



# NURSING BEAT

THE PULSE OF NURSING AT MOSES CONE HEALTH SYSTEM

Vol. 2, No. 4

Fall 2005

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Linda Donovan, RN, IBCLC, assists a new mother with breastfeeding.

## Breastfeeding in the Early Postpartum Period

By Linda Donovan, RN, IBCLC, and Anita Myers, RN, C, MSN

According to Healthy People 2010, the 1998 national breastfeeding rate in the early postpartum period was 64 percent, at six months it was 29 percent, and at one year it dropped to only 16 percent. The Healthy People 2010 initiative has set breastfeeding goals for early postpartum at 75 percent, for six months at 50 percent, and for one year at 25 percent. The early postpartum breastfeeding rate at The Women's Hospital of Greensboro is 76 percent, but in the last five months it has shown a trend toward 80 percent.

According to the American Academy of Pediatrics policy statement on breastfeeding, considerable research in recent years validates the advantages of breastfeeding. The benefits for the infant include overall improvements in health, immunity, and growth and development. For example, breastfed

infants may have less diarrhea, ear infections, and respiratory infections than their formula-fed counterparts. In addition, research has shown a decreased incidence of childhood leukemia and juvenile diabetes, as well as an increase in IQ scores by about six points. Advantages for mothers include a reduced risk of postpartum bleeding, a faster return to pre-pregnancy weight, a reduction in the incidence of premenopausal breast cancer, and a decrease in the incidence of osteoporosis.

Families and communities also benefit from the global effects of breastfeeding. These benefits include a reduction in annual healthcare costs and decreased costs for public health programs, such as the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). Research also has shown a decrease in

*See Breastfeeding, page 5*



**MOSES CONE**  
HEALTH SYSTEM

# Message from Joan: Katrina, Kate and Nursing

Katrina wreaked incredible damage, destroyed lives and property, and demonstrated the good and the bad of our disaster preparedness. Katrina also provided yet another example of the critical role nurses play in significant events in this country. Nurses were important members of the many disaster teams sent to the Gulf. Nurses were among the last to leave the hospitals, which were left without lights, water, plumbing or air conditioning, but still had very fragile patients needing life support. Nurses evacuated patients to hospital rooftops and bag breathed them in the dark of night while praying for rescue. Nurses in these hospitals slept little, went without showers and toilet facilities, and continued to care for their patients even while they were unsure about the safety of their own families and homes. These nurses truly made a difference. They deserve our respect and gratitude.

While Katrina continued her deadly trek across the Gulf Coast, my daughter, Kate, was admitted for



preterm labor at 28 weeks gestation. This is her first baby, and Kate was admitted to the Ohio hospital where I had been the Chief Nursing Officer for many years. As I flew to her side, I was scared but comforted by my knowledge of the real skill and expertise of the hospital's OB nursing staff. I prayed that Dana, the OB Clinical Nurse Specialist, was on duty. I knew she would take good care of

Kate and mobilize all the resources necessary to care for a premature baby, if that became necessary. Nurses were playing an important role in the lives of Kate, her husband and the rest of our family.

Fortunately, after a tense couple of days, Kate was discharged to home on bed rest. We hope that she stays pregnant for several more weeks! On our way home from the hospital, Kate, an attorney and very analytical, reflected on her care and her nurses. "I'm surprised how they all knew the answers to my questions (and there were many) – they really are experts in premature labor, aren't they?" Yes, they are, and I respect and thank them for that.

Katrina and Kate, new stories about nursing making a difference.

A handwritten signature in cursive script that reads "Joan".

Joan Wessman, RN, MS  
Chief Nursing Officer

## A Year In Review As A New Grad

By Sabrina Graham, RN, BSN, and Lisa Tuttle, RN



Lisa Tuttle, RN, (right) and her preceptor, Susan Seel, RN.

*Nursing graduates enter their nursing careers with excitement and with apprehension. Below, **Lisa Tuttle, RN, ICU/Step Down at Wesley Long Hospital, shares some of her experiences from her first year. She graduated in May 2004 from Randolph Community College.***

I encountered a variety of emotions this year. I shared with my patient's family the loss of a loved one, and I celebrated the elation of a patient's survival even though the odds were stacked against him. As a former Spanish teacher in the public school system, I seem to thrive when I am helping others. It enhances my own personal well-being. One of my special experiences occurred during the sixth month of my nursing career. It was my first encounter with death. Fortunately, the family seemed very well prepared. The patient, suffering from chronic obstructive pulmonary disease, had been bed bound for several years. The patient, who was transferred to my unit after surviving a code, was intubated. The family wished

# Dialysis Staff Performs First Red Blood Cell Exchange

By Sharon Shoffner, RN, and Peggy Eller, RN

In early 2004, James Granfortuna, MD, approached The Moses H. Cone Memorial Hospital Hemodialysis director about a new and exciting technology called red blood cell (RBC) exchange. The goal of an RBC exchange is to replace abnormal red blood cells with healthy ones in order to re-establish microvascular flow and restore oxygen delivery. The RBC procedure benefits sickle cell anemia patients in crisis, as well as patients with malaria, and carbon monoxide poisoning. The hemodialysis department had both the technology and the expertise in extracorporeal blood circuits to develop this procedure.

