nursingbeat

THE PULSE OF NURSING AT CONE HEALTH

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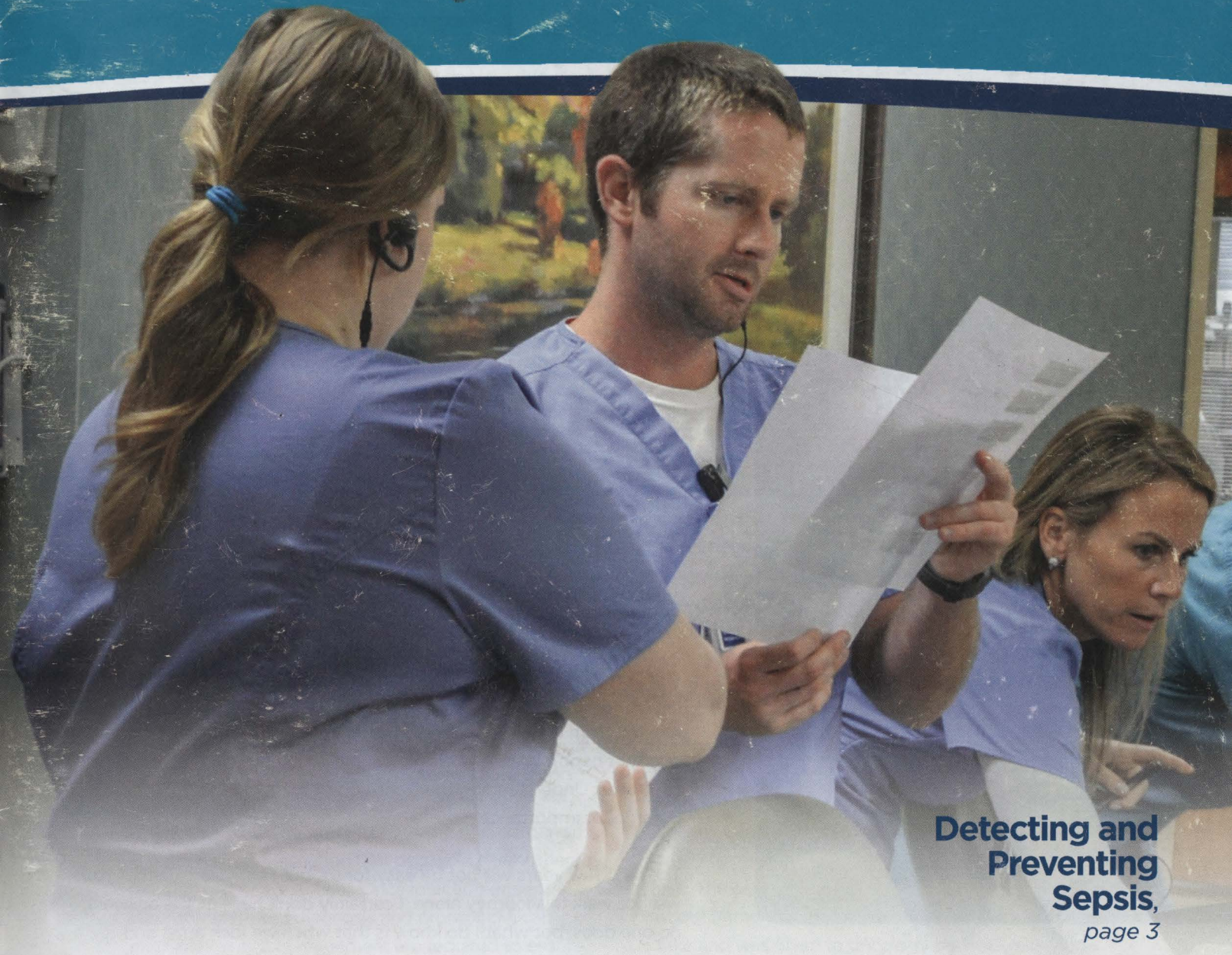

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CONE HEALTH®

The Network for Exceptional Care

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Greetings from your CNE

INSIDE THIS ISSUE

Greetings, Cone Health Colleagues! It is my sincere pleasure to share this first official communication with you as your new Executive Vice President and Chief Nurse Executive (CNE). I am honored to serve as your Chief Nurse and look forward to working with all of you as we build on the incredible history of this nationally recognized organization.

I am thrilled to be joining Cone Health at such an exciting time. As you all know, our industry is in the midst of tremendous change, and with change, comes opportunity. Cone Health is positioned to be a major force in the transformation of healthcare not only in our region, but in the nation. One of my primary goals as CNE is to ensure that as nurses, we have a strong voice in creating the future of healthcare. As we forge this new future, I will be depending on you to tell me what works, what doesn't work, and where you see possibilities. Together with our colleagues across disciplines, we will create a model for the delivery of healthcare that leverages our clinical expertise and our acumen for social engagement.

The future will also require us to expand our thinking and even acquire new skills. It will be important for nurses at all levels to better understand the business of healthcare, but not at the expense of creating meaningful connections with those we serve. Toward this end, I am committed to helping each of you understand the importance of moving from a system that rewards volume-based programs of care to one that honors and rewards high value, much of which is influenced by nurses. Understanding the transition from volume to value is of paramount importance.

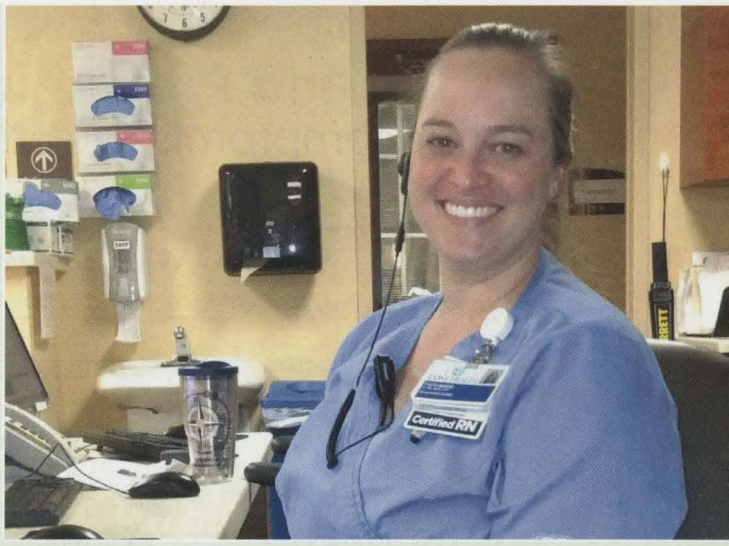
The next few years will not be easy for us, but I can promise that you will not walk this journey alone. I certainly don't have all the answers, no one does, but what I do know is that when we lock arms and focus our collective energy on a meaningful goal, nothing can stop us. We are in this together. Not only we will create a better nursing organization for the future, but it will be a fun and meaningful process along the way. ❖

Kenneth

We serve our communities by preventing illness, restoring health and providing comfort, through exceptional people delivering exceptional care.

WESLEY LONG HOSPITAL
EMERGENCY DEPARTMENT

Detecting and Preventing Sepsis in Immunocompromised Patients



Faith-Marie Hasz

By Faith-Marie Hasz, BSN, RN3, CEN; Sarah Lackey, DNP, APRN, CCNS

Sepsis is defined as the systemic inflammatory response to a pathogen. It can be triggered by an infection in any part of the body. Sepsis hospitalizations more than doubled from 2000 to 2008, with 17 percent ending in death in 2008. An estimated $14.6 billion was spent on hospitalizations for sepsis in 2008. Despite high treatment expenses, sepsis is often fatal.

Background

Chemotherapy patients are at particularly high risk for mortality when an infective agent invades the body. Chemotherapy works by killing the fastest growing cells in the body, including infection fighting white blood cells. For patients undergoing this treatment, the ability to fight off even the simplest invading microorganisms is compromised. Infection that occurs in chemotherapy patients is difficult to heal. Once infection or sepsis is suspected, rapid diagnosis and prompt clinical intervention and management are required to ensure safety, and the best possible outcome, for the patient.

The importance of chemotherapy patients knowing signs and symptoms of sepsis, as well as the importance of early treatment, lead the Center for Disease Control and Prevention (CDC) to publish recommended language for patients to use when speaking to healthcare professionals if an infection or sepsis is suspected. The development of a 'chemo alert card,' the result of a successful research study in London, gives patients and care givers specific information related to cancer and sepsis. It also include language to use in educating patients. The chemo card was used to address the problem of infection risk and mortality in chemotherapy patients.

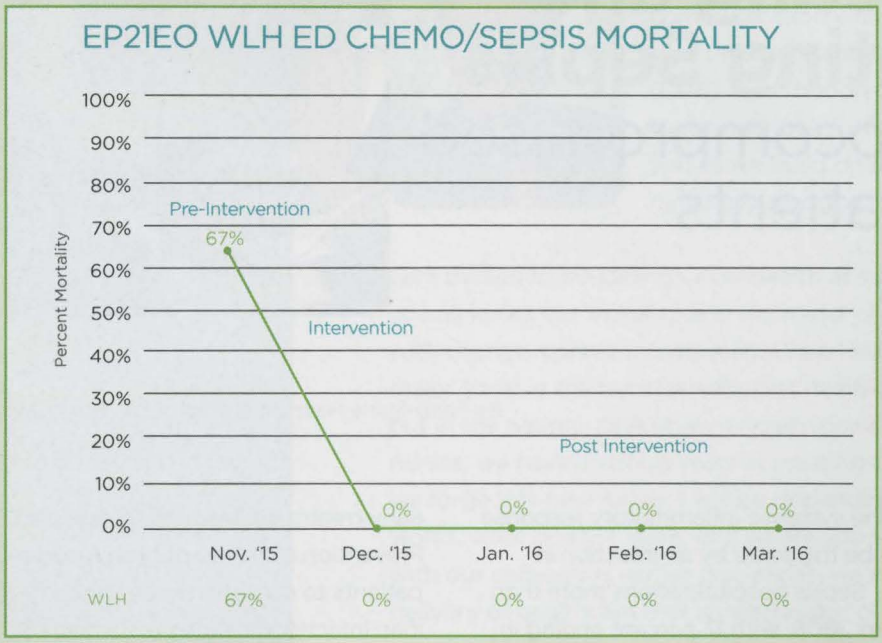
Intervention

Realizing there was an opportunity to improve care for chemotherapy patients at Wesley Long Hospital, the Wesley Long Emergency Department (ED) developed a study to replicate the 'chemo alert card' for our patients' use. The card had information for patients to remember about immunosuppression and what precautions to take and was given to oncology patients receiving chemotherapy infusions at the Cone Health Cancer Center at Wesley Long Hospital. It also had specific instructions for Emergency Department staff.

Continued page 4

Front Cover Photo: Faith-Marie and ED colleagues reduce mortality rates for chemotherapy septic patients with the use of a chemo card and a protocol for rapid identification and action. L to R: Faith-Marie Hasz, Matt Quick, Dana Guertin

Detecting and Preventing Sepsis
in Immunocompromised Patients, Continued



The aims of the patient portion of the card are to:

- Raise self-care awareness.
- Reinforce the need for early assessment if feeling unwell.
- Act as a further resource should patients feel they have any sign of infection.
- Fit into purse or wallet, to be carried at all times and shown when seeking health care.
- Improve safety if a patient arrives unconscious.
- Streamline the care pathway
- Aid swift access to treatment for extremely vulnerable patients.

The aims of the health care worker portion of the care are to:

- Raise awareness to the particular needs of oncology patients, such as the need to immediately test blood and administer IV antibiotics.
- Improve the existing system of assessment in triage.
- Improve safety and outcomes for oncology patients.
- Reduce patient risk and mortality by ensuring early identification and prompt treatment of this high-risk group of patients.
- Prescribe a series of appropriate and immediate actions to take when oncology patients arrive to the ED.

Emergency Department nurses, techs, physicians, phlebotomists, secretaries and registration personnel were educated about the chemo alert cards. Emphasis was placed on getting chemo card patients, and also cancer patients who did not have the card, evaluated quickly using sepsis screening tools and lab tests.

Results

Since implementation of the 'chemo alert' card, mortality rates for chemotherapy patients had dramatically decreased.

The results of this study suggest that use of the chemo card prompts faster sepsis screening and quicker treatment of these patients. Larger implications of this study support the use of identification cards that could decrease sepsis mortality rates more broadly. ❖

Welcome to Cone Health's **Chief Nurse Executive**

Kenneth Rempher, PhD, RN, MBA, CENP, began in his position as Executive Vice President and Chief Nurse Executive (CNE) for Cone Health on August 22. Besides Cone Health's national reputation for excellence in nursing practice, there were several aspects of the Cone Health CNE role that drew him from his previous position as the Chief Nurse Executive for University of Iowa Health System. Serving as our CNE is not only consistent with his career goals, but also affords him the opportunity to work with all of us to influence nursing practice across the entire enterprise. The portfolio of services offered by our organization is extraordinary, he says, and he is intrigued by the transformative work that is being done across the continuum of care. Kenneth believes one aspect of nursing's role in this transformation is to help reframe our patients' perspectives on their health as we return them to the community. This includes effectively influencing lifestyle decisions our patients make so fewer people need acute care and when they do need healthcare services, they feel compelled to find support in our primary care system.

