousness and disorganized thinking in her study of 555 bCAM observations. Twenty-four patients were positive for delirium based on her assessment as APRN, yet nurses in the acute care postoperative ward identified only four patients with delirium.

RESEARCH IMPLICATIONS FOR PRACTICE AND EDUCATION

Both researchers indicated that it can be difficult to detect hypoactive delirium symptoms in postsurgical patients since behaviors associated with this state are less visible than are signs of hyperactive delirium (characterized by agitation and, sometimes, aggressive behavior). In addition, if nurses do not answer the first question on the bCAM tool correctly — which asks if patients had fluctuations or alternations in mental status — patients may easily be falsely identified as negative for delirium. “Nurses may only look at the patient’s status from the start of their shift or from the handoff from ICU rather than at baseline assessments (before hospital admission) for comparison,” reports Dr. Colwill. “And if you say no to the first question on the bCAM, then you don’t need to finish the assessment.”

“We need to raise awareness and test strategies that will improve recognition by nurses in everyday clinical practice,” states Cook. Both researchers believe that multimodal education of nurses would be ideal, involving interactive case studies, simulations and didactic lectures. In addition, they say that implementing standardized processes — such as doing a better job of documenting mental status fluctuations in the electronic medical record — and operational supports are essential to improved recognition of delirium.

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Hiring Staff to Get Patients Moving May Help Them Go Home Sooner

When hospitals utilize mobility technicians — individuals hired to supplement the nursing staff with patient mobility and ambulation — patients may have improved outcomes. This was a finding from a study conducted by nurses on two medical-surgical units at Cleveland Clinic's Euclid Hospital.

“The study had some interesting findings related to falls and patient disposition,” says Nurse Manager Vickie Gardner, MSN, RN, at Cleveland Clinic Euclid Hospital. In the second half of the study, the research team found that patients with mobility technicians had a higher rate of discharge to home versus other dispositions. The raw data also showed a higher fall rate among patients seen by mobility technicians. This raised new questions for the research team. Were there more falls because patients had increased mobility and they now were getting out of bed without calling for help?

Research has shown that prolonged immobilization of patients can lead to poor patient outcomes that are reflected in higher fall rates and increased length of stay. This led Gardner and her nursing colleagues to conduct their own study to examine whether employing dedicated mobility technicians would improve patient outcomes.

The nursing research team applied for and received a \$150,000 grant from Cleveland Clinic's Risk Management Funding Group, which allowed them to hire and train 4.1 full-time equivalent personal care nursing assistants to become mobility technicians. Then, using a crossover, interventional design, they deployed the technicians for alternating six-month periods on two medical-surgical units during 2015 and 2016.

The mobility technicians received a two-week specialized orientation focused on safe transfer techniques, range of motion exercises, and accurate documentation in the medical record. The mobility technicians were scheduled from 7 a.m. to 7:30 p.m., seven days a week. They aided the nurses in promoting mobilization and increasing range of motion a minimum of three times during the day for each patient.

Gardner and her colleagues used electronic medical records to look at patient metrics concurrently and retrospectively, including pressure ulcers, catheter use, fall frequency,

length of stay and readmission rates. Analysis of the data showed patients who received help from the mobility technicians were discharged home at a higher rate, 54 percent versus 49 percent, compared with patients on the usual care unit.

Although the fall rate seemed higher numerically on both units when mobility technicians were in use — after analysis, the fall rate was “not statistically different.” After interviewing patients, Gardner learned many were eager to get out of bed after ambulating earlier with a mobility technician and were more willing to get out of bed without calling for assistance. There were no hospital-acquired pressure ulcers and only one catheter-associated urinary tract infection event during the study time frame, therefore, no formal statistical analyses of these measures were performed.

Gardner says more in-depth research is needed to identify significant metrics. Interviews with nursing staff and patients provided positive feedback and the desire to continue the mobility program. Patients reported that they appreciated the mobility technicians and that the encouragement and support they provided helped motivate them to get out of bed more often. The nursing staff also felt the additional support of the mobility technicians increased patient mobility and promoted awareness for the need to be active while in the hospital.

In addition to Gardner, the research team included Dawn Bailey, BSN, MAOM, RN, NEA-BC; Jackie Difiore, MSN, MHA, RN; and Esther Bernhofer, PhD, RN-BC

Email comments to notablenursing@ccf.org



Vickie Gardner
MSN, RN

Facts & Figures

WHO WE ARE

The Stanley Shalom Zielony Institute for Nursing Excellence oversees the practice, education and wellness offerings for 23,669 nursing caregivers throughout Cleveland Clinic in inpatient, outpatient, rehabilitation and home care fields.



Nurses provide care for:

- 4,450+ BEDS SYSTEM-WIDE
- 200+ OPERATING ROOMS
- 7.6 MILLION OUTPATIENT VISITS
- 140 SPECIALTIES
- PATIENTS FROM ALL 50 STATES AND 185 COUNTRIES AROUND THE WORLD
- THE NURSING STAFF INCLUDES:
 - 12,897 REGISTERED NURSES
 - 8,616 NURSING SUPPORT STAFF
 - 1,703 APRNS
 - 453 EXECUTIVE NURSE LEADERS

WHERE WE ARE



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Awards and Honors

In fall 2017, **Cleveland Clinic's South Pointe Hospital achieved Magnet® status** from the American Nurses Credentialing Center. South Pointe joins Cleveland Clinic main campus and three other regional hospitals in this prestigious designation.

Three cardiovascular stepdown units at Cleveland Clinic's main campus received the prestigious **Beacon Award for Excellence**, all at the Gold level. The units are part of the Sydell and Arnold Miller Family Heart & Vascular Institute. The Orthopaedic Nursing Unit at Cleveland Clinic Euclid Hospital was also honored with this award at the Silver level. Beacon Awards from the American Association of Critical-Care Nurses (AACN) recognize hospital units for demonstrating exceptional care through improved outcomes, greater overall satisfaction, and a positive and supportive work environment.

Deborah Klein, MSN, RN, ACNS-BC, CCRN, CHFN, received the 2017 Excellence in Clinical Practice Award from the American Heart Association. Klein is a clinical nurse specialist in the Coronary ICU, Heart Failure ICU and Cardiac Short Stay/PACU/CARU.

Meredith Foxx, MSN, MBA, APRN, PCNS-BC, PPCNP-BC, CPON, was selected to be the 2018 Nurse Advocate by the Ohio American Association of Nurse Practitioners. Foxx is Executive Director of Advanced Practice Nursing at Cleveland Clinic.

Joyce Lee, BSN, RN, Nurse Manager at Cleveland Clinic Hillcrest Hospital, received a Daisy Award, based on a patient submission for her exceptional care.

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