Sharon Shoffner, RN III, and Sandra Tedder, RN III, Hemodialysis, received special training by Fresenius, the company that manufactures the machine for RBC exchange.

After assisting with the development of policies and procedures, Sharon and Sandra trained their colleagues in hemodialysis to perform RBC exchanges.



From left to right, Robin Joyce, RN, and Britannia Moore, RN, assist a patient during an apheresis procedure similar to an RBC exchange.

On Feb. 10, Sandra performed the first RBC exchange on a sickle cell anemia patient. The procedure was repeated, totaling three exchanges. The patient's lab values improved greatly, and the first RBC exchange was deemed a success.

Although no other patients have had this procedure done, the dialysis department is very excited that they can now offer this new technology at Moses Cone Hospital. "Hopefully we will be able to reach more sickle cell patients and help them avoid a crisis situation," Sandra says.

for the patient to be comfortable and requested that his death be natural when they stated "to be left in God's hands." The patient's medical plan ultimately called for the removal of life support and the discontinuation of all medications that maintained his heart rate and blood pressure. I remember the morning when he was extubated. It was 8:30 a.m., and his oxygen saturations were progressively dropping. By noon his heart rate shot up to 185 and dropped precipitously to 70. At that time, I remember telling family in the patient's room that, "It was nearing time for him to pass." I instructed the family to gather all members in the waiting room "to come now" if they wanted to be

present for his death. I, too, was with them as we watched the patient and his monitor. When he took his final deep breaths, his heart rate slowed even more. Then, I gently placed my hand on his shoulder and said, "It's OK. You can now walk with your angels." As soon as those words came from my mouth, his monitor displayed a straight line. It was a sweet death, if there is such a thing. I felt blessed to have been part of his death experience. What an awesome responsibility we have.

I thoroughly enjoyed my first year in nursing, and I am very thankful for those who have assisted me. The Graduate Advancement Program

supported and encouraged me to share my journey with other colleagues going through their experience. My co-workers have been incredible in guiding and mentoring me through the challenges of this year. I have learned so many new skills, including time management. Now I am excited about learning more, especially how to care for complex patients with multiple problems. I appreciate my patients who have allowed me to take part in their healing. Nursing allows me to support patients and families in their most vulnerable times. As I continue my nursing journey, learning each day, I also learn even more about myself.

# Nurses Going Places

## Awards and Honors

### North Carolina Great 100

- Susan Brady, RN, 5500, The Moses H. Cone Memorial Hospital
- Carol Davis, RN, Adult Inpatient Department, Behavioral Health Center
- Stephanie Dillon, RN, ICU/ Stepdown, Wesley Long Community Hospital
- Melinda Madtes, RN, HealthServe Community Health Clinic
- Susan Seel, RN, ICU/ Stepdown, Wesley Long Community Hospital
- Debra Stanford, RN, Medical/ Surgical ICU, The Women's Hospital of Greensboro
- Youland Williams, RN, Inpatient Oncology, Wesley Long Community Hospital
- Jill Wine, RN, Inpatient Oncology, Wesley Long Community Hospital

### Invited member, North Carolina Center for Nursing Advisory Council

- Joan Wessman, RN, MS, Chief Nursing Officer

### Elected Delegate, 2006 North Carolina Nurses Association Convention

- Joan Wessman, RN, MS, Chief Nursing Officer

### Inductee, Sigma Theta Tau International Honor Society of Nursing

- Sherri Osborne, RN, BSN, Supervisor, Moses Cone Health System Extended Care Center

## Publications and Presentations

### Ninth Annual Magnet Conference, "Celebrating Excellence in Nursing"

Miami Beach, FL, October 26-28, 2005

- "Interdisciplinary Magnet Champion

Strategy for Magnet Appraisal," poster presentation - Susan Hamilton, RN, MSN, Service Director, and Beverly Harrelson, RN, MSN, Clinical Nurse Specialist

- "Incorporating Reflective Thinking Into Practice: A Research-based Approach to Enhancing Professional Development," poster presentation - Frostenia Milner, RN, MSN, Service Director
- "Research in the Magnet Setting: Diverse Views," panel presentation - Debbie Green, RN, MSN, ANP/GNP, Service Director and Daria Kring, RN, BC, MSN, Clinical Nurse Specialist

### Academy of Medical-Surgical Nurses 14th Annual Convention, "The Many Faces of Medical-Surgical Nursing"

Las Vegas, NV, October 26-30, 2005

- "The Impact of a Dedicated Charge Nurse on Team Perception," poster presentation - Candace Hughes, RN, MSN, Director, 5700/ 3500 and Daria Kring, RN, BC, MSN

### LPN 2005, July/ August, 2005

- "Get the lowdown on chronic kidney disease" - Daria Kring, RN, BC, MSN, Clinical Nurse Specialist

## Graduations

### Bachelor of Science in Nursing

- Sherri Osborne, RN, BSN, Supervisor, Extended Care Center, Winston-Salem State University