Another aspect of Cone Health that drew Kenneth to his new role is the executive commitment to creating the best environment possible for nurses and others to do their work. During the interview process for his new role he was impressed that the executive team 'walked the talk.' He recognized that our leaders live the values, not just talk about them once a year at orientation. He also identified that Cone Health is a place that values professional development, and has well established processes and structures for achievement of professional goals regardless of one's role in the organization.

So what is Kenneth's vision for Cone Health Nursing? He sees Cone Health as an entity much bigger than a healthcare provider. He sees us as a highly diverse enterprise poised to lead the transformation of healthcare at a national level and to lead our community to become a proactive, preventive care culture. He is excited about working with staff at all levels across the organization to help lead this change which in part, begins by understanding the relationship between the care we provide and the relief of human suffering. Thinking of providing care as a way to relieve suffering changes the nurse-patient dynamic and draws more deeply on our empathy which ultimately creates a better experience for our patients and their families, as well as a better experience for our nurses. Even though Cone Health nursing already has national presence, Kenneth wants to help us leverage all of our creative energy to help develop a national model that will set standards for partnering with patients in their care where they work, live and play.

He sees in us a group of people deeply engaged in the process of nursing, professionally driven to achieve great things by developing creative strategies for the delivery of nursing care.

Let's welcome Kenneth in his new role and support him as he helps us craft the future of nursing at Cone Health, building on the incredible history of our organization and the tremendous skill of our nurses. For additional insights and updates, look for Kenneth's monthly blog which debuted in November. ❖

Kenneth sees us as a highly diverse enterprise poised to lead the transformation of healthcare at a national level and to lead our community to become a proactive, preventive care culture.

Dennis Campbell (center) and staff receive a congratulatory certificate from the Magnet document writing team for their example of Transformational Leadership. The example will be featured in the Magnet document submitted in August 2018. Left to right: Heather Reddick, Eric Kaplan, Dennis Campbell, Kim Hutchinson, Kelly Southard.

BEHAVIORAL HEALTH HOSPITAL

BHH Nurse Leader Advocates for Transitions® Education for Nurses

By Sarah Lackey, DNP, APRN, CCNS and Lindsay Draper, BSN, RN-BC

Nurse leaders at Cone Health are involved in local and national trends in healthcare and healthcare needs. The mental health crisis across our nation has created the need for creative solutions to accommodate the needs of this patient population. Emergency Departments (ED) in the Cone Health network have experienced an influx of mental health patients, with attendant challenges of throughput and placement for these non-typical ED patients.

Across the Cone Health network, one of the overarching goals in 2015 was to improve ED throughput. In order to allow for placement of medical patients with active behavioral health diagnoses, a medical/psych floor was created on Wesley Long Hospital (WLH), department 5E. This unit functions as a specialized medical-surgical unit to accept and care for these patients, allowing them to be transferred to a more suitable environment for treatment in a timely manner.

Nurse leader advocacy

Debbie Green, DNP, RN, Robert Woods Johnson Executive Nurse Fellow, the president for Behavioral Health Hospital (BHH), participated in a national summit on the lack of education nurses receive to care for psychiatric patients. In her communication to BHH staff and leadership, she discussed the need for nurses from all areas of health care to have training in caring for psychiatric patients. During the summit, a newly created program entitled 'Transitions in Practice' was shared with attendees. This program is offered by the American Psychiatric Nurses Association, and includes four eLearning education modules with coursework in therapeutic engagement, psychopharmacology, risk assessments, co-morbid disorders, recovery and therapeutic environments.

CONE HEALTH STRATEGIC PRIORITIES: Value Leaders, Knowledge Driven Organization and Healthy Communities.

MAGNET TRANSFORMATIONAL LEADERSHIP

TRUE NORTH METRICS: Patient satisfaction with inpatient care and emergency care, staff engagement and patient safety.

Green returned from the summit and discussed the Transitions® program with BHH's Vice President of Nursing **Dennis Campbell**, BSN, RN, MS, NEA-BC, CPHQ. They reviewed how this program could benefit nurses in behavioral health and medical- psychiatric and emergency areas across the system. Campbell and the team at BHH developed a proposal for using the Transitions® program to educate nurses in areas that care for behavioral patients and determined which areas would be included and how many seats each would be granted.

Allocation of resources

Evaluating costs and benefits, Campbell advocated for 100 seats in the Transitions® program, at a total cost of over $14,000. In August 2015, the opportunity to attend the Transitions® program was offered to nurses in the organization. Attendance was offered to:

- All staff nurses on the Wesley Long Medical Unit
- All staff nurses at Alamance Regional Behavioral Medicine Unit
- All staff nurses in the psychiatric secure holding area within the Wesley Long Emergency Department
- All staff nurses with less than 3 years of experience at Cone Behavioral Health Hospital

5E nurses weigh in

Lindsay Draper, BSN RN-BC, says the staff of WLH 5E care for a significant number of psychiatric illnesses, yet had only basic knowledge of psychiatric nursing care and therapeutic communication. They requested education to provide them with current evidence-based practices in mental health medicine and nursing.

The self-paced, online Transitions® program increased the knowledge of the staff while providing them with 15 continuing education contact hours. Eighty percent of the nurses on 5E obtained a psychiatric certificate after completing the program.

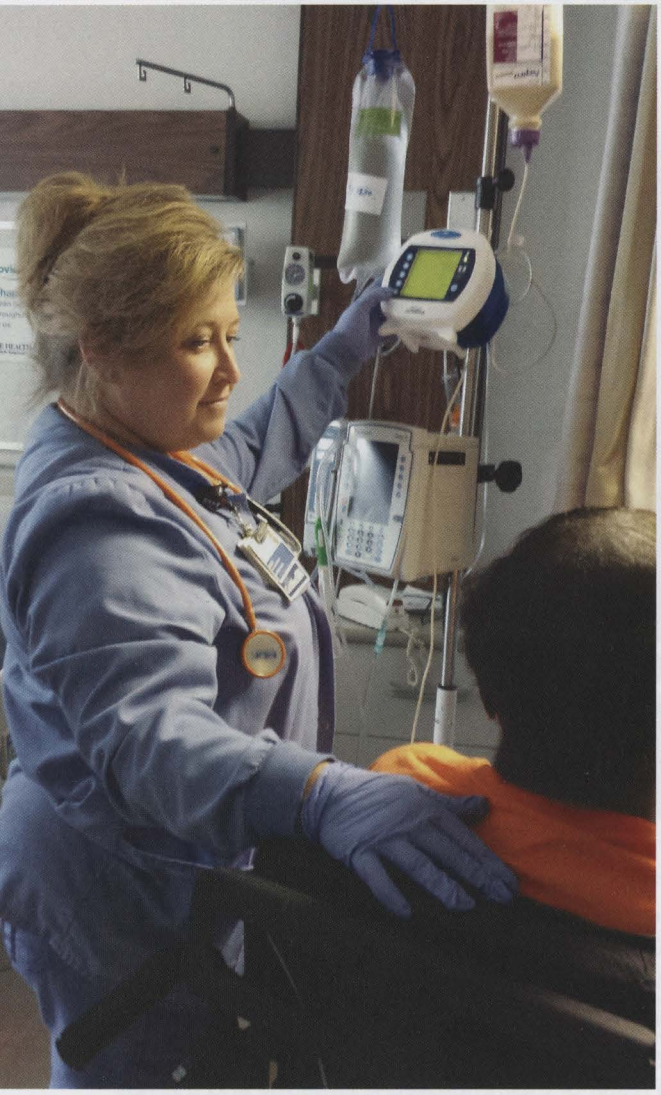
Kameka Totten and Dennis Campbell discuss use of Transitions® training resources for WLH 5E nurses.

Organizational goal impact

To help meet the goal of ED throughput for patients from the WLH Emergency Department to the WLH 5E Medical unit, 23 seats were dedicated to WLH 5E participants. Ten seats were allocated for psychiatric ED nurses. The Transitions® program education improved competence and confidence for nurses caring for these patients as well as improved skill. Department director for WLH 5E, **Kameka Totten**, BSN, RN, MBA/MHA, NE-BC thanked Campbell directly for his support in garnering the Transitions® education for nurses in her department. Her team has been more willing to receive medical psychiatric patients as a result of their improved knowledge and this has had an effect on throughput times from the ED. ❖

MOSES CONE HOSPITAL 4W INPATIENT REHAB

Patient Centered Practice, Value Driven Leaders



Angie Joyce cares for patients on MCH 4W Inpatient rehab.

CONE HEALTH STRATEGIC PRIORITIES: Value Leaders, Knowledge Driven Organization and Healthy Communities.

MCH 4 West is an inpatient rehabilitation unit with a large staff complement of physical and occupational therapists, nurses and other care team members. As a rehabilitation unit, collaboration among team members is essential for the best patient outcomes, and to meet our strategic goal of being a value leader in healthcare. Nurses were contributing to weekly team conferences, but felt that they could add more to the substance of the discussion.

Getting down to business

Certified Rehab Registered nurses (CRRNs) on the unit started to meet regularly to discuss their roles in the care of patients on the unit. With the help of a nurse leader/facilitator, they identified several key needs:

- Revision of the care delivery system by refining assignment of patients based on acuity
- Improvement of nursing communication with interdisciplinary team
- Enhancement of contributions to team conferences
- Delivery of more consistent information during nursing report
- Establishment of consistent expectations of nurse tech staff

Solutions

After gaining momentum by determining priorities, they devised strategies to meet each need. Within six weeks they had implemented their action plans. They developed an acuity rating scale utilizing an organized, consistent and structured method, and created a method for making assignments according to patient need.

They then created a central location where assignments are posted. Therapists working with patients could identify the nurse responsible for the care of that patient and began to seek out nurses for information sharing and questions.

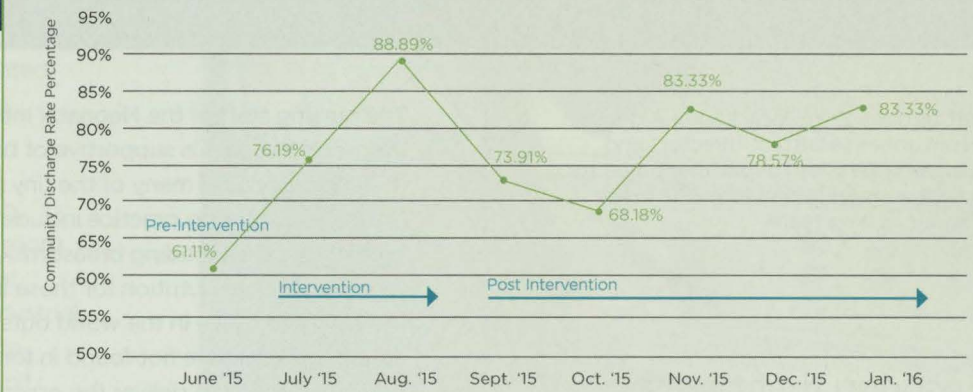
The nurses developed guidelines and education for what to contribute to team conferences. They presented these in several classes called "Team Conference/Case Management/Care Plan," and evaluated the education using post-tests. They also presented patient case studies at staff meetings and created a video for off shifts in order to model behaviors and contributions at team conferences.

They then developed a standard process for nurse-to-nurse handoffs, and involved the shared governance council in developing a standard work flow for nurse techs. The interim director for the department reinforced the

Nurses and department leadership for 4W accept the congratulatory certificate from the Magnet writing team for their example of Transformational Leadership. Left to right: Jamie Murray, Maryann Barbour (standing); Deborah Sharp (standing); Angie Joyce (standing); Jennifer Bailey, department director (seated).

MAGNET TRANSFORMATIONAL LEADERSHIP

TL1EO: MCH 4W Community Discharge Rate



	June '15	July '15	Aug. '15	Sept. '15	Oct. '15	Nov. '15	Dec. '15	Jan. '16
Discharge Rate	61.11%	76.19%	88.89%	73.91%	68.18%	83.33%	78.57%	83.33%

expectations as part of the nurse techs' performance appraisals, hard-wiring the structure into the function of the unit.

Outcomes

One of the outcomes measured for inpatient rehab patients is whether they can be discharged to home ("community discharge") as opposed to needing to be discharged, either short term or long term, to an assisted living, long term care or skilled nursing care facility. This consequence is always a concern for stroke patients, whose rehab trajectory can vary based on individual differences in the patient. Rehab team members, regardless of their discipline, are hopeful that the therapies, treatments and instructions patients and families receive will take them to their maximum capacity and allow them to be discharged to their home.

The community discharge rate is computed as a percentage of discharges for the month. In the stroke patient population on 4W, which comprises approximately 35-40% of the patient mix on the unit, the pre-intervention rate for community discharges was 61.11%. With the changes to clinical practice that were developed and implemented by 4W nurses in order to be value leaders for the organization, the community discharge rate for stroke patients showed a steady and sustained improvement.

Summary

Nurses on MCH 4W recrafted their clinical nursing practice. By streamlining work processes, re-aligning the work flow of clinical nurses and nurse support staff, and becoming more active participants in the planning and progression of patients, they contributed to the improvement in the community discharge rate for their stroke patients. ❖

WOMEN'S HOSPITAL NICU

Breast Milk Storage

Left to right: Erin Cecil, Laurie Alderman, Susan Jones (assistant director) and Juanyetta Beasley (department director) accept a recognition plaque from the Magnet writing team.

Ensuring that breast milk is well preserved so it can deliver the essential human nutrients these patients need is paramount in their care. An integral part of the nursing practice environment in the NICU is the structure by which breast milk is safely stored.

The nursing staff of the Neonatal Intensive Care Unit (NICU) at Cone Health Women's Hospital is supportive of breast feeding for the infants admitted to their unit. Because many of the tiny patients are too premature to actively breast feed, nursing practice includes encouraging mothers to pump their breast milk, then feeding breast milk to the infants through gavage or bottle feedings. Proper nutrition for these infants is vital to their survival and the ability to thrive in the world outside the womb. Breast milk provides advantages that are not found in formula. Ensuring that breast milk is well preserved so it can deliver the essential human nutrients these patients need is paramount in their care. An integral part of the nursing practice environment in the NICU is the structure by which breast milk is safely stored.

Background

Storage for a 24-to-96-hour supply of pumped breastmilk was provided in the NICU using small dorm-sized refrigerators located throughout the unit. A central freezer stored surplus breast milk for infants until it was needed. Temperature control requirements for the storage of refrigerated and frozen breastmilk are strict, defined by policy and based on current best practice.

In both the dorm-sized refrigerators and in the freezer, there was a problem with keeping temperatures consistently within a range that met standards and ensured the nutritional integrity of the breast milk was preserved. The frequency with which the nurses had to enter the small refrigerators diluted the cooling environment significantly. The age of the freezers made it difficult to maintain the temperature of these units in the required range. Temperature alarms frequently were alerting nurses to the need for intervention to maintain the temperatures within range. In addition to concerns for patient safety regarding improperly stored breast milk, there was increasing staff frustration because of the time and attention it took

to maintain proper temperatures. Monitoring of temperatures in the units showed that the storage units were not able to maintain a consistent 100 percent for adequate temperatures.

Difficulties with breast milk storage influenced nursing practice on the unit. Without the availability of strictly controlled temperatures for breast milk, nurses were unable to promote one of the key nursing objectives in the care of their patients: optimal nutrition.

Group think

A collaborative effort involving **Sue Pedaline**, DNP, RNC, MS, vice president of nursing and patient care services, Women's Hospital; **Mike Cooke**, director of facilities management; **Susan Jones**, BSN, RN, MHA, RNC-NIC, NICU assistant director; **Constance Jones**, RN, infection prevention and **Verna Watkins**, MSN, RN, NICU interim director was initiated to explore possible solutions to this issue. The group found that the current alcove housing the freezer and one of the small refrigerators, as well as an adjoining room, could be renovated to create a nutrition room that would provide space for an industrial strength refrigerator and freezer. The industrial strength equipment would have adequate space to store all the breastmilk on the unit and, because of the size and construction of the equipment, it would also have the ability to consistently maintain breast milk within the defined temperature range.

Putting the plan into motion

With Pedaline's support and executive sponsorship, the project progressed through its steps. Quotes were received and discussed for the purchase of a commercial grade refrigerator and freezer for the storage of the breastmilk. Capital funds were allocated from the executive administrative budget for renovation and construction and from the nursing administrative budget for the purchase of the commercial grade refrigerator and freezer. Renovation of the NICU space to create the NICU Nutrition Room occurred.

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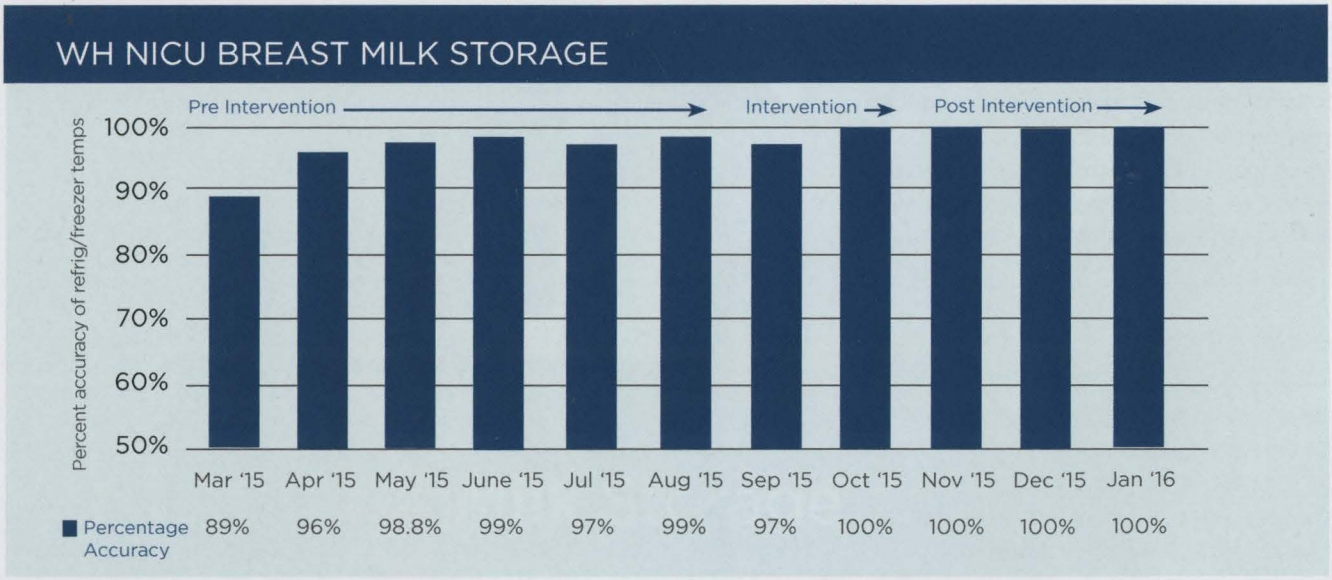
Ali Clem cares for tiny patients in the WH NICU.

Breast Milk Storage, Continued



Refrigerator and freezer were ordered. Commercial grade refrigerator was installed and put into service and was staff in-serviced. All other breastmilk refrigerators were removed.

Outcomes

Since the renovation of the space and the switch to using the industrial refrigerator and freezer, NICU remains at 100 percent accuracy for maintaining the temperatures to store breast milk within the desired range.

Summary

This example demonstrates how the identified element of the nursing strategic plan, "nurses being value leaders," resulted in an improvement in the nurse practice environment related to space and equipment, which lead to an improvement in the accurate and consistent storage of breastmilk for preterm infants. The practice environment structure which provides this vital supply of nutrition has an influence on nursing practice in the NICU. Nurses can now follow through with their treatment plans for their tiny patients, knowing that the breast milk they encourage and receive from mothers will be optimal.

NICU nurses are value leaders for our NICU patients, ensuring that they are receiving nutrition that is of the highest quality. The nursing strategic plan flows from organizational priorities to improve the network's performance. ❖

CONE HEALTH STRATEGIC PRIORITIES:
Value Leaders, Knowledge Driven Organization and Healthy Communities.

MAGNET TRANSFORMATIONAL LEADERSHIP:
TL1EO: Nursing's mission, vision, values and strategic plan align with the organization's priorities to improve the organization's performance.

Brenda Hall stands by her poster demonstrating NICHE at Cone Health System.

The 78 million strong baby boomer generation born between 1946 and 1964 began turning 65 in 2011. The number of people age 65 and older is expected to grow from 39 million in 2008 to 72 million in 2030.

MOSES CONE HOSPITAL 6N

NICHE: Specialty Training for our Future Patients

By Jill Moore, BSN, RN3, RN-C

The 78 million strong baby boomer generation born between 1946 and 1964 began turning 65 in 2011. The number of people age 65 and older is expected to grow from 39 million in 2008 to 72 million in 2030. This explosive growth will place increased demands on an already loaded healthcare system. What this means for us, as healthcare providers, is that a majority of our patients will be age 65 and older. In a six patient assignment, many are likely to be elderly with specialized physical, emotional and mental health needs. Young and middle aged adults will likely be seen on an outpatient basis for most of their healthcare needs.

Care for the elderly requires special attention to meet their specialized needs: skin and incontinence issues, nutritional support and assessment for fall risk and delirium. To prepare us for this specialized care, there is a nurse driven program called NICHE. NICHE stands for "Nurses Improving Care for Health System Elders." Its mission is to provide principles and tools to stimulate a change in the culture of healthcare facilities to achieve patient centered care for older adults. Based on its four guiding principles, the vision of NICHE is that all patients 65 and older will be given sensitive and exemplary care. The guiding principles of NICHE are:

1. Evidence based, geriatric care at the bedside
2. Patient/family centered environments
3. Healthy and productive practice environment
4. Multidimensional metrics of quality

Cone Health nurses use NICHE guiding principles for care of the elderly. **Brenda Hall**, RN on 6N at the Moses H. Cone Memorial Hospital, created a poster and presented it at the Magnet® Showcase in 2016 that explained NICHE at Cone Health. The title was "Cone Health: Growing Exceptional Care through NICHE." Hall used a tree to symbolize Cone Health's commitment to care for the geriatric population. The deep roots are made up of different therapies and healthcare providers: the NICHE steering committee, physicians, nurses and administration. The main base of the tree is NICHE with a quote from an elderly patient – he shared how frightened he was to be hospitalized, but was calmed when he discovered that the hospital was a NICHE facility. The branches and leaves of the tree are lit up with lights as they reach out and provide the specialized care the elderly need. Additional leaves on the right of the poster show the special needs of the elderly and all the ways that we provide training to address those needs. The left side of the poster shows the vision statement and the objectives of NICHE.

Hall is a part of Cone's NICHE committee. "It is so exciting to have the support through NICHE to know how to care for the geriatric population," Hall said. "The continuing education they offer through the website is free and provides excellent tools for healthcare providers." ❖

Jean Wolf (left) confers with Wesley Long Hospital nursing leaders Steve Marshall and Youland Williams.

WESLEY LONG
3W INPATIENT
ONCOLOGY

Lateral Violence in Nursing

By Jean Wolf, MSN, RN, OCN

The prevalence of lateral violence in nursing is alarming. Lachman (2015), citing Dulaney & Zager, (2010), refers to a statewide survey completed in South Carolina which found that 85 percent of nurses reported being victimized by lateral violence.

What exactly is "lateral violence?" (Other terms may include "horizontal violence," or "bullying"). Behaviors generally involve "unkind, discourteous, antagonistic interactions between nurses who work at comparable organization levels and commonly characterized as backbiting and infighting." (Alspah, 2008, in Lachman, 2015, p.40). It is further defined as "complaints shared with others without first discussing with the individual, sarcastic comments, withholding support, ignoring or discounting individual's input, insulting, condescending, patronizing behaviors." (Lachman, 2015, p.40).

So often it is the newer or younger members of the team who are the recipients of lateral violence. This becomes a real safety issue for our patients. New team members who do not feel comfortable asking questions of their peers, or are unable to communicate and collaborate effectively because of a lack of mutual trust and respect, cannot function to the best of their abilities. True interprofessional cooperation and dialogue suffers. This is such a serious issue that The Joint Commission has identified hostile workplace behavior and rude language as causative factors in compromising a culture of safety.

Negative outcomes from lateral violence include a compromised quality and safety of patient care, a negative workplace culture, and negative nursing turnover.

What are we to do? A literature search on lateral violence reveals current best practices for dealing with negative workplace behaviors are educating the staff on the presence and prevalence of lateral violence, teaching communication strategies for dealing with these types of negative interactions, and providing a strong leadership communication style.

Because of comments from new graduates on surveys taken at the end of their onboarding nursing academy program, it was evident that lateral violence continues to be a challenge in our work environments. I decided that education on lateral violence was vital, and I started with the unit were I work: WLH 3W. I

developed a three-hour class for shared governance representatives and used a variety of educational strategies.

Pre-intervention data

Prior to providing an educational intervention for lateral violence, attendees took pre-test to determine their level of knowledge of the topic, their ability to recognize examples of lateral violence and to measure the comfort they had in confronting these negative behaviors in the workplace.

Intervention and post test

A three hour class on lateral violence was provided. It included the definition of the issue, its prevalence and scenarios for discussion. We explored interventions for confronting these behaviors by teaching time out and cognitive rehearsal strategies. Time for role playing various scenarios of lateral violence with individuals responding to the behaviors was incorporated into the education plan. Pre-test surveys were completed by all attendees; questions were repeated in identical format on the post-test surveys.