## Promotions

### Registered Nurse, Level III

- Jennifer Britton, RN, SICU, Moses Cone Hospital
- Helle Layton, RN, SICU, Moses Cone Hospital
- Shannon Parrish, RN, Inpatient Oncology, Wesley Long Community

Hospital

- Robin Roberts, RN, SICU, Moses Cone Hospital
- Gwen Yates, RN, Inpatient Oncology, Wesley Long Community Hospital

### Assistant Director

- Trina Cleveland, RN, Mother/ Baby/ Central Nursery, The Women's Hospital
- Kathy Morrison, RN, Mother/ Baby/ Central Nursery, The Women's Hospital

## Certifications

### Certified Clinical Research Professional

- Cindy Shaw, RN, BSN, CCRP, Clinical Research Nurse, Regional Cancer Center

### Certified Gastroenterology Registered Nurse

- Brian Beard, RN, CGRN, Endoscopy, Moses Cone Hospital
- Susan Kincaid, RN, CGRN, Endoscopy, Wesley Long Community Hospital
- Anne Heilig, RN, CGRN, Endoscopy, Moses Cone Hospital
- Debi Mays, RN, CGRN, Endoscopy, Moses Cone Hospital
- Suzanne Peele, RN, CGRN, Assistant Director, Endoscopy, Moses Cone Hospital
- Karen Scoggins, RN, CGRN, Endoscopy, Wesley Long Community Hospital
- Mela Tucker, RN, CGRN, Director, Endoscopy, Moses Cone Hospital and Wesley Long Community Hospital
- Connie Williams, RN, CGRN, Assistant Director, Endoscopy, Wesley Long Community Hospital

### Certified Geriatric Nurse Practitioner

- Brenda Murphy, RN, MSN, APRN, BC, Clinical Nurse Specialist

See Nurses Going Places, page 12

# Why All the Talk About Length of Stay?

By Debbie Green, MSN, RN, ANP/GNP

Recently, patients' length of stay at Moses Cone Health System has been longer than expected. Excessive lengths of stay impact hospital capacity, staffing needs, patient satisfaction, and physician satisfaction. It also impacts the number of patients holding in the Emergency Departments, resulting in overcrowding. Patients have to wait longer for surgeries and admission to the hospital. Patients also have to wait longer for transfer from other hospitals.

A recent analysis of the System's length-of-stay data revealed that we have a variance of up to .37 days between the budgeted and actual length of stay for this fiscal year. This means that we have up to 25 extra patients a day in our system. Staffing for up to 25 extra patients per day equates to the need for as many as 36 extra registered nurses per week.

Many creative strategies have been implemented in order to address length-of-stay concerns. For example, Department 5000 piloted a "Discharge by Appointment" project. Upon admission to the floor, patients are educated about the date and time of anticipated discharge. This information is written on each patient's dry erase board. The dry erase board is also used for multidisciplinary team information (OT, PT, Pharmacy) and updates. As a result of this pilot, which involved 383



Gretta Frierson, RN, BSN, consults with Shannon Leach, RN, regarding patient discharge appointments on department 5000.

patients, 71.8 percent were discharged on or before the expected discharge date. The department has seen length of stay decrease from 7.0 days to 4.2 days. Additionally, staff states that this project has increased team spirit and patients like the concept.

Other strategies, developed through shared governance councils, include the use of "the green sticker" and dry erase boards for communication of the anticipated discharge date to patients and families. The green sticker is intended for use by physicians, in order to communicate to the

multidisciplinary team the anticipated discharge date. Nurses are asked to ensure that the sticker is placed on the front of the chart and that collaboration occurs with the medical staff in order to identify the anticipated date of discharge. The anticipated discharge date and time should also be entered onto patients' dry erase boards so that patients and families can visualize this information and begin to prepare for the event.

Preparing for discharge is often challenging for patients and families. As a result, the Care Management

*See Length of Stay, page 8*

## Breastfeeding, Continued

employee absenteeism among women who breastfeed.

Breastfeeding has been shown to be successful when it is started within the first hour of life. During this period after birth, the infant is more awake, alert, and has a more intense suck. There are immunological benefits to the baby who is breastfed within the first hour, as well as a decrease in jaundice and weight loss. For the mother, breastfeeding within the first hour promotes uterine contractions, which reduces postpartum blood loss and breast engorgement. Encouraging early breastfeeding supports mother and newborn bonding as well as patient

satisfaction.

To encourage breastfeeding within the first hour at The Women's Hospital, a quality initiative was developed. Our goal was to reduce the number of barriers associated with breastfeeding within the first hour and improve patient satisfaction. The Women's/Infant/Children Service Practice and Quality Council developed a multidisciplinary breastfeeding task force. After many months of work, a plan was developed that included formal staff education, a storyboard, and continuous monitoring of success. Additional interventions to promote breastfeeding included implementation

of the Breastfeeding Assessment Sheet and a process of alerting Mother/Baby staff to the breastfeeding plan.

In the first quarter after the plan was implemented, our breastfeeding rate within the first hour of birth was 69 percent and by the third quarter of 2005, it was up to 74 percent. To continue to reach our goal, ongoing education is planned and the task force will continue to evaluate the data. Our ultimate goal for early postpartum breastfeeding is 95 percent.