Results

Pre- and post-test results revealed that the class was effective. In response to the statement, "Raising my eyebrows, sighing or making a face in response to a co-worker is considered lateral violence," 40 percent of class attendees strongly agreed prior to the class whereas 90 percent strongly agreed after the class.

In response to the statement, "Complaining to a co-worker about another co-worker's performance or work ethic is considered lateral violence," 50 percent of class attendees strongly agreed prior to the class, and 100 percent strongly agreed after the class.

In response to the statement, "I am aware of effective communication strategies to use when confronted with lateral violence," no attendees responded "strongly agree" before the class, yet 70 percent responded "strongly agree" after the class.

In the six months since the class, there have been many discussions about lateral violence in the department. Staff members who had attended the class often speak about the changes they are making in communicating with others. Some changes are as simple as curbing their use of sarcasm.

It is important for us to be aware of our behaviors and what they communicate. When it comes to lateral violence, it is important for us to hone our communication skills. ""Nurses must be as proficient in communication skills as they are in clinical skills." (Brothers, 2011) ❖

Safety Zone portal is used to report disruptive, abusive, offensive or impaired behavior. Examples could include (but are not limited to):

- You witness or experience lateral violence between co-workers
- You see or hear co-workers speaking harshly to a patient, being impatient with a family, talking/gossiping about patients, families, co workers
- You see any staff members, regardless of discipline, engaged in unprofessional behavior
- You witness others talking about personal issues while transporting a patient

The 10 most common forms of lateral violence include:

- Non-verbal innuendo
- Verbal affront
- Undermining activities
- Withholding information
- Sabotage
- Infighting
- Scapegoating
- Backstabbing
- Failure to respect privacy
- Broken confidences

Embree and White, (2010, p.167-168)

References: Brothers, D., Condon, E., Cross, B., Ganske, K., & Lewis, E. (2011). Taming the beast of lateral violence among nurses. Virginia Nurses Today, 18 (4), 7-10.

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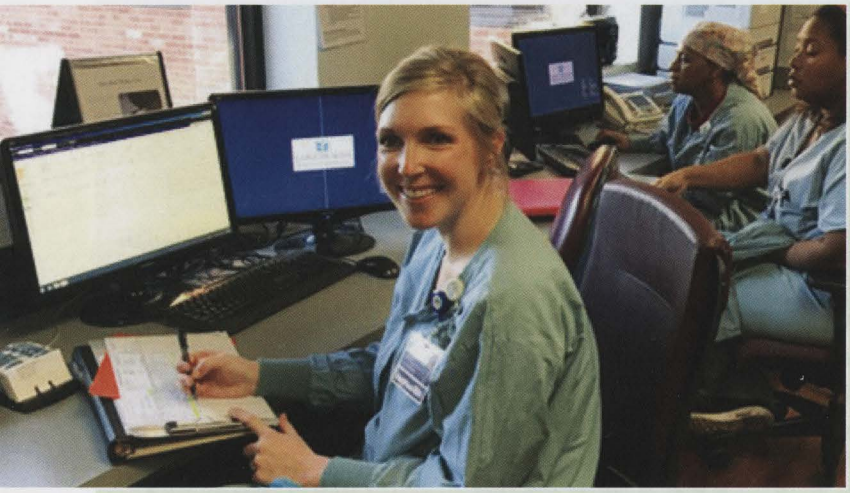
WOMEN'S HOSPITAL

Streamlining Care for Patients with Hypertension in Pregnancy



Heather Koran at work at Women's Hospital.

By Heather Koran, MSN, RN4, CNL, RNC-OB

Hypertension is a complication in approximately 10 percent of pregnant patients. It is one of the leading causes of fetal and maternal morbidity and mortality rates. Perinatal Quality Collaborative of North Carolina (PQCNC) recognized the need to address this issue with a focused initiative based on recent recommendations from the American Congress of Obstetricians and Gynecologists (ACOG) and the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN). Women's Hospital joined forces with this initiative to improve patient outcomes by streamlining nursing care for this patient group. The initiative aligns with Cone Health's values and true north metrics of decreasing mortality rates, improving patient safety and promoting staff and patient engagement.

Practicing as a nurse in this arena and completing a clinical residency for a Master of Science in Nursing degree led me to have a personal involvement in this project. Based on the significance hypertension in pregnancy can have on patient outcomes, changes were needed as there was a lack of standardized streamlined care. The initial data revealed that patient education was not being documented for those with hypertension and patients were not receiving appropriate medication treatment in a timely manner for severe range blood pressures. This led to the revelation through observation that not all healthcare providers were obtaining blood pressures correctly. Each of these areas were part of the initiative, which led to a core team of individuals working towards change. **Lauren McDaniel**, MSN, RNC-OB, Birthing Suites was a partner in this initiative.

Intervention

Working in conjunction with PQCNC led to specific goals, brainstorming, planning and development of education plans and handouts to make improvements in standards of care. Each of these played a pivotal role during my clinical residency in the Women's Hospital outpatient clinics and maternity admissions unit (MAU). Patients with hypertension in pregnancy received individualized education each week pertaining to their diagnosis. Providers and nurses collaborated to maintain a high standard of care throughout the patient's continuum of care.

Education played a key role during the initial stages. First I provided education through individual discussions, development of handouts and emails to nurses about how to effectively document and utilize the care plan within the patient's electronic medical record. Second, patient education was streamlined through the development of a handout provided to patients who came to the hospital with hypertension in pregnancy. I recently presented the handout at the Cone Health network-wide patient education committee and received approval to continue to utilize and print for patient use. To promote further engagement of each hospital unit, education was provided through PowerPoint presentations at staff meetings, hospital system wide skills fairs and unit bulletin boards. This included information about PQCNC, awareness about the significant impact hypertension has on morbidity and mortality, documentation of patient education, accurately measuring blood pressures, utilizing appropriate terminology and effective management of patient's severe range blood pressures.

SBP>160 OR DBP>110 CONTROLLED PERCENTAGE

Making a Difference Through Measuring:

- BP ≥ 160 and/or ≥ 110
- Recheck within 15 minutes
- Call provider to obtain HTN order set within 15 minutes
- Administer medication with 15 minutes
- Reassess BP within 15 minutes

In addition to education, a new order set was created and approved by providers to increase standardized patient care. This resulted in the development of a protocol sheet to help nurses identify what steps to follow regarding the new practice change. Finally, a clinical guideline document is in development for staff caring for patients with hypertension in pregnancy.

Outcomes

This initiative will continue over the next year to build upon standards of care that have been initiated. Procedures will be revised based on input from staff and patients. While much work remains, the steps taken to make improvements have shown to be effective. Documentation of patient education and use of the tool has improved by 50%. Participating with PQCNC and hospitals throughout the state, sharing information, tools and data have created an increased awareness of ways to improve care for patients with hypertension in pregnancy. The initiative has led to improved patient outcomes, satisfaction and team collaboration. Furthermore, learning about the disease process and evaluating data each month has resulted in a personal interest of investigating readmissions and a research project related to preeclampsia in the postpartum period in efforts to improve patient outcomes.

Above is the graph which indicates an improvement in the percentage of hypertensive pregnant women whose blood pressure was adequately controlled. ❖

Cone Health Symposium Spotlights **Nursing-Led Advances in Patient Care**

By Philip Craft

The fifth annual Nursing Research and Evidence-Based Practice Symposium, presented Nov. 18 by Cone Health and the Greensboro Area Health Education Center, featured scholarly work and clinical insights from nationally recognized health care innovators and more than 300 North Carolina nurses.

"This symposium is part of our promise to the community and our promise to the disciplines across health care that we are leading the way in transforming health care," said Cone Health Executive Vice President and Chief Nurse Executive **Kenneth Rempher**, PhD, RN, MBA, CENP. "It is a unique opportunity for nurses to share research findings that advance our common goal of continuously producing better care for patients."

Nationally Recognized Speakers

West Virginia University School of Nursing Dean Tara Hulsey surveyed innovations in nursing that have addressed community health needs and improved patient outcomes.

"Evidenced based practice is really being fueled by patients," Hulsey said. "They are coming in informed, they are asking questions and they are pushing accountability in health care."

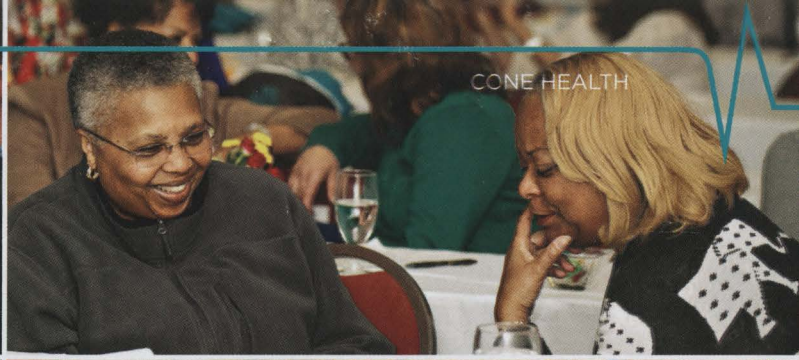
Hulsey reviewed the changing landscape of healthcare delivery in West Virginia, including a new law enabling advanced practice nurses to care for patients without physician oversight in a variety of contexts. She called for improvements in nursing education to prepare new nurses for the rapidly changing health care field.

"Nursing education needs to be blown up," Hulsey said. "We have a gap in what is needed in nursing and what we're training our students to do in nursing school, specifically around quality and safety."

Kathleen Vollman, a critical care clinical nurse specialist who consults internationally on nursing innovation and best practices, presented on strategies to reduce patient falls and hospital acquired infections. She also spoke on the benefits of high quality oral care in patients who are at risk of developing pneumonia.

"We are really looking at core, evidence-based, fundamental nursing care practices that have huge impact on patient outcomes," Vollman said.

"One of the wow moments of the symposium for me was the research findings around oral care," said Annie Penn Hospital's **Lisa Covington**, RN, MSN, CMSRN. "Timely oral care for patients can decrease health care associated pneumonia, thereby reducing sepsis. This kind of insight is a great example of the value of the knowledge exchanged at this symposium."



"The findings on the patient impacts of high quality oral care are the kind of insights I'm excited to take back to our nurse tech council and implement to enhance practice on the floor," said Cone Health nurse tech **Tamekia Lockhart**. "The symposium makes me feel that I'm a part of something larger, learning so I can empower others and improve patient care. Education is always the key."

Psychologist J. Bryan Sexton, director of the Patient Safety Center at Duke University Health System, presented on employee burnout in health care.

"It's not just having the right quality improvement initiative. It's not just having the perfect science behind what you do. If the people in your work setting are emotionally exhausted, if they're burned out, giving them the perfect science or the perfect tool doesn't make a difference," said Sexton. "This is about getting nurses to bring their whole selves to work, to find a sense of purpose and meaning in what they do and to reconnect with what brought them into health care in the first place."

Research Insights

Seven panel presentations and forty poster presentations by North Carolina nurses focused on many of today's key health care issues, including topics such as spotting the early signs of delirium in patients, preventing falls, managing diabetes, online interactive education for surgical patients and preventing hospital acquired infections.

"The scientifically rigorous nursing research presented here is a key part of our work to revolutionize care at the bedside and at the community level," said **Deborah Grant**, Cone Health's vice president of nursing, clinical support, ambulatory and health services. "We envision the knowledge gained here, and the practice of exchanging knowledge in this way, as a catalyst for change across our entire nation in population health."

Capt. Tameka Walker, RN, deputy chief of evidence-based practice at Womack Army Medical Center, reflected on the value of the symposium.

"Sometimes you feel like you're in the world by yourself, going through the motions and trying to figure out the best solution clinically," Walker said. "It's good to discover here

Continued on page 20

"This symposium is part of our promise to the community and our promise to the disciplines across health care that we are leading the way in transforming health care. It is a unique opportunity for nurses to share research findings that advance our common goal of continuously producing better care for patients."

Symposium planning committee.

Cone Health Symposium Spotlights
Nursing-led Advances in Patient Care Continued

that we share not only similar challenges, but also evidence-based solutions. It's great to see my nursing colleagues enjoy all of the knowledge and information that's been put forth, knowing that we can share this not only locally, but also spread it abroad."

Awards

The following three poster presentations were selected for first place honors in the categories of research, evidence-based practice and people's choice respectively.

"Frailty Assessment in Hospitalized Older Adults using the Electronic Health Record" by DA Lekan, DC Wallace, TP McCoy of the University of North Carolina at Greensboro and H. Whitson at Duke University.

"Access: Online, Anywhere, Anytime: Implementation and Utilization of Online Interactive Education During Pre-Admission Testing Visits for Total Joint Replacement Patients" by Cone Health nursing team members **Angela Daye, Tonda Gosnell, Eva Hyde, Barbara Morris, Darcy Parizek, Cynthia Rizzo, Michelle Savage, Terri Sharpe, Allison Sinkule, Nicole Small** and **Norine Tamborino**.

"Sweet Sadness...Identifying Depression in Diabetes" by Cone Health's Inpatient Glycemic Control Team: **Marie Byrd, Ann Clark, Gina Davis, Chrissy Dodson, Jeannine Fishel, ReGina Ingle** and **Jenny Simpson**.

"A lot of the work presented at the symposium was conducted by people who are at the front line doing the work that's important for our patients," Rempher said. "One of the things that makes Cone Health so impressive and so unique is regardless of your role, it's not only your right to conduct research and base your practice on evidence, but we see it as our responsibility to our patients as we endeavor to produce the best possible outcomes in the most reliable, efficient, way."

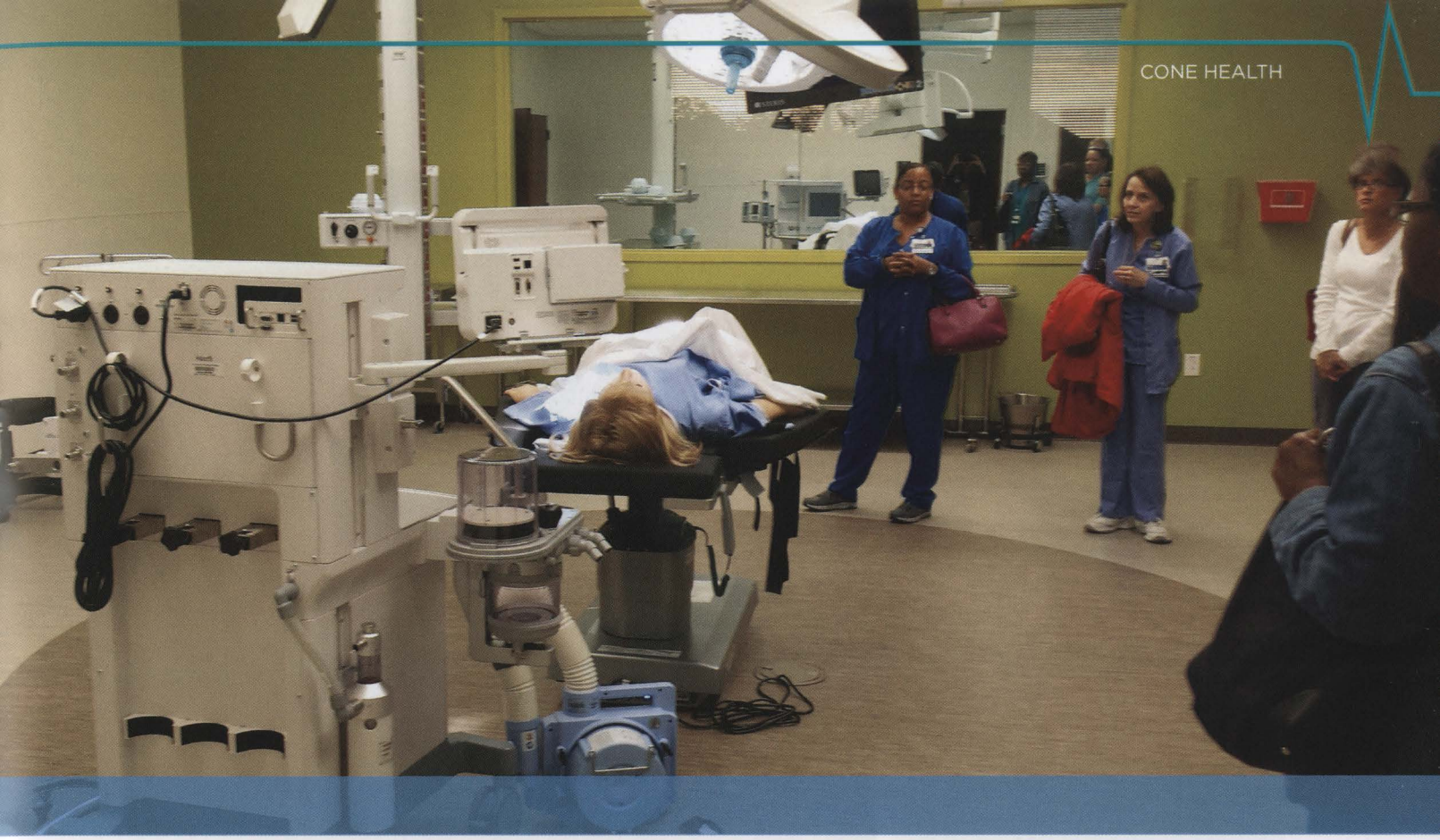
Acknowledgments

Cone Health and Greensboro AHEC expressed appreciation to the following symposium sponsors: Iredell Health System, Vidant Medical Center, Duke Health, Wake Med Health & Hospitals, Randolph Hospital and UNC Rex Healthcare.

"This symposium would not be possible without the partnership of sponsoring health care organizations," said Cone Health Director of Nursing Research **Marjorie Jenkins**. "They helped us to create an environment in which nurses and other disciplines could collaborate, raising the bar and growing a culture in which care teams can innovate."

The 2016 symposium planning group was comprised of the following Cone Health and GAHEC team members: **Jessica Buckner, Jenny Clapp, Barbara Deskins, Jennifer Fencl, Christopher Golding, Eva Hyde, Marjorie Jenkins, Danyel Johnson, Nita Johnston, Kathleen Kearney, Brenda Murphy, Denise Rhew, Carlita Brady, Stacey Toben** and **Marcel Turner**.

Jennifer Fencl, Cone Health's interim executive director for clinical support and research, and clinical nurse specialist for operative services, said, "We want to thank the nurses who participated in the symposium, from across the state of North Carolina, from the coast to the mountains, from Wilmington to Asheville, who showcased the amazing work that they're involved in each and every day." ❖



Union Square Campus

"Union Square will impact locally trained nurses and staff development at Cone Health in ways we haven't begun to realize."

The Union Square campus in downtown Greensboro opened Aug. 17, 2016 with a grand opening celebration. The campus is the result of a collaborative partnership among Cone Health, North Carolina A&T State University, the University of North Carolina at Greensboro and Guilford Technical Community College. The 85,000-square-foot campus includes a state-of-the-art simulation center, labs, classrooms and a 350-seat auditorium.

"Union Square offers so many exciting opportunities. We can use it for orientation, skills labs and patient care situations, where students can work side by side with Cone Health nurses and learn how they apply these skills and care for patients in the real practice setting," said **Jean Reinert**, director, Staff Education. "It also has great potential for interprofessional simulations with physicians, social workers, physical therapists and occupational therapists."

The demand for registered nurses in North Carolina is expected to reach 120,000 over the next decade. This state-of-the-art facility will help to meet that need.

On a recent tour of the facility, Moses Cone Hospital Internal Medicine staff saw classrooms, simulation rooms and a unique teaching tool called Anatomage. This device is a six-foot long lighted table with an image of a person on it. Cross sections of anatomy can be chosen, images rotated and labeled diagrams of anatomical structures pulled up. Similar to screens seen on TV programs like Hawaii Five-O and NCIS, images are selected and 'slid' to a projection wall for everyone to see.

"Union Square will impact locally trained nurses and staff development at Cone Health in ways we haven't begun to realize," Reinert said. ❖

MCH 3W staff in consultation at their metrics board.

MOSES CONE HOSPITAL 3WEST

Breaking the Cycle of Cardiac Transfers

By Jessica Honeycutt, BSN, RN; Robyn Wofford, MSN, RN4, PPCN; Sarah Lackey, DNP, APRN, CCNS

Cardiac patients, within a single admission to an acute care hospital, can sometimes be transferred between inpatient nursing units three or four times. This means three or four different groups of nurses; three or four waiting areas their families have to find; three or four opportunities to lose valuable possessions like dentures, glasses, clothing; and three or four unit routines to learn. Stress is a key risk factor for heart disease. Acute care hospital transfer routines for cardiac patients can add to the risk for heart disease through the stress created by this practice.

Best practice

Moses Cone Hospital (MCH) 3West is a unit that cares for a large number of cardiac patients. Nurses saw the trauma to their patients with the transfer routine and decided to address it. How could they decrease the number of times a cardiac patient had to be transferred within the hospital during a single admission? By decreasing transfers, they hoped to have a positive impact on the hospital experience for their patients, which they chose to measure with Press Gainey patient satisfaction scores. They also chose to measure patient perceptions to see if their efforts had a positive effect. Staff satisfaction and turnover rates for nursing staff on their unit were also measures they were interested in examining.

Levels of care

To start the project, a group of physicians, nurses, nurse leaders and social workers toured other hospitals to explore best practices nationwide. The group found that an acuity based model, which regulates the number of nurses on a shift according to the patient needs to determine nurse:patient ratios, was best practice.

MCH 3 West selected a team of nurses to develop guidelines to identify acuity levels for their patients. The levels were given ranks of 1, 2, 3 or 4. The expectation was that no nurse would have more than 11 total acuity points in their patient assignment. The goal was for patients to remain on the same department, receiving care from the same nurses they were. Acuity levels included medical-surgical care, telemetry care and progressive care. Patients requiring intensive care would be transferred off the unit.

Education for nurses to become skilled in providing care to higher acuity patients was rolled out over several months, and followed the curriculum for progressive care nursing. By the time the project was launched, every RN on 3W had the capability of caring for progressive care patients, as well as the other acuity levels. The project was launched after all participating nurses were educated, hospital personnel were oriented and all stakeholders were ready. That was Oct. 1, 2015.

The data collected prior to the intervention included:

- Length of stay for cardiac diagnosis patients
- Number of transfers from 3 West to a stepdown bed
- Number of rapid response calls for 3 West
- Results from a 3 West staff survey assessing satisfaction and workflow
- Press Gainey patient satisfaction scores.

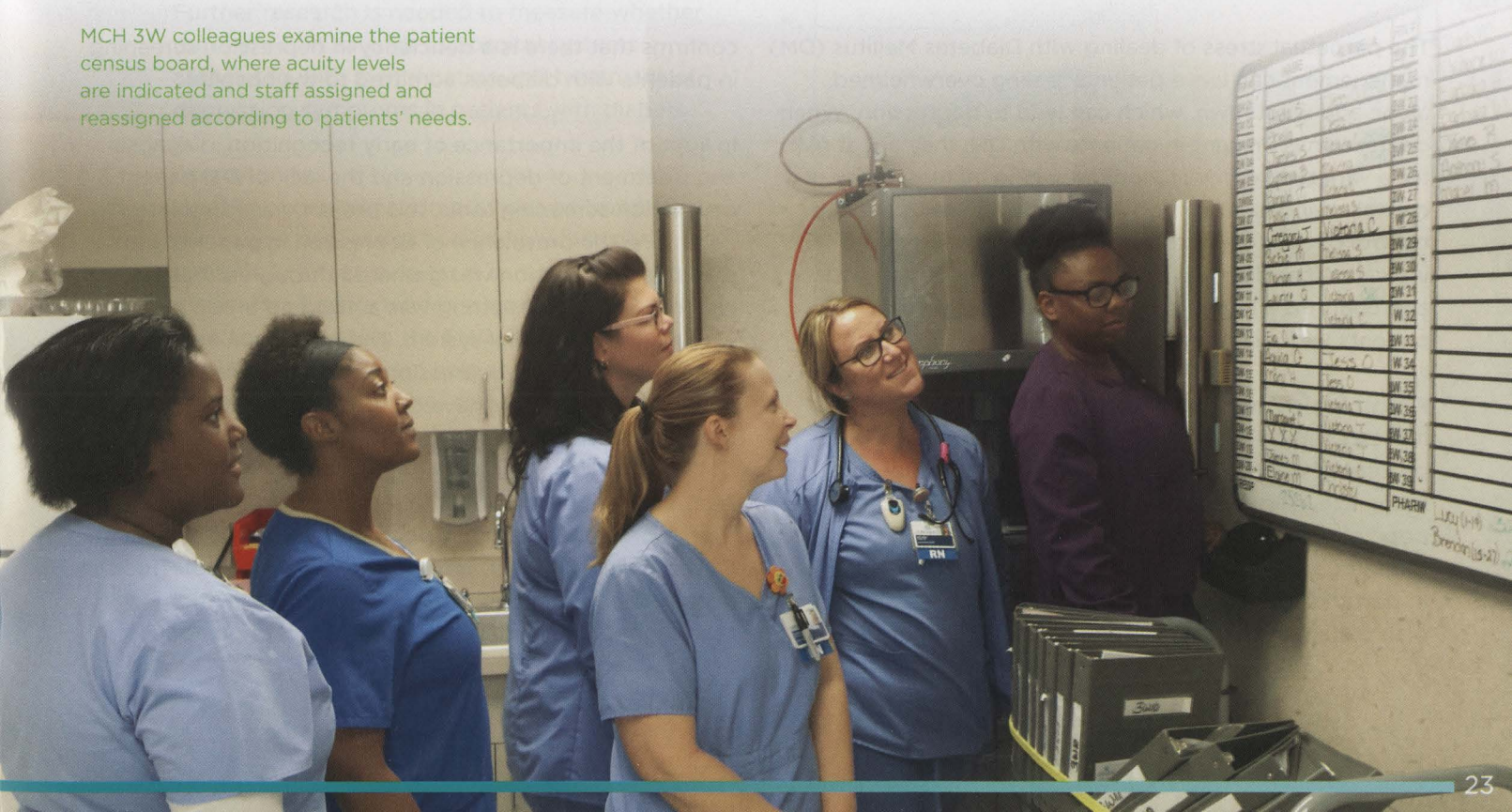
As a result of this project, satisfaction scores for patients and staff improved. The department has decreased the number of patient transfers to a step down unit significantly.