# Attention to Retention

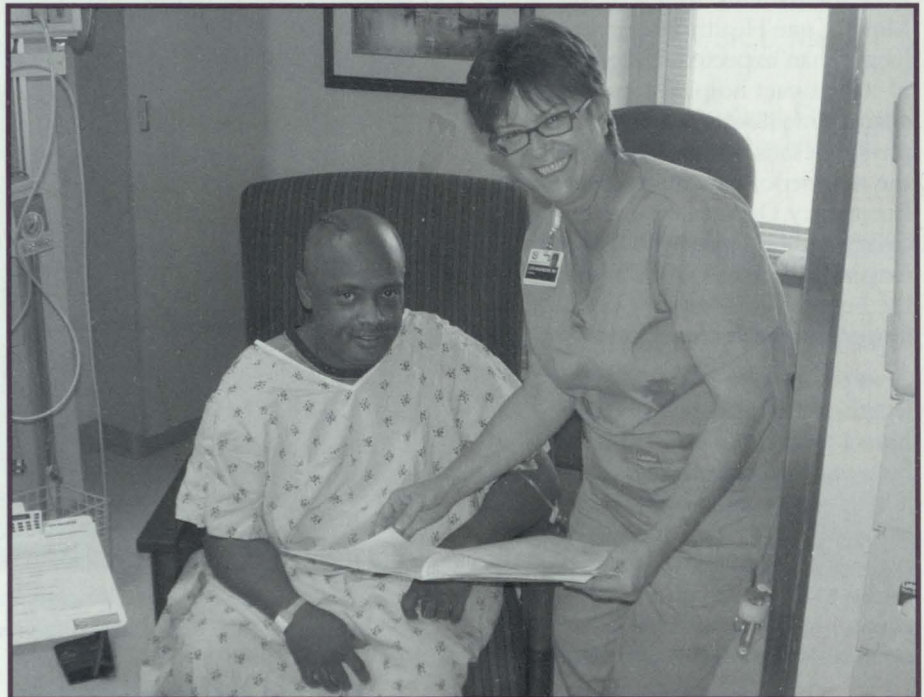
By Joan Hildebrandt, RN, CNOR

Retention is to nursing as location is to real estate. Everything! Attracting and retaining qualified nursing professionals is no small feat, and considering the importance of retention in today's healthcare arena, finding what works is key to employee satisfaction. To find out just how well we are doing regarding our retention efforts, several nurses were asked, "What's Moses Cone Health System doing right regarding retention?" We talked to nurses across the System whose years of experience ranged from four to 40. Their answers, like their experiences, were all different.

**Nancy Austin, RN**, Mother/Baby Unit, The Women's Hospital of Greensboro, became a registered nurse in 2001. In 2003, she was a Nursing Excellence recipient. She believes the retention of nurses within the System is due, in part, to the programs we offer. According to Nancy, the Graduate Advancement Program (GAP) is a great retention tool. Designed to facilitate the transition from student nurse to staff RN, this program seeks to instill a sense of confidence and preparedness in the novice nurse. "I found this to be invaluable as a new graduate nurse," says Nancy.

**Lois Washburn, RN**, Neurological Intensive Care Unit (3100), The Moses H. Cone Memorial Hospital, graduated in 1998 and says, "Moses Cone Health System really stands out in the retention race by offering creative scheduling, retention bonuses and tuition reimbursement. Also, allowing nurses to transfer throughout the System encourages both personal and professional growth."

**Susan Seel, RN**, Intensive Care Unit / Step Down, Wesley Long Community Hospital, became a registered nurse in 1991. Susan is a Great 100 nurse this year. She says, "I feel that retention efforts are successful because nurses are supported to succeed and then



Lois Washburn, RN, appreciates the retention efforts at Moses Cone Health System.

exceed their career goals." Susan also feels that shared governance empowers nurses to voice their opinions and concerns and allows input into practice. Financial support for national seminars and conferences is also valued.

Having been a member of the nursing profession for 25 years, **Germaine Williams, RN**, Adult Inpatient Unit, Moses Cone Health System Behavioral Health Center, says, "The things that keep me with the System include accessibility of leadership, the caliber of professionalism and the teamwork exhibited by my peers." She adds with a smile, "The retention bonus doesn't hurt either."

Lastly, we wanted to know what retention strategy works for a nurse with 40 years of nursing service. **Inatha Matthews, RN, BSN, 2A**, Annie Penn Hospital, finds our most successful retention tool to be, simply, communication. "I think communication between nursing staff and leadership has improved immensely. Nurses need to know what is going on, and thanks to the

formation over the years of a number of committees, nurses are now able to keep up with changes affecting both the System and our departments."

Retention is an around-the-clock endeavor and the System offers many programs not found at area hospitals. **Dianna Young, RN, MSN**, Retention Coordinator, states, "We are committed to our nursing staff and continually research and develop improved means of retention." Included in these efforts are the GEM program, Great 100, certification reimbursement, and clinical ladder opportunities. One of the most recent innovations is the development of Trading Spaces, a voluntary program offering nurses a break from their home departments. In addition to these strategies, the System paid \$2.6 million in retention bonuses last year.

Make no mistake, nurses do what they do, not for the perks, not for the money and surely not for the glamour. They do what they do for their patients. And that makes them ...priceless.

# Saving Lives Through Organ Donation

By Susan Moore, RN, BSN, CVN

Replacements of diseased organs are one of the great achievements in medicine, especially for the thousands with end-stage organ failure who have received them or are waiting for them. Transplantation offers hope and survival for those waiting, but unfortunately the need for organs outweighs the availability. Approximately 90,000 people in the United States are waiting for life-saving organs while only 20,000 will receive them. Every 12 minutes another name is added to the waiting list as 19 people die every day from organ failure.

To become an organ donor, a person must be certified by a physician as "brain dead." When someone is brain dead, it means that the brain is no longer working in any capacity and never will again. Other organs, such as the heart, kidney, liver, can still work for a short time if the breathing supports are left in place. When brain death is declared, it means the person has died. "Only 1.5 percent of deaths are declared brain deaths," says Thom Flick, Organ Donation Coordinator for Carolina Donor Services (CDS). According to Thom, timely consults are very important to increase our potential organ donations.

Efforts have been made to increase the number of potential organ donations at The Moses H. Cone Memorial Hospital. A team of administrators, physicians, and clinical staff from Moses Cone Hospital, has been working with Carolina Donor Services to set new standards regarding timely referrals and in identifying potential organ referrals. The federal law has mandated that Carolina Donor Services, our designated organ procurement agency, be notified of individual patients who have died or whose deaths are imminent. The law also requires that the person who approaches family members be a trained organ procurement representative.

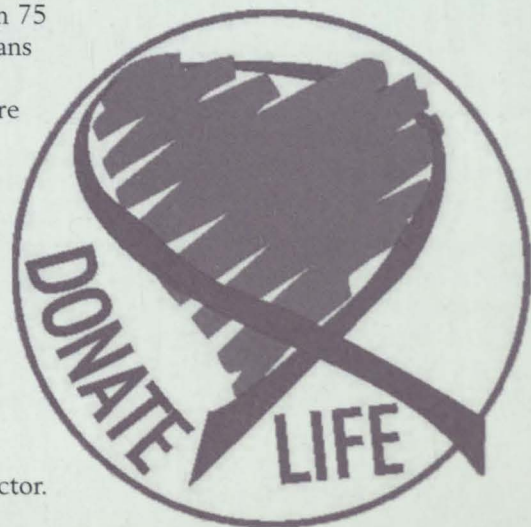
Carolina Donor Services has established clear criteria for timely referrals. Nurses are to contact CDS within one hour when the Glasgow coma scale is less than five for a patient with a neurological insult. Also, staff are to call when there are discussions for testing for brain death, when ventilator discontinuation is being considered for a patient with a neurological deficit, and when there is consideration of a "do not resuscitate" order in a patient with a neurological insult. Nurses should call CDS when inquiring about the appropriateness of an organ donation or when a family member initiates a discussion about organ donation. Nurses do not need a doctor's order to contact CDS. It is imperative for the nurse not to talk to the family about organ donation. If family approach, thank them and tell them that you will have CDS contact them. Carolina Donor Services will come on site and talk with the family. Carolina Donor Services has established an early intervention program called the "Huddles Process." It is designed to assist and support families in cases of brain death and organ donation.

Most of the potential organ donations come from 200 hospitals in the United States. Ten of these hospitals, including Moses Cone Hospital, are located in North Carolina. All of these hospitals have set goals to achieve a greater than 75 percent conversion rate. This means all referrals that are medically acceptable for organ transplant are reported to Carolina Donor Services for evaluation. Moses Cone Hospital is one of five hospitals in North Carolina that recently received an award for achieving this goal. Credit goes to our nursing staff for their consistency in reporting timely referrals. "The process of organ donation involves a team development approach," Thom says. Communication is a key factor.



Thom Flick, Organ Donation Coordinator, consults with Pam Alvord, RN, 2900, regarding a potential donor.

Since Oct. 1, 1997, the "Gift of Life Act" has greatly improved organ and tissue donation in North Carolina. The nurse's role is to be keenly aware of the functions of Carolina Donor Services. We can be advocates for those waiting for organs by facilitating potential donations. For more information regarding organ donation at Moses Cone Hospital, go to Public Folders on the e-mail system and click on organ donation.



# In Sickness and In Health

By Margaret Ann Martin, RN, BC

After two months of being in and out of the hospital and Wesley Long Nursing Center, Mr. S. was finally going home. As his nurse that day, I shared in his excitement. The discharge, however, would be bittersweet. His wife also was a patient in our department, and she was still very ill. He had been to visit her daily in her room – one of those tiny private rooms at the end of the hall with a narrow window in the corner. His own room had a large picture window overlooking Wendover Avenue, but Mrs. S. was too weak to visit him.