Staff members report increased confidence in caring for higher acuity patients. Nurses say they can be more flexible in their work flow now, because patient assignments can change during the shift as a result of the acuity based model. In a survey administered before and after their education, nurses reported being more comfortable caring for higher acuity patients, and some reported being more comfortable caring for specific urgent situations, such as patients with chest pain or atrial fibrillation with rapid ventricular response. There has also been improvement in the nurse retention rate.

Perhaps one of the best outcomes occurred in the relationships on the unit. **Jessica Honeycutt**, BSN, RN states, "It has been amazing to see the teamwork and comradery of everyone during the learning process and the ongoing work with levels of care on 3 West." ❖

Reference: American Sentinel University – Healthcare. How to Use the Acuity Based Staffing Model in Nursing. The Sentinal Watch, Nursing. February 5, 2014; http://www.americansentinel.edu/blog/2014/02/05/using-patient-acuity-to-determine-nurse-staffing/ Accessed Nov 7, 2016.

MCH 3W colleagues examine the patient census board, where acuity levels are indicated and staff assigned and reassigned according to patients' needs.



Marie Byrd, left, confers with colleagues Gina Ingle (social services) right, and Corinna Sullivan (physician) center.

MOSES CONE HOSPITAL

Sweet Sadness.... Identifying Depression in Diabetes

By Marie Byrd, MSN, RN, CDE

The perpetual stress of dealing with Diabetes Mellitus (DM) management can leave patients feeling overwhelmed, alone and withdrawn, which can lead to depression. When depression is present in patients with DM, they are at risk for a variety of complications including increased risk of mortality and lack of interest in managing self-care and control of their disease. A recent review of literature indicates that diabetes can double the risk of depression and confirms a high prevalence of depression among patients with diabetes.

Psychological assessment for diabetic patients

It is estimated that depression goes undiagnosed in 45 percent of patients with diabetes. It is important to recognize, diagnose and treat depression in the diabetes population. The American Diabetes Association (ADA) Standards of Care and literature review confirm the importance of integrating a psychological assessment and plan of care in patients with diabetes. The literature also confirms that there is a deficiency in depression screening in patients with diabetes admitted to the hospital.

In light of the importance of early recognition, diagnosis and treatment of depression and the lack of DM patient depression screening tools, this project was formulated to determine the prevalence of depression in patients with diabetes. Information was gathered through screening and history-taking. The setting was a 450 bed urban hospital within a multi-hospital system. The burning question was: "Would routine depression screening in hospitalized patients with diabetes have the potential to identify depressive symptoms?"

A cross-sectional design with random sampling was used for the project. Participants completed the Patient Health Questionnaire (PHQ-9) depression screening tool. Through history-taking they provided additional information regarding diabetes, depression and perception about

diabetes self-management behavior. The project included 232 inpatients who met the inclusion criteria.

Results

Results indicated a prevalence of depression in 48.8 to 61.6 percent of participants and found 29.7 percent of participants with no history of depression screened positive for depression symptoms. Further statistical analysis examined depression and length of time diagnosed with diabetes. That analysis revealed 25 percent of participants with diabetes for 6-10 years had the highest percentage of depression. It was also noted that 54.7 percent of patients with a Hemoglobin A1c over 8 percent screened positive for depression.

The results of the project demonstrate the need to screen routinely for depression among patients with diabetes. Additionally, continued work should occur to examine the long term effects of recognizing, diagnosing, and treating depression among patients with diabetes to determine if outcomes are improved for both conditions. Further research is needed to measure whether there are cost savings to hospital systems associated with identification and treatment of depression symptoms in patients with diabetes.

Opportunity

Inpatient hospitalization provides an opportunity for routine depression screening which can potentially affect long-term care management, general wellbeing, readmission rates and health care costs. By using the PHQ-9 to screen for depression, nurses can help resolve the issue of recognizing, diagnosing, and treating depression in the diabetes population. The integration of routine depression screening for all hospitalized patients has the potential to impact outcomes and quality of life for everyone living with a chronic disease. This benefits both the individual as well as society. ❖

When depression is present in patients with DM, patients are at risk for a variety of complications including increased risk of mortality and lack of interest in managing self-care and control of their disease. A recent review of literature indicates that diabetes can double the risk of depression and confirms a high prevalence of depression among patients with diabetes.

Setting the Pace
Graduations

DOCTORATE IN NURSING

Doctor of Nursing Practice
Stephanie Blake, ARMC NICU
Joshua Borders, ARMC-Elon Student Health
John Withrow, BH-Physician Services
Lobel Lurie, SW-Staff Education
Cameron Carlton, SW-Staff Education

Doctor of Philosophy – Nursing
Denise Rhew, SW-Clinical Nursing Support
Alexis Best-Rhodes, WHG-Mother Baby

Doctor of Caring Science
Marlienne Goldin, MCH 3MW

MASTERS IN NURSING

Elizabeth Edwards, APH Cancer Center
Nicole Small, APH-Endoscopy
Kristi Roberts, ARMC-Nursing Admin Lower Level
Wadiya Sterrett, ARMC-Ortho Rehab 1st level
Felicia Preudhomme, ARMC-Ortho Rehab 1st level
Vernicia Graves, ARMC-Gen Surgery-2nd level
Annie Hodges, ARMC-Urgent Care Mebane ASC
Denia Royster, ARMC-Emergency Room
Tanika Lewis, BH-Physician Services
Kelly Gibson, SW-Flexible Resources
Erin Zamora, SW-Flexible Resources
Katina Nichols, SW-Health at Work
Laura Stines, SW-Infection Prevention
Shannon Willis, SW-Inpatient Diabetes Program
Heather Welch, SW-MIS-Clinical Informatics
Theresa Morton, SW-Quality Informatics
Luke LaVecchia, SW-RN New Grad Academy
Heather Tripp, SW-Staff Education
Patricia Ness , SW-Staff Education
Amber Seiler, CVD-CV
Judy Burroughs, HSD-MC Surgery Center
Shayla Gray, HSD-MC Surgery Center
Wesley Webster, HSD-MC Surgery Center
Katherine Clark, LB-Primary Care Stoney Creek
Vickie Henson, LB-Primary Care Yanceyville
Ernest Dick, MHC-Electrophysiology Lab
Melissa Howdeshell, MHC-Flexible Resources
Judith Kome, MHC-CPCU
Carmen Minter, MHC-CPCU
Farrah Tarpley, MHC-CPCU
Janine Hammond, MHC-Div 2000-Cardiac Dept
Megan Piel, MHC-Div 2600-Stepdown Unit
Romana Hayes, MHC-Div 2900
Pamela Hawks, MHC-Operating Room
Sonja Davis, MHC-Operating Room
Jason Clum, MHC-The Stroke Center
Spenser Beasley, PDP-Piedmont Pediatrics
Lauren McDaniel, WHG-Birthing Suites
Heather Koran, WHG-Birthing Suites
Jonna Hunter, WHG-Mother Baby
LaWanda Gibbs-Staples, WHG-Mother Baby
Erin Lawrence, WHG-OB GYN Medicine
Heather Boelter, WLCH-CHCC-Advance Practice
Jason Upham, WLCH-Emergency Room
Natashia Broadnax, WLCH-Flexible Resources
Virginia Reynolds, WLCH-General Surgery
Jennifer Johnson, WLCH-Orthopedics
Katie Silk, WLCH-Orthopedics
Rachel Loftis, WLCH-Pre Admissions AM Admits

BACHELORS IN NURSING

Pamela Gillespie, AEC-EP Long-term 2nd floor
Heather Evans, AEC-EP Long-term 2nd floor
Lori Wade, AEC-TVAB Medical Clinic
Tracy Yoder, APH-Cancer Center
Sharley Hunnicutt, APH-Emergency Room
Lorrie Shore, APH-Emergency Room
Mindy Miller, APH-Emergency Room
Brenda Norman, APH-Emergency Room
Nedine Rowe, APH-Nursing ICCU
Raimondi Cummings, APH-Nursing ICCU
Mary Hawkins, APH-Nursing Unit 300
Christina Knight, APH-Nursing Unit 300
LaShawnna Rodgers, APH-Nursing Unit 300
Steven Woods, APH-Radiology Administration
Drusilla Jackson, ARMC-Onc Med Surg-1st level
Michele Williams, ARMC-ICU CCU-2nd level
Brooke Robertson, ARMC-Telemetry-2nd level
Charlotte Kyei, ARMC-Telemetry-2nd level
Tonya Cranford, ARMC-Gen Surgery-2nd level
Jeanna Denton, ARMC-Gen Surgery-2nd level
Tiffany England, ARMC-Special Care Neonatal
Courtney Greene, ARMC-Mother-Baby 3rd level
Laurie Neese, ARMC- Mother-Baby 3rd level
Jennifer Holmes, ARMC-Mother-Baby 3rd level
Brielle Burnett, ARMC-Mother-Baby 3rd level
Gary Barker, ARMC-Urgent Care Mebane ASC
Kimberly Cherry, ARMC-Emergency Room
Dallas Hurley, ARMC-Emergency Room
Tina Carr, ARMC-Emergency Room
Cheryl Rodrigues, ARMC-Emergency Room
Tiffany Johnson, ARMC-Emergency Room
Jill Cotrone-Shebestak, ARMC-Emergency Room
Jennifer Ingersoll, ARMC-Emergency Room
Delores Patterson, ARMC-Pain Management
Melody Tilley, ARMC-Operating Room

Brandy Kelly, ARMC-Operating Room
Misty Green, ARMC-Ambulatory Surgery
Candace Haizlip, ARMC-PACU
Penny Mcvey, ARMC-Endoscopy
Catherine Gaither, ARMC-Labor and Delivery
Jennifer Cummings, ARMC-Occupational Health
Eric Kaplan, BHC-Nursing
Gretchin Whelan, SW-Elink
Kristin Weddington, SW-Elink
Traci Zema, SW-Forensic Nursing Program
Sean Houle, SW-MIS-Clinical Informatics
Kimberly Hecker, CVD-CV Church Street
Theresa Masten, HSD-ED High Point MedCenter
Jessica Muckenfuss, HSD-ED High Point MedCenter
Jonathan Cook, HSD-ED High Point MedCenter
Sandra Shields, HSD-OP Wound Center
Pamela Caudell, HSD-WL Surgery Center
Jill Smith, LB-GI Endoscopy Center
Mary Teague, MCPS-Physent-Enterprise Admin
Joy Harmon, MC-5 Central Neuro Medic
Marcella Tom-Johnson, MC-5 Central Neuro Medic
Eunice Ofori, MC-5 Midwest Neuro Medic
Donna Niemela, MC-5 North Orthopedics
Chandler Thomas, MC-6 North Surgical
Nancy Irish, MC-6 North Surgical
Jamie Covington, MHC-Flexible Resources
Amy Sue Price, MHC-VAST and IV Nursing
Tasha Upham, MHC-3 East-CHF Telemetry
Tiffany Green, MHC-6100 Pediatrics
Paige Crown, MHC-6100 Pediatrics
Nicole Prescavage, MHC-6100 Pediatrics
Chelsea Garza, MHC-6100 Pediatrics
Kelly Donovan, MHC-6100 Pediatrics
Misty Faavesi, MHC-CARELink
Rebecca Berman, MHC-Clinical Decision Unit
Brittany Buckner, MHC-CPCU
Jessica Oddono, MHC-CPCU
Victoria Cummings, MHC-CPCU
Junris Parsons, MHC-Div 2000-Cardiac Dept
Kevin Dennis, MHC-Div 2300-Surgical ICU
Heather Bowman, MHC-Div 2300-Surgical ICU
Carolyn White, MHC-Div 2600-Stepdown Unit
Penny Shelton, MHC-Div 2900
Shanna Stowe, MHC-Div 2900
Elizabeth Moore, MHC-Div 3100-Neuro ICU
Katy Walton, MHC-Div 3100-Neuro ICU
Kami Moore, MHC-Div 6700-Med Renal Department
Andrew Brake, MHC-Div 6700-Med Renal Department
Jaclyn Watts, MHC-Emergency Department
Gabriella Santanella-Small, MHC-Emergency Department
Jennifer Gloster, MHC-Emergency Department
Victoria Philipps, MHC-Emergency Department
Cricket Hughes-Van Hoose, MHC-Emergency Department
Kristina Munnett, MHC-Emergency Department
Susanna Loudermilk, MHC-Emergency Department
Brittany Smith, MHC-Emergency Department
Eric Brewer, MHC-Emergency Department
Cassandra Albright, MHC-Emergency Department
Anna Reabold, MHC-Emergency Department
Kristyn Mills, MHC-Emergency Department
Michelle Beale, MHC-Emergency Department
Elisha Epperson, MHC-Infectious Dis OP Clinic
Katy Le, MHC-Med-Surg Telemetry 5500
Katie Brumagin, MHC-Med-Surg Telemetry 5500
Joseph Dixon, MHC-Operating Room
Lindsey Jones, MHC-Operating Room
Lisa Campbell, MHC-Operative Services Admin
Kelley Shyshko, MHC-Operative Services Admin
Janci Minor, THNM-THN CM Community
Stephanie Slade, WHG-Antenatal Unit
Kylie Wilson, WHG-Antenatal Unit
Erica Johnson, WHG-Birthing Suites
Veronica Mensah, WHG-Birthing Suites
Tracey Tucker, WHG-Birthing Suites
Jennifer Williard, WHG-Lactation Consultant
Christina Rossini Robinson, WHG-Maternity Admissions Unit
Stephanie Matthews, WHG-Mother Baby
Carmen Blair, WHG-Mother Baby
Sarah Riffey, WHG-Mother Baby
Tiffany Hicks, WHG-Neonatal ICU
Chassity Stewart, WHG-Operating Room
Jill Hamm, WHG-Women's Nursing Unit
Nakiyha Dumas, WLCH-5 East Medical Unit
Christine Brannock, WLCH-CHCC-Community Outreach
Margaret Morris, WLCH-CHCC-Medical Oncology
Mary Garner, WLCH-CHCC-Medical Oncology
Samantha Presnell, WLCH-CHCC-Radiation Oncology
Christina Infinger, WLCH-Emergency Room
Alaina Nease, WLCH-Emergency Room
Lynnsey Johnson, WLCH-Emergency Room
Haley Workman, WLCH-Emergency Room
Ajsa Khalid, WLCH-Emergency Room
Shelby Carpenter, WLCH-GI Lab Endoscopy
Michelle Reeves, WLCH-ICU Stepdown
Amy Arnold, WLCH-ICU Stepdown
Sonya Lamb, WLCH-Intermediate Urology
Valerie Stewart, WLCH-Intermediate Urology
Laurie Epperson, WLCH-Nursing Administration
Isatu Sesay, WLCH-Oncology West
Amy Fargo, WLCH-Orthopedics
Judy Cooper, WLCH-Short Stay
Irina Paolillo, WLCH-Sickle Cell Center ❖