About mid-morning, Mrs. S.'s nurse, **Anne Blankenship, RN**, Third Floor, approached me about transferring Mrs. S. to her husband's room after his discharge so she could see outside. Mrs. S. was doing very poorly and needed cheering. I thought it was a wonderful, compassionate idea, but Mr. S.'s ride home wouldn't come until mid-afternoon. Anne was concerned that his room might be automatically assigned to a new admission on our busy floor if she didn't "claim" it early in the day. Then we thought, "They've been married more than 50 years – why not put them in the room



Mr. S. holds his wife's hand one last time.

together?" I presented the plan to Mr. S. who liked it, but said he didn't feel strong enough to sit up in a chair for four hours until his ride came at 2 p.m. Then someone said, "That's a big room – we can fit two beds in there." And that is what we did!

The nurse techs shifted furniture until Mr. and Mrs. S. were side-by-side in their respective hospital beds – holding hands across the bedrails. The techs

even managed to fix the meal trays over the beds in that crowded room. It was a sweet moment.

Mr. S. went home that afternoon. His wife had as cheerful and bright a hospital room as could be had. The staff were pleased that we had helped Mr. and Mrs. S. be together. We didn't know it would be one of their last times. Mrs. S. died about a week later.

## Length of Stay, Continued

Department has taken the lead in ensuring that all departments have regularly scheduled Patient Outcome Planning (POP) conferences. During POP conferences obstacles to progression of care are discussed and plans developed. Department 6100 (Pediatrics), took this one step further. Families are involved in rounds and conferences. Staff has noted a positive impact on progression of care, length of stay, and patient and staff satisfaction.

Keeping up with progress on length of stay has caused the System to analyze reporting. As a result, departments now receive a regular report on department-specific, campus-specific and system-wide length of stay. Additionally, physicians are now receiving reports outlining their patients' length of stay compared with other physicians' patients and patients at other hospitals.

The information on the reports helps physicians and our System work together to determine possible opportunities for improvement.

Opportunities for improvement frequently result in quality improvement initiatives. For example, Clinical Performance Improvement (CPI) Teams are working with physicians to develop Clinical Practice Guidelines, revise clinical pathways based on evidence-based practice standards, and develop standing/default protocols. It is anticipated that these tools will help guide practitioners regarding key progression outcomes and interventions that will result in successful management of length of stay. Two examples are recent evidence of this collaboration. The Medical-Surgical CPI Team collaborated with medical staff to develop the Deep Vein

Thrombosis Protocol, intended to prevent the consequences of immobility associated with hospitalization. The Pulmonary CPI Team worked with medical staff to develop the vaccine protocol, designed to ensure patients are immunized for influenza and community-acquired pneumonia. This results in decreased admissions and shorter lengths of stay for these diagnoses.

With all disciplines working together length of stay can be reduced. The final result will be fewer patients in acute care beds each day, resulting in improved throughput of patients and increased quality of care. These outcomes will lead to increased effectiveness and efficiencies, as well as increased staff and patient satisfaction.

# Shared Governance

## Nursing Executive Council

Reporting: **Diane Warden, RN,**  
CPAN, Chairperson

- **Teresa Farr, RN,** is the new 2005-2006 chairperson.



Teresa Farr, RN

- A five-minute video is being developed for new patients to view on admission.
- The huddle sessions are going well.
- The new Suicide Precautions Policy is complete. Nursing staff is encouraged to complete the CBL. The forms will be ready for use in October.

## Professional Development Council

Reporting: **Wanda Scott, RN,**  
Chairperson

- **Karen Lynch, RN,** is the new 2005-2006 chairperson.



Karen Lynch, RN

- The first Magnet Meal took place on Aug. 11. Nursing representatives were chosen from each department to attend. There was a lot of positive feedback.
- The charge nurse workshop will continue due to popular demand.
- The LPN performance appraisal is complete. The nursing tech tool will be revised next.

## Med-Surg Service Practice and Quality Council

Reporting: **Teresa Farr, RN,**  
Chairperson



Gretta Frierson, RN

- **Gretta Frierson, RN,** is the new 2005-2006 chairperson.
- **Gretta Frierson, RN,** 5000, presented a quality project called Discharge by Appointment. A multi-disciplinary team anticipates the patient's discharge date, as well as time of day.

Not only did length of stay decrease, (71.8 percent were discharged on or before their expected date), but patients like the concept.

- The policy and procedure for clearing Alaris IV pumps every shift was discussed. Members with departments not following this procedure were asked to develop an action plan for their department.
- The DVT/PE Prophylaxis Order Form was implemented on nursing departments on Sept. 1. The form is placed on all inpatient charts. A risk assessment is initiated by the nurse to prompt physicians to consider prophylaxis for their patients. The physician completes the form.

## Women/Infant/Children Service Practice and Quality Council

Reporting: **Linda Donovan, RN,**  
IBCLC, Chairperson

- **Kelly Tuggle, RN,** is the new 2005-2006 chairperson.



Kelly Tuggle, RN

- Birthing Suites is doing a research project on the effectiveness of Elamax cream in reducing pain during IV insertions.
- An "Infant Misidentification Packet" has been put into place.
- **Melissa Wilkins, RN,** Birthing Suites presented a video titled, "Muslim Cultural Issues in Pregnancy."
- OB Triad and Peds Triad provide an opportunity to communicate with administrators, nursing and medicine. **Cindy Jarrett-Pulliam, RN, MSN,** is on the committee and encouraged staff to bring issues and concerns for the agenda.
- The WIC Model of Care Committee continues to work on Communication, Competency, and Employee Satisfaction. The Communication Sub Committee is ready to roll out a new form that will be faxed to the receiving RN before the transfer. The form will not replace face-to-face reports, however it is intended to help ease the transfer. This form will become part of the medical records.

- A Spanish class for clinical caregivers will be offered at The Women's Hospital. The classes will be four weeks, with each class lasting one to 1 1/2 hours.

## Operative Service Practice and Quality Council

Reporting: **Debbie Dallas, RN,**  
Chairperson

- **Pattie Schenk, RN, CPAN,** is the new 2005-2006 chairperson.



Pattie Schenk, RN,  
CPAN

## Behavioral Health Service Practice and Quality Council

Reporting: **Kelly Southard, RN,**  
Chairperson

- **Donna Shimp, RN** is the new 2005-2006 chairperson.



Donna Shimp, RN

## Nursing Leadership Council

Reporting: **Evette Law, RN, MSN,**  
Chairperson

- **Mona Easter, RN, MBA,** is the new 2005-2006 chairperson.



Mona Easter, RN,  
MBA

- After following up on several root cause analyses it was decided to use the Situation-Background-Assessment-Recommendation (SBAR) technique. This technique provides a briefing between two or more staff members using clear, concise and relevant information to improve safety and clinical outcomes. Preliminary evaluations of the technique have been extremely positive. A copy of the guidelines was provided.

# Continuing the Magnet Journey

By Gretchen Delametter, RN, MSN, CPNP-AC, CNS

Remember the anticipation last January when the Magnet appraisers finally arrived on our campuses? The excitement was palpable as group after group came together to share our achievements with each other, our non-nursing colleagues, and the Magnet Commission. In an effort to continue our Magnet journey, nurses representing all five campuses and 30 departments were invited to breakfast and dinner forums similar to the ones held last January. Attendance was outstanding. Of those nurses invited to the breakfast meetings, more than 90 percent attended and 75 percent attended the dinner meetings.

To keep the sessions focused, discussion centered around three of the Magnet forces: Quality of Nursing Leadership, Quality Improvement, and Nurses as Teachers. Nurses had an opportunity to network with their colleagues from throughout the System and learn firsthand how each department is maintaining the Magnet forces. The following questions were posed to the attendees.

**What team-building activities are occurring in your department?** This question focused on Quality of Nursing Leadership. The sharing of activities gave others ideas for team-building opportunities in their own departments. Responses included:

- Positive work experiences written on the bulletin board for all staff to read and share.
- Quarterly activities away from work.
- Clinical Nurse Specialists working with staff to evaluate needs and make improvements in patient care and skill of nursing staff.
- Skills fair.
- Administrative Coordinators attending various unit meetings.
- Huddle message shared with all staff, not just nursing, to promote teamwork.



Nurses network with each other at a recent Magnet breakfast.

**How is staff in your department recognized?** This question also focused on Quality of Nursing Leadership. Responses included:

- Celebrations are on the agenda of every staff meeting.
- Celebrations are noted in department newsletter.
- Unit Excellence Award recognizes excellent patient care.
- Banners posted with promotions, announcements, congratulations, etc.
- Pizza parties.
- Warm and fuzzy bulletin board recognizing each other.

**What Quality Improvement (QI) projects or research projects are your departments involved in?** Responses included:

- Outcomes of central line care done by nurses in ICUs, collaborative project with IV Team.
- Placenta previa quality project.
- Hyperglycemia protocol in the ICUs and outcomes of blood glucose levels.
- Interventions to decrease rates of ventilator-associated pneumonia (VAP).
- Decreasing rate of leaves against medical advice and elopement in the Emergency departments.

- Reducing the number of falls.
- Decreasing disabilities using a code stroke protocol.
- Decreasing hospital mortality rates with a Rapid Response Team.
- The impact of a vaccination protocol on community-acquired pneumonia and flu.
- Patient satisfaction with new hospital beds.

**Are there any teaching activities occurring in your department?** This last topic focused on Nurses as Teachers. Responses included:

- Nurses and nurse techs have a forum for improving patient care.
- Poster presentations at staff meetings.
- Skills fair.
- Conference attendees presenting information to staff.
- Nursing students.
- Attaining certification.
- CareLink nurses offering specialized training.

As the System continues its Magnet journey, there will be many more opportunities to share with others how we live the Magnet forces and standards.