Setting the Pace
Certifications

Congratulations to those who have attained certification during Fiscal Year 2016.

Jennifer Bailey, CCM, certified case manager, MHC - Div 4000 - IP Rehab
Heather Bowman, CWCA, certified wound associate, MHC-Div 2300-Surgical ICU
Andrew Brake, RN-BC, medical-surgical RN, MHC-Div 6700-Med Renal Departm
Caroline Brewer, C-EFM, electronic fetal monitoring, WHG-Maternity Admissions Unit
Natashia Broadnax, FNP-BC, family nurse practitioner-ANCC, WLCH-Flexible Resources
Diana Burleson, OCN, oncology certified nurse, WLCH-CHCC-Medical Oncology
Lacie Burton, OCN, oncology certified nurse, WLCH-CHCC-Medical Oncology
Benjamin Cassidy, CCRN, critical care RN, ARMC-ICU CCU-2nd level
Juan Claudio, CCRN, critical care RN, MHC-Med Surg ICU Unit
Brittany Clingan, PCCN-CMC, pccn card med subspec, ARMC-Telemetry-2nd level
LeeAnn Connors, RNC-OB, inpatient obstetric nursing, WHG-Birthing Suites
Nicholas Cranston, CNOR, certified nurse OR, MHC-Operating Room
Whitney Davis, PCCN, prog care nsg adult, MHC-Div3300-Intermed Care Unit
Laurie Deaton, CBN, certified bariatric nurse, WLCH-Bariatric Program
Theresa Delk, CNOR, certified nurse OR, WHG-Operating Room
Joseph Dixon, CNOR, certified nurse OR, MHC-Operating Room
Tracey Duncan, CNOR, certified nurse OR, WHG-Operating Room
Dawn Engels, CNS-BC, clinical nurse specialist-core, MHC-Woc Wound Ostomy Nurs
Dawn Engels, CWON, cert woc, MHC-Woc Wound Ostomy Nurs
Tracy Fast, RN-BC1, ambulatory care nursing, GWH-Variable
Doll Ferguson, CMSRN, certified medical-surgical RN, ARMC-Telemetry-2nd level
Judy Fields, COHN, cert occupational hlth nurse, HSD-Employer Health GSO
Roshanda Florance, CCM, certified case manager, THNM-THN CM Community
Lindsi Forte, WCC, wound care certified, MHC-Surgical Short Stay Ctr
Constance Foushee, RN-BC, medical-surgical RN, MC-5 North Orthopedics
Susan Frey, CFRN, certified flight RN, ARMC-Special Care Neonatal
Susan Frey, C-NPT, neonatal pediatric transport, ARMC-Special Care Neonatal
Susan Frey, CCRN, acute/crit carenrsing-neonatal, ARMC-Special Care Neonatal
Susan Frey, RNC-NIC, NICU nursing, ARMC-Special Care Neonatal
Marianna Furr, CCRN, critical care RN, MHC-Div 3100 - Neuro ICU
Juanita Futrell, CHFN, certified heart failure nurse, MHC-3 East-CHF Telemetry
Pamela Gillespie, GNC, geront nurse cert, AEC-EP Long-term 2nd floor
Melissa Goss, RNC-OB, inpatient obstetric nursing, WHG-Birthing Suites
Shantelle Greene, CMSRN, certified medical-surgical RN, ARMC-Gen Surgery-2nd level
Martha Gustaveson, CEN, certified emergency nurse, SW-Clinical Nursing Support
Janine Hammond, NP-C, adlt nurse practitioner-aanpcp, MHC-Div 2000-Cardiac Dept
Elizabeth Hawkins, RN-C, ARMC-PEDS-3rd level
Romana Hayes, NP-C, fam np-aanpcp, MHC-Div 2900
Annie Hodges, CNL, clinical nurse leader, ARMC-Urgent CR Mebane ASC
Georgianna Hodgin, CCRN, acute/critical care nursing-adult, HSD-ED High Point MedCenter
Adrienne Jacobs, ONC, orthopedic nurse certified, MC-5 North Orthopedics
Deedra Jamison, CEN, certified emergency nurse, MC-5 Midwest Neuro Medicine
Luke LaVecchia, CNL, clinical nurse leader, SW-RN New Grad Academy
Rita Law, CCM, certified case manager, LB-Wstrn Rock Fam Med- Madison
Monette Mabolo, NEA-BC, nrs exec adv, MHC-3 East-CHF Telemetry
Crystal Manus, CCRN, acute/criticalcarenrsing-adult, MHC-Med Surg ICU Unit
Steven Marshall, CBIS, cert brain injury specialist, WLCH-Oncology West

Pamela Martin, CMSRN, certified medical-surgical RN, MHC-Med-Surg Telemetry 5500
Chanin Maynard, CEN, certified emergency nurse, HSD-ED High Point MedCenter
Elizabeth McAtee, CCRN, acute/criticalcarenrsing-adult, MHC-Div 2300-Surgical ICU
Amy McDowell, NE-BC, nurse exec cna bc, ARMC-Mother-Baby 3rd level
Douglas Wayne McFatter, CNOR, certified nurse OR, MHC-Operative Services Admin
Leigh Miles, RN-BC, medical-surgical RN, ARMC-Gen Surgery-2nd level
Vicki Mobley, RN-BC, informatics nurse, SW-MIS-Clinical Informatics
Vickie Moore, CPAN, cert PACU nurse, ARMC-PACU
Benjamin Moore, CPEN - certified pediatric emergency nurse, SW-Flexible Resources
Kristina Munnett, CEN, certified emergency nurse, MHC-Emergency Department
Erin Pardini, RN-BC, medical-surgical RN, ARMC-ONC Med Surg-1st level
Jordan Perkins, CCRN, critical care RN, MHC-Div 2900
Kristin Phillips, OCN, oncology certified nurse, ARMC-ONC Chemotherapy ADM
Sophia Pickett, MSRN, MS NURSE, WLCH-Intermediate Urology
Megan Piel, NP-C, FAM NP-AANPCP, MHC-Div 2600-Stepdown Unit
Tonia Polite, NP-C, FAM NP-AANPCP, WLCH-5 East Medical Unit
Kelly Rassette, CMPE, cert medical practice exec, WHG-Outpatient Clinic
Denise Rhew, CCNS, acute/crit care CNS AACN, SW-Clinical Nursing Support
Hayley Rhode, OCN, oncology certified nurse, ARMC-Onc Chemo Admin
Jennifer Rimmer, SCRN, cert stroke RN, MC-5 Midwest Neuro Medic
Anabella Robinson, RN-BC, medical-surgical RN, ARMC-Gen Surgery-2nd level
Lauren Robinson, CCRN, critical care RN, MHC-Div 2300-Surgical ICU
Alexis Robinson, OCN, oncology certified nurse, WLCH-CHCC-Medical Oncology
Bernadette Roncallo, PCCN-CMC, PCCN card med subspec, MHC-Div 2600-Stepdown Unit
Luz Rosero, CWS, certified wound specialist, MHC - Div 4000 - IP Rehab
Nicole Simmons, CEN, certified emergency nurse, MHC-Emergency Department
Monica Smith, CNRN, certified neuroscience RN, MC-5 Central Neuro Medicine
Caleb Smith, CCRN, critical care RN, MHC-CARELink
Bonnie Smith, VA-BC, vasc access-board certified, MHC - VAST and IV Nursing
Janice Smith, CHPN, cert hospice and palliative care nurse, WLCH-ICU Stepdown
Tim Smith, CEN, certified emergency nurse, WLCH-Emergency Room
Valerie Stewart, RN-BC, medical-surgical RN, WLCH-Intermediate Urology
Debra Stowe, SCRN, cert stroke RN, MHC-The Stroke Center
Ashley Strader, RN-BC, psych/mental health nurse, BH-IP Adult Services
Tiffany Tatum, CMSRN, certified medical-surgical RN, WLCH-Sickle Cell Center
Amber Thomas, CMSRN, certified medical-surgical RN, ARMC-Gen Surgery-2nd level
Lisa Thomas, A-GNP, adult-geront primary care NP, WLCH-CHCC-Advance Practice Pro
Amy Tippett, RN-BC, medical-surgical RN, ARMC-PACU
Donna Trotter, CEN, certified emergency nurse, SW-Office of Patient Experience
Lindsay Vance, PCCN, progressive care nursing adult, WLCH-Flexible Resources
Jacqueline Vickers, CEN, certified emergency nurse, ARMC-Nurse Admin lower level
Sara Wall, CIC, certified infection control, SW-Infection Prevention
Kristin Wiggins, CNOR, certified nurse OR, ARMC-OPERATING ROOM
Ryan Wilkinson, CCRN-CMC, critical care RN with cardiac med, MHC-Div 2300-Surgical ICU
Leslie Williams-James, CMSRN, certified medical-surgical RN, WLCH-General Surgery
Lisa Yow, CNML, certified nurse manager and leader, MHC-Div 2900 ❖

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Can a Geriatric Workshop for Emergency Nurses Change their Knowledge, Attitudes and Behaviors in Caring for Older Adults?

Denise Rhew, PhD, RN, CNS, CEN

Further research should focus on identifying exactly what knowledge gaps exist among ED nurses and what factors influence their attitudes toward caring for older adult patients.

From 2000-2010 the number of persons in the United States aged 65 and over rose from 35 million to 40.3 million. In 2010 this age group represented 13 percent of the population and the percentage continues to increase. Given their growing proportion of the population, older individuals will comprise an increasing share of emergency department (ED) patients in coming years (www.cdc.gov). The purpose of this study was to explore the effect of an educational intervention on attitudes and knowledge of ED nurses toward the older adult.

A quasi-experimental design, the study used a non-randomized convenience sample. There were 67 participants from the five Cone Health EDs (control sample size = 23, intervention sample size = 44). No statistically significant differences in the characteristics of the control and intervention groups were identified. Of note, 81 percent of the nurses in both groups reported not having received specialized geriatric education previously.

Both the experimental and control groups received three online surveys measuring knowledge and attitudes. The experimental group attended a geriatric workshop (educational intervention) and completed the online pre-survey and an immediate post-survey at the workshop in a reserved computer room. The control group (no educational intervention) completed an online pre-survey and immediate post-survey at their convenience on the same day the geriatric workshop was being offered. Both the experimental and control groups received an additional online survey four weeks after the date of the geriatric workshop.

Although not statistically significant, data analysis showed a positive effect of the educational intervention on ED nurses' knowledge of and attitude toward geriatric patients. The four-week follow-up survey demonstrated continued positive attitudes and knowledge scores remained higher than at the pre-intervention.