# From the Editor

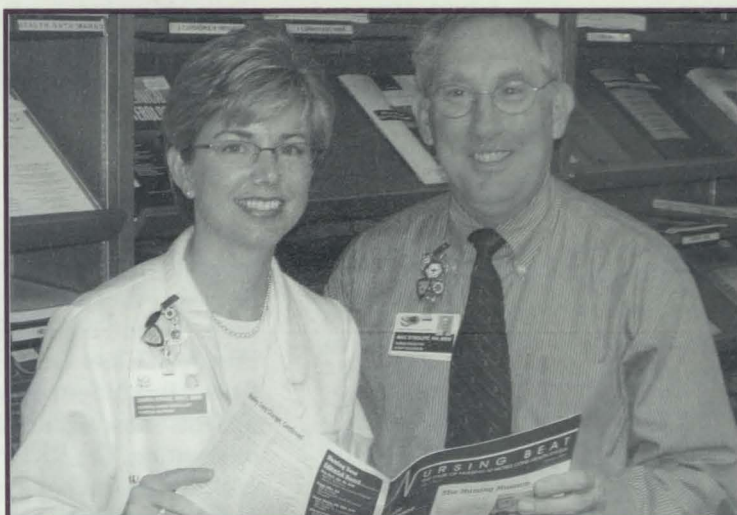
Going back to school is like having a baby. The first thought of it was dreamy and exciting. But it was a private thought, not ready to be shared. As the idea started invading my mind on a regular basis, I began to realize it wouldn't be ignored. What would it hurt anyway, just to look into it? But the next step was a little riskier – trying it out on friends. But only my closest confidants. This type of news did not need publicity. After all, what if I didn't get accepted? Everyone would be asking me when I would start school, and I'd have to admit my failure. People would whisper sympathetically behind my back, "I always thought she'd have no trouble..."

When the acceptance letter came, the feeling was pure joy! But even then, I was cautious in telling friends and family. I needed time to let this new reality sink in. It was like the pregnancy test—I knew my life was about to change but not for several months. I had lots of time to plan and think about this life-altering event. But before I knew it, and before I was 100 percent ready, I was thrown head first into my new reality. I knew it would be a lot of work. I just didn't really grasp the whole meaning until the first week had passed, and there

was literally no relief in sight. When I had my first midnight study session, it reminded me of late night feedings with my sons, when I was barely able to stay awake.

And once I had made it that far, I could not keep it a secret

anymore. The reduced work hours, the bags under my eyes, the glazed-over look... My family, friends and colleagues have been extremely supportive of me during this transition. But I wanted to say a special thanks to my colleague **Mac Stroupe, RN, MSN, Staff Educator**. Mac will be joining me as co-editor of *Nursing Beat*. Together we will share responsibilities to ensure that our nursing accomplishments and celebrations don't miss a beat. Feel free to send either Mac or myself your comments, suggestions and most



I look forward to sharing the editor role with my colleague Mac Stroupe.

importantly, your stories.

Just like you can't be a little bit pregnant, you can't be a little bit committed. Thanks to everyone who is allowing me — and others within our System — to commit time and energy to further education.

*Daria*

Daria Kring, RN, BC, MSN, Editor,  
daria.kring@mosescone.com

## Rapid Response Team

By Edward White Jr., RN, MSN, CCRN, and Barbara Cooper, MSN

According to recent studies, hospitalized patients often show early signs of physiological deterioration before they arrest. Some arrests can be prevented by a planned response to early signs of deteriorating patient conditions. The Moses H. Cone Memorial Hospital has implemented an intervention strategy to provide nurses with support to manage crises from onset before a full-blown code occurs. This new approach is the Rapid Response Team (RRT). Any nurse can activate the RRT by dialing



Nurses will be integral members of the Rapid Response Team.

See *Rapid Response Team*, page 12

## Rapid Response Team, Continued

the hospital's emergency line -2-4050 - in response to a worsening patient situation.

The Rapid Response Team consists of an intensive care nurse, a respiratory therapist and a medical resident, who collaborate with the patient's nurse to rescue, stabilize, communicate and transfer unstable patients if appropriate. The RRT works independently but closely with the Code Blue team. The nurse can call the RRT in response to signs and symptoms of physiological deterioration, uneasiness regarding a patient's clinical status, or when there is not a response from the physician after repeated pages.

The overall goal of the team is to rescue patients prior to arrest and decrease

patient mortality. Eventually, the program could be expanded to other System hospitals. The program's effectiveness will be measured by these indicators: the number of codes, number of RRT activations, including time of day, number of patients transferred to a higher level of care, number of arrests after interventions, hospital mortality rates, and the number of Code Blues outside the intensive care units. **Brian Fillipo, MD**, Vice President/Chief Quality Officer, Moses Cone Health System, says, "Most patients show signs of instability prior to arresting. The RRT brings intensive critical-care level of expertise anywhere in the hospital and assistance in stabilizing patients prior to an arrest."

## Shared Governance, Continued

- The Moses H. Cone Memorial Hospital's Rapid Response Team (RRT) began its pilot and will soon become available to all nursing units. The team consists of clinicians able to bring critical care expertise to unstable patients. They will provide assistance with patient assessment, interventions,

and stabilization until transfer can occur.

- NLC's new meeting time will be the second Wednesday of each month from 2 to 4 p.m.

## Nurses Going Places, Continued

### *Certified Post-Anesthesia Nurse*

- **Elisa Haynes, RN, BSN, CPAN**, PACU, Annie Penn Hospital

### *Critical Care Registered Nurse*

- **Ruby Johnson, RN, BSN, CCRN**, ICU/ Stepdown, Wesley Long Community Hospital

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