Further research should focus on identifying exactly what knowledge gaps exist among ED nurses and what factors influence their attitudes toward caring for older adult patients. ❖

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Reaching into the Looking Glass...
and Pulling Out a Diabetes Scoring Tool

Jenny Simpson, MSN, RN, BC-ADM; Marsena Pardee, BSN, RN-BC, MHA; Susan Strauss, RPh

Diabetes and hyperglycemia are risk factors for increased length of stay (LOS), infection, complications and mortality for hospitalized patients. The inpatient diabetes program at Cone Health is comprised of an innovative and unique team of clinical nurse specialists, certified RNs and dieticians who specialize in the care of patients with both diabetes and hyperglycemia.

Prior to the implementation of EPIC as our electronic medical record, the team used lab reports to identify patients with diabetes, hyperglycemia and hypoglycemia. Most of the lab reports were only available every 24 hours, which too often caused a lag in both identification of and interventions for at-risk patients. When Cone Health "went live" with EPIC, the inpatient diabetes program nurses began searching for an efficient system both to identify high risk patients and to keep internal notes on patients. Using evidence-based resources and standards of care, the team devised criteria for a scoring tool to identify patients needing daily assessment by the team. Criteria included hyperglycemia (blood glucose >180 mg/dL), hypoglycemia (blood glucose <70 mg/dL), elevated hemoglobin A1C, use of insulin drips, diabetes ketoacidosis (DKA), oral diabetes agents, Type 1 diabetes and ICU hyperglycemia.

The diabetes scoring system was developed in collaboration with the pharmacy and EPIC build teams. Patient scores are calculated based on the presence of the criteria listed above. For example, the higher the A1C or blood glucose level, the higher the patient's score on the tool. Further, if a diabetes team consult is requested, this is reflected immediately in the scoring tool.

This tool allows for quick and real-time identification of patients needing to be seen by the diabetes team. The tool is dynamic and updates almost continuously based on new admissions, new glucose or other lab values, changes in patient locations and even new medications such as insulin drips and U500 insulin. The ability to prioritize patients is a key component of the scoring tool. Patients can be quickly sorted by their score and the higher scored patients evaluated first. The tool has eliminated the need to print and save internal paper documentation. All notes are in the electronic medical record and can be accessed by the team at any time. The diabetes scoring tool has allowed the diabetes team to intervene earlier and more globally, ensuring the highest quality of care for diabetes patients. ❖

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Evaluation of Health Literacy as a Predictor of the Need for Additional Medical Care

Cameron Elgin Carlton, DNP, RN-BC; Maren J. Coffman, PhD, RN, CNE; Kathleen Jordan, DNP, RN, MS, FNP-BC, ENP-BC, SANE-P; Olugbemiga E. Jegede, MD; Kathryn Foster, MSN, RN

In the current healthcare environment, hospitals are under intense pressure to transition patients from acute care to outpatient settings, allowing little time for patient education. There is little time to identify patients and families who may be challenged with understanding health-related information. In order to improve health outcomes, patients and their caregivers must understand medical information and self-care instructions provided to them.

The purpose of this study was to utilize the Single Item Literacy Screen (SILS) and the Newest Vital Sign (NVS) to identify participants with limited reading ability and/or low health literacy in an outpatient primary care clinic, and to determine if health literacy level and reading skills predicted higher healthcare utilization.

Methodology included participant assessment and medical record review. Participants were evaluated on the initial visit utilizing the SILS and NVS to establish their literacy level. The SILS asks one question, "How often do you need to have someone help you when you read instructions, pamphlets or other written material from your doctor or pharmacy?" The NVS involves giving the patient a specially designed ice cream label to review and asking six questions that require both reading and mathematical skills.

Following the initial visit and literacy assessment, a medical record review was performed to evaluate the participant's compliance with attending their scheduled follow-up visit, as well as the evaluation of any additional visits to the emergency department, urgent care or clinic.

Although there was not a statistically significant difference in health care utilization between participants identified as having low health literacy and those with adequate health literacy, useful information was discovered. For all participants in the project, more than 63 percent of scheduled follow-up visits were no-shows and 50 percent of participants had unplanned, unrelated visits. Participants' inability to navigate the health care system was evident in this project. Data showed that patients considered their ability to read and understand health related information at a much higher level than was actually determined by testing. Results suggest that a patient's health literacy may be an indication of their use of medical care. Patient education, information and direction regarding the effective and efficient use of medical resources is needed in order for patients to receive care in the appropriate setting. ❖

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Scrubbing Away the Barriers to Hand Hygiene on an Inpatient Nephrology Nursing Unit

Allyson Kirkman, MSN, RN-BC, RN 3; Kim Gengler, RN-BC, WTA; Danyel Johnson, MSN, RN, CNN, CNS; Ryanne Hill, BSN, RN-BC, RN 3; Tamara Caple, MSN, MBA, RN, CNML

Exposure to healthcare-acquired infections (HAIs) is a risk end-stage renal disease (ESRD) patients encounter when hospitalized. Unfortunately many ESRD patients are hospitalized at least once a year. Since they are immunocompromised, they are four times more vulnerable to *C. diff* infections and are 100 times more susceptible to sepsis than the general population. Current literature reports a strong correlation between decreased hand hygiene and HAIs. Infections acquired in acute care settings adversely affect health care costs, length of stay and, for hemodialysis patients, carry a 23 percent mortality rate.

After discovering their hand hygiene compliance rate was only 50 percent, the nursing staff on Moses Cone Hospital unit 6E, a nephrology/medical-surgical/telemetry unit, embarked on an evidence-based practice project to increase compliance and prevent further complications in their already fragile patient population.

An interprofessional team was formed, comprised of infectious disease physicians, infection prevention specialists, a clinical nurse specialist and nursing staff members of the nursing unit. A peer education plan was developed and implemented to educate unit staff on appropriate hand hygiene practice and to validate proper technique. Literature supports the use of peer education to implement practice changes because it empowers staff, is more readily accepted and leads to actual integration into practice.

Mandatory classes were provided and a competency checklist was created to validate retention of information. Staff were surveyed to assess perceived barriers to consistent hand hygiene. These barriers, including inconveniently located gel dispensers and frequently empty dispensers, were addressed. Staff participated in activities such as viewing their hands under a black light before and after washing, and examining Petri dishes of bacteria collected from their own hands before and after cleaning and after touching common items like pens, phones and keyboards. Random audits of hand hygiene compliance were conducted during the campaign. Staff observed cleaning their hands were awarded "Thank You Tickets."

Hand hygiene compliance among staff peaked at 93 percent. Non-unit staff (physicians, dietary staff, transporters, etc.) who did not receive the intervention remained low at 51%. A modified version of the intervention was shared with all health system staff members encountering ESRD patients.

After 18 months, this program demonstrated a hand hygiene compliance rate of 90 percent for the nephrology unit staff and 86 percent for non-unit staff. A culture change involving hand hygiene responsibility and accountability has proven sustainable for this nephrology unit. ❖

CONTRIBUTING TO NURSING SCIENCE

Individual Monitoring Increases Hand Hygiene Compliance in Multicenter Registry Utilizing Badge-Based Locating Technology

Jessica Buckner, MSN, RN, AGCNS-BC, Cone Health; Megan Read, MPH, MLS,CIC, Dartmouth Hitchcock Medical Center; Liberty Dykehouse, MSN, RN, ACNS-BC, CIC, Mercy Health Saint Mary's

Hand hygiene (HH) is a key component of infection prevention. Historically, direct observation has been used to measure compliance, but it is subject to inaccuracy due to limited observations recorded and the Hawthorne effect (changes in behavior due to awareness of being observed). Badge-based technology using a real-time locating system (RTLS) provides continuous monitoring of HH compliance, and offers feedback to the caregiver that can be customized by staff group, individual, room or time.

This study evaluated the impact of implementing an automated badge-based RTLS HH monitoring system with individual feedback on HH compliance rates across multiple hospitals. Objectives of the study included comparing direct observation HH compliance rates with electronic monitor system compliance rates, and evaluating group versus individual feedback methods.

After installation of the RTLS system, an ongoing registry collected over 80 months of real-world HH compliance data from three hospitals, capturing data at room entry and exit. Compliance rates were also collected following education, after group level feedback and following individual feedback.

The dramatic difference between HH compliance assessed by direct observation and baseline compliance recorded by an automated system demonstrates the inaccuracy of direct observation. Prior to installing the badge-based monitoring system, monthly HH compliance rates determined by direct observation were between 79-96 percent. However, actual baseline compliance measured by the automated system was 48 percent. Each of the three sites demonstrated a large difference between compliance rates reported by direct observation and those determined by the automated system.

With group feedback/reporting, HH compliance increased to 56 percent. Individual feedback/reporting raised HH compliance in all sites to greater than 80 percent. HH monitoring systems that are not capable of individual feedback may limit the increase in compliance. This study showed that individual monitoring using RTLS technology provides a reliable measure of HH compliance. ❖

From the **Editor**

This fall we refined the peer review process that is part of our annual performance appraisals. We made revisions to the tool we used last year after receiving over 900 responses about what worked and what didn't following last year's survey. By expecting peer review of all licensed RNs in the Cone Health network, we are meeting a high standard for professionalism in nursing.

Last year our nursing leaders took this professionalism one step further. Instead of just participating in peer review, they decided to incorporate a suggestion made to us by our Magnet appraisers - that of transparency. The high level bar for peer review is not just that we do it, but that we are able to see and accept what others say about us in a process that is transparent and open. Last year, and again this year, our nursing leaders opened their minds, and their vulnerability, and had peer review conversations with each other.

The high level bar for peer review is not just that we do it, but that we are able to see and accept what others say about us in a process that is transparent and open.

So, think about this for a moment. Not only was a peer asked for feedback, but that feedback was delivered face-to- face in a personal interchange. This laid responsibility on both parties: on the reviewer to be honest, straightforward and kind in delivering feedback, and on the receiver to be willing to hear what was said as an offering for a better practice and not as personal criticism.

Not many of us can handle these kinds of conversations easily - as the reviewer or the receiver. Yet the process challenges us to move into higher ground when considering our nursing practice. Can we put ourselves aside for just a moment and see what possibilities there might be? Have we spent enough time in self-reflection to know what our true strengths are, and that we have many of them, so we can receive with balance something that might make us better? In the pressure cooker of our work, with constant demands on our time and attention, can we keep holding onto that iCare value of 'Respect,' which reminds us "I will assume the best of intentions and embrace differences."

Cone Health nursing is opening its next chapter. What if we deepen in our culture the presence of respect and professionalism that naturally starves out horizontal violence, gives us renewed courage to speak up about things that are wrong and things we value, and moves us into a space where we can talk to each other as reviewers and receivers with the same kindness and compassion we show our patients and their families? It won't necessarily be easy, but when has that stopped us before? ❖

Sarah

Sarah Lackey, RN, DNP, CCNS, Editor-in-Chief
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Editors

Nursing Beat

MISSION STATEMENT

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Author Bios

Marie Byrd, MSN, RN, CDE, inpatient diabetes coordinator and certified diabetes educator, has a passion for understanding the impact of depression on the diabetic patient population. She has presented locally and nationally on this topic, most recently at the 2016 American Association of Diabetes Educators Conference.

Lindsay Draper, MSN, RN, MBA, Wesley Long 5E Medical, is a certified medical/surgical RN. She is interested in bridging the knowledge gap nurses may have in the treatment of medical/mental health patients.

Faith-Marie Hasz, BSN, RN3, CEN, Wesley Long Emergency Department, is enrolled in a family nurse practitioner program. She has a particular interest in sepsis, a topic on which she presented at the 2016 Cone Health Nursing Research Day.

Jessica Honeycutt, BSN, RN, has been a Cone Health nurse for over three years. She works at Moses Cone Hospital on department 3W. When Honeycutt finished her nursing degree at the University of North Carolina, Charlotte, she was hired by Cone Health and completed the medical/surgical new graduate academy before taking a clinical position on 3W.

Heather Koran, MSN, RN4, CNL, RNC-OB, Women's Hospital Maternal Admissions Unit, has a specialization as a Clinical Nurse Leader. She is interested in all areas of maternal and infant health.

Jill Moore, BSN, RN3, RN-C, is a clinical nurse with 30 years' experience with medical/surgical, trauma and palliative care nursing. She works at Moses Cone Hospital on department 6N. She has a particular interest in working with breast cancer patients.

Robyn Wofford, MSN, RN4, PCCN, has 28 years of progressive and medical/surgical nursing experience. She was instrumental in ensuring the RN's on 3W at Moses Cone Hospital were competently prepared in caring for higher level of acuity patients.

Jean Wolf, MSN, RN, OCN, Wesley Long Hospital, is the assistant director for 3W Oncology. She finds the topic of lateral violence pertinent and time sensitive. Having worked in Oncology for 24 years, all at Cone Health, she is determined to improve work relationships to impact job satisfaction.